CONSOLIDATED FINANCIAL STATEMENTS

(Unaudited)

SEPTEMBER 30, 2021

ONE Adventist Health Way
Roseville, CA 95661

Consolidated Financial Statements (Unaudited)
and Supplementary Information

Adventist Health

September 30, 2021

Consolidated Financial Statements

Supplementary Information

Adventist Health

Consolidated Balance Sheets
(In millions of dollars)

	September 30 2021 (Unaudited)	December 31 2020 (Audited)
Assets		
Cash and cash equivalents	**$ 179**	$ 261
Short-term investments	**197**	176
Patient accounts receivable	**690**	612
Receivables from third-party payors	**480**	501
Other current assets	**219**	243
Total current assets	**1,765**	1,793
Noncurrent investments	**2,264**	2,236
Other assets	**416**	413
Property and equipment, net	**2,235**	2,302
Total assets	**$ 6,680**	$ 6,744
Liabilities and net assets		
Accounts payable	**$ 327**	$ 265
Accrued compensation and related payables	**321**	306
Liablitities to third-party payors	**336**	232
Other current liabilities	**144**	140
Short-term financing	**60**	60
Current maturities of long-term debt	**36**	20
Total current liabilities	**1,224**	1,023
Long-term debt, net of current maturities	**2,002**	2,036
Other noncurrent liabilities	**382**	570
Total liabilities	**3,608**	3,629
Net assets without donor restrictions:		
Controlling	**2,989**	3,040
Noncontrolling	**15**	14
Net assets with donor restrictions	**68**	61
Total net assets	**3,072**	3,115
Total liabilities and net assets	**$ 6,680**	$ 6,744

Adventist Health

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

	Nine months ended September 30	
	2021 (Unaudited)	**2020 (Unaudited)**
Revenues and support:		
Patient service revenue	**$ 3,424**	$ 3,036
Premium revenue	**141**	120
Other revenue	**187**	373
Net assets released from restrictions for operations	**18**	8
Total revenues and support	**3,770**	3,537
Expenses:		
Employee compensation	**1,712**	1,670
Professional fees	**536**	432
Supplies	**576**	470
Purchased services and other	**885**	784
Interest	**49**	51
Depreciation and amortization	**144**	149
Total expenses	**3,902**	3,556
Loss from operations	**(132)**	(19)
Nonoperating income:		
Investment income	**88**	57
Loss on acquisition and divestitures	**–**	(1)
Other nonoperating gain	**–**	5
Total nonoperating income	**88**	61
(Deficit) excess of revenues over expenses	**(44)**	42
(Deficit) of revenues over expenses from noncontrolling interests	**(1)**	–
(Deficit) excess of revenues over expenses from controlling interests	**(45)**	42

Adventist Health

Consolidated Statements of Operations and Changes in Net Assets - Continued
(In millions of dollars)

	Nine months ended September 30	
	2021 (Unaudited)	**2020 (Unaudited)**
Net assets without donor restrictions:		
Controlling:		
Excess (deficit) of revenues over expenses from controlling interests	**$ (45)**	$ 42
Net change in unrealized gains and losses on other-than-trading securities	**(8)**	7
Donated property and equipment	**–**	1
Net assets released from restrictions for capital additions	**4**	2
Transfers from (to) related parties	**–**	–
Increase in net assets without donor restrictions before discontinued operations	**(49)**	52
Loss from discontinued operations	**(2)**	–
Increase in net assets without donor restrictions – controlling	**(51)**	52
Noncontrolling:		
Excess of revenues over expenses from noncontrolling interests	**1**	–
Increase in net assets without donor restrictions – noncontrolling	**1**	–
Net assets with donor restrictions:		
Restricted gifts and grants	**28**	12
Net assets released from restrictions	**(22)**	(10)
Other donor-restricted activity	**1**	**–**
Increase in net assets with donor restrictions	**7**	2
Increase in net assets	**(43)**	54
Net assets, beginning of year	**3,115**	2,988
Net assets, end of year	**$ 3,072**	$ 3,042

Note A – Summary of Significant Accounting Policies

Reporting Entity and Principles of Consolidation: Adventist Health System/West (Adventist Health) is a California not-for-profit religious corporation that controls and operates hospitals and other healthcare facilities, and wellness promoting operations in the western United States (collectively, the "System"). Many of the hospitals now controlled and operated by Adventist Health were formerly operated by various conferences of the Seventh-day Adventist Church (the "Church"). The obligations and liabilities of Adventist Health and its hospitals and other healthcare facilities are neither obligations nor liabilities of the Church or any of its other affiliated organizations.

Note B – Fair Value of Financial Instruments

The System accounts for certain assets at fair value. A fair value hierarchy for valuation inputs has been established to prioritize the valuation inputs into three levels based on the extent to which inputs used in measuring fair value are observable in the market. Each fair value measurement is reported in one of the three levels determined by the lowest level of input considered significant to the fair value measurement in its entirety. These levels are defined as follows:

Level 1: Quoted prices are available in active markets for identical assets as of the measurement date. Financial assets in this category include U.S. treasury securities, U.S. and foreign equities, and exchange-traded mutual funds.

Level 2: Pricing inputs are based on quoted prices for similar instruments in active markets, quoted prices for identical or similar instruments in markets that are not active, and model-based valuation techniques for which all significant assumptions are observable in the market or can be corroborated by observable market data for substantially the full term of the assets. Financial assets in this category generally include U.S. government agencies and municipal bonds, asset-backed securities, and U.S. corporate bonds.

Level 3: Pricing inputs are generally unobservable for the assets and include situations where there is little, if any, market activity for the investment. The System had no Level 3 investments at September 30, 2021.

There were no transfers of financial assets between Level 1 and Level 2 of the fair value hierarchy.

(In millions of dollars)

Note B – Fair Value of Financial Instruments (continued)

The following represents assets measured at fair value or at NAV as a practical expedient on a recurring basis at September 30, 2021:

	Quoted Prices in Active Markets for Identical Instruments (Level 1)	Significant Observable Inputs (Level 2)	Totals
Cash and cash equivalents	**$ 238**	**$ –**	**$ 238**
Fixed income:			
U.S. government treasury obligations	**56**	**–**	**56**
U.S. corporation and agency debentures	**–**	**46**	**46**
U.S. agency mortgage-backed securities	**–**	**6**	**6**
U.S. Corporate debt securities	**–**	**497**	**497**
Municipal bonds	**–**	**8**	**8**
Mutual funds	**268**	**164**	**432**
Equities:			
Equity	**8**	**–**	**8**
Mutual funds	**844**	**–**	**844**
Total financial assets stated at fair value	**$ 1,414**	**$ 721**	**2,135**
Commercial real estate			**23**
Investments measured at NAV			**482**
Other investments			**88**
Total cash and investments			**$ 2,728**

Cash and cash equivalents of $238 at September 30, 2021 includes $54 of cash equivalents held in the System's investments held by trustees for self-insurance programs and $5 in unrestricted investments.

