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VIA CERTIFIED OVERNIGHT MAIL

October 20, 2025

California Attorney General
Melissa Hamill, Deputy Attorney General
Healthcare Rights and Access
1300 I Street, 15th Floor
Sacramento, CA 95814

Re: Notice of Proposed Modification to the Affiliation Agreement between Adventist Health System/West and Central California Foundation for Health and Request to Modify Attorney General's consent letter dated November 22, 2019 ("Consent Letter")

Dear Ms. Hamill:

Please consider this letter a request to amend the terms of the above referenced Affiliation Agreement and Consent Letter pursuant to Cal. Code Regs. Title 11 § 999.5(h) and Article II of the Attorney General's Consent Letter. On January 4, 2019, Adventist Health System/West, a California nonprofit religious corporation ("Adventist Health"), and Central California Foundation for Health, a California nonprofit public benefit corporation entered an Affiliation Agreement (the "Transaction") whereby Adventist Health would become the sole member of Central California Foundation for Health. On November 22, 2019, the California Attorney General issued its Consent Letter and on December 31, 2019, the Parties completed the affiliation. In accordance with the Transaction, Central California Foundation for Health has operated as Adventist Health Delano ("AHDL").

By this letter AHDL and Adventist Health System/West's (collectively, the "Parties") hereby requests (1) an amendment to Condition IV of the Consent Letter, which requires the building of a new obstetrics and delivery unit ("New OB Unit") and (2) approval of the Parties proposed amendment of the Affiliation Agreement, which include a revised section 3.1 and deletion of Exhibit 3.1.

Introduction and Summary of the Reasons for the Request

Since closing the transaction in December of 2019, AHDL's obstetrics and delivery service ("OB Unit") has been underutilized by the community. With the low utilization, the service is not financially sustainable and has operated at a significant loss. Additionally, due to the struggling nature of the service line, AHDL has struggled to recruit and maintain staff. These conditions do not support the significant capital and resource investment that is currently required under the Affiliation Agreement.

The OB Unit struggles must also be viewed in light of the rapidly changing healthcare landscape since the Parties closed the Transaction. Three months after closing, the COVID-19 pandemic began, which resulted in significant financial stress to AHDL operations. The financial impacts on hospitals are well

documented, but can be generalized as increasing expenses (supplies and labor), decreased patient volumes, stagnate reimbursement, which all resulted in margin compression[1]. These effects were especially difficult for safety net hospitals, such as AHDL.

Looking to the future, the Parties see more financial pressure on the horizon. On July 4, 2025, President Trump signed the "One Big Beautiful Bill Act" ("OBBBA"), which makes several significant changes to the Medi-Cal and Medicare program. The California Hospital Association has estimated OBBBA will reduce provider Medi-Cal and Medicare reimbursement by up to 128 billion over a ten-year period[2]. With respect to AHDL's operations, the Parties are estimating the changes to the provider tax will reduce AHDL's revenue by approximately $22 million.

To best serve the community need, the Parties are proposing two initiatives in lieu of the New OB Unit. First, the Parties are proposing to develop a hospital-based clinic to increase access to specialty care and primary care on the AHDL campus. This will provide greater access to primary care, specialist care, and care coordination for AHDL patients. Second, the Parties are proposing to expand the number of beds in the Special Care Unit from 51 to 55. AHDL's Special Care Unit has high utilization by the community with a 96% occupancy rate for 2024.

Enclosed with this letter are the Affiliation Agreement (**Exhibit A)**, the Consent Letter (**Exhibit B**), and the proposed Affiliation Agreement Amendment (**Exhibit C)**, and market analysis (**Exhibit D**).

I. DESCRIPTION OF THE CHANGE IN CIRCUMSTANCE

Under the terms of the Affiliation Agreement, the Parties agreed to develop and open an inpatient obstetrics and delivery service ("New OB Unit"). (See section 3.1 of the Affiliation Agreement). This obligation was further described in Exhibit 3.1 of the Affiliation Agreement. The Attorney General's Consent Letter also incorporated this project into Condition IV(b) of the Consent Letter, which states the following:

> For ten years from the closing date of the Affiliation Agreement, Delano Regional Medical Center shall be operated and maintained as a licensed general acute care hospital (as defined in California Health and Safety Code Section 1250) and shall maintain and provide the following healthcare services at current licensure and designations and certification with the current types and/or levels of services, including the following:
> …
> b) Perinatal services, including a minimum of 16 licensed perinatal beds until the completion of a new obstetrics and delivery facility on Delano Regional Medical Center's campus as set forth in Exhibit 3.1 of the Affiliation Agreement. Once completed, Delano Regional Medical Center is required to maintain no less than 12 separate individual patient rooms with labor, delivery, recovery, and post-partum beds, and a separate cesarean-section, recovery and observation areas for the remaining portion of the ten years;

[1] Kaufman Hall, Hospital Services at Risk Throughout California. April 2023. https://www.kaufmanhall.com/sites/default/files/2023-04/CHA-Financial-Impact-Report.pdf
[2] https://calhospital.org/file/cha-summary-and-impact-estimate-of-obbba/

…

Under Utilization

AHDL's OB Unit has 16 licensed beds distributed across 7 rooms. Four of the rooms are allocated to labor, delivery, recovery and postpartum, two rooms are for post-partum, and one room is used for triage, preoperative procedures, and post anesthesia care. Since closing the Transaction, the OB Unit has averaged approximately 550 deliveries per year, which is less than 2 deliveries per day on average. This patient volume results in an Average Daily Census of less than 3 and an implied bed occupancy rate of 18.8%. Over the last six years, the OB Unit has never had more than 12 patients in the unit at one time.

The underutilization OB Unit is the result of several factors beyond AHDL's control. First, the number of reproductive age females living in AHDL's service area has declined. From 2010-2023 Delano's population shrank by 2.9% (Exhibit D, Figure 4). Second, the rate at which babies are being born continues to decrease. From 2017-2022 the fertility rate for women in Kern County, declined 12.5% (Exhibit D, Figure 5a). Third, 67% of patients in AHDL's service area are seeking OB services outside of AHDL's service area (Exhibit D, Figure 6a and 6b). Of the 6 hospitals in the Bakersfield, Visalia, and Porterville, AHDL performs the fewest number of births (542), with the most being Bakersfield Memorial Hospital (3,656) and the second to second to fewest births being Sierra View Medical Center (1,318).

Staffing Challenges

AHDL has had significant challenges with both physician and nonphysician staffing, which has increased the cost of service delivery. Despite the low utilization, AHDL's OB Unit must be staffed 24 hours a day by a team of professionals. AHDL's OB Unit is currently staffed by 26.69 FTEs[3] and 6 physicians. Since closing the Transaction, 5 physicians have left the community and FTE turnover has been well above the industry average (14.5%), with RN turnover peaking in 2023 at 45.9%.

As a result of the staffing challenges, AHDL increased the use of *locum tenen* agreements with physicians and contracted labor agreements to ensure continued operation of the OB Unit. In 2020, AHDL spent $96,891 in professional fees and 2024 AHDL this increased to $569,093. Similarly, AHDL's contract labor expense went from $0 in 2019, to $621,839 in 2024 with a peak of $1.1 million in 2022. As of the date of this Notice, and despite providing numerous recruitment and retention incentives, AHDL is still actively recruiting for 2 full time OB/GYN's and has four OB RN positions open, three of which have been open for 7 months. In the last 8 months, 4 different recruitment firms have been engaged to help with identifying physician candidates, with a result of 1 applicant who did not meet minimum education and training requirements.

2022 Community Needs Health Assessment

The most recent Community Needs Health Assessment ("CHNA"), conducted in 2022, did not find that obstetrics, delivery, or related services was a critical community health need. Rather, the CHNA found the highest priority healthcare needs were (1) access to care, primary care in particular, (2) financial stability (Delano's poverty rate is almost double the national average), and (3) health conditions- chronic conditions. (Exhibit D page 7). This finding is consistent with CHNA's finding that AHDL's service area also has significantly fewer primary care physicians per 100,000 (41.59) than Kern County (65.00) and California (99.79).

[3] The FTE total consists of 14.02 RNs, 9.71 tech, 2.45 Charge RN, .37 Manager, and .14 educator

Operational Losses and Financial Stress

AHDL's OB Unit has operated at a loss every year since closing the Transaction and the operating losses have continued to grow. In 2020, the OB Unit had a net operating loss of just under a million dollars, but in 2024, the operating loss was $2,399,794 (Exhibit D Figure 8a). The operational losses are the result of expenses continuing to outpace reimbursement and there is no expectation that this will change. Based on 2024 financial data, AHDL expects each birth will cost $4,000 more than it receives in reimbursement.

In addition to the OB Unit's financial performance, AHDL's hospital operations have not generated the margin necessary to make a significant capital investment for the New OB Unit in addition to subsidizing the current service. Since completing the Transaction, AHDL's Net Income Margin went from 20.5% in 2019 to 1.2% in 2024. AHDL's financial performance was the result of operating expenses increasing (40.5%) more than revenue (9.5%), which were largely a consequence of the COVID-19 pandemic. In total, AHDL has had a Net Operating Loss of $45.9 million from 2020 to 2024.

AHDL is expecting additional financial stress with President Trump signing OBBBA. The majority of AHDL's patients are Medi-Cal beneficiaries. As a consequence, AHDL receives supplemental funding from the Disproportionate Share Hospital Program. OBBBA imposes new rules with respect to Medi-Cal provider taxes[4] and state directed payments[5] and Medi-Cal eligibility and enrollment[6]. The expected effect of these rules will reduce the number of patients on Medi-Cal, increase the number of uninsured patients, lower reimbursement for services provided to Medi-Cal patients (and potentially Medicare patients), and increase the amount of uncompensated care. Safety net hospitals, such as AHDL, will feel the impact the most. AHDL currently estimates a reduction in revenue of 22 million caused by changes to the provider tax rules. AHDL cannot forecast changes caused by OBBBA's eligibility changes.

In sum, community need and business case for the New OB Unit no longer exists. The financial stress caused by low utilization and rising labor costs have made significant investment untenable. Existing providers in AHDL's service area are the preferred providers for patients in AHDL's service area. AHDL can better serve its community by developing a Hospital Based Multispecialty and Primary Care Clinic and increasing the number of beds in its Special Care Unit.

II. DESCRIPTION OF THE PROPOSED AMENDMENT

The Parties are proposing Condition IV of the Consent Letter eliminate section (b) and replace it with the following:

> b) Within ten (10) years following the Closing Date, Adventist Health shall develop and open a hospital based multispecialty and primary care clinic located on the campus of Delano. The types

[4] Section 71115- Provider tax will be reduced to a maximum of 3.5% by FY 3032

[5] Section 71116- State directed payments are limited to 100% of Medicare

[6] Section 71107- beginning January 1, 2027, Medi-Cal will need to make redeterminations every 6 months; Section71112- limits retroactive eligibility to 1 or 2 months depending on the basis of patient eligibility, Section 71109- limits Medi-Cal eligibility to U.S. citizens and lawful permanent residents, Section 71110- reduces the federal matching rate emergency services provided to non-U.S. citizens and those not lawfully residing in the U.S.

of specialty services offered at the clinic will be determined by Delano based on community need. Additionally, Delano shall expand the number of beds in its Special Care Unit to 55.

Consistent with the Consent Letter amendment, the Parties are proposing to delete section 3.1 of the Affiliation Agreement, which reads as follows:

> 3.1 Obstetrics Solution. Within five (5) years following the Closing Date, Adventist Health shall develop and open an inpatient obstetrics and delivery service at Delano in furtherance of Delano's mission and the obstetrics needs of the Delano Market ("***Obstetrics Solution***"). It is anticipated that the size and scope of the Obstetrics Solution shall be as specified in forth in Exhibit 3.1.

The Parties are proposing a new section 3.1 the Affiliation Agreement, which reads as follows:

> 3.1 Hospital Based Clinic and Expansion of Specialty Care. Within ten (10) years following the Closing Date, Adventist Health shall develop and open a hospital based multispecialty and primary care clinic located on the campus of Delano. The types of specialty services offered at the clinic will be determined by Delano based on community need. Additionally, Delano shall expand the number of beds in its Special Care Unit to 55.

The Parties are proposing to delete Exhibit 3.1 in its entirety.

III. DESCRIPTION OF HOW AMENDMENT IS CONSISTENT WITH THE ATTORNEY GENERAL'S CONSENT TO THE TRANSACTION

The proposed amendment to the Affiliation Agreement and amendment to Condition IV of the Consent Letter will not impact any obligations other than the New OB Unit. The nature and scope of services provided by AHDL will continue and AHDL will continue to provide OB services. All other terms of the Affiliation Agreement have been fulfilled and will continue to be described in the annual report on consent conditions. As stated above, the purpose of the amendment is to ensure AHDL's resources are used to meet the needs of the community.

IV. DESCRIPTION OF THE EFFORTS OF THE ENTITY MAKING THE REQUEST TO AVOID THE NEED FOR AMENDMENT

AHDL has tried to expand its OB program through multiple initiatives, including recruiting providers, staff, and advertising. Since closing the Transaction, AHDL has spent over $100,000 on advertising its OB services, which did not result in increased volume. These advertising dollars were used in both internal and external campaign tactics working on creating service awareness and brand/reputation building. Billboards were utilized, magazine and radio advertisements and direct mailers to the homes of women of child bearing age to ensure awareness of services in the community.

V. CORPORATIONS CODE § 5923 FACTORS FROM ARTCLE II OF THE CONSENT LETTER

Under Section II of the Consent Letter, the California Attorney General will consider whether the Proposal affects the factors provided in Corporations Code section 5923. The Parties submit the following with respect to each of the Section 5923 factors.

a) **Whether the terms and conditions of the transaction are fair and reasonable to the nonprofit corporation**.

The development of a hospital based multispecialty and primary care clinic and expansion of the Special Care beds in lieu of the New OB Unit is being proposed to ensure the continued viability of AHDL and highest and best use of its resources are used to deliver healthcare services supported by community need.

b) **Whether the transaction will result in inurement to any private person or entity**.

The development of a hospital based multispecialty and primary care clinic and expansion of the Special Care beds in lieu of the New OB Unit will not result in any private inurement to any private person or entity.

c) **Whether the transaction is at fair market value. Fair market value means the most likely price that the assets being sold would bring in a competitive and open market under all conditions requisite to a fair sale, the buyer and seller, each acting prudently, knowledgeably, and in their own best interest, and a reasonable time being allowed for exposure in the open market**.

The development of a development of a hospital based multispecialty and primary care clinic and expansion of the Special Care beds will be done under contract at fair market value. This includes physician services provided at the clinic and Special Care Unit.

d) **Whether the market value has been manipulated by the actions of the parties in a manner that causes the value of the assets to decrease**.

Development of hospital based multispecialty and primary care clinic and expansion of the Special Care beds does not present a market value issue.

e) **Whether the proposed use of the proceeds from the transaction is consistent with the charitable trust on which the assets are held by the health facility or by the affiliated nonprofit health system**.

The Parties are proposing an alternative project, which is intended to meet community need. The proceeds from this alternative service are designed to be financially sustainable, which will further the charitable purposes of AHDL.

f) Whether the transaction involves or constitutes any breach of trust.

The development of a hospital based multispecialty and primary care clinic and expansion of the Special Care beds in lieu of the New OB Unit does not present a breach of trust issue.

g) Whether the Attorney General has been provided, pursuant to Section 5250, with sufficient information and data by the nonprofit public benefit corporation to evaluate adequately the transaction or the effects thereof on the public.

The Parties have provided the affiliation agreement and related documents, proposed modified documents and terms, market data, financial information, and presented information on the challenges and changed circumstances related to this request. The Parties will provide additional information reasonably available upon request.

h) Whether the transaction may create a significant effect on the availability or accessibility of health care services to the affected community.

The hospital based multispecialty and primary care clinic and expansion of the Special Care beds in lieu of the New OB Unit will not significantly limit the access to perinatal and obstetric services in the AHDL service area. AHDL will continue providing OB services at the current level. Currently, the community is not utilizing the perinatal and obstetric services to AHDL's capacity. The majority of the need is being satisfied by other AHDL service area providers. The hospital based multispecialty and primary care clinic and expansion of the Special Care beds will increase access to more specialized health services. On balance, the elimination of one commitment in favor of another will have a net positive impact on eliminating health disparities in the AHDL service area.

i) The proposed agreement or transaction is in the public interest.

The public interest is best served by using AHDL's resources to the highest and best use. Accordingly, the elimination of project that supports an underutilized service in favor of another that will be driven by community need will best serve the public interest.

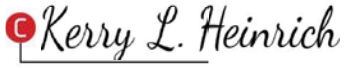
j) The agreement or transaction may create a significant effect on the availability and accessibility of cultural interests provided by the facility in the affected community.

The alternative hospital based multispecialty and primary care clinic and expansion of the Special Care beds will increase access to health services and potentially reach a broader and more diverse population.

AHDL is proposing to eliminate the New OB Unit to ensure the AHDL's resources are used to best serve the community. Approving the alternative proposals will help ensure AHDL is able to effectively

serve the community today and in the future. We look forward to discussing our proposal with you and providing additional information you may need in your decision making.

Sincerely,



Kerry L. Heinrich
President and CEO

Enclosures

EXHIBIT A
TRANSACTION DOCUMENTS 2019

See Attached.

January 4, 2019

ADVENTIST HEALTH SYSTEM/WEST, D.B.A. ADVENTIST HEALTH, a California nonprofit religious corporation;

and

CENTRAL CALIFORNIA FOUNDATION FOR HEALTH, D/B/A DELANO REGIONAL MEDICAL CENTER, a California nonprofit public benefit corporation

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AFFILIATION AGREEMENT

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AFFILIATION AGREEMENT

THIS AFFILIATION AGREEMENT (this "***Agreement***") is made and effective as of January 4, 2019 (the "***Execution Date***") between ADVENTIST HEALTH SYSTEM/WEST, D.B.A. ADVENTIST HEALTH, a California nonprofit religious corporation ("***Adventist Health***"), and CENTRAL CALIFORNIA FOUNDATION FOR HEALTH, d/b/a DELANO REGIONAL MEDICAL CENTER, a California nonprofit public benefit corporation ("***Delano***").

Before the Closing Date, Adventist Health and Delano are referred to individually as a "***Party***" or collectively as the "***Parties***."

RECITALS

WHEREAS, Delano owns and operates a general acute care hospital located in Delano, California (the "***Hospital***"), serving Delano and surrounding rural central California communities;

WHEREAS, in addition to operating the Hospital, Delano also provides various outpatient services in the communities it serves through hospital-based clinics, rural health clinics and several other health care related businesses;

WHEREAS, Adventist Health is a faith-based, non-profit integrated health care system serving communities in California, Hawaii, Oregon and Washington, consisting of hospitals, clinics (hospital-based, rural health and physician clinics), home care agencies, hospice agencies and retirement centers;

WHEREAS, the Parties desire for Delano to affiliate with Adventist Health on the terms and conditions set forth in this Agreement (the "***Affiliation***");

NOW, THEREFORE, the Parties agree as follows:

ARTICLE I
DEFINITIONS

1.1 Definitions. As used in this Agreement, and unless the context requires a different meaning, the following terms have the meanings given:

(a) "***Action***" shall mean any action, complaint, claim, suit, litigation, proceeding, arbitration, mediation, labor dispute, arbitral action, governmental audit, inquiry, criminal prosecution, investigation or unfair labor practice charge or complaint.

(b) "***Affiliate***" means any person or entity that directly, or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with another person or entity. For purposes of this definition, control means the direct or indirect power, through ownership of securities or otherwise, to direct or cause the direction of the management and policies of a person or entity.

(c) "***AG Approval Date***" means the date on which the written consent of the Attorney General with respect to Membership Issuance is obtained.

(d) "***Attorney General***" means the California Attorney General.

(e) "***Business Day***" means a day other than a Saturday, Sunday or other day on which banks located in California are authorized or required by law to close.

(f) "***Clinics***" means those hospital-based, community-based and rural health clinics listed on Exhibit 1.1(f).

(g) "***Code***" means the Internal Revenue Code of 1986, as amended.

(h) "***Contracts***" means all commitments, contracts, leases, licenses, agreements and understandings, written or oral, relating to the Delano Operations, including agreements with payors, physicians and other providers, agreements with health maintenance organizations, independent practice associations, preferred provider organizations and other managed care plans and alternative delivery systems, joint venture and partnership agreements, management, employment, retention and severance agreements, vendor agreements, real and personal property leases and schedules, maintenance agreements and schedules, agreements with municipalities and labor organizations, collective bargaining agreements and bargaining obligations, and bonds, mortgages and other loan agreements.

(i) "***Delano Assets***" means any and all assets used in the ordinary course of the Delano Operations taken as a whole or in the individual operations of any Delano Entity, including the Delano Real Property, the Delano Personal Property, the Delano Inventory and the Delano Intellectual Property.

(j) "***Delano Entity***" means Delano and/or any Delano Subsidiary.

(k) "***Delano Healthcare Facility***" means each of the Hospital, the Clinics, the diagnostic imaging center, physical therapy center, the laboratory, the wound care center, the urgent care center, and the outpatient pharmacy.

(l) "***Delano Intellectual Property***" means all marks, names, trademarks, service marks, patents, patent rights, assumed names, logos, copyrights, trade secrets and similar intangibles (including variants of and applications for any of the foregoing) used in the ordinary course of the Delano Operations taken as a whole or in the individual operations of the Hospital or any Delano Healthcare Facility.

(m) "***Delano Inventory***" means all inventories of useable supplies, drugs, food, janitorial and office supplies, maintenance and shop supplies, and other disposables and consumables owned by any Delano Entity and used in connection with the Delano Operations.

(n) "***Delano Market***" means the following zip codes: 93215, 93216, 93218, 93219, 93250, 93256, 93261, 93270 and 93280.

(o) "***Delano Operations***" means any and all operations conducted by any Delano Entity, whether at the Hospital, a Delano Healthcare Facility, or elsewhere.

(p) "***Delano Personal Property***" means all tangible personal property owned by Delano and used in connection with the Delano Operations, of every kind and nature, including all furniture, fixtures, equipment, machinery, vehicles, and owned or licensed computer systems.

(q) "***Delano Real Property***" means all real property interests owned or leased by any Delano Entity, including buildings and improvement comprising the Hospital and each Delano Healthcare Facility and all of Delano's interests therein, and all right, title and interest of Delano in all appurtenances, options, easements, servitudes, rights-of-way and other rights associated therewith.

(r) "***Delano Subsidiaries***" means any entities, including Affiliates, in which Delano holds a majority ownership, membership or other majority control or participatory interest.

(s) "***Due Diligence Request***" means that certain due diligence request list originally provided by Adventist Health to Delano and its advisors on May 25, 2018, the supplemental due diligence request list provided on August 8, 2018 and all other supplemental diligence requests made by or will be made by Adventist Health thereafter until the Closing Date.

(t) "***Employee Benefit Program***" means any pension, profit-sharing, savings, retirement, employment, collective bargaining, severance pay, termination, executive compensation, incentive compensation, deferred compensation, bonus, phantom stock or other equity-based compensation, change-in-control, retention, salary continuation, vacation, sick leave, disability, death benefit, group insurance, hospitalization, medical, dental, life, Code Section 125 "cafeteria" or "flexible" benefit, employee benefit, or material fringe benefit plan, program, policy, practice, agreement or arrangement, whether written or oral, formal or informal, legally binding or not (including every "employee benefit plan," within the meaning of ERISA Section 3(3)) (i) currently maintained, sponsored or contributed to (or with respect to which any obligation to maintain, sponsor or contribute has been undertaken) by any Delano Entity or any ERISA Affiliate, (ii) under which any current or former employee or director of any Delano Entity has any present or future right to benefits, and (iii) with respect to which any Delano Entity has any material liability.

(u) "***Encumbrances***" means all liabilities, levies, claims, charges, assessments, mortgages, security interests, liens, pledges, conditional sales agreements, title retention contracts, leases, subleases, rights of first refusal, options to purchase, restrictions and other encumbrances, and agreements or commitments to create or suffer any of the foregoing.

(v) *"**Environmental Claim**"* means any written, or to Delano's knowledge threatened, claim, action, cause of action, investigation or notice by any Person alleging potential liability arising out of, based on or resulting from (a) the presence, release, or threatened release, of any Hazardous Materials at (or to Delano's knowledge adjacent to) any location owned or

operated by a Delano Entity, or (b) circumstances forming the basis of any violation or alleged violation of any Environmental Law.

(w) "***Environmental Laws***" means any and all Laws relating to pollution, contamination or protection of human health or the environment (including ground water, land surface or subsurface strata), including Laws relating to emissions, discharges, releases or threatened releases of Hazardous Materials, or otherwise relating to the manufacture, processing, distribution, use, treatment, storage, disposal, transport, recycling, reporting or handling of Hazardous Materials.

(x) "***ERISA***" means the Employee Retirement Income Security Act of 1974, as amended.

(y) "***ERISA Affiliate***" means an Affiliate of a Person if it is considered a single employer with such Person under ERISA Section 4001(b) or Section 414 of the Code, or part of the same "controlled group" as such Person for purposes of ERISA Section 302(d)(3).

(z) "***Financial Statements***" means the balance sheet and income statement of the Hospital as of and for the year ended December 31, 2017 and the interim balance sheet and income statement of the Hospital as of September 30, 2018.

(aa) "***Governmental Entity***" means any United States federal, state, provincial, county, municipal, regional or local governmental, or any political subdivision thereof, and any entity, department, commission, bureau, agency, authority, board, court or other similar body or quasi-governmental body exercising executive, legislative, judicial, regulatory or administrative functions of or pertaining to any government or other political subdivision thereof.

(bb) "***Government Payment Programs***" means federal and state Medicare, Medicaid and TRICARE (f/k/a CHAMPUS) programs, and similar or successor programs with or for the benefit of Governmental Entities.

(cc) "***Hazardous Materials***" means all chemicals, pollutants, contaminants, wastes (including medical waste), toxic substances, petroleum and petroleum products, including hazardous wastes under the Resource, Conservation and Recovery Act, 42 U.S.C. §§ 6903 et seq., hazardous substances under the Comprehensive Environmental Response, Compensation and Liability Act of 1980, 42 U.S.C. §§ 9601 et seq., asbestos, polychlorinated biphenyls and urea formaldehyde, and low-level nuclear materials, special nuclear materials or nuclear-byproduct materials, all within the meaning of the Atomic Energy Act of 1954, as amended, and any rules, regulations or policies promulgated thereunder.

(dd) "***Health Information Laws***" means all federal and state Laws relating to the privacy and security of patient, medical or individual health information, including the Health Insurance Portability and Accountability Act of 1996, as amended and supplemented by the Health Information Technology for Clinical Health Act of the American Recovery and Reinvestment Act of 2009, Pub. Law No. 111-5 and its implementing regulations, when each is effective and as each is amended from time to time (collectively, "***HIPAA***").

(ee) "***Hill-Burton Act***" means the Public Health Service Act, 42 U.S.C. §§ 291 et seq.

(ff) "***HSR Act***" means the Hart-Scott-Rodino Antitrust Improvements Act of 1976 and the rules and regulations promulgated thereunder.

(gg) **"*Knowledge of Delano"*** means the current actual knowledge of the Members of Delano, William Noble, currently serving as the Chief Executive Officer of Delano, and Bahram Ghaffari, currently serving as the President and Chief Financial Officer of Delano.

(hh) "***Law***" or "***Laws***" means all laws, codes, regulations, rules, orders, common law and ordinances applicable to a Delano Entity and/or Delano Operations including: state corporate practice of medicine Laws and regulations, state professional fee-splitting laws and regulations, Medicare Law (Title XVIII of the Social Security Act), Medicaid Law (Title XIX of the Social Security Act), TRICARE Law (10 U.S.C. § 1071 et seq.) and the regulations promulgated thereunder, the Civilian Health and Medical Program of the Uniformed Services, workers' compensation; state and federal controlled substance and drug diversion, including the Federal Controlled Substances Act (21 U.S.C. § 801 et seq.) and the regulations promulgated thereunder, the Patient Protection and Affordable Care Act as amended by the Health Care and Education Affordability Reconciliation Act (the "***Affordable Care Act***"), the federal Anti-kickback Statute (42 U.S.C. § 1320a-7b(b)), the Stark Law (42 U.S.C. § 1395nn), any applicable state fraud and abuse prohibitions, including those that apply to all payors (governmental, commercial insurance and self-payors), the Anti-Inducement Law (42 U.S.C. § 1320a-7a(a)(5)), the civil False Claims Act (31 U.S.C. §§ 3729 et seq.), the administrative False Claims Law (42 U.S.C. § 1320a-7b(a)), the civil monetary penalty laws (42 U.S.C. § 1320a-7a), the National Labor Relations Act (29 U.S.C. § 151 et seq.), laws and regulations applicable to organizations described under Section 501(c)(3) of the Code and any other state or federal law or regulation which regulates a Delano Entity and/or Delano Operations (e.g., kickbacks, patient or program charges, recordkeeping, claims process, documentation requirements, medical necessity, referrals, the hiring of employees or acquisition of services or supplies from those who have been excluded from government health care programs, quality, safety, privacy, environmental, information technology, security, licensure, accreditation or any other aspect of providing health care services).

(ii) "***Letter of Intent"*** or "***LOI***" means that certain non-binding letter of intent between Adventist Health and Delano dated as of August 21, 2018 (the "***LOI Execution Date***") that outlined such parties' intent with respect to the Affiliation.

(jj) "***Material Adverse Change***" or "***MAC***" means an event, change or circumstance, which, individually or together with any other event, change or circumstance, does or would be reasonably expected to have a material adverse effect, either individually or in the aggregate, on the business, assets, liabilities, financial condition or results of Delano Operations regardless of whether such effect is or would be realized before or after the Closing. A MAC shall not include: (i) changes in the financial or operating performance due to or caused by the announcement of the Affiliation or seasonal changes; (ii) requirements, reimbursement rates, policies or procedures of third-party payors or accreditation commissions or organizations that

are generally applicable to hospitals or health care facilities; (iii) general business, industry or economic conditions, including such conditions related to Delano; (iv) local, regional, national or international political or social conditions, including the engagement by the United States in hostilities, whether or not pursuant to the declaration of a national emergency or war, or the occurrence of any military or terrorist attack; (v) changes in financial, banking or securities markets (including any disruption thereof and any decline in the price of any security or any market index); or (vi) changes in Generally Accepted Accounting Principles.

(kk) "***Material Contract,***" when used in Article IV or Article VI means, any Contract that (i) results in or reasonably could result in One Hundred Thousand Dollars ($100,000) or greater in annual expenditures by, or revenues to, any Delano Entity and (ii) cannot be terminated by either party within three hundred sixty five (365) days of the Execution Date.

(ll) "***Members***" means Wesley Bilson and Gregory M. Bilson, each of whom hold membership in Delano on an individual basis.

(mm) "***Multiemployer Plan***" shall have the meaning set forth in Section 3(37) of ERISA or Section 4001(a)(3) of ERISA.

(nn) "***Person***" means an individual, corporation, partnership, limited liability company, firm, joint venture, association, joint stock company, trust, unincorporated organization or other entity, or any Governmental Entity or quasi-governmental body or regulatory authority.

(oo) "***Plant Closure Laws"*** means any "plant closure" or "mass layoff" Law, which includes the Federal Worker Adjustment and Retraining Notification Act (29 U.S.C. §§ 2101 et seq.) and its California counterpart (California Labor Code Sections 1400 et seq.).

(pp) "***Special Employee Liabilities***" shall mean "Paid Time Off" ("**PTO**"), which has been accrued, but not used, donated or cashed-out.

(qq) "***Tax***" means (a) (i) any federal, state, local or foreign income, gross receipts, franchise, estimated, alternative minimum, add-on minimum, sales, use, transfer, real property gains, registration, value added, excise, natural resources, severance, stamp, occupation, windfall profits, environmental (under Section 59A of the Code), customs, duties, real property, personal property, capital stock, social security (or similar), unemployment, disability, payroll, license, employee, service, ad valorem, profits, capital, premium, production, consumption, commercial rent, capital gains, business privilege, recording, inventory, merchandise, intangibles, transaction, title, business, deduction at source or other withholding (including withholding liability as a representative taxpayer), or other tax, (ii) any impost, fee, levy, charge, or assessment, in each case, in the nature of taxes, (iii) any liability under unclaimed property, escheat or any similar Law, and (iv) any interest, penalties or additions in respect of the foregoing (whether disputed or not) or in respect to failure to comply with any requirement with respect to Tax Returns and (b) any liability for the payment of any amounts of the type described in clause (a) as a result of any Contract to pay or assume any such amounts or to indemnify any other Person for such amounts, any transferee or successor liability, the operation of Law

(including pursuant to Treasury Regulations Section 1.1502-6 or any similar provision of state, local or foreign Law) or otherwise.

(rr) "***Tax Return***" means any return, declaration, report, claim for refund, information return or statement, including schedules and attachments thereto and amendments, relating to Taxes.

(ss) "***Transaction Document***" means each of the Agreement, and the New Organizational Documents.

(tt) "***Utilities***" means water, sewer, gas, electricity, internet, television and telephone services.

1.2 Other Defined Terms. The following terms shall have the meanings defined for such terms in the Sections set forth below:

Term	**Section**
"Arbitrable Dispute"	9.1(c)
"Adventist Health"	Preamble
"Affiliation"	Recitals
"Agreement"	Preamble
"AH Board"	3.4(a)
"AH Certificates"	11.2(f)
"AH Charity Policy"	3.9(a)
"AH Indemnified Party"	8.1(a)
"Arbitration Notice"	9.1(c)(i)
"Cerner EMR Conversion"	3.2
"Change of Control"	3.5
"Closing Date"	12.1
"Closing"	12.1
"Corporate Board"	3.4(a)
"Delano"	Preamble
"Delano Certificates"	11.1(h)
"Delano Community Health Programs"	3.9(b) below
"Delano Employee"	3.12(a)
"Delano Indemnified Party"	8.1(b)
"Disclosure Schedules"	Article IV
"Dispute"	9.1
"Dispute Notice"	9.1(a)
"DOL"	4.15(b)
"Drop Dead Date"	10.2(c)
"EMR"	3.2
"Execution Date"	Preamble
"Governing Board"	2.2
"Government Authorizations"	7.2

"Hearing"	9.1(c)(v)
"Hospital"	Recitals
"Indemnified Party"	8.2
"Indemnifying Party"	8.2
"Initial Resolution Period"	9.1(b)
"IRS"	4.15(b)
"JAMS"	9.1(c)
"Licenses"	4.12
"Losses"	8.1(a)
"Medical Staff"	3.10
"Medical Staff Bylaws"	3.10
"Meet and Confer"	9.1(b)
"Membership Approval"	6.1(c)
"Membership Issuance"	2.1(c)
"New Organizational Documents"	2.1(c)
"Obligated Group Entry Date"	3.3
"Obstetrics Solution"	3.1
"Party" or "Parties"	Preamble
"PBGC"	4.15(b)
"Powers of Attorney"	12.2(d)
"Representatives"	4.29
"SEC"	4.15(b)
"Section 5914"	6.1(b)
"State"	2.1(c)
"Term"	10.1
"VCP"	4.15(b)

ARTICLE II
DELANO MEMBERSHIP AND RESTRUCTURING

2.1 Issuance of Membership; Restructuring.

(a) The Parties shall work cooperatively and use good faith efforts to obtain the resignation of Delano's current Members, and shall each take those actions that are necessary or appropriate for the Party to take so that Delano's current Members' withdrawal is effective, on or before the Closing Date.

(b) Without limiting the generality of the foregoing, Delano shall take all appropriate action to cause, effective as of 12:01 AM on the Closing Date: (i) amendment of the Delano Amended and Restated Bylaws in accordance with Exhibit 2.1(b) making Adventist Health the sole corporate member of Delano (***"Membership Issuance"***) under Sections 5310 *et seq.* of the Corporations Code of the State of California (the ***"State"***); and (ii) the resignation of the Members by written resignation in form and substance satisfactory to Adventist Health. Promptly after completion of such actions, Adventist Health, in its new capacity as the sole corporate member of Delano, shall appoint new members to the Delano board of directors (the

"Corporate Board"), and the current members of the Corporate Board shall simultaneously resign, pursuant to forms of resignation previously tendered but effective upon the appointment of the new Corporate Board members, all in form and substance reasonably satisfactory to Adventist Health.

(c) Promptly after completion of the actions contemplated by Section 2.1(b), Adventist Health, in its capacity as the sole corporate member of Delano, and the Corporate Board shall adopt amended and restated articles, second amended and restated bylaws and new governing board bylaws, all as set forth in Exhibit 2.1(c) (collectively the "***New Organizational Documents***") that, among other things, will (i) convert Delano from a nonprofit public benefit corporation to a nonprofit religious corporation under the Law of the State, (ii) change Delano's corporate name to "Adventist Health Delano," consistent with Adventist Health's then existing branding guidelines, and (iii) provide for the creation of an advisory committee tasked with oversight responsibilities of the local operations of Delano (the ***"Governing Board"***)..

(d) After the Closing Date, Adventist Health shall operate Delano as a separate non-profit religious corporation, holding its own, separate balance sheet, including cash and investment assets (although cash will be consolidated for investment purposes, but remain available to Delano when needed, subject to Adventist Health approval).

2.2 Delano Governing Board. With the adoption of the New Organizational Documents, Delano shall appoint the Governing Board Members, with powers and functions as further described below.

ARTICLE III
ADVENTIST HEALTH DUTIES

3.1 Obstetrics Solution. Within five (5) years following the Closing Date, Adventist Health shall develop and open an inpatient obstetrics and delivery service at Delano in furtherance of Delano's mission and the obstetrics needs of the Delano Market ("***Obstetrics Solution***"). It is anticipated that the size and scope of the Obstetrics Solution shall be as specified in forth in Exhibit 3.1.

3.2 Cerner EMR Conversion. After the Closing Date, Adventist Health shall, at its cost, convert Delano's current electronic medical record ("***EMR***") system to Adventist Health's standard Cerner Millennium EMR system ("***Cerner EMR Conversion***"). Within six (6) months after the Closing Date, Adventist Health shall commence implementation of information technology infrastructure upgrades at Delano necessary to support the Cerner EMR Conversion.

3.3 Debt Guaranty. Effective on the Closing Date, Adventist Health shall guarantee all of Delano's existing long-term debt identified in Exhibit 3.3. The Parties intend for Delano to join Adventist Health's Obligated Group when Adventist Health determines that it is advantageous for Delano to do so (the "***Obligated Group Entry Date***"). If Adventist Health determines that Delano needs to borrow or otherwise obtain additional funds prior to the Obligated Group Entry Date, Adventist Health shall in its discretion either: (a) loan Delano such necessary funds directly or (b) guarantee Delano's borrowing of funds from a third party. After the Closing Date, Delano shall participate in the Adventist Health capital allocation process,

which shall include consultation and collaboration with the senior management of Delano and the Governing Board, for both routine and strategic capital needs.

3.4 Delano Governance.

(a) The Corporate Board is the board of directors ultimately responsible for the actions of Delano under State Law. Effective on the Closing Date, the members of the Corporate Board shall be reconstituted to mirror the composition of the Adventist Health board of directors (the "***AH Board***").

(b) Delano shall have a Governing Board, to which specific powers are delegated by the Corporate Board as set forth in the New Organizational Documents.

(c) Prior to the Closing Date, the Parties shall consult and offer suggestions as to the individuals who will comprise the Governing Board. Following such consultation, the Corporate Board shall appoint the individuals to serve on the Governing Board following the Closing Date, all of whom shall have been approved by the AH Board. Thereafter, new Governing Board appointees shall be identified by a Governing Board nominating committee, subject to the approval by the Corporate Board.

(d) The most senior Adventist Health corporate executive on the Governing Board shall serve as chairperson of the Governing Board.

(e) All operations and governance of the Governing Board shall be as set forth in the New Organizational Documents.

3.5 Limitations on Change of Control. During the Term, Adventist Health shall not sell, convey, or otherwise transfer all or substantially all of the Delano Assets to a third party, or merge Delano with or assign a membership interest in Delano to a third party (whether in a single transaction or in a series of transactions) (collectively, a "***Change of Control***"); provided, that nothing in this regard shall limit in any way actions of Adventist Health as a system, including any change of control of Adventist Health or any transaction involving another Affiliate of Adventist Health.

3.6 Corporate Services.

(a) Following the Closing Date, Adventist Health and its Affiliates shall provide Delano access to administrative and corporate support services, in the same manner, at the same cost structure and at levels that are no less than what is provided to other hospitals Affiliated with Adventist Health. Such administrative and corporate support shall include branding and marketing services, access to efficiencies in administrative and clinical operations (including revenue cycle management, labor productivity systems, overhead management systems and system policies and procedures), and fundraising expertise.

(b) Following the Closing Date, Adventist Health and its Affiliates will provide Delano with access to their applicable group purchasing contract(s), vendor contracts, payor contracts, managed care support systems and strategies (including administrative and

technical support with respect to capitation and integration of Delano into Adventist Health's managed care networks and payor contracts, as applicable), accountable care organizations and other health reform initiatives and physician networks in the same manner and on the same footing as other hospitals Affiliated with Adventist Health.

3.7 Clinical Services. During the Term, Adventist Health shall cause Delano to operate the Hospital as a licensed general acute care hospital facility (as defined in California Health and Safety Code Section 1250), with an operating bed count for emergency, acute care (including perinatal and intensive care) and skilled nursing care not less than the bed count as of the Execution Date of this Agreement, all as set forth on Exhibit 3.7. Any changes to the foregoing will be approved by the Governing Board in the manner described in the Governing Board bylaws.

3.8 Quality, Compliance and Patient Satisfaction. Adventist Health shall operate Delano with a commitment to quality, compliance, patient safety and patient satisfaction, including maintaining the appropriate accreditation and participation in Medicare, Medi-Cal and TRICARE programs, subject to any material changes in any of those programs after Closing that materially and adversely financially impact, hinder, or preclude participation by Delano or Adventist Health.

3.9 Charity and Community Care.

(a) Effective upon the Closing Date, Adventist Health shall cause Delano to adopt the Adventist Health policies on charity and indigent care, as set forth in Exhibit 3.9(a) and as may be modified by Adventist Health system-wide from time to time (the "***AH Charity Policy***"). Delano shall follow Adventist Health's procedures for implementing, maintaining and adhering to the AH Charity Policy.

(b) Adventist Health shall also ensure that Delano reasonably continues to provide care through at least the specified community-based health programs listed on Exhibit 3.9(b) (the "***Delano Community Health Programs***"), including cooperation with local organizations that sponsor healthcare initiatives to address identified community needs and improve the health status of the elderly, poor, and other at-risk populations in the Delano Market.

(c) If Delano has a charity care patient or discounted care patient on the Closing Date, Delano shall finish the course of treatment for such patient under the same financial arrangement as existed with Delano prior to the Closing Date.

3.10 Medical Staff. Changes, if any, to the Hospital's medical staff ("***Medical Staff***") bylaws (the "***Medical Staff Bylaws***") and Medical Staff policies and procedures upon the Closing Date or thereafter shall be subject to current amendment procedures of the Medical Staff Bylaws and policies and procedures in effect as of the Execution Date of this Agreement. The Medical Staff members in good standing as of the Closing Date shall maintain Medical Staff privileges at the Hospital after the Closing Date. Adventist Health shall cause Delano to use commercially reasonable efforts to recruit and retain a quality Medical Staff serving the Delano

Market, and to facilitate the provision of the clinical services as set forth above, subject to all Laws (including all requirements for maintaining tax-exempt status and tax-exempt financing).

3.11 Physician Affiliation Strategies. Adventist Health and its Affiliates shall support Delano in the continuity and growth of the Clinics as currently structured or as reorganized to be integrated with Adventist Health Physicians Network, establishment of new Clinic locations, and shall facilitate the staffing of such Clinics by an Adventist Health affiliated physician organization. Adventist Health and its Affiliates shall work with Delano to strengthen physician affiliation strategies in the Delano Market by providing Delano access to Adventist Health's existing physician recruitment programs and practice development vehicles, and to deploy and/or develop Delano physician affiliation resources as necessary to meet the physician recruitment needs of the Delano Market.

3.12 Employees.

(a) Subject to the provisions of this Section 3.12(a), all Delano Entity active employees in good standing (including those on Delano-approved or legally required leaves of absence) as of Closing (each a "***Delano Employee***") initially shall either remain Delano Employees, or as reasonably determined by Adventist Health in consultation with Delano, shall become employees of Adventist Health, one of Adventist Health's Affiliates, or of Cerner or Jones Lang LaSalle (Adventist Health's outsourced service vendors); provided that in each case, such Delano Employee shall remain in a substantially similar position, under substantially similar terms and conditions of each employee's then-current employment arrangement, and at their existing compensation and benefits levels; provided, further that each Delano Employee successfully passes routine sanctions check of Adventist Health, its Affiliates and/or outsourced service providers, prior to the Closing Date, and provided further that if any Delano Employee is subject to an ongoing progressive discipline or termination procedure as of the Closing Date, such procedure shall continue in due course and not be restarted, interrupted or concluded solely as a result of the Affiliation. For the purposes of this Agreement, except as provided in Exhibit 3.12(a), the term Delano Employee shall not include any licensed physician providing professional medical services to any Delano Entity, regardless of whether such physician is employed by a Delano Entity. Further, to the extent permitted by any benefit plan, Delano Employees shall retain their current years of service for purposes of vesting in the applicable Delano Entity's benefit program (or any successor benefit program or benefit program of Adventist Health, an Adventist Health Affiliate, Cerner or Jones Lang LaSalle, as applicable) and shall retain their years of services as of the Closing Date for purposes of determining Special Employee Liabilities as of the Closing Date. As applicable, Delano Employees shall, and each shall provide their express written consent, to roll over their Special Employee Liabilities from the applicable Delano Entity to Adventist Health, an Adventist Health Affiliate, Cerner or Jones Lang LaSalle, as applicable, and such new employer shall assume the obligation to honor such Special Employee Liabilities, including, as applicable, cash-out of any amounts above such employer's cap on Special Employee Liabilities.

(b) After the Closing Date, the terms and conditions (e.g., salaries, wages, job duties, titles and responsibilities) of each Delano Employee's employment arrangement shall be subject to review by Delano management, Adventist Health, an Adventist Health Affiliate, or the

outsourced service provider, as applicable. The Parties anticipate that Adventist Health will offer to Delano Employees after the Closing Date rates of compensation and/or benefits comparable to those such Delano Employees received immediately prior to the Closing Date. Subject to applicable Law, Adventist Health shall have the right to terminate any Delano Employee with or without cause or notice after the Closing Date, provided, that, notwithstanding the foregoing provisions of this Section 3.12, except for good cause, no Delano Employee will be terminated or laid off or suffer any loss either in rate of compensation or benefits for a period of one hundred eighty (180) days following the Closing Date. Nothing in the foregoing shall restrict Adventist Health and a Delano Employee from entering into a mutually agreeable arrangement whereby such Delano Employee assumes a position with Adventist Health's corporate office in Roseville, California, an Adventist Health Affiliate or any Adventist Health outsourced service vendor (e.g., Cerner or Jones Lang LaSalle).

(c) Notwithstanding the foregoing paragraph (b), Adventist Health shall assume or cause Delano to honor the obligations of performance under the employee and executive contracts set forth in Exhibit 3.12(c), including, without limitation, the payment of severance compensation, the amounts and payment dates of which will be reflected on Exhibit 3.12(c).

3.13 Community Relations; Commitments. Consistent with commitments that Delano made to the community it serves, Adventist Health shall cause Delano to:

(a) Continue to permit community residents to maintain a "Community Garden" consisting of approximately one acre in its present location in a remote section of Delano's vacant land, unless and until there is a need to utilize such land for expansion of facilities or such land is otherwise disposed of; and

(b) Not to use the vacant land located on the northwest corner of Garces Highway and Lexington Avenue (which formerly served as the location of a Veterans of Foreign Wars building demolished in 2015) for a parking lot, although such land may be used for any other purpose.

