Care Plus Bergen, Inc.

Financial Statements
Years Ended December 31, 2020 and 2019

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Contents

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Independent Auditor's Report

The Board of Directors
Care Plus Bergen, Inc.
Paramus, New Jersey

Opinion

We have audited the accompanying financial statements of Care Plus Bergen, Inc. (the Organization), which comprise the statements of financial position as of December 31, 2020 and 2019, and the related statements of operations and cash flows for the years then ended, and the related notes to the financial statements.

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the Organization as of December 31, 2020 and 2019, and the changes in its net deficit and its cash flows for the years then ended, in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the *Auditor's Responsibilities for the Audit of the Financial Statements* section of our report. We are required to be independent of the Organization and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Organization's ability to continue as a going concern within one year after the date that the financial statements are issued or available to be issued.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and, therefore, is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit 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 Organization's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Organization's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

BDO USA, LLP

June 29, 2021

Care Plus Bergen, Inc.

Statements of Financial Position

December 31,	**2020**	2019
Assets		
Current Assets		
Cash and cash equivalents	**$ 25,276,776**	$ 879,991
Patient escrow funds	**875,196**	607,507
Patient accounts receivable, net	**16,740,294**	20,689,813
Long-term care pharmacy receivable, net	**262,821**	424,028
Due from third-party payors	**19,020,643**	11,812,104
Grants receivable	**9,031,138**	-
Due from Bergen County Improvement Authority	**1,216,056**	246,663
Inventories	**2,143,941**	1,977,735
Prepaid expenses and deposits	**2,383,547**	2,526,850
Total Current Assets	**76,950,412**	39,164,691
Fixed Assets, Net	**18,052**	30,797
Total Assets	**$ 76,968,464**	$ 39,195,488
Liabilities and Net Deficit		
Current Liabilities		
Accounts payable and accrued expenses	**$ 12,559,848**	$ 16,059,164
Accrued salaries, benefits and other payroll liabilities	**8,666,670**	7,888,237
Due to Bergen County Improvement Authority	**18,710,528**	1,123,185
Deferred revenue – contract liability	**1,017,751**	1,318,426
Government contract liability	**21,873,713**	-
Patient escrow funds	**875,196**	607,507
Due to third-party payors	**4,358,890**	4,897,045
Total Current Liabilities	**68,062,596**	31,893,564
Notes Payable – Bergen County Improvement Authority	**20,823,681**	20,823,681
Total Liabilities	**88,886,277**	52,717,245
Commitments and Contingencies (Note 8)		
Net Deficit		
Without donor restrictions	**(11,917,813)**	(13,521,757)
Total Liabilities and Net Deficit	**$ 76,968,464**	$ 39,195,488

See accompanying notes to financial statements.

Care Plus Bergen, Inc.

Statements of Operations

Year ended December 31,	**2020**	2019
Net Patient Service Revenue	**$ 157,635,087**	$ 161,647,014
Other Support		
Subsidy revenue	**18,904,375**	33,135,747
Pandemic relief grant income	**72,367,954**	-
Other revenue	**6,198,020**	11,663,819
Total Net Patient Service Revenue and Other Support	**255,105,436**	206,446,580
Expenses		
Salaries and wages	**122,383,134**	121,447,978
Employee benefits and related services	**25,680,061**	25,948,122
Supplies and other expenses	**86,007,168**	69,468,210
Total Expenses	**234,070,363**	216,864,310
Net Operating Income (Loss), before rent expense, interest expense, and depreciation	**21,035,073**	(10,417,730)
Rent Expense	**18,931,570**	-
Interest Expense	**486,814**	769,459
Depreciation	**12,745**	12,745
Change in Net Deficit Without Donor Restrictions	**1,603,944**	(11,199,934)
Net Deficit Without Donor Restrictions, beginning of year	**(13,521,757)**	(2,321,823)
Net Deficit Without Donor Restrictions, end of year	**$ (11,917,813)**	$ (13,521,757)

See accompanying notes to financial statements.

Care Plus Bergen, Inc.

Statements of Cash Flows

Year ended December 31,		**2020**		2019
Cash Flows from Operating Activities				
Change in net deficit without donor restrictions	**$**	**1,603,944**	$	(11,199,934)
Adjustments to reconcile change in net deficit without donor restrictions to net cash provided by operating activities:				
Depreciation		**12,745**		12,745
Changes in operating assets and liabilities:				
Patient accounts receivable		**3,949,519**		14,125,014
Long-term care pharmacy receivable		**161,207**		(64,499)
Due from/to third-party payors		**(7,208,539)**		44,257
Grants receivable		**(9,031,138)**		-
Due from/to Bergen County Improvement Authority		**16,617,950**		(1,936,879)
Inventories		**(166,206)**		(67,195)
Prepaid expenses and deposits		**143,303**		366,385
Accounts payable and accrued expenses		**(3,499,316)**		2,541,373
Accrued salaries, benefits and other payroll liabilities		**778,433**		(592,766)
Deferred revenue – contract liability		**(300,675)**		138,013
Government contract liability		**21,873,713**		-
Patient escrow funds		**267,689**		112,772
Due to third-party payors		**(538,155)**		-
Net Cash Provided by Operating Activities		**24,664,474**		3,479,286
Cash Flows from Financing Activities				
Repayments of notes payable – Bergen County Improvement Authority		**-**		(17,476,972)
Proceeds from notes payable – Bergen County Improvement Authority		**-**		13,300,000
Net Cash Used in Financing Activities		**-**		(4,176,972)
Net Increase (Decrease) in Cash, Cash Equivalents, Restricted Cash, and Restricted Cash Equivalents		**24,664,474**		(697,686)
Cash, Cash Equivalents, Restricted Cash, and Restricted Cash Equivalents, beginning of year		**1,487,498**		2,185,184
Cash, Cash Equivalents, Restricted Cash, and Restricted Cash Equivalents, end of year	**$**	**26,151,972**	$	1,487,498
Supplemental Disclosure of Cash Flow Information				
Interest paid	**$**	**486,814**	$	769,459

See accompanying notes to financial statements.