Commercial real estate investments are recorded at cost or fair market value if donated. These investments are periodically reviewed for impairment and written down if necessary. Other investments include retirement plan assets, joint ventures, and partnerships and are included in other assets.

(In millions of dollars)

Note B – Fair Value of Financial Instruments (continued)

As of September 30, 2021, the Level 2 instruments listed in the fair value hierarchy tables above use the following valuation techniques and inputs:

U.S. corporation and agency debentures: The fair value of investments in U.S. corporation and agency debentures is primarily determined using consensus pricing methods of observable market-based data. Significant observable inputs include quotes, spreads, and data points for yield curves.

U.S. agency mortgage-backed securities: The fair value of U.S. agency mortgage-backed securities is primarily determined using matrices. These matrices utilize observable market data of bonds with similar features, prepayment speeds, credit ratings, and discounted cash flows. Additionally, observed market movements, tranche cash flows, and benchmark yields are incorporated in the pricing models.

U.S. corporate debt securities: The fair value of investments in corporate debt securities is primarily determined using techniques that are consistent with the market approach. Significant observable inputs include reported trades, dealer quotes, security-specific characteristics, and multiple sources of spread data points in developing yield curves.

Municipal bonds: The fair value of municipal bonds is determined using a market approach. The inputs include yield benchmark curves, prepayment speeds, and observable market data, such as institutional bids, dealer quotes, and two-sided markets.

Certain of the investments are reported using a calculated NAV or its equivalent. These investments are not expected to be sold at amounts that are different from NAV. The following table and explanations identify attributes relating to the nature of the risk of such investments:

	September 30, 2021			
	NAV	**Unfunded Commitments**	**Redemption Frequency (if currently Eligible)**	**Redemption Notice Period (if Currently Eligible)**
Commingled funds – equity securities	$ 105	$ –	Weekly/Monthly	4-30 days
Hedge Funds	287	10	Monthly/Quarterly	45-60 days
Private Equity Funds	90	36	None	None
Total	$ 482	$ 46		

Commingled funds – equity securities: This class includes investments in commingled funds that invest primarily in U.S. or foreign equity securities and attempt to match the returns of specific equity indices.

(In millions of dollars)

Note B – Fair Value of Financial Instruments (continued)

Hedge funds: This class includes investments in hedge funds that expand the universe of potential investment approaches available by employing a variety of strategies and techniques within and across various asset classes. The primary objective for these funds is to balance returns while limiting volatility by allocating capital to external portfolio managers selected for expertise in one or more investment strategies, which may include, but are not limited to, equity long/short, event driven, relative value, and directional. The following summarizes the redemption criteria for the hedge fund portfolio as of September 30, 2021:

% of Hedge Funds	Redemption Criteria	Notice Period
39%	Redeemable weekly	30 days
28%	Redeemable monthly	45–60 days
28%	Redeemable quarterly	45 days
5%	Up to 12.5% redeemable quarterly on non-consecutive quarters	60 days

Private equity funds: These investments cannot be redeemed by the System; rather the System has committed an amount to invest in the private funds over the respective commitment periods. After the commitment period has ended, the nature of the investments in this category is that the distributions are received through the liquidation of the underlying assets.

(In millions of dollars)

Note C – Investments and Assets Whose Use is Limited

The following is a summary of unrestricted investments and assets whose use is limited:

	September 30 2021	December 31 2020
Total unrestricted investments	**$ 2,343**	$ 2,232
Assets designated by the Board, primarily for property and equipment	**26**	13
Investments held by trustees for:		
Self-insurance programs	**76**	150
Charitable annuities and other	**2**	3
Total investments held by trustees	**78**	153
Donor-restricted investments for:		
Charitable trusts and life estate tenancies	**5**	5
Other purposes	**9**	9
Total donor-restricted investments	**14**	14
Total investments	**2,461**	2,412
Less short-term investments	**197**	176
Total noncurrent investments	**$ 2,264**	$ 2,236

Liquidity Management: As part of its liquidity management, the System's strategy is to structure its financial assets to be available to satisfy general operating expenses, current liabilities, and other obligations as they come due. The System invests cash in excess of daily requirements in short-term investments and has a committed syndicated line of credit and a commercial paper program to help manage unanticipated liquidity needs. Additionally, other unrestricted noncurrent investments of $2,227 at September 30, 2021 may be utilized if necessary.

The System's financial assets available for general operating expenses within one year are as follows:

	September 30, 2021
Cash and cash equivalents	$ 179
Short-term investments	197
Patient accounts receivable	690
Receivables from third-party payors	480
Other receivables	65
	$ 1,611

(In millions of dollars)

Note D – Investment Income

Net realized and unrealized investment income, including capital gains on unrestricted, board designated, and trustee-held funds, includes the following:

	Nine Months Ended September 30	
	2021	**2020**
Realized gains, net	**$ 68**	$ 5
Unrealized gains, net	**20**	3
	88	8
Interest and dividend income	**32**	18
	$ 120	$ 26

Interest and dividend income are included in other revenue. For purposes of performance evaluation, management considers interest and dividend earnings to be components of operating income. Realized and unrealized gains and losses are components of nonoperating income and are reported in investment income on the accompanying consolidated financial statements.

Changes in net unrealized gains and losses on other-than-trading debt securities, reported at fair value, are separately disclosed in the consolidated statements of operations and changes in net assets. Unrealized gains and losses associated with these securities relate principally to market changes in interest rates for similar types of securities. Since the System has the intent and ability to hold these securities for the foreseeable future, and it is more-likely-than-not that the System will not be required to sell the investments before their recovery, the declines are not reported as realized unless they are deemed to be other-than-temporary. In determining whether the losses are other-than-temporary, the System considers the length of time and extent to which the fair value has been less than cost or carrying value, the financial strength of the issuer, and the intent and ability of the System to retain the security for a period of time sufficient to allow for anticipated recovery or maturity.

Note E – Patient Accounts Receivable

The System manages its receivables by regularly reviewing its patient accounts and contracts and by providing appropriate allowances for contractual reimbursement, policy discounts, charity and uncollectible amounts. These allowances are estimated based upon an evaluation of governmental reimbursements, negotiated contracts and historical payments.

