Care Plus Bergen, Inc.

Financial Statements
Years Ended December 31, 2019 and 2018

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Contents

BDO

Tel: +212 885-8000
Fax: +212 697-1299
www.bdo.com

622 Third Avenue, 31st Floor
New York, NY 10017

Independent Auditor's Report

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

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, 2019 and 2018, and the related statements of operations and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

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

Change in Accounting Policy

As discussed in the summary of significant accounting policies to the financial statements, on January 1, 2019, the Organization adopted new accounting guidance related to revenue from contracts with customers.

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 of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from 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.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Care Plus Bergen, Inc. as of December 31, 2019 and 2018, 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.

BDO USA, LLP

June 30, 2020

Care Plus Bergen, Inc.

Statement of Financial Position

December 31,		**2019**		2018
Assets				
Current Assets:				
Cash and cash equivalents	$	**879,991**	$	1,690,449
Patient escrow funds		**607,507**		494,735
Patient accounts receivable, less estimated allowance for uncollectible accounts of $4,214,570 in 2019 and $38,992,095 in 2018		**20,689,813**		34,814,827
Long-term care pharmacy receivable, less estimated allowance for uncollectible accounts of $319,746 in 2019 and $317,033 in 2018		**424,028**		359,529
Due from third-party payors		**11,812,104**		11,856,361
Due from Bergen County Improvement Authority		**246,663**		2,004,241
Inventories		**1,977,735**		1,910,540
Prepaid expenses and deposits		**2,526,850**		2,893,235
Total Current Assets		**39,164,691**		56,023,917
Fixed Assets, Net		**30,797**		43,542
Total Assets	$	**39,195,488**	$	56,067,459
Liabilities and Net Deficit				
Current Liabilities:				
Due to Bergen County Improvement Authority	$	**1,123,185**	$	4,817,642
Accounts payable and accrued expenses		**16,059,164**		13,517,791
Accrued salaries, benefits and other payroll liabilities		**7,888,237**		8,481,003
Deferred revenue		**1,318,426**		1,180,413
Patient escrow funds		**607,507**		494,735
Due to third-party payors		**4,897,045**		4,897,045
Total Current Liabilities		**31,893,564**		33,388,629
Notes Payable - Bergen County Improvement Authority		**20,823,681**		25,000,653
Total Liabilities		**52,717,245**		58,389,282
Commitments and Contingencies (Notes 5, 7 and 8)				
Net Deficit				
Without donor restrictions		**(13,521,757)**		(2,321,823)
Total Liabilities and Net Deficit	$	**39,195,488**	$	56,067,459

See accompanying notes to financial statements.

Care Plus Bergen, Inc.

Statement of Operations

December 31,	2019	2018
Net Patient Service Revenue	**161,647,014**	176,701,176
Subsidy revenue	**33,135,747**	30,455,173
Other revenue	**11,663,819**	3,552,966
Total Net Patient Service Revenue and Other Support	**206,446,580**	210,709,315
Expenses:		
Salaries and wages	**121,447,978**	114,750,378
Employee benefits and related services	**25,823,962**	23,337,150
Contracted labor	**124,160**	162,751
Supplies and other expenses	**69,468,210**	62,168,794
Total Expenses	**216,864,310**	200,419,073
Net Operating (Loss) Income, before rent expense, interest expense and depreciation	**(10,417,730)**	10,290,242
Rent Expense	**-**	9,261,218
Interest Expense	**769,459**	467,214
Depreciation	**12,745**	7,433
(Increase) Decrease in Net Deficit Without Donor Restrictions	**(11,199,934)**	554,377
Net Deficit Without Donor Restrictions, beginning of year	**(2,321,823)**	(2,876,200)
Net Deficit Without Donor Restrictions, end of year	**$ (13,521,757)**	$ (2,321,823)

See accompanying notes to financial statements.

Care Plus Bergen, Inc.