1. Description of the Organization

Care Plus Bergen, Inc. (the Organization) is a nonprofit corporation located in Paramus, New Jersey. The Organization was formed to serve as the special-purpose vehicle to operate and manage Bergen New Bridge Medical Center (Bergen New Bridge or the Medical Center) as the Tenant-Operator, pursuant to a certain Sublease, Lease, and Operating Agreement (SLOA) signed on July 14, 2017 with the Bergen County Improvement Authority (BCIA) as the Lessor. BCIA is a public body corporate and politic, created by the governing body of Bergen County, New Jersey. The Organization entered into a 19-year agreement to operate the Medical Center and commenced operations on October 1, 2017. Upon expiration of the contract, substantially all of the Organization's revenue and a significant portion of the expenses will be discontinued.

Bergen New Bridge is a county-owned, 1,070-bed acute care hospital that provides acute care, long-term care, behavioral health, and other related healthcare and medical services. BCIA holds all the necessary licenses to operate Bergen New Bridge, which is the fourth largest publicly owned hospital in the country. Bergen New Bridge is located in Paramus, New Jersey and is one of the largest medical resources for behavioral health patients and residents and is a safety-net provider for the mentally impaired, elderly, and uninsured and underinsured in the state of New Jersey.

Bergen New Bridge is operated and managed by the Organization, a New Jersey nonprofit corporation that is contracted with three third-party-operators (service line managers), comprised of Care Plus NJ, Inc. and Integrity House—both New Jersey nonprofit corporations, exempt from federal income tax under Section 501(c)(3) of the Internal Revenue Code (the Code)—and Rutgers New Jersey Medical School (NJMS), an unincorporated unit of Rutgers, the State University of New Jersey (Rutgers), an instrumentality of the State of New Jersey. The Organization has been charged with and is committed to (1) providing quality healthcare to residents of Bergen County; (2) providing a healthcare safety net for the elderly, indigent, and those in need of emergency services; (3) improving access for Veteran's Affairs services; (4) adapting to the changes in the healthcare market; and (5) providing quality healthcare services in a cost-efficient manner.

Both Care Plus NJ, Inc. and Integrity House provide strategic direction related to behavioral health services. This includes programmatic changes and billing optimization for inpatient services, among other expertise and support to the Organization.

Rutgers, on behalf of its unincorporated unit NJMS, provides clinical and administrative support for clinical and physician leadership for the Medical Center.

For the year ended December 31, 2020, the Organization reported net income of $1,603,944, which decreased the net deficit as of December 31, 2020 to $(11,917,813). As of December 31, 2020, cash and cash equivalents was $25,276,776 and cash provided by operations for the year ended December 31, 2020 was $24,664,474. Based on the Organization's business plan, existing cash resources, revenues generated from operations, allocation of monies to the Organization from the Coronavirus, Relief, and Economic Security Act (the CARES Act), and certain qualified reimbursable expenses from Federal Emergency Management Agency (FEMA), the Organization expects to satisfy its working capital requirements for at least 12 months and a day after the date that these financial statements are issued. However, if performance expectations fall short or expenses exceed budget, the Organization has the ability to adjust its operating plan levels accordingly. Please reference Note 12 for a detailed discussion of the impact of COVID-19 and the CARES Act funding.

2. Summary of Significant Accounting Policies

Basis of Presentation

The financial statements of the Organization have been prepared on the accrual basis and conform to accounting principles generally accepted in the United States of America (U.S. GAAP). In the statements of financial position, assets and liabilities are presented in order of liquidity or conversion to cash and their maturity resulting in the use of cash, respectively.

Financial Statement Presentation

The classification of a not-for-profit organization's net assets and its support, revenue, and expenses is based on the existence or absence of donor-imposed restrictions. It requires that the amounts for each of two classes of net assets—without donor restrictions and with donor restrictions—be displayed in the statement of financial position and that the amounts of change in each of those classes of net assets be displayed in the statement of operations.

The classes of net assets are defined as follows:

With Donor Restrictions - This class consists of net assets resulting from contributions and other inflows of assets whose use by the Organization is limited by donor-imposed stipulations that either expire by passage of time or can be fulfilled and removed by actions of the Organization, pursuant to those stipulations. When such stipulations end or are fulfilled, such donor-restricted net assets are reclassified to net assets without donor restrictions and reported in the statements of operations. Net assets resulting from contributions and other inflows of assets whose use by the Organization is limited by donor-imposed stipulations that neither expire by passage of time nor can be fulfilled or otherwise removed by actions of the Organization are classified as net assets with donor restrictions - perpetual in nature.

