Pascack Valley Health System, LLC

Consolidated Financial Statements with Report of Independent Auditors
December 31, 2021

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Report of Independent Auditors

To the Board of Managers and Members of Pascack Valley Health System, LLC

Opinion

We have audited the consolidated financial statements of Pascack Valley Health System, LLC (the Company), which comprise the consolidated balance sheet as of December 31, 2021, and the related consolidated statements of operations, cash flows, and members' equity for the year then ended, and the related notes (collectively referred to as the "financial statements").

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the Company at December 31, 2021, and the results of its operations and its cash flows for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

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

Responsibilities of Management for the Financial Statements

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

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

Auditor's Responsibilities for the Audit of the Financial Statements

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

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In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Company's ability to continue as a going concern for a reasonable period of time.

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

Ernst & Young LLP

April 19, 2022

Pascack Valley Health System, LLC
Consolidated Balance Sheet
December 31, 2021
(In Thousands)

	December 31, 2021
Assets	
Current assets:	
Accounts receivable	$ 15,283
Inventories	3,107
Prepaid expenses	869
Other current assets	838
Total current assets	20,097
Property and equipment, net	108,049
Goodwill	582
Amounts due from affiliate	23,066
Other assets	3,514
Total assets	$ 155,308
Liabilities and members' equity	
Current liabilities:	
Accounts payable	$ 8,933
Accrued salaries and benefits	3,460
Contract liabilities	6,772
Other accrued expenses and liabilities	1,595
Current portion of long-term debt	206
Total current liabilities	20,966
Long-term debt, less current portion	11
Other long-term liabilities	1,103
Total liabilities	22,080
Members' equity:	
Common units	175,205
Accumulated deficit	(41,977)
Members' equity	133,228
Total liabilities and members' equity	$ 155,308

See accompanying notes.

Pascack Valley Health System, LLC
Consolidated Statement of Operations
Year Ended December 31, 2021
(In Thousands)

	Year Ended December 31, 2021
Total net revenue	$ 140,449
Expenses:	
Salaries and benefits	48,607
Professional fees	17,302
Supplies	23,953
Other operating expenses	15,136
Government stimulus income	(3,783)
Depreciation and amortization	9,035
Management fees	2,859
Total operating expenses	113,109
Income from operations	27,340
Interest income, net	40
Net income	$ 27,380

See accompanying notes.

Pascack Valley Health System, LLC
Consolidated Statement of Members' Equity
Year Ended December 31, 2021
(Dollars in Thousands)

	Units	Amount	Accumulated Deficit	Total
Balance at December 31, 2020	1,477	$ 175,205	$ (35,932)	$ 139,273
Distributions made to:				
LHP Pascack Valley, LLC	–	–	(21,726)	(21,726)
Hackensack UMC	–	–	(11,699)	(11,699)
Net income	–	–	27,380	27,380
Balance at December 31, 2021	**1,477**	**$ 175,205**	**$ (41,977)**	**$ 133,228**

See accompanying notes.

Pascack Valley Health System, LLC
Consolidated Statement of Cash Flows
Year Ended December 31, 2021
(In Thousands)

	Year Ended December 31, 2021
Cash flows from operating activities:	
Net income	$ 27,380
Adjustments to reconcile net income to net cash provided by operating activities:	
Depreciation and amortization	9,035
Change in cash from operating assets and liabilities	
Accounts receivable	(1,927)
Inventories and other assets	2,368
Accounts payable and accrued expenses	896
Refundable advances of government stimulus income	(1,375)
Medicare accelerated payments	(4,226)
Net cash provided by operating activities	32,151
Cash flows from investing activities:	
Purchases of property and equipment	(4,456)
Net cash used in investing activities	(4,456)
Cash flows from financing activities:	
Payments on borrowings	(359)
Distributions to members	(33,425)
Payments to affiliate	6,089
Net cash used in financing activities	(27,695)
Change in cash and cash equivalents	–
Cash and cash equivalents at beginning of period	–
Cash and cash equivalents at end of period	$ –

See accompanying notes.

1. Organization and Basis of Presentation

Pascack Valley Health System, LLC (the "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, 2021, 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. Many of the restrictions implemented by government agencies at the onset of the pandemic have been eased; however, some restrictions may be reinstituted from time to time. During the year ended December 31, 2021, the Company's patient volumes and operations were significantly impacted by the effects of the COVID-19 pandemic.