Statement of Cash Flows

December 31,		**2019**		2018
Cash Flows from Operating Activities				
(Increase) decrease in net deficit without donor restrictions	$	**(11,199,934)**	$	554,377
Adjustments to reconcile change in net deficit without donor restrictions to net cash provided by (used in) operating activities:				
Provision for bad debts		**191,342**		18,914,180
Depreciation		**12,745**		7,433
Changes in operating assets and liabilities:				
Patient accounts receivable		**13,933,672**		(36,873,756)
Long-term care pharmacy receivable		**(64,499)**		(2,486)
Due from third-party payors		**44,257**		(8,560,452)
Due (to) from Bergen County Improvement Authority		**(1,936,879)**		12,138,628
Inventories		**(67,195)**		43,464
Prepaid expenses and deposits		**366,385**		(587,473)
Other assets		**-**		209,369
Accounts payable and accrued expenses		**2,541,373**		7,280,165
Accrued salaries, benefits and other payroll liabilities		**(592,766)**		(3,178,683)
Deferred revenue		**138,013**		(276,273)
Due to third-party payors		**-**		2,005,247
Net Cash Provided by (Used in) Operating Activities		**3,366,514**		(8,326,260)
Cash Flows from Investment Activities				
Purchase of property and equipment		**-**		(50,975)
Net Cash Used in Investment Activities		**-**		(50,975)
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**		5,000,653
Net Cash (Used in) Provided by Financing Activities		**(4,176,972)**		5,000,653
Net Decrease in Cash and Cash Equivalents		**(810,458)**		(3,376,582)
Cash and Cash Equivalents, beginning of year		**1,690,449**		5,067,031
Cash and Cash Equivalents, end of year	$	**879,991**	$	1,690,449
Supplemental Disclosure of Cash Flow Information:				
Interest paid	$	**769,459**	$	467,214

See accompanying notes to financial statements.

1. Description of the Organization

Care Plus Bergen, Inc. (the Organization or CPB) 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 CPB, 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, 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 New Jersey Medical School (NJMS), provides clinical and administrative support for clinical and physician leadership for the Medical Center.

For the year ended December 31, 2019, the Organization incurred a net loss of $11,199,934 which increased the net deficit as of December 31, 2019 to $13,521,757. As of December 31, 2019, cash and cash equivalents was $879,991 and cash provided by operations for the year ended December 31, 2019 was $3,366,514. Based on the Organization’s business plan, existing cash resources, existing capacity on its working capital loan with BCIA, revenues generated from operations, allocations to Hospitals of the Provider Relief Fund 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 the next 12 months and a day after the date that these financial statements are issued. However, if performance expectations fall short or expenses exceed expectations, the Organization has the ability to adjust its operating plan spending levels accordingly. The Organization has also obtained a waiver from BCIA due to non-compliance with the Earnings Before Interest, Taxes, Depreciation, Amortization, and Rent (EBITDAR) provisions of the SLOA and that it will not terminate the SLOA and/or sever the relationship with the Organization for at least the next 12 months after the date that these financial statements are issued. BCIA has also pledged to support the operating cash flow needs of the Organization. See Note 12 for a detailed discussion of COVID-19.

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 statement 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 statement 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, 2019 and 2018, 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.

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 includes 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. The Organization does not receive consideration prior to the transfer of goods or services and, therefore, does not recognize contract liabilities.

Other 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. For the years ended December 31, 2019 and 2018, amounts due from DSRIP totaled $10,427,981 and $8,927,982, 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.

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, 2019 and 2018, the Organization received a net distribution of $14,993,034 and $15,822,325, respectively, from the indigent care pool, which is included in subsidy revenue in the accompanying statements of operations.

DSRIP 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. The Organization assesses the collectability of accounts receivable balances by considering factors such as historical collection experience, customer creditworthiness, the age of accounts receivable balances, regulatory changes and current economic conditions and trends that may affect a customer's ability to pay. Actual results could differ from those estimates.

December 31, 2018

For the year ended December 31, 2018 and prior, patient accounts receivable was recorded at the reimbursable or contracted amount and did not bear interest. The allowance for doubtful accounts was the Organization's best estimate of the amount of probable credit losses in the Organization's existing accounts receivable. The Organization determined the allowance based on historical write-off experience. The Organization reviewed its allowance for doubtful accounts monthly. Past due balances were reviewed individually for collectability. Account balances were charged off against the allowance after all means of collection were exhausted and the potential for recovery was considered remote.