Without Donor Restrictions - This class consists of the part of net assets that is not restricted by donor-imposed stipulations.

As of December 31, 2020 and 2019, the Organization had no donor-restricted net assets.

Cash and Cash Equivalents

The Organization considers all highly liquid financial instruments with maturity dates of three months or less from the date purchased to be cash equivalents, excluding assets whose use is limited.

Restricted Cash and Cash Equivalents

The Organization is required to maintain escrow funds for its long-term care residents. These accounts are funded by patients to help them cover any extra expenses incurred as long-term care residents. When the resident leaves the facility, any unspent funds must be returned to the resident or the resident's estate within 30 days.

The following table provides a reconciliation of cash, cash equivalents, restricted cash, and restricted cash equivalents reported within the statements of financial position that sums to the total of the cash, cash equivalents, restricted cash, and restricted cash equivalents shown in the statements of cash flows:

December 31,	**2020**	2019
Cash and cash equivalents	**$ 25,276,776**	$ 879,991
Patient escrow funds	**875,196**	607,507
Total	**$ 26,151,972**	$ 1,487,498

Fair Value Measurements

U.S. GAAP defines fair value, establishes a framework for measuring fair value and expands the disclosures about fair value measurements. U.S. GAAP defines fair value as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date in a principal or most advantageous market. Fair value is a market-based measurement that is determined based on inputs, which refer broadly to assumptions that market participants use in pricing assets or liabilities. These inputs can be readily observable, market corroborated, or unobservable. U.S. GAAP established a fair value hierarchy, which prioritizes the inputs to valuation techniques used to measure fair value in three broad levels. The standard requires that assets and liabilities be classified in their entirety based on the level of input that is significant to the fair value measurement. Assessing the significance of a particular input may require judgment considering factors specific to the asset or liability and may affect the valuation of the asset or liability and their placement within the fair value hierarchy. The Organization classifies fair value balances based on the fair value hierarchy defined by U.S. GAAP as follows:

Level 1 - Valuations are based on observable inputs that reflect quoted market prices in active markets for identical investments at the reporting date.

Level 2 - Valuations are based on (i) quoted prices—those investments, or similar investments, in active markets; (ii) quoted prices—those investments, or similar investments, in markets that are not active; or (iii) pricing inputs other than quoted prices that are directly or indirectly observable at the reporting date. Level 2 assets include those investments or similar investments that are redeemable at or near the statement of financial position date and for which a model was derived for valuation.

Level 3 - Valuations are based on pricing inputs that are unobservable and include situations where (i) there is little, if any, market activity for the investments; (ii) the investments cannot be independently valued; or (iii) the investments cannot be immediately redeemed at or near the fiscal year-end.

Use of Estimates

The preparation of financial statements in conformity with U.S. GAAP requires management to make estimates and assumptions that affect the reported amounts of assets, including estimated uncollectibles for accounts receivable for services to patients and residents, and liabilities, including estimated payables to third-party payors, and disclosures of contingent assets and

liabilities at the date of the financial statements. Estimates also affect the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates.

Patient Accounts Receivable and Revenue Recognition

Revenue Recognition

Effective January 1, 2019, upon the adoption of the Financial Accounting Standards Board's (FASB) Accounting Standards Update (ASU) 2014-09, *Revenue from Contracts with Customers (Topic 606)* (ASC 606), net patient service revenue is reported at the amount that reflects the consideration to which the Organization 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 include variable consideration (reductions to revenue) for retroactive revenue adjustments due to settlement of ongoing and future audits, reviews, and investigations.

The Organization 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 major payor classes and types of services provided for outpatient revenue. Based on historical collection trends and other analyses, the Organization 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 Organization's initial estimate of the transaction price for services provided to patients subject to revenue recognition is determined by reducing the total standard charges related to the patient services provided by various elements of variable consideration, including contractual adjustments, discounts, implicit price concessions, and other reductions to the Organization's standard charges. The Organization 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 in Note 3). The estimates for contractual allowances and discounts are based on contractual agreements, the Organization's discount policies, and historical experience. For uninsured and under-insured patients who do not qualify for charity care, the Organization 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 Organization's historical collection experience for applicable patient portfolios. Under the Organization's charity care policy, a patient who has no insurance or is under-insured and is ineligible for any government assistance program has his or her bill reduced to (1) the lesser of charges or the Medicare diagnostic-related group for inpatient and (2) a discount from Medicare fee-for-service rates for outpatient. Patients who meet the Organization's criteria for charity care are provided care without charge; such amounts are not reported as revenue.

Generally, the Organization 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 Organization. Net patient service revenue for performance obligations satisfied over time is recognized based on actual charges incurred in relation to total charges. The Organization 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 Organization's outpatient settings.

The Organization 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.

As substantially all of its performance obligations relate to contracts with a duration of less than one year, the Organization has elected to apply the optional exemption provided in ASC 606 and, therefore, is not required to disclose the aggregate amount of the transaction price allocated to performance obligations that are unsatisfied or partially unsatisfied at the end of the reporting period.

Contract Assets and Contract Liabilities

In accordance with ASC 606, contract assets are to be recognized when an entity has the right to receive consideration in exchange for goods or services that have been transferred to a customer when that right is conditional on something other than the passage of time. The Organization does not recognize contract assets, as the right to receive consideration is unconditional in accordance with the passage of time criteria. Also, in accordance with ASC 606, contract liabilities are to be recognized when an entity is obligated to transfer goods or services for which consideration has already been received.