3.14 Name Recognition. Adventist Health shall cause Delano to maintain the existing signage reading, "THE BILSON WING," located at the entrance to the ICU Building leading from the main facility or some other suitable recognition of Wesley Bilson, that the parties may agree upon prior to Closing.

ARTICLE IV
REPRESENTATIONS AND WARRANTIES OF DELANO

Except as otherwise set forth on the disclosure schedules attached hereto ("***Disclosure Schedules***"), Delano represents and warrants to Adventist Health with respect to each Delano Entity, as applicable, the Delano Operations and the Delano Assets that the following representations and warranties are true and correct as of the Execution Date. These representations and warranties shall also be true and correct as of the Closing Date, subject to any amendment allowed by Section 6.2.

4.1 Organization, Power, Absence of Conflicts.

(a) Organization; Good Standing. Each Delano Entity is a corporation or limited liability company, as the case may be, is duly organized, validly existing and in good standing under the laws of the State and has full power and authority to carry on its respective business in the State and to own or lease and operate the Delano Assets at and where now owned or leased and operated by it. No Delano Entity is licensed, qualified or admitted to do business in any jurisdiction other than the State and there is no other jurisdiction in which the ownership, use or leasing of any Delano Asset, or the conduct or nature of the Delano Operations, makes such licensing, qualification or admission necessary.

(b) Authority; No Conflict; Required Filings and Consents.

(i) Delano has all requisite corporate power and authority to conduct its businesses, including those of the Delano Subsidiaries, as now being conducted, to execute, deliver and enter into this Agreement, to consummate the Affiliation contemplated hereby and to perform its obligations hereunder. The execution and delivery of this Agreement, and the consummation of the Affiliation contemplated hereby, have been duly authorized by all necessary corporate or other action on the part of all Delano Entities. This Agreement has been duly executed and delivered by Delano and is a legal, valid and binding obligation of Delano, enforceable against each Delano Entity in accordance with its terms, except to the extent that enforceability may be limited by applicable bankruptcy, reorganization, insolvency, moratorium or other Laws affecting the enforcement of creditors' rights generally and by general principles of equity, regardless of whether such enforceability is considered in a proceeding at law or in equity. As of Closing, no vote or written consent of any holder of any membership or ownership interests of any Delano Entity is necessary to approve this Agreement or any of the Affiliation contemplated hereby.

(ii) The execution and delivery by Delano of this Agreement does not, and the consummation of the Affiliation contemplated hereby will not, (A) result in any breach or contravention of, or permit the acceleration of the maturity of, any material Encumbrances of any Delano Entity, (B) result in the creation of any Encumbrances on the Delano Assets (other than Encumbrances created pursuant to the terms of this Agreement and the other agreements and documents executed in connection with the consummation of the Affiliation contemplated hereby), (C) conflict with, or result in any violation or breach of any provision of the formation or governing documents of any Delano Entity, as amended to date, (D) violate any Laws applicable to any Delano Entity, or (E) except as set forth on Schedule 4.1(b)(ii), conflict with or result in a breach of, or give rise to a right of termination or amendment of or loss of benefit under, or accelerate the performance required by the terms of any judgment, court order or consent decree, or any Material Contract or constitute a default thereunder for any Delano Entity.

(iii) Neither the execution and delivery by Delano of this Agreement nor the consummation of the Affiliation contemplated hereby will require any consent, approval, order or authorization of, or registration, declaration or filing with, or notification to any Governmental Entity or any Person, except for (A) such consents, approvals, orders, authorizations, registrations, declarations and filings as are identified in this Agreement and (B)

such other consents, approvals, authorizations, permits, filings, registrations and notifications which are listed on Schedule 4.1(b)(iii).

4.2 Affiliates and Third-Party Rights. Other than the Delano Subsidiaries, no Affiliate of Delano conducts any Delano Operations and Delano has no subsidiaries or other interests in any Persons that conduct any Delano Operations. There are no Contracts with, or rights of, any Person to acquire, directly or indirectly, any material Delano Assets, or any interest therein.

4.3 Transactions. Except as set forth on Schedule 4.3, since January 1, 2018, no Delano Entity has sold, gifted, transferred or leased any material Delano Asset to any Affiliate of any Delano Entity or to any other Person, other than sales, gifts, transfers or leases between Delano Entities themselves.

4.4 Legal Compliance.

(a) Except as described in Schedule 4.4, each Delano Entity is, and has been since January 1, 2013, in compliance in all material respects with all applicable Laws and has timely filed all reports, data and other information required to be filed with Governmental Entities, in each instance in which non-compliance or failure to timely file reasonably would result in material liability to Delano. To the knowledge of Delano, no Delano Entity has received notice from any Person of any proceeding or investigation by Governmental Entities alleging or based upon a violation of any Laws that is currently pending. Except as disclosed on Schedule 4.4, to the knowledge of Delano, no Delano Entity has been threatened by any Person with any proceeding or investigation by Governmental Entities alleging a violation of any Laws with respect to the Delano Operations.

(b) Except as set forth on Schedule 4.4: (i) each Delano Entity has (A) developed a compliance plan for being in compliance with the Health Information Laws, (B) to the knowledge of Delano, used its best efforts to implement those provisions of such compliance plan in all respects necessary to ensure that the applicable Delano Operations are in compliance with the Health Information Laws, including undertaking surveys, audits, inventories, reviews, analyses and/or assessments of all areas of its business and operations required by the Health Information Technology for Economics and Clinical Health Act of 2009 and the administrative simplification provisions of HIPAA and (C) to the knowledge of Delano, maintained all individually identifiable health information, including protected health information (as defined under HIPAA at 45 C.F.R. § 160.103), governed by the Health Information Laws and in accordance with the Health Information Laws; (ii) to the knowledge of Delano, each Delano Entity has entered into Business Associate Contracts (as defined under HIPAA at 45 C.F.R. §§ 164.308(b) and 164.314(a)), where required, and is, and has been, in compliance with the terms of such Business Associate Contracts to which such Delano Entity is a party or otherwise bound; (iii) to the knowledge of Delano, since January 1, 2013, no Delano Entity has received any inquiries, complaints or notices from the U.S. Department of Health and Human Services, U.S. Office for Civil Rights, or any other Governmental Entity regarding the Delano Operations' compliance with the Health Information Laws, and no security breach or other incident has occurred that could reasonably be expected to result in any such inquiries,

complaints or notices; and (iv) each Delano Entity and, to the knowledge of Delano, its respective Business Associates (as defined under HIPAA at 45 C.F.R. § 160.103) are not the subject of, or a party to, any civil, criminal or administrative proceeding or investigation by a Governmental Entity in connection with any actual or potential violation of the Health Information Laws (other than routine surveys or reviews).

(c) Except as set forth in Schedule 4.4, each Delano Entity and each Delano Healthcare Facility meets all requirements of participation, claims submission and payment of the Government Payment Programs and other third-party payment programs and is a party to valid participation agreements for payment by such Government Payment Programs and other third-party payment programs. No Delano Entity or, to the knowledge of Delano, any of their respective officers, directors, employees, agents or contractors has been or is currently excluded from participation in any Government Payment Program.

(d) Except as set forth in Schedule 4.4, there are no material Government Payment Program recoupments or material recoupments of any third-party payor being sought, requested, claimed, or, to the knowledge of Delano, threatened against any Delano Entity. Except as set forth in Schedule 4.4, (i) there is no Action pending, received or, to the knowledge of Delano, threatened against any Delano Entity which relates in any way to a violation of any Law pertaining to the Government Payment Programs or which could result in the imposition of material penalties on or the exclusion of any Delano Entity or any Delano Healthcare Facility from participation in any Government Payment Programs, and (ii) to the knowledge of Delano, no Delano Entity or any of their respective officers, directors, employees or agents have engaged in any activities which are cause for civil penalties or mandatory or permissive exclusion from any Government Payment Program. Except as set forth in Schedule 4.4, no Delano Entity is a party to any corporate integrity agreements, deferred prosecution agreements, monitoring agreements, consent decrees, settlement orders, plans of correction or similar agreements imposed by any Governmental Entity.

(e) Each Delano Entity is in material compliance with all Laws regarding the selection, deselection, and credentialing of contracted providers, including, but not limited to, verification of licensing status and eligibility for reimbursement under the Government Payment Programs. To the knowledge of Delano, each Delano Entity's contracted providers are properly licensed and hold appropriate clinical privileges, as applicable, for the services which they provide, and, with respect to providers that perform services eligible for reimbursement under any Government Payment Program, are not debarred or excluded from any such Government Payment Program.

(f) All reports, data, and information required to be filed by any Delano Entity in connection with any Government Payment Program have been timely filed and were true and complete at the time filed (or were corrected in or supplemented by a subsequent filing), to the extent any such failure to timely file would be a default under such program in any material respect. There are no Actions or appeals pending (and no Delano Entity has made any filing or submission that would result in any Actions or appeals) before any court, regulatory body, administrative agency, governmental body, arbitrator or other authority (including governmental administrative contractors) with respect to any Government Payment Program

reports or claims filed by any Delano Entity on or before the date hereof, or with respect to any disallowances by any regulatory body, administrative agency, governmental body or other authority (including governmental administrative contractors) in connection with any audit. Except as set forth in Schedule 4.4, since January 1, 2013, no validation review or program integrity review related to any Delano Entity or any Delano Healthcare Facility has been conducted by any regulatory body, administrative agency, governmental body or other authority (including governmental administrative contractors) in connection with any Government Payment Program and no such reviews are scheduled, pending, or, to the knowledge of Delano, threatened against or affecting any Delano Entity or any Delano Healthcare Facility.

4.5 Financial Statements. Except as set forth on Schedule 4.5, the Financial Statements fairly and accurately present in all material respects the financial condition and results of operations of the Delano Operations as of the respective dates thereof and for the period therein referred to, subject to normal recurring year-end adjustments (the effect of which will not, individually or in the aggregate, be materially adverse) and the absence of notes; and the Financial Statements reflect the consistent application of Generally Accepted Accounting Principles throughout the periods involved.

4.6 Conduct of Business in Ordinary Course; Absence of Material Adverse Change.

(a) To the knowledge of Delano, except as described in Schedule 4.6(a) and except for actions taken in connection with the process of affiliating with Adventist Health (including preparing for and implementing the Affiliation contemplated by this Agreement), from January 1, 2018, Delano has conducted its businesses, and caused each Delano Subsidiary to conduct its business, in the ordinary course consistent with past practice.

(b) Except as described in Schedule 4.6(b), since January 1, 2018, no Material Adverse Change has occurred in the financial condition, assets, liabilities, income or prospects of any Delano Entity or the Delano Operations.

4.7 Inventory and Supplies. To the knowledge of Delano, all items of Delano Inventory on hand consist of items of a quality usable or saleable in the ordinary course of business, except for those items which are obsolete, below standard quality or in the process of repair and for which adequate reserves have been provided in the Financial Statements. To the knowledge of Delano, the quantities of all Delano Inventory are reasonable and justified under the normal conduct of the Delano Operations.

4.8 Equipment. Since January 1, 2018, except in the ordinary course of the Delano Operations, no Delano Entity has sold or otherwise disposed of any equipment (except obsolete equipment not in use) having an original cost in excess of One Hundred Thousand Dollars ($100,000) except with a comparable replacement thereof. To the knowledge of Delano and except as described in Schedule 4.8, all equipment material to the Delano Operations is in good working order and has been properly maintained. For purposes of this Section 4.8, equipment is deemed "material" if it has a replacement value in excess of One Hundred Thousand Dollars ($100,000).

4.9 Title to Personal Property. A Delano Entity owns and holds good and valid title or leasehold title, as the case may be, to all Delano Assets (other than the Delano Real Property) material to the Delano Operations free and clear of any Encumbrances, other than those Encumbrances listed on Schedule 4.9. Delano shall take, and shall cause each Delano Subsidiary to take, all necessary actions to ensure that a Delano Entity has good and valid title to all owned Delano Assets (other than the Delano Real Property) material to the Delano Operations at Closing, free and clear of any Encumbrances, other than those Encumbrances listed on Schedule 4.9. For purposes of this Section 4.9, an asset is "material" to the Delano Operations if it has a replacement value in excess of One Hundred Thousand Dollars ($100,000).

4.10 Real Property.

(a) A Delano Entity owns fee simple title to the owned Delano Real Property, free and clear of any Encumbrances, other than those Encumbrances listed on Schedule 4.10(a).

(b) The Delano Real Property comprises all of the real property owned or leased by the Delano Entities or their Affiliates.

(c) To the knowledge of Delano, no Delano Entity has received notice of condemnation or similar proceeding relating to the Delano Real Property or any part thereof.

(d) To the knowledge of Delano, no part of the Delano Real Property contains, is located within or abuts any flood plain, navigable water or other body of water, tideland, wetland, or marshland.

(e) Except for those tenants in possession of the Delano Real Property under Contracts in the rent roll attached as Schedule 4.10(e), there are no Persons in possession of, or, to the knowledge of Delano, claiming any possession, adverse or not, to or other interest in, any portion of the Delano Real Property other than a Delano Entity, whether as lessees, tenants at sufferance, trespassers or otherwise. The documents constituting the leases that are delivered to Adventist Health pursuant to this Agreement are true, correct, and complete copies of all of the leases affecting the Delano Real Property, including all amendments and guarantees. To the knowledge of Delano, all information set forth in Schedule 4.10(e) is true, correct, and complete in all material respects as of its date. Except as disclosed in Schedule 4.10(e), no tenants have asserted nor are there any defenses or offsets to rent accruing after the Closing Date and, to the knowledge of Delano, no default or breach exists on the part of any tenant. To the knowledge of Delano, no Delano Entity has received any written notice of any default or breach on the part of the landlord under any lease of Delano Real Property, nor, to the knowledge of Delano, does there exist any such default or breach on the part of the landlord.

(f) To the knowledge of Delano, no tenant is entitled to any rebate, concession or free rent, other than as reflected in the Contract with such tenant; no commitments have been made to any tenant for repairs or improvements other than for normal repairs and maintenance in the future or improvements required by the Contract with such tenant; and no rents due under any of the Contracts with tenants have been assigned or hypothecated to, or encumbered by, any Person.

(g) All material obligations of any Delano Entity as landlord, including painting, repairs, alterations and other work required to be performed by such Delano Entity as landlord under each of the Contracts with tenants, have been fully performed in all material respects.

(h) All Utilities are available to the Delano Real Property and, to the knowledge of Delano, there are no conditions existing which could result in the termination or reduction of the current access from the Delano Real Property to existing roadways.

(i) Schedule 4.10(i) identifies all those construction or capital projects currently in progress with respect to the Delano Real Property for which all final approvals needed from Governmental Entities have not been obtained.

4.11 Environmental Matters.

(a) To the knowledge of Delano, there are no circumstances in existence that may prevent or interfere with compliance by any Delano Entity in all respects with Environmental Laws. Since January 1, 2014, no Delano Entity has received any written communication (or reduced to writing any oral communication) from any Person alleging that any Delano Entity is not in full compliance with Environmental Laws, which noncompliance reasonably would result in material liability to Delano. The applicable Delano Entity has (or has applied for or caused the applicable Delano Entity to apply for) all material permits, licenses, approvals and authorizations required under applicable Environmental Laws to conduct the Delano Operations ("***Environmental Licenses***"). All Environmental Licenses currently held by any Delano Entity or any Delano Healthcare Facility related to the Delano Operations and the Delano Real Property pursuant to the Environmental Laws are identified in Schedule 4.11(a).

(b) Since January 1, 2014, there is no Environmental Claim pending or, to the knowledge of Delano, threatened against any Person whose liability for any Environmental Claim has or may have been retained or assumed either contractually or by operation of law by a Delano Entity.

(c) No actions, activities, circumstances, conditions, events or incidents, including the release, emission, discharge or disposal of any Hazardous Materials, have occurred in the Delano Operations, any Delano Healthcare Facility or the Delano Real Property that could form the basis of any Environmental Claim against any Person whose liability for any Environmental Claim has or, to the knowledge of Delano, may have been retained or assumed either contractually or by operation of Law by a Delano Entity.

4.12 Licenses and Permits. Schedule 4.12 contains an accurate list of all material licenses, permits, certifications, registrations, accreditations, certificates of need, authorizations and franchises (including for each, any applications therefor) (the "***Licenses***") owned or held by any Delano Entity or any Delano Healthcare Facility relating to the Delano Operations and the Delano Assets, all of which are in good standing (to the extent granted) or have been applied for and are not subject to meritorious challenge. Each Delano Healthcare Facility is duly licensed by the appropriate State or federal agencies and any ancillary services operated or provided at each Delano Healthcare Facility that are required to be separately licensed are duly licensed (or such

Licenses have been applied for) by the appropriate State or federal agencies in each instance in which the failure to be so licensed reasonably would result in material liability to Delano. The Delano Operations are in compliance in all material respects with such licensing requirements. There are no provisions in or Contracts relating to any such Licenses which would preclude or limit any Delano Entity from conducting the Delano Operations and using all the beds of the Hospital as they are currently classified (other than those beds held in suspense). Delano has made available to Adventist Health, and has caused each Delano Subsidiary to make available to Adventist Health, complete and genuine copies of the latest License, survey and/or fire marshal reports of each Delano Healthcare Facility and plans of correction or responses thereto. All violations set forth in such reports, if any, have been corrected in all respects by Delano.

4.13 Insurance. Delano has provided to Adventist Health copies of all insurance arrangements, including self-insurance, in place for the benefit of the Delano Entities, the Delano Assets and the conduct of the Delano Operations. All of such policies are now and until Closing will remain valid, outstanding and in full force and effect. No Delano Entity has been denied, or reduced the amount of, any insurance or indemnity bond coverage.

4.14 Employment Matters.

(a) Employee and Employee Relations.

(i) Delano has provided Adventist Health with a complete list of all Delano Employees, that sets forth for each such individual the following: (i) name; (ii) title or position (including whether full or part time); (iii) hire date; (iv) base hourly compensation rate; (v) commission, bonus or other incentive-based compensation; and (vi) a description of the employee benefits provided to each such individual as of the date hereof. Except as set forth on Schedule 4.14(a), as of the date hereof, all compensation, including wages, commissions and bonuses, and employee benefits payable to all Delano Employees for services performed on or prior to the date hereof have been paid in full (or accrued in full on the balance sheet contained in the Financial Statements, or, in the case of employee benefits, funded in full) (or will be paid, accrued or funded in accordance with Delano's normal payroll and similar practices).

(ii) There is no pending or, to the knowledge of Delano, threatened employee strike, work stoppage or slowdown, labor dispute or unfair labor practices at the Delano Operations.

(iii) No employees of any Delano Entity at the Delano Operations are represented by, or have made written demand for recognition of, a labor union or employee organization with respect to their work at the Delano Operations.

(iv) To the knowledge of Delano, there is no other union organizing or collective bargaining activities by or with respect to any employees of any Delano Entity with respect to such employment.

(v) Delano has complied with any and all obligations and liabilities under any Plant Closure Laws as a result of (i) the Delano Operations prior to the Closing Date and/or (ii) the consummation of the Affiliation.

(b) Pending Proceedings. There are no material active, pending or, to the knowledge of Delano, threatened administrative or judicial proceedings under Title VII of the Civil Rights Act of 1964, the Age Discrimination in Employment Act, the Fair Labor Standards Act, the Occupational Safety and Health Act, the National Labor Relations Act, the Fair Employment and Housing Act, the California Labor Code, ERISA or any other foreign, federal, state or local law (including common law), ordinance or regulation relating to current employees or former employees of any Delano Entity involved in the Delano Operations.

4.15 Employee Benefit Plans.

(a) Delano has provided Adventist Health with a true, correct and complete list of each Employee Benefit Program. No Employee Benefit Program is maintained outside the jurisdiction of the United States, or covers any employee working for a Delano Entity outside the United States.

(b) Except with respect to any voluntary correction procedure ("***VCP***") filing or form 5330 filing as set forth on Schedule 4.15, to the knowledge of Delano, each Employee Benefit Program that is intended to qualify under Section 401(a), 403(b) or 457(b) of the Code is so qualified and, in the case of a 401(a) plan, has received a favorable determination or opinion letter from the Internal Revenue Service ("***IRS***") regarding its qualification thereunder, and, to the knowledge of Delano, no event has occurred and no condition exists that would reasonably be expected to result in the revocation of any such qualification, including, in the case of the 401(a) plan, such determination, or the imposition of any liability, penalty or tax under ERISA, the Code or any other Laws. With respect to each Employee Benefit Program, to the knowledge of Delano, all reports, returns, notices, and other documentation that are required to have been filed with or furnished to the IRS, the United States Department of Labor (the "***DOL***"), the Pension Benefit Guaranty Corporation (the "***PBGC***"), the Securities and Exchange Commission (the "***SEC***") or any other Governmental Entity, or to the participants or beneficiaries of such Employee Benefit Program, have been filed or furnished on a timely basis, including all documents relating to any IRS VCP submission or similar filing made with respect to any Employee Benefit Program.

(c) With respect to each Employee Benefit Program, Delano has made available to Adventist Health, or caused the Delano Subsidiaries to make available to Adventist Health (in each case, if applicable to such Employee Benefit Program): (i) all material documents embodying or governing such Employee Benefit Program, and any funding medium for the Employee Benefit Program (including plan documents, trust agreements and amendments thereto); (ii) the most recent IRS determination letter, if any, with respect to such Employee Benefit Program under Code Section 401(a); (iii) IRS Forms 5500 filed with the IRS for the three (3) most recent plan years, together with audited financial statements and actuarial reports; (iv) the summary plan description for such Employee Benefit Program and all modifications thereto; (v) any insurance policy related to such Employee Benefit Program; and (vi) for the last three (3) years, all material correspondence with the IRS, the DOL, the PBGC, the SEC or any other Governmental Entity regarding the operation or the administration of any Employee Benefit Program, including correspondence and filings made in connection with any VCP filing or form 5330 filing.

(d) Except as set forth in Schedule 4.15, each Employee Benefit Program has been established, operated, and administered in all material respects in accordance with the requirements of Law, including ERISA, the Code, and the Affordable Care Act, and is being administered and operated in all material respects in accordance with its terms, and is being administrated in a manner that avoids the imposition of material liabilities or penalties imposed by Law, including penalty taxes. No Employee Benefit Program is subject to Title IV of ERISA or is a Multiemployer Plan, within the meaning of ERISA Section 3(37) and no Delano Entity or any ERISA Affiliate has within the past six (6) years sponsored, maintained, contributed to or had any liability in respect to any (i) employee benefit plan subject to Title IV of ERISA, (ii) any Multiemployer Plan, (iii) any "multiple employer plan" (within the meaning of Section 413(c) of the Code), or (iv) any multiple employer welfare arrangement (within the meaning of Section 3(40) of ERISA).

(e) Except as set forth in Schedule 4.15, each Delano Entity has complied with any payment obligations, or has otherwise properly accrued on the books and records of any Delano Entity or any ERISA Affiliate, of all amounts that any such Delano Entity or any such ERISA Affiliate are required under the terms of the Employee Benefit Programs to have paid as contributions to such Employee Benefit Programs on or prior to the date hereof (excluding any amounts not yet due) and the contribution requirements, on a prorated basis, for the current year have been made or otherwise properly accrued on the books and records of such Delano Entity through the Closing. Full payment has been made, or otherwise properly accrued, of all amounts that any Delano Entity or any Employee Benefit Program is reasonably expected to pay or contribute (including any compliance fees) as a result of any failures giving rise to any VCP filing or form 5330 filing, and each Delano Entity and Employee Benefit Program will timely pay or contribute any additional amounts required to be paid or contributed prior to the Closing and timely perform any actions required by the IRS to be performed prior to the Closing in order to obtain a compliance statement from the IRS.

(f) No Delano Entity or ERISA Affiliate or, to the knowledge of Delano, any Person appointed or otherwise designated to act on behalf of such Delano Entity or such ERISA Affiliate, has engaged in any transactions in connection with any Employee Benefit Program that is reasonably expected to result in the imposition of a material penalty pursuant to Section 502(i) of ERISA, material damages pursuant to Section 409 of ERISA or a material Tax pursuant to Section 4975(a) of the Code.

(g) No material Action or lien has been made, commenced or, to the knowledge of Delano, threatened with respect to any Employee Benefit Program (other than routine claims for benefits payable in the ordinary course of business) and, to the knowledge of Delano, no facts or circumstances exist that are reasonably likely to give rise to any such liability, Action or lien. No administrative investigation, audit or other administrative proceeding by the DOL, the PBGC, the IRS or any other Governmental Entity is pending, in progress, or, to the knowledge of Delano, threatened (including any routine requests for information from the PBGC) and there are no audits or proceedings initiated pursuant to the Voluntary Fiduciary Correction Program, the Employee Plans Compliance Resolution System or similar proceedings pending with the IRS or DOL with respect to any Employee Benefit Program.

(h) No Employee Benefit Program provides for health or welfare benefits (other than as required pursuant to Section 4980B of the Code or pursuant to State health continuation laws) to any current or future retiree or former employee beyond the month of termination.

(i) Except as set forth in Schedule 4.15, neither the execution and delivery of this Agreement, obtaining the approval of Delano's membership, nor the consummation of the Affiliation will (either alone or in combination with a termination of employment prior to the second anniversary of the Execution Date) result in (A) any increase in severance pay upon any termination of employment after the date of this Agreement; (B) the acceleration of the time of payment or vesting or result in any funding of compensation or benefits; (C) any payment, compensation or benefit becoming due, or increase in the amount of any payment, compensation or benefit due, to any current or former employee of any Delano Entity; (D) any new obligation pursuant to any Employee Benefit Program; or (E) any limitation or restriction on the right of any Delano Entity to merge, amend or terminate any Employee Benefit Program.

4.16 Litigation. Except as described in Schedule 4.16, (a) there are no Actions pending, affecting or, to the knowledge of Delano, threatened against any Delano Entity or with respect to any Delano Assets that, if decided adversely to Delano, would reasonably likely result in material liability to any Delano Entity, (b) there exist no facts known to Delano that might form the basis of any such Action, and (c) there is no pending or, to the knowledge of Delano, threatened, litigation, arbitration, investigation or other proceeding involving any Delano Entity or Delano Assets of or before any court, arbitrator or governmental, regulatory or administrative official, body or authority that is reasonably likely to prevent or materially delay or affect the consummation of the Affiliation.

4.17 Intellectual Property. To the knowledge of Delano: except for customary licensing and maintenance fees payable under the Contracts, each Delano Entity has the right to use, free and clear of any royalty or other payment obligations, claims of infringement or other liens, (a) all Delano Intellectual Property used by such Delano Entity, and (b) all software, hardware, application programs and similar systems owned by or licensed under Contracts to such Delano Entity; and such Delano Entity is not in conflict with or in violation or infringement of, nor has any Delano Entity received a notice alleging any conflict with or violation or infringement of, any rights of any other Person with respect to any such Delano Intellectual Property or software, hardware, application programs or similar systems. No other Person is in conflict with or in violation or infringement of such Delano Entity's rights in such Delano Intellectual Property or software, hardware, application programs or similar systems. To the knowledge of Delano, except for customary licensing and maintenance fees payable under the Contracts, subsequent to the Closing Date and without further action or the payment of additional fees, royalties or other compensation to any Person, Adventist Health will be entitled to use of all Delano Intellectual Property currently used by a Delano Entity in accordance with the Contracts related thereto.

4.18 Governmental Programs. Each Delano Entity and Delano Healthcare Facility is qualified for participation in and has current and valid provider Contracts with, the Government Payment Programs and/or their fiscal intermediaries or paying agents and complies in all

material respects with the conditions of participation therein. Each Delano Entity receives payment under the Government Payment Programs for services rendered to qualified beneficiaries and has received or applied for all approvals or qualifications necessary for capital reimbursement on the Delano Assets (if applicable). Except to the extent liabilities and contractual adjustments of each Delano Entity under the Government Payment Programs have been properly reflected and adequately reserved in the Financial Statements, to the knowledge of Delano, no Delano Entity has received or submitted any claim for payment in excess of the amount provided by law or any applicable Contract and no Delano Entity has received notice of any dispute or claim by any Governmental Entity, administrative contractors or other Person regarding the Government Payment Programs or participation therein. Each Delano Entity and Delano Healthcare Facility is duly accredited with no contingencies by the accrediting organizations. Delano has made available to Adventist Health, or caused the applicable Delano Subsidiary to make available to Adventist Health, complete and genuine copies of the most recent accreditation survey, reports, deficiency lists, statements of deficiency, plans of correction and similar materials. Delano has corrected any deficiencies noted therein.

4.19 Contracts. Other than as expressly set forth in Schedule 4.19, Material Contracts: (a) are in full force and effect, (b) are valid, legal and binding upon the parties thereto, and (c) have not been modified or amended in any material way. To the knowledge of Delano, no event has occurred and no state of facts exists which may result in the termination or limitation of the rights of any Delano Entity under any of the Material Contracts, except for a natural termination or expiration of a Contract pursuant to the terms thereof. Each Delano Entity and, to the knowledge of Delano, each other party to the Material Contracts, have performed all material obligations required to be performed by them under such Contracts to date, and are not in default (and would not by the lapse of time or the giving of notice or both be in default) under any provision of the Material Contracts.

4.20 Taxes.

(a) Each Delano Entity has filed all material Tax Returns required to be filed relating to the Delano Operations. All such Tax Returns are complete and genuine in all material respects, and each Delano Entity has paid or made provision in the Financial Statements for the payment of all such Taxes. No claim by a Governmental Entity is pending against any Delano Entity for failure to file Tax Returns. There are no Encumbrances on any Delano Assets that arose in connection with any failure (or alleged failure) to pay any Tax.

(b) To the knowledge of Delano, each Delano Entity has withheld proper and accurate amounts from its employees' compensation in compliance with all withholding and similar provisions of the Code and any and all other Laws, and is in compliance with any obligation to withhold and pay, or cause to be withheld and paid, all Taxes on monies paid by the Delano Operations to independent contractors, creditors and other Persons for which withholding or payment is required by Law.

(c) To the knowledge of Delano, no Governmental Entity intends to assess any additional Taxes for any period for which Tax Returns have been filed. There is no dispute or claim concerning any Tax liability of any Delano Entity either claimed or raised by any

Governmental Entity in writing, or as to which any Delano Entity has notice or knowledge based upon personal contact with any agent of such authority relating to the Delano Operations.

(d) Delano is a corporation exempt from federal and state income taxation. Delano has provided Adventist Health copies of Delano's favorable letters of determination from the IRS and the State regarding such Tax status.

4.21 Medical Staff; Physician Relations. Delano has made available to Adventist Health complete and genuine copies of the bylaws, policies, rules and regulations of the medical staff and medical executive committees of the Hospital, the Hospital's current medical staff roster, and the names of current Hospital medical staff members in respect of whom Delano has made a report to the Medical Board of the State during the last three (3) years concerning disciplinary action that resulted in termination or revocation of staff privileges for a medical disciplinary cause or reason.

4.22 Experimental Procedures and Research Studies. Except as set forth on Schedule 4.22, no member of the medical staff of the Hospital has conducted or otherwise participated in any clinical trials, experimental procedures or research studies at any Delano Healthcare Facility within the prior three (3) years, in each case, for which the Hospital was a sponsor.

4.23 Special Funds. None of the Delano Assets are subject to any liability due to funds received by a Delano Entity for the purchase, improvement or use of any of the Delano Assets or the conduct of the Delano Operations under restricted or conditioned grants or donations, including monies received under the Hill-Burton Act.

4.24 Certain Affiliations. To the knowledge of Delano, except as set forth in Schedule 4.24, no officer or director of any Delano Entity, nor, to the knowledge of Delano, any child, spouse, parent or sibling or any other family member of any such officer or director of any Delano Entity:

(a) directly or indirectly owns, in whole or in part, any property, asset or right of material significance, used in connection with the Delano Operations; or

(b) directly or indirectly has an interest in or is party to any Material Contract.

4.25 Operation of the Delano Operations**.** No Delano Entity conducts any business operations outside of the Delano Operations. The Delano Assets constitute all assets, properties, goodwill and businesses necessary to conduct the Delano Operations, in the aggregate and with respect to each Delano Healthcare Facility, in all material respects in the manner in which the Delano Operations are currently conducted as of the Execution Date.

4.26 Material Misstatements or Omissions. Subject to qualifications specifically and expressly set forth in this Article IV regarding knowledge and materiality, the representations and warranties of Delano in this Article IV, together with the disclosures set forth in the Disclosure Schedules, do not contain any untrue statement of fact or omit to state any fact necessary in order to make the representations and warranties of Delano in this Article IV not misleading in any material respect.

4.27 Brokers and Finders. Delano has not entered into any contracts, agreements, arrangements or understandings with any Person that could give rise to any claim for a broker's, finder's or agent's fee or commission or other similar payment in connection with the negotiations leading to this Agreement or the consummation of the Affiliation, other than Kaufman Hall & Associates, LLC.

4.28 Due Diligence. Delano has provided, or has caused the Delano Subsidiaries to provide, all items responsive to the Due Diligence Request and such items, either individually or in the aggregate, do not, to the knowledge of Delano, contain any untrue statement of fact or omit to state any fact that could reasonably be expected to be material to Adventist Health's decision regarding the Affiliation. In addition, Delano has used its best efforts to inform Adventist Health of any fact that could reasonably be expected to be material to Adventist Health regarding the Affiliation, even if such fact was not requested by the Due Diligence Request.

4.29 No Other Representations. Adventist Health acknowledges and agrees that, except as expressly set forth in this Agreement or any other Transaction Document, Delano and its respective officers, directors, attorneys, financial advisors, agents or other representatives (collectively "***Representatives***") are not making any representation or warranty, express or implied, with respect to the Delano Entities.

ARTICLE V
REPRESENTATIONS AND WARRANTIES OF ADVENTIST HEALTH

Adventist Health represents and warrants to Delano that the following representations and warranties are true and correct as of the Execution Date. These representations and warranties shall also be true and correct as of the Closing Date, subject to any amendment allowed by Section 6.2.

5.1 Organization, Power, Absence of Conflicts.

(a) Organization; Good Standing. Adventist Health is a nonprofit religious corporation duly organized, validly existing and in good standing under the laws of the State, and has full power and authority to carry on its business in the State and is duly licensed, qualified or admitted to do business and is in good standing in every jurisdiction in which Adventist Health conducts business.

(b) Authority; No Conflict; Required Filings and Consents.

(i) Adventist Health has all requisite corporate power and authority to conduct its business as now being conducted, to execute, deliver and enter into this Agreement, to consummate the Affiliation contemplated hereby and to perform its obligations hereunder. The execution and delivery of this Agreement, and the consummation of the Affiliation contemplated hereby, have been duly authorized by all necessary corporate action on the part of Adventist Health. This Agreement has been duly executed and delivered by Adventist Health and is a legal, valid and binding obligation of Adventist Health, enforceable against Adventist Health in accordance with its terms, except to the extent that enforceability may be limited by applicable bankruptcy, reorganization, insolvency, moratorium or other Laws affecting the

enforcement of creditors' rights generally and by general principles of equity, regardless of whether such enforceability is considered in a proceeding at law or equity. No vote or written consent of any holder of any membership interests of Adventist Health is necessary to approve this Agreement or the Affiliation except such as has been obtained prior to the date hereof.

(ii) The execution and delivery by Adventist Health of this Agreement does not, and consummation of the Affiliation contemplated hereby will not, (A) conflict with, or result in any violation or breach of any provision of the formation or governing documents of Adventist Health, as amended to date, (B) to the knowledge of Adventist Health, violate any Law applicable to Adventist Health, or (C) to the knowledge of Adventist Health, conflict with or result in a breach of, or give rise to a right of termination of or loss of benefit under, or accelerate the performance required by the terms of any judgment, court order or consent decree, or any material agreement to which Adventist Health is party or constitute a default thereunder.

(iii) Neither the execution and delivery of this Agreement by Adventist Health nor the consummation of the Affiliation contemplated hereby will require any consent, approval, order or authorization of, or registration, declaration or filing with, or notification to any Governmental Entity or any Person by Adventist Health, except for such consents, approvals, orders, authorizations, registrations, declarations and filings that are identified in this Agreement, or which are listed on Schedule 5.1(b)(iii).

5.2 Litigation. There is no Action pending or, to Adventist Health's knowledge, threatened against Adventist Health (a) which, if adversely determined, could reasonably be expected to materially adversely affect Adventist Health's ability to perform hereunder, or (b) which seeks to enjoin or obtain damages due to the Affiliation.

5.3 Brokers and Finders. Adventist Health has not entered into any contracts, agreements, arrangements or understandings with any Person that could give rise to any claim for a broker's, finder's or agent's fee or commission or other similar payment in connection with the negotiations leading to this Agreement or the consummation of the Affiliation.

5.4 Independent Analysis. Adventist Health has had a reasonable opportunity to ask questions of and receive information and answers from Persons acting on behalf of Delano concerning the Delano Operations and has had an opportunity to conduct a due diligence investigation of Delano. In entering into this Agreement, Adventist Health has relied upon (a) the express representations and warranties of Delano set forth in the Agreement (including the Disclosure Schedules), (b) other express obligations of Delano that are set forth in this Agreement (including but not limited to covenants) and (iii) Adventist Health's own due diligence and analysis.

5.5 Material Misstatements or Omissions. Subject to qualifications specifically and expressly set forth in this Article V regarding knowledge, the representations and warranties of Adventist Health in this Article V do not contain any untrue statement of fact and do not omit any fact necessary to make the representations and warranties of Adventist Health not misleading in any material respect.

5.6 No Other Representations. Delano acknowledges and agrees that, except as expressly set forth in this Agreement or any other Transaction Document, Adventist Health and its Representatives are not making any representation or warranty, express or implied, with respect to Adventist Health.

ARTICLE VI
PRE-CLOSING COVENANTS

6.1 Consents and Approvals.

(a) HSR Act.

(i) If an HSR Act filing is necessary, each Party agrees to file the appropriate Notification and Report Form pursuant to the HSR Act with respect to the Affiliation contemplated hereby as soon as reasonably practicable after the Execution Date and to supply promptly any additional information and documentary material that may be requested pursuant to the HSR Act. Each Party agrees to use its best efforts to obtain early termination of the waiting period under the HSR Act. In addition, each Party agrees to promptly make any other filing that may be required under any antitrust law or by any antitrust authority and effect all other filings with and notifications to the government agencies in any other jurisdiction where such filings and notifications are required. Each Party agrees to take any and all steps necessary to avoid or eliminate as soon as possible each and every impediment under any antitrust law that may be asserted by any United States antitrust authority so as to enable the parties to expeditiously close the Affiliation contemplated hereby including committing to and/or effecting, by consent decree, hold separate orders, or otherwise, the sale or disposition of such assets or shares as are required to be divested in order to facilitate the expiration or termination of the HSR Act waiting period or otherwise obtain all applicable merger control clearances.

(ii) Delano and Adventist Health mutually commit to instruct their respective counsel to cooperate with each other and use reasonable best efforts to facilitate and expedite the identification and resolution of any issues under any antitrust law and, consequently, expiration or termination of the applicable HSR Act waiting period at the earliest practicable date. Delano and Adventist Health will supply each other with copies of all correspondence, filings or communications with antitrust authorities, with respect to the Affiliation contemplated by this Agreement and any related or contemplated Affiliation, including but not limited to documents filed pursuant to Item 4(c) of the Notification and Report Form or communications regarding the same; provided, however, that to the extent any of the documents or information are commercially or competitively sensitive, a Party may satisfy its obligations by providing such documents or information to the other Party's outside antitrust counsel, with the understanding that such antitrust counsel shall not share such documents and information with its client.

(iii) Adventist Health shall pay the filing fees associated with the HSR Act filings.

(b) California Attorney General. Delano shall notify the Attorney General of the proposed Affiliation in accordance with Sections 5914 et seq. of the California Corporations

Code ("***Section 5914***") as soon as possible, but no later than thirty (30) days after the Execution Date, in consultation with Adventist Health. Delano shall use commercially reasonable efforts to file such filings and notices as soon as possible, but no later than thirty (30) days after the Execution Date, shall provide such other information as the Attorney General shall request, and shall generally use its commercially reasonable efforts to obtain the Attorney General's approval of the Affiliation. Adventist Health shall provide such information and communications to the Attorney General as Delano may reasonably request and shall otherwise cooperate with Delano in obtaining the Attorney General's approval of the transaction. Adventist Health shall reasonably cooperate with Delano's notification filing.

(c) Membership. Delano shall use its best efforts to obtain the approval of Delano's membership to terminate such membership in Delano without requiring any changes to this Agreement as soon as reasonably practical following the Execution Date (the "***Membership Approval***"), and Adventist Health shall reasonably cooperate as requested by Delano with Delano's efforts to accomplish this.

(d) No Consent. If the Attorney General fails to provide the consent required by Section 5914, then Delano may, in its sole discretion, pursue any available remedies it may have against the Attorney General. If the Federal Trade Commission, United States Department of Justice or the Attorney General challenges, objects to, prohibits, enjoins, or fails to provide any consent or approval required to complete the transaction contemplated by this Agreement, then Adventist Health may in its sole discretion and at its sole cost and expense, contest or appeal such objection, prohibition or injunction.

(e) Contracts. Delano and Adventist Health shall cooperate and Delano shall use commercially reasonable efforts to obtain prior to Closing all required consents and approvals necessary from all Contract parties to ensure that each Contract remains in full force and effect following the Closing Date.

6.2 Notification of Certain Matters.

(a) Delano Disclosure Schedule Amendments. From time to time prior to the Closing, Delano may promptly supplement or amend the Disclosure Schedules in Article IV in order to keep such information therein timely, complete and accurate, and each supplement to or amendment of the Disclosure Schedules made after the Execution Date pursuant to this Section 6.2 shall be deemed to amend the Disclosure Schedules as of the date the Disclosure Schedule is accepted by Adventist Health; provided, however, if any such supplement or amendment is not acceptable to Adventist Health, and the Parties cannot resolve the matter satisfactorily to both Parties, then Adventist Health may, in its sole discretion and as its sole remedy, terminate this Agreement by giving written notice of such termination to Delano within five (5) Business Days after the Parties determine they cannot resolve the matter.

(b) Adventist Health Disclosure Schedule Amendments. From time to time prior to the Closing, Adventist Health may promptly supplement or amend the Adventist Health Disclosure Schedules in Article IV in order to keep such information therein timely, complete and accurate, and each supplement to or amendment of the Disclosure Schedules made after the Execution Date pursuant to this Section 6.2 shall be deemed to amend the Adventist Health

Disclosure Schedules as of the date the Disclosure Schedule is accepted by Delano; provided, however, if any such supplement or amendment is not acceptable to Delano and cannot be solved by Adventist Health within a reasonable time period, then Delano may, in its sole discretion and as its sole remedy, terminate this Agreement by giving written notice of such termination to Adventist Health within five (5) Business Days after such supplement or amendment is delivered to Delano, and Delano is notified that Adventist Health cannot solve the problem.

6.3 Negative Covenants of Adventist Health. From the Execution Date until the earlier of the Closing or the termination of this Agreement, Adventist Health shall not (and shall not agree to) take any action which would cause Delano to be in breach of any covenant, representation or warranty contained in this Agreement, or which would have a material adverse effect on the ability of any Party hereto to perform their respective covenants and agreements under this Agreement and the documents and agreements contemplated hereby, without the prior written consent of Delano.

6.4 Negative Covenants of Delano. From the Execution Date until the earlier of the Closing or the termination of this Agreement, Delano shall not (and shall not agree to) take any action which would cause Adventist Health to be in breach of any covenant, representation or warranty contained in this Agreement, or which would have a material adverse effect on the ability of any Party hereto to perform their respective covenants and agreements under this Agreement and the documents and agreements contemplated hereby, without the prior written consent of Adventist Health.

6.5 Conduct of the Delano Operations. After the Execution Date and up to the Closing, except as expressly contemplated by this Agreement or as Adventist Health otherwise consents to in writing, which consent shall not be unreasonably delayed, conditioned or withheld, and in compliance with all applicable laws, Delano shall conduct the Delano Operations in the ordinary course of business consistent with past practices. For the sake of clarity, nothing herein shall be construed to confer on Adventist Health the right to require Delano to take any action or forego any action in connection with conducting business in the ordinary course. Without limiting the generality of the foregoing, Delano shall:

(a) use commercially reasonable efforts to preserve the business organization and operations of the Delano Entities and Delano Operations intact, preserve the Delano Assets, keep available the services of each Delano Entity's present employees involved in the Delano Operations (other than terminations consistent with past practice and Delano policies), and preserve the goodwill of each Delano Entity's suppliers, patients, physicians and others with whom a Delano Entity has business relationships relating to the Delano Operations;

(b) use commercially reasonable efforts to maintain the Delano Inventory at any Delano Healthcare Facility at levels not materially less than or greater than those usually maintained at such Delano Healthcare Facility;

(c) pay in full before delinquency all bills and invoices for labor, services, materials, supplies and equipment of any kind arising from the ownership, operation, management, repair, maintenance or leasing of the Delano Real Property as well as all other debts and liabilities in the ordinary course of business consistent with such obligations;

(d) use commercially reasonable efforts to make and continue to make or cause to be made all repairs and maintenance that may be necessary to maintain the Delano Assets, ordinary wear and tear excepted;

(e) not sell or transfer any of the Delano Assets, except in the ordinary course of business;

(f) not mortgage, pledge or encumber any of the Delano Assets, except liens for taxes not yet due;

(g) use its commercially reasonable efforts to retain the services of each Delano Entity's employees that are not in breach of their employment obligations;

(h) use commercially reasonable efforts to preserve each Delano Entity's rights under the Material Contracts;

(i) not renew, extend, terminate or amend the Contracts (but excluding any Material Contract with a physician, medical group or other physician services provider), or do any act or omit to do an act that would cause a material breach of or violation or default under such Contracts, or enter into any Material Contract, except in the ordinary course of the Delano Operations or as otherwise required herein;

(j) not enter into or extend any employment agreement with any Delano Entity employee for a term extending beyond the Closing Date, or increase the compensation or benefits of any Delano Entity employee or incur any obligations not currently part of any Delano Entity's compensation arrangement for payment of bonuses or similar payments, except in the ordinary course of business;

(k) not agree, whether in writing or otherwise, to do any of the foregoing actions specified in items (i) and (j) above;

(l) not enter into a new, or extend or renew a, Material Contract with a physician, medical group or other physician services provider without first providing notice to Adventist Health and an opportunity of not less than five (5) Business Days for Adventist Health to consult with Delano; provided, however, should Delano notify and consult with Adventist Health regarding a new Material Contract under this item (l), Adventist Health will take all steps reasonably necessary to ensure that the information provided by Delano remains confidential and not be shared with anyone at Adventist Health responsible for entering into such contracts;

(m) take all actions reasonably necessary and appropriate to maintain title to the Delano Assets free and clear of all Encumbrances not already in place as of the Execution Date and to obtain appropriate releases, consents, estoppels, certificates, opinions and other instruments, if required, to facilitate the Affiliation as Adventist Health may reasonably request;

(n) keep in full force and effect present insurance policies or other comparable insurance benefiting the Delano Assets and the conduct of the Delano Operations and maintain

sufficient liquid reserves reasonably estimated to be sufficient to meet all deductible, self-insurance and copayment requirements under such policies;

(o) not sell, assign, transfer, distribute or otherwise transfer or dispose of any Delano Assets having an original cost in excess of One Hundred Thousand Dollars ($100,000) except in the ordinary course of the Delano Operations with comparable replacement thereof or except obsolete equipment not in use;

(p) not materially alter the manner of keeping Delano's books, accounts or records of the Delano Operations or the accounting practices therein reflected, unless required to do so by Law or Generally Accepted Accounting Principles;

(q) not terminate, amend or otherwise modify any Employee Benefit Program in any material respect, except for amendments required to comply with Laws;

(r) except as required by Law, not (i) recognize any labor organization or employee association as the collective bargaining representative of any Delano Entity employee; (ii) agree to a representation election conducted by the National Labor Relations Board or any other Governmental Entity involving any Delano Entity employee; or (iii) agree with any labor organization or employee association to a recognition card check involving any Delano Entity employee; and

(s) address any legal compliance issues and establish commercially reasonable reserves on Delano's financial books for any potential financial liability arising from legal compliance issues.