Note F – Patient Service Revenue

Patient service revenue is recognized when services are provided and reported at the estimated net realizable amounts from patients, third-party payors, and others, including estimated retrospective settlements under reimbursement agreements with third-party payors. Retrospective settlements are accrued on an estimated basis in the period the related services are rendered.

Patient service revenue includes revenues from California Medicaid Quality Assurance Fee programs in the amount of $328 for the nine months ending September 30, 2021. Related fees for the programs of $131 for the nine months ending September 30, 2021 are recorded in purchased services and other expenses. These amounts are based on management's current estimate of the amounts that meet the criteria for revenue recognition as both probable and estimable.

Note G – Leases

The System leases certain locations, office space, land, and equipment. The System determines whether an arrangement contains a lease at inception. Assets held under finance leases are included in property and equipment. Operating leases are expensed on a straight-line basis over the life of the lease beginning on the commencement date. Any direct and indirect costs for the leases are expensed and are immaterial for the System.

At lease commencement, the System determines the lease term by assuming the exercise of the renewal option that are reasonably certain to be exercised. The exercise of lease renewal or termination options are at the System's sole discretion. The depreciable life of assets and leasehold improvements is limited by the expected lease terms, unless there is a transfer of title or purchase option reasonably certain of exercise.

Some lease agreements include rental payments based on annual percentage increases, and others include rental payments adjusted periodically for inflation. Certain leases require the System to pay real estate taxes, insurance, maintenance, and other operating expenses associated with the leased premises.

The System's lease agreements do not contain any material residual value guarantees or material restricted covenants.

The System uses the incremental borrowing rate based on the information available at the lease commencement date to determine the present value of lease payments. The System used the incremental borrowing rate at January 1, 2019 for operating leases that commenced prior to that date.

The System elected the package of practical expedients within the lease transitional guidance, which allow it to carry forward its historical assessments of: 1) whether contracts are or contain leases, 2) lease classification and 3) initial direct costs, where applicable. The System also elected the practical expedient to not separate lease components from non-lease components for all existing lease classes. The System implemented a policy of not recording leases on its balance sheets when the leases have a term of 12 months or less. The System did not elect the practical expedient allowing the use-of-hindsight, which would require the System to reassess the lease term of its leases based on all facts and circumstances through the effective date.

(In millions of dollars)

Note G – Leases (continued)

	Classification	September 30, 2021
Leased assets	Other assets	$ 178
Lease liabilities		
Current	Other current liabilities	$ 29
Noncurrent	Other noncurrent liabilities	154
Total lease liabilities		$ 183

	Classification	September 30, 2021
Operating lease expense	Purchase services and other	$ 28

Cash paid for amounts not included in the measurement of lease liabilities:	September 30, 2021
Operating cash outflows for operating leases	$ 28

Operating lease payments include payments relating to options to extend lease terms that are reasonably certain of being exercised. Excluded are any legally binding lease payments for signed leases not yet commenced, which are immaterial for the System. Minimum lease payments for operating leases with initial terms in excess of one year are as follows for the period ended September 30, 2021:

Maturity of Lease Liabilities	Operating Leases
2021	$ 9
2022	33
2023	28
2024	24
2025	20
Thereafter	111
Total lease payments	225
Less imputed interest	(47)
	$ 178

Lease Term and Discount Rate	September 30, 2021
Weighted average remaining lease term (years)	10.26
Weighted average discount rate	3.59%

Note H – COVID-19

On March 11, 2020, the World Health Organization declared the novel coronavirus disease (COVID-19) a pandemic. Following this, the Center for Disease Control declared a national public health emergency, followed by state emergency declarations, and the Centers for Medicare and Medicaid Services (CMS) issued guidance regarding elective procedures. Several national restrictions were put in place and the governors in the states in which the System has operations issued shelter-in-place orders and executive orders postponing nonessential or elective surgeries. Several unavoidable factors are impacting both revenue and expense as the result of necessary actions by the System as well as local, state, and federal governments to mitigate the spread and effect of the virus. Clinic visits and elective surgical volumes have dropped as patients have been directed or have chosen to stay home to avoid unnecessary exposure. Medical patient volumes in most markets have experienced significant fluctuations throughout the year. Labor costs have increased as a result of shortages in nurses and support teams that have been quarantined related to COVID-19 or are faced with childcare issues related to school closures. Supply shortages are ongoing impacting both cost per unit and changes in treatment protocol, which have increased the quantity of supplies required. This has caused significant increases in supplies expense.

The System took measures to respond to COVID-19, including:

- Initiated System and hospital incident command centers to coordinate readiness, monitor and manage labor, personal protective equipment and other supplies, and resolve issues;
- Ensured local, state, and federal guidelines were followed for screening, triaging, testing, isolating, and caring for COVID-19 patients while protecting staff and other patients;
- Launched virtual ambulatory care services that allow patients to visit their doctors by phone or computer;
- Opened a virtual 150-bed hospital, Adventist Health Hospital@Home, in collaboration with Medically Home and Huron, to create capacity for COVID-19 patients by caring for patients with other specified diagnosis in their homes through medical command centers and rapid response teams;
- Reconfigured facilities to maximize patient service capacity during COVID-19 surge periods and to allow for social distancing, screening and other safety measures;
- Temporarily closed unused services or minimized services at medical office buildings, clinics and hospitals to meet the critical need to conserve personal protective equipment, and limit exposure to COVID-19 for both patients and employees;
- Launched web pages, a chatbot and patient email responses to answer community members' questions and direct them to appropriate services;
- Used System marketing and communication campaigns to remind community members not to neglect emergency care, inform the community as services resumed and shared enhanced safety measures to reduce patients' fears;
- Adjusted supplemental and contract workforce, flexed staffing, furloughed positions and temporarily or permanently reduced staff;
- The System has 29 locations that administered 317,604 COVID-19 vaccine doses thru September 30,2021.