Subsidy Revenue

The New Jersey Department of Health (DOH) operates the Delivery System Reform Incentive Payment (DSRIP) program, which is designed to result in better care for individuals, better health for the population, and lower costs by transitioning hospital funding. As of December 31, 2020 and 2019, amounts due from DSRIP totaled $2,173,791 and $10,427,981, respectively. DSRIP is funding from the government that drives the initiatives that will support payment reform and transition away from fee-for-service payments toward alternative payment arrangements that reward high-quality, efficient, and integrated systems of care. To support continued population health improvement across New Jersey following the conclusion of DSRIP program on June 30, 2020, the State had planned to implement the Quality Improvement Program (QIP) promoting the health of New Jersey's Medicaid population through performance-based payments focused specifically on improvements for the behavioral health population. QIP was proposed to run for five years, from July 1, 2020 through June 30, 2025, but was delayed a year due to COVID-19. On September 17, 2020, the Centers for Medicare and Medicaid Services (CMS) approved a bridge payment to cover the period from July 1, 2020 through March 31, 2021. The payments are pre-determined by the State and not performance based. QIP revenue is recognized based on State-estimated payments prorated over the period of performance. For the year ended December 31, 2020, the Organization recognized a net revenue for DSRIP and QIP in the amount of $2,765,489, which is included in subsidy revenue in the accompanying statements of operations.

New Jersey state regulations provide for the distribution of funds from the indigent care pool, which is intended to partially offset the cost of services provided to the uninsured. The funds are distributed to the Organization based on the Organization's level of bad debt in relation to all other New Jersey hospitals. For the years ended December 31, 2020 and 2019, the Organization received a net distribution of $16,138,886 and $14,993,034, respectively, from the indigent care pool, which is included in subsidy revenue in the accompanying statements of operations.

DSRIP and QIP payments and New Jersey state Bad Debt and Charity Care subsidies are not exchange transactions pursuant to Accounting Standards Codification (ASC) 958-605 *Not-for-Profit Entities,* which states that if the recipient solicits assets from the resource provider without the intent of exchanging goods or services of commensurate value, it is a non-exchange transaction. The Organization provides patient services to the patients, not the government. The government provides the funds to the Organization to help with its bad debt resulted from charity care patients and to drive the initiatives that will support payment reform and transition away from fee-for-service payments toward alternative payment arrangements that reward high-quality, efficient, and integrated systems of care. This does not indicate exchange of services of commensurate value and, therefore, these two government programs are non-exchange contracts and do not qualify to be exchange transactions under ASC 606.

Patient Accounts Receivable

Patient accounts receivable are recorded at the reimbursable or contracted amount and do not bear interest. Billings for services under third-party payor programs are included in revenue, net of allowances for contractual discounts and implicit price concessions for differences between the amounts billed and estimated program payment amounts. Adjustments to the estimated payment amounts based on final settlement with the programs are recorded in the period the final settlement occurs as an adjustment to revenue.

Inventories

Inventories consist of pharmaceutical and medical supplies and are stated at the lower of average cost (determined principally by the first-in, first-out method) or market.

Fixed Assets

Fixed assets are stated at cost. Depreciation expense is computed using the straight-line method over the estimated useful lives of the assets.

Income Taxes

The Organization is incorporated in the state of New Jersey and is exempt from federal, state, and local income taxes under Section 501(c)(3) of the Code, and therefore has made no provision for income taxes in the accompanying financial statements. In addition, the Organization has been determined by the Internal Revenue Service (IRS) to not be a "private foundation" within the meaning of Section 509(a) of the Code.

The Organization has not taken an unsubstantiated tax position that would require provision of a liability under ASC 740, *Income Taxes*. Under ASC 740, an organization must recognize the tax liabilities associated with tax positions taken for tax return purposes when it is more likely than not that the position will not be sustained upon examination. The Organization does not believe there are any material uncertain tax positions and, accordingly, has not recognized any liability for unrecognized tax benefits as of December 31, 2020 and 2019. The Organization has filed IRS Form 990 tax returns, as required, and all other applicable returns in jurisdictions where it is required. For the years ended December 31, 2020 and 2019, there were no interest or penalties recorded or included in the accompanying financial statements.

Concentration of Credit Risk

The Organization grants credit without collateral to its patients and residents, most of whom are local New Jersey residents and are insured under various third-party payor agreements.

The mix of receivables from patients and residents and third-party payors is as follows:

December 31,	**2020 (%)**	2019 (%)
Medicaid	**7**	19
Medicaid HMO	**19**	13
Medicare	**18**	22
Medicare HMO	**9**	13
Self-pay/other	**15**	10
Commercial Insurance	**24**	18
Blue Cross	**8**	5
Total	**100**	100

Financial instruments that potentially subject the Organization to concentration of credit risk consist primarily of cash and cash equivalents in excess of Federal Deposit Insurance Corporation (FDIC) insurance limits. At various times during the year, the Organization may have cash deposits at financial institutions in excess of FDIC insurance limits. These financial institutions have strong credit ratings and management believes that credit risk related to these accounts is minimal.

Performance Indicator

The statements of operations include net patient service revenue and other support, less expenses as the performance indicator. Changes in net deficit without donor restrictions that are excluded from the performance indicator include rent expense, interest expense, and depreciation.