6.6 Access and Information; Inspections. From the Execution Date until the Closing Date, Delano shall give, and shall cause each Delano Subsidiary to give, to Adventist Health and its Representatives, reasonable access during normal business hours to each Delano Entity's corporate, financial, litigation, insurance and personnel files, books, accounts, records and all other relevant documents and information with respect to the Delano Assets and the Delano Operations as Representatives of Adventist Health may from time to time request, all in such manner as to not unduly disrupt Delano's normal business activities and be in compliance with Law, including without limitation anti-trust laws, and any contractual obligations relating to confidentiality. Such access may include consultations with the personnel of any Delano Entity (including physicians), *provided* that Adventist Health shall provide reasonable advance notice to Delano, and such consultations shall not unreasonably interfere with the duties and responsibilities of such personnel. From the Execution Date until the Closing Date, Delano shall make, and shall cause each Delano Subsidiary to make, the Delano Real Property and tangible Personal Property reasonably available for inspection by Adventist Health and its Representatives during normal business hours upon prior written request. The access to and disclosure of all such books, contracts and records shall be subject to and continued to be governed by the terms and conditions of that certain Confidentiality and Non-Disclosure Agreement between Adventist and Delano dated as of February 26, 2018.

6.7 Delano's Efforts to Close. Delano shall use commercially reasonable efforts to satisfy all of the conditions precedent set forth in Article XI to Delano's or Adventist Health's

obligations under this Agreement to the extent that Delano's action or inaction can control or influence the satisfaction of such conditions.

6.8 Adventist Health's Efforts to Close. Adventist Health shall use commercially reasonable efforts to satisfy all of the conditions precedent set forth in Article XI to Adventist Health's or Delano's obligations under this Agreement to the extent that Adventist Health's action or inaction can control or influence the satisfaction of such conditions.

ARTICLE VII
ADDITIONAL COVENANTS AND AGREEMENTS

7.1 Contracts. If there are any Material Contracts with vendors and suppliers (i.e., not physicians, medical groups, physician services providers, Delano Employees and consultants) that are (a) renewable or terminable during the six (6) month period commencing from the Execution Date in favor of Delano and (b) identified by Adventist Health during diligence, Adventist Health will notify Delano within forty-five (45) days after the Execution Date, and Delano shall provide Adventist Health opportunities to consult with Delano with respect to the continuation of any such Material Contracts; provided, however, should Delano notify and consult with Adventist Health regarding any such Material Contracts under this Section, Adventist Health will take all steps reasonably necessary to ensure that the information provided by Delano remains confidential and not be shared with anyone at Adventist Health responsible for entering into such contracts.

7.2 Government Authorizations. Delano shall promptly apply for and use good faith efforts to obtain, as promptly as practicable, all material Government Authorizations that are necessary to consummate the proposed transaction as set forth in this Agreement. Adventist Health shall cooperate in good faith with Delano's efforts, as requested by Delano. For purposes of the preceding, "***Government Authorizations***" means all Licenses, no objection letters, clearances and other consents or approvals of any Governmental Entity which are required for Delano to legally own and operate the Hospital and receive payer reimbursement after Adventist Health becomes Delano's sole member.

7.3 Further Assurances. Each Party shall execute and deliver such instruments, in form and substance mutually agreeable to the Parties, as the other Party may reasonably require in order to carry out the terms of this Agreement or the Affiliation.

ARTICLE VIII
SURVIVAL OF REPRESENTATIONS; INDEMNIFICATION

8.1 Indemnification Prior to the Closing Date.

(a) Indemnification by Delano. Prior to the Closing Date, Delano shall defend, indemnify and hold harmless Adventist Health and its Representatives, members, employees, and Affiliates (each, an "***AH Indemnified Party***"), and will reimburse such persons, from, against and for any damages, claims, costs, loss, liabilities, expenses or obligations (including reasonable attorneys' fees and associated expenses), whether or not involving a third-party claim (collectively, "***Losses***") incurred or suffered by any of them as a result of or arising

from: (i) any breach of, or any inaccuracy in, any representation or warranty made by Delano in this Agreement; and (ii) any breach of any covenant, obligation or agreement of Delano in this Agreement, *provided,* that except in cases where any such breach or inaccuracy is due to fraud or intentional misrepresentation, Delano's indemnification obligation under this Section 8.1(a) shall not in the aggregate exceed Five Hundred Thousand Dollars ($500,000),

(b) Indemnification by Adventist Health. Prior to the Closing Date, Adventist Health shall defend, indemnify and hold harmless Delano and its Representatives, members, employees, and Affiliates (each, an "***Delano Indemnified Party***"), and will reimburse such persons, from, against and for any Losses incurred or suffered by any of them as a result of or arising from: (i) any breach of, or any inaccuracy in, any representation or warranty made by Adventist Health in this Agreement; and (ii) any breach of any covenant, obligation or agreement of Adventist Health in this Agreement, *provided,* that except in cases where any such breach or inaccuracy is due to fraud or intentional misrepresentation, Adventist Health's indemnification obligation under this Section 8.1(a) shall not in the aggregate exceed Five Hundred Thousand Dollars ($500,000).

8.2 Notice, Cooperation and Opportunity to Defend. The AH Indemnified Party or Delano Indemnified Party (each a "***Indemnified Party***"), as applicable, shall promptly notify in writing the indemnifying Party (the "***Indemnifying Party***") of any matter giving rise to an obligation to indemnify, and the Indemnifying Party shall defend a third-party claim at its expense with counsel reasonably acceptable to the Indemnified Party; provided, however, that if settlement of any such claim would impose any obligation on the Indemnified Party, the Indemnifying Party may not settle any such claim without the consent of the Indemnified Party, which consent shall not be unreasonably withheld, conditioned or delayed. The Indemnified Party agrees to cooperate with the Indemnifying Party and to make reasonably available to the Indemnifying Party any necessary records or documents in the possession of the Indemnified Party that are necessary to defend such claim. If the Indemnified Party desires to participate in the defense of a claim being defended by the Indemnifying Party, it may do so at its sole cost and expense, provided that the Indemnifying Party shall retain control over such defense. In the event the Indemnifying Party does not defend or settle such claim, the Indemnified Party may do so without the Indemnifying Party's participation, in which case the Indemnifying Party shall pay the expenses of such defense, and the Indemnified Party may settle or compromise such claim without the Indemnifying Party's consent. The failure of any Indemnified Party to give notice as provided herein shall not relieve the Indemnifying Party of its obligations hereunder except to the extent that the Indemnifying Party is actually prejudiced by such failure to give notice.

8.3 Exclusive Remedy. Any claim arising under this Agreement or in connection with or as a result of the Affiliation or any damages or injury suffered or alleged to be suffered by any Party as a result of the actions or failure to act by any other Party shall be governed solely and exclusively by the provisions of this Article VIII and Article IX.

8.4 Survival of Representations and Warranties. The representations and warranties of Delano and Adventist Health shall not survive the Closing Date.

ARTICLE IX
DISPUTE RESOLUTION

9.1 Dispute Resolution. Except as otherwise provided in this Agreement, any dispute, claim or controversy arising out of or relating to this Agreement, or the breach, termination, enforcement, interpretation, or validity thereof, including the determination of the scope or applicability of this Agreement to arbitrate (collectively, a "***Dispute***") shall be resolved in accordance with the procedures set forth in this Section. Notwithstanding anything that may be construed to the contrary herein, each of the Parties expressly acknowledges that (i) it has an affirmative duty to expedite the process and procedures described below to the extent reasonably practical in order to facilitate a prompt resolution of any Dispute and (ii) each Party has a mission of serving their communities, and all communications and proposed resolutions of the Dispute shall take these missions into consideration.

(a) Dispute Notice. Notice by either Party of the existence of a Dispute shall (i) be delivered in writing to the other Party, (ii) specify what provision(s) of the Agreement is the subject of the Dispute and (iii) recommend a course of action to resolve the Dispute (the "***Dispute Notice***").

(b) Meet and Confer. If, within fifteen (15) days after receipt by the applicable Party of a Dispute Notice (the "***Initial Resolution Period***"), the Parties do not resolve such dispute, then the Dispute shall be referred to the designated senior executives with authority as then determined by the Parties to resolve the Dispute from each Party for further negotiation (the "***Meet and Confer***") and such Meet and Confer shall occur within fifteen (15) days after the Initial Resolution Period. The obligation to conduct a Meet and Confer pursuant to this Section 9.1(b) does not obligate any Party to agree to any compromise or resolution of the Dispute that such Party does not determine, in its sole and absolute discretion, to be a satisfactory resolution of the Dispute. The Meet and Confer shall be considered a settlement negotiation for the purpose of all applicable laws protecting statements, disclosures, or conduct in such context, and any offer in compromise or other statements or conduct made at or in connection with any Meet and Confer shall be protected under such laws, including California Evidence Code Section 1152.

(c) Arbitration. In the event of any Dispute (i) whether there has been an alleged breach by a Party of any representation, warranty or covenant made in this Agreement and/or (ii) as to the amount of a Party's indemnification obligation under Section 8.1 of this Agreement (each an "***Arbitrable Dispute***") that is not resolved to the mutual satisfaction of the Parties within thirty (30) days after delivery of the Dispute Notice (or such other period as may be mutually agreed upon by the Parties in writing), the Arbitrable Dispute shall be resolved through arbitration proceedings that shall take place in Kern County, California at the election of either Party exercised by notice to the other Party as provided below. The arbitration shall be administered by Judicial Arbitration and Mediation Services, Inc. ("***JAMS***") pursuant to its Comprehensive Arbitration Rules and Procedures.

(i) Either Party may commence arbitration by giving written notice to the other Party demanding arbitration (the "***Arbitration Notice***"). The Arbitration Notice shall

specify the Arbitrable Dispute, the particular claims and/or causes of action alleged by the Party demanding arbitration, and the factual and legal basis in support of such claims and/or causes of action.

(ii) The Parties shall cooperate in good faith to identify one person that is acceptable to both Parties to act as an arbitrator within fifteen (15) days after the commencement of arbitration. In the event the Parties are unable or fail to agree upon the arbitrator within the allotted time, the arbitrator shall be appointed by JAMS in accordance with its rules. The arbitrator agreed upon or appointed shall serve as a neutral, independent and impartial arbitrator and shall have authority to determine the amount of a Party's indemnification obligation hereunder and if there has been a breach of any representation, warranty or covenant by a Party, as well as any procedural question raised by a Party.

(iii) The Parties shall be entitled to reasonable production of relevant, non-privileged documents, carried out expeditiously. If the Parties are unable to agree upon same, the arbitrator shall have the power, upon application of any Party, to make all appropriate orders for production of documents by any Party. Depositions shall be permitted only upon a showing of substantial need. No other discovery is to be permitted absent agreement by the Parties.

(iv) The substantive internal law (and not the conflict of laws) of the State shall be applied by the arbitrator to the resolution of the Arbitrable Dispute.

(v) The following time limits are to apply to any arbitration arising out of or related to this Agreement: The evidentiary hearing on the merits ("***Hearing***") is to commence within six (6) months of the service of the Arbitration Notice. A brief, reasoned award is to be rendered no later than forty-five (45) days from the close of the Hearing or forty-five (45) days from service of post-hearing briefs if the arbitrator directs the submission of such briefs. The arbitrator must agree to the foregoing deadlines before accepting appointment. Failure to meet any of the foregoing deadlines will not render the award invalid, unenforceable or subject to being vacated.

(vi) The Parties shall maintain the confidential nature of the arbitration proceeding and the award, including the Hearing, except as may be necessary to prepare for or conduct the arbitration hearing on the merits, or except as may be necessary in connection with a court application for a preliminary remedy, a judicial challenge to an award or its enforcement, or unless otherwise required by law or judicial decision.

(vii) The award of the arbitrator shall be final and binding upon the Parties without appeal or review except as permitted by applicable law. Judgment on the award issued by the arbitrator may be entered in any court having jurisdiction.

9.2 Provisional Measures. Nothing in this Agreement shall prevent either Party from seeking provisional measures from any court of competent jurisdiction, and any such request shall not be deemed incompatible with the agreement to arbitrate or a waiver of the right to arbitrate.

9.3 Attorneys' Fees and Costs. The arbitrator(s) in Section 9.1(c) shall award to the prevailing Party, if any, the costs and attorneys' fees reasonably incurred by the prevailing Party in connection with the arbitration. In addition, the prevailing Party shall be entitled to its reasonable attorneys' fees and other costs for any other Action, including court proceedings for provisional measures or for the enforcement of any arbitral award.

ARTICLE X
TERMINATION OF AGREEMENT

10.1 Term. The term of this Agreement shall commence upon the Execution Date and shall expire ten (10) years after the Closing Date ("***Term***"). Adventist Health shall remain the sole corporate member of Delano after any termination of this Agreement that occurs after the Closing Date.

10.2 Termination of Agreement.

(a) Mutual Agreement. This Agreement may be terminated at any time prior to the Closing by the mutual written agreement of the Parties.

(b) Breach of Agreement.

(i) Breach By Delano. This Agreement may be terminated by Adventist Health at any time prior to the Closing if Delano has materially breached its covenants, representations or warranties prior to the Closing, provided that this Agreement shall not be terminated if such breach shall have been cured to the reasonable satisfaction of Adventist Health within thirty (30) days of written notice thereof, or, if such breach is reasonably capable of cure, but not within thirty (30) days, Delano shall have commenced to cure it within such thirty-day period, and shall be diligently pursuing the cure.

(ii) Breach By Adventist Health. This Agreement may be terminated by Delano at any time prior to the Closing if Adventist Health has materially breached its covenants, representations and warranties prior to the Closing, provided that this Agreement shall not be terminated if such breach shall have been cured to the reasonable satisfaction of Delano within thirty (30) days of written notice thereof, or, if such breach is reasonably capable of cure, but not within thirty (30) days, Adventist Health shall have commenced to cure it within such thirty-day period, and shall be diligently pursuing the cure.

(c) Failure of Condition. This Agreement may be terminated by Adventist Health or Delano if the Closing has not occurred on or before December 31, 2019 (the "***Drop Dead Date***"); provided, however, that (i) Adventist Health shall not be permitted to terminate this Agreement if the Closing is delayed beyond the Drop Dead Date by the breach of a covenant by Adventist Health or the failure of a condition which was Adventist Health's responsibility to fulfill; (ii) Delano shall not be permitted to terminate this Agreement if the Closing is delayed beyond the Drop Dead Date by the breach of a covenant by Delano or the failure of a condition which was Delano's responsibility to fulfill; and (iii) neither Party may terminate this Agreement if the Closing is delayed beyond the Drop Dead Date because the AG Approval Date is after the Drop Dead Date or because the Attorney General or any other Governmental Entity whose

consent or approval is required has otherwise taken action or not taken action such that the Parties are legally precluded from Closing.

(d) Failure to Finalize Disclosure Schedules. This Agreement may be terminated pursuant to the provisions of Section 6.2.

(e) Failure to Obtain Attorney General Approval. This Agreement may be terminated by either Delano or Adventist Health if the Attorney General does not approve the Affiliation pursuant to Section 5914, with or without conditions, within one hundred eighty (180) days after the Attorney General has received the completed notice from Delano.

(f) Expiration of Term. This Agreement shall automatically terminate upon the expiration of the Term.

10.3 Return of Information. Upon the termination of this Agreement prior to the Closing Date, Adventist Health and Delano shall, and shall use good faith efforts to cause their Representatives or Affiliates to, promptly return to the appropriate Party the original and all copies (in whatever form made or stored) of the confidential or non-public information of such other Party, or shall destroy the same, and shall certify in writing to such other Party that all such confidential or non-public information and all copies thereof have been returned or destroyed. Notwithstanding the foregoing, a Party's obligation to destroy or return data and documents shall, with respect to digital media and computer memory, apply only to memory in active, currently accessible media, and not to tapes and other back-up media.

ARTICLE XI
CONDITIONS TO CLOSING

11.1 Conditions Precedent to Obligations of Adventist Health. The obligations of Adventist Health to complete the Affiliation at the Closing shall be subject to fulfillment of all of the following conditions, except those conditions which are waived by Adventist Health:

(a) Accuracy of Representations and Warranties. The representations and warranties of Delano, as amended pursuant to this Agreement, shall be true and correct in all material respects on the Closing Date.

(b) Governmental Consents. The consent of the Attorney General with respect to Membership Issuance shall have been obtained and any condition imposed by the Attorney General reasonably determined to be atypical of conditions and commitments required by the Attorney General in similar change of ownership transactions involving nonprofit general acute care hospitals, shall have been approved by Adventist Health, in Adventist Health's sole discretion. It is expressly understood that this condition may not be waived by Adventist Health, and that if the consent of the Attorney General is not obtained as required herein, this Agreement shall automatically terminate and neither Delano nor Adventist Health shall have any liability to the other, except as specifically provided in this Agreement.

(c) Performance of Covenants and Agreements. Delano shall have performed in all material respects all covenants and agreements contained in this Agreement required to be performed by Delano before the Closing.

(d) Licenses and Other Government Authorizations. Any Government Authorizations required for Adventist Health to become the sole corporate member of Delano and manage the Delano Operations shall have been obtained.

(e) Approval of Documentation. The form and substance of all certificates, transfer documents, opinions, consents, instruments and other documents and agreements contemplated hereby delivered to Adventist Health shall be reasonably satisfactory in all respects to Adventist Health and Adventist Health's counsel.

(f) No Litigation. Except as disclosed in this Agreement, no Action shall be pending or threatened against Delano or Adventist Health to the knowledge of either Party that adversely affects the consummation of the Affiliation contemplated by this Agreement.

(g) INTENTIONALLY LEFT BLANK

(h) Officers Certificates. Delano shall deliver to Adventist Health, in forms reasonably acceptable to Adventist Health, (i) a closing and incumbency certificate of an officer of Delano and (ii) resolutions of the board of directors of Delano authorizing the execution and delivery of this Agreement and the performance by Delano of its obligations hereunder (collectively, the "***Delano Certificates***").

(i) HSR Act. The requirements of the HSR Act, if applicable to the Affiliation, shall be complied with.

(j) Supplemental Disclosure Schedules. Any supplements to the Disclosure Schedules delivered by Delano prior to or at Closing shall be reasonably acceptable to Adventist Health. Adventist Health shall have the right to terminate this Agreement if this condition is not satisfied, but shall not have the right to any damages therefrom.

(k) MAC. There has been no MAC with respect to a Delano Entity since the Execution Date.

(l) Estoppel Certificates. Delano shall have obtained tenant estoppel certificates under any lease of Delano Real Property.

(m) Membership Approval. The Membership Approval shall have been obtained.

(n) New Organizational Documents. Delano shall have adopted and delivered to Adventist Health the New Organizational Documents contemplated hereunder.

(o) Deliveries at Closing. All of the deliverables described in Section 11.2 shall have been provided to Adventist Health or waived by Adventist Health.

11.2 Conditions Precedent to Obligations of Delano. The obligations of Delano to complete the Affiliation at the Closing shall be subject to fulfillment of all of the following conditions, except those conditions that are waived by Delano:

(a) Accuracy of Representations and Warranties. The representations and warranties of Adventist Health as amended pursuant to this Agreement shall be true and correct in all material respects on the Closing Date.

(b) Governmental Consents. The consent of the Attorney General with respect to Affiliation shall have been obtained.

(c) Performance of Covenants and Agreements. Adventist Health shall have performed in all material respects all covenants and agreements contained in this Agreement required to be performed by Adventist Health before the Closing.

(d) Approval of Documentation. The form and substance of all certificates, opinions, consents, instruments and other documents and agreements contemplated hereby delivered to Delano under this Agreement shall be reasonably satisfactory in all respects to Delano and Delano's counsel, and the Membership Approval shall have been provided to Delano.

(e) No Litigation. No Action shall be pending or threatened against Delano or Adventist Health adversely affecting the consummation of the Affiliation contemplated by this Agreement.

(f) Officers Certificates. Adventist Health shall deliver to Delano, in forms reasonably acceptable to Delano, (i) a closing and incumbency certificate of an officer of Adventist Health and (ii) resolutions of the AH Board authorizing the execution and delivery of this Agreement and the performance by Adventist Health of its obligations hereunder (collectively, the "***AH Certificates***").

(g) HSR Act. The requirements of the HSR Act, if applicable to the Affiliation, shall be complied with.

(h) Supplemental Disclosure Schedules. Any supplements or modifications to the Disclosure Schedules delivered by Adventist Health prior to or at Closing shall be reasonably acceptable to Delano. Delano shall have the right to terminate this Agreement if this condition is not satisfied, but shall not have the right to any damages therefrom.

(i) Deliveries at Closing. All of the deliverables described in Section 12.3 shall have been provided to Delano or Foundation, as applicable, or waived by Delano.

ARTICLE XII
CLOSING

12.1 Closing and Closing Date. Subject to the provisions of Article XI, the closing of the Affiliation (the "***Closing***") shall take place on April 1, 2019, or at such earlier or later date

seven (7) days after all the conditions to Closing have been satisfied or waived; or such other date, time or place as may hereafter be agreed upon in writing by the Parties. The Membership Issuance and Affiliation contemplated by the Parties pursuant to this Agreement shall occur at 12:01 AM on the business day immediately following the Closing (the "***Closing Date***"). All proceedings to take place at the Closing shall take place simultaneously.

12.2 Deliveries by Delano. At the Closing, Delano shall deliver to Adventist Health the following:

(a) Membership Interest. An original document evidencing Adventist Health as the sole corporate member of Delano.

(b) Delano Certificates. Certified copies of the Delano Certificates.

(c) Licenses. Copies of all Licenses and Government Authorizations required to conduct the Delano Operations.

(d) Powers of Attorney. Limited Powers of Attorney for Adventist Health's use of the pharmacy licenses, DEA and other registration numbers, and DEA order forms, in one or more forms mutually acceptable to the Parties (the "***Powers of Attorney***"), provided that Delano is legally authorized to grant such Powers of Attorney.

(e) Good Standing Certificates. For each Delano Entity, (i) original Certificates of Status, or comparable status issued by the California Secretary of State, and (ii) original Entity Status Letters from the Franchise Tax Board of California, each as dated no earlier than a date which is ten (10) calendar days prior to the scheduled Closing Date.

(f) Other Documents. Any other documents contemplated by this Agreement or requested by Adventist Health and reasonably required or necessary for the consummation of the Affiliation.

12.3 Deliveries by Adventist Health. At the Closing, Adventist Health shall deliver to Delano or Foundation the following:

(a) AH Certificates. Certified copies of the AH Certificates.

(b) Powers of Attorney. The Powers of Attorney.

(c) Good Standing Certificates. Original Certificates of Status, or comparable status, of Adventist Health, issued by the California Secretary of State dated no earlier than a date which is ten (10) calendar days prior to the scheduled Closing Date.

(d) Other Documents. Any other documents contemplated by this Agreement or requested by Delano and reasonably required or necessary for the consummation of the Affiliation.

ARTICLE XIII
CONFIDENTIAL INFORMATION

13.1 Confidential Information. The Parties shall not disclose, divulge, discuss, copy or otherwise use or suffer to be used in any manner, in competition with, or contrary to the interests of, Adventist Health, Delano, patient, customer and provider lists, business methods or other trade secrets of either Party, other than (i) as required for financial reporting purposes, (ii) as reasonably necessary in connection with the Affiliation and (iii) to indemnify a Party pursuant to Article VIII or to enforce a Party's obligations or covenants in this Agreement, it being acknowledged by all Parties that all such information regarding the Delano Operations is confidential information and upon the Closing shall become the exclusive property of Adventist Health.

13.2 Remedies. The Parties expressly agree and understand that the remedy at law for any breach of this Article shall be inadequate and that the damages flowing from such breach are not readily susceptible to being measured in monetary terms. Accordingly, it is acknowledged that upon adequate proof of a violation by any Party of any legally enforceable provision of this Article, the other Party shall be entitled to immediate injunctive relief and may obtain a temporary order restraining any threatened or further breach. Nothing in this Article shall be deemed to limit any Party's remedies at law or in equity for any breach by another Party of any of the provisions of this Article that may be pursued or availed of by a Party.

13.3 Tolling of Restriction Period. In the event any Party shall violate any legally enforceable provision of this Article as to which there is a specific time period during which such Party is prohibited from taking certain actions or from engaging in certain activities, as set forth in such provision, then, in such event, such violation shall toll the running of such time period from the date of such violation until such violation shall cease.

13.4 Mutual Confidentiality.

(a) Neither Party shall, without the written consent of the other Party, make any public announcement or press release with respect to this Agreement except to their consultants, accountants, investors, attorneys, the Attorney General, Governmental Entities, and/or to other Persons when such announcement or press release to other Persons is necessary to comply with any Law, governmental or court order or regulation. Each Party shall be entitled to participate, to the extent practicable, in conversations with personnel in the Office of the Attorney General in connection with the Affiliation contemplated hereby.

(b) Any Party may make internal announcements to its personnel on an "as needed" basis. Delano may also make announcements to Delano's medical staff, provided that Adventist Health shall be notified of any such announcement at least five (5) days beforehand and may send a Representative to attend any such meeting, or provide comment as to any written announcement.

(c) Delano may not discuss the existence or contents of this Agreement and the conditions of Closing with any Person that has expressed interest in any way to Delano regarding an alternative transaction to this Agreement.

ARTICLE XIV
MISCELLANEOUS

14.1 Notices. All notices, requests, demands and other communications under this Agreement must be in writing and shall be deemed duly given, unless otherwise expressly indicated to the contrary in this Agreement, (i) when personally delivered, or (ii) one Business Day after delivery to a nationally recognized overnight courier service for next Business Day delivery, in any case addressed to the Parties or their permitted assigns at the following addresses (or at such other address as is given in writing by a Party to the other Parties):

To Delano:	Delano Regional Medical Center 881 Alma Real Dr., Suite 301 Pacific Palisades, CA 90272 Attn: Bill Noble Email: wlnnoble@aol.com
With a copy to:	Foley & Lardner LLP 555 California Street, Suite 1700 San Francisco, California 94104-1520 Attention: Mark Schieble, Esq. Email: MSchieble@foley.com
To Adventist Health:	Adventist Health System/West Adventist Health 2100 Douglas Boulevard Roseville, CA 95661 Attn: Robert J. Beehler, Vice President of Market Development Email: Bob.Beehler@ah.org
Copies of Emails also to:	Adventist Health Vice President, General Counsel Meredith.Jobe@ah.org
With a copy to:	Latham & Watkins LLP 355 South Grand Avenue, Suite 100 Los Angeles, California 90071-1560 Attn: Daniel Settelmayer, Esq. Telephone: (213) 891-8762 Email: daniel.settelmayer@lw.com

14.2 Counterparts. This Agreement may be executed in one or more counterparts and may be exchanged by email transmission, each of which shall be deemed to be an original but all of which together shall constitute one and the same document.

14.3 Captions and Section Headings. Captions and section headings are for convenience only, are not a part of this Agreement and may not be used in construing it.

14.4 Cooperation. Each of the Parties agrees to cooperate in the effectuation of the Affiliation and to execute any and all additional documents and to take such additional action as is reasonably necessary or appropriate for such purposes.

14.5 Entire Agreement. This Agreement, including any certificate, schedule, exhibit or other document delivered pursuant to its terms, constitutes the entire agreement between the Parties, and supersedes all prior agreements and understandings between the Parties relating to the subject matter hereof. There are no verbal agreements, representations, warranties, or undertakings between the Parties other than as provided herein, and this Agreement may not be amended or modified in any respect, except by a written instrument signed by the Parties to this Agreement. In the event of any inconsistency or conflict between the terms and conditions set forth in this Agreement and the terms and conditions set forth in the attachments or exhibits to this Agreement, the terms and conditions of this Agreement shall govern.

14.6 Governing Laws. This Agreement is to be governed by and construed in accordance with the internal laws of the State.

14.7 Assignment. This Agreement shall not be assigned or otherwise transferred by any Party without the prior written consent of the other Party, which may be granted or withheld in that Party's sole and absolute discretion.

14.8 Expenses. Each Party shall be responsible for the payment of all attorney fees and costs incurred by such Party in connection with the negotiation, due diligence and completion of the final terms of this Agreement and the Affiliation. Adventist Health shall be solely responsible for the cost of its engineers, consultants and other advisors, if any, engaged by or on behalf of Adventist Health in connection with the Affiliation. The Parties shall evenly split the costs of any third party virtual dataroom utilized for due diligence.

14.9 No Third-Party Beneficiaries. Except as expressly provided otherwise in this Agreement, the terms and provisions of this Agreement (including provisions regarding employee and employee benefit matters) are intended solely for the benefit of the Parties and their respective successors and permitted assigns, and are not intended to confer third-party beneficiary rights upon any other person.

14.10 Certain References. As used in this Agreement, and unless the context requires otherwise: references to "*include*" or "*including*" mean including without limitation; references to "*partners*" include general and limited partners of partnerships and members of limited liability companies; references to "*partnerships*" include general and limited partnerships, joint ventures and limited liability companies; references to any document are references to that document as amended, consolidated, supplemented or replaced by the Parties thereto from time to time; references to any law are references to that law as amended, consolidated, supplemented or replaced from time to time and all rules and regulations promulgated thereunder; references to time are references to California time; and the gender of all words includes the masculine, feminine and neuter, and the number of all words includes the singular and plural; and "Adventist Health" or "AH" refers to only the single organization that is a Party to this Agreement, and does not include any subsidiary or Affiliate of Adventist Health.

14.11 Waiver. No delay or failure to require performance of any provision of this Agreement shall constitute a waiver of the performance of such provision or any other instance. Any waiver granted by a Party must be in writing, and shall apply solely to the specific instance expressly stated.

14.12 Severability. If any provision of this Agreement is held to be unenforceable for any reason, it shall be adjusted rather than voided, if possible, in order to achieve the intent of the Parties to the greatest extent possible. All other provisions of this Agreement shall remain in full force and effect.

14.13 Successors and Assigns. The covenants and conditions contained herein, subject to the provisions as to assignment and subletting, apply to and bind the heirs, successors, executors, administrators and assigns of the Parties.

[Signature page follows]

Adventist Health:

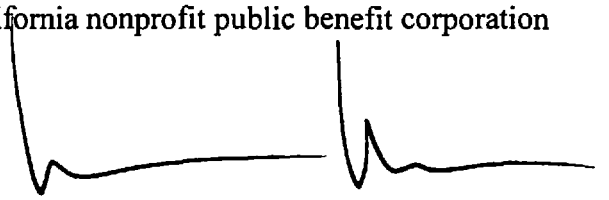
ADVENTIST HEALTH SYSTEM/WEST, D.B.A.
ADVENTIST HEALTH,
a California nonprofit religious corporation

By: _____
Name: Joseph Reppert
Title: Chief Financial Officer

IN WITNESS WHEREOF, the Parties have duly executed this Agreement effective as of the date first above written.

Delano:

CENTRAL CALIFORNIA FOUNDATION FOR HEALTH, d/b/a DELANO REGIONAL MEDICAL CENTER,
a California nonprofit public benefit corporation

By: 

William L. Noble, Chief Executive Officer

Exhibit 1.1(f)

List of Clinics

CLINIC NAME	ADDRESS
DELANO WOMEN'S CLINIC *	1201 JEFFERSON ST. DELANO
DELANO URGENT CARE CLINIC *	1201 JEFFERSON ST. DELANO
DELANO WOUND CARE CLINIC	1519 GARCES HWY, DELANO
WASCO MEDICAL PLAZA	2300 7TH STREET, WASCO
* Under the same CA State License.	

ADDITIONALLY, SEE EXHIBIT 3.7 FOR LICENSED CLINICAL SERVICES

Exhibit 2.1(b)

AMENDMENT
OF
THE AMENDED AND RESTATED BYLAWS
OF
CENTRAL CALIFORNIA FOUNDATION FOR HEALTH

Article II, Section 1 of the Amended and Restated Bylaws of Central California Foundation for Health is hereby amended to read in its entirety as follows:

Section 1. Members

The corporation shall have one Member pursuant to Section 5310 *et seq.* of the California Corporations Code and that one Member shall be Adventist Health System/West, a California nonprofit religious corporation. No membership certificate shall be issued. No membership fees or dues shall be assessed. The Member shall not be liable for the debts, liabilities or obligations of the corporation.

Exhibit 2.1(c)

NEW ORGANIZATIONAL DOCUMENTS

(See Attached)

AMENDED RESTATED ARTICLES OF INCORPORATION

OF

CENTRAL CALIFORNIA FOUNDATION FOR HEALTH

The undersigned certify that:

1. They are the President and the Secretary, respectively, of CENTRAL CALIFORNIA FOUNDATION FOR HEALTH, a California nonprofit public benefit corporation (the "Corporation").

2. The Articles of Incorporation of the Corporation are amended and restated to read in their entirety as follows:

ARTICLE I

The name of the Corporation is: ADVENTIST HEALTH DELANO.

ARTICLE II

The Corporation is a nonprofit religious corporation and is not organized for the private gain of any person. It is organized under the Nonprofit Religious Corporation Law exclusively for religious purposes. More specifically, the purposes of the Corporation are to promote the wholeness of humanity physically, mentally and spiritually, in a manner which is consistent with the philosophy, teachings and practices of the Seventh-day Adventist Church (the "**Church**"), including, without limitation, the following activities:

A. To establish, manage and maintain an acute care hospital as an affiliate corporation and in harmony with the administrative guidelines and religious objectives of Adventist Health System/West, a California nonprofit religious corporation ("**Adventist Health**").

B. To establish and maintain an institution or institutions within or without the state where incorporated with permanent facilities that include in-patient beds and medical services to provide diagnosis and treatment for patients (and associated services such as, but not limited to, extended care, out-patient care and home care).

C. To carry on any educational activities related to rendering care to the sick and injured or to the promotion of health, that in the opinion of the board of directors may be justified by the facilities, personnel, funds and other requirements that are, or can be, made available.

D. To establish, manage and maintain a health maintenance organization or similar organizations utilizing health delivery systems designed and coordinated to maximize benefits to the communities served.

E. To create and manage live-in conditioning centers in resort-type environments featuring educational programs in preventive medicine designed to enhance lifestyle quality and prevent illness.

F. To promote and carry on scientific research related to the care of the sick and injured.

G. To participate, so far as circumstances may warrant, in any activity designed and carried on to promote the general health of the community.

ARTICLE III

The name of the Corporation's initial agent for service of process is Corporation Service Company which will do business in California as CSC–Lawyers Incorporating Service.

ARTICLE IV

The board of directors shall have sole authority to amend or repeal the Articles of Incorporation by the vote of two-thirds of the directors, provided that such action shall not be valid or enacted unless also approved by Adventist Health at any regular meeting or special meeting of the membership or by two-thirds of the members voting by mail ballot.

ARTICLE V

The initial street and mailing address for the principal office of the Corporation shall be located at [2100 Douglas Boulevard, Roseville, California 95661].

ARTICLE VI

A. The property of the Corporation is irrevocably dedicated to religious purposes. No part of the net income or assets of this organization shall ever inure to the benefit of a director, officer or member of the Corporation, or to the benefit of any private individual.

B. The Corporation is affiliated with and operates subject to and in harmony with the policies, guidelines and procedures of Adventist Health. Upon winding up and dissolution of the Corporation, after paying or adequately providing for the debts and obligations of the Corporation, the remaining assets shall be distributed to Adventist Health, which is organized and operated exclusively for religious purposes and which has established its tax-exempt status under Section 501(c)(3) of 1986 Internal Revenue Code (the "**Code**"). In the event that Adventist Health has either failed to maintain its tax-exempt status, or been previously dissolved, or for any other reason is disqualified from receiving such remaining assets, then all such assets shall be distributed to the successor to Adventist Health providing that the successor is a nonprofit fund, foundation or corporation which is organized and operated exclusively for religious purposes and has established its tax-exempt status under the Code; or if no successor, all remaining assets shall be distributed to the organized conference of Seventh-day Adventist churches having jurisdiction within the geographic area in which the Corporation is located where that local conference is a nonprofit religious corporation or association organized and operated exclusively for religious purposes that has established its tax-exempt status under the Code.

ARTICLE VII

A. The Corporation is organized exclusively for religious purposes within the meaning of the Code. Notwithstanding any other provision of these Articles, the Corporation shall not carry on any other activities not permitted to be carried on: (1) by a corporation exempt from federal income tax under the Code (or the corresponding provision of any future United States Internal Revenue Law); or (2) by a corporation, contributions to which are deductible under Section 170(c)(2) of the Code (or the corresponding provision of any future United States Internal Revenue Law).

B. No substantial part of the activities of the Corporation shall consist of the carrying on of propaganda or otherwise attempting to influence legislation, nor shall the Corporation participate in, or intervene in (including the publishing or distributing of statements), any political campaign on behalf of any candidate for political office.

3. The foregoing amendment and restatement of Articles of Incorporation has been duly approved by the board of directors of the Corporation.

4. The foregoing amendment and restatement of Articles of Incorporation has been duly approved by the required vote of the Corporation's sole member.

We further declare under penalty of perjury under the laws of the State of California that the matters set forth in this certificate are true and correct of our own knowledge.

DATE:[●], 2019

_____
[_____], President

_____
[_____], Secretary

AMENDED AND RESTATED BYLAWS
OF
ADVENTIST HEALTH DELANO
(the "Corporation")

ARTICLE 1
PRINCIPAL OFFICE AND PURPOSE

1.1 Office. The principal office for the transaction of the business of the Corporation shall be fixed from time to time by the Corporation's board of directors (the "Board").

1.2 Purpose. The Corporation is a nonprofit religious corporation organized pursuant to the Nonprofit Religious Corporation Law of the State of California (the "Nonprofit Code") and is affiliated with Adventist Health System/West, a California nonprofit religious corporation ("Adventist Health"). The primary purpose of the Corporation is to promote the wholeness of humanity physically, mentally, and spiritually in a manner that is consistent with the philosophy, teachings, and practices of the Seventh-day Adventist Church (the "Church").

ARTICLE 2
MEMBERSHIP

2.1 Members. Adventist Health is the sole member of the Corporation, within the meaning of Section 5056 of the California Corporations Code.

2.2 Transfer of Membership. No membership or right arising from membership may be assigned, transferred or encumbered in any manner whatsoever, either voluntarily or involuntarily. Any purported or attempted assignment, transfer or encumbrance of such membership shall be void and shall be grounds for termination of the membership.

2.3 Exercise of Membership Rights. Adventist Health shall exercise its membership rights through its board of directors, which may, by resolution, authorize one or more of its officers to exercise its vote on any matter to come before the membership of the Corporation.

2.4 Action by the Member. The vote, written assent or other action of Adventist Health shall be evidenced by, and the Corporation shall be entitled to rely upon, a certificate of the secretary of Adventist Health stating (a) the actions taken by Adventist Health, (b) that such actions were taken in accordance with the articles of incorporation and bylaws of Adventist Health, and (c) the authorization of Adventist Health for such certification. Requests for action by Adventist Health may be made through the chair of Adventist Health's board of directors or such other person as Adventist Health's board of directors shall designate in writing.

2.5 Place of Meetings. Meetings (whether regular or special) of Adventist Health, as member of the Corporation, shall be held at the principal office of Adventist Health, or at such other place designated by the Corporation's Board, which location will be stated in the notice of the meeting.

2.6 Regular Meeting. The regular meeting of Adventist Health, as member of the Corporation, shall be held annually within one-hundred-twenty (120) days after the close of the fiscal year or at such time as the Board determines. The regular meeting shall be held for the purpose of transacting business as may come before the meeting.

2.7 Special Meetings. Special meetings of Adventist Health, as member of the Corporation, for any purpose or purposes, may be called upon request of the chair of the Board or by Adventist Health.

2.8 Notice of Meeting. Notice of a time and place for a regular or special meeting shall be delivered not less than fifteen (15) nor more than sixty (60) days before the date of the meeting: (a) personally to Adventist Health; (b) via electronic transmission; or (c) sent by first-class, registered or certified mail to the address of Adventist Health, as it appears on the Corporation's records. Notices of special meetings shall state the general nature of the business to be transacted. Adventist Health must consent in writing to receipt of notice by electronic transmission, as provided in Section 9.3.

2.9 Action by Written Ballot. Any action may be taken without a meeting if a written or electronic ballot is distributed to Adventist Health, setting forth the proposed action, providing an opportunity for Adventist Health to specify approval or disapproval of any proposal, and providing a reasonable period of time within which to return the ballot to the Corporation. The written and/or electronic ballot shall be filed with the secretary of the Corporation and maintained in the corporate records. Except for the election of directors, any action that may be taken at a membership meeting may also be taken by written ballot without a meeting.

2.10 Liabilities of Members. There shall be no membership fees, dues or assessments. No person who is now or later becomes a member of the Corporation shall be personally liable to its creditors for any indebtedness or liability and any or all creditors of the Corporation shall look only to the assets of the Corporation for payment.

ARTICLE 3
BOARD OF DIRECTORS

3.1 Powers. The Board shall control and generally manage the business of the Corporation and exercise all of the powers, rights and privileges permitted to be exercised by directors of nonprofit religious corporations under the Nonprofit Code, except as limited by the Corporation's articles of incorporation and these bylaws. All corporate powers of the Corporation shall be exercised by or under the authority of the Board.

3.2 Number, Qualifications, and Selection. Each individual who is a director of the board of Adventist Health shall automatically be a director of the Corporation's Board, and shall serve as a director until such time as that person is no longer a director of Adventist Health.

3.3 Quorum. A majority of the directors of the Board shall constitute a quorum for the transaction of business. Except as otherwise required by law, the articles of incorporation, or these bylaws, the directors present at a duly called or held Board meeting at which a quorum is present may continue to transact business until adjournment, even if enough directors have withdrawn to leave less than a quorum, if any action taken (other than adjournment) is approved by at least a majority of the directors required to constitute a quorum. If less than a quorum is present at a regular meeting, any resulting actions shall be subject to the ratification of the Board at the next meeting in which a quorum is present.

3.4 Term of Office. The term of office of each director serving on the Board of the Corporation shall be the same as the term that the director serves on the Adventist Health board.

3.5 Vacancies. If the director resigns or is removed from the Board, such position shall remain vacant until such time as a new or additional director is appointed to the Adventist Health board.

3.6 Place of Meeting. Meetings of the Board shall be held at the principal office of the Corporation or at any place within or without the state that has been designated by the chair or president or by resolution of the Board. Any Board meeting may be held by conference telephone, video screen communication, or electronic transmission. Participation in a meeting under this Section shall constitute presence in person at the meeting if both the following apply: (a) each director participating in the meeting can communicate concurrently with all other directors; and (b) each director is provided the means of participating in all matters before the Board, including the capacity to propose, or to interpose an objection to, a specific action to be taken by the Corporation.

3.7 Regular Meetings; Special Meetings. A regular meeting of the Board shall be held at least once each year at such time as the Board may fix by resolution. Regular meetings of the Board shall consist of those meetings reflected on the Corporation's annual calendar. Special meetings of the Board for any purpose or purposes may be called at any time by the president or chair.

3.8 Meeting Notices; Waiver. Written notice of the time and place of meetings (regular or special) shall be delivered to each director or sent to each director by mail or by other form of written communication, or by electronic transmission by the Corporation (as defined in Section 9.3), charges prepaid, addressed to the director at that director's address as it is shown on the records of the Corporation. The notice shall be sent (a) for regular Board meetings, at least fifteen (15) days, but not more than forty-five (45) days, before the time of the holding of the meeting; and (b) for special meetings, at least four (4) days before the time of the meeting, if notice is sent by mail, and at least forty-eight (48) hours before the time of the meeting, if notice is delivered personally, telephonically or by electronic transmission. Each director must consent in writing to receipt of notice by electronic transmission, as provided in Section 9.3. The meeting of the Board, however called and noticed and wherever held, shall be as valid as though the meeting had been held after a proper call and notice if a quorum is present and if, either before or after the meeting, each of the directors not present signs a written waiver of notice or consent to hold the meeting or an approval of the minutes. All waivers, consents or approvals shall be filed with the corporate records or made a part of the minutes of the meeting.

3.9 Voting; Action without a Meeting. Each director shall have one vote on each matter presented to the Board for action. No director may vote by proxy. Any action by the Board may be taken without a meeting if all directors, individually or collectively, consent in writing or by electronic transmission to the action. Such written consent shall be filed with the minutes of the proceedings of the Board.

3.10 Resignation and Removal. Except as provided below, any director may resign by giving written notice to the chair or to the president. The resignation shall be effective when the notice is given unless it specifies a later time for the resignation to become effective. No director may resign when the Corporation would be left without a duly elected director. A director may resign by giving notice of resignation to the chair of the Board and may be removed from office by Adventist Health.

3.11 Compensation. Directors shall receive no compensation for their services as directors although directors may be full-time employees of the Corporation, one of its affiliated corporations or the Church.

3.12 Conflicts of Interest. Upon election to the Board and annually, each director shall sign a conflict of interest form, certifying that the director has read, understood and is in complete compliance with, and agrees to continue to comply with, the Board's conflict of interest policy.

ARTICLE 4
COMMITTEES

4.1 Board Committees. The Board may appoint standing or special Board committees consisting exclusively of directors, to serve at the pleasure of the Board. The Board may delegate to such committees any of the powers and authority of the Board, except that the Board may not delegate the following powers:

(a) To take any final action on matters that, under the Nonprofit Code or these bylaws, also require Adventist Health's approval;

(b) To fill vacancies on the Board or in any committee;

(c) To fix any compensation of the directors for serving on the Board or any committee;

(d) To amend or repeal these bylaws or adopt new bylaws;

(e) To amend or repeal any resolution of the Board that by its express terms is not so amendable or repealable; and

(f) To appoint committees of the Board or committee members.

4.2 Advisory Committees. The Board may establish one or more advisory committees, consisting of directors, nondirectors or both. Except to the extent provided in Subsection 9210(b) of the Nonprofit Code, advisory committees may not exercise any authority of the Board, but shall be limited to making recommendations to the Board and to implementing Board decisions and policies.

4.3 Committee Chairs. A Board committee chair must be a director of the Board, and an advisory committee chair must be an officer of Adventist Health or a director of the Board. All chairs shall be appointed by the Board and shall serve until they no longer are qualified to serve as chairs, until they are removed or resign as chairs, or until their committees are terminated.

4.4 Meetings and Actions. Meetings and actions of committees shall be governed by, held, and taken under the provisions of these bylaws concerning Board meetings, except that the time for general meetings and the calling of special meetings may be set either by Board resolution or, if none, by the committee chair or by resolution of the committee. No act of a committee shall be valid unless approved by the vote of a majority of its committee members with a quorum present. Committees shall keep regular minutes of proceedings and report the same to the Board, and the minutes will be filed with the Corporation's records.

4.5 Removal. The Board may remove at any time, with or without cause, a member or members of any committee.

4.6 Medical Staff. Any Board committee that deliberates issues of medical staff responsibilities shall include medical staff members.

