Pascack Valley Health System, LLC

Consolidated Financial Statements with Report of Independent Auditors
December 31, 2020

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Report of Independent Auditors

The Board of Directors of
Pascack Valley Health System, LLC

We have audited the accompanying consolidated financial statements of Pascack Valley Health System, LLC, which comprise the consolidated balance sheet as of December 31, 2020 and the related consolidated statements of operations, members' equity, and cash flows for the year then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit 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 of material misstatement.

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

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

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of Pascack Valley Health System, LLC at December 31, 2020 and the consolidated results of its operations and its cash flows for the year then ended in conformity with U.S. generally accepted accounting principles.

Ernst & Young LLP

April 7, 2021

Pascack Valley Health System, LLC
Consolidated Balance Sheet
December 31, 2020
(In Thousands)

	December 31, 2020
Assets	
Current assets:	
Accounts receivable	$ 13,356
Inventories	5,237
Prepaid expenses	500
Other current assets	727
Total current assets	19,820
Property and equipment, net	112,483
Goodwill	582
Amounts due from affiliate	29,155
Other assets	4,232
Total assets	$ 166,272
Liabilities and members' equity	
Current liabilities:	
Accounts payable	$ 7,682
Accrued salaries and benefits	3,306
Refundable advances	1,375
Contract liabilities	4,754
Other accrued expenses and liabilities	776
Current portion of long-term debt	292
Total current liabilities	18,185
Long-term debt, less current portion	139
Long-term contract liabilities	7,011
Other long-term liabilities	1,664
Total liabilities	26,999
Members' equity:	
Common units	175,205
Accumulated deficit	(35,932)
Members' equity	139,273
Total liabilities and members' equity	$ 166,272

See accompanying notes.

Pascack Valley Health System, LLC
Consolidated Statement of Operations
Year Ended December 31, 2020
(In Thousands)

	Year Ended December 31, 2020
Total net revenue	$ 120,807
Expenses:	
Salaries and benefits	48,471
Professional fees	25,230
Supplies	20,863
Other operating expenses	12,851
Government stimulus income	(14,929)
Depreciation and amortization	9,452
Management fees	2,427
Total operating expenses	104,365
Income from operations	16,442
Interest income, net	148
Net income	$ 16,590

See accompanying notes.

Pascack Valley Health System, LLC
Consolidated Statement of Members' Equity
Year Ended December 31, 2020
(Dollars in Thousands)

	Units	Amount	Accumulated Deficit	Total
Balance at December 31, 2019	1,477	$ 175,205	$ (29,368)	$ 145,837
Distributions made to:				
LHP Pascack Valley, LLC	–	–	(15,050)	(15,050)
Hackensack UMC	–	–	(8,104)	(8,104)
Net income	–	–	16,590	16,590
Balance at December 31, 2020	**1,477**	**$ 175,205**	**$ (35,932)**	**$ 139,273**

See accompanying notes.

Pascack Valley Health System, LLC
Consolidated Statement of Cash Flows
Year Ended December 31, 2020
(In Thousands)

	Year Ended December 31, 2020
Cash flows from operating activities:	
Net income	$ 16,590
Adjustments to reconcile net income to net cash provided by operating activities:	
Depreciation and amortization	9,452
Change in cash from operating assets and liabilities	
Accounts receivable	4,207
Inventories and other assets	302
Accounts payable and accrued expenses	1,549
Refundable advances of government stimulus income	1,375
Medicare accelerated payments	11,765
Net cash provided by operating activities	45,240
Cash flows from investing activities:	
Purchases of property and equipment	(989)
Net cash used in investing activities	(989)
Cash flows from financing activities:	
Payments on borrowings	(362)
Distributions to members	(23,154)
Payments to affiliate	(21,641)
Net cash used in financing activities	(45,157)
Change in cash and cash equivalents	(906)
Cash and cash equivalents at beginning of period	906
Cash and cash equivalents at end of period	$ –

See accompanying notes.