Accounting Pronouncement Issued but Not Yet Adopted

Accounting for Leases

In February 2016, the FASB issued ASU 2016-02, *Leases (Topic 842).* The guidance in this ASU supersedes the leasing guidance in Topic 840, *Leases*. Under the new guidance, lessees are required to recognize lease assets and lease liabilities on the statement of financial position for all leases with terms longer than 12 months. Leases will be classified as either finance or operating, with classification affecting the pattern of expense recognition in the statement of operations. ASU 2020-05 deferred the effective date for this new standard for fiscal years beginning after December 15, 2021, including interim periods within those fiscal years. A modified retrospective transition approach is required for lessees for capital and operating leases existing at, or entered into after, the beginning of the earliest comparative period presented in the financial statements, with certain practical expedients available. Management is currently evaluating the impact of the adoption of the new standard on the financial statements.

Reclassifications

Certain prior-year amounts were reclassified to conform to the current financial statement presentation.

3. Third-Party Payor Arrangements

Medicare

The Organization is paid for most Medicare inpatient and outpatient services under the prospective payment system (PPS) and other methodologies of the Medicare program for certain other services. The Organization's reimbursements from Medicare are now subject to certain variations under Medicare's single bundled payment rate system, whereby reimbursements can be adjusted for certain patient characteristics and other factors.

Non-Medicare Payments

Service rendered to Medicaid program beneficiaries is paid at prospectively determined rates per discharge. These rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. The DOH updated the data utilized to calculate the New Jersey state Diagnostic Related Groups (DRG) service intensity weights (SIWs) in order to utilize more data in DOH-promulgated rates.

Revenues associated with commercial health plans are estimated based on contractual terms for the patients and residents under healthcare plans with which the Organization has formal agreements, non-contracted health plan coverage terms (if known), estimated secondary collections, historical collection experience, and historical trends of refunds and payor payment adjustments.

Psychiatric Cost Sharing/State Aid Program

As a county hospital, the Organization participates in a state aid program referred to as Psych Cost Sharing. It is a mechanism through which hospitals are assured reimbursement at-cost for psychiatric services rendered. The net estimated Psych Cost Sharing receivable was $2,818,413 as of December 31, 2020. The net estimated reserve for recoveries recorded due to Psych Cost Sharing as of December 31, 2019 was $3,512,922.

Laws, Regulations, and Settlements with Third-Party Payors

Laws and regulations concerning government programs, including Medicare and Medicaid, are complex. As a result of investigations by governmental agencies, various healthcare organizations have received requests for information and notices regarding alleged noncompliance with those laws and regulations, which, in some instances, have resulted in organizations entering into significant settlement agreements. Compliance with such laws and regulations may also be subject to future government review and interpretation, as well as significant regulatory action, including fines, penalties, and potential exclusion from the related programs. While there can be no assurance that regulatory authorities will not challenge the Organization's compliance with these laws and regulations, and it is not possible to determine the impact (if any) such claims or penalties would have upon the Organization, it is the Organization's belief that it submits all claims for reimbursement in a manner that is compliant with existing provisions of Medicare and Medicaid law, regulation, and those payors' billing and reimbursement manuals. In addition, the contracts the Organization has with commercial payors also provide for retroactive audit and review of claims.

Settlements with third-party payors for retroactive revenue adjustments due to 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 Organization's historical settlement activity, 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. 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.

Net patient service revenue was comprised of the following:

December 31,	**2020**	2019
Patient service revenue:		
Medicare and Medicaid	**$ 296,186,375**	$ 326,408,468
Commercial	**86,022,746**	98,558,510
Self and other	**90,466,909**	106,182,840
Psych Cost Sharing	**35,586,840**	31,387,022
Total	**508,262,870**	562,536,840
Less: contractual adjustments, including provision for uncollectibles	**(350,627,783)**	(400,889,826)
Net Patient Service Revenue	**$ 157,635,087**	$ 161,647,014

The Organization's net patient service revenue from Medicare and Medicaid programs accounted for 65% and 62%, respectively, for the years ended December 31, 2020 and 2019. There are various proposals at the federal and state levels that could, among other things, significantly reduce or modify reimbursement rates. The ultimate outcome of these proposals and other market changes cannot be presently determined, and any reduction of funding could have an adverse effect on the Organization.

4. Liquidity and Availability of Resources

The Organization's financial assets available within one year of the statement of financial position date for general expenditures are as follows:

December 31,	**2020**	2019
Cash and cash equivalents	**$ 25,276,776**	$ 879,991
Patient accounts receivable, net	**16,740,294**	20,689,813
Long-term care pharmacy receivable, net	**262,821**	424,028
Due from third-party payors	**19,020,643**	11,812,104
Grants receivable	**9,031,138**	-
Due from Bergen County Improvement Authority	**1,216,056**	246,663
Total Resources Available	**$ 71,547,728**	$ 34,052,599

The Organization has a practice to structure its financial assets to be available as its general expenditures, liabilities, and other obligations come due as part of its liquidity management. Actual cash receipts are monitored monthly against expected budgeted collections. If there are shortfalls,

the various teams in Finance, Revenue Cycle, and Accounts Payable will have weekly calls to closely monitor the status of any potential issues.