ARTICLE 5
OFFICERS

5.1 Officers. The officers of the Corporation shall be a chair of the Board, a vice chair of the Board, a president, a secretary, a chief financial officer (who may also be referred to as treasurer) and any other person designated as an officer by the Board. Any person may hold more than one office, except that neither the chair nor president may serve concurrently as the secretary or chief financial officer. Only directors of the Corporation may serve as chair or vice chair of the Board. Other than the executive vice president (if any), in no event shall the title of vice president of the Corporation make a person an officer within the meaning of the Nonprofit Code or these bylaws unless designated by the Board.

5.2 Election of Officers. Any executive vice presidents shall be appointed by the president. The secretary and chief financial officer of the Corporation shall be elected by and serve at the pleasure of the Board, and each shall hold that office until that officer resigns, or is removed, or is otherwise disqualified to serve, or until that officer's successor is appointed.

5.3 Chair of the Board. The chair of the Board shall be the chief executive officer of Adventist Health or the chief executive officer's designee, who shall preside at the meetings of the Board. The chair shall call regular and special meetings of the Board in accordance with these bylaws.

5.4 Vice Chair of the Board. The vice chair of the Board shall be the president of Adventist Health. In the absence of the chair of the Board, the vice chair or another designee of the chair shall preside at the meetings of the Board.

5.5 President. The president shall, in order to qualify for office, be and remain an employee of Adventist Health. The Board chair shall appoint the president. The president may be the chief executive officer of the Corporation, if designated by the Board chair. Subject to the control of the Board, the president shall have general supervision of the business of the Corporation and shall have such other powers and duties usually vested in such an office. The responsibilities of the president shall include:

(a) Carrying out all policies and procedures established by the Board consistent with the philosophy, teachings, and practices of the Church;

(b) Development of a plan of organization of the personnel and others concerned with the operation of the Corporation's hospital;

(c) Preparation of an annual operating capital expenditure and cash flow budget showing the expected receipts and expenditures and such other information as is required by the Board, and submission of such budgets to the Board for approval;

(d) Selection, employment, control, and discharge of all employees and development and maintenance of personnel policies and practices for the Corporation's hospital;

(e) Maintenance of physical properties in a good state of repair and operating condition;

(f) Supervision of business affairs to ensure that funds are collected and expended to the best possible advantage and within the provision of the annual budgets;

(g) Cooperation with the medical staff and with all those concerned with rendering of professional service to the end that high quality care may be rendered to the patients consistent with the policies set forth by the Board;

(h) Presentation to the Board or to its authorized committees of periodic reports reflecting the professional service and financial activities of the Corporation's hospital as prescribed by corporate administrative policies, and preparation and submission of such special reports as may be required by the Board;

(i) Reporting all activities and recommendations of the medical staff to the Governing Board;

(j) Execution of the contracts authorized by the Board, or a Board committee, except as is otherwise provided by these bylaws and subject further to the limitations of authority delegated by the Board;

(k) Performance of other duties assigned by the Board that may be necessary in the best interest of the Corporation's hospital;

(l) Designation of a qualified individual who shall be responsible to the president in matters of administration and shall represent the president during the president's absence; and

(m) Establishing goals and objectives for the Corporation, which shall include a long-range strategic plan.

The president of the Corporation will be formally reviewed based upon performance criteria presented to the president. The review will be conducted by the chair of the Governing Board.

5.6 Executive Vice President. Executive vice presidents, if any, shall have such powers and duties as the Board or the bylaws may provide. During the absence of the president, and in the absence of a designation under Subsection 5.5(l), any executive vice president may act in the place and the stead of the president.

5.7 Secretary. The secretary shall keep, or cause to be kept, the records of the Corporation, including a record of the proceedings of the Corporation, and shall perform all of the duties usually incident to the office of secretary. The secretary shall have such other powers and duties as the Board or the bylaws may require.

5.8 Chief Financial Officer. The chief financial officer shall keep, or cause to be kept, correct books and accounts of the Corporation's properties and transactions. The chief financial officer shall perform all the duties pertaining to the office of chief financial officer and shall have such other powers and duties as the Board or these bylaws may require. During the unavailability or incapacity of the president and any executive vice president, and in the absence of a designation under Subsection 5.5(l), the chief financial officer will act in the place and stead of the president.

5.9 Assistant Secretaries. The chief financial officer shall be an assistant secretary and there shall be such other assistant secretaries as may be designated by the Board, any one of whom shall perform the duties of the secretary in the absence of the secretary.

5.10 Assistant Chief Financial Officers. There shall be such assistant chief financial officers (who may also be referred to as assistant treasurers) as may be designated by the Board, any of whom shall perform the duties of the chief financial officer in the absence of the chief financial officer.

ARTICLE 6
GOVERNING BOARD

6.1 Appointment of Governing Board. The Board shall appoint the members of a committee called the "Governing Board," with each appointment for a two-year term, and approximately one-half of the members of the Governing Board appointed every year. The Governing Board shall consist of from nine (9) to twenty-one (21) members, depending upon the size and needs of the Corporation, as determined by the Board. The Board may at any time, in its sole discretion, remove or replace a Governing Board member or revoke any or all of the Governing Board's delegated authority.

6.2 Nominating Committee. The Governing Board shall appoint a nominating committee pursuant to its own bylaws ("Governing Board Bylaws"), which shall make nominations to the Board for the Board to consider in appointing Governing Board members.

6.3 Bylaws. The Governing Board shall have its own Governing Board Bylaws, which shall be adopted and may be amended by the Board, subject to the limitations contained within the Governing Board Bylaws. The Governing Board shall comply with its bylaws and the resolutions of the Board.

6.4 Qualifications for Members of the Governing Board. Each member of the Governing Board:

(a) Shall be more than twenty-one (21) years of age;

(b) Shall have an interest in health care matters; and

(c) Must support the goals, objectives, and philosophies of the Church.

6.5 Delegated Powers to the Governing Board. The Governing Board Bylaws shall specify the exact functions of the Governing Board, consistent with these bylaws. Subject to the Board's ultimate oversight and authority to take action, the Board delegates the following responsibilities to the Governing Board:

(a) Overseeing safety and quality;

(b) Providing institutional planning to meet the health care needs for the community the Corporation's hospital serves;

(c) Providing market planning, including local physician integration strategies, community mission and clinical delivery;

(d) Determining that the Corporation's hospital, its employees and the appointees of the medical staff will conduct their activities so as to conform with the requirements and

principles of all applicable laws and regulations, including the Health Care Quality Improvement Act;

(e) Overseeing and supervising the medical staff of the Corporation's hospital, which includes approving the medical staff bylaws and rules and regulations, and assuring that the medical staff establishes mechanisms to achieve and maintain high quality medical practice and patient care;

(f) Establishing and approving policies and procedures for those functions of the Corporation's hospital that have been delegated to the Governing Board;

(g) Assuring a safe environment within the Corporation's hospital for employees, medical staff, patients, and visitors; and

(h) Organizing itself effectively so that it establishes and follows the policies and procedures necessary to discharge its responsibilities and adopt rules and regulations in accordance with legal requirements.

ARTICLE 7
INDEMNIFICATION

7.1 Advancement of Expenses. To the fullest extent permitted by law and except as otherwise determined by the Board in a specific instance (and in the Board's sole and absolute discretion), expenses incurred by an agent (defined below) seeking indemnification under this Article of these bylaws in defending any proceeding covered by this Article shall be advanced by the Corporation before final disposition of the proceeding, on receipt by the Corporation of an undertaking by or on behalf of that person that the advance will be repaid unless it is ultimately found that the person is entitled to be indemnified by the Corporation for those expenses. The Board must approve any advance made to the president under this section, prior to such advance being paid to the president. For purposes of this article, an "agent" shall have the meaning established in the Nonprofit Code applicable to the Corporation.

7.2 Indemnification upon Successful Defense. If an agent of the Corporation is successful on the merits in defense of any proceeding, claim or other contested matter brought against the agent in connection with the agent's actions or omissions in relation to the Corporation, the Corporation shall indemnify the agent against that agent's actual and reasonable expenses incurred in the defense against such proceeding or claim.

7.3 Indemnification upon Unsuccessful Defense.

(a) Mandatory Indemnification. To the maximum extent permitted by law, the Corporation shall indemnify each of its present and former (1) directors, (2) officers, (3) persons who are or were regularly invited for six (6) consecutive months or more to attend and participate at Board meetings or Board committee meetings, and (4) persons identified in a duly approved Board resolution as qualifying for this mandatory indemnification (each of whom is an "**indemnitee**") against expenses (collectively, "**payments**") actually and reasonably incurred by such indemnitee in connection with defending that indemnitee against an action or proceeding. An employee of the Corporation may be an indemnitee if that employee meets one or more of the definitions

of indemnitee set forth above. Notwithstanding the above, mandatory indemnification shall be given to a potential indemnitee only if all of the following apply:

1. The potential indemnitee was not a director, officer or other person who was removed from one or more of their positions with the Corporation;

2. The action or proceeding against the indemnitee is based on or relates to an action or inaction taken by the indemnitee on behalf of the Corporation and within the scope of the indemnitee's role or relationship with the Corporation;

3. The Board (excluding vacancies and directors who have a conflict of interest) has made all findings required by the Nonprofit Code (the indemnitee shall not be eligible to receive this mandatory indemnification if such findings are not made by the Board); and

4. The potential indemnitee has not procured any illegal profit, remuneration or advantage, as determined by the Board in its sole discretion.

IF A PERSON DOES NOT QUALIFY FOR THIS MANDATORY INDEMNIFICATION, SUCH PERSON MIGHT STILL RECEIVE DISCRETIONARY INDEMNIFICATION AS OUTLINED BELOW.

(b) Discretionary Indemnification. To the maximum extent permitted by law, the Board may in its sole discretion, by a majority vote (excluding vacancies and directors with a conflict of interest), indemnify an agent (including former directors who were removed by the Board, employees or agents identified by the Board as acting on behalf of the Corporation or Adventist Health and not entitled to mandatory indemnification) (each of which is a "**recipient**") against any or all of the expenses, judgments, fines, settlements or other amounts actually and reasonably incurred by such recipient in connection with an action or proceeding against the recipient, subject to the following:

1. The action or proceeding against the recipient must be based on or relate to an action or inaction taken by the recipient on behalf of the Corporation and within the scope of the recipient's role or relationship with the Corporation;

2. The Board (excluding vacancies and directors who have a conflict of interest) must have made all findings required by the Nonprofit Code (the recipient shall not be eligible to receive this discretionary indemnification if such findings are not made); and

3. Indemnification is not available if the recipient is found to have procured illegal profit, remuneration or advantage.

ARTICLE 8
LEGAL INSTRUMENTS

8.1 Execution of Legal Documents.

(a) The president and any other officer of the Corporation shall sign any deeds or mortgages or other legal documents for real estate transactions under authority given them by the Board (either by resolution specific to a transaction or by a general resolution authorizing such persons to enter into certain types of real estate transactions). The Board may also authorize other persons or officers to execute the documents described in this Subsection.

(b) The president or any executive vice president and the secretary or such other officers as the Board may select for that purpose are authorized to vote, represent and exercise on behalf of the Corporation all rights incident to any and all voting securities of any other corporation or corporations standing on the name of the Corporation. The authority granted by these bylaws to the officers to vote or represent the Corporation arising from any voting securities held by the Corporation and any other corporation or corporations may be exercised by the officers in person or by any person authorized to do so by proxy or power of attorney duly executed by the officers.

(c) With respect to all contracts, transactions or arrangements other than those described in Subsections 8.1(a) or 8.1(b), the president or chief financial officer may execute, and the Board may authorize specific other persons or officers to execute, the appropriate agreements and other documents related to such transactions or arrangements. The president or chief financial officer may sign individually. Any Board resolution authorizing other persons or officers to execute documents shall specify whether one person may sign the appropriate documents or whether two signatures are required under specified circumstances.

8.2 Seal. The Corporation may have a corporate seal, and the same shall have inscribed thereon the name of the Corporation, the date of its incorporation and the state of its incorporation.

ARTICLE 9
GENERAL PROVISIONS

9.1 Auditor. The books of the Corporation shall be reviewed annually by an auditor selected by Adventist Health.

9.2 Amendment of Bylaws. The bylaws may only be amended or repealed and new bylaws adopted by Adventist Health. The Board shall review the bylaws of the Corporation annually and shall recommend any necessary revisions.

9.3 Electronic Transmission.

(a) "**Electronic transmission by the Corporation**" means a communication (1) delivered by (A) facsimile telecommunication or electronic mail when directed to the facsimile number or electronic mail address for that recipient on record with the Corporation; (B) posting on an electronic message board or network that the Corporation has designated for those communications, together with a separate notice to the recipient,

which transmission shall be considered delivered upon the later of the posting or delivery of the separate notice thereof; or (C) other means of electronic communication; (2) to a recipient who has provided an unrevoked consent to the use of those means of transmission for communications pursuant to the Nonprofit Code; and (3) that creates a record that is capable of retention, retrieval, and review, and that may thereafter be rendered into clearly legible tangible form.

(b) An electronic transmission to an individual member of the Corporation who is a natural person, or to a director, must be preceded by or include a clear written statement to the recipient as to (1) any right of the recipient to have the record provided or made available on paper or in nonelectronic form; (2) whether the consent applies only to that transmission, to specified categories of communications, or to all communications from the Corporation; and (3) the procedures the recipient must use to withdraw consent.

(c) "**Electronic transmission to the Corporation**" means a communication (1) delivered by (A) facsimile telecommunication or electronic mail when directed to the facsimile number or electronic mail address that the Corporation has provided to members or directors for communications; (B) posting on an electronic message board or network that the Corporation has designated for those communications, which transmission shall be considered delivered upon posting; or (C) other means of electronic communication; (2) as to which the Corporation has placed in effect reasonable measures to verify that the sender is the member or director purporting to send the transmission; and (3) that creates a record that is capable of retention, retrieval, and review, and that may thereafter be rendered into clearly legible tangible form.

(d) "**Electronic transmission**" means any combination of electronic transmission by or to the Corporation.

Amended and Restated Bylaws Certificate

I, Meredith Jobe, hereby certify that I am the Secretary of Adventist Health Delano, a California nonprofit religious corporation (the **"Corporation**"), and that the foregoing amended and restated bylaws are a true and correct copy of the bylaws of the Corporation as duly adopted in a Membership Meeting held on _____, 20__, by the consent of the sole Member of the Corporation.

IN WITNESS WHEREOF, I have hereunto set my hand this ____ day of _____.

Adventist Health Delano

By: _____
Meredith Jobe, Secretary

BYLAWS OF THE GOVERNING BOARD OF ADVENTIST HEALTH DELANO

The Board of Directors (the "**Corporate Board**") of Adventist Health Delano, a California nonprofit religious corporation (the "**Corporation**") adopts these bylaws for the governing board (the "**Governing Board**") of Adventist Health Delano's hospital facility and its provider-based ambulatory clinics (collectively, the "**Hospital**") to govern certain day-to-day operations of the Hospital. The Hospital is owned and operated by the Corporation. Adventist Health System/West, a California nonprofit religious corporation ("**Adventist Health**") is the sole corporate member of the Corporation.

Article 1
Corporation Role and Purpose

1.1 Purpose. The Corporation is organized pursuant to the Nonprofit Religious Corporation Law of the State of California (the "**Nonprofit Code**"). The primary purpose of the Corporation is to promote the wholeness of humanity physically, mentally, and spiritually in a manner which is consistent with the philosophy, teachings, and practices of the Seventh-day Adventist Church (the "**Church**").

Article 2
Governing Board Role and Responsibility

2.1 General Principles of Delegation. The Corporation, which owns and operates the Hospital, is controlled and managed by the Corporate Board. All powers and functions with respect to the management and governance of the Hospital are vested in the Corporate Board as set forth in the bylaws of the Corporation (the "**Corporate Bylaws**") and the Nonprofit Code. Subject to its own oversight and ultimate authority as required by the Nonprofit Code, the Corporate Board has delegated (a) certain responsibilities and functions to the Governing Board as set forth in the Corporate Bylaws and these bylaws of the Governing Board (the "**Governing Board Bylaws**") and (b) certain powers and functions to the Corporation's president for the day-to-day management of the Hospital's business. The Corporation's president and the Governing Board shall exercise their delegated responsibilities and powers under the ultimate direction of the Corporate Board.

2.2 Delegation of Functions and Responsibilities. Subject to the oversight and ultimate authority of the Corporate Board, the Corporate Board delegates to the Governing Board, and the Governing Board shall be responsible to the Corporate Board for, the following responsibilities and functions:

(a) Overseeing quality and safety;

(b) Providing institutional planning to meet the health care needs of the community the Hospital serves;

(c) Providing market planning, including local physician integration strategies, community mission and clinical delivery;

(d) Approving of any proposed changes to the Hospital's clinical services as described under that Affiliation Agreement between Corporation and Adventist Health, dated January 4, 2019;

(e) Determining that the Hospital, its employees, and the appointees of the medical staff conduct their activities so as to conform with the requirements and principles of all applicable laws and regulations, including the Health Care Quality Improvement Act;

(f) To the extent requested by the Corporate Board, reviewing the Hospital's annual operating budget and long-term capital expenditures plan and advising the Corporation's president regarding them;

(g) Providing input and oversight of the Community Health Needs Assessment and population health strategy;

(h) Organizing and supervising the medical staff of the Hospital, which includes approving the medical staff bylaws and rules and regulations, and ensuring that the medical staff establishes mechanisms to achieve and maintain high quality medical practice and patient care;

(i) Deciding upon medical staff appointments and reappointments, the granting of clinical privileges, and the reduction, modification, suspension, or termination of medical staff appointments and clinical privileges pursuant to the provisions of the medical staff bylaws;

(j) Encouraging programs for continuing education for medical staff appointees and appropriate in-service education programs for Hospital employees;

(k) Requiring the medical staff to periodically review the medical staff bylaws, rules and regulations, and policies governing the medical staff;

(l) Approving the adoption, amendment, or repeal of medical staff bylaws, rules and regulations, and policies governing the medical staff;

(m) Providing communication among duly authorized representatives of the governing body, the administration, and the medical staff;

(n) Ensuring that the medical staff is represented by attendance and has the opportunity to comment at all Governing Board meetings;

(o) Ensuring that all medical staff members practice within the scope of the clinical privileges delineated by the Governing Board;

(p) Requiring the development of a quality assurance program that includes a mechanism for review of the quality of patient care services provided by individuals who are not subject to the staff privilege delineation process, reviewing the quality assurance program on an ongoing basis, and ensuring that the medical staff is provided with the administrative assistance necessary to conduct quality assurance activities in accordance with the Hospital's quality assurance program;

(q) Reviewing and advising the Corporation's president regarding the short-range and long-range plans and goals for the Hospital in consultation with the medical staff and others;

(r) Establishing and approving policies and procedures for those functions of the Hospital that have been delegated to the Governing Board;

(s) Ensuring a safe environment within the Hospital for employees, medical staff, patients, and visitors;

(t) Organizing itself effectively so that it establishes and follows the policies and procedures necessary to discharge its responsibilities and adopts rules and regulations in accordance with legal requirements;

(u) Establishing and revising standards for the quality of service to be made available at the Hospital and Hospital policies implementing such standards;

(v) Maintaining liaison with the Corporate Board through the Corporation's president by sending to the chair of the Corporate Board notice of all meetings with an agenda and subsequent minutes of actions taken, and being available for and consulting with the Corporate Board;

(w) Evaluating the performance of the Governing Board;

(x) Cooperating with the Corporation's president to ensure that the Hospital obtains and maintains accreditation by the applicable accrediting bodies and eligibility for participation in the Medicare, Medicaid, or other payment programs selected by the Hospital; and

(y) Monitoring the Hospital's performance through the regular review of reports from the Corporation's president on the overall activities of the Hospital.

Article 3
Governing Board Structure and Procedures

3.1 Composition of Governing Board. The Governing Board shall be appointed by the Corporate Board, with approximately one-half of the members appointed each year, and shall be selected from individuals representing a variety of interests and abilities. The Governing Board shall consist of from nine (9) to twenty-one (21) members, depending upon the size and needs of the institution, as determined from time to time by the Corporate Board. Each member of the Governing Board shall be more than twenty-one (21) years of age, shall have an interest in health care matters, and shall support the goals, objectives, and philosophies of the Church.

3.2 Qualifications of Governing Board Members.

(a) Ecclesiastical. Since the Corporation is a religious corporation whose purposes are consistent with the philosophy, teachings, and practices of the Church, the Governing Board shall include the following:

1. The chief executive officer of Adventist Health, or the chief executive officer's designee;

2. The president of the local conference of Seventh-day Adventist churches in the geographic area where the Corporation is located, or the local conference president's designee who must be a senior officer of the conference; and.

3. The president of this Corporation.

(a) Medical Staff Physicians. The chief of staff of the medical staff may be a member of the Governing Board. In addition, up to five (5) other physicians who are members of the medical staff of a facility operated by the Corporation may be selected to serve as members of the Governing Board. Physicians may, at the discretion of the Governing Board, provide the liaison for communication between the medical staff and the Governing Board and thus function in lieu of a joint conference committee.

(b) Other Representatives. This category shall be composed of individuals other than the medical staff physicians who reside or work in the geographic areas generally served by the Corporation or who have expertise beneficial to the Corporation. Such Governing Board members shall be selected on the basis of the following considerations:

1. Well-known and respected among a significant segment of the population;

2. Involved in humanitarian activities, civic and service organizations, and community affairs;

3. Successful in personal business matters;

4. Ability to listen, to analyze, to think independently and logically, to make meaningful, relevant, and concise contributions to discussions, and to be generally helpful in the making of decisions; and

5. Possession of practical and technical or professional knowledge and skills that enable the giving of expert counsel.

3.3 Governing Board Nominating Committee. The Nominating Committee shall be appointed by the Governing Board and shall consist of five (5) Governing Board members: the chair and vice chair of the Governing Board, the Corporation's president, and two (2) other members of the Governing Board who are selected by the chair of the Governing Board and whose terms are not expiring. The vice chair of the Governing Board shall serve as chair of the Nominating Committee. The Nominating Committee shall recommend to the Corporate Board candidates for election to the Governing Board to replace members of the Governing Board whose terms are expiring or to fill vacancies in unexpired terms on the Governing Board.

3.4 Conflict of Interest Policy. Upon appointment to the Governing Board and annually, each member shall sign a conflict of interest form as required by the Corporate Board, certifying that the member has read, understands and is in complete compliance with the Corporate Board's conflict of interest policy.

3.5 Term of Office. Each Governing Board member, except for the individuals described in Section 3.2(a) and the chief of staff of the medical staff (if the chief of staff is a Governing Board

member), shall hold office for a term of two (2) years or until that person's successor has been elected and qualified or until that person's earlier resignation or removal, or until the member's office has been declared vacant in the manner provided in these Governing Board Bylaws. A member appointed to fill a vacancy shall serve for the remainder of the term of that person's predecessor. Except for the individuals described in Section 3.2(a) and the chief of staff of the medical staff (if the chief of staff is a Governing Board member), no person may be elected or appointed to hold office on the Governing Board if at the time of that election or appointment the person is more than seventy-six (76) years of age. The chief of staff may hold office on the Governing Board while serving as chief of staff of the medical staff and that person's term shall expire when a successor chief of staff takes office.

3.6 Vacancies.

(a) When Vacancies Exist. A vacancy or vacancies on the Governing Board shall occur upon the death, resignation, or removal of any member, or if the authorized number of members is increased, or if the Corporate Board fails, at any annual or special meeting of the Corporate Board at which any Governing Board members are elected, to elect the full authorized number of members to be voted for at the meeting.

(b) Filling Vacancies. Any vacancy occurring on the Governing Board may be filled by an appointment by the Corporate Board upon a recommendation from the Governing Board Nominating Committee.

3.7 Place of Meeting. Meetings of the Governing Board shall be held at any place within or without the state that has been designated by the chair or the Corporation's president or by resolution of the Governing Board. In the absence of this designation, meetings shall be held at the principal office of the Corporation. Any Governing Board meeting may be held by conference telephone, video screen communication, or electronic transmission. Participation in a meeting under this Section shall constitute presence in person at the meeting if both of the following apply: (a) each member participating in the meeting can communicate concurrently with all other members; and (b) each member is provided the means of participating in all matters before the Governing Board, including the capacity to propose, or to interpose an objection to, a specific action to be taken by the Governing Board.

3.8 Regular Meetings; Special Meetings. Regular meetings of the Governing Board shall be held at least three (3) times each year at such time as is fixed by the chair of the Governing Board. Regular meetings of the Governing Board shall consist of those meetings reflected on the Corporation's annual calendar. Special meetings of the Governing Board for any purpose or purposes may be called at any time by the Corporation's president or the chair of the Governing Board.

3.9 Meeting Notices; Waiver. Written notice of the time and place of meetings (regular or special) shall be delivered personally to each member of the Governing Board or sent to each member by mail or by other form of written communication, or by electronic transmission by the Corporation (as defined in Section 9.4), charges prepaid, addressed to the member at that member's address as it appears on the records of the Corporation. The notice shall be sent (a) for regular Governing Board meetings, at least fifteen (15) days, but not more than forty-five (45) days, before the time of the holding of the meeting; and (b) for special meetings, at least four (4) days before the time of the meeting, if notice is sent by mail, and at least forty-eight (48) hours before the time of the meeting, if notice is delivered personally, telephonically or by electronic transmission. Each member of the Governing Board must consent in writing to receipt of notice

by electronic transmission, as provided in Section 9.4. The transaction of any meeting of the Governing Board, however called and noticed and wherever held, shall be as valid as though the meeting had been held after a call and notice if a quorum is present and if, either before or after the meeting, each of the Governing Board members not present signs a written waiver of notice or consent to hold the meeting or an approval of the minutes. All such waivers, consents or approvals shall be filed with the corporate records or made a part of the minutes of the meeting.

3.10 Quorum. A majority of the members of the Governing Board shall constitute a quorum for the transaction of business. Except as otherwise required by law, the Corporation's articles of incorporation ("**Corporate Articles**"), the Corporate Bylaws or these Governing Board Bylaws, the members present at a duly called or held Governing Board meeting at which a quorum is present may continue to transact business until adjournment, even if enough members have withdrawn to leave less than a quorum, if any action taken (other than adjournment) is approved by at least a majority of the members required to constitute a quorum. If less than a quorum is present at a regular meeting, any resulting actions shall be subject to the ratification of the Governing Board at the next meeting in which a quorum is present.

3.11 Voting; Action without a Meeting. Each Governing Board member shall have one vote on each matter presented to the Governing Board for action. No member may vote by proxy. Any action by the Governing Board may be taken without a meeting if all members of the Governing Board, individually or collectively, consent in writing or by electronic transmission to this action. Such written or electronic consent shall be filed with the minutes of the proceedings of the Governing Board.

3.12 Resignation and Removal. Any Governing Board member may resign by giving written notice to the Governing Board chair or to the Corporation's president. The resignation shall be effective when the notice is given unless it specifies a later time for the resignation to become effective. If a member's resignation is effective at a later time, the Corporate Board, on the Governing Board's recommendation, may appoint a successor to take office as of the date when the resignation becomes effective. Failure to attend three (3) consecutive meetings shall automatically be considered to be a resignation from the Governing Board, unless written reasons acceptable to the Governing Board chair are presented. A member of the Governing Board may be removed from office, at any time, either with or without cause, by the Corporate Board.

3.13 Compensation. The Governing Board members shall receive no compensation for their services as members of the Governing Board.

3.14 Governing Board Records. The Governing Board members shall keep, or cause to be kept at the Hospital, correct and complete books and records of accounts and correct and complete minutes of the proceedings of the Governing Board's meetings and the meetings of committees of the Governing Board, if any. Copies of any and all such minutes shall promptly be provided to the Corporate Board.

Article 4
Governing Board Officers

4.1 Officers. The officers of the Governing Board shall be a chair, a vice chair, and a secretary. Any number of offices may be held by the same person. Designation as an officer of the Governing Board shall not make such individual an officer of the Corporation.

4.2 Removal and Resignation of Officers. Any officer may be removed, at any time, either with or without cause, by the Corporate Board. Any officer may resign at any time by giving written notice to the Corporation's president, or to the chair or vice chair of the Governing Board. Any such resignation shall take effect upon receipt of such notice or at any later time specified therein. Unless otherwise specified therein, the acceptance of an officer's resignation by any person shall not be necessary to make it effective.

4.3 Vacancies. A vacancy in any office because of death, resignation, removal, disqualification, or any other cause shall be filled in the manner prescribed in these Governing Board Bylaws for regular election or appointment to such office.

4.4 Chair of the Governing Board. The chair of the Governing Board shall be Adventist Health's most senior corporate executive on the Governing Board or his designee. The chair shall preside at all meetings of the Governing Board and exercise and perform such other powers and duties as may be from time to time assigned by the Governing Board.

4.5 Vice Chair of the Governing Board. The vice chair of the Governing Board shall assist the chair in the conduct of the business of the Governing Board and shall preside at Governing Board meetings in the chair's absence. The vice chair shall be the president of the local conference of Seventh-day Adventist churches in the geographic area where the Corporation is located, or the local conference president's designee (who must be a senior officer of the local conference).

4.6 President. In the absence of both the chair of the Governing Board and the vice chair of the Governing Board, the Corporation's president shall preside at meetings of the Governing Board, provided that either the chair or vice chair has provided prior written approval for the Corporation's president to do so. The Governing Board will be consulted in the selection and retention of the Corporation's president. The chair of the Corporate Board shall appoint the Corporation's president. The Corporate Board has delegated to the Corporation's president the responsibility for the day-to-day management of the Hospital. The Corporation's president has been vested with broad authority and charged with a wide range of duties, including the duties set forth in the Corporate Bylaws, which duties shall be carried out in consultation with the chair of the Governing Board. The Corporation's president may be the chief executive officer of the Hospital, if designated by the Corporate Board chair, and shall have general supervision, direction and control of the day-to-day business and affairs of the Hospital. The Corporation's president shall also have such other powers and duties as may be prescribed by the Corporate Board or the Corporate Bylaws. The Corporation's president shall be primarily responsible for carrying out all proper orders and resolutions of the Governing Board.

4.7 Secretary. The Corporation's president shall serve as secretary of the Governing Board and shall attend all meetings of the Governing Board and record all the proceedings of the meetings of the Governing Board in a book to be kept for that purpose. The secretary shall give, or cause to be given, notice for all special meetings of the Governing Board, and shall perform such duties as may be prescribed by the Governing Board.

Article 5
Governing Board Operations

5.1 General Functions. The Governing Board performs its delegated duties as a committee-of-the-whole rather than through an executive committee or other committees.

5.2 Committees. In the event that a committee of the Governing Board must be designated, the committee shall operate in the following manner:

(a) The Governing Board, at its discretion, by resolution adopted by a majority of the authorized number of members, may designate one (1) or more committees, each of which shall be composed of two (2) or more Governing Board members, to serve at the pleasure of the Governing Board. The Governing Board may designate one (1) or more members as alternate members of any committee. Committees designated to deliberate issues directly affecting the discharge of medical staff responsibilities shall include at least one (1) Governing Board member who is also a member of the medical staff.

(b) The Governing Board may delegate to any committee, to the extent provided in the resolution, any of the Governing Board's powers and authority except that the committee may not appoint or reappoint any person as a member of the Hospital's medical staff if that person's application presents any question or doubt as to whether the person should be a member of the medical staff. The committee may, however, make such appointment or reappointment if there are no evident issues questioning the person's qualifications to be a medical staff member.

(c) The Governing Board may prescribe appropriate rules, not inconsistent with these Governing Board Bylaws, by which proceedings of any such committee shall be conducted. The provision of these Governing Board Bylaws relating to the calling of meetings of the Governing Board, notice of meetings of the Governing Board and waiver of such notice, adjournments of meetings of the Governing Board, written or electronic consents to Governing Board meetings and approval of minutes, action by the Governing Board by written or electronic consent without a meeting, the place of holding such meetings, the quorum for such meetings, the vote required at such meetings, and the withdrawal of members after commencement of a meeting shall apply to committees of the Governing Board and action by such committees. In addition, any member of the Governing Board serving as the chair or as secretary of the committee, or any two (2) members of the committee, may call meetings of the committee. Regular meetings of any committee may be held without notice if the time and place of such meetings are fixed by the Governing Board or the committee.

5.3 Medico-Administrative Liaison. The Corporation's president shall function as a liaison between the Governing Board and the medical staff.

5.4 Education Programs. The Corporation's president shall provide orientation and continuing education programs for members of the Governing Board.

5.5 Volunteer Program. The Governing Board may establish a volunteer services department of the Hospital. If the Governing Board establishes such a department, the Governing Board shall maintain proper oversight and management of Hospital volunteers by ensuring that all volunteers provide volunteer work only as members of the volunteer services department.

5.6 Role in Accreditation. The Governing Board shall assist Hospital administration, as requested, in the accreditation process, including participation by one or more Governing Board representatives in the Hospital's survey and its summation conference.

5.7 Strategic Planning. The Governing Board, through the Corporation's president, shall establish a strategic planning process to evaluate periodically the Hospital's goals, policies, and

programs. This strategic planning may be performed by a committee, which includes representatives of the Governing Board, administration, medical staff, nursing, and other departments/services as appropriate.

5.8 Compliance with Law and Regulations. The Governing Board, through the Corporation's president, shall take all reasonable steps to ensure that the Hospital is in conformance with applicable law and the requirements of authorized planning, regulatory, and inspection agencies.

5.9 Control of Physical and Financial Resources.

(a) Adventist Health maintains and operates its own financial and management information systems. The purchasing and materials management policies and procedures of Adventist Health govern the Hospital's procedures for the purchase, evaluation and distribution of supplies, and control of inventories.

(b) The Corporation carries property insurance, self-insures or self-retains to cover damage to or destruction of the Hospital's property and any financial loss due to theft or business interruptions, and has professional liability insurance, or self-insures or self-retains, for acts performed by employees of the Hospital or Hospital volunteers within the scope of their capacity and duties as employees or volunteers of the Hospital.

(c) The books of the Corporation shall be reviewed annually by an auditor selected by Adventist Health.

Article 6
Medical Staff

6.1 Organization. There exists a medical staff organization, known as the medical staff of the Hospital, whose membership is comprised of all physicians who are privileged to attend patients in the Hospital, and, where appropriate, such dentists, podiatrists, and psychologists who are privileged to attend patients in the Hospital.

6.2 Medical Staff Bylaws, Rules, and Regulations.

(a) Purpose. The medical staff shall propose and adopt by a majority vote bylaws, rules, and regulations for its internal governance, which shall be effective only when approved by the Governing Board, which approval shall not be unreasonably withheld. The medical staff bylaws shall create an effective administrative unit to discharge the functions and responsibilities assigned to the medical staff by the Governing Board. The medical staff bylaws, rules, and regulations shall state the purpose, functions, and organization of the staff, and shall set forth the policies by which the medical staff exercises and accounts for its delegated authority and responsibilities. The medical staff bylaws shall be supportive of the policies of the Corporation and the health care philosophy of the Church.

(b) Procedure. The medical staff shall have the initial responsibility to formulate, adopt, and recommend to the Governing Board medical staff bylaws and amendments thereto, which shall be effective when approved by the Governing Board. Proposed medical staff bylaws changes will be presented to a meeting of the Governing Board and

sent to each Governing Board member at least seven (7) days prior to the meeting at which a vote is to be taken on adoption of the proposed change. No medical staff bylaws or amendments shall become effective without approval by the Governing Board as provided above.

6.3 Medical Staff Membership and Clinical Privileges.

(a) Delegation to the Medical Staff. The Governing Board delegates to the medical staff the responsibility and authority to investigate and evaluate all matters relating to medical staff membership status, clinical privileges and corrective action, and requires that the staff adopt and forward to it specific written recommendations with appropriate supporting documentation that will allow the Governing Board to take informed action.

(b) Action by the Governing Board. The Governing Board shall take final action on all matters relating to the medical staff membership status, clinical privileges, and corrective action after considering the staff recommendations, and subject to any hearing rights under the fair hearing procedures set forth in the medical staff bylaws, provided that the Governing Board shall act in any event if the staff fails to adopt and submit any such recommendation within the time periods set forth in the medical staff bylaws. Such Governing Board action without a staff recommendation shall be taken only after appropriate notice to the staff and a reasonable time for the staff to act thereon and shall be based on the same kind of documented investigation and evaluation of current ability, judgment, and character as is required for staff recommendations. In the event the Governing Board does not concur in a medical staff recommendation, it shall refer the matter to a joint committee of the Governing Board and medical staff for review and recommendation before a final decision is made by the Governing Board.

(c) Criteria for Board Action. In acting on matters of medical staff membership status, the Governing Board shall consider the staff's recommendations, the needs of the Hospital and the community, and such additional criteria as are set forth in the medical staff bylaws. In granting and defining the scope of clinical privileges to be exercised by each practitioner, the Governing Board shall consider the staff's recommendations, the supporting information on which they are based, and such criteria as are set forth in the medical staff bylaws. No aspect of membership status nor specific clinical privileges shall be limited or denied to a practitioner on the basis of sex, age, race, creed, color, or national origin.

(d) Terms and Conditions of Staff Membership and Clinical Privileges. The terms and conditions of membership status in the medical staff and of the exercise of clinical privileges shall be as specified in the medical staff bylaws or as more specifically defined in the notice of individual appointment. Appointments to the medical staff may be for a maximum term of two (2) years.

(e) Procedure. The procedure to be followed by the medical staff and the Governing Board in acting on matters of membership status, clinical privileges, and corrective action shall be as specified in the medical staff bylaws, rules and regulations, and policies governing the medical staff.

6.4 Fair Hearing Procedures. The Governing Board shall require that any adverse recommendations made by the Executive Committee of the medical staff or any adverse action taken by the Governing Board with respect to a practitioner's staff appointment, reappointment,

department affiliation, staff category, admitting prerogative, or clinical privileges shall, except under circumstances for which specific provision is made in the medical staff bylaws and/or by contract, be accomplished in accordance with the Governing Board-approved fair hearing procedures then in effect. Such procedures shall be compliant with applicable law and shall ensure fair treatment and afford opportunity for the presentation of all pertinent information. For the purposes of this Section, an "**adverse recommendation**" of the Medical Staff Executive Committee and an "**adverse action**" of the Governing Board shall be as defined in the fair hearing procedures as indicated in the medical staff bylaws.

6.5 Allied Health Professionals. The Governing Board delegates to the medical staff the responsibility and authority to investigate and evaluate each category of allied health professional and each application by an allied health professional for specified services, department affiliation and modification in the services such allied health professional may perform, and requires that the staff or a designated component thereof make recommendations to it or to its designee thereon.

6.6 Department Chair. The Governing Board delegates to the medical staff the responsibility and authority to evaluate and elect candidates to serve as chair for each basic and supplemental medical service in accordance with the procedure and for the terms specified in the medical staff bylaws.

Article 7
Quality of Professional Services

7.1 Governing Board Responsibility. The Governing Board shall ensure:

(a) That the medical staff and administrative personnel prepare and maintain adequate and accurate medical records for all patients;

(b) That the person responsible for each basic and supplemental medical service cause written policies and procedures to be developed and maintained and that such policies be approved by the Governing Board; and

(c) That the medical staff conduct specific review and evaluation activities to assess, preserve, and improve the overall quality and efficiency of patient care in the Hospital. The Governing Board shall consider the recommendations of the medical staff respecting these review and evaluation activities and shall provide whatever administrative assistance is reasonably necessary to support and facilitate the implementation and ongoing operation of these review and evaluation activities.

7.2 Accountability to Governing Board. Subject to the ultimate authority of the Corporate Board, the medical staff shall conduct and be accountable to the Governing Board for conducting activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided in the Hospital. These activities shall include:

(a) Conducting periodic meetings at regular intervals to review and evaluate the quality of patient care (generally on a retrospective basis) through valid and reliable patient medical records;

(b) Monitoring and evaluating patient care, identifying and resolving problems, and identifying opportunities to improve care through the medical staff committee assigned to oversee quality in the medical staff bylaws. This mechanism is to ensure the provision of the same level of quality of patient care regardless of the patient's age, sex, religion, race, disability, or financial status. This mechanism is assured by all individuals with delineated clinical privileges, within medical staff departments, across department/services, between members and the nonmembers of the medical staff who have delineated clinical privileges, the other professional services, and the Hospital administration;

(c) Defining the clinical privileges for members of the medical staff commensurate with individual credentials and demonstrated ability and judgment, and assigning patient care responsibilities to other health care professionals consistent with individual licensure, qualifications, demonstrated ability, and approved clinical privileges;

(d) Providing for continuing professional education; and

(e) Providing for such other measures as the Governing Board may, after considering the advice of the medical staff and other professional services and the Hospital administration, deem necessary for the preservation and improvement of the quality and efficiency of patient care.

7.3 Documentation. The Governing Board shall require, receive, consider, and act upon the findings and recommendations emanating from the activities required in this Article. All such findings and recommendations shall be in writing and supported and accompanied by appropriate documentation upon which the Governing Board can take informed action.

Article 8
Indemnification; Insurance

8.1 Advancement of Expenses. To the fullest extent permitted by law and except as otherwise determined by the Corporate Board in a specific instance (and in the Corporate Board's sole and absolute discretion), expenses incurred by a member of the Governing Board seeking indemnification under this Article of these Governing Board Bylaws in defending any proceeding covered by this Article shall be advanced by the Corporation before final disposition of the proceeding, on receipt by the Corporation of an undertaking by or on behalf of that person that the advance will be repaid unless it is ultimately found that the person is entitled to be indemnified by the Corporation for those expenses. The Corporate Board must approve any advance to the Corporation's president under this Section, prior to such advance being paid to the Corporation's president.

8.2 Indemnification upon Successful Defense. If a Governing Board member is successful on the merits in defense of any proceeding, claim or other contested matter brought against the Governing Board member in connection with the Governing Board member's actions or omissions in relation to the Corporation, the Corporation shall indemnify the Governing Board member against that member's actual and reasonable expenses incurred in the defense against such proceeding or claim.

8.3 Indemnification upon Unsuccessful Defense.

(a) Mandatory Indemnification. To the maximum extent permitted by law, the Corporation shall indemnify each of its present and former Governing Board members as qualifying for this mandatory indemnification (each of whom is an "**indemnitee**") against expenses (collectively, "**payments**") actually and reasonably incurred by such indemnitee in connection with defending that indemnitee against an action or proceeding. Notwithstanding the above, mandatory indemnification shall be given to a potential indemnitee only if all of the following apply:

1. The potential indemnitee was not a Governing Board member who was removed from one or more of their positions with this Corporation;

2. The action or proceeding against the indemnitee is based on or relates to an action or inaction taken by the indemnitee on behalf of the Corporation and within the scope of the indemnitee's role or relationship with the Corporation;

3. The Corporate Board (excluding vacancies and directors who have a conflict of interest) has made all findings required by the Nonprofit Code (the indemnitee shall not be eligible to receive mandatory indemnification if such findings are not made by the Corporate Board); and

4. The potential indemnitee has not procured any illegal profit, remuneration or advantage, as determined by the Corporate Board in its sole discretion.

If a Governing Board member does not qualify for this mandatory indemnification, such Governing Board member might still receive discretionary indemnification as outlined below.

(b) Discretionary Indemnification. To the maximum extent permitted by law, the Corporate Board may in its sole discretion, by a majority vote (excluding vacancies and directors with a conflict of interest), indemnify a Governing Board member (including former Governing Board members who were removed by the Corporate Board or Governing Board members not entitled to mandatory indemnification) (each of which is a "**recipient**") against any or all of the expenses, judgments, fines, settlements or other amounts actually and reasonably incurred by such recipient in connection with an action or proceeding against the recipient, subject to the following:

1. The action or proceeding against the recipient must be based on or relate to an action or inaction taken by the recipient on behalf of the Corporation and within the scope of the recipient's role or relationship with the Corporation;

2. The Corporate Board (excluding vacancies and directors who have a conflict of interest) must have made all findings required by the Nonprofit Code (the recipient shall not be eligible to receive this discretionary indemnification if such findings are not made by the Corporate Board); and

3. Indemnification is not available if the recipient is found to have procured illegal profit, remuneration or advantage.

8.4 Insurance. The Corporation shall have the power to purchase and maintain insurance on behalf of any member of the Governing Board against any liability asserted against or incurred by that Governing Board member in such capacity or arising out of the Governing Board member's

status as such whether or not the Corporation would have the power to indemnify that person against such liability under the provisions of this Article.

Article 9
General Provisions

9.1 Evaluation of Performance. The Governing Board shall establish a mechanism to evaluate its own performance on an annual basis.

9.2 Review and Amendment of Governing Board Bylaws. A bylaws committee, appointed by the Corporate Board, shall review these Governing Board Bylaws annually. Recommended amendments to the Governing Board Bylaws shall be forwarded to the Corporate Board for its decision. Any recommended amendments shall not be effective unless adopted by the Corporate Board. These Governing Board Bylaws may only be amended or repealed, and new Governing Board Bylaws adopted, by a vote of the Corporate Board.

9.3 Corporate Bylaws. If any provision of these Governing Board Bylaws conflicts with the Corporate Articles or Corporate Bylaws, then the provision in the Corporate Articles or Corporate Bylaws shall prevail.

9.4 Electronic Transmission.

(a) "**Electronic transmission by the Corporation**" means a communication (1) delivered by (A) facsimile telecommunication or electronic mail when directed to the facsimile number or electronic mail address for that recipient on record with the Corporation; (B) posting on an electronic message board or network which the Corporation has designated for those communications, together with a separate notice to the recipient, which transmission shall be considered delivered upon the later of the posting or delivery of the separate notice thereof; or (C) other means of electronic communication; (2) to a recipient who has provided an unrevoked consent to the use of those means of transmission for communications pursuant to the Nonprofit Code; and (3) that creates a record that is capable of retention, retrieval, and review, and that may thereafter be rendered into clearly legible tangible form.

(b) An electronic transmission to a Governing Board member must be preceded by or include a clear written statement to the recipient as to (1) any right of the recipient to have the record provided or made available on paper or in nonelectronic form; (2) whether the consent applies only to that transmission, to specified categories of communications, or to all communications from the Corporation; and (3) the procedures the recipient must use to withdraw consent.

(c) "**Electronic transmission to the Corporation**" means a communication (1) delivered by (A) facsimile telecommunication or electronic mail when directed to the facsimile number or electronic mail address which the Corporation has provided to Governing Board members for communications; (B) posting on an electronic message board or network which the Corporation has designated for those communications, which transmission shall be considered delivered upon posting; or (C) other means of electronic communication; (2) as to which the Corporation has placed in effect reasonable measures to verify that the sender is the Governing Board member purporting to send the

transmission; and (3) that creates a record that is capable of retention, retrieval, and review, and that may thereafter be rendered into clearly legible tangible form.

(d) "**Electronic transmission**" means any combination of electronic transmission by or to the Corporation.

Adopted by the Corporate Board on_____, 20__.

By: _____
Meredith Jobe, Secretary

Exhibit 3.1

OBSTETRICS SOLUTION

Adventist Health will build an obstetrical unit with a minimum of twelve (12) beds at Delano (the "***OB Unit***"), to be complete within five (5) years following the Closing. While the final plan of the construction has not been established as of the Execution Date, the OB Unit will have the following characteristics and attributes:

1) The OB Unit will be street fronting with good street visibility;
2) The OB Unit will have a separate entrance;
3) The OB Unit will have at least twelve (12) separate individual patient rooms;
4) The OB Unit will consist of either (a) all labor, delivery, recovery and postpartum ("***LDRP***") beds, or (b) a combination of LDRP and post-partum beds; and
5) The OB Unit will have separate Cesarean-section ("***C-section***"), recovery and observation areas.

The ultimate layout will be influenced by overflow considerations, reimbursement analysis, visual appeal, and parking considerations.

Exhibit 3.3

DELANO LONG-TERM DEBT

Certificates of Participation, Series 2012, original amount of $27,695,000, collateralized by a pledge of revenues, principal payments due through January 2025, interest payments payable annually on January 1 at rates varying from 2.00% to 5.00%.