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 Act ("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 could 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 years ended December 31, 2021 and 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 permitted 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 duration and severity of the pandemic and negative economic conditions arising from the pandemic, the volume of canceled or rescheduled procedures at our facility, the demand for clinical personnel and its corresponding impact on labor costs and hospital availability,

the timing, availability, pace of administration, efficacy and adoption of medical treatments and vaccines, including the ongoing rollout of currently available vaccines, the spread of potentially more contagious and/or virulent forms of the virus, supply chain disruptions, including shortages, delays, and significant price increases for medical supplies, and the impact of government actions and administrative regulation on the healthcare industry and broader economy, including through existing and any future stimulus efforts. 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

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 (the "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 revenues 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:

- 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 revenues, 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 revenues 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 revenues when applying funds. The October 2020 Notice effectively reinstated the definition of lost revenue to that which existed prior to the September 2020 Notice. The October 2020 Notice defined lost revenue as the difference between 2019 and 2020 actual patient care revenue.
- On January 15, 2021, the HHS issued a Post-Payment Notice of Reporting Requirements that, among other things, further expanded the definition of lost revenue. Recipients may apply payments to lost revenue up to the amount (a) of the difference between 2019 and 2020 actual patient care

revenue, (b) of the difference between 2020 budgeted patient care revenue, as approved by the Company's Board of Managers prior to March 27, 2020, and 2020 actual patient care revenue, or (c) calculated by any reasonable method of estimating revenue. Additionally, the HHS issued an updated CARES Act Provider Relief Fund Frequently Asked Questions on January 28, 2021 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.

- On June 11, 2021, the HHS issued a Post-Payment Notice of Reporting Requirements ("June 2021 Notice") outlining new timelines for using and reporting on the use of Provider Relief Funds for eligible COVID-19 attributable expenses and losses. Funds are available to use for at least 12 months from the date of receipt and may be available for a maximum of 18 months, depending on the time period during which the payments were received. Recipients who received one or more payments exceeding a total of $10,000 during a "Payment Received Period" are required to report in each applicable "Reporting Time Period." Deadlines for reporting on the use of such funds depend on the time period in which the payments were received. Recipients who do not report within the appropriate Reporting Time Period will be considered out of compliance with the payment Terms and Conditions and the funds may be subject to recoupment. The June 2021 Notice also provided guidance on other matters, including reporting by parent entities on behalf of subsidiaries and directions on how to report on the use of funds using an entity's normal basis of accounting (e.g., cash basis, accrual basis) and to submit consolidated reports.

During the year ended December 31, 2021, the Company received $3.9 million in distributions from the Provider Relief Fund and other state and local programs and recognized $3.8 million as government stimulus income, a reduction of operating expenses, on its consolidated statement of operations for the funds received and to be retained by the Company. During the year ended December 31, 2021, the Company transferred $1.5 million of unrecognized general and targeted Provider Relief distributions to affiliates of Ardent, which included amounts received in 2020. The transfer occurred in accordance with interpretive guidance issued by HHS, which permits a parent organization to allocate general distributions received by a subsidiary to other eligible health care subsidiaries at its discretion. Further, a parent organization is permitted to allocate targeted distributions received by a subsidiary to other eligible health care subsidiaries up to its pro rata ownership share of the subsidiary. At December 31, 2021, the Company had no unrecognized distributions remaining. Issuance of new guidance, as well as government compliance audits, may result in changes to management's estimate of government stimulus income and, in certain cases, may result in derecognition of amounts previously recognized and repayment of such amounts.

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, 2021, the current portion of outstanding Medicare accelerated payments expected to be recouped was $6.8 million and recorded as contract liabilities on the Company's consolidated balance sheet. The current portion of Medicare accelerated payments expected to be repaid in full after the recoupment period was $0.8 million at December 31, 2021 and is included in other accrued expenses and liabilities on the Company's consolidated balance sheet.

Deferred Employer Portion of Social Security Taxes

The Company deferred payment of its portion of Social Security payroll taxes incurred between March 27, 2020 and December 31, 2020. As required by the CARES Act, 50% of the total deferred payments was due December 31, 2021 and the remaining 50% is due December 31, 2022. At December 31, 2021, the Company's remaining deferred balance was $0.6 million and included in other accrued expenses and liabilities on the Company's consolidated balance sheet.

Adoption of Recently Issued Accounting Standards

Effective January 1, 2021, the Company adopted 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*, 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. The adoption of this standard had no material impact on the Company's consolidated balance sheets, statements of operations and cash flows.

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 had no material impact on total net revenue for the year ended December 31, 2021.