5. Transactions with BCIA

Use of Facility

Under the terms of the SLOA, the Organization is to pay BCIA rent in consideration for the use of the land, property, and equipment provided by BCIA at the Medical Center. Rent is equal to 90% of EBITDAR, payable on a monthly basis, which commenced on October 1, 2017. For the year ended December 31, 2020, rent expense totaled $18,931,570. There was no rent expense charged for the year ended December 31, 2019, as the Organization reported negative year-end EBITDAR.

Due from BCIA

Cash flow obligations of the Organization are passed through by BCIA on a daily basis. All cash receipts related to patient service revenue generated by the Organization shall be collected by BCIA, except for professional medical services that are provided by Rutgers' physicians and/or billed by Rutgers. Amounts due from BCIA, including estimated collections of net patient service revenue of the Medical Center and prepaid rent, at December 31, 2020 and 2019, amounted to $1,216,056 and $246,663, respectively.

Due to BCIA

For the years ended December 31, 2020 and 2019, amounts due to BCIA totaled $18,710,528 and $1,123,185, respectively, which is comprised of amounts owed for rent, inventory supplies, accrued interest, and information technology expenses.

Notes Payable – BCIA

The Organization entered into a promissory note with BCIA as part of the SLOA, which provided a $20,000,000 working capital loan to the Organization, which is interest-bearing at a rate equal to BCIA's note rate interest expense. At December 31, 2020 and 2019, the daily interest rate was 0.0063%. The principal balance of the note, plus any outstanding interest, will become immediately due and payable upon expiration or termination of the SLOA.

The Organization entered into a second promissory note on November 28, 2018 with BCIA under the county-guaranteed project notes, which provided a $10,000,000 working capital fund requisition. At December 31, 2020 and 2019, the daily interest rate was 0.0097%. In 2018, total drawdowns of $5,000,653 were used to cover working capital needs of the Organization.

In 2020, the Organization did not make principal payments or take additional draw-downs.

Total notes payable to BCIA were $20,823,681 at December 31, 2020 and 2019.

6. Charity Care and Other Uncompensated Services

The gross charges foregone related to charity care were $48,751,204 and $53,245,634 for the years ended December 31, 2020 and 2019, respectively. In addition, the Medical Center provided community service programs for free or below cost and provided a variety of patient care services

where reimbursement under federal and state agreements are below cost. These services include, but are not limited to, inpatient services and emergency room care.

7. Employee Benefit Plan

The Organization sponsors two contributory 401(k) plans covering substantially all employees. For the years ended December 31, 2020 and 2019, non-union employees contributing up to 3% and union employees contributing up to 4% of their salaries are entitled to receive a matching contribution from the Organization equal to 50%, such that the matching contribution may equal up to 2% of an employee's salary. The Organization's matching contribution for both plans amounted to $859,408 and $824,770 for the years ended December 31, 2020 and 2019, respectively.

8. Commitments and Contingencies

Self-Insured

The Organization self-insures a portion of certain insurable risks consisting of employee medical and prescription claims. The Organization records its estimated ultimate liability for reported claims plus an estimate for claims incurred but not reported. Accrual for self-insurance claims of $850,000 is included in accounts payable and accrued expenses as of December 31, 2020 and 2019 in the accompanying statements of financial position.

Litigation

The Organization is involved in various other claims and legal actions arising in the ordinary course of business. In the opinion of management and the Organization's legal counsel, the ultimate disposition of these matters will not have a material adverse effect on the Organization's statements of financial position, results of operations, or liquidity.

Other Commitments

As described in Note 5, the Organization has rental commitments to BCIA for the term of the SLOA, which relates to the use of the Medical Center facility and equipment. The Organization has the responsibility to keep the property in good, safe order and maintain, repair, and replace items at its own cost.

Union Contracts

The Organization has contracts with several unions covering substantially all employees, which expire at various dates.

9. Medical Malpractice Liabilities

The Organization purchased professional liability insurance to cover medical malpractice claims on a claims-made basis through Princeton Insurance Company. The policy currently provides coverage of $1,000,000 per occurrence and $3,000,000 annually in the aggregate. The Organization has also purchased excess liability coverage up to $10,000,000 from the same commercial carrier. It is the opinion of the Organization that adequate insurance is being maintained and that loss, if any, resulting from claims will not have a material adverse effect on the Organization's financial position or results of operations.

There are known incidents, and possibly unknown incidents, that occurred through December 31, 2020 and 2019 that may result in the assertion of additional malpractice claims. In the opinion of management, the final disposition of such claims will either be within available insurance coverage, have been provided for in the accompanying statements of financial position, or otherwise not have a material adverse effect on the Organization's financial position, results of operations, or liquidity.

10. Functional Expenses

The majority of the Organization's expenses can generally be directly identified with program or supporting services to which they relate and are allocated accordingly. Program services consist of providing healthcare and related services to residents within its geographic location. Other expenses have been allocated among program and supporting service classifications. These expenses include rent, interest, and general and administrative operations. Interest expense and rent expense are allocated based on usage of space. Costs of other categories were allocated on estimates of time and effort.