At December 31, 2017, balance	$20,950,000
Less bond issue cost, net	(292,432)
Add unamortized premium	992,859
Less current portion	(2,260,000)
	$19,390,427

Exhibit 3.7

CLINICAL SERVICES

General Acute Care (Licensed by CA for 105 Acute Care and 51 Skilled Nursing Beds) and for the following services:
Perinatal Services, Intensive Care, Unspecified General Acute Care, Basic Emergency, Nuclear Medicine, Occupational Therapy, Outpatient Clinics, Diagnostic Imaging, Physical Therapy, Podiatry Services, Social Services, Speech Pathology, Birthing Suites, Nursery, Blood Bank, Dialysis, Long Term Care, OB/GYN, Pathology, Pediatrics, Radiology, Mammography, Sleep Lab and Hospital Based Clinics

Exhibit 3.9(a)

AH CHARITY POLICY

(See Attached)

☐ **Facility:**
☒ **System-wide Corporate Policy** | **Policy No.** | **PFS-112**
☒ **Standard Policy** | **Page** | **1 of 18**
☐ **Model Policy:** | **Department:** | **Revenue Management**

POLICY: Patient Billing: Financial Assistance

I. PURPOSE

Adventist Health (AH) facilities exist to serve patients. They are built on a team of dedicated health care professionals – physicians, nurses and other health care professionals, management, trustees, and volunteers. Collectively, these individuals protect the health of their communities. Their ability to serve well requires a relationship with their communities built on trust and compassion. Through mutual trust and goodwill, Adventist Health and patients will be able to meet their responsibilities. These principles and guidelines are intended to strengthen that relationship and to reassure patients, regardless of their ability to pay, of AH's commitment to caring.

The purpose of this policy is to enact and ensure a fair, non-discriminatory, consistent, and uniform method for the review and completion of charitable emergency and other Medically Necessary care for individuals of our community who may be in need of Financial Assistance.

It is the intent of this policy to comply with all federal, state, and local regulations.

II. DEFINITIONS

Allowable Medical Expenses: Total Family Members' medical expenses that would be deductible for federal income tax purposes without regard to whether the expenses exceed the medical expense deduction allowed by the IRS. Paid and unpaid bills may be included.

Amount Generally Billed (AGB): The charge amount generally collected from individuals who have insurance covering such care at AH. The method used to calculate the AGB is a historical look-back method based on actual paid claims for Medicare fee-for-service together with all private health insurers, including portions paid by insured individuals.

Billed Charges: Charges for services by AH as published in the charge description master (CDM).

Charity Care: Full charity or free care is provided when the patient is not expected to pay or pay only a nominal amount of the Billed Charges.

Discounted Care: Facility determines that the patient does not qualify for Charity Care, but is eligible for a discount and is expected to pay only a portion of Billed Charges.

Emergency Medical Care: Refers to Emergency Services and Care as defined in the AH policy in "compliance with the Emergency Medical Treatment and Labor Act (EMTALA)."

Essential Living Expenses (ELE): Any of the following: rent or house payment and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child or spousal support, transportation and auto expenses - including insurance, gas, and repairs, installment payments, laundry and cleaning, and other extraordinary expenses.

Family Members*:* Family Members of **persons 18 years and older** include spouse, domestic partner as defined by the state where the facility is licensed, and dependent children under 21 years, whether living at home or not. Family Members of **persons under 18 years** include parents, caretaker relatives and other children less than 21 years of age of the parent or caretaker relative, whether living at home or not.

Federal Income Tax Return: The form which is submitted to the IRS for purpose of reporting taxable income. The form must be a copy of the signed and dated form submitted to the IRS.

Federal Poverty Level (FPL): The income level set by the federal government that establishes households living above or below defined poverty or subsistence annual incomes.

Financial Assistance: An AH program that will prospectively or retroactively reduce the amount owed by an Uninsured Patient or Underinsured Patient for AH Billed Charges.

High Medical Costs: Defined as any of the following: a) annual Out-of-Pocket Costs incurred by the individual at the facility that exceed ten percent (10%) of the patient's family income in the prior 12 months; OR b) annual Out-of-Pocket expenses that exceed ten percent (10%) of the patient's family income, if the patient provides documentation of the patient's medical expenses paid by the patient or the patient's family in the prior 12 months.

Household Income: Income of all Family Members who reside in the same household as the patient, or at the address the patient uses on tax returns or other government documents as the home address.

Limited English Proficiency (LEP) group: A group that constitutes the lesser of 1,000 individuals or five percent (5%) of the community served by the facility, or the populations likely to be affected or encountered by the facility. The facility may use any reasonable method to determine the number or percentage of LEP patients likely affected or encountered by the facility.

Medically Necessary: A service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. See California Welfare & Institutions Code §14059.5.

Out-of-Pocket Costs: Costs which the patient pays from personal funds.

Patient Financial Services (PFS): AH department responsible for billing, collection, and payment processing.

Payment Plan: Plan that sets a series of payments over a period of time to satisfy the patient-owed amounts of AH Billed Charges. Monthly payments are not more than ten percent (10%) of a patient's family income for a month, excluding deductions for Essential Living Expenses.

Qualifying Assets: Monetary assets that are counted toward the patient's income in determining if the patient will meet the income eligibility for the program. For purposes of this policy, "Qualifying Assets": 1) include 50% of the patient's monetary assets in excess of $10,000, including cash, stocks, bonds, savings accounts, or other bank accounts; 2) exclude IRS qualified retirement plans, such as IRAs, 401(k) or 403(b) retirement accounts, or deferred-compensation plans; 3) exclude certain real property or tangible assets (primary residences, automobiles, etc.; however, additional residences in excess of a single primary residence and recreational vehicles may be included).

Qualifying Patient: Patient who meets the financial qualifications for the Financial Assistance program as defined in Section III.C.

Self-Pay Liability: Any balance due when the financially responsible party is the patient or the patient's guarantor (not a third-party payer).

Third-party Insurance: An entity (corporation, company health plan or trust, automobile medical pay benefit, workers' compensation, etc.) other than the patient that will pay all or a portion of the patient's medical bills.

Uninsured Patient: A patient who does not have third-party insurance from a health insurer, health care service plan, Medicare or Medicaid, and whose injury is not a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance as determined and documented by the facility.

Underinsured Patient A patient who has some level of Third-party insurance or assistance but still has Out-of-Pocket Costs that exceed the patient's financial abilities

III. POLICY

AH is committed to providing Financial Assistance to patients who have sought Emergency Medical Care or Medically Necessary care but have limited or no means to pay for that care. Financial Assistance refers to what is commonly known as Charity Care and Discounted Care. AH will provide, without discrimination, Emergency Medical Care or Medically Necessary care as defined in this policy, to individuals regardless of their ability to pay, their eligibility under this policy, or eligibility for government assistance.

Accordingly, this written policy:

- Includes eligibility criteria for Financial Assistance – Charity (free) and Discounted (partial charity) Care;
- Describes the basis for calculating amounts charged to patients eligible for Financial Assistance under this policy;
- Describes the method by which patients may apply for Financial Assistance;
- Describes how the facility will widely publicize the policy within the community served by the facility; and
- Limits the amounts the facility will charge for Emergency Medical Care or other Medically Necessary care provided to individuals eligible for Financial Assistance to an amount equal to or below the Amount Generally Billed (received by) the facility

Charity is not considered to be a substitute for personal responsibility. Patients are expected to cooperate with the facility's procedures for obtaining charity or other forms of payment or Financial Assistance, and to contribute to the cost of their care based on their individual ability to pay. Individuals with the financial capacity to purchase health insurance will be encouraged to do so, as a means of assuring access to health care services for their overall personal health and for the protection of their individual assets.

A. Qualifying Care Under This Policy

This policy shall apply to any Emergency Medical Care or other Medically Necessary care provided at AH owned and operated, facilities listed in Appendix A. AH facilities that provide billing services for emergency room physicians are required to treat the physician charges in the same manner as the facility charges relevant to charity and uninsured discount procedures.

Emergency room physicians who provide emergency medical services in a general acute care facility are excluded from this policy unless listed as a "Covered Provider" in the documentation from Appendix C. These physicians should, and in California are required to, have their own Financial Assistance policies to limit expected payment from eligible patients that are uninsured or have High Medical Costs who are at or below 350% of the Federal Poverty Level. Patients who are uninsured or have High Medical Costs and income at or below 350% of the Federal Poverty Level and receive a bill from an emergency room physician should contact that physician's office and inquire about their Financial Assistance policy.

B. Communication of Financial Assistance

Adventist Health provides notice of the availability of Financial Assistance by various means, which may include, but are not limited to, the publication of posted, conspicuous notices in emergency rooms, in the Conditions of Registration form, in admitting and registration areas, in facility Patient Financial Services, and other public places as the facility may elect. One post-discharge billing statement will include standard language informing patients they may request financial screening to determine eligibility for Financial Assistance and how the request may be made. At no cost to the patient, the facility shall publish and widely publicize a plain language summary of this Financial Assistance policy and the policy itself on the facility website, in brochures, by mail and at other places within the community served by the facility as the facility may elect. Such notices and summary information shall be provided in the primary languages of the

patient when the patient is identified as being within a Limited English Proficiency (LEP) group. In addition to the above, AH provides individual notice of Financial Assistance availability to any patient who may be at risk of meeting their financial responsibility. Referral of patients for Financial Assistance may be made by any member of the facility staff or medical staff. A request for charity may be made by the patient or his or her guardian or family member, subject to applicable privacy laws.

Individuals can receive information about the Financial Assistance policy, free of charge, by calling 1-844-827-5047 or writing to:

Adventist Health
ATTN: Financial Assistance
PO Box 619122
Roseville, CA 95661

C. Eligibility for Financial Assistance

Eligibility for Financial Assistance will be considered for those individuals who are uninsured and underinsured with High Medical Costs and who are unable to pay for their care, based upon a determination of financial need in accordance with this policy. Any decisions made under this policy, including the decision to grant or deny Financial Assistance, shall be based on an individualized determination of financial need, and shall not take into account race, color, national origin, citizenship, religion, creed, gender, sexual preference, age, or disability.

Medicaid Share of Cost (SOC) amounts are not eligible for Financial Assistance, as the SOC is determined by the state to be an amount the patient must pay before the patient is eligible for Medicaid

A patient may qualify for Financial Assistance under this policy if they meet one of the following guidelines based on income or expenses.

1. Income. A patient is eligible to receive Charity or Discounted Care based on income under this policy if Household Income (as defined in policy) is at or below 400% of the FPL.

2. Expenses. Patients not eligible based on income may be eligible for Financial Assistance through an exception-based review if their Allowable Medical Expenses have depleted the family's income and resources so that they are unable to pay for eligible services. The following two qualifications must both apply:

    a. Expenses: The patient's Allowable Medical Expenses must be greater than 50% of the Household Income.
    b. Resources: The patient's excess medical expenses (the amount by which Allowable Medical Expenses exceed 50% of the Household Income) must be greater than available Qualifying Assets

Charity Care: In determining eligibility for Charity Care, also known as free care, Household Income and Qualifying Assets do not exceed an amount equal to 200% of the Federal Poverty Level.

Emergency and Medically Necessary Care

Uninsured Patients	
Family Income	Amounts Charged
200% or less of the Federal Poverty Level	Zero

Discounted Care: In determining eligibility for **Discounted Care**, documentation of income shall include recent pay stubs or income tax returns.

Emergency and Medically Necessary Care

Uninsured Patients	
Family income	Amounts Charged
> 200% to 300% of the Federal Poverty Level	50% of the Amount Generally Billed
>300% to 400% of the Federal Poverty Level	75% of the Amount Generally Billed
>400% of the Federal Poverty Level	Not covered under the Financial Assistance Policy, refer to the Uninsured Discount Policy

Patients with Commercial Insurance or non-Contracted Managed Care plans & High Medical Costs	
Family Income	Amounts Charged
400% or less of the Federal Poverty Level	The amount that would be allowed by the Amount Generally Billed for the same service LESS the amount paid by the patient's insurer. If the insurer paid an amount equal to or greater than the Amount Generally Billed, patient liability is zero.
>400% of the Federal Poverty Level	Not covered under the Financial Assistance Policy, the patient is responsible for their Self-Pay Liability amount

Non-Emergency and non-Medically Necessary Care

Uninsured Patients	
Family income	Amounts Charged
200% or less of the Federal Poverty Level	50% of the Amount Generally Billed
>200% to 400% of the Federal Poverty Level	100% of the Amount Generally Billed
>400% of the Federal Poverty Level	Not covered under the Financial Assistance Policy, refer to the Uninsured Discount Policy

Patients with Commercial Insurance or non-Contracted Managed Care plans & High Medical Costs	
Family Income	Patient Liability
350% or less of the Federal Poverty Level	The amount that would be allowed by the Amount Generally Billed for the same service LESS the amount paid by the patient's insurer. If the insurer

	paid an amount equal to or greater than the Amount Generally Billed, patient liability is zero.
>350% of the Federal Poverty Level	Not covered under the Financial Assistance Policy; the patient is responsible for their Self-Pay Liability amount

D. Method by Which Patients May Apply for Financial Assistance

1. In order to qualify for Financial Assistance under this Policy, a patient or guarantor must:

   a. Cooperate with AH in identifying and determining alternative sources of payment or coverage from public and private payment programs;
   b. Submit a true, accurate and complete confidential Financial Assistance application within 240 days of the first post-discharge billing statement;
   b. AH staff members including financial counselors and Patient Financial Services staff can assist individuals who request or require assistance to complete an application;
   c. Provide a copy of patient's or guarantor's most recent pay stub (or certify that he or she is currently unemployed);
   d. Provide a copy of patient's or guarantor's most recent Federal Income Tax Return (including all schedules); and
   e. Provide such documents and information regarding patient's or guarantors' monetary assets as may be reasonably requested by AH.

2. If the patient has Third-party insurance that would have covered the qualifying services, the patient or guarantor is responsible for complying with the conditions of coverage for their health insurance. Failure to do so, when the patient could have reasonably complied, may result in a denial of eligibility under the Financial Assistance program.

3. An uncooperative patient is any patient or guarantor who is unwilling to disclose the necessary financial information as requested for Medicaid and/or Financial Assistance determination during the application process. Uncooperative patients or guarantors will be notified in writing that unless they comply and provide information, no further consideration will be given for Financial Assistance processing and standard A/R follow-up will commence.

4. AH values of human dignity and stewardship shall be reflected in the application process, financial need determination, and granting of Financial Assistance.

5. AH shall not use any information submitted by a patient regarding the patient's monetary assets in connection with his or her application for any collection activities of AH. Information provided by the patient regarding the patient's monetary assets will only be used for the determination of whether or not such patient qualifies for Financial Assistance under this policy.

E. Eligibility for Other Government Programs

The facility shall make all reasonable efforts to obtain from the patient or his or her representative information about whether private or public health insurance or sponsorship may fully or partially cover the charges for care rendered to a patient, including but not limited to, any of the following:

1. Private health insurance, including coverage offered through the Health Benefit Exchange;

2. Medicare; or

3. The Medicaid program, the Healthy Families Program, the Children's Services program, or other state-funded programs designed to provide health coverage.

If a patient applies, or has a pending application, for another health coverage program at the same time that he or she applies for a facility Financial Assistance program, neither application shall preclude eligibility for the other program.

F. Presumptive Financial Assistance Eligibility

On an individual patient basis, the staff or management member of Patient Financial Services will complete an internal Financial Assistance application to include a full explanation of:

1. The reason the patient or patient's guarantor cannot apply on his/her own behalf, and the patient's documented extenuating medical or socio-economic circumstances that preclude the patient or patient's guarantor from completing the application.

2. AH may also assign accounts to presumptive Charity Care eligibility, without a Financial Assistance application submitted by the patient, based on predetermined criteria collected from approved sources. These criteria include:

    a. The patient having documented in his/her medical record as being homeless or verification received through AH or a family member that the patient is expired with no known estate or currently incarcerated; **OR**

    b. The patient qualifies for a public benefit program including Social Security, Unemployment Insurance Benefits, Medicaid, County Indigent Health, AFDC, Food Stamps, WIC, or other similar indigence-related programs with eligibility requirements that reasonably meet the qualifications for the AH Financial Assistance program; **OR**

    c. After normal collection efforts have not produced any payment and the patient has been unable to complete a Financial Assistance application, or comply with requests for documentation, or is otherwise nonresponsive to the application process the account will be screened for presumptive eligibility using demographic software. As a result, these accounts may be screened for the patient's qualification for Financial Assistance without completing the formal assistance application. Under these circumstances, an AH facility will utilize other sources of information to make an individual assessment of financial need. This information will enable AH to make an informed decision on the financial need of nonresponsive patients utilizing the best estimates available in the absence of information provided directly by the patient.

        AH facilities will utilize a third-party to conduct an electronic review of patient information to assess financial need. This review utilizes a healthcare industry-recognized model that is based on public record databases. This predictive model incorporates public record data to calculate a socio-economic and financial capacity score that includes estimates for income, assets and liquidity. The electronic technology is designed to assess each patient to the same standards as the traditional application process.

        The electronic technology will be deployed prior to bad debt assignment after all other eligibility and payment sources have been exhausted. This allows AH facilities to screen all patients for financial assistance prior to pursuing any extraordinary collection actions. The data returned from this electronic eligibility review will constitute adequate documentation of financial need to qualify at 200% FPL or less for retrospective dates only.

        Patient accounts granted presumptive eligibility will be reclassified under the Financial Assistance policy. They will not be sent to collection, will not be subject to further collection actions, will not be notified of their qualification and will not be included in the facility's bad debt expense.

G. Eligibility Period

If a patient qualifies for Charity Care or Discounted Care for a specific eligible service or facility stay, a retroactive Financial Assistance discount will be applied to all patient balances for eligible services prior to the application approval date. Also, any eligible services for an additional 180 days after the approval date of an application will qualify for a Financial Assistance discount. For any services that occur 180 days after the application approval date, the patient must submit a new application to be considered for Financial Assistance for that episode of care.

H. Refund of Amounts Previously Paid

In the event a patient pays all or part of his or her bill for services rendered, and is subsequently determined to qualify for Charity Care or Discounted Care under this policy, AH shall promptly refund to the patient the amount of any such overpayment made to AH.

I. Appeal Regarding Application of this Policy

In the event any patient believes his or her application for Financial Assistance was not properly considered in accordance with this policy, or he or she otherwise disagrees with the application of this policy in his or her case, a patient may submit a written request for reconsideration to the Chief Financial Officer (CFO) of the AH facility where the eligible services were rendered who shall be the final level of appeal.

J. Billing and Collection

AH facilities will follow standard procedures for assignment to collection agencies including levels of authorization. Collection agency contracts will define the agencies' scope of practices that includes collection practices within this policy as well as a requirement to report to an AH facility when a patient indicates that they are financially unable to pay their bill.

Before commencing any collection activity against a patient, the facility must provide a plain language summary of the patient's rights. The summary language will be sufficient if it appears in substantially the following form:

> "State and federal law require debt collectors to treat you fairly and prohibit debt collectors from making false statements or threats of violence, using obscene or profane language, and making improper communications with third parties, including your employer. Except under unusual circumstances, debt collectors may not contact you before 8:00 a.m. or after 9:00 p.m. In general, a debt collector may contact another person to confirm your location or to enforce a judgment. For more information about debt collection activities, you may contact the Federal Trade Commission by telephone at 1-877-FTC-HELP (382-4357) or online at www.ftc.gov."

The facility must also include a statement that nonprofit credit counseling services may be available in the area. The above wording will be incorporated into a data mailer attachment and be included in the initial data mailer for all patient liabilities.

AH facilities will halt collection efforts from a patient or guarantor while they are in the process of applying for government assistance programs, such as Medicaid, which includes any time necessary to appeal an eligibility determination. When the facility determines the individual is not eligible for coverage for which they have applied or failed to cooperate, then collection efforts can continue. Any failure to meet eligibility requirements or failure to cooperate must be thoroughly documented.

Upon submission of a Financial Assistance application for a patient or guarantor, all collection activity will cease until a determination has been made and the patient is notified of that determination. The determination must be communicated to the patient by sending the letter found in Exhibit B (English or in a Limited English Proficiency language that meets definition).

In cases where the patient or the patient's guarantor is approved for Charity Care under the Financial Assistance program, then all collection efforts will cease and reasonable efforts must be made to reverse any extraordinary collection actions taken against the patient or the patient's guarantor.

In cases where the patient or the patient's guarantor is approved for Discounted Care with a liability under the Financial Assistance program, the facility may negotiate a reasonable monthly Payment Plan when requested to do so by the patient or guarantor with the patient or guarantor and will not send unpaid bills to outside collection agencies, and will cease any extraordinary collection actions. Any extended Payment Plan agreed to by the facility to assist patients eligible under the facilities' Financial Assistance policy shall be interest free. Extended Payment Plans may be declared inoperative when the patient or guarantor fails to make all consecutive payments due during a 90-day period. Before declaring the agreement inoperative, the facility or collection agency will make a reasonable attempt to contact the patient by phone and, to give notice in writing, that the extended Payment Plan may become inoperative, and of the opportunity to renegotiate the extended Payment Plan. Before the facility can declare the extended Payment Plan inoperative, they must attempt to renegotiate the terms of the defaulted extended Payment Plan, if requested by the patient or their guarantor. Neither the facility nor the collection agency may report adverse information to a credit-reporting bureau before the extended Payment Plan has been declared inoperative.

AH facilities and collection agencies will not engage in any **extraordinary collection actions** such as wage garnishments, selling the debt, reporting debt to credit bureau(s), requiring payment prior to delivery of care, liens on primary residences, or other legal actions for any patient, within 241 days of the first post-discharge patient billing statement .

The facility and collection agencies will make reasonable efforts to notify the patient prior to engaging in any extraordinary collection actions. Reasonable actions include providing written notice of the Financial Assistance policy, providing a written Plain Language Summary, identifying and notifying of the specific extraordinary collection action in writing that will be performed, and making reasonable efforts to verbally notify the patient or guarantor. All of these actions are required to take place at least 30 days prior to performing any extraordinary collection actions to allow reasonable time to respond to the notice.

In those cases where the collection agency has an indication the patient or guarantor has the ability to pay for the medical services received but is refusing to do so, the agency may be permitted to take legal action to collect the unpaid balance as long as it is not within 240 days of the first post-discharge billing statement. When the agency has determined that legal action is appropriate and criteria for extraordinary collection actions have been met, the agency must forward an individual written request to the facility's CFO for approval prior to taking any legal action. The request must include all the particulars of the encounter including a copy of the agency's documentation that led them to believe that the patient or guarantor has the ability to pay for the services. The facility CFO must approve each individual legal action in writing. This authority may not be delegated by the CFO. Facilities must maintain a permanent copy of the signed authorization for legal action and there must be a notation in the electronic PFS patient account notes. In no case will the agency be allowed to file a legal action as a last resort to motivate the patient to pay when they have no information as to the patient or guarantors financial means.

K. Patient/Family Education

Provided through publication of this policy on the AH website, direct education from financial counselors, and posted information as outlined in this policy (Section III.B.).

L. Documentation

Confidential Financial Assistance application (See Exhibit A to this policy.)

M. List of Covered Providers

The list of Covered and Noncovered providers, in Appendix C of this policy, who deliver Emergency Medical Care and other Medically Necessary care within the facility will be maintained at least quarterly, and made available using methods described in the section III.B. of this policy.

N. Financial Assistance Standard Procedures

The facility will adhere to standard internal procedures to administer the Financial Assistance policy that are maintained in a separate Financial Assistance procedures document published by AH.

O. Authorized Body

Adventist Health Legal Board of Directors is the authorized body to approve this policy and any subsequent changes to this policy.

AUTHOR: Patient Financial Services
APPROVED: Revenue Cycle Governance 9/18/2015; Exec Cabinet 12/1/2014; Board Approved 12/15/2015
EFFECTIVE DATE: 12/29/2015
REVIEWED: 11/12/14; REVISION: 12/21/09, 1/25/11, 6/3/2011, 1/27/11, 5/13/13, 2/3/14, Nov 2014 (SB1276), 1/22/15 (revised FPL); 12/17/2015 (501(r)); 4/19/17 (revised PFS); 3/1/18 (revised FPL & AGB rates)
DISTRIBUTION: PFS Directors, CFOs

EXHIBIT A

Patient Name_____	**Facility:** **DOS:**
Patient Number_____	**Confidential Financial Statement (Application)**

RESPONSIBLE PARTY

Name		Marital Status	Social Security Number
Street Address, City, State, Zip		How long at this address	Home Phone
Employers Name and Address (If Unemployed –How Long)			Business Phone
Position / Title	Monthly income – Gross	Monthly income - Net	Length of current employment

SPOUSE

Name			Social Security Number
Employer Name and Address			Business Phone
Position / Title	Monthly income – Gross	Monthly income – Net	Length of current employment

DEPENDENTS

Name & Year of Birth of all dependents in household	Total Number of dependents in household____	Do Any Other Persons Contribute? If Yes, Amount: Yes/No _____ Amount _____

INCOME PER MONTH & ASSETS

Dividends, Interest	$	Child Support / Alimony	$
Public Assistance / Food Stamps	$	Rental Income	$
Social Security	$	Grants	$
Unemployment Compensation	$	IRA	$
Workers' Compensation	$	Other	$
Savings	$		

EXPENSES PER MONTH

Mortgage / Rent Payment:	$	Balance: $	Medical / Dental		$
Own Home? (Yes/No)			Doctor – Name		$
Food	$		Doctor – Name		$
Utilities:	$		Doctor – Name		$
Electric	$		Credit Cards:		$
Gas	$		Visa	Limit	$
Water / Sewer	$		Mastercard	Limit	$
Trash	$		Discover	Limit	$
Phone	$		Other	Limit	$
Cable	$		Installment Loans		$
Auto Payments	$		Child Support		$
Auto Expenses	$		Miscellaneous Expenses		$
Insurance:					
Auto Premium	$				
Life Insurance	$				
Health Insurance	$				

OFFICE USE ONLY
Gross income_____
Net income_____
Total Expenses_____
Total Net income(loss)_____

To my knowledge the information provided above is true.

_____ _____
PATIENT/GUARANTOR SIGNATURE DATE

EXHIBIT B

Facility Name
Facility Address
Facility Phone

Date

Guarantor Name
Guarantor Address

RE: Account Number:
Patient Name:
Dates of Service:
Account Balance:

- ❑ Your account has been reviewed for possible charity assistance. After review of all of your submitted financial documentation it has been determined you do meet eligibility guidelines for full charity assistance on this account.
- ❑ Your account has been reviewed for possible charity assistance. After review of all of your submitted financial documentation it has been determined you do not meet eligibility guidelines for full charity assistance on this account.
- ❑ Your account has been reviewed for possible charity assistance. After review of all of your submitted financial documentation it has been determined you meet eligibility guidelines for partial charity assistance on this account. (account balance) is the remaining portion, which is your responsibility to pay.

If you believe this decision is in error, you have the right to submit an appeal. Your appeal must be made in writing, addressed to the Patient Financial Services Director and mailed to the address on this letter.

If you have any questions, please feel free to contact us at (facility phone) during normal business hours.

Patient Financial Services Department
Facility Name
Facility Phone Number

EXHIBIT C

2018 FEDERAL POVERTY LEVELs (FPL)

Persons in family	48 Contiguous States and the District of Columbia	Alaska	Hawaii
1	$12,140	$15,180	$13,960
2	16,460	20,580	18,930
3	20,780	25,980	23,900
4	25,100	31,380	28,870
5	29,420	36,780	33,840
6	33,740	42,180	38,810
7	38,060	47,580	43,780
8	42,380	52,980	48,750
For each additional person, add	4,320	5,400	4,970

http://www.aspe.hhs.gov/poverty/

APPENDIX A

COVERED FACILITY LIST

List of Adventist Health facilities covered under this policy:

Doing Business As (DBA)
Adventist Health Hanford
Adventist Medical Center - Portland
Adventist Health Reedley
Adventist Health Tehachapi Valley
Adventist Health Selma
Adventist Health Castle
Adventist Health Feather River
Adventist Health Glendale
Adventist Health Howard Memorial
Adventist Health Lodi Memorial
Adventist Health Clear Lake
Adventist Health St. Helena
Adventist Health Vallejo
Adventist Health Bakersfield
Adventist Health Simi Valley
Adventist Health Sonora
Tillamook Regional Medical Center
Adventist Health Ukiah Valley
Adventist Health White Memorial
Adventist Health Physicians Network
Western Health Resources

APPENDIX B

Amount Generally Billed (AGB) for facilities in California:

AGB Table #1

The method used to calculate the AGB is a historical look-back method based on actual paid claims for Medicare fee-for-service, including portions paid by insured individuals. A single average percentage of gross charges, or multiple percentages for separate categories of care or separate items or services. The AGB rate will be updated annually on January 1st of each year and implemented within 120 days of any AGB rate change

Facility	Service	Effective	AGB Rate
Adventist Health Hanford	All Services	3/1/2018	25%
Adventist Health Selma	All Services	3/1/2018	25%
Adventist Health Reedley	All Services	3/1/2018	11%
Adventist Health Tehachapi Valley	All Services	3/1/2018	38%
Adventist Health Feather River	All Services	3/1/2018	13%
Adventist Health Glendale	All Services	3/1/2018	18%
Adventist Health Howard Memorial	All Services	3/1/2018	35%
Adventist Health Lodi Memorial	All Services	3/1/2018	12%
Adventist Health Clear Lake	All Services	3/1/2018	30%
Adventist Health St. Helena	All Services	3/1/2018	15%

Adventist Health Vallejo	All Services	3/1/2018	15%
Adventist Health Bakersfield	All Services	3/1/2018	17%
Adventist Health Simi Valley	All Services	3/1/2018	15%
Adventist Health Sonora	All Services	3/1/2018	22%
Adventist Health Ukiah Valley	All Services	3/1/2018	18%
Adventist Health White Memorial	All Services	3/1/2018	20%

Amount Generally Billed (AGB) for facilities in Oregon, Washington and Hawaii:

AGB Table #2

The method used to calculate the AGB is a historical look-back method based on actual paid claims for Medicare fee-for-service together with all private health insurers, including portions paid by insured individuals. A single average percentage of gross charges, or multiple percentages for separate categories of care or separate items or services. The AGB rate will be updated annually on January 1st of each year and implemented within 120 days of any AGB rate change.

Facility	Service	Effective	AGB Rate
Adventist Medical Center - Portland	All Services	3/1/2018	29%
Adventist Health Castle	All Services	3/1/2018	38%
Tillamook Regional Medical Center	All Services	3/1/2018	46%

AGB Table #3

The method used to calculate the AGB is a historical look-back method based on actual paid claims for Medicare fee-for-service, including portions paid by insured individuals. A single average percentage of gross charges, or multiple percentages for separate categories of care or separate items or services. The AGB rate will be updated annually on January 1st of each year and implemented within 120 days of any AGB rate change.

Facility	Service	Effective	AGB Rate
Adventist Health Physician Network	All Services	3/1/2018	30%
Western Health Resources	All Services	3/1/2018	74%

APPENDIX C
Covered and Noncovered Physicians List

The list of Covered and Noncovered Physicians within the facility who are covered under this policy who provide Emergency Medical Care or other Medically Necessary care in the facility is maintained in a supplemental document called "PFS-112 Financial Assistance Covered and Noncovered Physicians List". This list is updated quarterly and is published on the website and provided in writing with the policy.

Below is a list of facilities included within this supplemental document:

Doing Business As (DBA)
Adventist Health Hanford
Adventist Health Selma
Adventist Medical Center - Portland
Adventist Health Reedley
Adventist Health Tehachapi Valley
Adventist Health Castle
Adventist Health Feather River
Adventist Health Glendale
Adventist Health Howard Memorial
Adventist Health Lodi Memorial
Adventist Health Clear Lake
Adventist Health St. Helena
Adventist Health Vallejo
Adventist Health Bakersfield
Adventist Health Simi Valley
Adventist Health Sonora
Tillamook Regional Medical Center
Adventist Health Ukiah Valley
Adventist Health White Memorial
Adventist Health Physicians Network
Western Health Resources

Exhibit 3.9(b)

DELANO COMMUNITY HEALTH PROGRAMS

Community Partner	Community Benefit Provided
Central Valley Farmworker's Foundation	Health Screenings, Diabetes Education, Health Care Referrals, Flu Shot Clinics, Sponsorships
Delano Union Elementary School District	Health Screenings, Flu Shot Clinics, Education Seminars
Delano Community Alliance	Health Screenings, Health Education, Sponsorships
Kiwanis Club of Delano	Health Screenings, Sponsorships
Delano Joint Union HS District	Health Screenings, Flu Shot Clinics, Education Seminars
Rotary Club of Delano	Education Seminars
Bakersfield College	Health Education Seminars
Community Action Partnership of Kern	Community Farmers' Market partnership
Relay for Life	Healthcare Information/Sponsorship
City of Delano	Trunk or Treat, City Walk-Health Screening
American Diabetes Association	Flu Shot Clinic, Health Screenings, Education, Sponsorship
Kern County Hispanic Chamber of Commerce	Health Education, Sponsorships
Delano Chamber of Commerce	2 Street Fairs-Flu Shot Clinic and Healthcare Info.
Central CA Medical Group	Bariatric Seminars-9

2018 Health Screenings consisted of A1C, Blood Pressure, Glucose, Cholesterol, & BMI, per Delano's most recent Community Health Needs Assessment. In 2018, Delano has conducted about 45 community health screening events.

Disclosure Schedules

These Disclosure Schedules are delivered by the Central California Foundation for Health, d/b/a Delano Regional Medical Center, a California nonprofit public benefit corporation ("***Delano***") to Adventist Health System/West, d.b.a. Adventist Health, a California nonprofit religious corporation ("***Adventist Health***"), pursuant to the Affiliation Agreement dated as of January 4, 2019, by and between Delano and Adventist Health ("***Agreement***" or "***Affiliation Agreement***").

Any exception, qualification, limitation, document or other item described in any provision, subprovision, section or subsection of any Schedule of these Disclosure Schedules shall be deemed set forth for all purposes in any other Schedule of this Disclosure Schedules to the extent a reasonable person, without the benefit of any prior knowledge of, or experience with Delano would understand from reading these Disclosure Schedules that such disclosure also relates to such other Schedule of these Disclosure Schedules, regardless of whether or not a specific cross-reference is made thereto. Accordingly, any numbering or references herein to Sections of the Affiliation Agreement are made for convenience only and do not in any way limit, and shall not be regarded as limiting, the disclosure concerning such numbered or referred to Sections. Additionally, certain agreements and other matters are listed in these Disclosure Schedules for informational purposes only, notwithstanding the fact that, because they do not rise above applicable materiality thresholds or otherwise, they are not required to be listed herein by the terms of the Affiliation Agreement. In no event shall the listing of such agreements or other matters in these Disclosure Schedules be deemed or interpreted to broaden or otherwise amplify Delano's representations, warranties, covenants or agreements contained in the Affiliation Agreement and nothing in these Disclosure Schedules shall influence the construction or interpretation of any of the representations and warranties contained in the Affiliation Agreement.

The headings contained in these Disclosure Schedules are for convenience and reference only and shall not be deemed to modify or influence the interpretation of the information contained in these Disclosure Schedules or the Affiliation Agreement. Furthermore, the disclosure of a particular item of information in these Disclosure Schedules shall not be taken as an admission by Delano that such disclosure is required to be made under the terms of any such representations and warranties.

Where any information set forth in these Disclosure Schedules comprises expressions of opinion, no warranty is given as to their accuracy, but unless otherwise stated herein, such opinions are bona fide held by Delano, or, to Delano's knowledge, by such other person to whom they are attributed. Terms defined in the Affiliation Agreement and not otherwise defined in these Disclosure Schedules are used herein as defined in the Affiliation Agreement.

Schedule 4.1(b)(iii)

CONSENTS AND APPROVALS

Delano to identify by supplemental schedule any consents, approvals, authorizations, permits, filings, registration or notifications of or to any Governmental Entity or Person required by execution and delivery of the Agreement or consummation of the Affiliation.

Schedule 4.3

TRANSACTIONS

Sale of approximately two (2) acres of vacant land to the City of Delano evidenced by that certain Purchase and Sale Agreement by and between Delano and the City of Delano dated September 5, 2018.

Schedule 4.5

FINANCIAL STATEMENTS

None

Schedule 4.6(a)

OPERATION OUTSIDE ORDINARY COURSE

None

Schedule 4.6(b)

MATERIAL ADVERSE CHANGE

None

Schedule 4.8

EQUIPMENT

None

Schedule 4.10(a)

REAL PROPERTY ENCUMBRANCES

Delano real property is encumbered by a blanket lien under the Master Indenture of Trust dated July 1, 1998 with Bank of New York as successor trustee.

Available on request is the Seventh Supplemental Deed of Trust with Fixture Filing and Security Agreement dated as of March 1, 2018 recorded in the Kern County Official Reports on May 4, 2018.

Delano real property is also subject to the encumbrances and other matters reflected on the Condition of Title Guarantees issued by Ticor Title Company on November 30, 2018, and emailed by Mark Schieble to Daniel Settelmayer on December 28, 2018.

Schedule 4.10(i)

CAPITAL PROJECTS

Water heater Boilers valued at approximately $150,000 await OSHPD approval.

Schedule 4.11(a)

ENVIRONMENTAL LICENSES & PERMITS

1. San Joaquin Valley Air Pollution Control District – Delano Regional Medical Center (07-31-23)

2. County of Kern Public Health Services Department Environmental Health Service Division – Delano Regional Medical Center – Business Plan Medium Low Risk 1 Unit, APSA 1,320-9,999 gallon capacity, RCRA Large Quantity Hazardous Waste Generator – 07-01-17

Schedule 4.12

LICENSES & PERMITS

1. American College of Radiology Mammographic Imaging Services – Delano Regional Medical Center (01-24-20)
2. Centers for Medicare/Medicaid Services CLIA – Delano Regional Medical Center (01-21)
3. Centers for Medicare/Medicaid Services CLIA - Wasco Medical Plaza (03-27-20)
4. City of Delano Business License – Central California Medical Group (CCMG) (12-18)
5. City of Delano Business License – Delano Family Pharmacy (12-31-18)
6. City of Delano Business License – Delano Regional Medical Center (12-31-18)
7. City of Delano Business License – Delano Women's Clinic (12-31-18)
8. City of Wasco Business Tax Certificate – Wasco Urgent Care Clinic (12-31-18)
9. County of Kern Fictitious Business Name - Delano Urgent Care Clinic (07-22)
10. County of Kern Fictitious Business Name – Delano Diabetic Clinic (07-03-22)
11. County of Kern Fictitious Business Name – Delano Family Pharmacy (01-17-22)
12. County of Kern Fictitious Business Name – Delano Regional Medical Center (05-07-23)
13. County of Kern Fictitious Business Name – Delano Women's Clinic (07-03-22)
14. County of Kern Fictitious Business Name – Wasco Urgent Care Clinic (06-26-22)
15. Healthcare Facilities Accreditation Program (HFAP) – Delano Regional Medical Center (10-15-20)
16. State of California Board of Pharmacy – Delano Family Pharmacy (03-01-19)
17. Board of Pharmacy Retail Pharmacy Permit – Delano Regional Medical Center (03-01-19)
18. Board of Pharmacy – Delano Regional Medical Center Inpatient Pharmacy Permit (06-19)
19. State of California Department of Consumer Affairs Board of Pharmacy Sterile Compounding Permit – Delano Regional Medical Center (06-01-19)
20. State of California Department of Public Health – Radiology Branch – Delano Regional Medical Center (02-28-19)
21. State of California Department of Public Health – State License – Delano Regional Medical Center (05-28-19) (General Acute Care Hospital License)
22. State of California Department of Public Health Clinical Laboratory License – Central California Foundation for Health dba Delano Regional Medical Center (11-29-18
23. State of California Department of Public Health Mammography X-Ray Equipment and Facility Accreditation Certificate Two Dimension – Delano Regional Medical Center (01-24-20)
24. US Department of Health and Human Resources – Certified Mammography Facility (01-24-20)

25. State of California Department of Public Health – Facility License Wasco Medical Plaza Radiology – FAC00052213 (06-30-20)
26. State of California Department of Public Health – Facility License Delano Regional Medical Center Radiology – FAC00025408 (06-30-20)
27. State of California Department of Public Health – Facility License – Delano Regional Medical Center Outpatient Facility Radiology – FAC00078676 (08-31-20)
28. State of California Department of Public Health – Facility License – Delano Regional Medical Center Radiology Suite 105 – FAC0043152 (02-28-19)
29. State of California Department of Public Health – Nuclear Medical Radioactive Materials – 4000-15 (01-26-24)
30. American College of Radiology – Delano Regional Medical Center – CT – CTAP#52750-01 (05-16-20)
31. American College of Radiology – Outpatient Services – CT – CTAP#54319-01) (09-21)
32. Lorad Selenia Dimensions 2015 Mammography (Suite 105) – MAP#09093-04 (01-24-20)
33. Lorad Selenia Dimensions 2016 DBT Mammography (Outpatient) – MAP#510080-02 (08-02-21)
34. Lorad Selenia Dimensions 2016 Mammography (Outpatient) – MAP#510080-01 (08-21)
35. Federal Drug Administration – Delano Regional Medical Center – Radiology - Suite 105 – 180372 (01-24-20)
36. Federal Drug Administration – Delano Regional Medical Center Outpatient – 243644 (08-02-21)
37. State of California Department of Industrial Relations – Permit to Operate Air Pressure Tank – A024539-96 (04-21-21)
38. State of California Department of Industrial Relations – Permit to Operate Air Pressure Tank – A007563-11 (04-21-21)
39. State of California Department of Industrial Relations – Permit to Operate Air Pressure Tank – A017311-11 (04-21-21)
40. State of California Department of Industrial Relations – Permit to Operate Steam Boiler – B017335-03 (09-21-19)
41. State of California Department of Industrial Relations – Permit to Operate Steam Boiler – B017219-05 (09-12-19)
42. State of California Department of Industrial Relations – Conveyance Permit (elevator) - #100594 (10-02-18 – new permit being issued)
43. State of California Department of Industrial Relations – Conveyance Permit (elevator) - #099698 (10-02-18 – new permit being issued)

Schedule 4.19

MATERIAL CONTRACTS

None

Schedule 4.22

RESEARCH STUDIES

None

Schedule 4.24

RELATED PARTY AFFILIATIONS

None except Executive contracts listed in Exhibit 3.12(c).

Schedule 5.1(b)(iii)

ADVENTIST HEALTH CONFLICTS

None

EXHIBIT B
ATTORNEY GENERAL'S CONSENT LETTER
See Attached.

XAVIER BECERRA
Attorney General

State of California
DEPARTMENT OF JUSTICE

300 SOUTH SPRING STREET, SUITE 1702
LOS ANGELES, CA 90013

Public: (213) 269-6000
Telephone: (213) 269-6552
Facsimile: (213) 897-7605
E-Mail: wendi.horwitz@doj.ca.gov

November 22, 2019

Sent by Email and U.S. Mail
Mark Schieble
Foley & Lardner LLP
555 California Street, Suite 1700
San Francisco, CA 94109

RE: Proposed change in control and governance of Central California Foundation for Health

Dear Mr. Schieble:

Pursuant to Corporations Code section 5920 *et seq.*, the Attorney General hereby conditionally consents to the proposed change in governance and control of Central California Foundation for Health, a California nonprofit public benefit corporation, pursuant to the terms of the Affiliation Agreement dated January 4, 2019 with Adventist Health System/West.

Corporations Code section 5923, and California Code of Regulations, title 11, section 999.5, subdivision (f), set forth factors that the Attorney General shall consider in determining whether to consent to a proposed transaction between a nonprofit corporation and another nonprofit corporation. The Attorney General has considered such factors and consents to the proposed transaction subject to the attached conditions that are incorporated by reference herein.

Thank you for your cooperation throughout the review process.

Sincerely,

WENDI A. HORWITZ
Deputy Attorney General

For XAVIER BECERRA
Attorney General

cc: Daniel Settelmayer

Attorney General's Conditions to Change in Control and Governance of Delano Regional Medical Center[1] and Approval of Affiliation Agreement by and between Central California Foundation for Health and Adventist Health System/West

I.

These Conditions shall be legally binding on the following entities: Central California Foundation For Health, a California nonprofit public benefit corporation, Adventist Health System/West, a California nonprofit religious corporation, Adventist Health Delano, a California nonprofit religious corporation, any other subsidiary, parent, general partner, limited partner, member, affiliate, successor, successor in interest, assignee, or person or entity serving in a similar capacity of Central California Foundation For Health, Adventist Health System/West, or Adventist Health Delano, any entity succeeding thereto as a result of consolidation, affiliation, merger, or acquisition of all or substantially all of the real property or operating assets of Delano Regional Medical Center or the real property on which Delano Regional Medical Center is located, any and all current and future owners, lessees, licensees, or operators of Delano Regional Medical Center, and any and all current and future lessees and owners of the real property on which Delano Regional Medical Center is located.

II.

The transaction approved by the Attorney General consists of the Affiliation Agreement by and between Central California Foundation For Health and Adventist Health System/West dated January 4, 2019, Adventist Health System/West's letter dated February 13, 2019 regarding Delano Employees During 180-Day Period Post Closing, First Amendment to Affiliation Agreement, and any and all amendments, agreements, or documents referenced in or attached to as an exhibit or schedule to the Affiliation Agreement.

All of the entities listed in Condition I shall fulfill the terms of these agreements or documents including, but not limited to, any exhibits or schedules to the Affiliation Agreement, and shall notify the Attorney General in writing of any proposed modification or rescission of any of the terms of these agreements or documents including, but not limited to, the Amended Restated Articles of Incorporation of Central California Foundation For Health, and Amended and Restated Bylaws of Adventist Health Delano, and Bylaws of the Governing Board of Adventist Health Delano attached as Exhibit 2.1(c) to the Affiliation Agreement. Such notifications shall be provided at least sixty days prior to their effective date in order to allow the Attorney General to consider whether they affect the factors set forth in Corporations Code section 5923 and obtain the Attorney General's approval.

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[1] Throughout this document, the term "Delano Regional Medical Center" shall mean the general acute care hospital located at 1401 Garces Hwy., Delano, CA 93215-3690 and any other clinics, laboratories, units, services, or beds included on the license issued to Central California Foundation For Health by the California Department of Public Health, effective May 29, 2019, unless otherwise indicated.

III.

For eleven fiscal years from the closing date of the Affiliation Agreement, Central California Foundation For Health, Adventist Health System/West, Adventist Health Delano, and all future owners, managers, lessees, licensees, or operators of Delano Regional Medical Center shall be required to provide written notice to the Attorney General sixty days prior to entering into any agreement or transaction to do any of the following:

a) Sell, transfer, lease, exchange, option, convey, manage, or otherwise dispose of Delano Regional Medical Center; or

b) Transfer control, responsibility, management, or governance of Delano Regional Medical Center. The substitution or addition of a new corporate member or members of Central California Foundation For Health, Adventist Health System/West, or Adventist Health Delano that transfers the control of, responsibility for, or governance of Delano Regional Medical Center shall be deemed a transfer for purposes of this Condition. The substitution or addition of one or more members of the governing bodies of Central California Foundation For Health, Adventist Health System/West, or Adventist Health Delano, or any arrangement, written or oral, that would transfer voting control of the members of the governing bodies of Central California Foundation For Health, Adventist Health System/West, or Adventist Health Delano shall also be deemed a transfer for purposes of this Condition.

IV.