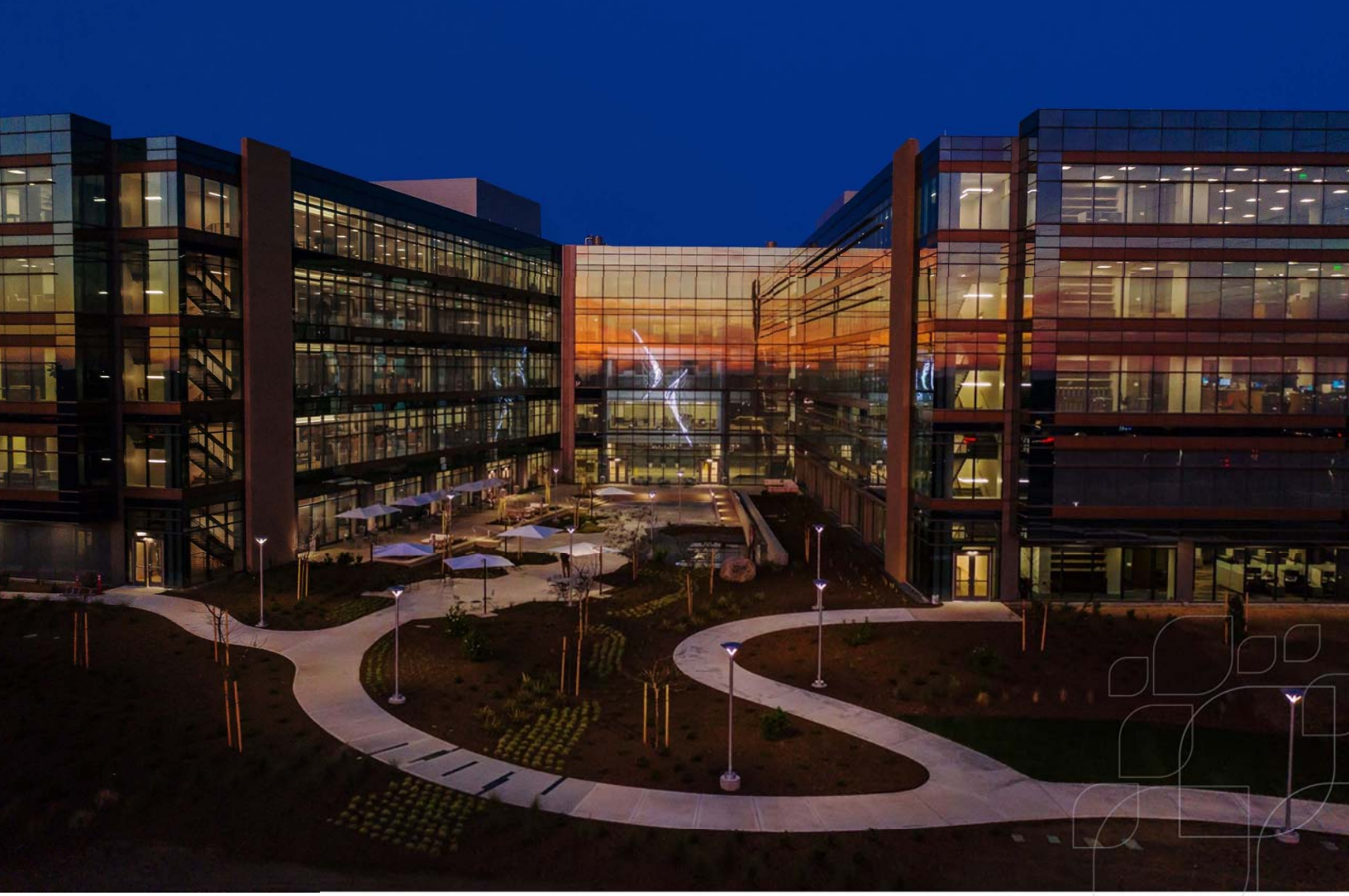
Note H – COVID-19 (continued)

In response to COVID-19, the Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act") was enacted on March 27, 2020. The CARES Act authorizes funding to hospitals and other healthcare providers through the Public Health and Social Services Emergency Fund (Provider Relief Fund). Grant payments from the Provider Relief Fund are intended to reimburse healthcare providers for lost revenue and increased expenses due to the pandemic. As of September 30, 2021, the System has received approximately $308 million of provider relief funds from various provisions in the CARES Act, of which $20 million and $288 million has been recognized in 2021 and 2020, respectively, as contributions in other revenue in the consolidated statement of operations and changes in net assets.

On March 28, 2020, CMS expanded the existing Accelerated and Advance Payments Program to a broader group of Medicare Part A providers and Part B suppliers. At the end of April 2020, the System received approximately $358 of Medicare advance payments as part of the CMS Accelerated and Advance Payments Program. Originally, CMS announced that it will begin to offset the payments by future Medicare reimbursements up to 210 days after disbursement, depending on whether a facility is an acute or non-acute facility. On October 1, 2020, a continuing resolution was signed, which included an extension to delay repayments to one year from receipt of these accelerated and advance disbursements. The repayment terms specify that for the first 11 months after repayment begins, repayment will occur through an automatic recoupment of 25% of Medicare payments otherwise owed to the provider. At the end of the eleven-month period, recoupment will increase to 50% for six months. At the end of the six months (29 months from the receipt of the initial accelerated payment), Medicare will issue a letter for full repayment of any remaining balance, as applicable. The System has recorded $253 in other current liabilities and $7 in other noncurrent liabilities in the consolidated balance sheet.

The CARES Act also allows for deferred payment of the employer portion of certain payroll taxes between March 27, 2020 and December 31, 2020, with half due December 31, 2021 and the remaining half due December 31, 2022. As of September 30, 2021, the System had deferred payroll tax payments of approximately $75 with $37.5 included in accrued compensation and related payable and $37.5 included in other noncurrent liabilities in the consolidated balance sheet.

Due to the evolving nature of the COVID-19 pandemic, the future impact to the System and its consolidated financial condition is presently unknown.



Management Discussion and Analysis of Financial Condition and Results of Operations

Year End: September 30, 2021

AdventistHealth

Adventist Health Overview

Adventist Health System/West, doing business as Adventist Health (the "Corporation"), is a faith-based, nonprofit organization. The health system serves more than 80 communities in California, Hawaii, Oregon and Washington (collectively with the Corporation, the "System" or "Adventist Health") along with more than 60 others nationwide through its Blue Zones organization. With a workforce of approximately 37,000 associates including physicians, allied health professionals and support services, this transformational organization is realizing its mission by providing health, wholeness and hope. Teams of clinical staff provide coordinated care across networks utilizing advanced medical technology, innovative models of health transformation and compassionate care, to revolutionize the delivery of health. Adventist Health owns or operates 23 hospitals, 379 clinics (physician clinics, hospital-based clinics, and the largest rural health clinic network in California), 15 home care agencies, eight hospice agencies, one fully-owned continuing care retirement community and three joint-venture retirement centers.