Expenses related to providing these services are as follows:

December 31, 2020

	Healthcare and Related Services	Management and General	Total
Salaries and wages	$ 110,767,150	$ 11,615,984	$ 122,383,134
Employee benefits and related services	23,242,640	2,437,421	25,680,061
Supplies and other	78,588,919	7,418,249	86,007,168
Interest expense	427,423	59,391	486,814
Depreciation	12,745	-	12,745
Rent expense	16,621,918	2,309,652	18,931,570
	$ 229,660,795	$ 23,840,697	$ 253,501,492

December 31, 2019

	Healthcare and Related Services	Management and General	Total
Salaries and wages	$ 109,646,762	$ 11,801,216	$ 121,447,978
Employee benefits and related services	23,426,718	2,521,404	25,948,122
Supplies and other	61,878,665	7,589,545	69,468,210
Interest expense	675,585	93,874	769,459
Depreciation	12,745	-	12,745
	$ 195,640,475	$ 22,006,039	$ 217,646,514

11. Related-Party Transactions

For the years ended December 31, 2020 and 2019, Care Plus NJ, Inc. charged the Organization a management fee of approximately $1,140,000 to manage and oversee the behavioral health services, and for the years ended December 31, 2020 and 2019, Integrity House charged the Organization a management fee of $860,000 to manage and oversee the substance abuse services.

For the years ended December 31, 2020 and 2019, the Organization paid Rutgers $10,791,076 and $7,639,943, respectively to provide clinical physicians to the Medical Center. A component of the 2020 fee is two medical directorship stipends of $50,000 and $25,000 that are included as part of the acting physician's salary. A component of the 2019 fee is two medical directorship stipends of $50,000 and $25,000 that are included as part of the acting physician's salary.

At December 31, 2020, amounts due to Rutgers, Care Plus NJ, Inc., and Integrity House are $1,278,314, $190,000, and $215,000, respectively, and are included in accounts payable and accrued expenses in the accompanying statements of financial position. At December 31, 2019, amounts due to Rutgers, Care Plus NJ, Inc., and Integrity House are $3,745,502, $475,000, and $286,667, respectively, and are included in the accompanying statements of financial position.

12. Impact of COVID-19 and CARES Act Funding

On January 30, 2020, the World Health Organization (WHO) announced a global health emergency because of the outbreak of an infectious disease caused by the discovered coronavirus (the COVID-19 outbreak). In March 2020, the WHO classified the COVID-19 outbreak as a pandemic, based on the rapid increase in exposure globally at the time. The full impact of the COVID-19 outbreak continues to evolve as of the date of this report. As such, it is uncertain as to the full magnitude of the impact that the pandemic could have on the Organization's financial condition, liquidity, and future results of operations.

On March 27, 2020, the CARES Act was enacted and passed by Congress as a result of the economic fallout from the COVID-19 pandemic. Together with the Paycheck Protection Program and Health Care Enhancement Act (the PPPHCE Act), which was enacted on April 24, 2020, the CARES Act includes $175 billion in funding to be distributed to eligible providers through the Public Health and Social Services Emergency Fund (the Provider Relief Fund or PRF). The Secretary of the U.S. Department of Health and Human Services (HHS) has allocated the Provider Relief Fund among eligible health care providers through two completed phases of general distributions and a number of targeted distributions beginning in April 2020. In October 2020, HHS announced an additional $20 billion general distribution from the Provider Relief Fund that considers financial losses and changes in operating revenues and expenses, including expenses attributable to COVID-19, and payments already received through PRF distributions. Additionally, the CARES Act established a $150 billion Coronavirus Relief Fund, for payments to state, local, and tribal governments to navigate the impact of the COVID-19 outbreak.

The CARES Act also alleviates some of the financial strain on hospitals, physicians, other healthcare providers, and states through a series of Medicare and Medicaid payment policies that temporarily increase Medicare and Medicaid reimbursement and allow for added flexibility, as described below:

(1) Effective May 1, 2020 through March 31, 2021, the 2% sequestration reduction on Medicare fee for service (FFS) and payments to hospitals, physicians, and other providers is suspended and will resume effective April 2021, as authorized by the Sequestration Transparency Act of 2020 and amended by the Consolidated Appropriations Act of 2021. The estimated impact of this change on the Organization’s operations is an increase of $429,155 of revenues in calendar year 2020. The suspension is financed by a one-year extension of the sequestration adjustment through 2030.

(2) The CARES Act expanded the Medicare Accelerated and Advance Payments Program, which provides prepayment of claims to providers in certain circumstances, such as national

emergencies or natural disasters. Under this measure, providers could request accelerated and advance payments, during which time providers continue to receive payments for services. Under the CARES Act, accelerated and advance payments could be retained for 120 days; at the end of the 120-day period, the accelerated payment would be repaid via an offset of payments on claims that would otherwise be paid. Generally, repayments of the accelerated and advance payments the Organization received were to commence during August 2020; however, under legislation passed in October 2020, providers may retain the accelerated payments for one year from the date of receipt before CMS commences recoupment, which will be effectuated by a 25% offset of claims payments for 11 months, followed by 50% offset for the succeeding six months. At the end of the 29-month period, interest on the unpaid balance will be assessed at 4% per annum. As of December 31, 2020, the Organization had received Medicare accelerated and advance payments of $9,184,035, which were reflected in government contract liability in the accompanying statements of financial position.