For ten years from the closing date of the Affiliation Agreement, Delano Regional Medical Center shall be operated and maintained as a licensed general acute care hospital (as defined in California Health and Safety Code Section 1250) and shall maintain and provide the following healthcare services at current[2] licensure and designations and certification with the current types and/or levels of services, including the following:

a) 24-hour Emergency Services, including a minimum of 10 Emergency Treatment Stations and designation as an Emergency Department Approved for Pediatrics;

b) Perinatal services, including a minimum of 16 licensed perinatal beds until the completion of a new obstetrics and delivery facility on Delano Regional Medical Center's campus as set forth in Exhibit 3.1 of the Affiliation Agreement. Once completed, Delano Regional Medical Center is required to maintain no less than 12 separate individual patient rooms with labor, delivery, recovery, and post-partum beds, and a separate cesarean-section, recovery and observation areas for the remaining portion of the ten years;

c) Pediatric services, including a designated area of six general acute care beds;

d) Intensive care services, including a minimum of 10 intensive care beds;

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[2] The term "current" or "currently" throughout this document means as of May 29, 2019.

e) Skilled Nursing (D/P) and sub-acute services, including a minimum of 51 licensed skilled nursing beds; and

f) Women's healthcare services including women's reproductive services, mammography services, those services currently provided at Delano Women's Medical Clinic located at 1201 Jefferson St., Delano, CA, and those services, policies, and procedures set forth in Exhibit 2.

Central California Foundation For Health, Adventist Health System/West, and Adventist Health Delano shall not place all or any portion of the above-listed licensed-bed capacity or services in voluntary suspension or surrender its license for any of these beds or services.

V.

For ten years from the closing date of the Affiliation Agreement, Delano Regional Medical Center shall maintain and provide the following healthcare services at current licensure and designation with the current types and/or levels of services:

a) Nuclear medicine services;
b) Occupational therapy;
c) Outpatient Clinic –Wasco Medical Plaza & Urgent Care, located at 2300 7th St., Wasco, CA;
d) Outpatient Clinic –Delano Urgent Care Clinic, located at 1201 Jefferson St., Delano, CA;
e) Outpatient Clinic – Delano Wound Care Clinic, located at 1519 Garces Hwy., Delano, CA;
f) Radiology services;
g) Diagnostic imaging;
h) Physical therapy;
i) Podiatry services;
j) Social services;
k) Speech pathology;
l) Blood bank services;
m) Dialysis services;
n) Pathology services; and
o) Sleep lab services.

VI.

For five years from the closing date of the Affiliation Agreement, Central California Foundation For Health, Adventist Health System/West, and Adventist Health Delano shall:

a) Be certified to participate in the Medi-Cal program at Delano Regional Medical Center;

b) Maintain and have Medi-Cal Managed Care contracts with the below listed Medi-Cal Managed Care Plans to provide the same types and/or levels of emergency and non-emergency services at Delano Regional Medical Center to Medi-Cal beneficiaries (both Traditional Medi-Cal and Medi-Cal Managed Care) as required in these Conditions, on the same terms and conditions as other similarly situated hospitals offering substantially the same services, without any loss, interruption of service or diminution in quality, or gap in contracted hospital coverage, unless the contract is terminated for cause:

i) Local Initiative: Kern Family Health Care or its successor; and
ii) Commercial Plan: Health Net Community Solutions, Inc. or its successor;

c) Be certified to participate in the Medicare program by maintaining a Medicare Provider Number to provide the same types and/or levels of emergency and non-emergency services at Delano Regional Medical Center to Medicare beneficiaries (both Traditional Medicare and Medicare Managed Care) as required in these Conditions; and

d) Be certified to participate in the TRICARE program to provide the same types and/or levels of emergency and non-emergency services at Delano Regional Medical Center to TRICARE beneficiaries as required in these Conditions.

VII.

For six fiscal years from the closing date of the Affiliation Agreement, Central California Foundation For Health, Adventist Health System/West, and Adventist Health Delano shall provide an annual amount of Charity Care (as defined below) at Delano Regional Medical Center equal to or greater than $522,542 (the Minimum Charity Care Amount). For purposes hereof, the term "charity care" shall mean the amount of charity care costs (not charges) incurred by Central California Foundation For Health, Adventist Health System/West, and Adventist Health Delano in connection with the operation and provision of services at Delano Regional Medical Center. The definition and methodology for calculating "charity care" and the methodology for calculating "costs" shall be the same as that used by the Office of Statewide Health Planning Development (OSHPD) for annual hospital reporting purposes.[3]

Central California Foundation For Health, Adventist Health System/West, and Adventist Health Delano shall use and maintain a charity care policy that is no less favorable than Adventist Health System/West's Patient Billing: Financial Assistance Policy (Policy No. PFS-112 effective December 29, 2015) (Financial Assistance Policy) and in compliance with California and Federal law.

Central California Foundation For Health, Adventist Health System/West, and Adventist Health Delano's obligation under this Condition shall be prorated on a daily basis if the closing date of the Affiliation Agreement is a date other than the first day of Central California Foundation For Health, Adventist Health System/West, or Adventist Health Delano's fiscal year.

For the second fiscal year and each subsequent fiscal year, the Minimum Charity Care Amount shall be increased (but not decreased) by an amount equal to the Annual Percent increase, if any, in the 12 Months Percent Change: All Items Consumer Price Index for All Urban Consumers in U.S. City Average Base Period: 1982-84=100 (as published by U.S. Bureau of Labor Statistics).

If the actual amount of charity care provided at Delano Regional Medical Center for any fiscal year is less than the Minimum Charity Care Amount (as adjusted pursuant to the above-

[3] OSHPD defines charity care by contrasting charity care and bad debt. According to OSHPD, "the determination of what is classified as . . . charity care can be made by establishing whether or not the patient has the ability to pay. The patient's accounts receivable must be written off as bad debt if the patient has the ability but is unwilling to pay off the account."

referenced Consumer Price Index) required for such fiscal year, Central California Foundation For Health, Adventist Health System/West, and Adventist Health Delano shall pay an amount equal to the deficiency to one or more tax-exempt entities that provide direct healthcare services to residents in the Delano Regional Medical Center's service area (8 ZIP codes), as defined on page 31 of the Delano Regional Medical Center's Health Care Impact Statement, dated April 26, 2019, and attached hereto as Exhibit 1. Such payment(s) shall be made within six months following the end of such fiscal year.

VIII.

Within 90 days from the closing date of the Affiliation Agreement, Central California Foundation For Health, Adventist Health System/West, and Adventist Health Delano shall take the following steps to ensure that patients at Delano Regional Medical Center are informed about Adventist Health System/West's Patient Billing: Financial Assistance Policy (Policy No. PFS-112 effective December 29, 2015):

a) A copy of the Financial Assistance Policy and the plain language summary of the Financial Assistance Policy must be posted in a prominent location in the emergency room, admissions area, and any other location in Delano Regional Medical Center where there is a high volume of patient traffic, including waiting rooms, billing offices, and outpatient service settings;

b) A copy of the Financial Assistance Policy, the Application for Financial Assistance, and the plain language summary of the Financial Assistance Policy must be posted in a prominent place on Delano Regional Medical Center's website;

c) If requested by a patient, a copy of the Financial Assistance Policy, Application for Financial Assistance, and the plain language summary of the Financial Assistance Policy must be sent by mail at no cost to the patient;

d) As necessary and at least on an annual basis, Delano Regional Medical Center will place an advertisement regarding the availability of financial assistance at Delano Regional Medical Center in a newspaper of general circulation in the communities served by Delano Regional Medical Center, or issue a Press Release to widely publicize the availability of the Financial Assistance Policy to the communities served by Delano Regional Medical Center;

e) Delano Regional Medical Center will work with affiliated organizations, physicians, community clinics, other health care providers, houses of worship, and other community-based organizations to notify members of the community (especially those who are most likely to require financial assistance) about the availability of financial assistance at Delano Regional Medical Center; and

f) All staff that interacts with patients and their families concerning payment of services shall be given annual training to make patients and their families aware of and informed of the Financial Assistance Policy.

IX.

For six fiscal years from the closing date of the Affiliation Agreement, Central California Foundation For Health, Adventist Health System/West, and Adventist Health Delano shall provide an annual amount of Community Benefit Services at Delano Regional Medical Center equal to or greater than $830,194 (the Minimum Community Benefit Services Amount) exclusive of any funds from grants. For six fiscal years, the following community benefit programs and services shall continue to be offered:

a) Childbirth and Family Education;
b) Transportation Program; and
c) Workforce Development/Job Training.

Central California Foundation For Health, Adventist Health System/West, and Adventist Health Delano's obligation under this Condition shall be prorated on a daily basis if the effective date of the Affiliation Agreement is a date other than the first day of Central California Foundation For Health, Adventist Health System/West, or Adventist Health Delano's fiscal year.

For the second fiscal year and each subsequent fiscal year, the Minimum Community Benefit Services Amount shall be increased (but not decreased) by an amount equal to the Annual Percent increase, if any, in the 12 Months Percent Change: All Items Consumer Price Index for All Urban Consumers in U.S. City Average Base Period: 1982-84=100 (as published by U.S. Bureau of Labor Statistics).

If the actual amount of community benefit services provided at Delano Regional Medical Center for any fiscal year is less than the Minimum Community Benefit Services Amount (as adjusted pursuant to the above-referenced Consumer Price Index) required for such fiscal year, Central California Foundation For Health, Adventist Health System/West, and Adventist Health Delano shall pay an amount equal to the deficiency to one or more tax-exempt entities that provide community benefit services for residents in Delano Regional Medical Center's service area (8 ZIP codes), as defined on page 31 of the Delano Regional Medical Center's Health Care Impact Statement, dated April 26, 2019, and attached hereto as Exhibit 1. Such payment(s) shall be made within six months following the end of such fiscal year.

X.

For five years from the closing date of the Affiliation Agreement, Delano Regional Medical Center shall maintain all contracts, including any superseding, successor, or replacement contracts, and any amendments and exhibits thereto, with the City of Bakersfield or the County of Kern or their subdivisions, departments, or agencies for services at Delano Regional Medical Center including the following:

a) Transfer Agreement between Delano Regional Medical Center and Kern Medical Center; and
b) Professional Service Agreement – Kern County.

XI.

Adventist Health/West shall comply with section 3.2 of the Affiliation Agreement entitled "Cerner EMR Conversion."

XII.

Central California Foundation For Health, Adventist Health System/West, and Adventist Health Delano shall commit the necessary investments required to meet and maintain OSHPD seismic compliance requirements at Delano Regional Medical Center until January 1, 2030 under the Alfred E. Alquist Hospital Facilities Seismic Safety Act of 1983, as amended by the California Hospital Facilities Seismic Safety Act, (Health & Saf. Code, §§129675-130070) and as such Acts may be subsequently amended, modified, or replaced.

XIII.

Central California Foundation For Health, Adventist Health System/West, and Adventist Health Delano shall maintain privileges for current medical staff at Delano Regional Medical Center who are in good standing as of the closing date of the Affiliation Agreement. Further, the closing of the Affiliation Agreement shall not change the medical staff officers, committee chairs, or independence of the medical staff, and such persons shall remain in good standing for the remainder of their tenure as medical staff officers or committee chairs at Delano Regional Medical Center.

XIV.

For ten years from the closing date of the Affiliation Agreement, Delano Regional Medical Center shall have a Local Governing Board. Central California Foundation For Health, Adventist Health System/West, and Adventist Health Delano's Board of Directors shall consult with Delano Regional Medical Center's Local Governing Board prior to making changes to medical services and community benefit programs. The members of the Delano Regional Medical Center's Local Governing Board shall include physicians, medical staff, and the Chief of Staff from Delano Regional Medical Center, and community representatives from Delano Regional Medical Center's service area (8 ZIP codes), as defined on page 31 of Delano Regional Medical Center Health Care Impact Statement, dated April 26, 2019 and attached hereto as Exhibit 1, including at least one member from a local healthcare advocacy or community group. Such consultation shall occur at least sixty days prior to the effective date of such changes or actions unless done so on an emergency basis. The Delano Regional Medical Center's Local Governing Board's approval is required of all reports submitted to the Attorney General regarding compliance with these Conditions.

XV.

There shall be no discrimination against any lesbian, gay, bisexual, transgender, or queer individuals at Delano Regional Medical Center. This prohibition must be explicitly set forth in Central California Foundation For Health, Adventist Health System/West, and Adventist Health Delano's written policies applicable at Delano Regional Medical Center, adhered to, and strictly enforced.

XVI.

Central California Foundation For Health, Adventist Health System/West, and Adventist Health Delano are required to continue Delano Regional Medical Center's participation in the California Department of Health Care Services' Hospital Quality Assurance Fee Program as set forth in California law and the provider bulletins dated August 26, 2014 and May 13, 2016 (located at http://www.dhcs.ca.gov/provgovpart/Pages/HQAF.aspx).

XVII.

For six fiscal years from the closing date of the Affiliation Agreement, Central California Foundation For Health, Adventist Health System/West, and Adventist Health Delano shall (a) support Delano Regional Medical Center in the continuity and growth of the its clinics as currently structured or as reorganized to be integrated with Adventist Health Physicians Network, including exercising reasonable best efforts to establish, within five years following the closing date of the Affiliation Agreement, a minimum of three new clinic locations that are certified under the Rural Health Clinics Program as defined by 42 C.F.R. Pt. 405 and provide or arrange for the provision of professional medical services to the beneficiaries covered under the Rural Health Clinics Program serving Delano Regional Medical Center's service area (8 ZIP codes), as defined on page 31 of Delano Regional Medical Center Health Care Impact Statement, dated April 26, 2019 and attached hereto as Exhibit 1, and (b) facilitate the staffing of such clinics by an Adventist Health affiliated physician organization. Central California Foundation For Health, Adventist Health System/West, and Adventist Health Delano shall work with Delano Regional Medical Center to strengthen physician affiliation strategies in Delano Regional Medical Center's service area (8 ZIP codes), as defined on page 31 of Delano Regional Medical Center Health Care Impact Statement, dated April 26, 2019 and attached hereto as Exhibit 1, by providing Delano Regional Medical Center access to Adventist Health's existing physician recruitment programs and practice development vehicles, and to deploy and/or develop Delano Regional Medical Center's physician affiliation resources as necessary to meet the physician recruitment needs of Delano Regional Medical Center's service area (8 ZIP codes), as defined on page 31 of Delano Regional Medical Center Health Care Impact Statement, dated April 26, 2019 and attached hereto as Exhibit 1, particularly with respect to the recruitment of needed family practitioners, orthopedists, urologists, obstetricians, pediatricians, general surgeons, and ear, nose and throat doctors.

For six fiscal years from the closing date of the Affiliation Agreement, Central California Foundation For Health, Adventist Health System/West, and Adventist Health Delano shall submit to the Attorney General a report every six months providing information and relevant documents regarding the progress and development of the establishment of the three new clinic locations and to strengthen physician affiliation and recruitment strategies in Delano Regional Medical Center's service area particularly with respect to the recruitment of needed family practitioners, orthopedists, urologists, obstetricians/gynecologists, pediatricians, general surgeons, and ear, nose and throat doctors as required in Condition XVII. The Chief Executive Officers of Central California Foundation For Health, Adventist Health System/West, Adventist Health Delano, and Delano Regional Medical Center's Local Governing Board shall each certify that the report is true, accurate, and complete and provide documentation of the review and approval of the report by these individuals.

XVIII.

After the closing date of the Affiliation Agreement, Central California Foundation For Health, Adventist Health System/West, and Adventist Health Delano shall operate Delano Regional Medical Center as a separate California nonprofit religious corporation. Consistent with charitable trust law, the assets reflected on the balance sheet effective as of the closing date of the Affiliation Agreement, including, without limitation cash, investment assets and supplemental payments received by Delano Regional Medical Center relating to periods of service prior to the closing date under (i) the Medi-Cal Hospital Reimbursement Improvement Act of 2013, California Welfare & Institutions Code Sections 14169.50 et. seq. and (ii) the Medi-Cal Disproportionate Share Hospital Program, California Welfare & Institutions Code Sections 14105.98 et. seq. and 42 U.S.C. § 1396r-4 et. seq., shall be utilized by Central California Foundation For Health, Adventist Health System/West, and Adventist Health Delano to benefit Delano Regional Medical Center and Delano Regional Medical Center's service area (8 ZIP codes), as defined on page 31 of Delano Regional Medical Center Health Care Impact Statement, dated April 26, 2019 and attached hereto as Exhibit 1. Such cash and receipts will be consolidated for investment purposes under Adventist Health System/West's cash management program, but remain available to Delano Regional Medical Center when needed, subject to Adventist Health System/West's approval."

XIX.

For eleven fiscal years from the closing date of the Affiliation Agreement, Central California Foundation For Health, Adventist Health System/West, and Adventist Health Delano shall submit to the Attorney General, no later than six months after the conclusion of each fiscal year, a report describing in detail compliance with each Condition set forth herein. The Chairman(s) of the Board of Directors of Central California Foundation For Health, Adventist Health System/West, Adventist Health Delano, and Delano Regional Medical Center's Local Governing Board and the Chief Executive Officers of Central California Foundation For Health, Adventist Health System/West, Adventist Health Delano, and Delano Regional Medical Center's Local Governing Board shall each certify that the report is true, accurate, and complete and provide documentation of the review and approval of the report by these Boards of Directors.

XX.

At the request of the Attorney General, all of the entities listed in Condition I shall provide such information as is reasonably necessary for the Attorney General to monitor compliance with these Conditions and the terms of the transaction as set forth herein. The Attorney General shall, at the request of a party and to the extent provided by law, keep confidential any information so produced to the extent that such information is a trade secret or is privileged under state or federal law, or if the private interest in maintaining confidentiality clearly outweighs the public interest in disclosure.

XXI.

Once the Affiliation Agreement is closed, all of the entities listed in Condition I are deemed to have explicitly and implicitly consented to the applicability and compliance with each and every Condition and to have waived any right to seek judicial relief with respect to each and every Condition.

The Attorney General reserves the right to enforce each and every Condition set forth herein to the fullest extent provided by law. In addition to any legal remedies the Attorney General may have, the Attorney General shall be entitled to specific performance, injunctive relief, and such other equitable remedies as a court may deem appropriate for breach of any of these Conditions. Pursuant to Government Code section 12598, the Attorney General's office shall also be entitled to recover its attorney fees and costs incurred in remedying each and every violation.

EXHIBIT 1

Analysis of the Hospital's Service Area

Service Area Definition

Based upon the Hospital's CY 2017 inpatient discharges, the Hospital's service area is comprised of eight ZIP Codes from which 91% of inpatient discharges originated. Nearly 70% of the Hospital's discharges originated from the top two ZIP Codes located in Delano and McFarland. In CY 2017, the Hospital's market share in the service area was approximately 33% based on total area discharges.

PATIENT ORIGIN CY 2017						
ZIP Codes	Community	Total Discharges	% of Discharges	Cumulative % of Discharges	Total Area Discharges	Market Share
93215	Delano	1,581	55.1%	55.1%	3,699	42.7%
93250	McFarland	397	13.8%	69.0%	951	41.7%
93219	Earlimart	231	8.1%	77.0%	794	29.1%
93280	Wasco	195	6.8%	83.8%	1,864	10.5%
93261	Richgrove	74	2.6%	86.4%	186	39.8%
93216	Delano	68	2.4%	88.8%	169	40.2%
93201	Alpaugh	27	0.9%	89.7%	116	23.3%
93249	Lost Hills	25	0.9%	90.6%	164	15.2%
Sub-Total		**2,598**	**90.6%**	**90.6%**	**7,943**	**32.7%**
Other ZIPs		**270**	**9.4%**	**100%**		
Total		**2,868**	**100%**			

Source: OSHPD Patient Discharge Database, CY 2017

Note: Excludes normal newborns

EXHIBIT 2

EXHIBIT 2: ADVENTIST HEALTH SYSTEM/WEST'S SERVICES, POLICIES, AND PROCEDURES

While Adventist Health System/West (Adventist Health) does not allow *elective* abortions to be performed in its facilities, it does allow counseling around such options to be given to a woman by her provider, who would then make an appropriate referral out of the system for such services if the woman choses an *elective* abortion. There are no restrictions placed on performing *therapeutic* abortions including, but not limited to, abortions for fetal distress and other medical reasons, in an Adventist Health facility. In the case of a woman undergoing chemotherapy or similar situations where there would be a *medical* necessity for terminating a pregnancy, this is fully allowed. In addition, if a woman has a miscarriage and needs a D&E or D&C, Adventist Health would provide such services in its hospitals or surgery centers. If a woman (including a transman) needs a tubal ligation or a hysterectomy, Adventist Health would provide them in its hospitals. Below are Adventist Health's answers to several questions.

Q1. What family planning counseling does Adventist Health perform? Is it nondirective, does it encompass all 18 FDA-approved methods, and does it include medication abortion?
A. The family planning counseling performed at Adventist Health is non-directive. Any physician or provider is at liberty of discussing family planning with his/her patients. We do not direct them on what to do on this front.

Q2. Can you help unpack the following response you gave in a previous email to a question about whether Adventist Health administers medication abortion, Plan B or IUDs: "Those services are typically done with the woman and her medical practitioner. Adventist Health does not interfere in the physician's relationship with their patients. That includes birth control of all types. The exception that would be in a hospital is in our ER where there is a victim of sexual assault. If she is not on some form of birth control, they would likely be offered a plan B pill."
A. The services related to medication abortion, Plan B or IUDs are typically discussed with the woman and her medical practitioner. Adventist Health does not interfere in the physician's relationship with their patients. This includes discussion of Plan B and IUDs. There is no exception.

> **Q2a. If the decision is between a doctor and patient, does Adventist Health's position mean (1) that the doctor provides nondirective counseling, and (2) that the hospital will allow the doctor to prescribe a form of contraceptive or medication abortion (mifepristone)?**
> A. Adventist Health's position is the doctor provides nondirective counseling and the organization will allow prescriptions based on the physician judgment but does not support on demand abortions (an elective abortion without medical justification).
>
> If a woman is sexually assaulted, and she presents at some point to the hospital for a medical forensic exam, the hospital will administer mifepristone if the doctor prescribes it.

Q2b. And second, can you clarify the language concerning an "exception" in the ER for a victim of sexual assault? It seems to suggest that people cannot get Plan B or Medication abortion unless they have experienced sexual assault.
A. The language concerning any exceptions is not correct as stated above. Physicians provide the necessary counseling and referrals as they see fit based on their medical judgment and their patient's wishes. Patients will not be administered Plan B in the hospital emergency department because it is available over the counter, so it does not require a prescription. Although the drug is available over the counter, it is also available in the hospital pharmacy. The physician can and would give it to a patient in the hospital or the emergency room at their discretion. Adventist Health does not in any way restrict Plan B. Medical abortions are performed in Adventist Health facilities.

Q3. Under what circumstances will Adventist Health perform elective operations that result in sterilization, including tubal ligations and hysterectomies?
A. Adventist Health physicians can and do perform tubal ligations and hysterectomies in Adventist Health facilities based on their clinical judgment and mutual decision making with their patients. If a woman gives birth in an Adventist Health facility and then asks her physician to do a tubal ligation after the birth and the doctor agrees, the woman is given a tubal ligation.

Q4. Does Adventist Health provide contraceptive services, including IUD placement and sterilization, immediately postpartum?
A. It is the prerogative of the Adventist Health physician and patients to make decisions and treatment modalities on contraceptive services immediately postpartum.

Q5. If Adventist Health makes referrals for abortion care, where does it refer to? Does it always act following the patient's direction?
A. Abortions are not performed on demand. The clinical team and providers would refer the patients based on her wishes. Adventist Health as a system does not interfere or guide those referrals. The decisions are between the physician and the patient. Adventist Health does support the patient's wishes for such a referral as feasible and possible.

Q6. What criteria does Adventist Health use to determine whether it considers an abortion to be elective or therapeutic? Do these criteria allow for abortion in all circumstances of miscarriage, ectopic pregnancy, and other cases of unexpected pregnancy loss?
A. Any patient including a pregnant mother will be given all needed and necessary life saving treatment at all times. In rare cases of non-life threatening situations, and where there is lack of clarity between on demand abortions and life saving intervention for the mother, a case will be referred to an ethics committee in consultation with the board. A miscarriage, ectopic pregnancy or unexpected pregnancy loss are non-viable pregnancies and would be considered managing the patient as any other patient. Adventist Health prioritizes the safety and health of our patients and would provide the care necessary post such event as we provide any other care to our patients.

As an example, the Ethics Committee is comprised of at least five (5) members consisting of physicians and such other Staff members as the Medical Executive Committee may deem appropriate. It may include nurses, lay representatives, social workers, clergy, ethicists, attorneys, administrators and representatives from the Governing Board. The committee may, in

its discretion, invite individuals with competence in special areas to assist in the review of complex issues which require expertise beyond or in addition to that available on the committee. These individuals may not vote.

For example a pregnant woman is diagnosed with breast cancer. It is recommended that she receive chemotherapy which could harm her baby and is contemplating an abortion. Since this is not an immediate life threatening issue it would be referred to the ethics committee. Typically an ethics committee meeting would be called within a couple of days and the recommendation given. Since abortions are available in the community most women would just access that care directly.

An abortion would be performed in rare cases of non-life threatening situations, and where there is lack of clarity between on demand abortions and life saving intervention for the mother, a case will be referred to an ethics committee in consultation with the board. An abortion would also be performed for a miscarriage, ectopic pregnancy or unexpected pregnancy loss or other are non-viable pregnancies and would be considered managing the patient as any other patient.

Q7. What treatment or referrals does Adventist Health provide for patients with gender dysphoria, (such as hormone therapy and gender-affirmation surgery)?
A. A physician can refer their patients as the patient wishes and the physician recommends. It is between the physician and their patients. Adventist Health does not direct care and would support our patients based on their wishes. Within our system some physicians provide hormone therapy however none of our facilities currently provide gender reconstruction surgery.

Q8. Assuming that it is medically indicated by their physician, do you provide any or all of the following health care services to all patients, including to patients who are seeking such services related to a gender transition:

- **Hormone therapy**
- **Hysterectomy**
- **Mastectomy**

A. Adventist Health does not direct hormone therapy, hysterectomies or mastectomies. It is a physician-patient decision and if elected could be done in our facilities.

EXHIBIT C
PROPOSED AMENDED AFFILIATION AGREEMENT
See Attached.

AMENDMENT NO. 3 TO AFFILIATION AGREEMENT

THIS AMENDMENT NO. 3 TO AFFILIATION AGREEMENT (the "***AMENDMENT NO. 3***") is entered into as of October 20, 2025, by and between ADVENTIST HEALTH SYSTEM/WEST, d/b/a ADVENTIST HEALTH, a California nonprofit religious corporation ("***Adventist Health***"), and ADVENTIST HEALTH DELANO f/k/a CENTRAL CALIFORNIA FOUNDATION FOR HEALTH, a California nonprofit religious corporation ("***Delano***") with respect to the following:

RECITALS

A. WHEREAS, Delano owns and operates a general acute care hospital located in Delano, California (the "***Hospital***"), serving Delano and surrounding rural central California communities.

B. WHEREAS, Delano and Adventist Health entered into that certain Affiliation Agreement dated January 4, 2019 and amended August 13, 2019 ("Amendment No. 1"). On November 22, 2019, the Attorney General Conditionally Consented to the transaction ("Consent Letter"). The transaction closed on December 31, 2019.

C. WHEREAS, on May 26, 2020, Adventist Health and Delano requested to amend the Agreement ("Amendment No. 2") and the terms of the Consent Letter to remove a sleep lab service from the list of clinical services, which Delano was never licensed to provide. On October 15, 2020, the Attorney General consented to the Parties' request. The Affiliation Agreement, Amendment No. 1, and Amendment No. 2 are hereinafter referred to as the "Agreement".

D. WHEREAS, under section 3.1 of the Agreement, Delano is obligated to develop and open an inpatient obstetrics and delivery service with specific characteristics described in Exhibit 3.1 of the Agreement (the "New OB Unit").

E. WHEREAS, since closing the transaction, Delano obstetrics and delivery services has struggled with low patient volumes, has not reached a level of sustainable operations, has experienced significant financial stress as a result of the COVID-19 Pandemic, and the New OB Unit is no longer supported by community need.

F. WHEREAS, the Parties now wish to further amend the Agreement and the terms of the Consent Letter. Accordingly, the Parties hereby wish to remove the New OB Unit Obligation from the Agreement and make a new commitment described in this Amendment No. 3.

AGREEMENT

Now, therefore, the parties restate and amend the agreement as follows**:**

1. **Defined Terms**. Capitalized terms used herein and not defined herein shall have the meanings assigned to them in the Agreement.

2. **Deletion and Replacement of Section 3.1**. Section 3.1 of the Agreement is

hereby deleted in its entirety and replaced with the following:

> 3.1 Hospital Based Clinic and Expansion of Specialty Care. Within ten (10) years following the Closing Date, Adventist Health shall develop and open a hospital based multispecialty and primary care clinic located on the campus of Delano. The types of specialty services offered at the clinic will be determined by Delano based on community need. Additionally, Delano shall expand the number of beds in its Special Care Unit to 55.

3. **Deletion and no replacement of Exhibit 3.1.** Exhibit 3.1 of the Agreement is hereby deleted in its entirety with no replacement exhibit.

4. **Counterparts.** This Erratum may be executed in one or more counterparts, each of which shall be deemed to be an original, but all of which together shall constitute one and the same instrument.

5. **Continuing Effect of Agreement.** Except as herein provided, all of the terms and conditions of the Agreement remain in full force and effect from the Execution Date of the Agreement.

6. **Reference.** After the Effective Date, any reference to the Agreement shall mean the Agreement as amended by this Amendment No. 3.

7. **Effective Date**. This Amendment No. 3 shall become effective immediately upon the approval of the "Request for Amendment of the Attorney General's November 22, 2019 Conditions to Change in Control and Governance of Delano Regional Medical Center and Approval of the Affiliation Agreement by and between Central California Foundation for Health and Adventist Health System/West" submitted to the Attorney General of California on October 20, 2025, in accordance with Cal. Code Regs. tit. 11, § 999.5(h).

[*Signature Page Follows*]

IN WITNESS WHEREOF**,** Adventist Health and Delano have executed this Amendment No. 3 as of the day and year first written above.

ADVENTIST HEALTH

ADVENTIST HEALTH SYSTEM/WEST,
a California nonprofit religious corporation

_____

By: Kerry Heinrich
Its President

DELANO

ADVENTIST HEALTH DELANO,
a California nonprofit religious corporation

_____

By: Jason Wells
Its President

EXHIBIT D
ADVENTIST HEALTH DELANO SERVICE AREA ANALYSIS
See Attached.

ADVENTIST HEALTH DELANO SERVICE AREA ANALYSIS

Report Contents

Purpose of this Report

This report is submitted by Adventist Health System/West and Adventist Health Delano (collectively "Adventist Health") in support of its request to amend (i) the terms of the Attorney General's Conditional Consent letter dated November 22, 2019, and (ii) the Affiliation Agreement. This report provides detailed analysis of the Adventist Health Delano service area and the health needs of the community. In short, the Obstetrics Solution required under section 3.1 of the Affiliation Agreement ("OB Project") is no longer aligned with the needs of the Delano community. The Delano community OB service needs are being filled by other market participants, and the community's health needs would be better served by a multispecialty hospital-based clinic located within Adventist Health Delano, the expansion of primary care and urgent care clinic services, and the expansion of the Special Care Unit at Adventist Health Delano.

In preparing this report, the following materials were reviewed:

- Historical information related to original Affiliation Agreement, including the Affiliation Agreement, the Attorney General's Conditional Consent letter, and the Delano Regional Medical Center Health Care Impact Statement;
- Financial and operational information prepared by Adventist Health Delano and the Department of Health Care Access and Information (HCAI) for 2019 through 2024;
- 2019 and 2022 Community Health Needs Assessment (CHNA) and Community Health Improvement Plan (CHIP) for Adventist Health Delano;
- 2023 Physician Needs Assessments for Adventist Health Delano, prepared by Premier Inc.;
- Publicly available data and reports related to Adventist Health Delano, Adventist Health Delano's service area, and the State of California, including demographic statistics and trends, health status indicators, quality indicators, and other financial and operational data;
- Discussions with Adventist Health and Adventist Health Delano management and clinical representatives.

Description of Adventist Health Delano and its Service Area

Adventist Health Delano

Since Adventist Health Delano joined the Adventist Health network in early 2020, the hospital has continued to provide a wide range of medical services, ensuring comprehensive care for its patients and community. Adventist Health Delano has a total of 156 licensed beds, including a Medical-Surgical Unit, a Special Care Unit, an Intensive Care Unit, an Obstetrics/Gynecology Unit, and a dedicated Surgical Pavilion, as outlined in **Figure 1** below.

Figure 1: Adventist Health Delano Inpatient Hospital Beds and Utilization (2024)

Inpatient Unit	Licensed Beds	Average Daily Census[1]	Occupancy Rate %
Medical-Surgical Unit[2]	79.0	9.1	*11.5%*
Special Care Unit	51.0	48.7	*95.5%*
Obstetrics Unit	16.0	2.8	*17.5%*
Intensive Care Unit	10.0	2.6	*26.0%*
Total Beds	**156.0**	**63.2**	***40.5%***

Of the 156 licensed beds, 63.2 are currently utilized, on average, implying an occupancy rate of only approximately 40.5%, which is inclusive of the highly utilized Special Care Unit.

When excluding the Special Care Unit[3], which accounts for a significant portion of the overall hospital's patient volume, the utilization of the remainder of the hospital is relatively low. Notably, out of the 105 remaining beds (including Medical-Surgical, Obstetrics, and Intensive Care beds), the Average Daily Census is 14.5 patients, representing an occupancy rate of a mere 13.8% and leaving over 90 beds unused per day.

Obstetrics and Delivery Services

Adventist Health Delano offers obstetrics and women's health services, including prenatal care, labor and delivery, and postnatal care. Through its women's health clinics located in Delano and Wasco, Adventist Health Delano provides pregnancy testing, prenatal check-ups, prescriptions for medications, nutritional support, and other pregnancy advice and support. When it comes time for delivery, Adventist Health Delano has multiple birthing rooms for delivery and recovery, a dedicated surgical suite for caesarean deliveries, and a newborn nursery. After birth, Adventist Health Delano provides baby care instructions and manuals, breastfeeding education and coaching, car seat education, and baby wellness check-ups.

Adventist Health Delano has 16 licensed beds within its hospital-based Obstetrics Unit, of which 2.8 are currently utilized, on average, implying an occupancy rate of 17.58%.

[1] The average daily census (ADC) is the average number of inpatients in the hospital on a given day over the course of a year and excludes newborn babies in the nursery unit.
[2] Medical-Surgical Unit represents general acute care, including intermediate care, telemetry, medical-surgical, and pediatric beds.
[3] The Special Care Unit provides specialized sub-acute care services to seriously ill, but stable patients. The Special Care Unit is designed for patients who need extended care, requiring ongoing medical support and rehabilitation, over a longer period.

Service Area Definition

Adventist Health Delano's service area, as defined in the Attorney General's Conditional Consent letter dated November 22, 2019, is comprised of the following eight zip codes ("Service Area"): 93215, 93216, 93219, 93249, 93250, 93261, 93280, 93201. These zip codes account for over 90% of Adventist Health Delano's total hospital discharges in 2023. Nearly 71% of Adventist Health Delano's discharges originated from two zip codes located in Delano and McFarland.

Zip Code	Community	County	Total Adventist Health Delano Discharges	% of Total Adventist Health Delano Discharges	Cumulative % of Discharges
93215	Delano	Kern	1,173	57.8%	57.8%
93250	McFarland	Kern	257	12.7%	70.5%
93219	Earlimart	Tulare	163	8.0%	78.5%
93280	Wasco	Kern	181	8.9%	87.4%
93261	Richgrove	Tulare	61	3.0%	90.4%
93216	Delano	Kern	39	1.9%	92.4%
93201	Alpaugh	Tulare	6	0.3%	92.7%
93249	Lost Hills	Kern	22	1.1%	93.7%
Sub-Total[4]			**1,902**	**93.7%**	**93.7%**
Other Zip Codes			127	6.3%	100.0%
Total[5]			**2,029**	**100.0%**	**100.0%**

[4] Source: INTELLIMED Market Share Profile System based on publicly available data in 2023 from the following area zip codes: 93215, 93216, 93219, 93249, 93250, 93261, 93280, 93201.
[5] Source: Total discharges based on information sourced from California Department of Health Care Access and Information (HCAI) Annual Audited Financial Reports.

Summary of the Obstetrics Solution and Condition IV

Section 3.1 of the Affiliation Agreement, which is incorporated into Condition IV, requires Adventist Health to develop and open an inpatient obstetrics and delivery service ("Obstetrics Solution"). The Obstetrics Solution is to have the following characteristics:

1) The OB Unit will be street fronting with good street visibility;
2) The OB Unit will have a separate entrance;
3) The OB Unit will have at least twelve (12) separate individual patient rooms;
4) The OB Unit will consist of either (a) all labor, delivery, recovery and postpartum ("LDRP") beds, or (b) a combination of LDRP and post-partum beds; and
5) The OB Unit will have separate Cesarean-section ("C-section"), recovery and observation areas.

Condition IV of the Affiliation Agreement incorporates the Obstetrics Solution requirements and adds an additional ten year service condition.

The Community Health Needs Assessment

In accordance with the Patient Protection and Affordable Care Act of 2010, in 2022, Adventist Health Delano completed a comprehensive and multifaceted Community Health Needs Assessment (CHNA)[6] to identify the community's highest priority healthcare needs[7], which are as follows:

1) **Access to care**, particularly primary care where extreme physician shortages and limited access points present serious barriers for patients to receive the care they need;

2) **Financial stability**, as high unemployment and high poverty rates (double the national average) create barriers to accessing insurance coverage, healthcare services, and healthy food; and

3) **Health conditions,** especially chronic health conditions, that highlight the need for early intervention, including obesity, heart disease, cancer, and diabetes.

Addressing these critical health needs will require significant investment, county-wide collaboration, and new approaches and avenues to delivering care. The CHNA does not include any existing or expected community needs or priorities related to obstetrics and delivery services.

Given these findings, it is a crucial time to reassess the allocation of scarce resources to ensure Adventist Health Delano is investing where the community needs it most.

[6] The Patient Protection and Affordable Care Act of 2010 requires nonprofit hospitals to complete community health needs assessments (CHNAs) every 3 years. The CHNA is a public document and represents the collaborative work between community stakeholders and the local hospital(s), partnering to identify, gather and analyze the most significant health needs of their community.

[7] The lower priority significant identified health needs included: Community Vitality, Housing, Food Security, Mental Health, Public Safety, Health Risk Behaviors, Education, and COVID.

Adventist Health Delano Service Area Analysis

An assessment of Adventist Health Delano's current operations, the Obstetrics Solution, and the vital needs of the Service Area indicates that the Obstetrics Solution initially considered is no longer necessary, and the significant resources and investments required to support the Obstetrics Solution could be better utilized to address the community's most critical health needs.

More specifically and as discussed in more detail below, an evaluation of the Adventist Health Delano's obstetrics and delivery service line revealed:

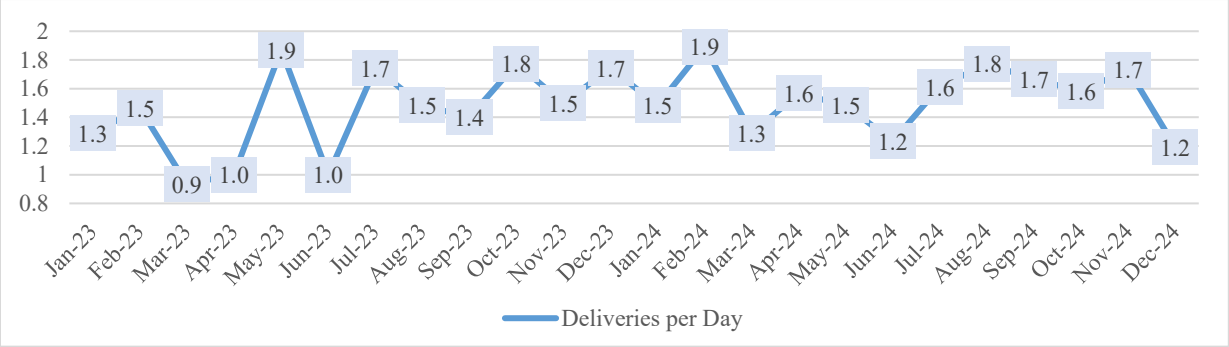
1. Obstetrics and delivery utilization is far from reaching capacity,
2. Patients are choosing to seek care elsewhere,
3. Staffing challenges and shortages limit expansion opportunities,
4. Utilization and staffing challenges compound to drive recurring financial losses, and
5. Resources can be better optimized to address the community's most critical needs.

1. Obstetrics and Delivery Utilization is Far from Reaching Capacity

Utilization of the Obstetrics Unit

Over the past 5 years, Adventist Health Delano has averaged approximately ~550 deliveries per year, or less than two deliveries per day on average as illustrated in **Figure 2** below. This is significantly less than nearby hospitals in Kern County – for example, 4 hospitals in Bakersfield (all less than 35 miles away) perform approximately 3 to 7 times more deliveries than Adventist Health Delano[8].

Figure 2: Average Deliveries per Day from January 2023 through December 2024



To effectively care for these patients, Adventist Health Delano currently maintains 16 licensed beds distributed across 7 rooms. Due to low patient volumes (i.e., less than two deliveries per day on average), and to afford patients privacy, the 7 rooms are typically utilized as single occupancy spaces.[9] These rooms are currently configured as follows: 4 Labor, Delivery, Recovery, and Postpartum (LDRP) rooms, 2

[8] See Figure 6b for additional detail.
[9] This arrangement allows for the flexibility to expand and utilize additional beds (up to 16 in total) if necessary.

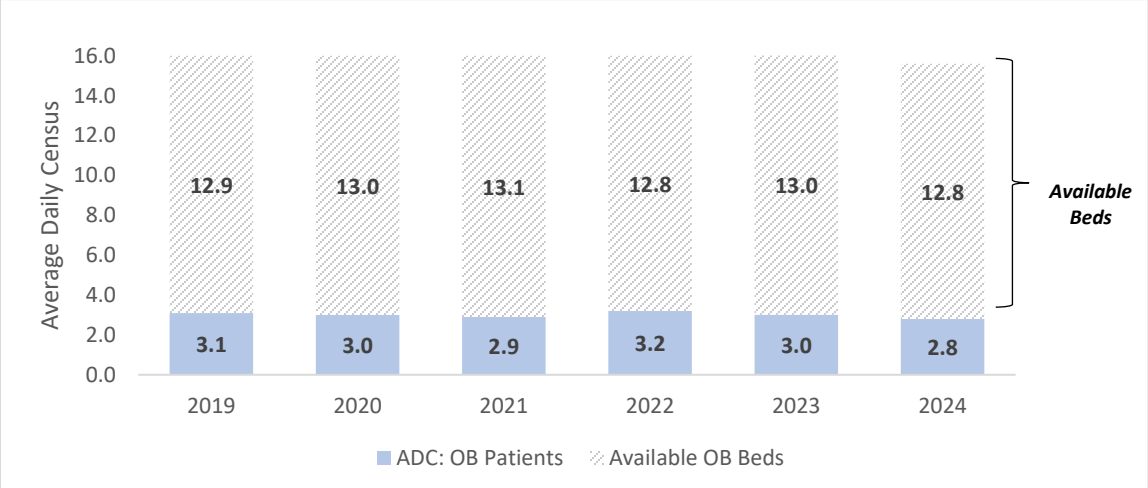
Postpartum rooms, and 1 room for triage, preoperative procedures, and post-anesthesia care, as needed. Notably, Adventist Health Delano is in the process of acquiring additional LDRP beds in order to convert the 2 existing Postpartum rooms into full LDRP rooms, increasing the flexibility of these rooms to be utilized for both labor and delivery as well as recovery and postpartum care, while also improving the continuity of care and patient experience[10].

Given the low patient volumes at Adventist Health Delano, the utilization of these beds and rooms is very low. An analysis of the Average Daily Census (ADC) for obstetrics and delivery services at Adventist Health Delano indicates that fewer than 3.0 beds are being utilized on average per day for all obstetrical and delivery services, including labor and delivery, postpartum, recovery, triage, and all other OB services (see **Figure 3a and 3b** below). When comparing this to 16 available beds and 7 rooms, the implied occupancy is low (i.e., approximately 18.8% and 42.9%, respectively, over the past 6 years, on average).

Figure 3a: OB Bed/Room Utilization

OB Bed Utilization	2019	2020	2021	2022	2023	2024	Average
Average Daily Census (ADC)	3.1	3.0	2.9	3.2	3.0	2.8	3.0
Obstetrics Beds	16.0	16.0	16.0	16.0	16.0	16.0	16.0
Implied Occupancy Rate – Beds[11]	***19.4%***	***18.8%***	***18.1%***	***20.0%***	***18.8%***	***17.6%***	***18.8%***
Obstetrics Rooms[12]	7.0	7.0	7.0	7.0	7.0	7.0	7.0
Implied Occupancy Rate - Rooms[13]	***44.3%***	***42.9%***	***41.4%***	***45.7%***	***42.9%***	***45.7%***	***42.9%***

Figure 3b: OB Average Daily Census (Patients in Beds)



[10] Project expected to be complete in 2025.
[11] Calculated as ADC divided by number of licensed beds (16).
[12] Represents OB-dedicated rooms. Other rooms (i.e., Med-Surg rooms) are readily available to support OB patients as needed.
[13] Calculated as ADC divided by number of rooms (7).

The existing unit is also more than sufficient to comfortably accommodate patient surges. Although the ADC has remained below 3.2 over the past 5 years (on average), occasionally there are patient surges due to the unpredictable nature of labor and delivery. The peak daily census, or the highest number of inpatients seen within the unit on any given day throughout the year, has ranged from 9 to 12 patients over the last 6 years, which is well below the 16 available beds.

As illustrated above, Adventist Health Delano has more than enough capacity within its existing obstetrics and delivery unit to support the current needs of the community, and current patient demand does not warrant an expansion of these services. Rather, Adventist Health Delano has been able to continue to meet the needs of the community through the targeted investments and enhancements it has (and continues to make) within its existing unit.

Utilization of the Overall Hospital

Further, not only does the obstetrics and delivery unit have sufficient capacity, but Adventist Health Delano has ample available capacity across its larger hospital campus of 156 licensed beds to accommodate any additional patient needs. The hospital currently only utilizes 40.5%, or 63.2, of its total licensed beds of 156, on average (as illustrated in **Figure 1** above). Furthermore, the majority of these volumes (48.7 of the 63.2 ADC) relate to the Special Care Unit, a long-term care sub-acute care unit that provides services to seriously ill but stable patients. When excluding the Special Care Unit, Adventist Health Delano's average daily census is 14.5, including obstetrics and delivery patients, across 105 total available beds (~14% occupancy). In a hypothetical (but highly unlikely) situation where labor and delivery volumes increased significantly beyond historical levels, Adventist Health Delano would have more than enough physical capacity to care for these patients.

In an attempt to draw more patients to Delano and better utilize its available capacity, Adventist Health Delano has proactively invested in a number of marketing efforts. For example, over the past 4 years, Adventist Health has invested over $100,000 in advertisements for obstetrics and delivery services, including billboards, social media ads, paid Google searches, and print magazines ads. However, despite these efforts, volumes have remained consistently low and relatively static.

Demographic Trends

Based on an analysis of demographic data and trends, Adventist Health Delano does not anticipate the utilization of these services to materially increase in the near future. Notably, as discussed in further detail below, the overall population in the city of Delano is relatively small and has been decreasing in recent years, a portion of that population is incarcerated in nearby prisons or receives care elsewhere, and birth rates have been on the decline.