1. Organization and Basis of Presentation

Pascack Valley Health System, LLC (Company) is a privately held New Jersey limited liability company that operates Hackensack Meridian Health Pascack Valley Medical Center. The term the Company, as used in these consolidated financial statements, refers to Pascack Valley Health System, LLC and its subsidiaries, Pascack Valley Hospital, LLC and Pascack Valley Health Services, LLC and its subsidiaries. Membership units in the Company are owned by an affiliate of Ardent Health Services, LLC (Ardent), LHP Pascack Valley, LLC, and Hackensack UMC (Hackensack), collectively, the Members. The Members of the LLC are not personally liable for the debts and liabilities of the LLC in accordance with the LLC agreement and applicable statutes.

In March 2017, Ardent completed a merger with LHP Pascack Valley, LLC, an indirect wholly owned subsidiary of LHP Hospital Group, Inc. (LHP), pursuant to the Agreement and Plan of Merger. Through the transaction, LHP became a wholly-owned subsidiary of Ardent. Under the terms of the agreement, Ardent assumed LHP's management and operational responsibilities within the Company. At December 31, 2020, Ardent owned 65% of the Company and Hackensack owned 35%.

The consolidated financial statements include the accounts of the Company and all subsidiaries and entities controlled by the Company through the Company's direct or indirect ownership of a majority interest and exclusive rights granted to the Company as the sole general partner or controlling member of such entities. All intercompany balances and transactions have been eliminated in consolidation.

2. Summary of Significant Accounting Policies

Coronavirus Disease 2019 Pandemic

In March 2020, the World Health Organization declared the outbreak of Coronavirus Disease 2019 (COVID-19), a disease caused by a novel strain of coronavirus, a global pandemic. Federal, state and local governments implemented policies in response to the COVID-19 pandemic that forced restrictions on certain businesses, including periodic suspensions of elective procedures by health care facilities, and caused many individuals to remain at home. Such restrictions had a significant unfavorable impact on the Company's patient volumes and operations throughout the year ended December 31, 2020. As restrictions were eased, patient volumes and revenue gradually increased.

Federal and state governments enacted legislation and administrative actions to assist health care facilities in providing care to patients during the pandemic. On March 27, 2020, the Coronavirus Aid, Relief and Economic Security (CARES) Act was enacted. Among other provisions, the CARES Act authorized relief funding to health care providers through the Public Health and Social Services Emergency Fund (Provider Relief Fund) and expanded the Medicare Accelerated and Advance Payment Program through which eligible providers may request accelerated Medicare payments of up to 100% of historical Medicare payments for a six-month period to be repaid through withholdings against future Medicare fee-for-services payments. During the year ended December 31, 2020, the Company was a beneficiary of distributions and payments from the Provider Relief Fund and Medicare Accelerated and Advance Payment Program, along with other state and local programs. The CARES Act also permits the deferred payment of the employer portion of Social Security payroll taxes incurred between March 27, 2020 and December 31, 2020.

The ongoing extent of the COVID-19 pandemic's impact on the Company's operations, cash flows and financial position will be driven by many factors, most of which are beyond the Company's control or ability to forecast. Such factors include, but are not limited to, the scope and duration of social distancing, ongoing business closures and restrictions, increases in uninsured or underinsured patients as a result of high levels of unemployment, and supply chain disruptions, including shortages, delays, and significant price increases for medical supplies. The impact of the pandemic on the Company's cash flows and operations could impact

assumptions used in significant accounting estimates, including estimates of implicit price concessions related to uninsured or underinsured patients, reserves for professional and general liabilities, and impairment of goodwill and long-lived assets. Because of these factors and the changing scale and severity of the pandemic, its ultimate impact on the Company's operations is unknown.

CARES Act Provider Relief Funding

During the year ended December 31, 2020, the Company received $16.3 million in distributions from the Provider Relief Fund and other state and local programs. Distributions from the Provider Relief Fund are intended to reimburse health care providers for lost revenue and increased expenses related to the pandemic and are not subject to repayment provided recipients attest to and comply with applicable terms and conditions set forth by legislation. Such terms and conditions include, among other things, that distributions received are used for expenses and to replace lost revenue resulting from COVID-19. Distributions provided by the Provider Relief Fund are accounted for as government grants and are recognized in the consolidated statement of operations once there is reasonable assurance that the applicable terms and conditions required to retain the distributions are met.

