CONSOLIDATED FINANCIAL STATEMENTS

(Unaudited)

MARCH 31, 2022

ONE Adventist Health Way
Roseville, CA 95661

Consolidated Financial Statements (Unaudited)
and Supplementary Information

Adventist Health

March 31, 2022

Consolidated Financial Statements

Supplementary Information

Adventist Health

Consolidated Balance Sheets
(In millions of dollars)

	March 31 2022 (Unaudited)	December 31 2021 (Audited)
Assets		
Cash and cash equivalents	**$ 220**	$ 304
Short-term investments	**122**	157
Patient accounts receivable	**720**	689
Receivables from third-party payors	**409**	379
Other current assets	**213**	227
Total current assets	**1,684**	1,756
Noncurrent investments	**2,146**	2,291
Other assets	**443**	432
Property and equipment, net	**2,169**	2,185
Total assets	**$ 6,442**	$ 6,664
Liabilities and net assets		
Accounts payable	**$ 396**	$ 370
Accrued compensation and related payables	**377**	325
Liablitities to third-party payors	**215**	209
Other current liabilities	**215**	242
Short-term financing	**–**	30
Current maturities of long-term debt	**87**	36
Total current liabilities	**1,290**	1,212
Long-term debt, net of current maturities	**1,922**	2,000
Other noncurrent liabilities	**321**	323
Total liabilities	**3,533**	3,535
Net assets without donor restrictions:		
Controlling	**2,821**	3,044
Noncontrolling	**15**	15
Net assets with donor restrictions	**73**	70
Total net assets	**2,909**	3,129
Total liabilities and net assets	**$ 6,442**	$ 6,664

Adventist Health

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

	Three months ended March 31	
	2022 (Unaudited)	**2021 (Unaudited)**
Revenues and support:		
Patient service revenue	**$ 1,173**	$ 1,128
Premium revenue	**50**	46
Other revenue	**66**	64
Net assets released from restrictions for operations	**4**	3
Total revenues and support	**1,293**	1,241
Expenses:		
Employee compensation	**633**	560
Professional fees	**211**	183
Supplies	**196**	187
Purchased services and other	**311**	301
Interest	**16**	16
Depreciation and amortization	**46**	50
Total expenses	**1,413**	1,297
Loss from operations	**(120)**	(56)
Nonoperating income:		
Investment income (loss) gain	**(101)**	20
Other nonoperation gains	**4**	–
Total nonoperating income (loss) gain	**(97)**	20
Deficit of revenues over expenses	**(217)**	(36)
Deficit (excess) of revenues over expenses from noncontrolling interests	**–**	–
Deficit of revenues over expenses from controlling interests	**(217)**	(36)

Adventist Health

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

	Three months ended March 31	
	2022 (Unaudited)	**2021 (Unaudited)**
Net assets without donor restrictions:		
Controlling:		
Excess of revenues over expenses from controlling interests	**$ (217)**	$ (36)
Net change in unrealized gains and losses on other-than-trading securities	**(6)**	(3)
Net assets released from restrictions for capital additions	**–**	2
Increase in net assets without donor restrictions – controlling	**(223)**	(37)
Noncontrolling:		
Excess of revenues over expenses from noncontrolling interests	**–**	–
Increase in net assets without donor restrictions – noncontrolling	**–**	–
Net assets with donor restrictions:		
Restricted gifts and grants	**7**	5
Net assets released from restrictions	**(4)**	(5)
Increase in net assets with donor restrictions	**3**	–
Increase in net assets	**(220)**	(37)
Net assets, beginning of year	**3,129**	3,115
Net assets, end of year	**$ 2,909**	$ 3,078

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 March 31, 2022.