Based on the latest U.S. Census Bureau data, the population of the City of Delano, or the city in which Adventist Health Delano is located and where approximately 60% of the hospital's volume originates, was estimated to be 51,500 in 2023 (relative to a total Kern County population of 909,235). Between 2010 and 2023, the population in the City of Delano *decreased* by 2.9%, while the population within the State of California and the United States *increased* by 4.6% and 8.5%, respectively. In addition, the City of Delano has a lower portion of females (42.5%) relative to both California (50.1%) and the United States (50.5%). It is also important to note that approximately 13% of the population in the City of Delano consists of prison inmates as the city is home to two all-male prisons – North Kern State Prison

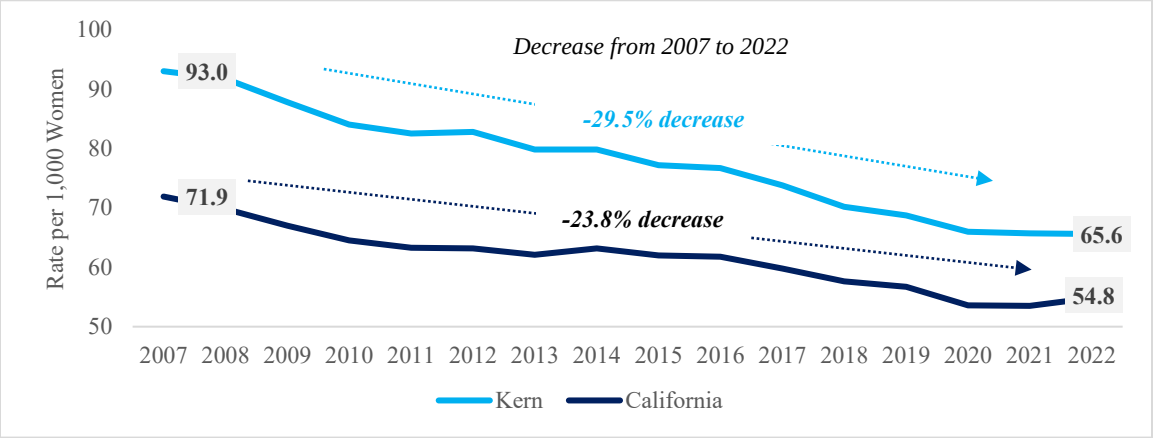
and Kern Valley State Prison[14] – meaning that the true City of Delano population size that Adventist Health Delano can reach is less than 45,000 people.

Figure 4: Demographic Data[15]

	City of Delano	Kern County	State of California	United States
Population – 2010 Census	53,041	839,631	37,253,956	308,745,538
Population – 2023 Estimate	51,500	909,235	39,538,223	331,449,281
Change from 2010 to 2023, Percent	-2.9%	8.8%	4.6%	8.5%
Female Persons, Percent	42.5%	49.3%	50.1%	50.5%

In addition to the already low population in the area, the number of babies being born each year has been on a steady decline, following national, state and county trends, and declining at a faster rate than the State of California overall. As illustrated in **Figure 5a** below, the Fertility Rate, or the number of live births per 1,000 females of reproductive age, defined as ages 15-44 years, in Kern County has decreased by 29.5% since 2007 and 12.5% in the most recently reported 5 years alone (2017 through 2022). Over the same period, births per 1,00 females of reproductive age declined at a slower 23.8% within the State of California overall.

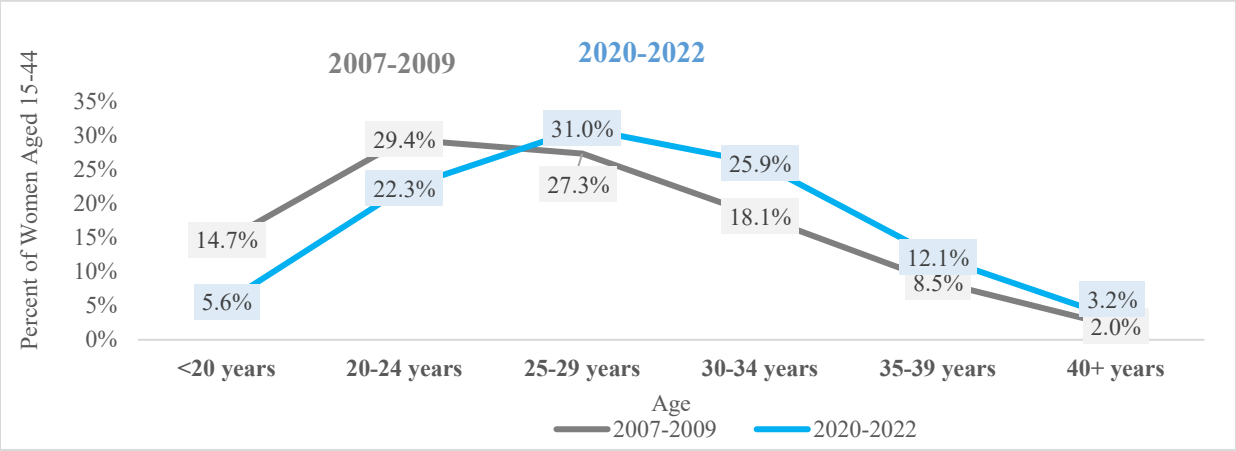
Figure 5a: State of California and Kern County Fertility Rates[16]



[14] City of Delano 2022-2023 Annual Action Plan, City Manager's Office.
[15] United States Census Bureau.
[16] California Department of Public Health data: https://www.cdph.ca.gov/Programs/CFH/DMCAH/surveillance/Pages/Births.aspx.

Birth rates in California have plummeted due to economic challenges, an increase in women pursuing education or work, fewer young adults marrying, and reduced immigration, mirroring broader nation-wide and even global trends.[17] Several of these factors, particularly economic challenges, have also been felt in Kern County. These factors have not only led to a decline in fertility rates but also caused a structural age shift, resulting in an increase in births among older women and a decrease among younger women. As a result, the peak child-bearing age in Kern County has moved from ages 20 to 24 (2007-2009) to 25 to 29 (2020-2022), as shown in **Figure 5b.**[18] This delay in childbirth further contributes to a lower fertility rate due to the natural decline in reproductive health and increased pregnancy complications with age.[19]

Figure 5b: Births by Age in Kern County[20]



While historical and current patient volumes remain low, and nationwide, state, and local demographic trends, as indicated above, suggest no imminent increase, Adventist Health Delano remains steadfast in its efforts to modernize and enhance its existing infrastructure to continue to meet the needs of its evolving patient base.

2. Patients are Seeking Care Elsewhere

Based on average patient volumes from 2019 through 2023, ~67% of patients in Adventist Health Delano's Service Area[21] leave the area to receive obstetrical and delivery services with the majority of these patients seeking care in Bakersfield, California (see **Figures 6a and 6b** below).

[17]Source: Public Policy Institute of California: https://www.ppic.org/publication/whats-behind-californias-recent-population-decline-and-why-it-matters/ and https://www.ppic.org/blog/californias-plunging-birth-rates/
[18] California Department of Public Health data: https://www.cdph.ca.gov/Programs/CFH/DMCAH/surveillance/Pages/Births.aspx
[19]Source: California Department of Public Health data: https://www.cdph.ca.gov/Programs/CFH/DMCAH/Pages/default.aspx and American College of Obstetricians and Gynecologists (ACOG): https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2014/03/female-age-related-fertility-decline
[20] California Department of Public Health data: https://www.cdph.ca.gov/Programs/CFH/DMCAH/surveillance/Pages/Births.aspx
[21] Based on Service Area definition included in the Attorney General's Conditional Consent letter dated November 22, 2019, which includes the following eight zip codes: 93215, 93216, 93219, 93249, 93250, 93261, 93280, 93201. More than 90% of Adventist Health Delano's total inpatient discharges originate from the Service Area.

Figure 6a: Service Area Obstetrical and Delivery Patient Volume by Facility[22]

Hospitals	# of Encounters					As a % of Total				
	2019	2020	2021	2022	2023	2019	2020	2021	2022	2023
Adventist Health Delano	**550**	**515**	**524**	**606**	**536**	**32.2%**	**30.1%**	**31.5%**	**35.4%**	**35.1%**
Other Facilities	**1,157**	**1,198**	**1,142**	**1,108**	**989**	**67.8%**	**69.9%**	**68.5%**	**64.6%**	**64.9%**
Bakersfield Memorial Hospital	390	367	379	294	211	22.8%	21.4%	22.7%	17.2%	13.8%
Kern Medical Center	231	278	261	293	264	13.5%	16.2%	15.7%	17.1%	17.3%
Mercy Hospital Bakersfield	218	220	215	197	218	12.8%	12.8%	12.9%	11.5%	14.3%
Adventist Health Bakersfield	167	142	143	153	149	9.8%	8.3%	8.6%	8.9%	9.8%
Kaweah Delta Medical Center	93	103	64	87	78	5.4%	6.0%	3.8%	5.1%	5.1%
Sierra View Medical Center	24	36	22	24	27	1.4%	2.1%	1.3%	1.4%	1.8%
Other	34	52	58	60	42	2.0%	3.0%	3.5%	3.5%	2.8%
Total	**1,707**	**1,713**	**1,666**	**1,714**	**1,525**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Bakersfield is located less than 35 miles from Delano and offers patients a number of high-quality OB care options, including Bakersfield Memorial Hospital, Kern Medical Center, Mercy Hospital Bakersfield, and Adventist Health Bakersfield. In addition to Bakersfield, patients also travel to Kaweah Delta Medical Center in Visalia and Sierra View Medical Center in Porterville, both of which are located in Tulare County.

Figure 6b: Patients in the Service Area Seek Obstetrical and Delivery Services at Various Facilities

Hospitals[23]	System Affiliation	City	Licensed OB Beds[24]	Total Annual Births[25]	Leapfrog Rating[26]	Baby Friendly Designation	Level of Maternal Care (LoMC)[27]	Distance From Delano[28]
Adventist Health Delano	Adventist Health	Delano	16 beds	542	B	No	1	***n/a***
Bakersfield Memorial Hospital	Dignity Health	Bakersfield	30 beds	3,656	A	Yes	2	*32 miles*
Kern Medical Center	UCLA Health	Bakersfield	54 beds	1,961	B	Yes	2	*34 miles*
Mercy Hospital - Bakersfield	Dignity Health	Bakersfield	26 beds	2,407	A	Yes	2	*33 miles*
Adventist Health Bakersfield	Adventist Health	Bakersfield	23 beds	2,032	B	Yes	2	*31 miles*
Kaweah Delta Medical Center	Kaweah Health	Visalia	89 beds	4,558	B	No	3	*48 miles*
Sierra View Medical Center	Independent	Porterville	10 beds	1,318	B	Yes	2	*30 miles*
Other	Various	Various	Various	Various	Various	Various	Various	*various*

As illustrated in the tables above, the six hospitals in Bakersfield, Visalia, and Porterville, where the majority of patients from the Adventist Health Delano Service Area are choosing to receive care as an alternative to Adventist Health Delano, are all located 30-40 miles from Adventist Health Delano and provide higher acuity care with more comprehensive support services. Further, all six hospitals see significantly higher obstetrics and delivery volumes than Adventist Health Delano – notably, in 2023,

[22] Source: INTELLIMED Market Share Profile System based on publicly available data from 2019 to 2023 from the following area zip codes: 93215, 93216, 93219, 93249, 93250, 93261, 93280, 93201; Major Diagnostic Category (MDC) / Service Line filtered to 14, *Pregnancy Childbirth & The Puerperium,* which includes Diagnosis-Related Group (DRG) codes from the "Obstetrics-Delivery" and "Obstetrics-Other" Service Lines.
[23] Delano Regional Medical Center and San Joaquin Community Hospital have been rebranded to Adventist Health Delano and Adventist Health Bakersfield, respectively.
[24] Source: California Department of Public Health, Licensed and Certified Healthcare Facility Bed Types and Counts.
[25] Source: California Department of Health Care Access and Information (HCAI) Annual Audited Financial Reports for fiscal year 2023.
[26] Source: Leapfrog Hospital Safety Grade, Spring 2025.
[27] Source: https://www.acog.org/programs/lomc. Actual rating for each hospital sourced from hospital websites as of December 2024.
[28] Source: Google Maps; estimated mileage from Adventist Health Delano.

each of the other hospitals averaged 3.6 to 12.5 births per day (or an average of 7.3 births per day) while Adventist Health Delano averaged 1.5 births per day. Like most service lines, research suggests there is a volume-outcome relationship in obstetrics and delivery services, where higher hospital delivery volumes are often associated with better outcomes for infants and others, particularly in high-risk cases.[29]

All 6 hospitals have either a Level 2 (Specialty Care) or Level 3 (Subspecialty Care) Maternal Level of Care (LoMC), as defined by the American College of Obstetricians and Gynecologists (ACOG)[30], whereas Adventist Health Delano is the only hospital with a Level 1 (Basic Care) rating. The ACOG defines **Level 1** as Basic Care for low to moderate-risk pregnancies, **Level 2** as Specialty Care for moderate to high-risk antepartum, intrapartum, and postpartum conditions, and **Level 3** as Subspecialty Care for more complex maternal medical conditions, obstetric complications, and fetal conditions. As previously highlighted and discussed in more detail later in the report, residents of Delano and the broader Kern County area exhibit high rates of diabetes and chronic diseases, and consequently, many women in the area enter pregnancy with pre-existing health conditions, categorizing them as high-risk patients. These women often require the more specialized and higher acuity medical care that is offered at the Bakersfield hospitals.

In addition to the Level 2 rating, all four hospitals in Bakersfield and Sierra View Medical Center have been awarded the Baby-Friendly designation by the Baby-Friendly Hospital Initiative (BFHI), a global program launched by the World Health Organization (WSO) and United Nations Children's Fund (UNICEF). The Baby-Friendly designation signifies a hospital's commitment to providing optimal care for infant feeding and mother-baby bonding, promoting better health outcomes.[31] Adventist Health Delano has not received this designation.

Patients tend to choose Bakersfield over Adventist Health Delano for medical care due to convenience and habit. Many of the residents of Delano travel to Bakersfield (and elsewhere) for their jobs and everyday tasks (e.g., shopping, dining, etc.). Based on demographic data, 95.1% of working women in Delano commute to work with an average commute of 18.5 minutes.[32] Since many of these women travel outside of Delano for work, particularly to Bakersfield, the proximity makes scheduling medical appointments in Bakersfield convenient. This data indicates that accessing services in Bakersfield is both a practical and frequently preferred choice for these women.

3. Staffing Challenges and Shortages Limit Expansion Opportunities

The healthcare industry is facing a widespread shortage of qualified medical staff, and Adventist Health Delano's Maternity Care[33] is no exception. Recruiting for Maternity Care services is particularly challenging as a typical inpatient unit requires a range of dedicated and specialized talent, including obstetricians, midwives, obstetric nurses, anesthesiologists, pediatricians, and respiratory therapists. Additionally, Maternity Care units require 24-hour staff and a full-time team even when there are few births. Like many health systems across the country, Adventist Health Delano has faced significant

[29] American College of Obstetricians and Gynecologists (ACOG).
[30] Source for Level of Maternal Care rating definition: https://www.acog.org/programs/lomc. Actual rating for each hospital sourced from hospital websites.
[31] Source: https://www.babyfriendlyusa.org/about/. Approximately 25% of births nationally take place in a Baby-Friendly designated facility.
[32] Source: U.S. Census Bureau, U.S. Department of Commerce, "Commuting Characteristics by Sex." American Community Survey, ACS 5-Year Estimates Subject Tables, Table S0801, 2023.
[33] The Maternity Care service line at Adventist Health Delano includes obstetrics and delivery services.

challenges in recruiting and retaining the staffing levels, particularly for physicians and nurses, needed to provide robust and high-quality Maternity Care services.

Physician Challenges

Adventist Health Delano has experienced difficulty recruiting and retaining physicians to the Adventist Health Delano Service Area. Staffing challenges were exacerbated by COVID-19 and are not expected to lessen in the near future. According to estimates from the Federal Health Resources and Services Administration, California is projected to have a shortage of 1,100 obstetricians by 2030.[34] The shortage, seen both nationwide and at Adventist Health Delano, is exacerbated by an aging pool of physicians with many reaching retirement age, along with widespread feelings of burnout among healthcare professionals.[35]

Given the critical nature of labor and delivery services, aging and soon-to-retire physicians can have significant repercussions. Recruiting new physicians is particularly challenging for Adventist Health Delano due to its remote location and relatively low patient volumes. In order to attract and retain new physicians, Adventist Health Delano typically has to subsidize physicians, offering financial incentives, such as higher salaries and bonuses. Despite these efforts, Adventist Health Delano is still actively recruiting for three additional OB/GYN providers, including: 1 Medical Doctor (MD), 1 Certified Nurse Midwife (CNM), and 1 Advanced Practice Provider (APP).

To address the immediate need for medical professionals and ensure continuous patient care, Adventist Health Delano, like other hospitals, has had to rely on locum tenens, or third-party doctors to fill critical staffing gaps. These ongoing efforts to fill these positions have contributed to the rise in professional fees from $96,891 in 2020 to $569,093 in 2024 (refer to **Figure 7** below), due to higher hourly rates, agency fees, and travel expenses associated with employing locum tenens. Last year, one locum covered over 50% of the on-call labor and delivery physician shifts at Adventist Health Delano. Furthermore, the reliance on locum tenens exacerbates the lack of preceptorship and training opportunities. This creates a challenging environment where the shortage of permanent staff leads to fewer training opportunities, which in turn makes it harder attract and retain new staff.

Registered Nurse (RN) Challenges

The staffing challenge extends beyond physicians. High turnover for RNs has significantly impacted the stability and appropriateness of nursing staffing levels. In 2023, the turnover rate was a staggering 45.9%. Although turnover has improved in 2024 to 19.7%, this remains well above the 2024 industry benchmark of 14.5% for RNs.[36] This persistent turnover necessitates continuous hiring efforts. For instance, Adventist Health Delano currently has four open positions for obstetrics registered nurses (RN), three of which have been open for more than six months.

To address staffing challenges, Adventist Health Delano has implemented several strategic initiatives to fill open positions. These initiatives include offering a $15,000 hiring incentive for all obstetric RN positions and featuring these roles on Indeed, a popular job search platform. Further, Adventist Health's standard practice (for all employees) is to routinely assess employee compensation rates and to adjust timely as needed to ensure employee compensation is at market rates. Despite these recruiting and

[34] U.S. Department of Health and Human Services Data: https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/projections-supply-demand-2018-2030.pdf
[35] Source: Definitive Healthcare: https://www.definitivehc.com/resources/research/healthcare-staffing-shortage
[36] Industry benchmark based on annual report published by Saratoga.

employee initiatives, Adventist Delano Health has experienced limited success in stabilizing its workforce and filling critical staffing gaps.

Similar to the use of third-party physician locums to address physician shortages, as outlined above, Adventist Health Delano has increasingly turned to contract labor nurses to fill critical RN staffing gaps. Not only can this disrupt the continuity of care and patient and employee experience, but it is considerably more expensive, further deteriorating the financial position of the hospital. Since 2019, Adventist Health Delano has contracted 28 OB personnel, including 26 registered nurses and 2 technicians, to fill in the shortage.

Rising Labor Costs

As illustrated in **Figure 7** below, total labor costs associated with Maternity Care services have more than doubled between 2020 and 2024, increasing from $2.3 million to $5.1 million (or approximately 22% on average each year), despite relatively flat deliveries, which only increased by approximately 4% on average each year over that same period. Contract labor costs and other premium labor costs (e.g., overtime) have represented a significant portion of this increase.

Figure 7: Direct Labor Expense for the Maternity Care Service Line[37]

Direct Expenses ($'s)	2020	2021	2022	2023	2024
Salaries and Wages	$1,535,627	$1,803,594	$2,523,479	$2,181,344	$2,708,104
Benefits	$678,574	$761,936	$975,932	$926,224	$1,211,141
Contract Labor	0	$133,099	$1,109,352	$813,996	$621,839
Professional Fees	$96,891	$476,450	$$515,017	$565,300	$569,093
Total Labor Expense	**$2,311,092**	**$3,175,079**	**$5,123,780**	**$4,486,864**	**$5,110,177**
Annual Growth %		***37.4%***	***61.4%***	***-12.4%***	***13.9%***

Despite these significant staffing challenges, Adventist Health is committed to continuing to maintain, invest in, and enhance its current Maternity Care unit and services, as appropriate; however, the expansion of this unit as originally contemplated in the Affiliation Agreement is not justified by current patient volumes or the availability of the critical clinical staff. Additionally, given the limited supply of obstetrics staff for the larger service area (i.e., Kern County), which is well below current demand for these staff, it is in the best interests of the community to carefully align staffing and investment with overall labor and delivery care utilization patterns to best meet patient needs.

4. Financial Losses

Financial Performance of the Maternity Care Service Line at Adventist Health Delano

The financial performance of the Maternity Care service line at Adventist Health Delano is significantly impacted by the operational challenges highlighted in sections above, from low patient volumes, to staffing shortages rendering high costs, to challenges faced in recruiting, and the ongoing efforts to address these issues. Operating expenses more than doubled the revenue for these services, driving significant, recurring operating losses. Over the past 5 years, these operating losses have ranged from approximately $1 million to $4 million per year, or $11.9 million in total, as illustrated in **Figure 8a**.

[37] The Maternity Care service line at Adventist Health Delano includes the Obstetrics Unit and Nursery Unit, including normal newborns and neonatology.

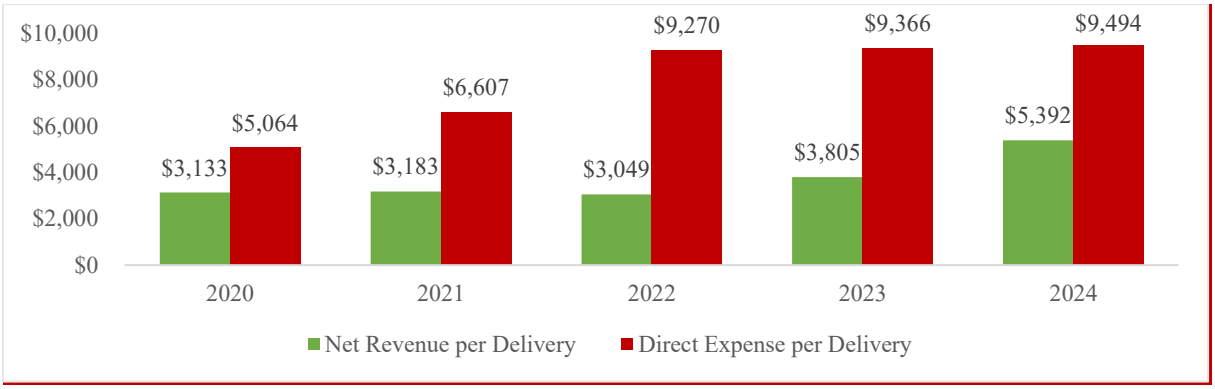
Figure 8a: Profit & Loss Statement for Maternity Care Service Line

Profit & Loss Statement ($'s)	2020	2021	2022	2023	2024
Deliveries (volume)	502	525	608	522	585
Gross Revenue	$4,130,225	$4,287,309	$4,870,556	$5,215,116	$8,284,634
Less: Contractual Allowance (Discounts)[38]	2,557,309	2,616,488	3,016,480	3,229,040	5,130,476
Net Patient Service Revenue	**1,572,916**	**1,670,821**	**1,854,076**	**1,986,076**	**3,154,158**
Less: Direct Expenses[39]	2,542,374	3,468,937	5,636,233	4,889,083	5,553,952
Operating Gain (Loss)	**($969,458)**	**($1,798,116)**	**($3,782,157)**	**($2,903,007)**	**($2,399,794)**
Operating Margin %	*-61.6%*	*-107.6%*	*-204.0%*	*-146.2%*	*-76.1%*

As shown in the table above, Net Patient Service Revenue has remained relatively steady over the past 5 years outside of an increase from $2.0 million in 2023 to $3.2 million in 2024, which was driven by an improvement in revenue cycle processes (e.g., billing and coding) versus increases in patient volume. Over the same 5-year period, expense growth significantly outpaced revenue growth, surging from $2.5 million in 2020 to a $5.6 million in 2024 (118% growth), resulting in increasing operating losses.

As expense growth continues to outpace revenue growth, Adventist Health Delano is losing an increasing amount of money year-over-year (see **Figure 8b** below). As illustrated in the chart, revenue per delivery is not sufficient to cover expenses per delivery, resulting in Adventist Health Delano having to fund these additional expenses (or operating losses). For example, as of 2024, Adventist Health Delano is losing $4,102 per delivery on average before administrative and operational overhead is even considered or accounted for (revenue minus direct expenses).

Figure 8b: Average Revenue and Expenses per Delivery



A few factors contribute to this trend. As discussed previously, the utilization rate of Maternity Care services has been low at Adventist Health Delano, due to declining birth and fertility rates and patients seeking care elsewhere. This results in the high, and increasing, fixed costs associated with running a Maternity Care unit (e.g., 24/7 specialized staffing and equipment requirements) being spread over a relatively low number of patient volumes, driving high per-delivery costs, and contributing to the operating losses.

[38] Contractual Allowances (Discounts) are estimated based on based on overall collection rates for Adventist Health Delano as payments (i.e., Net Patient Service Revenue) are not tracked at the service line level.
[39] Direct expenses do not account for certain indirect expenses (e.g., corporate and administration costs, facility costs, etc.). When accounting for these additional costs, the operating losses would be even more significant.

Even in a (highly unlikely) scenario where Adventist Health Delano were to see higher patient volumes, the financial picture described above, i.e., significant operating losses, would likely not be materially impacted, or lessened, due to reimbursement challenges. Reimbursement for obstetrics and delivery services is typically not sufficient to cover the high expenses required to support these patients, particularly for Medicaid patients. Medicaid plans provide significantly lower reimbursement than commercial payors, and Medi-Cal, California's Medicaid program, has the fifth lowest reimbursement rates for obstetric care in the nation.[40] This has a significant impact on Adventist Health Delano, which has a nearly 90% Medicaid OB patient base on average.[41] Reimbursement per patient is not sufficient to cover costs per patient (even before considering fixed overhead and facility costs), resulting in incremental losses for each incremental patient.

[40] Source: KFF Medicaid-to-Medicare Fee Index, 2019.

[41] OB Medicaid volume estimated based on the encounters at Adventist Health Delano within the Adventist Health Delano's Service Area (average of ~87.1% of OB volume from 2019 to 2023); Medicaid as a percentage of total OB volume was 90.2% (2019), 88.7% (2020), 87.6% (2021), and 86.1% (2022), 83.0% (2023). Source: INTELLIMED Market Share Profile System based on publicly available data from 2019 to 2023; Major Diagnostic Category (MDC) / Service Line filtered to 14, *Pregnancy Childbirth & The Puerperium,* which includes Diagnosis-Related Group (DRG) codes from the "Obstetrics-Delivery" and "Obstetrics-Other" Service Lines.

Financial Performance of the Overall Adventist Health Delano Hospital

Since completing the affiliation on December 31, 2019, the financial performance of Adventist Health Delano has significantly deteriorated, as expense growth has outpaced revenue growth – notably, between 2019 and 2024, operating expenses grew by 40.5%, while revenue grew only by 9.5% – driving increasing Operating Losses for the hospital.

As illustrated in **Figure 9** below, Adventist Health Delano has experienced Operating Losses in four of the five years since the affiliation (2020 through 2024), with total net Operating Losses of -$45.9 million over the five years. Adventist Health Delano has had to rely on investment income (included in Net Non-Operating Income in **Figure 9** below) to help fund these Operating Losses, but even when accounting for investment income, Adventist Health Delano still had a total Net Income Losses of -$18.4 million over the past five years.

The following factors contributed significantly to these increasing Operating Losses post-affiliation:

- The COVID-19 pandemic and the associated increases in labor and supply expenses (COVID-related expenses estimated to be approximately $15.0 million between 2020 and 2023)
- Unexpected post-affiliation investments, notably, an estimated annual increase of $10.5 million in employee Salary/Wages and Benefits to be in-line with Adventist Health standards/programs and to reduce employee turnover
- Funding of unprofitable services lines (e.g., Maternity Care)

Figure 9: Profit & Loss Statement for Adventist Health Delano

Profit & Loss Statement ($'s)[42]	2019	2020	2021	2022	2023	2024
Patient Days	24,316	25,186	25,738	23,927	23,009	23,574
Discharges (Excluding Nursery)	2,316	1,950	2,115	2,126	2,029	2,565
Average Length of Stay	10.5	12.9	12.2	11.3	11.3	9.2
Net Patient Service Revenue	$99,723,561	$82,633,610	$98,896,954	$79,101,524	$96,148,674	$100,351,865
Other Operating Revenue	$493,935	$2,598,428	$4,812,451	$1,503,533	$718,461	$9,377,218
Total Operating Revenue	**$100,217,496**	**$85,232,038**	**$103,709,405**	**$80,605,057**	**$96,867,135**	**$109,729,083**
Growth (%)	*n/a*	*(15.0%)*	*21.7%*	*(22.3%)*	*20.2%*	*13.3%*
Operating Expenses	$83,219,502	$86,186,057	$102,627,401	$114,313,045	$102,030,757	$116,889,679
Growth (%)	*n/a*	*3.6%*	19.1%	*11.4%*	*(10.7%)*	*14.6%*
Operating Income (Loss)	**$16,997,994**	**($954,019)**	**$1,082,004**	**($33,707,988)**	**($5,163,622)**	**($7,160,596)**
Operating Margin %	*17.0%*	*(1.1%)*	*1.0%*	*(41.8%)*	*(5.3%)*	*(6.5%)*
Net Non-Operating Income	$3,565,781	$1,991,705	$4,721,876	($2,010,374)	$14,388,979	$8,457,384
Net Income (Loss)	**$20,562,775**	**$1,037,686**	**$5,803,880**	**($35,718,362)**	**$9,225,357**	**$1,296,788**
Net Income Margin %	*20.5%*	*1.2%*	*5.6%*	*(44.3%)*	*9.5%*	1.2%

[42] Source: California Department of Health Care Access and Information (HCAI) Annual Audited Financial Reports. For 2024, the Annual Audited Financial Report was not available as of the date of this report; therefore, the sum of the four Quarterly Reports was used for 2024. Note that figures do not include the estimated $8.4 million in COVID-19 funding that Adventist Health Delano received from FEMA between 2022 and 2024.

5. Community Needs and Resource Optimization

As discussed previously, Adventist Health Delano's most recent CHNA[43] revealed that 1) Access to Care, 2) Financial Stability, and 3) Health Conditions were the highest priority needs for the Delano community. Voices in the community noted that that it can take months to see a primary care doctor, and specialty care is viewed as extremely difficult to arrange. The CHNA reveals that Delano's Primary Service Area (CHNA PSA)[44] has 41.59 primary care providers per 100,000 people, significantly lower than Tulare County (61.72), Kern County overall (65.00), California (99.79), and the U.S. (104.44), indicating the severe shortage of primary care providers.

Due to the long wait times in connecting patients to providers, residents of Delano are less likely to receive early preventative care, which often escalates to more serious eventual health issues. The lack of interaction with primary care providers can also lead to an overall lack of awareness regarding basic health and wellbeing practices such as diet and exercise.

As presented in **Figure 10** below, data collected between 2020 and 2022 by the California Health and Human Services Agency paints a severe picture of the health status of Kern County[45], with age adjusted mortality due to a number of diseases and other death causes being significantly worse than California overall as well compared to the other 57 counties in the state.

Figure 10: Kern County Health Status Indicators[46]

Age Adjusted Mortality (Per 100,000 Population)	Year	Kern County	California	% Difference	Rank out of 58 Counties
Deaths Due To All Causes	*2020-2022*	951.1	670.0	42%	53
Diabetes	*2020-2022*	48.8	23.6	107%	58
Coronary Heart Disease	*2020-2022*	118.6	77.2	54%	57
Alzheimer's Disease	*2020-2022*	51.9	35.5	46%	55
Chronic Lower Respiratory Disease	*2020-2022*	52.6	24.5	115%	55
Chronic Liver Disease and Cirrhosis	*2020-2022*	21.6	14.4	50%	38
All Cancers	*2020-2022*	138.1	122.0	13%	38
Lung Cancer	*2020-2022*	24.1	20.6	17%	33
Influenza & Pneumonia	*2020-2022*	14.2	10.9	30%	47
Cerebrovascular Disease (Stroke)	*2020-2022*	38.4	37.0	4%	33
Unintentional Injuries (excluding motor vehicles)	*2020-2022*	85.2	47.9	78%	48
Drug Overdose Deaths	*2020-2022*	50.0	25.3	98%	52
Suicide	*2020-2022*	12.7	10.1	26%	34
Motor Vehicles	*2020-2022*	21.9	11.5	90%	45

Key:

Indicates Kern County is worse than California by more than 10.0%
Indicates Kern County is within 5.0% of California
Indicates Kern County is better than California by more than 5.0%
Indicates that Kern County is ranked in the bottom quartile of all 58 counties

As evident in the table above, diabetes is one of the most significant health issues facing Kern County with an age adjusted mortality that is 107% higher than California, ranking Kern County as the highest county in the state for diabetes mortality (58 of 58). The Adventist Health Delano 2022 CHNA also

[43] Adventist Health Delano 2022 Community Health Needs Assessment (CHNA).
[44] For the CHNA, Adventist Health Delano expanded the Service Area by inviting Steering Committee members to include the zip codes of those they serve. As a result, the service area is comprised of the following zip codes: 93263, 93256, 93250, 93261, 93280, 93249, 93304, 93305, 93270, 93201, 93215, 93274, 93307, 93219.
[45] Adventist Health Delano is located in Kern County and more than 85% of Adventist Health Delano's patient discharges originate from Kern County.
[46] Source: California Health and Human Services Agency: County Health Status Profiles 2024. Age Adjusted Mortality, per 100,000 population, calculated using deaths between 2020-2022, and population from 2021.

highlights diabetes as a severe problem in the Delano community, emphasizing the need for primary care physicians and comprehensive diabetes management to help address the issue. Meeting this need could reduce amputations, blindness, and heart disease. As indicated in **Figure 10** above, age adjusted mortality due to heart disease is 54% higher in Kern County compared to California, with the county being ranked 57 out of 58 counties in California.

In addition to higher rates of diabetes, Kern County has significantly higher rates of other chronic health conditions than most counties in the state, including heart disease, liver disease, lung disease, and cancer. Kern County ranks 53 (of 58) counties in California in overall age adjusted mortality rates (deaths due to all causes). Clearly, the community faces significant health disparities and addressing these health conditions is crucial in order to improve the overall health and wellbeing of the community and reduce the burden on the healthcare system.

The Adventist Health Delano CHNA notes obesity as a leading factor in health issues as the community has a significantly higher rate of obesity with 37.3% of adults recorded as obese (BMI: BMI≥30.0 kg/m^2), which is nearly 10% higher than the California state average and 6% higher than the national average.

Based on the data cited above and ongoing assessments by Adventist Health Delano leadership and Kern County civil, public, and business stakeholders, increased access to primary care and specialty care is the highest priority healthcare need today and over the next several years.

Description of the Alternative Project

Based on the detailed analysis of its Service Area (above), Adventist Health Delano believes the community needs would be better served through the development of a multispecialty hospital-based clinic within Adventist Health Delano, the expansion of primary care and urgent care clinic services, and the expansion of the Special Care Unit in lieu of the Obstetrics Solution.

Multispecialty Hospital-Based Clinic

Adventist Health Delano has identified existing, available space within the hospital that would be well suited for the development of a new, multispecialty, hospital-based clinic. The clinic would include multiple exam rooms and allow for increased patient access to a variety of specialists in a single location such as General Surgery, Orthopedic Surgery, Breast Surgery, Medical Oncology, Gastroenterology (GI), and Obstetrics/Gynecology (OB/GYN). In addition, the hospital-based location of the clinic allows patients much more convenient access to imaging, lab, and other ancillary services appointments, which are located on the hospital campus, and that typically accompany specialist visits (saving patients from having to make multiple visits to different locations).

The development of the hospital-based clinic would require a number of investments by Adventist Health Delano, including, for example, construction costs to refresh and reconfigure space within the hospital into a hospital-based clinic (e.g., exam rooms, waiting room), sterile process and robotic technology investments, new surgical equipment, and wayfinding (e.g., signage). In addition, Adventist Health Delano would need to hire additional staff to assist patients in locating and accessing the clinic, including, for example, a referral coordinator, patient navigators, etc.

Expansion of Primary Care and Urgent Care Clinic Services

Not only would the development of the hospital-based clinic allow for increased access to specialists and more comprehensive care, but it would also free up valuable space in its rural health clinics to expand primary care services, which is the community's highest priority need. Some of the specialist providers are currently located in rural health clinics, so by relocating these specialists to a hospital-based clinic (and closer to patients), Adventist Health Delano would also be able to further expand primary care and urgent services and offerings in is rural health clinics (which are currently operating at capacity). For example, Adventist Health Delano would be able to add additional primary care providers to the clinics and expand hours in its Prompt Care (urgent care) locations.

Together, Adventist Health Delano's development of both the multispecialty hospital-based clinic and the related expansion of primary care and urgent care clinic services, would directly serve the community's highest priority needs as identified in the CHNA – i.e., 1) Access to Care, 2) Financial Stability, and 3) Health Conditions. Through increased and more convenient access to both primary and specialty providers and services, more patients can receive the preventative and comprehensive care required to help treat, prevent, and reduce the severe health conditions present in the community (e.g., diabetes, heart disease, cancer etc.). It would also increase the coordination of care, as Adventist Health Delano would be better positioned to help coordinate care between different specialists and levels of care, ensuring the continuity of treatment. It would also allow for a reduction in the current over-utilization of the Emergency Room that Adventist Health Delano faces, as patients would have expanded and more convenient access, to primary care and specialist providers.

Expansion of the Special Care Unit

A distinctive feature of Adventist Health Delano its Special Care Unit, which plays a crucial role in the hospital's operations. The unit provides specialized sub-acute care services to seriously ill, but stable patients. The Special Care Unit accommodates ventilator and non-ventilator dependent patients with degenerative diseases, tracheostomy and/or feeding tubes, major trauma, and coma. Unlike typical hospital units that focus on short-term acute care, the Special Care Unit is designed for patients who need extended care, requiring ongoing medical support and rehabilitation, over a longer period.

The Special Care Unit is currently operating near full capacity – notably, last year (2024) the unit had an average occupancy rate of nearly 96% throughout the year as 49 of the unit's 51 licensed beds were occupied on average (see **Figure 1**). Given the high patient demand for this service within the community, Adventist Health Delano seeks to expand the current capacity (or number of beds) within this unit. Expanding this unit will allow Adventist Health Delano to serve more patients requiring this specialized level of care that is often required for the long-term and severe Health Conditions that the community faces.

Similar to the hospital-based clinic and primary care expansion, the expansion of the Special Care Unit would require number of investments by Adventist Health Delano, including, for example, refreshing and enhancing existing patient rooms and buying new equipment in order to support the unique needs of patients within the Special Care Unit.

Conclusion

In order to be responsive to the soundings of the Delano community members and to be the best financial stewards of scarce resources, it is imperative to direct near-term efforts and investments in addressing the prioritized health needs of the community as identified in the CHNA. The Delano community has a number of healthcare challenges and elevated health conditions that require focused intervention.

The Obstetrics Solution as originally contemplated is no longer necessary and does not best address these critical needs of the community. As explored in detail in this report, an analysis of obstetrics and delivery services revealed: 1) utilization of these services is low and far from reaching current available capacity (notably, less than 3 (of 16) beds are occupied on average), 2) patients are choosing to seek care elsewhere, 3) staffing challenges and shortages limit expansion opportunities, 4) utilization and staffing challenges compound and have driven recurring (and increasing) financial losses, and 5) resources can be better optimized to address the community's most critical needs.

Ultimately, expanding this already underutilized service line through the development of a new, and costly, obstetrics and delivery facility will only further increase operating expenses, contributing to additional operating losses at Adventist Health Delano. Rather, the capital could be reallocated to support other critical health needs of the community while serving to mitigate future losses and having limited (to no) impact on Adventist Health Delano's ability to the serve the community with obstetrics and delivery. Mitigating future financial losses is critically important in order to ensure Adventist Health Delano has the financial resources it needs to both support the current operations of the hospital as well as identify and invest in new capabilities and services to continue to meet the evolving needs of its community.

Alternatively, Adventist Health Delano has an opportunity to better serve the community's needs and make a larger impact on the community through the development of a multispecialty hospital-based clinic located within Adventist Health Delano, the expansion of primary care and urgent care clinic services, and the expansion of the Special Care Unit. These investments directly address the community's highest priority needs – notably increasing Access to Care, particularly primary care and specialty care, to help manage and decrease the community's elevated and severe Health Conditions. Adventist Health Delano's community has some of the highest rates of disease and associated mortality rates in the state (and nation) which requires focused and thoughtful intervention.

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VIA CERTIFIED OVERNIGHT MAIL

October 20, 2025

California Attorney General
Melissa Hamill, Deputy Attorney General
Healthcare Rights and Access
1300 I Street, 15th Floor
Sacramento, CA 95814

Re: 2022 and 2025 Community Needs Health Assessment Submitted in Support of the Notice of Proposed Modification to the Affiliation Agreement between Adventist Health System/West and Central California Foundation for Health and Request to Modify Attorney General's consent letter dated November 22, 2019 ("Consent Letter")

Dear Ms. Hamill:

Enclosed with this letter is the (1) 2022 Community Health Needs Assessment and (2) the 2025 Community Needs Health Assessment. These two reports are being submitted to the Attorney General in support of the above referenced notice, which is being submitted concurrently.

Sincerely,

Kerry L. Heinrich
Kerry L. Heinrich
President and CEO

Enclosures

EXHIBIT A
2022 COMMUNITY HEALTH NEEDS ASSESSMENT

See Attached.

ADVENTIST HEALTH DELANO

COMMUNITY HEALTH NEEDS ASSESSMENT

2022

Adventist Health
Delano

Executive Summary

Non-profit health systems, community-based organizations and public health agencies across the country all share a similar calling: to provide public service to help improve their community members' lives. One area of public service where these entities share responsibility is ensuring all community members have the opportunity to live a healthy life.

The Community Health Needs Assessment (CHNA) is one-way public service agencies support the health of their communities. These assessments are required of non-profit hospitals and public health departments every three and five years, respectively, to understand the health needs of the communities they serve. The purpose of this assessment is to engage the communities in identifying community health needs, and to align resources across the community benefit functions of a non-profit hospital, strategies of public health, and services of community-based organizations to drive towards improved health for all.

For 2022, Adventist Health Delano took this requirement one step further with the vision of designing a story-centric and people-centric CHNA. We envisioned a concise report that the entire community could contribute to and access, regardless of public health context or reading ability. This process involved input from community focus groups and key informant interviews representing the broad interests of the community served by hospitals and collaborative organizations. In addition, input was gathered from local public health officials, community-based organizations, medical providers, students, parents, and members of selected underserved, low-income and minority populations. We intentionally prioritized understanding the social and health needs of uninsured or underinsured, low-income and minority persons in the community (see description of Focus Group participants, Section III.B).

To conduct this assessment, we used secondary and primary data from focus groups and key informant interviews conducted between October 2021 – January 2022. A local Steering Committee (see Section I.E) reviewed data and prioritized community health needs over the course of three meetings (data collection planning, data review and needs prioritization) taking place between October 2021 – March 2022. This group determined the following final community health priority areas:

Access to Care

Financial Stability

Health Conditions

In this report, you will first find a Community Summary that introduces the community served by our hospital and lists the prioritized community health needs. The Community Summary is a brief overview of the main points from the CHNA followed by an in-depth and detailed report including:

Our Partners: CHNA Steering Committee (see Section I.E)

Description of Hospital and Community Served (see Section II)

Significant Identified Health Needs and Priority Areas Selected (see Section III)

Data Collection and Analysis (see Section IV)

Prioritization Process (see Section IV)

Next Steps (see Section IV.C)

We hope this report is leveraged by all local partners and community members, empowering them to own the potential of healthy living for all. The entire report is published online and available in print form by contacting community.benefit@ah.org.

Table of Contents

What if . . .

Everyone from newborns to older patients, easily received the unique care they needed?

Families and individuals had jobs and the financial resources they needed to live a safe and healthy life?

Health concerns were managed or even eliminated through education and engagement?

Community Vision Summary

Taking a step toward a healthier, better life

This is the vision of the future as seen through the Community Health Needs Assessment, or CHNA. The goal of the CHNA is to leverage community stakeholders and data to identify and maximize resources and to focus on meeting the most significant health needs of our community over the next three years.

Members of the CHNA Steering Committee – comprised of healthcare, civic, public, and business leaders – led this process of identifying and addressing health needs for a healthier community. These members took a deep look at where people live, learn, work and play to discover areas of opportunity that, through collaboration, could be strengthened and lead to a healthier you, stronger families and safer communities.

This CHNA involved interviews with behavioral health, childhood development, city council, city government, domestic violence, education, family community-based organization, farm workers, formerly incarcerated, grape growers, healthcare, health and human services, higher education, Hispanic Chamber of Commerce, those experiencing homelessness, indigenous populations, food banks, formerly incarcerated, law enforcement, managed care, NAACP, Public Health, senior community-based organizations, students and transportation agency. We also conducted a community survey and gathered public data. Through this process, we learned about our community members' current state of health and listened to their greatest concerns for their friends and family.

There were 11 significant health needs focusing on the social determinants of health identified through this in-depth analysis and discussion. These needs were access to care, community safety, community vitality, COVID, education, financial stability, food security, health conditions, health risk behaviors, housing and mental health. The Steering Committee then selected high priority needs based on severity and prevalence, intentional alignment around common goals, feasibility of potential interventions, and opportunities to maximize available resources over a three-year period, which were: access to care, financial stability and health conditions.

The following pages share opportunities where you, your family and your community can drive change for improved well-being.

Join us to activate our diverse community, improve lives, and make a "what if" dream into a powerful "what is" reality.

What if . . .

Everyone from newborns to older patients easily received the unique care they needed, thanks to good **Access to Care**

Families and individuals had jobs and the financial resources they needed to live safe and healthy lives, with access to organizations that can help when needed to ensure **Financial Stability**

Health concerns were managed or even eliminated through education and engagement, resulting in patients' fears being reduced after an awareness about their **Health Conditions**

Getting to know our Delano CHNA service area*

The greater Delano area is recognized as one of the largest grape-growing regions in the nation, yet the unique community with a total population of 402,651 in the area offers more: it's a youthful community, with 72% of the population being younger than 44 as well as diverse with Hispanics representing 75.91% of the population.

Among this population, 33.82% of children live in poverty, and 3.23% of students are unhoused, compared to the state average of 4.25% and a national average of 2.77%. While residents spend 55.97% of their income on housing and transportation, on average, Delano offers families many opportunities to play and learn together, including activities like fishing and boating at Lake Woollomes and attending a variety of academy classes like college prep and language courses.

Let's begin with an overview of the last three years, including a closer look at community member comments, priorities and numbers that guided the decisions to move toward better health, wholeness and hope.

**This service area represents Adventist Health Delano's primary service areas (PSA), accounting for 75% of hospital discharges. Additionally, we took a collaborative approach and expanded our PSA by inviting Steering Committee members to include the zip codes of those they serve, creating the Delano CHNA service area.*

What if our community worked together and made life all-around better? What if we offered various pathways to meet our diverse needs, so every member of our community experienced better health, prosperity and longevity?

CHNA 2019 successes and lessons learned

Before we begin to look ahead, let's look back at a few highlights from our 2019 CHNA prioritized health needs to see what has been accomplished and learned over the last three years. We focused on Access to Care, Chronic Health Conditions, and Food Insecurity.