With an emphasis on wellness and prevention of disease rooted in the Seventh-day Adventist healthcare legacy, the team is focused on caring for mind, body and spirt. The System is dedicated to the integration of hospitals, physicians and other providers in a manner that best serves and cooperates with its communities, both in terms of commitment to quality and a demonstrated ability to provide cost-effective care in an environment increasingly driven by competitive market forces.

Adventist Health's brand is woven throughout the Western United States. The map on the next page of this analysis shows the location of the Corporation's headquarters and the System's owned or leased hospital facilities. The corporate office is centrally located in Roseville, California. Outside California, the System includes Hawaii medical services and two medical centers in Oregon. While the map does not show the location of each of the System's 379 clinics, the geographic area served by the System's clinics, as well as its hospital facilities, is depicted in the map.

Strategy and Mission

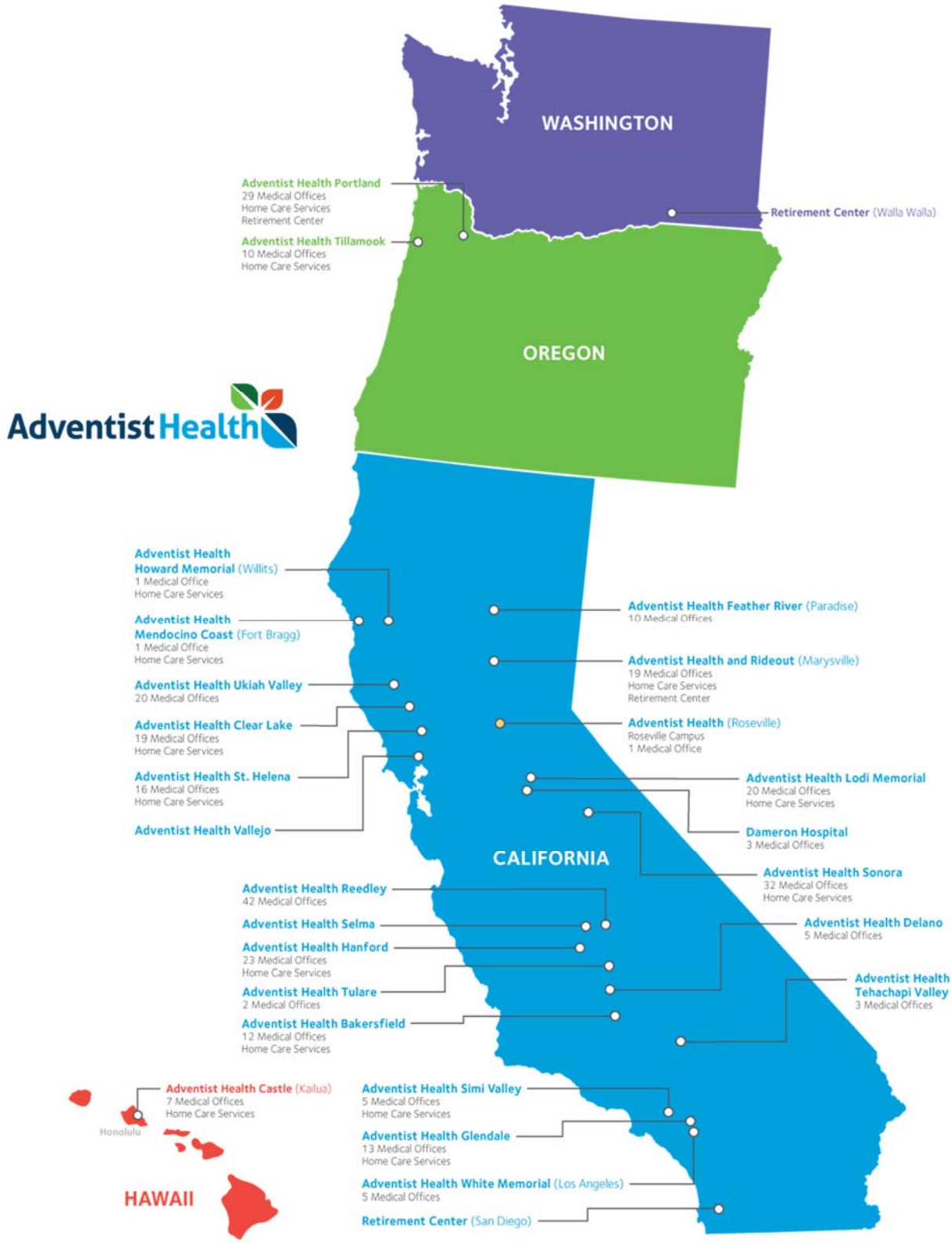
The 2030 Strategy:

Adventist Health has laid out an aggressive plan based on the calling of our mission of living God's love by inspiring health, wholeness and hope. The diversified, growth-oriented strategy focuses on building an organization that will bring **"affordable consumer health and well-being within reach"** for everyone we serve. Within 10 years we will grow to reach more than 10 million individuals annually with well-being initiatives or health services, operate near a 10% margin, and achieve $10 billion of annual revenue.

Embedded within the Adventist Health strategy are several key themes:

- Becoming a consumer-oriented company by using **consumer insights** and segmentation to **develop products and service**s to better serve individuals on their **personal well-being** path.
- **Transforming costs and pricing** to improve **affordability of health** services for individuals, employers, communities and payers.
- **Integrating with payers** to **manage health** of populations, lower costs, and **improve market share**.
- Innovating and integrating around **early-intervention behavioral health** services.
- Developing standalone **community well-being** businesses that can be implemented in and beyond communities where Adventist Health has care delivery services.
- Elevating and **uniting philanthropic efforts** in support of both community care services and large-scale well-being initiatives.