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 March 31, 2022:

	Quoted Prices in Active Markets for Identical Instruments (Level 1)	Significant Observable Inputs (Level 2)	Totals
Cash and cash equivalents	**$ 262**	**$ –**	**$ 262**
Fixed income:			
U.S. government treasury obligations	**49**	**–**	**49**
U.S. corporation and agency debentures	**–**	**42**	**42**
U.S. agency mortgage-backed securities	**–**	**6**	**6**
U.S. Corporate debt securities	**–**	**332**	**332**
Municipal bonds	**–**	**8**	**8**
Mutual funds	**205**	**154**	**359**
Equities:			
Equity	**8**	**–**	**8**
Mutual funds	**876**	**–**	**876**
Total financial assets stated at fair value	**$ 1,400**	**$ 542**	**1,942**
Commercial real estate			**22**
Investments measured at NAV			**524**
Other investments			**108**
Total cash and investments			**$ 2,596**

Cash and cash equivalents of $262 at March 31, 2022 includes $37 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 March 31, 2022, 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:

	March 31, 2022			
	NAV	**Unfunded Commitments**	**Redemption Frequency (if currently Eligible)**	**Redemption Notice Period (if Currently Eligible)**
Commingled funds – equity securities	$ 95	$ –	Weekly/Monthly	4-30 days
Hedge Funds	314	41	Weekly/Monthly/ Quarterly	30-65 days
Private Equity Funds	115	160	None	None
Total	$ 524	$ 201		

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 March 31, 2022:

% of Hedge Funds	Redemption Criteria	Notice Period
31%	Redeemable weekly	30 days
25%	Redeemable monthly	45-65 days
37%	Redeemable quarterly	45-65 days
7%	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:

	March 31 2022	December 31 2021
Total unrestricted investments	**$ 2,165**	$ 2,352
Assets designated by the Board, primarily for property and equipment	**29**	24
Investments held by trustees for:		
Self-insurance programs	**58**	55
Charitable annuities and other	**2**	2
Total investments held by trustees	**60**	57
Donor-restricted investments for:		
Charitable trusts and life estate tenancies	**5**	6
Other purposes	**9**	9
Total donor-restricted investments	**14**	15
Total investments	**2,268**	2,448
Less short-term investments	**122**	157
Total noncurrent investments	**$ 2,146**	$ 2,291

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 $2,109 at March 31, 2022 may be utilized if necessary.

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

	March 31 2022
Cash and cash equivalents	$ 220
Short-term investments	122
Patient accounts receivable	720
Receivables from third-party payors	409
Other receivables	53
	$ 1,524

(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:

	Three Months Ended March 31	
	2022	**2021**
Realized gains, net	**$ 115**	$ 8
Unrealized gains, net	**(216)**	12
	(101)	20
Interest and dividend income	**6**	10
	$ (95)	$ 30

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 $110 for the three months ending March 31, 2022. Related fees for the programs of $44 for the three months ending March 31, 2022, 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 options that are reasonably certain to be exercised. The exercise of lease renewal or termination options is 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 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	March 31, 2022
Right-of-use Assets		
Operating	Other assets	**$ 178**
Finance	Other assets	**6**
		$ 185
Current Lease liabilities		
Operating	Other current liabilities	**$ 29**
Finance	Other current liabilities	**1**
Non-current Lease liabilities		
Operating	Other noncurrent liabilities	**155**
Finance	Other noncurrent liabilities	**5**
Total lease liabilities		**$ 190**

	Classification	March 31, 2022
Operating lease expense		
Operating lease cost	Purchased services and other	**$ 9**
Finance lease cost:		
Amortization of leased Assets	Depreciation	**$ –**
Interest on lease liabilities	Interest Expense	**$ –**

Cash paid for amounts not included in the measurement of lease liabilities	March 31, 2022
Operating cash outflows for operating leases	**$ 9**

(In millions of dollars)

Note G – Leases (continued)

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 March 31, 2022:

Maturity of Lease Liabilities	**Operating Leases**	**Finance Leases**
2022	**$ 26**	**$ 1**
2023	**30**	**2**
2024	**26**	**1**
2025	**22**	**1**
2026	**17**	**1**
Thereafter	**104**	**–**
Total lease payments	**225**	**6**
Less imputed interest	**(46)**	**–**
	$ 179	**$ 6**

Lease Term and Discount Rate	**March 31, 2022**
Weighted average operating remaining lease term (years)	10.24
Weighted average finance remaining lease term (years)	4.27
Weighted average operating lease discount rate	3.45%
Weighted average finance lease discount rate	2.42%

Note H – COVID-19

On March 11, 2020, the World Health Organization declared the novel coronavirus disease (COVID-19) a pandemic. Following this, the Centers for Disease Control and Prevention declared a national public health emergency, followed by state emergency declarations, and the Centers for Medicare & 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.