Management performs ongoing analyses of the impact of the pandemic on the Company's operations and considers the compliance and reporting requirements set forth by the CARES Act, including subsequent issuance of all frequently asked questions and interpretive guidance issued by the U.S. Department of Health and Human Services (HHS), to determine the amount of government funds to recognize. The Relief Fund Payment Terms and Conditions distributed by the HHS directs recipients to use distributed funds to prevent, prepare for, and respond to the COVID-19 pandemic and reimburses recipients only for health care expenses and lost revenue attributable to the pandemic. Guidance on the recognition and reporting of government stimulus funds continues to evolve through the issuance of Post-Payment Notices of Reporting Requirements, each of which supplements and supersedes previously issued notices. The following notices, among others, were considered by management when determining the amount of government stimulus income to recognize during the year ended December 31, 2020:

- On September 19, 2020, the HHS issued a Post-Payment Notice of Reporting Requirements (September 2020 Notice) that directed recipients to use a two-step approach in recognizing reimbursement of COVID-19 expenses and lost revenue. Health care expenses attributable to COVID-19 are reimbursable up to the amount that another source has not reimbursed and is not obligated to reimburse. Payments that are not applied to COVID-19 costs may be recognized as reimbursements for lost revenue, defined as a negative change in year-over-year actual net patient care operating income. The September 2020 Notice permits providers to apply stimulus funds to lost revenue up to the amount of their 2019 net gains or, for providers that reported net operating losses during 2019, up to a net zero gain in 2020.
- On October 22, 2020, the HHS issued a Post-Payment Notice of Reporting Requirements (October 2020 Notice) that, among other things, revised the policy for transferring relief funds among providers in a hospital system and significantly modified the methodology used to determine lost revenue when applying funds. The October 2020 Notice effectively reinstated the definition of lost revenue to that which existed prior to the September 2020 Notice. According to the October 2020 Notice, lost revenue is defined as the difference between 2019 and 2020 actual patient care revenue.
- Subsequent to December 31, 2020, the HHS issued a Post-Payment Notice of Reporting Requirements on January 15, 2021 (January 2021 Notice) that, among other things, further expanded the definition of lost revenue. Recipients may apply payments to lost revenue up to the amount of (a) the difference between 2019 and 2020 actual patient care revenue or (b) the difference between 2020 budgeted patient care revenue, as approved by the Company's Board of Directors, and 2020 actual patient care revenue. Additionally, the HHS issued an updated CARES Act Provider Relief Fund Frequently Asked Questions on January 28, 2021 (January 2021 FAQ) that, among other

things, clarified the methodology used by a parent organization to allocate targeted and general distributions from the Provider Relief Fund to its subsidiaries. The January 2021 Notice and January 2021 FAQ provide additional information on conditions existing as of December 31, 2020; therefore, the Company's management considered the impact of the updated guidance on the amounts of Provider Relief Fund payments recognized during the year ended December 31, 2020.

During the year ended December 31, 2020, the Company recognized $14.9 million related to distributions from the Provider Relief Fund and state and local grant programs as government stimulus income, a reduction of operating expenses, on its consolidated statement of operations. Unrecognized distributions of $1.4 million are recorded within refundable advances on the consolidated balance sheet at December 31, 2020. Unrecognized distributions may be recognized as reductions to operating expenses in future periods as criteria for recognition are met. Issuance of new guidance and/or amended interpretations of existing guidance may result in changes to management's estimate of government stimulus income and, in certain cases, may result in derecognition of amounts previously recognized.

Medicare Accelerated and Advance Payments

In April 2020, the Company received Medicare accelerated payments of $11.8 million. No additional Medicare accelerated payments were received, or are expected to be received, by the Company. Payments under the Medicare Accelerated and Advance Payment Program represent consideration that must be repaid. Effective October 1, 2020, providers are required to repay Medicare accelerated payments beginning one year after the date of payment issuance via recoupment against future claims for Medicare beneficiaries in accordance with the repayment terms. For the first 11 months of the repayment term, the Centers for Medicare and Medicaid Services (CMS) will automatically recoup 25.0% of Medicare payments otherwise owed to providers. After the first 11 months of the repayment term, CMS will increase the recoupment amount to 50.0% of Medicare payments otherwise owed to providers for a six-month period. If a balance remains after the six-month period, providers will receive a letter for full repayment. If full payment is not received within 30 days of the letter's issuance, the balance will accrue interest at an annual percentage rate of 4.0% assessed for each 30-day period during which the balance remains unpaid.