Adventist Health Overview (Continued)



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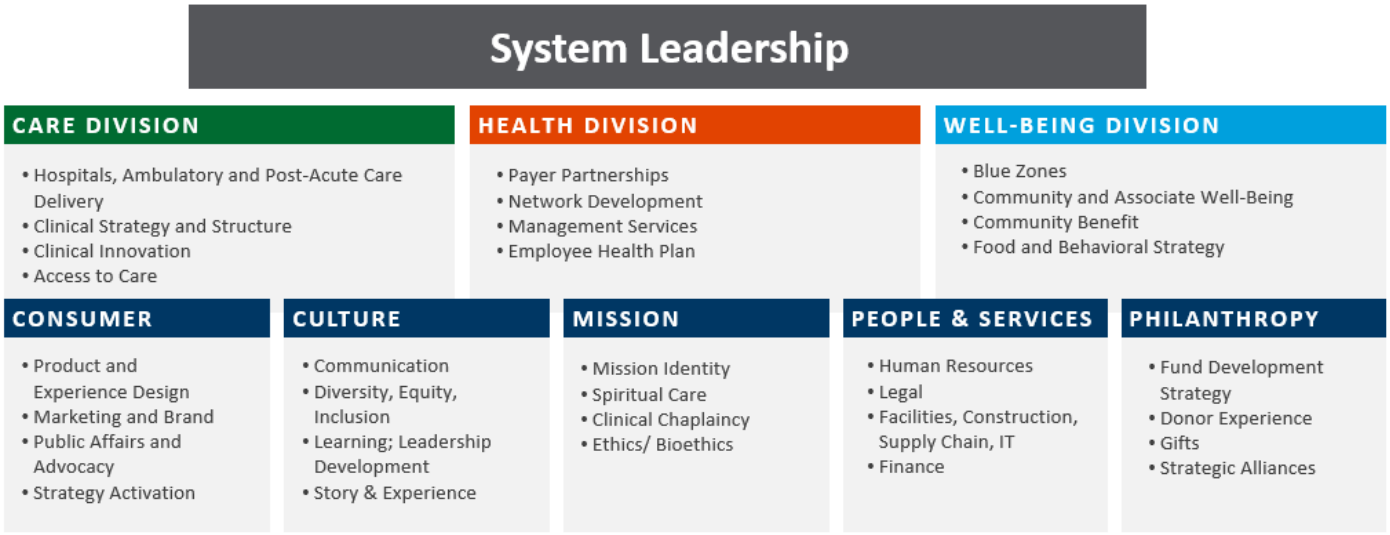
Organization Structure

Operating Structure Updates:

Adventist Health has reorganized itself around its 2030 strategic plan. Three key divisions, oriented around product rather than geography, were formed with five offices of service supporting each of them. Building off the progress toward standardization, modernization and optimization, Adventist Health transitioned to a single Care Division with a unified leadership team in 2020. The Care Division has been positioned alongside newly established Well-Being and Heath Divisions, with support from Consumer, Culture, Mission, People & Services and Philanthropy offices providing the capabilities necessary to accomplish our 2030 strategic plan. All three divisions are guided by system leadership, our governance model, and most importantly our mission.

Scott Reiner, who leads system leadership as CEO, announced on July 30, 2021 that he is leaving at the end of the year to help build a family foundation for global health and well-being. The Adventist Health Board of Directors has selected Kerry Heinrich to replace Scott. Kerry brings extensive executive experience and expertise to this role, having led Loma Linda University Medical Center, Children's Hospital and Behavioral Medicine Center as CEO for more than seven years. He oversaw the construction of the new 16-story, $1.5 billion hospital and nine-story Children's Hospital tower that opened in August, helping to bring in $476 million in donations and $165 million in state funding. Named one of Becker's Hospital Review's "135 Nonprofit Hospital and Health System CEOs to Know" in 2017, Kerry has more than 30 years of experience in healthcare legal counsel and leadership. He earned his bachelor's degree in history and a minor in business with an emphasis in finance and management from Walla Walla University in Washington, followed by his juris doctor (JD) degree from the University of Oregon's School of Law. Beginning in December, Kerry will partner with Scott to ensure a smooth transition.



Care Division Affiliation and Other Activities

Dameron Hospital

In December 2019, Adventist Health entered into an 18-month agreement to manage Dameron Hospital in Stockton, California. This agreement was subsequently extended to March 31, 2022. Extending the service area of Adventist Health Lodi Memorial in neighboring Lodi, California, Dameron Hospital adds more than 200 inpatient beds to Adventist Health's footprint and ensures ongoing access to a population of more than 310,000. At the conclusion of the management services agreement, the corporation will have the option to pursue a membership transfer.

Adventist Health Mendocino Coast

On March 3, 2020 more than 90% of the voters of the Mendocino Coast Healthcare District in Mendocino County, California voted to approve terms of Adventist Health's long-term lease of Mendocino Coast District Hospital (MCDH) in Fort Bragg. Adventist Health entered into a management services agreement with MCDH effective May 4, 2020 allowing Adventist Health to manage MCDH alongside the other Adventist Health assets in the county. A long-term lease agreement commenced on July 1, 2020 and the hospital is now operating as Adventist Health Mendocino Coast (AHMC). AHMC is a 25-bed critical access acute care hospital that includes operations of rural health clinics. The agreement extends Adventist Health's coverage in Mendocino County and ensures continued access to a coastal population of more than 15,000.

Adventist Health Feather River - Camp Fire

In November 2018, the System's Adventist Health Feather River (AHFR) facilities in Paradise, California and neighboring communities incurred extensive damage as a result of the most destructive wildfire in California history. The fire destroyed the majority of homes and businesses throughout the community. Most of the AHFR properties, including the 100-bed acute care hospital, remain temporarily closed and non-operational as the System completes damage assessments. As of September 30, 2021, the timelines of Adventist Health's fixed acute care services in Paradise was yet to be determined.

Adventist Health St. Helena - Glass Fire

On September 27, 2020, a large fire erupted near St. Helena, California causing local residents to evacuate and businesses to temporarily close, including Adventist Health St. Helena's hospital and adjacent Medical Office Building. The hospital building endured minimal damage, although there was extensive damage to the outlying water and sewer systems. While the hospital and clinics at the Medical Office Building were temporarily closed, services that were available on campus were relocated to local clinics, thus minimizing the disruption of services to the community. The Medical Office Building reopened on November 18, 2020, and the hospital reopened on December 8, 2020.

COVID-19 Update

On March 11, 2020, the World Health Organization declared the novel coronavirus disease (COVID-19) a pandemic. Following this, the Centers for Disease Control declared a national public health emergency, followed by state emergency declarations and the Centers for Medicare and Medicaid Services (CMS) issued guidance regarding elective procedures. Several national restrictions were put into place and the governors in the states in which the System has operations issued shelter-in-place orders and executive orders postponing nonessential or elective surgeries.

Several unavoidable factors are impacting both revenue and expense as the result of necessary actions by our System as well as local, state, and federal governments to mitigate the spread and effects of the virus. Clinic visits and elective surgical volumes have dropped as patients have been directed or have chosen to stay home to avoid unnecessary exposure. Medical patient volumes in most markets have experienced significant fluctuations throughout the year. Labor costs have increased as a result of shortages in nurses and support teams that have been quarantined related to COVID-19 or are faced with childcare issues related to school closures or exposures. Supply shortages are ongoing, impacting cost per unit, and changes in treatment protocol have increased the quantity of supplies required. These factors have caused significant increases in supplies expense.