Net operating revenues were recognized in the period services were performed and consisted primarily of net patient service revenue that was reported at estimated net realizable amounts from patients, third-party payors and others for services rendered and included estimated retroactive revenue adjustments due to future audits, reviews, and investigations. Retroactive adjustments were considered in the recognition of revenue on an estimated basis in the period the related services were rendered, and such amounts are adjusted in future periods as adjustments became known or as years were no longer subject to such audits, reviews, and investigations.

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, 2019 and 2018. 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, 2019 and 2018, 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,	**2019 (%)**	2018 (%)
Medicaid	**19**	21
Medicaid HMO	**13**	27
Medicare	**22**	18
Medicare HMO	**13**	5
Self-pay/other	**10**	9
Commercial Insurance	**18**	15
Blue Cross	**5**	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 includes revenues 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.

Recently Adopted Accounting Pronouncement

Revenue from Contracts with Customers (Topic 606)

In May 2014, the FASB issued ASC 606, "Revenue Recognition from Contracts with Customers" (ASC 606). The core principle of guidance is that an entity should recognize revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. The Organization adopted ASC 606 on January 1, 2019 and elected the modified retrospective approach for implementation. The adoption of this ASU did not materially impact the financial statements.

Accounting Pronouncement Issued but Not Yet Adopted

Leases (Topic 842)

In February 2016, the FASB issued ASU 2016-02, "Leases (Topic 842)," which applies a right-of-use (ROU) model that requires a lessee to record, for all leases with a lease term of more than 12 months, an asset representing its right to use the underlying asset and a liability to make lease payments. For leases with a term of 12 months or less, a practical expedient is available, whereby a lessee may elect, by class of underlying asset, not to recognize an ROU asset or lease liability. At inception, lessees must classify all leases as either finance or operating, based on five criteria. The statements of financial position recognition of finance and operating leases is similar, but the pattern of expense recognition in the statements of operation, as well as the effect on the statements of cash flows, differs depending on the lease classification. In addition, lessees and lessors are required to provide certain qualitative and quantitative disclosures to enable users of financial statements to assess the amount, timing, and uncertainty of cash flows arising from leases. The amendments are effective for fiscal years beginning after December 15, 2021. Management is currently evaluating the impact of this ASU on its financial statements.

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 reserve for recoveries recorded due to Psych Cost Sharing for the years ended December 31, 2019 and 2018 were $3,512,922 and $1,968,666, respectively.

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 which 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, for the years ended December 31:

December 31,	**2019**	2018
Patient service revenue:		
Medicare and Medicaid	**$ 326,408,468**	$ 400,771,295
Commercial	**98,558,510**	49,394,286
Self and other	**106,182,840**	85,518,574
Psych cost sharing	**31,387,022**	29,790,124
Total	**562,536,840**	565,474,279
Less: contractual adjustments including provision for uncollectibles	**(400,889,826)**	(388,773,103)
Net Patient Service Revenue	**$ 161,647,014**	$ 176,701,176

The Organization's net patient service revenue from Medicare and Medicaid programs accounted for 62% and 76%, respectively, for the years ended December 31, 2019 and 2018. 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

Liquidity

CPB's financial assets available within one year of the statements of financial position date for general expenditures are as follows:

December 31,		2019		2018
Cash and cash equivalents	$	879,991	$	1,690,449
Patient accounts receivable, net		20,689,813		34,814,827
Long-term care pharmacy receivable, net		424,028		359,529
Due from third-party payors		11,812,104		11,856,361
Due from Bergen County Improvement Authority and other receivables		246,663		2,004,241
Total Resources Available	$	34,052,599	$	50,725,407

Liquidity Management

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. In 2018, rent expense was calculated at $9,261,218 of which the Organization paid $5,425,000 in October and November 2018 and an additional $50,000 in January 2019, with the remaining balance owed of $3,786,218 recorded in due to Bergen County Improvement Authority. In 2019, the Organization recorded a change in estimate in accounts receivable which resulted in 2018 adjusted rent expense of $2,698,028 and resulted in an excess rent payment of $2,776,972 which was applied as a debt service payment to the notes payable. The 2018 adjusted rent expense also resulted in a rent recovery of $6,563,190, which is recorded in other revenue. In addition, the Organization also paid rent in the amount of $6,200,000 in November and December 2019 which was then applied as debt service payment of the notes payable as described below in "Notes Payable – BCIA".

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, at December 31, 2019 and 2018, amounted to $246,663 and $2,004,241, respectively.