The Company classifies outstanding Medicare accelerated payments as current or long-term liabilities based on estimates of future consideration for patient care provided to Medicare beneficiaries that will not be due from Medicare and used to offset outstanding accelerated payment balances within one year. At December 31, 2020, the current portion of outstanding Medicare accelerated payments was $4.8 million and recorded as contract liabilities on the Company's consolidated balance sheet. The long-term portion of outstanding Medicare accelerated payments expected to be repaid during the recoupment period was $7.0 million and recorded as long-term contract liabilities on the Company's consolidated balance sheet.

Deferred Employer Portion of Social Security Taxes

At December 31, 2020, the Company had deferred payments of $1.2 million related to its portion of Social Security taxes as permitted by the CARES Act, with 50% of the deferred amount due December 31, 2021 and the remaining 50% due December 31, 2022. The current and long-term portions of the deferred payments each totaled $0.6 million and were recorded as other accrued expenses and liabilities and other long-term liabilities, respectively, on the Company's consolidated balance sheet.

Adoption of Recently Issued Accounting Standards

Effective January 1, 2020, the Company adopted Accounting Standards Update (ASU) 2016-13, *Financial Instruments – Credit Losses (Topic 326): Measurement of Credit Losses on Financial Instruments*, which replaced the current incurred loss impairment methodology with a new methodology that reflects expected credit losses and requires consideration of a broader range of reasonable and supportable information to inform credit loss estimates. The adoption of this standard had no material impact on the Company's consolidated balance sheet, statement of operations and statement of cash flows.

Accounting Standards Not Yet Adopted

In August 2018, the FASB issued ASU 2018-15, *Intangibles – Goodwill and Other – Internal-Use Software (Subtopic 350-40): Customer's Accounting for Implementation Costs Incurred in a Cloud Computing Arrangement That Is a Service Contract* (ASU 2018-15), which requires a customer in a cloud computing arrangement that is a service contract to follow the internal-use software guidance in ASC 350-40, *Intangibles – Goodwill and Other – Internal-Use Software*, to determine which implementation costs to capitalize as assets. ASU 2018-15 is effective for fiscal years beginning after December 15, 2020, and interim periods in annual periods beginning after December 15, 2020. Early adoption is permitted. Management is evaluating the impact of ASU 2018-15 on the Company's consolidated financial statements.

Accounting Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States requires management to make estimates and judgments that affect the amounts reported in the consolidated financial statements and accompanying notes. On an ongoing basis, the Company evaluates its estimates. The Company bases its estimates on historical experience and on various other assumptions that are believed to be reasonable under the circumstances, the results of which form the basis for making judgments about the carrying values of assets and liabilities that are not readily apparent from other sources. Actual results may differ from these estimates.

Revenue Recognition

The Company's revenue generally relates to contracts with patients in which its performance obligations are to provide health care services to the patients. Revenue is recorded during the period the Company's obligations to provide health care services are satisfied. Revenue for performance obligations satisfied over time is recognized based on charges incurred in relation to total expected charges. The Company's performance obligations for inpatient services are generally satisfied over periods that average approximately five days. The Company's performance obligations for outpatient services are generally satisfied over a period of less than one day. The contractual relationships with patients, in most cases, also involve a third-party payer (Medicare, Medicaid, and managed care health plans) and the transaction prices for the services provided are dependent upon the terms provided by (Medicare and Medicaid) or negotiated with (managed care health plans) the third-party payers. The payment arrangements with third-party payers for the services provided to the related patients typically specify payments at amounts less than the Company's standard charges.

The Company's revenue is based upon the estimated amounts the Company expects to be entitled to receive from patients and third-party payers. Estimates of contractual allowances under managed care insurance plans are based upon the payment terms specified in the related contractual agreements. Revenue related to uninsured patients and copayment and deductible amounts for patients who have health care insurance coverage may have discounts applied (uninsured discounts and contractual discounts). The Company also records estimated implicit price concessions (based primarily on historical collection experience) related to uninsured accounts to record self-pay revenue at the estimated amounts expected to be collected.

Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. Estimated reimbursement amounts are adjusted in subsequent periods as cost reports are prepared and filed and as final settlements are determined (in relation to certain government programs, primarily Medicare, this is generally referred to as the cost report filing and settlement process). Settlements under reimbursement agreements with third-party payers are estimated and recorded in the period in which the related services are rendered and are adjusted in future periods as final settlements are determined. Final determination of amounts earned under the Medicare, Medicaid and other third-party payer programs often occurs in subsequent years because of audits by the programs, rights of appeal, and the application of technical provisions. Settlements are considered in the recognition of net patient service revenue on an estimated basis in the period the related services are rendered, and such amounts are subsequently adjusted in future periods as adjustments become known or as years are no longer subject to such audits and reviews. These settlements resulted in an increase to total net revenue of $0.1 million for the year ended December 31, 2020.

At December 31, 2020, the Company's settlements under reimbursement agreements with third-party payers was a net receivable of $0.3 million and consisted of a receivable of $0.4 million included in other current assets and a payable of $0.1 million included in other accrued expenses and liabilities on the consolidated balance sheet.

Final determination of amounts earned under prospective payment and other reimbursement activities is subject to review by appropriate governmental authorities or their agents. In the opinion of the Company's management, adequate provision has been made for any adjustments that may result from such reviews.

Subsequent adjustments that are determined to be the result of an adverse change in the patient's or the payer's ability to pay are recognized as bad debt expense. Bad debt expense for the year ended December 31, 2020 was not material for the Company.

The Company's total net revenue has been presented in the following table (in thousands):

	Year Ended December 31, 2020	
	Amount	% of Total Net Revenue
Medicare	$ 33,612	27.8%
Medicaid	6,866	5.7%
Other managed care	74,088	61.3%
Self-pay and other	4,696	3.9%
Net patient service revenue	119,262	98.7%
Other revenue	1,545	1.3%
Total net revenue	$ 120,807	100.0%

The Company provides care without charge to certain patients that qualify under its local charity care policy. The Company estimates that its costs of care provided under its charity care programs were approximately $32,000 for the year ended December 31, 2020. The Company does not report a charity care patient's charges in revenue as it is the Company's policy not to pursue collection of amounts related to these patients, and, therefore, contracts with these patients do not exist.

The Company's management estimates its costs of care provided under its charity care programs utilizing a calculated ratio of costs to gross charges multiplied by the Company's gross charity care charges provided. The Company's gross charity care charges include only services provided to patients who are unable to pay and qualify under the Company's local charity care policies. To the extent the Company receives reimbursement through the various governmental assistance programs in which it participates to subsidize its care of indigent patients, the Company does not include these patients' charges in its cost of care provided under its charity care program.

Patient Accounts Receivable

Patient accounts receivable are recorded at net realizable value based on certain assumptions applicable to each payer. For third-party payers including Medicare, Medicaid and managed care, the net realizable value is based on the estimated contractual reimbursement percentage, which is based on current contract prices or historical paid claims data by payer. For self-pay accounts receivable, which includes patients who are uninsured and the patient responsibility portion for patients with insurance, the net realizable value is determined using estimates of historical collection experience. These estimates are adjusted for expected recoveries and any anticipated changes in trends.

Patient accounts receivable can be impacted by the effectiveness of the Company's collection efforts. Additionally, significant changes in payer mix, business office operations, economic conditions or trends in federal and state governmental health care coverage could affect the net realizable value of accounts receivable. The Company also continually reviews the net realizable value of accounts receivable by monitoring historical cash collections as a percentage of trailing net patient service revenue, as well as by analyzing current period net revenue and admissions by payer classification, aged accounts receivable by payer, days revenue outstanding, the composition of self-pay receivables between pure self-pay patients and the patient responsibility portion of third-party insured receivables and the impact of recent acquisitions and dispositions.

Patient accounts receivable is the Company's primary concentration of credit risk, which consists of amounts owed by various governmental agencies, managed care payers, commercial insurance companies, employers and patients. The Company manages its patient accounts receivable by regularly reviewing its accounts and contracts and by providing appropriate allowances for uncollectible amounts. The number of patients and payers limits concentration of credit risk from any one payer.

Concentration of Revenue

Revenue related to patients participating in the Medicare and Medicaid programs, collectively, represented 33.5% of the Company's total net revenue for the year ended December 31, 2020. Revenue and receivables from government agencies are significant to the Company's operations, but Company management does not believe that there are significant credit risks associated with these government agencies. The Company's management does not believe that there are any other significant concentrations of revenue from any particular payer that would subject the Company to any significant credit risks in the collection of its accounts receivable.