In response to COVID-19, the Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act") was enacted on March 27, 2020 and the American Rescue Plan ("ARP") was enacted on March 11, 2021. The CARES Act and the ARP authorize funding to hospitals and other healthcare providers through Provider Relief Funds. Grant payments from the Provider Relief Fund are intended to reimburse healthcare providers for lost revenue and increased expenses due to the pandemic. The System received approximately $462 through December 31, 2021 and an additional $1 through March 31, 2022. The consolidated statements of operations and changes in net assets recognized contributions in other revenue in the amount of $10 for the period ending March 31, 2022.

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 would 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. In other current liabilities, the System has recorded $121. In other noncurrent liabilities the system has recorded $0 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 March 31, 2022, the System had deferred payroll tax payments of approximately $37.5 which is included in accrued compensation and related payables. Included in other noncurrent liabilities in the consolidated balance sheet is $0.

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

Adventist Health System/West
Municipal Secondary Market Disclosure
March 31, 2022
(In millions of dollars)

The following information is provided pursuant to Section 3(b) of the Continuing Disclosure Certificate executed by the System in connection with the issuance of:

California Health Facilities Financing Authority Revenue Bonds, 2009 Series B
California Health Facilities Financing Authority Revenue Bonds, 2013 Series A
Adventist Health System/West Taxable Bonds, Series 2013

Section 3(b)(2) Long-term debt disclosure:

On March 31, 2022, the long-term debt of the Members of the Obligated Group (including current maturities) totaled $2,003. Of that amount, $47 was variable interest rate debt, with the remaining $1,956 being fixed interest rate debt.

Section 3(b)(3) Statement regarding accounts receivable liens:

During the year ended March 31, 2022 no Member of the Obligated Group has granted a Lien on accounts receivable nor sold any accounts receivable as permitted under the Master Indenture.

Management Discussion and Analysis of Financial Condition and Results of Operations

Year End: March 31, 2022

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 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, two medical centers in Oregon and a clinic and joint-venture retirement center in Washington. 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.