Due to BCIA

For the years ended December 31, 2019 and 2018, amounts due to BCIA totaled $1,123,185 and $4,817,642, respectively, which is comprised of amounts owed for 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. 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. In 2018, total drawdowns of $5,000,653 were used to cover working capital needs of the Organization.

In 2019, the Organization paid $8,500,000 of the note but also drew down $13,300,000. In addition, the overpayments of rent in 2018 and 2019 (as noted in "Use of Facility" above) were applied as debt service payments in the total amount of $8,976,972.

Total notes payable to BCIA were $20,823,681 and $25,000,653 at December 31, 2019 and 2018, respectively.

6. Charity Care and Other Uncompensated Services

The gross charges foregone related to charity care were $53,245,634 and $55,471,627, respectively, for the years ended December 31, 2019 and 2018. 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, 2019 and 2018, 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 $824,770 and $751,428, respectively, for the years ended December 31, 2019 and 2018.

8. Commitments and Contingencies

Self-Insured

CPB self-insures a portion of certain insurable risks consisting of employee medical and prescription claims. CPB 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, 2019 and 2018 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, 2019 and 2018 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, 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.

Operating expenses related to providing these services are as follows:

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

December 31, 2018

	Healthcare and Related Services	Management and General	Total
Salaries and wages	$ 104,976,972	$ 9,773,406	$ 114,750,378
Employee benefits and related services	21,349,501	1,987,649	23,337,150
Supplies and other	47,396,808	14,934,737	62,331,545
Interest expense	410,214	57,000	467,214
Depreciation	7,433	-	7,433
Rent expense	8,131,349	1,129,869	9,261,218
	$ 182,272,277	$ 27,882,661	$ 210,154,938

11. Related Party Transactions

For the years ended December 31, 2019 and 2018, 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 year's ended December 31, 2019 and 2018, 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, 2019 and 2018, the Organization paid Rutgers $7,639,943 and $3,110,722, respectively to provide clinical physicians to the Medical Center. 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. A component of the 2018 fee is a medical directorship stipend of $22,916 that is included as part of the acting physician's salary.

12. Subsequent Events

On January 30, 2020, the World Health Organization (WHO) announced a global health emergency because of a new strain of coronavirus originating in Wuhan, China (the COVID-19 outbreak) and the risks to the international community as the virus spreads globally beyond its point of origin. In March 2020, the WHO classified the COVID-19 outbreak as a pandemic, based on the rapid increase in exposure globally.

As the recent COVID-19 outbreak continues to spread throughout areas in which we operate, our facilities have become impacted by the number of COVID-19 patients and, accordingly, we opened up various areas of the Organization in order to accommodate these patients. The level of federal, state, or local assistance provided to our facilities to assist with the increased costs of treating patients with COVID-19 is uncertain. Further, COVID-19 has impacted our operations by causing staffing and supply shortages. The extent of the impact of COVID-19 on our operational and financial performance will depend on certain developments, including the duration and spread of the outbreak, impact on our patients, employees, and vendors, all of which are uncertain and cannot be predicted. Given these uncertainties, we cannot reasonably estimate the related impact to our business, operating results, and financial condition. While expected to be temporary, these disruptions and excessive impact of treating COVID-19 patients may negatively impact the Hospital's patient service revenue, its results of operations, financial condition, and liquidity in fiscal year 2020.

On March 27, 2020, President Trump signed into law the CARES Act. The CARES Act, among other things, includes $100 billion for the Public Health and Social Services Emergency Fund for eligible healthcare providers for healthcare-related expenses or lost revenue associated to COVID-19. Eligible healthcare providers for this fund includes public entities, Medicare or Medicaid enrolled suppliers and providers, for-profit and nonprofit entities in the United States. To date, the Organization received approximately $9,100,000 from the Centers for Medicare & Medicaid Services for advance and accelerated payments. In addition, the Organization also received $25,100,000 from the CARES Act. The Organization received $3,900,000 in advanced charity care payments as well. We continue to examine the impacts this CARES Act may have on our business.

The Organization has performed subsequent events procedures through June 30, 2020, which is the date the financial statements were available to be issued. Advances from the CARES Act are still subject to audit. No events arose during the period, other than the event noted above, that would require adjustments or additional disclosures.