On September 19, 2020, HHS issued a Post-Payment Notice of Reporting Requirements for the PRF that were disbursed under the CARES Act. This notice changed guidance that had been previously communicated during June and July 2020. Key differences include introduction of the concept of calendar-year measurement as opposed to quarterly measurement, the requirement to first apply stimulus monies received to healthcare-related expenses attributable to COVID-19 (net of reimbursements from other sources), and change (negative change comparing calendar year 2020 over calendar year 2019) from lost revenues, as defined to net patient care operating income as defined, net of healthcare-related expenses previously applied. The notice also allowed for an additional six months through June 30, 2021, for companies to use the remaining amounts toward expenses attributable to COVID-19 that have not been reimbursed by other sources, or apply toward lost net patient care operating income in an amount not to exceed the calendar 2019 net gain. Also, on October 22, 2020, HHS issued a notice that amended the September 19, 2020 guidance, to replace the comparison of operating income to lost revenues. On January 7, 2021, HHS issued further guidance for the PRF that were disbursed under the CARES Act by allowing the use for the calculation of lost revenues to use budgeted revenues as an alternative to comparing with prior-year actuals, and allowing for targeted distributions to be used in the same way as general distributions. On June 11, 2021, HHS released a Reporting Requirements Policy Update related to PRF reporting requirements. The updated Post-Payment Notice of Reporting Requirements amended the period of availability of funds and specified reporting requirements for each Payment Received Period. The definitions included in the Post-Payment Notice of Reporting Requirements may be subject to change or further interpretation. Management will continue to evaluate and monitor compliance with the terms and conditions through June 30, 2021.

Funds received during the year ended December 31, 2020	$	53,034,423
Funds applied to incremental expenses and lost revenues		(40,344,745)
Funds Unused, December 31, 2020	$	12,689,678

The amount of lost revenues (represented as a negative change in net revenues from the approved 2020 budgeted revenues, as compared to actual net revenues from patient care-related sources) and incremental expenses were recorded in pandemic relief grant income within the accompanying statements of operations for the year ended December 31, 2020. The recognition of amounts received is conditioned upon the provision of care for individuals with possible or actual cases of COVID-19 after January 31, 2020, certification that payment will be used to prevent, prepare for, and respond to coronavirus and shall reimburse the recipient only for healthcare-related expenses or lost revenues that are attributable to coronavirus, and receipt of the funds. These monies have

been recognized following the grant accounting model, recognizing income over the applicable reporting period as management becomes reasonably assured of meeting the required criteria. As of December 31, 2020, the Organization had accounted for all of the funds received. Funds unused totaling $12,689,678 as of December 31, 2020 were reflected in government contract liability in the accompanying statements of financial position.

The United States Treasury has made payments to States from the Coronavirus Relief Fund to cover expenses that were necessary expenditures incurred due to the public health emergency with respect to COVID-19, were not accounted for in the budget most recently approved as of March 27, 2020 (the date of enactment of the CARES Act) for the State or government, and were incurred during the period that begins March 1, 2020 and ends on December 31, 2021. The Organization was provided $22,992,071 from the County, which received proceeds from the State of New Jersey for use in 2020 to cover payroll for employees that were determined to be "substantially dedicated" to COVID-19 and leasehold improvements warranted in dealing with the pandemic. This amount is reported as pandemic relief grant income within the accompanying statements of operations for the year ended December 31, 2020. These monies have been recognized following the grant accounting model, recognizing income over the applicable reporting period as management becomes reasonable assured of meeting the required criteria.

FEMA has provided federal funds to the Organization in response to the COVID-19 pandemic to cover costs incurred in disinfecting the campus, purchasing personal protective equipment, agency staffing, and partnership pay. The Organization applied for and was granted $9,031,138 from FEMA and the proceeds were subsequently received in March and April 2021. This amount is reported as pandemic relief grant income within the accompanying statements of operations for the year ended December 31, 2020. These monies have been recognized following the grant accounting model, recognizing income over the applicable reported period as management becomes reasonably assured of meeting the required criteria.

The Organization believes that the extent of the COVID-19 pandemic's impact on its operating results and financial condition has been and will continue to be driven by many factors, most of which are beyond its control and ability to forecast. Such factors include, but are not limited to, the severity or duration of the pandemic, including whether there will be additional periods of increases in the number of COVID-19 cases in the areas in which it operates, the rollout and availability of effective medical treatments and vaccines, the efficacy of public health controls, including vaccines, and the impact of any mutations of the virus; the scope and duration of stay-at-home practices and business closures and restrictions; recommended or required suspensions of elective procedures; continued declines in patient volumes for an indeterminable length of time; increases in the number of uninsured and underinsured patients as a result of higher sustained rates of unemployment; incremental expenses required for supplies and personal protective equipment; and changes in professional and general liability exposure. Because of these and other uncertainties, the Organization cannot estimate how long or how severely the pandemic will impact its business.

On December 27, 2020, the President signed the Consolidated Appropriations Act, 2021 (the Act), which includes $900 billion in stimulus relief as a result of the COVID-19 pandemic. The Organization continues to examine the impact the CARES Act may have on its business. Currently, the Organization is unable to determine any additional impact on its financial condition, results of operations, or liquidity.

13. Subsequent Events

The Organization's management has performed subsequent event procedures through June 29, 2021, which is the date the financial statements were available to be issued. No events arose during the period that would require adjustment or additional disclosure other than the event described below.

On March 10, 2021, President Biden signed the $1.9 trillion American Rescue Plan Act into law. The Organization has not applied for and does not expect to apply for any of the American Rescue Plan Act funding or benefits.