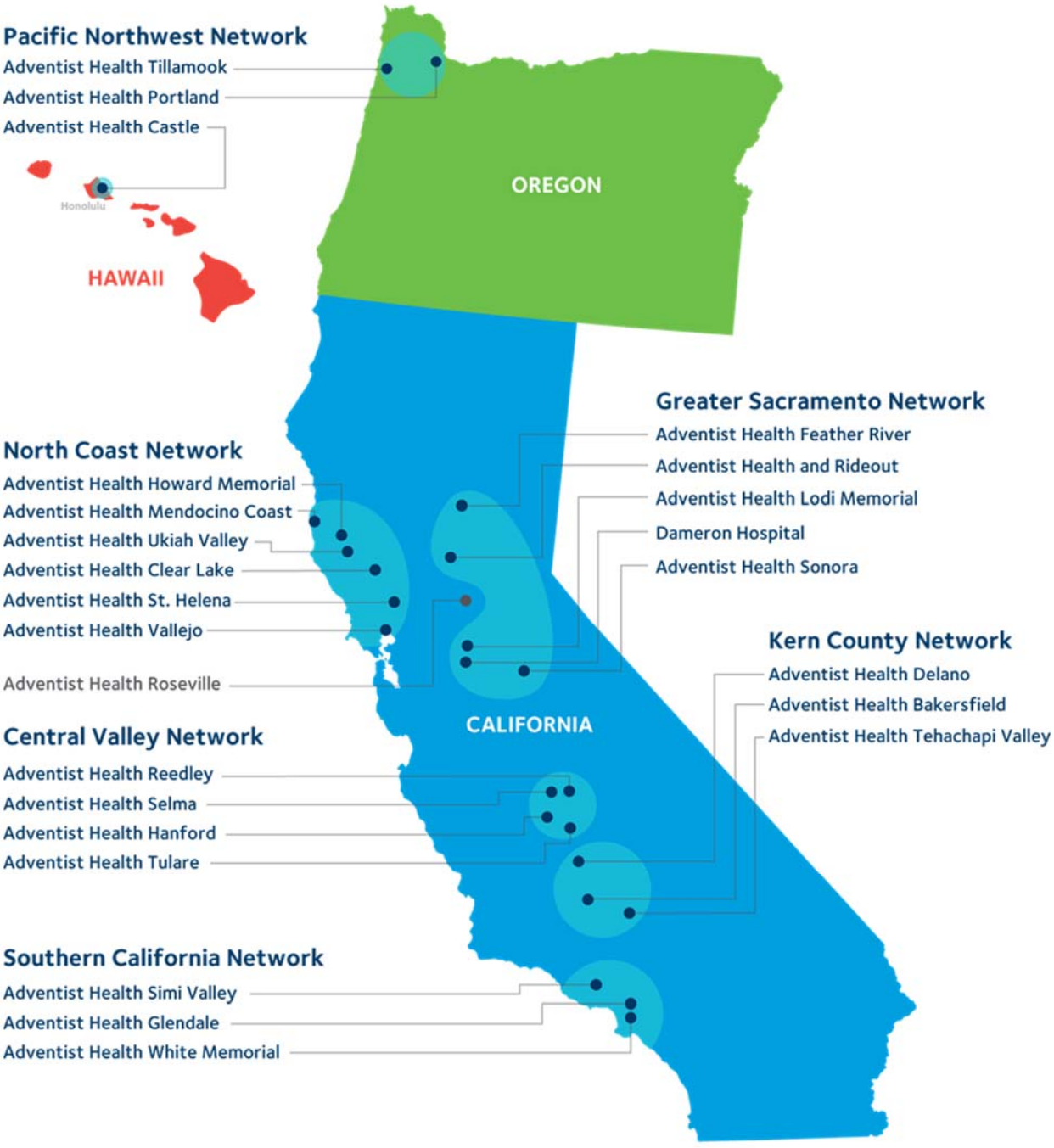
Strategy and Mission

Adventist Health has laid out an aspirational 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.

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)



AdventistHealth

Organization Structure

Operating Structure Updates:

Adventist Health has reorganized itself to build unity, optimize performance and enhance its core expertise of serving millions of patients. Six care networks that are situated geographically work hand-in-hand with system shared services. The system Executive Cabinet includes both network presidents and system leaders in clinical care, operations, mission, human resources, strategy, philanthropy and other areas.

Kerry Heinrich became the organization's new president and CEO in January 2022. Kerry brings extensive executive experience and expertise to this role, having led Loma Linda University Medical Center, Children's Hospital, Medical Center - Murrieta, East Campus, Surgical Hospital and Behavioral Medicine Center. Named one of Becker's Hospital Review's "Nonprofit Hospital and Health System CEOs to Know" in 2016 and 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.

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, 2027. 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 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 March 31, 2022, the timelines of Adventist Health's fixed acute care services in Paradise was yet to be determined.

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 along with cost inflation 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 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 temporary or permanent staff reductions
- The System administered 371,150 COVID-19 vaccine doses at 30 locations as of March 31, 2022

In response to COVID-19, the Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act"), was enacted on March 27, 2020 and the American Rescue Plan was enacted on March 11, 2021. These Acts authorize funding to hospitals and other healthcare providers through the Public Health and Social Services Emergency Fund (Provider Relief Fund) and other mechanisms. Grant payments from these Acts are intended to reimburse healthcare providers for lost revenue and increased expenses due to the pandemic and to fund treatment and mitigation of the impacts of COVID-19. As of March 31, 2022, the System has received approximately $463 million of provider relief funds from various provisions in these Acts, of which $10 million and $105 million have been recognized in 2022 and 2021, 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 $121 million in other current liabilities in the consolidated balance sheet as of March 31, 2022.