The System took measures to respond to COVID-19 including:

- Initiated System and hospital incident command centers to coordinate readiness, resolve issues and monitor and manage labor, personal protective equipment (PPE) and other supplies
- Ensured local, state, and federal guidelines were followed for screening, triaging, testing, isolating, and caring for COVID-19 patients while protecting staff and other patients
- Launched virtual ambulatory care services that allow patients to visit their doctors by phone or computer

- Opened a virtual 150-bed hospital, Adventist Health Hospital@Home, in collaboration with Medically Home and Huron, to create capacity for COVID-19 patients by caring for patients with the coronavirus and other specified diagnoses in their homes through medical command centers and rapid response teams
- Reconfigured facilities to maximize patient service capacity during COVID-19 surge periods and to allow for social distancing, screening and taking other safety measures
- Temporarily closed unused services or minimized services at medical office buildings to meet the critical need to conserve PPE, and limit exposure to COVID-19 for both team members and patients
- Launched web pages, a chatbot and patient email responses to answer community members' questions and direct them to appropriate services
- Used System marketing and communication campaigns to remind community members not to neglect emergency care, informed the community as services resumed, shared enhanced safety measures to reduce patients' fears and promoted COVID-19 vaccination
- Adjusted supplemental and contract workforce, flexed staffing, furloughed positions and announced temporarily or permanent staff reductions
- The System administered 317,604 COVID-19 vaccine doses at 29 locations as of September 30, 2021

In response to COVID-19, the Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act"), was enacted on March 27, 2020. The CARES Act authorizes funding to hospitals and other healthcare providers through the Public Health and Social Services Emergency Fund (Provider Relief Fund). Grant payments from the Provider Relief Fund are intended to reimburse healthcare providers for lost revenue and increased expenses due to the pandemic. As of September 30, 2021, the System has received approximately $308 million of provider relief funds from various provisions in the CARES Act, of which $20 million and $288 million have been recognized in 2021 and 2020, respectively, as contributions in other revenue in the consolidated statement of operations and changes in net assets.

On March 28, 2020, CMS expanded the existing Accelerated and Advance Payments Program to a broader group of Medicare Part A providers and Part B suppliers. At the end of April 2020, the System received approximately $358 million of Medicare advance payments as part of the CMS Accelerated and Advance Payments Program. Originally, CMS announced that it would begin to offset the payments by future Medicare reimbursements up to 210 days after disbursement, depending on whether a facility was an acute or non-acute facility. On October 1, 2020, a continuing resolution was signed, which included an extension to delay repayments to one year from receipt of these accelerated and advance disbursements. Repayment terms specify that for the first 11 months after repayment begins, repayment will occur through an automatic recoupment of 25% of Medicare payments otherwise owed to the provider. At the end of the 11-month period, recoupment will increase to 50% for six months. At the end of the six months (29 months from the receipt of the initial accelerated payment), Medicare will issue a letter for full repayment of any remaining balance, as applicable. The System has recorded $253 million in other current liabilities and $7 million in other noncurrent liabilities in the consolidated balance sheet.

The CARES Act also allows for deferred payment of the employer portion of certain payroll taxes between March 27, 2020 and December 31, 2020, with half due December 31, 2021 and the remaining half due December 31, 2022. As of September 30, 2021, the System had deferred payroll tax payments of approximately $75 million with $37.5 million included in accrued compensation and related payable and $37.5 million included in other noncurrent liabilities in the consolidated balance sheet.

Due to the evolving nature of the COVID-19 pandemic, the future impact to the System and its financial condition is presently unknown.

Well-Being Division Activities

Adventist Health's Well-Being Division & Blue Zones, LLC

Since Adventist Health purchased Blue Zones in early 2020 and integrated it into the Well-Being Division, the System has been building on its 150-year well-being heritage to help associates and community members live their best lives while also diversifying services and establishing itself as a leader in the future of healthcare. This is being driven in the following areas:

- Blue Zones Projects in Adventist Health communities to make healthy choices easier through permanent and semi-permanent changes to the environment, policy and social networks
- Blue Zones Campus Certifications in Adventist Health facilities and markets to create a culture of well-being and empower associates to move more, eat better and connect to purpose and friends
- Mental and behavioral well-being strategies with Synchronous Health which leverages AI technology to connect patients and providers through a tele-health approach
- Expansion of our health equity solutions which is work aimed at well-being improvement for the most vulnerable in our communities

Outside of the Adventist Health footprint, Blue Zones has seen renewals, expansions and sales of its transformation solutions in multiple communities despite the pandemic. Blue Zones Brands continue to grow and gain traction particularly in the food, beverage and real estate sectors. These well-being strategies are proven to improve the health and well-being of communities. Participating communities and organizations have experienced double-digit drops in obesity and tobacco use and reductions in body mass index, achieving hundreds of millions of dollars in savings in healthcare costs. All of these initiatives are intended to be replicated to serve other communities and organizations in their well-being goals.

Health Division Activities

With the creation of the Health Division, Adventist Health continues to expand its capitated lives and risk-based arrangements within its geographical footprint while establishing new strategic risk-based partnerships with third parties. The division is concentrating its efforts on functional capabilities that will standardize and coordinate care and navigation across the network while improving utilization, outcomes and financial performance through a centralized set of tools.

The division is focused on membership growth through expansion of the accountable care organization partnership with Blue Shield. This value-based network expansion will add nine counties in California. Additionally, partnerships are being developed with strategic payors around operations, clinical care, and finance. Opportunities in the CalAim space are being explored, primarily in Enhanced Care Management services. The division is championing an integrated approach to health solutions by implementing system-wide remote patient monitoring, piloting a Food as Medicine trial for select populations and integrating behavioral health access into primary care.

Ratings and Outlook Updates

In September 2021, Fitch Ratings downgraded its long-term rating from 'A+' to 'A' while maintaining a Stable outlook and S&P Global Ratings affirmed its 'A' long-term rating and revised the outlook from Stable to Negative on Adventist Health's bonds. The Fitch rating reflects Adventist Health's historically solid operating income levels, which have more recently, through a series of one-time events and the lingering deleterious impact from the novel coronavirus, resulted in lower than anticipated operating EBIDA margins. Strength of the credit is still conferred through Adventist's position as the leading acute care provider in multiple growing markets, a gradually improving balance sheet, and accretive

affiliation and expansion activity. The S&P outlook revision reflects a multiyear trend of negative operating performance that has pressured the financial profile. Precluding a downgrade is Adventist Health's historical operating strength prior to fiscal 2019, indicating a solid run rate can be achieved, as well as the system's largescale improvement plan being implemented during the outlook period. In addition, Adventist Health's balance sheet continues to improve.