At December 31, 2021, the Company's settlements under reimbursement agreements with third-party payers consisted of a receivable of $0.5 million included in other current assets and a payable of $44,000 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, 2021 was not material for the Company.

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

	Year Ended December 31, 2021	
	Amount	% of Total Net Revenue
Medicare	$ 38,116	27.1%
Medicaid	6,978	5.0%
Other managed care	88,599	63.1%
Self-pay and other	5,165	3.7%
Net patient service revenue	138,858	98.9%
Other revenue	1,591	1.1%
Total net revenue	$ 140,449	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 $33,000 for the year ended December 31, 2021. 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 estimated conversions of patient responsibility portions, 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 healthcare 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 operating revenues, 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 32.1% of the Company's total net revenue for the year ended December 31, 2021. 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 revenues and cash flows, reviews of recent sales of similar assets and independent appraisals. No impairment was recorded during the year ended December 31, 2021.

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. In accordance with ASU 2017-04, *Simplifying the Test for Goodwill Impairment*, 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, 2021. 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 2021. The Company bases its estimates of fair value of the 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.

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. 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, prepaid expenses, other current assets, accounts payable, accrued salaries and benefits, contract liabilities and other accrued expenses and liabilities (other than those pertaining to lease liabilities) are reflected in the accompanying consolidated balance sheet 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

(other than those pertaining to lease 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, 2021, consists of the following (in thousands):

Land and improvements	$	16,115
Buildings and improvements, including leasehold improvements		101,803
Equipment		66,464
Construction in progress		1,445
		185,827
Less accumulated depreciation and amortization		(77,778)
Property and equipment, net	$	108,049

Depreciation of property and equipment was $9.0 million for the year ended December 31, 2021.

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, 2020	$ 582	$ —	$ 582
Goodwill acquired	—	—	—
Balance at December 31, 2021	**$ 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, 2021, the Company had other assets related to allocated capitalized software costs of $3.0 million. Amortization expense for software was $0.7 million for the year ended December 31, 2021.

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 $2.9 million to Ardent and its affiliates for the year ended December 31, 2021.

MPV New Jersey MD Services, P.C. ("NJ MD"), a New Jersey non-profit corporation licensed by the New Jersey State Board of Medical Examiners and a managed division of LHP, provides the Company with the following services: (1) acquisition or establishment, and operation of practice sites in the community; (2) employment of physicians, as needed, to provide professional health care services to patients and to provide additional administrative and supervisory services relating to the clinical operations of the practice sites; and (3) recruitment, employment, or other engagement of the services of (a) clinical personnel to provide health care services to patients under the supervision of the physicians and of (b) administrative personnel to provide certain practice management services and carry out the day-to-day operations of the practice sites and the physicians' practices. The Company reimburses NJ MD for these services based on an Affiliation Agreement, which was effective March 2013. During the year ended December 31, 2021, the Company recorded $5.8 million for reimbursement of services provided by NJ MD, which was offset by a credit from NJ MD of $5.4 million for government stimulus income recognized by NJ MD. The net impact of $0.4 million was recorded as professional fees on the Company's consolidated statement of operations for the year ended December 31, 2021.

Amounts due from affiliate of $23.1 million at December 31, 2021, represent 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, 2021, the Company recorded interest income on amounts due from affiliate of $40,000.

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 portion of the 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, 2021, the outstanding balance owed by the Company was $0.2 million.

Future Installments

Future scheduled installments of long-term debt at December 31, 2021 are as follows (in thousands):

2022	$	206
2023		11
Total	$	217

8. Other Accrued Expenses and Liabilities

A summary of other accrued expenses and liabilities as of December 31, 2021 is as follows (in thousands):

Third-party settlements payable	$	44
Deferred employer Social Security payroll taxes - current portion		584
Refund liabilities		767
Other		200
Other accrued expenses and liabilities	**$**	**1,595**

9. 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, 2021, third party policies cover claims totaling up to $100.0 million, per occurrence and in the aggregate, subject, in most cases, to a $7.5 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 $1.2 million for the year ended December 31, 2021, 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 $2.4 million for the year ended December 31, 2021, and is included in other operating expenses on the consolidated statement of operations.

10. 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, 2021.

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, 2021 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 $3.0 million for the year ended December 31, 2021, and are included in salaries and benefits expense on the consolidated statement of operations.

11. 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.

12. Subsequent Events

The Company has evaluated its financial statements and disclosures for the impact of subsequent events through April 19, 2022, the date these consolidated financial statements were available for issuance.