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 December 31, 2021, the System had deferred payroll tax payments of approximately $37.5 million included in accrued compensation and related payables 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.

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 three months ended March 31, 2022, the System's inpatient discharges increased by 1.9%. Combined inpatient and observation stays increased by 19.6% from the same period in the previous year.

Total inpatient surgeries increased by 3.9% and outpatient surgeries increased by 25.1% from the same period in the previous year.

UTILIZATION STATISTICS

Three Months Ended March 31,	2022	2021
Discharges	30,911	30,329
Patient days	172,169	173,992
Observation stays	4,890	4,087
Outpatient procedures	1,036,502	968,607
Emergency department visits	176,923	141,563
Inpatient surgeries	5,294	5,096
Outpatient surgeries	13,086	10,457
Capitated lives	230,238	210,777
Average length of stay (in days)	5.6	5.7
Outpatient revenues as % of gross patient revenue	47.5%	42.6%

Key Operating Metrics: Total Operating Revenue and Income from Operations

Total operating revenue increased 4.2% for the three months ended March 31, 2022 as compared to the previous year. The increase in operating revenue was the result of stronger inpatient volume (measured in discharges), inpatient acuity (measured in Case Mix Index) and Outpatient Surgeries compared to the prior year. $10 and $20 of pandemic relief funding was recognized in the three months ended March 31, 2022 and 2021 respectively.

Total operating expenses increased 9.7% for the three months ended March 31, 2022 as compared to the previous year. The current year includes $14 of expenses related to organizational restructuring. Salaries and benefits expenses increased 13.0% for the three months ended March 31, 2022 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. Staff shortages also drove an increase in contract labor which is reported as Professional Fees and was 27.8% above the previous year.

Supplies increased by 4.8% 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 3.3% from the previous year due to rapidly increasing costs of property insurance, increased purchased services under capitated contracts, and restructuring costs of $7.5.

Loss from operations as a percent of total operating revenue was (9.3%) and (4.5%) for the three months ended March 31, 2022 and March 31, 2021, respectively.

Lost revenue and expenses attributed to the COVID-19 pandemic exceeded relief funds by $157 million in the year ended December 31, 2020 and by $160 million in the year ended December 31, 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

Three Months Ended March 31,	2022	2021
Total operating revenue	$1,293	$1,241
Total EBIDA expenses	$1,351	$1,231
EBIDA	($58)	$10
EBIDA as a percentage of total operating revenue	(4.5%)	0.8%
Depreciation and interest expense	$62	$66
Loss from operations	($120)	($56)
Loss from operations as a percentage of total operating revenue	(9.3%)	(4.5%)

EBIDA Expenses for the three months ended March 31, 2022 include $14 of one-time costs associated with organizational restructuring. Excluding these items, EBIDA as a percentage of total operating revenue would have been (3.4%) and Loss from operations as a percentage of total operating revenue would have been (8.2%).

Key Operating Metrics: Total Nonoperating Income

Investment income decreased by 605% for the three months ended March 31, 2022 as compared to the previous year. Management maintains a long-term asset allocation strategy.

NONOPERATING INCOME

Three Months Ended March 31,	2022	2021
Investment income	($101)	$20
Other nonoperating gains (losses)	$4	$0
Nonoperating income before gain on acquisition and divestitures	($97)	$20
Gain (Loss) on acquisition and divestitures	$0	$0
Nonoperating income	($97)	$20

Balance Sheet Ratios

Cash and unrestricted investments decreased by $266 for the three months ended March 31, 2022. Days cash on hand decreased to 158.9 on March 31, 2022 from at December 31, 2021. Long-term debt to capitalization increased to 40.4% on March 31, 2022 from 39.5% at December 31, 2021. 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	Mar 31, 2022	Dec 31, 2021
Total cash and unrestricted investments	$2,414	$2,680
Days cash on hand	158.9	189.2
Cash to debt	125.6%	134%
Long-term debt to capitalization	40.4%	39.5%
Capital expenditures as a percentage of depreciation expense	66.5%	70.5%

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