Inventories

Inventories consist primarily of hospital supplies and pharmaceuticals and are stated at the lower of cost (first-in, first-out method) or market. These inventory items are primarily operating supplies used in the direct or indirect treatment of patients.

Property and Equipment

Property and equipment additions are recorded at cost. Property and equipment acquired in connection with business combinations are recorded at estimated fair value in accordance with the acquisition method of accounting as prescribed in ASC 805-10, *Business Combinations* (ASC 805-10). Routine maintenance and repairs are charged to expense as incurred. Expenditures that increase values, change capacities or extend useful lives are capitalized. Depreciation is computed by applying the straight-line method over the lesser of the estimated useful lives of the assets or lease term, ranging generally from ten to 25 years for buildings and improvements and three to ten years for furniture and equipment.

When events, circumstances or operating results indicate the carrying values of certain long-lived assets expected to be held and used might be impaired, the Company prepares projections of the undiscounted future cash flows expected to result from the use of the assets and their eventual disposition. If the projections indicate the recorded amounts are not expected to be recoverable, such amounts are reduced to estimated fair value. Fair value may be estimated based upon internal evaluations that include quantitative analyses of revenue and cash flows, reviews of recent sales of similar assets and independent appraisals. No impairment was recorded during the year ended December 31, 2020.

Goodwill

Goodwill represents the excess of the purchase price over the estimated fair value of identifiable net assets acquired in business combinations. In accordance with ASC 350, *Intangibles — Goodwill and Other*, goodwill and intangible assets acquired in a purchase business combination and determined to have an indefinite useful life are not amortized but are subject to annual impairment tests. The Company tests for goodwill impairment at the reporting unit level and has determined that it has one reporting unit for purposes of the assessment of goodwill impairment.

In addition to an annual impairment test, the Company evaluates goodwill and intangible assets for impairment whenever circumstances indicate a possible impairment may exist. During 2018, the Company adopted ASU 2017-04, *Simplifying the Test for Goodwill Impairment*. Under this standard, the Company first assesses qualitative factors to determine whether it is more likely than not (that is, a likelihood of more than 50%) that the fair value of a reporting unit is less than its carrying amount, including goodwill. If, after assessing qualitative factors, the Company determines that it is more likely than not that the fair value of a reporting unit is less than its carrying amount, a quantitative impairment test is performed to identify potential goodwill impairment and measure the amount of goodwill impairment loss to be recognized, if any.

The Company completed its most recent qualitative goodwill impairment assessment as of October 1, 2020. After evaluating the results, events and circumstances of the Company, the Company concluded that sufficient evidence existed to assert qualitatively that it was more likely than not that the estimated fair value of the reporting unit remained in excess of its carrying value. Therefore, a quantitative impairment assessment was not necessary. There were no goodwill or other intangible impairment charges in 2020. The Company bases its estimates of fair value of a reporting unit on various assumptions on a qualitative and, when necessary, quantitative basis that are believed to be reasonable under the circumstances. Such assumptions include estimates using the income approach, which estimates fair value based on discounted cash flows, and the market approach, which estimates fair value based on comparable market prices. Actual results may differ from the estimates used in the Company's assumptions, which may require a future impairment charge that could have a material adverse impact on the Company's financial position and results of operations. Refer to Note 4 for further information.

Leases

The Company leases property and equipment under operating leases but is not party to any leases with durations greater than 12 months. As a result, the adoption of ASU 2016-02, *Leases (Topic 842)* had no impact on the Company's consolidated balance sheet, statement of operations and statement of cash flows.

Self-Insured Liabilities

Ardent maintains a professional and general liability policy and workers' compensation insurance on behalf of its affiliates. Additionally, Ardent is self-insured for substantially all of the medical benefits of its employees. Ardent maintains reserves for these self-insured liabilities reflective of known claims and estimated incurred but not reported claims. These amounts are billed as premiums to each affiliate.