Key Operating Metrics: Volume Trends

During the nine months ended September 30, 2021, the System's inpatient discharges increased by 3.6%. Combined inpatient and observation stays increased by 5.4% from the same period in the previous year. On a same store basis that excludes Adventist Health Mendocino Coast, inpatient discharges increased by 3.2% primarily driven by impacts of COVID-19.

Total inpatient surgeries increased by 0.9% and outpatient surgeries increased by 15.8% from the same period in the previous year. On a same store basis, inpatient surgeries increased by 0.8% and outpatient surgeries increased by 14.5% from the same period in the previous year.

UTILIZATION STATISTICS

Nine Months Ended September 30,	2021	2020
Discharges	95,657	92,313
Patient days	509,112	433,799
Observation stays	14,556	13,812
Outpatient procedures	3,010,368	2,625,017
Emergency department visits	505,182	486,006
Inpatient surgeries	16,763	16,609
Outpatient surgeries	38,000	32,814
Capitated lives	220,289	213,212
Average length of stay (in days)	5.3	4.7
Outpatient revenues as % of gross patient revenue	46.3%	45.3%

Key Operating Metrics: Total Operating Revenue and Income from Operations

Total operating revenue increased 6.6% for the nine months ended September 30, 2021 as compared to the previous year. On a same store basis, total operating revenue increased 5.7% for the nine months ended September 30, 2021 as compared to the previous year. The increase in operating revenue was the result of recognizing $32 million of CARES Act Provider Relief funds and stronger inpatient volume (measured in patient days) and inpatient acuity (measured in Case Mix Index) compared to the prior year, offset by aged A/R write-off at recently acquired hospital. 2020 Q2 volumes were weak due to patient hesitancy and restrictions imposed at the beginning of the pandemic. Approximately $218 million CARES Act Provider Relief Funds were recognized as of September 30, 2020.

Total operating expenses increased 10.5% for the nine months ended September 30, 2021 as compared to the previous year. On a same store basis, total operating expenses increased 9.6% for the nine months ended September 30, 2021 as compared to the previous year. Salaries and benefits expenses increased 2.5% for the nine months ended September 30, 2021 as compared to the previous year. This increase was primarily due to challenges from retaining and recruiting staff during the peak of the COVID-19 pandemic. It was compounded by increases in contract labor which are reported as Professional Fees and were 24.1% above the previous year.

Supplies increased by 22.6% from the previous year due to increase in per unit pricing and utilization of PPE and other supplies related to COVID-19.

Purchased services and other increased by 12.9% from the previous year due to the consolidation of Adventist Health Plan, which was previously unconsolidated, an increase in revenue cycle costs and purchased services under capitated contracts and an outsourcing of certain costs that were previously performed internally.

On both an all-inclusive and same-store basis, income (loss) from operations as a percent of total operating revenue was (3.5%) and (0.5%) for the nine months ended September 30, 2021 and September 30, 2020, respectively.

Lost revenue and expenses attributed to the COVID-19 pandemic exceeded relief funds by $108 million in the year ended December 31, 2020 and by $97 million in the nine months ended September 30, 2021. The System is pursuing additional opportunities to fund these losses, most notably FEMA. The amount and timing of further relief payments is uncertain.

A multi-pronged approach is underway to address financial performance. There are nine areas of focus: growth, revenue optimization, labor and benefits, length of stay, administrative cost structure, program review, focused markets, purchased services and supplies and professional fees. Additionally, efforts to minimize COVID-19-related volume declines, specifically in surgery and clinics, are underway along with yield enhancement through revenue cycle initiatives. Capital deployment is focused on critical and high return projects.

TOTAL OPERATING REVENUE AND INCOME FROM OPERATIONS

Nine Months Ended September 30,	2021	2020
Total operating revenue	$3,770	$3,537
Total EBIDA expenses	$3,709	$3,356
EBIDA	$61	$181
EBIDA as a percentage of total operating revenue	1.6%	5.1%
Depreciation and interest expense	$193	$200
Loss from operations	($132)	($19)
Loss from operations as a percentage of total operating revenue	(3.5%)	(0.5%)

Key Operating Metrics: Total Nonoperating Income

Investment income increased by 54.4% for the nine months ended September 30, 2021 as compared to the previous year. Management maintains a long-term asset allocation strategy.

NONOPERATING INCOME

Nine Months Ended September 30,	2021	2020
Investment income	$88	$57
Other nonoperating gains (losses)	$0	($1)
Nonoperating income before gain on acquisition and divestitures	$88	$56
Gain (Loss) on acquisition and divestitures	$0	($1)
Nonoperating income	$88	$55

Balance Sheet Ratios

Cash and unrestricted investments increased by $42 for the nine months ended September 30, 2021. Days cash on hand decreased to 185.1 on September 30, 2021 from 197.4 at December 31, 2020. Long-term debt to capitalization was unchanged at 40.0% on September 30, 2021 and December 31, 2020. Adventist Health is able to maintain lower-than-median cash to debt and long-term debt to capitalization ratios as the system has no pension liability and operates under a defined contribution plan.

BALANCE SHEET RATIOS

Period Ended	Sep 30, 2021	Dec 31, 2020
Total cash and unrestricted investments	$2,548	$2,506
Days cash on hand	185.1	197.4
Cash to debt	127%	123%
Long-term debt to capitalization	40.0%	40.0%
Capital expenditures as a percentage of depreciation expense	73.5%	83.1%

Adventist Health Hospitals

OBLIGATED GROUP MEMBERS

Adventist Health Bakersfield
Adventist Health Castle
Adventist Health Delano
Adventist Health Feather River
Adventist Health Glendale
Adventist Health Hanford
Adventist Health Selma
Adventist Health Howard Memorial
Adventist Health Lodi Memorial
Adventist Health Portland
Adventist Health Reedley
Adventist Health and Rideout
United Com-Serve
Adventist Health Simi Valley
Adventist Health Sonora
Adventist Health St. Helena
St. Helena Center for Behavioral Health
Adventist Health Tillamook
Adventist Health Ukiah Valley
Adventist Health White Memorial

NON-MEMBER ENTITIES

Adventist Health Clear Lake
Adventist Health Plan, Inc.
Adventist Health Mendocino Coast
Adventist Health Tehachapi Valley
Adventist Health Tulare

Entities in italics are consolidated with their respective parent entities