Income Taxes

The Company is organized as a limited liability company and taxed as a partnership for federal and state income tax purposes under the Internal Revenue Code and various state statutes. As such, all income is taxable directly to its members; therefore, no federal or state income tax provision is recorded in the Company's financial statements. Additionally, no deferred tax assets or liabilities are recorded in the consolidated balance sheet. Management is not aware of any course of action or series of events that has occurred that might adversely affect the Company's tax status.

Fair Value Disclosures of Financial Instruments

The Company applies the provisions of ASC 820, *Fair Value Measurements and Disclosures* (ASC 820), which provides a single definition of fair value, establishes a framework for measuring fair value, and expands disclosures concerning fair value measurements. The Company applies these provisions to the valuation and disclosure of certain financial instruments. ASC 820 establishes a three-tier fair value hierarchy, which prioritizes the inputs used in measuring fair value. These tiers include: (i) Level 1, which is defined as quoted prices in active markets that can be accessed at the measurement date; (ii) Level 2, which is defined as inputs other than quoted prices in active markets that are observable, either directly or indirectly; and (iii) Level 3, which is defined as unobservable inputs resulting from the existence of little or no market data, therefore potentially requiring an entity to develop its own assumptions.

Accounts receivable, inventories, other current assets, accounts payable, accrued salaries and benefits, and other accrued expenses and liabilities are reflected in the accompanying consolidated financial statements at amounts that approximate fair value because of the short-term nature of these instruments. The fair value of the Company's long-term liabilities approximates their carrying value based on current interest rate assumptions and remaining term to maturity. The fair value of amounts due from affiliate cannot be determined due to the uncertainty of timing of payment.

3. Property and Equipment

Property and equipment as of December 31, 2020, consists of the following (in thousands):

Land and improvements	$	16,115
Buildings and improvements		101,615
Equipment		63,625
Construction in progress		73
		181,428
Less accumulated depreciation and amortization		(68,945)
Property and equipment, net	$	112,483

Depreciation of property and equipment was $9.5 million for the year ended December 31, 2020.

4. Goodwill

The following table summarizes the changes in the carrying amount of goodwill for the following period (in thousands):

	Gross	Accumulated Impairment	Net
Balance at December 31, 2019	$ 582	$ —	$ 582
Goodwill acquired	—	—	—
Balance at December 31, 2020	**$ 582**	**$ —**	**$ 582**

5. Internal-Use Software

The Company has been allocated certain costs from Ardent related to implementation costs incurred associated with the Company's conversion to a new patient accounting system in 2019. The costs were either capitalized or expensed by the Company in accordance with ASC 350-40, *Internal-Use Software* (ASC 350-40-25).

Under the guidance of ASC 350-40-25, costs incurred during the implementation stage are generally capitalizable, subject to the conditions detailed in the accounting standard. Additionally, costs incurred for clearly identifiable upgrades and enhancements after implementation are also generally capitalizable to the extent they provide additional functionality. Costs incurred prior to implementation, and costs for training, maintenance, and support services are expensed as incurred.

Costs capitalized by Ardent and allocated to the Company are included in other assets on the consolidated balance sheet and are amortized over a seven year period. At December 31, 2020, the Company had other assets related to allocated capitalized software costs of $3.7 million. Amortization expense for software was $0.7 million for the year ended December 31, 2020. Costs allocated by Ardent and expensed during the year, excluding software amortization expense, were $0.1 million for the year ended December 31, 2020 and are included in other operating expenses on the consolidated statement of operations.

6. Related Party Transactions

Ardent provides services to the Company with regard to management and administration, financial management, clinical and patient care, medical staff relations, group purchasing programs, information technology, and other services. The Company reimburses Ardent and its affiliates for these services based on a management fee arrangement. The Company recorded management fee expense of $2.4 million to Ardent and its affiliates for the year ended December 31, 2020.

Amounts due from affiliate of $29.2 million at December 31, 2020, represents the excess of amounts transferred by the Company to an affiliate of Ardent over the amounts paid by an affiliate of Ardent on behalf of the Company. Amounts paid by affiliate on behalf of the Company generally include operating expenses and fees and services provided by Ardent to the Company. Outstanding amounts due from affiliate bear interest at a rate per annum equal to the London interbank offered rate applicable for an interest period of three months. During the year ended December 31, 2020, the Company recorded interest income on amounts due from affiliate of $0.1 million.

7. Long-Term Debt

In October 2018, the Company entered into an agreement with Public Service Electric and Gas Company (PSE&G) to implement various energy cost-reduction strategies and measures to improve the hospital's energy

efficiency. Pursuant to the terms of the agreement, PSE&G funded a portion of certain energy-reducing capital projects without requiring repayment from the Company. The total funding received from PSE&G that is required to be repaid over five years and does not bear interest was $1.8 million. At December 31, 2020, the outstanding balance owed by the Company was $0.4 million.

Future Installments

Future scheduled installments of long-term debt at December 31, 2020 are as follows (in thousands):

2021	$	292
2022		129
2023		10
Total	$	431

8. Self-Insured Liabilities

Professional and General Liability

Ardent maintains claims-made professional liability insurance coverage and occurrence-based general liability insurance coverage with independent third-party carriers on behalf of its affiliates. During the year ended December 31, 2020, third party policies cover claims totaling up to $100.0 million, per occurrence and in the aggregate, subject, in most cases, to a $5.0 million self-insured retention per occurrence.

Ardent maintains reserves for estimates of loss that will ultimately be incurred on claims that have been reported but not paid and claims that have been incurred but not reported. These reserves are established based on consultation with independent actuaries and billed as premiums to each affiliate. No reserve for professional and general liability losses is recorded on the accompanying consolidated balance sheet.

The costs of professional and general liability coverage are allocated to the Company based on actuarially determined estimates. Expenses for professional and general liability coverage allocated to the Company were $0.5 million for the year ended December 31, 2020, and are included in other operating expenses on the consolidated statement of operations.

Workers Compensation and Occupational Injury Liability

Ardent maintains workers' compensation liability insurance with statutory limits and employer liability policy limits of $1.0 million for each occurrence from an unrelated commercial insurance carrier subject, in most cases, to a $500,000 deductible per occurrence. Ardent maintains the associated reserves for its workers' compensation and employer liabilities and allocates the cost of the self-insured coverage to the Company based, in part, on actual claims experience.

Based on valuations from the Company's independent actuary, a net expense was allocated to the Company of $1.5 million for the year ended December 31, 2020, and is included in other operating expenses on the consolidated statement of operations.

9. Employee Benefit Plans

Defined Contribution Plan

The Company participates in Ardent's contributory benefit plan that is available to employees who meet certain minimum requirements. The plan requires the Company to match 100% of a participant's contributions up to the first 3% of the participant's compensation. The Company incurred total contribution costs related to the retirement plan of $0.9 million for the year ended December 31, 2020.

Employee Health Plan

Ardent is self-insured for substantially all of the medical benefits of its employees. Ardent maintains reserves for medical benefits that reflect known claims and an estimate of incurred but not reported claims based on an actuarial analysis as of December 31, 2020 and are billed as premiums to each affiliate. The reserve for incurred but not paid claims is maintained by Ardent and adjusted as necessary through additional allocations. Expenses for medical benefit coverage allocated to the Company were approximately $4.1 million for the year ended December 31, 2020, and are included in salaries and benefits expense on the consolidated statement of operations.

10. Commitments and Contingencies

From time to time, claims and suits arise in the ordinary course of the Company's business. In certain of these actions, plaintiffs request punitive or other damages against the Company that may not be covered by insurance. The Company does not believe that it is a party to any proceeding that, in management's opinion, would have a material adverse effect on the Company's business, financial condition, results of operations or cash flows.

The Company has acquired and plans to continue to acquire businesses with prior operating histories. Acquired companies may have unknown or contingent liabilities, including liabilities for failure to comply with health care laws and regulations, such as billing and reimbursement, fraud and abuse and anti-kickback laws.

The Company has from time to time identified certain past practices of acquired companies that do not conform to its standards. Although the Company institutes policies designed to conform such practices to its standards following completion of acquisitions, there can be no assurance that the Company will not become liable for the past activities of these acquired facilities that may later be asserted to be improper by private plaintiffs or government agencies. Although the Company generally seeks to obtain indemnification from prospective sellers covering such matters, there can be no assurance that any such matter will be covered by indemnification, or if covered, that such indemnification will be adequate to cover potential losses and fines.

11. Subsequent Events

The Company has evaluated its financial statements and disclosures for the impact of subsequent events through April 7, 2021, the date these consolidated financial statements were available for issuance.