The healthcare challenges in the city of Delano are daunting, ranging from homelessness and chronic diseases to food insecurity and diabetes. However, Adventist Health Delano stepped up to help in many ways. They promoted the availability of healthcare services for the medically underserved, along with providing 1,500 free vaccines to community members. The impact of chronic diseases was a focus of education outreach, and blood sugar testing kits and glucose strips were provided to individuals with diabetes. Community partners helped residents address food insecurity and 5,200 meals were provided to the local homeless navigation center. The needs seem overwhelming, but the care and support bring hope and healing.

It is this kind of support and engagement that helps to make our communities safe and healthy.

The COIVD-19 global pandemic caused extraordinary challenges for Adventist Health Delano, leading us to pivot our focus to helping patients and families stop the spread of the virus, and provide access to free vaccines all throughout the county.

Access to Care

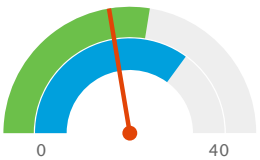
COMMUNITY VOICES

- People noted it can take months to see a primary care doctor, and specialty care is viewed as extremely difficult to arrange.
- Some residents don't attend scheduled doctor's appointments because they may need to wait hours at the doctor's office, interviewees stated.
- Some residents believe financial struggles require people to choose which priorities they can pay for.

- The Central Valley has difficulty recruiting adequate physician coverage- that includes behavioral health, medical services, and specialty areas, community leaders said.
- It was stated that there are long wait time sometimes for specialty care. It's difficult connecting to a provider in a timely manner. So rather than getting in fast, preventative early care, health concerns across the board escalate quicker, become more unmanageable, causing more serious health issues.

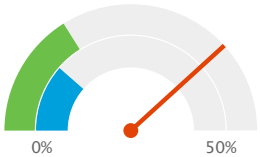
SECONDARY DATA INFOGRAPHIC STATS:

Intensive Care Unit Hospital Beds, Rate per 100,000 Population



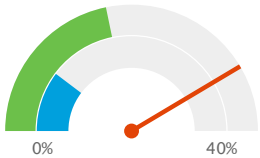
- Adventist Health (17.89)
- California (22.04)
- United States (28.05)

Population Age 25+ with No High School Diploma, Percent

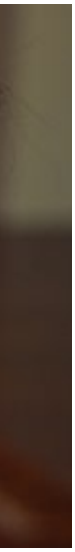


- Adventist (38.25%)
- California (16.08%)
- United States (11.47%)

Population Age 5+ with Limited English Proficiency, Percent



- Adventist (33.16%)
- California (17.41%)
- United States (8.25%)



Community Health Needs Survey:

Central Valley* 23% of those surveyed selected Access to Care as a top health concern.

*Survey region is defined by the survey administrator.

See Section V. B. for more information.

Find Access to Care resources in your community to live better, longer.

Delano Area Dial-A-Ride
661-721-3333
cityofdelano.org/183/Delano-Area-Dial-A-Ride

Delano Area Rapid Transit (DART)
661-721-3333
cityofdelano.org/92/Delano-Area-Rapid-Transit-DART

Delano Transit Dial-a-Ride
800-431-9711, ridetcat.org/dial-a-ride/delano

Kern Transit: Dial-A-Ride
800-323-2396, kerntransit.org/dial-a-ride

Get Connected Get Help with 211, Powered by people in your community, available 24/7, 800-273-2275, 211kerncounty.org

Healthcare provider shortages, the inability to access primary health care, an uninsured population, adults without a high school diploma — these are challenges facing Delano.

A survey showed 23% of participants identified Access to Care as a top health concern. Residents expressed worry regarding the shortage of providers in rural areas. Specialty care is difficult to access, and residents face frustration when it takes months to reach a primary care provider. Delano has fewer intensive care unit hospital beds available compared to state and national numbers, so patients may have to leave the community to receive care.

Residents faced barriers in accessing public transportation. And a third of the population age 5 and older has limited English proficiency, which makes accessing services more difficult.

Voices were heard and there is much work to do, but Delano remains a proud city with common goals and strong work ethic.

Primary Care Providers, Rate per 100,000 Population

Report Area	Total Population (2020	Number of Facilities	Number of Providers	Providers, Rate per 100,000 Population
Adventist Health Delano	402,582	54	167	41.59
Tulare County, CA	473,117	113	292	61.72
Kern County, CA	909,235	203	591	65.00
California	39,538,223	12,051	39,455	99.79
United States	334,735,155	117,465	349,603	104.44

Financial Stability

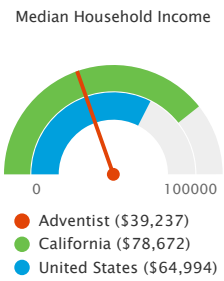
COMMUNITY VOICES

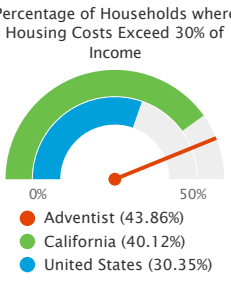
- Focus group participants said low wages for hourly jobs make it very difficult for many to afford to live in the area.
- Daily expenses like food, gas, car, and clothing items are seen as difficult for many to afford.
- Limited employment opportunities, and higher unemployment, leave residents feeling hopeless, they said.
- One of the things that key informants see as affecting healthcare is the high poverty rate. One in three kids is believed to live below the poverty level.

- Poverty makes it harder to access healthcare and healthy food options, community leaders who were interviewed stated.
- Affordable housing is seen as something that only the wealthy can manage.

Quality of life is a term that can be understood in many ways. For the Delano CHAN service area, the quality of community can be seen in its diverse activities, but beneath the healthy activities are children in poverty and family members who struggle to meet the family's needs. Thirty-three percent of children in Delano ages 0 to 17 live in poverty. Fifty-three percent of Black children live in poverty. Seventy-six percent of those surveyed consider the cost of living a top

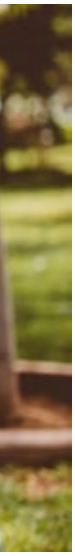
SECONDARY DATA INFOGRAPHIC STATS:





Employment – Unemployment

Report Area	Labor Force	Number Unemployed	Unemployment Rate
Adventist Health Delano	162,021	17,157	10.59%
Kern County, CA	381,634	34,847	9.13%
Tulare County, CA	204,090	20,214	9.90%
California	19,875,973	1,229,079	6.18%
United States	164,759,496	8,870,516	5.38%



Community Health Needs Survey:

Central Valley* 76% of those surveyed selected Financial Stability as a top health concern.

*Survey region is defined by the survey administrator.

See Section V. B. for more information.

health concern. And 44% of families spend more than 30% of their income on housing – a sign of financial risk. And over a third of the population has debt in collections.

Residents noted daunting costs such as transportation, food and gas costs. However, working together leads to thriving communities with the keys to brighter futures.

Find Financial Stability resources in your community to live better, longer.

Kern County Superintendent of Schools
661-636-4000, kern.org

America's Job Center of California
661-721-5800, americasjobcenterofkern.com/contact-locations.asp

Mexican American Opportunity Foundation Kern County
(661) 336-6826, maof.org/community-development/employment-support

Career Services Center – Delano
661-721-5800, careercenteroffices.com/center/181/career-services-center-delano

Get Connected Get Help with 211, Powered by people in your community, available 24/7, 800-273-2275, 211kerncounty.org

Children in Poverty by Race, Percent

Report Area	Non-Hispanic White	Black or African American	Native American or Alaska Native	Asian	Some Other Race	Multiple Race
Adventist Health Delano	23.83%	53.41%	37.77%	30.37%	37.31%	26.94%
Kern County, CA	16.92%	45.32%	35.85%	20.29%	32.96%	22.68%
Tulare County, CA	12.52%	34.89%	47.63%	22.29%	36.69%	20.29%
California	8.30%	27.13%	25.30%	9.84%	24.94%	12.86%
United States	10.58%	31.80%	31.16%	10.58%	27.24%	17.63%

Health Conditions

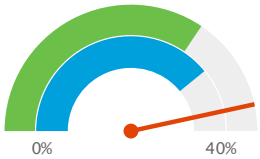
COMMUNITY VOICES

- The large number of fast-food restaurants in the community is seen as a driver toward unhealthy eating.
- Obesity is seen as a leading factor in other health issues and the rate is seen as high in Kern County.
- Increased cancer screening opportunities are viewed as important.
- The lack of easily accessible public exercise spaces was identified as a major barrier for many in the community.

- "If I were to pick one disease that affects our community most, it would be diabetes. I think there's a need for comprehensive diabetes centers as opposed to individual primary care doctors. We have very few endocrinologists in our community, we are very understaffed, but if we were to comprehensively deal with it, you could cut the amputations rate by 50%, cut heart disease, cut blindness. There's a limited relationship to cancer but a huge relationship to heart disease."

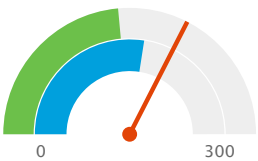
SECONDARY DATA INFOGRAPHIC STATS:

Percentage of Adults Obese (BMI ≥30.0 kg/m²)



- Adventist (37.28%)
- California (27.54%)
- United States (31.30%)

Heart Disease Mortality, Age-Adjusted Death Rate (Per 100,000 Pop.)



- Adventist Health (195.2)
- California (141.3)
- United States (164.8)

For some, health is a sweet gift that carries through a lifetime with few bumps. For others, health is a daily challenge of medications and doctor appointments. Those appointments are more challenging than ever, as the population grows and health needs expand. A survey showed that 23% of participants identified Access to Care as a top concern, yet specialty care is difficult to access due to the shortage of providers.

Delano residents commented that they commonly observe the high rate of obesity, death due to diabetes, and a high blood pressure rate, all of which lead to additional health concerns that require specialized care.

Fortunately, there are partners and organizations in Delano working to make the healthy choice the easy choice and to help community members enjoy the gift of life.

Find Health Conditions resources in your community to live better, longer.

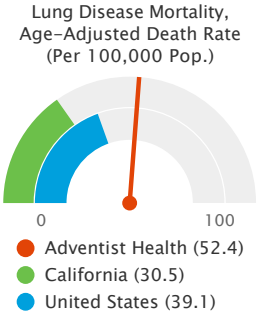
Community Connections Center
661-721-7036

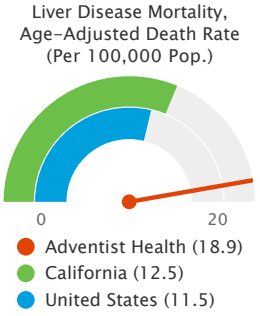
Clinica Sierra Vista
661-635-3050, clinicasierravista.org

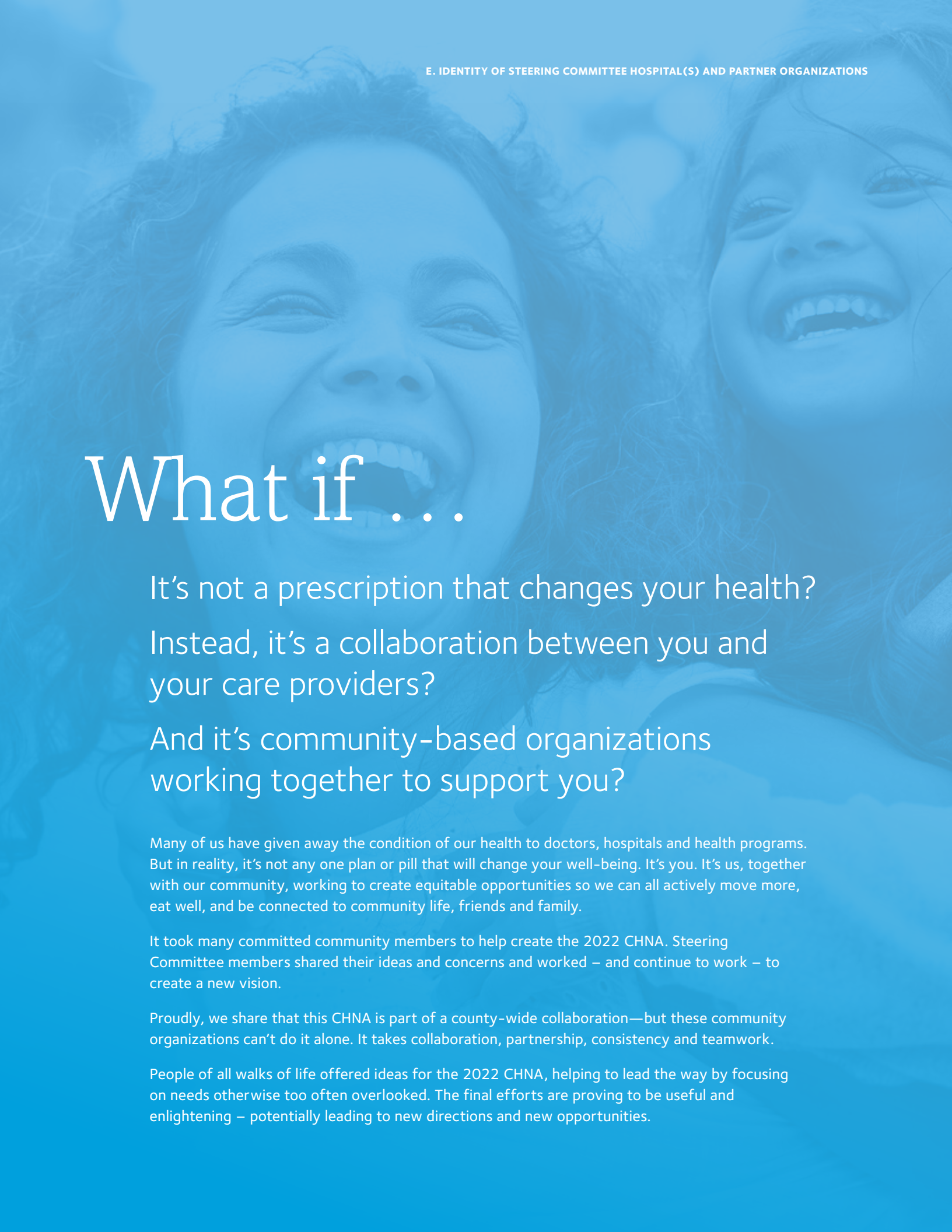
Telecare Delano Recovery Station
661-394-2441, telecarecorp.com/delano-recovery-station

Clinica Sierra Vista Health Insurance Program
(661) 328-4245, clinicasierravista.org/programs-services/health-insurance-assistance-program

Get Connected Get Help with 211, Powered by people in your community, available 24/7, 800-273-2275, 211kerncounty.org







What if . . .

It's not a prescription that changes your health?

Instead, it's a collaboration between you and your care providers?

And it's community-based organizations working together to support you?

Many of us have given away the condition of our health to doctors, hospitals and health programs. But in reality, it's not any one plan or pill that will change your well-being. It's you. It's us, together with our community, working to create equitable opportunities so we can all actively move more, eat well, and be connected to community life, friends and family.

It took many committed community members to help create the 2022 CHNA. Steering Committee members shared their ideas and concerns and worked – and continue to work – to create a new vision.

Proudly, we share that this CHNA is part of a county-wide collaboration—but these community organizations can't do it alone. It takes collaboration, partnership, consistency and teamwork.

People of all walks of life offered ideas for the 2022 CHNA, helping to lead the way by focusing on needs otherwise too often overlooked. The final efforts are proving to be useful and enlightening – potentially leading to new directions and new opportunities.

To all who helped, we say **THANK YOU**. To those who now see the needs and opportunities, we welcome you. Change changes. Let's work together to inspire health, wholeness and hope in our community.

We thank the Kern County CHNA Steering Committee, which collaborated and partnered to create the 2022 CHNA. Through a series of three collaborative meetings, engagement of community members, and reviewing data, each committee member brought their unique perspective and view as seen through their job and the work they performed during the development of the CHNA.

Juan Avila
Garden Pathways

Rene Ayon
Delano Joint Union High School District

Kristen Beall Watson
California State University, Bakersfield

Ja'Nette Beck
City of Bakersfield, Parks and Recreation Dept.

Brynn Carrigan
Kern County Department of Public Health

Matthew Cauthron
Adventist Health Delano

Miguel Ceja
United Farm Workers Union

Tom Corson
Kern County Network for Children

Emily Duran
Kern Health Systems

Erica Easton
Kern Medical Foundation

Aaron Ellis
Americas Job Center/ Employers Training Resource

Natasha Felkins
Bitwise Industries

Stacy Ferreira
Clinica Sierra Vista

Steve Flores
Ravi and Naina Patel Foundation

Greg Garrett
City of Tehachapi

Louis Gill
Bakersfield Homeless Center

Jan Hefner
Center for Sexuality and Gender Diversity

Hernan Hernandez
California Farmworkers Foundation

Linda Hinojosa
Delano Union School District

Pamela Holiwell
Kern County Department of Human Services

Josh Jennings
Kern County Sheriff s Office

Heather Kimmel
CA Veterans Assistance Foundation

Anna Laven
Bakersfield-Kern Regional Homeless Collaborative

Terry Lindsey
Bakersfield City School District

Roland Maier
First 5 Kern County

Tonya Mann
Kern Behavioral and Recovery Services

Traco Matthews
Community Action Partnership of Kern

Jeremy Oliver
Aging & Adult Services

Steve Peterson
Mission of Kern County

Robin Robinson
CityServe

Leonardo Ruiz
Univision Communications

Cindy Stewart
Omni Family Health

Jay Tamsi
Kern County Hispanic Chamber of Commerce

Kiyoshi Tomono
Adventist Health Kern County

Barbara Vadnais
Alliance Against Family Violence

Amanda Valenzuela
Alzheimer s Association of Kern

Rebecca Vaughan
Kern County Probation Department

Desiree Von Flue
Kern County Superintendent of Schools

Caroline Wasielewski
Tehachapi Valley Healthcare District

Laura Lynn Wyatt
Access Real Estate

II. About Us

A. Adventist Health Delano

Adventist Health Delano is a not-for-profit, full-service community and regional teaching hospital that serves 10 rural central California towns and is committed to providing an exceptional patient experience. With a total of 156 beds, Adventist Health Delano offers services including an Intensive Care Unit, a Sub-Acute Care Unit, a Medical Surgical Unity, a dedicated Surgical Pavilion and an Obstetrics/Gynecology Unit.

B. Adventist Health

Adventist Health is a faith-inspired, nonprofit integrated health system serving more than 80 communities on the West Coast and Hawaii. Founded on Adventist heritage and values, Adventist Health provides care in hospitals, clinics, home care agencies, hospice agencies and joint-venture retirement centers in both rural and urban communities. Our compassionate and talented team of 34,000 includes associates, medical staff physicians, allied health professionals and volunteers driven in pursuit of one mission: living God's love by inspiring health, wholeness and hope. Together, we are transforming the American healthcare experience with an innovative, yet timeless, whole-person focus on physical, mental, spiritual and social healing to support community well-being.

C. Adventist Health Community Benefit & Well-Being Approach to CHNA

Adventist Health is committed to health, wholeness and hope in the communities across our system, which includes improving well-being. Diseases of despair including mental health, substance abuse, suicide and chronic illness continue to escalate.

America leads the world in medical research and medical care, and for all we spend on health care, we should be the healthiest people on Earth. Yet some of the most important indicators, like how long we live, are areas where we don't make the top 25. It's time we stop thinking of health as something we get at the doctor's office and rather as something that starts within our families, schools, places of worship and workplaces—in our playgrounds, parks, and in the air we breathe, the food we eat and the water we drink. The more we see the problem of health in this way, the more opportunities we have to improve it.

The conditions in which we live, work and play have an enormous impact on our health long before we ever see a doctor—these are the principles of well-being. A key aspect of our strategy to support individual, organizational and community well-being is our relationship with Blue Zones®, a pioneer in taking a systemic and environmental approach to improving the well-being of entire cities and communities. Together, we have built the Well-Being Division, an entity within our organization that exists to empower everyone, everywhere to live longer, better lives.

D. Who We Serve

DEMOGRAPHIC PROFILE

The following zip codes represent Adventist Health Delano's primary service area (PSA), accounting for 75% of hospital discharges. Additionally, we took a collaborative approach and expanded our PSA by inviting Steering Committee members to include the zip codes of those they serve.

The Adventist Health Delano CHNA market has a total population of 402,651(based on the 2020 Decennial Census). The largest city in the service area is Tulare, with a population of 59,312. The service area is comprised of the following zip codes: 93263, 93256, 93250, 93261, 93280, 93249, 93304, 93305, 93270, 93201, 93215, 93274, 93307, 93219.

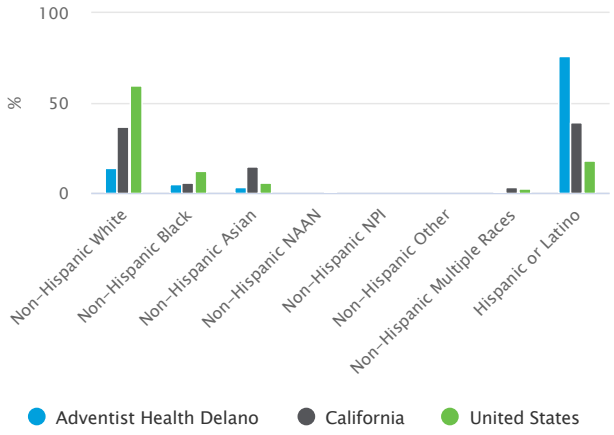
Total Population

402,651

51.05%
of the population owns their home

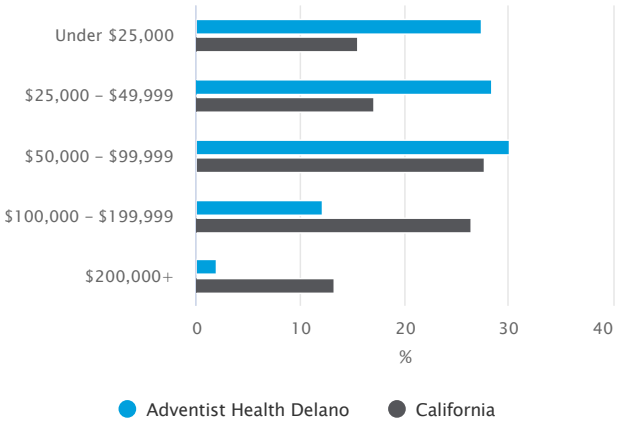
48.95%
of the population rents their home

Population by Combined Race and Ethnicity



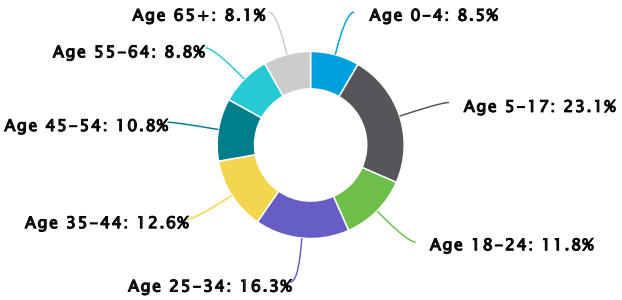
Note: NAAN = Native American or Alaska Native, NPI = Native Hawaiian or Pacific Islander.

Household Income Levels



Total Population by Age Groups, Total

Adventist Health Delano



III. Significant Identified Health Needs, Primary, Secondary Data & Written Comments

A. Significant Identified Health Needs

Steering Committee members, alongside their staff, boards and constituencies reviewed and discussed a presentation of significant identified health needs, which was a list of the top five needs across each data source (see section V for methodology). They then voted to select priorities that demonstrated the greatest need based on severity and prevalence, intentional alignment around common goals, feasibility of potential interventions, and opportunities to maximize available resources over a three-year period. From the list of significant identified health needs in the table, the following three health needs were prioritized as a high priority need, based on the criteria considered (see Section IV. A for full prioritization methodology): Access to Care, Health Risk Behaviors and Mental Health.

TABLE OF SIGNIFICANT IDENTIFIED HEALTH NEEDS

Table of Identified Significant Health Needs-Delano*

High Priority Needs	
Access to Care	See Sections III.C - E
Financial Stability	See Sections III.C - E
Health Conditions	See Sections III.C - E
Lower Priority Needs	
Community Vitality 211kerncounty.org/category/income-employment/	Fiscal challenges, especially in home ownership, decrease economic and civic engagement. High crime and rates of substance use problems are also seen as factors limiting community vitality.
Housing 211kerncounty.org/category/housing/	The limited housing stock, and high housing costs, push many into an unstably housed environment. Service needs for this group are very high, and the overall cost of living makes stable housing unrealistic for some community residents.
Food Security 211kerncounty.org/category/food/	With 74% of students receiving free or reduced-priced lunches, and nearly 20% of the community living in low food access neighborhoods, food security is an ongoing problem for many.
Mental Health 211kerncounty.org/category/mental-health/	49% of surveyed residents identified mental health issues as community health need.
Public Safety 211kerncounty.org/category/government/	Key informants noted that there has been an increase in crime in the area during COVID, especially among youth.
Health Risk Behaviors 211kerncounty.org/category/mental-health/ 211kerncounty.org/category/substance-abuse/	The area has smoking and substance use disorder rates higher than state averages. Key informants note that illicit drug use is prevalent and service needs exceed availability.
Education 211kerncounty.org/category/education/	24% of the community has an associates degree or higher. Focus group members said there are inadequate childcare options, both in quantity and quality.
COVID 211kerncounty.org/category/health-care/	46% of surveyed residents identified COVID as a community health need.

*The data presented to the local Steering Committee for prioritization was Kern County data, which is reflected in this table. Throughout the CHNA you'll see hospital-specific data included.

B. Primary, Secondary, and Survey Data Overview

This Community Health Needs Assessment was developed using four separate sources of primary and secondary data. This mixed methods approach is considered a preferred practice for needs assessments because it allows for the greatest understanding of community needs from the broadest range of perspectives. Primary data refers to data collected and analyzed specifically for this project, while secondary data refers to data compiled and analyzed by external groups and utilized here.

Qualitative primary data collection involved focus group interviews with local service providers and service recipients and individual key informant interviews with local leaders. These were conducted in-person and virtually. Direct quotes were taken from a transcription of key informant interviews and are intended to be 100% accurate but could not be verified in all situations. This information was collected by the Adventist Health Community Well-Being team and evaluation consultants from the Center for Behavioral Health Integration. Secondary data was amassed and analyzed across 45 different data sets by the University of Missouri Extension Center for Applied Research and Engagement Systems (CARES). Finally, survey data sets of registered voters in the community were collected and analyzed by UC Berkeley Institute of Governmental Studies (IGS). A detailed explanation of data collection methodology can be found in Sections IV and V.

In total, 12 focus groups were conducted with 78 participants, and 16 key informant interviews were held. Survey data was gathered from the Central Valley region (region name defined by survey administrator, UC Berkeley IGS). See Section V. B. for more information.

DESCRIPTION OF PARTICIPANTS

The CHNA Steering Committee (membership found in Section I. E) identified vulnerable populations and worked with local organizations to coordinate focus groups and key informant interviews to ensure that minority populations – the voices of those with chronic disease, low incomes and the underserved – were heard. Analytical methods for focus groups and key informant interviews found in Section IV. B.

FOCUS GROUPS

- Twelve (12) focus groups
- Seventy-eight (78) people participated

Focus group comments were gathered during in-person, virtual and hybrid focus groups, typically running 90-minutes.

KEY INFORMANTS

- Sixteen (16) individual interviews

During 60-minute interview key informants shared their greatest concerns around health needs, health equity and social determinants of health for those they serve.

PARTICIPATING ORGANIZATIONS

Alliance Against Family Violence, American Indian Health Project, Bakersfield College, Bakersfield Homeless Shelter, Bakersfield Police Department, Bakersfield Women's Homeless Shelter, City of Tehachapi, City Serve, Community Action Partnership of Kern, Delano Union School District, First Five Kern, Garden Pathways, Kern Behavioral Health & Recovery Services, Kern County Children's Dental Health Network, Kern County Department of Public Health, Kern County Hispanic Chamber of Commerce, Kern County Housing Authority, Kern County Network for Children, Kern Family Health Care, Kern Medical, National Association for the Advancement of Colored People, Transitional Youth Mobilizing for Change, and United Farm Workers Foundation Kern County

REPRESENTED RACE/ETHNICITIES

American Indian, Asian, Black, Hispanic, Multi-Race and White

REPRESENTED POPULATIONS

Agricultural workers, civic government, community-based healthcare workers focusing on behavioral health, children, domestic abuse, early education, education, families, formerly incarcerated, higher education, law enforcement, low-income, medically underserved, men, minority populations, older adults, providers, public health, students, unhoused and women populations

The three high-priority health needs are described in further detail on the following pages.

SURVEY RESULTS

REGION & STATEWIDE SUMMARY

Central Valley: Survey Results of Top Needs
See Section V. B. for more information.

Needs	Delano	Statewide
Financial Stability-Cost of Living	76%	83%
Housing- Cost	55%	63%
Housing- Unhoused	54%	55%
Mental Health	49%	48%
COVID	46%	47%
Food Security	34%	31%
Education	27%	24%
Employment	25%	22%
Access to Care-Primary	23%	23%
Access to Care-Senior	16%	15%
Environment & Infrastructure-Transportation	15%	15%

C. Access to Care

People living in the Delano community face challenges in accessing healthcare due to provider-level, community and individual barriers.

Delano has an enormous shortage of primary care providers compared to the rest of Kern County, California and the nation. 62.47% of the total Delano population lives in a Health Profession Shortage Area (HPSA) compared to 22.5% nationwide. The majority of the population not being able to access primary care readily increases the risk for serious, costly and recurrent health problems.

Delano also has fewer Intensive Care Unit hospital beds than the rest of California and the nation and a slightly higher rate of uninsured population (9.95%) than the rest of California (7.23%) and the nation (8.73%). In addition, 15.2% of the uninsured are between ages 18 and 64, which is also higher than state and national averages.

Multiple barriers to care accessibility at the individual level are evident. Only 40.42% of the population live within half a mile of public transportation, which is well below the statewide average. Over 38% of the population aged 25 and above do not have a high school diploma. A third of the population age five and older have limited English proficiency, numbers that are double or greater than state and national averages. This creates barriers to healthcare access, provider communication, and health literacy/education and is a critical driver behind health disparities.

Scan QR Code for more information on the full Report

PRIMARY COMMENTS

FOCUS GROUPS COMMENTS (PARAPHRASED FROM PRIMARY DATA INTERVIEW NOTES)

- People noted it could take months to see a primary care doctor, and specialty care is viewed as extremely difficult to arrange.
- Some residents don't attend scheduled doctor's appointments because they may need to wait hours at the doctor's office, interviewees stated.
- Some residents believe financial struggles require people to choose which priorities they can pay for.
- People shared that there is a shortage of healthcare providers in local, rural areas.
- It was noted it might be difficult to get service providers in general, but especially difficult to get service providers out in the mountain community.
- Daily expenses like food, gas, car, and clothing items are difficult for many to afford, interviewees said.
- Low wages for hourly jobs make it very difficult for many to afford to live in the area, per focus group attendees.
- There are not enough childcare services. Interviewees noted most childcare is found within one's community, family or friends.
- People noted farmworkers often have to rely on family or friends for childcare since daycare operating hours don't line up well with their work schedules.
- Rents are believed by community members to have increased substantially.
- Interviewees said in some cases, people don't qualify for food stamps because they are working.

KEY INFORMANT COMMENTS

- The Central Valley has difficulty recruiting adequate physician coverage- that includes behavioral health, medical services, and specialty areas, community leaders said.
- It was stated that there are sometimes long wait times for specialty care. It's difficult connecting to a provider in a timely manner. So rather than getting in fast, preventative early care, health concerns across the board escalate quicker and become more unmanageable, causing more serious health issues.
- People noted it could take months to see a primary care doctor, and specialty care is viewed as extremely difficult to arrange.
- Some residents don't attend scheduled doctor's appointments because they may need to wait hours at the doctor's office, interviewees noted.
- Access to care challenges are attributed by many to the limited number of doctors in the area.
- Transportation is an issue within the community, people indicated, including accessing buses that are not conveniently located.
- Very few rentals and high housing purchase prices mean only the wealthy can have housing stability, community members believe.
- It was suggested that housing rates should be calculated as a portion of SSI for those receiving that support.
- There are believed to be not enough dental providers.

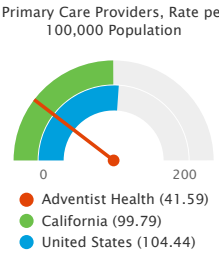
Secondary Data Summary

Access to Care

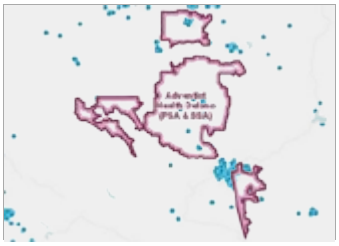
Availability - Primary Care - Primary Care Providers

This indicator reports the number of providers with a CMS National Provider Identifier (NPI) that specialize in primary care. Primary health providers include practicing physicians specializing in general practice medicine, family medicine, internal medicine, and pediatrics. The number of facilities that specialize in primary health care are also listed (but are not included in the calculated rate). Data are from the latest Centers for Medicare and Medicaid Services (CMS) National Provider Identifier (NPI) downloadable file.

Report Area	Total Population (2020)	Number of Facilities	Number of Providers	Providers, Rate per 100,000 Population
Adventist Health Delano	402,582	54	167	**41.59**
Tulare County, CA	473,117	113	292	61.72
Kern County, CA	909,235	203	591	65.00
California	39,538,223	12,051	39,455	99.79
United States	334,735,155	117,465	349,603	104.44



Note: This indicator is compared to the state average.
Data Source: Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES). July 2022. Source geography: Address



Primary Care Physicians, All, CMS NPPES July 2022

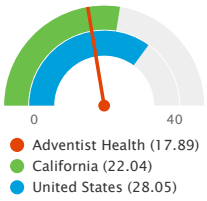
Primary Care Physicians, All, CMS NPPES July 2022
Adventist Health Delano

Availability - Hospitals & Clinics - Hospital Beds Per Capita

This indicator reports information about the availability of hospital beds across the United States. The data behind this layer comes from Definitive Healthcare; the group is providing their proprietary hospital bed count data "in order to enable observation of the care capacity of hospitals across the country as cases of COVID-19 proliferate". In the report area, the amount of Intensive Care Unit hospital beds is 71 in total or 17.89 per 100,000 population.

Report Area	Licensed Beds	Staffed Beds	ICU Beds	Licensed Beds, Rate per 100,000 Pop.	Staffed Beds per 100,000 Pop.	ICU Beds, Rate per 100,000 Pop.
Adventist Health Delano	686	655	71	172.97	165.19	**17.89**
Kern County, CA	1,535	1,497	160	171.17	166.93	17.84
Tulare County, CA	830	746	84	178.16	160.13	18.03
California	162,424	161,604	17,438	205.30	204.27	22.04
United States	1,872,694	1,602,386	183,514	286.20	244.89	28.05

Intensive Care Unit Hospital Beds, Rate per 100,000 Population



Note: This indicator is compared to the state average.
Data Source: Definitive Healthcare. Accessed via Hospital Beds Dashboard on Esri's COVID-19 GIS Hub. 2020. Source geography: County

ICU Beds, Rate per 100,000 by County, Definitive Healthcare 2020

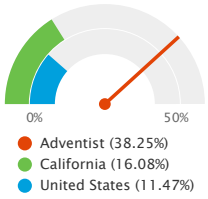
- No ICU Beds
- 0.1 - 10.0
- 10.1 - 20.0
- 20.1 - 40.0
- Over 40.0
- Adventist Health Delano

Barriers - Health Literacy - Educational Attainment

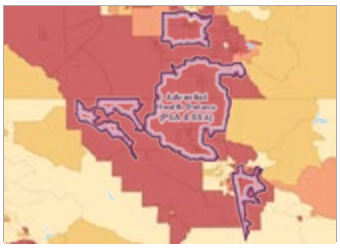
Within the report area there are 85,645 persons aged 25 and older without a high school diploma (or equivalency) or higher. This represents 38.25% of the total population aged 25 and older. This indicator is relevant because educational attainment is linked to positive health outcomes (Freudenberg & Ruglis, 2007).

Report Area	Total Population Age 25+	Population Age 25+ with No High School Diploma	Population Age 25+ with No High School Diploma, Percent
Adventist Health Delano	223,915	85,645	**38.25%**
Kern County, CA	543,837	134,122	24.66%
Tulare County, CA	274,201	76,949	28.06%
California	26,665,143	4,286,538	16.08%
United States	222,836,834	25,562,680	11.47%

Population Age 25+ with No High School Diploma, Percent



Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2016-20. Source geography: Tract

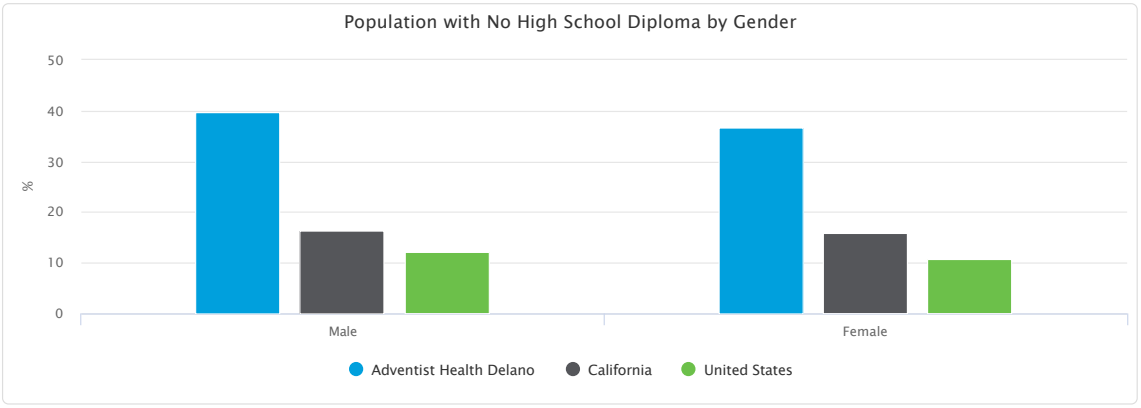


Population with No High School Diploma (Age 25+), Percent by Tract, ACS 2016-20

- Over 21.0%
- 16.1 - 21.0%
- 11.1 - 16.0%
- Under 11.1%
- No Data or Data Suppressed
- Adventist Health Delano

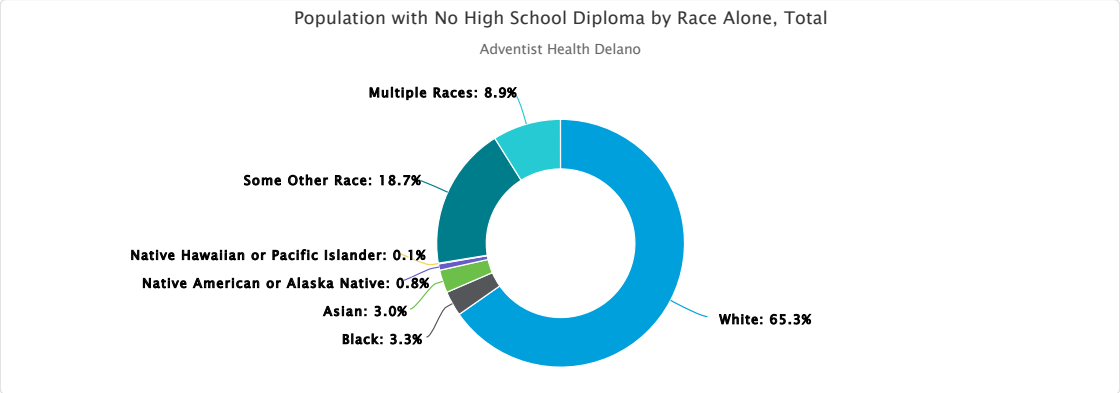
Population with No High School Diploma by Gender

Report Area	Male	Female	Male, Percent	Female, Percent
Adventist Health Delano	46,601	39,044	39.75%	36.60%
Kern County, CA	72,478	61,644	26.11%	23.16%
Tulare County, CA	39,385	37,564	29.17%	26.99%
California	2,135,833	2,150,705	16.34%	15.82%
United States	13,141,042	12,421,638	12.19%	10.80%



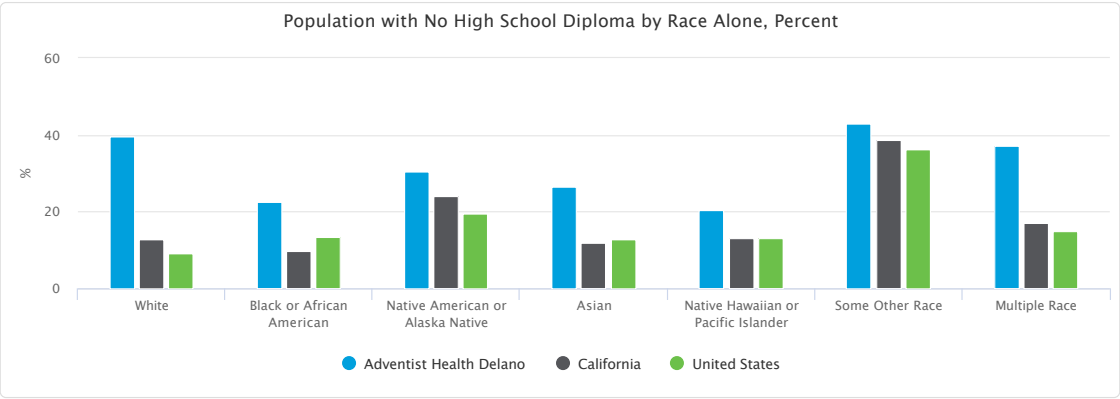
Population with No High School Diploma by Race Alone, Total

Report Area	White	Black	Asian	Native American or Alaska Native	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Races
Adventist Health Delano	55,891	2,807	2,546	710	73	15,990	7,628
Kern County, CA	88,144	4,533	5,349	1,197	104	23,959	10,836
Tulare County, CA	49,640	542	2,009	930	121	18,263	5,444
California	1,977,822	151,677	510,287	49,513	13,418	1,312,799	271,022
United States	15,123,109	3,547,596	1,655,662	327,426	51,083	3,624,534	1,233,270



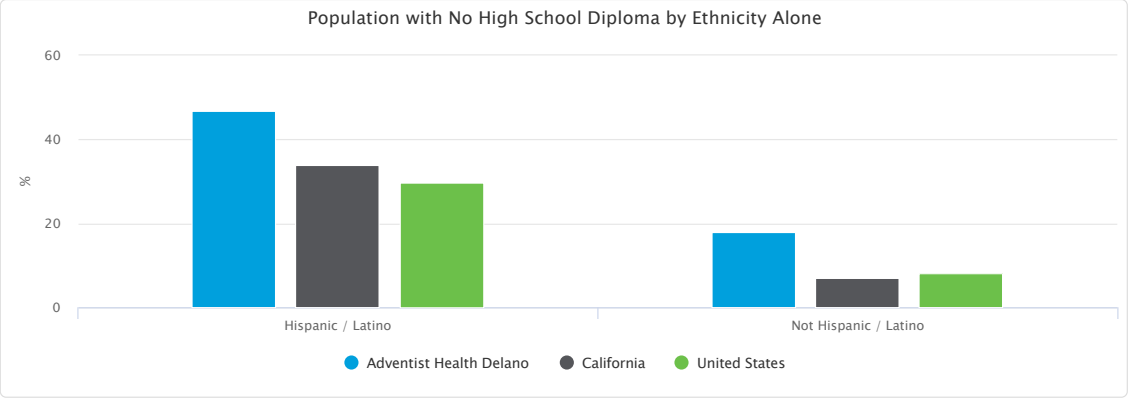
Population with No High School Diploma by Race Alone, Percent

Report Area	White	Black or African American	Native American or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
Adventist Health Delano	39.51%	22.61%	30.43%	26.47%	20.33%	43.05%	37.05%
Kern County, CA	23.35%	15.87%	23.64%	17.90%	11.74%	38.06%	27.84%
Tulare County, CA	26.27%	12.43%	25.22%	18.48%	29.80%	39.22%	28.08%
California	12.72%	9.82%	23.96%	11.96%	13.03%	38.68%	16.99%
United States	9.28%	13.33%	19.41%	12.71%	13.15%	36.14%	15.01%



Population with No High School Diploma by Ethnicity Alone

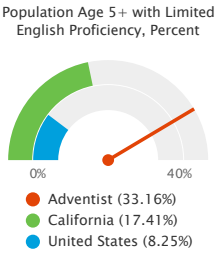
Report Area	Hispanic or Latino	Not Hispanic or Latino	Hispanic or Latino, Percent	Not Hispanic or Latino, Percent
Adventist Health Delano	73,798	11,847	46.89%	17.81%
Kern County, CA	102,198	31,924	40.17%	11.03%
Tulare County, CA	64,422	12,527	40.93%	10.72%
California	3,025,438	1,261,100	33.80%	7.12%
United States	10,134,213	15,428,467	29.74%	8.17%



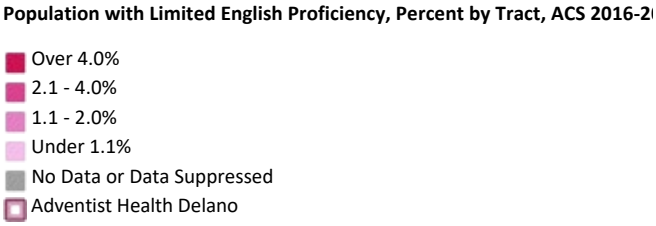
Barriers - Health Literacy - Limited English Proficiency

This indicator reports the percentage of the population aged 5 and older who speak a language other than English at home and speak English less than "very well". This indicator is relevant because an inability to speak English well creates barriers to healthcare access, provider communications, and health literacy/education. Of the 361,858 total population aged 5 and older in the report area, 119,975 or 33.16% have limited English proficiency.

Report Area	Population Age 5+	Population Age 5+ with Limited English Proficiency	Population Age 5+ with Limited English Proficiency, Percent
Adventist Health Delano	361,858	119,975	**33.16%**
Kern County, CA	823,391	149,785	18.19%
Tulare County, CA	427,013	113,094	26.48%
California	36,936,941	6,432,102	17.41%
United States	306,919,116	25,312,024	8.25%



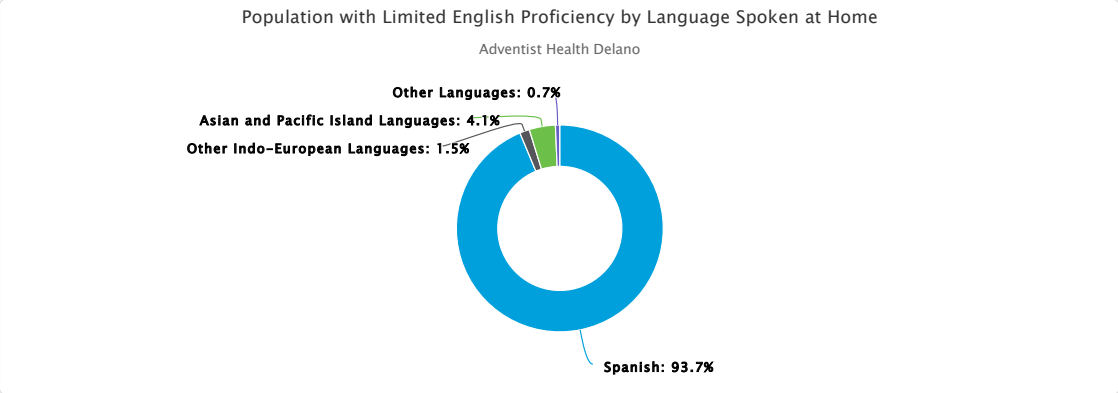
Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2016-20. Source geography: Tract



Population with Limited English Proficiency by Language Spoken at Home

This indicator reports the total population aged 5 and older who speak a language other than English at home and speak English less than "very well" by language spoken at home in the report area.

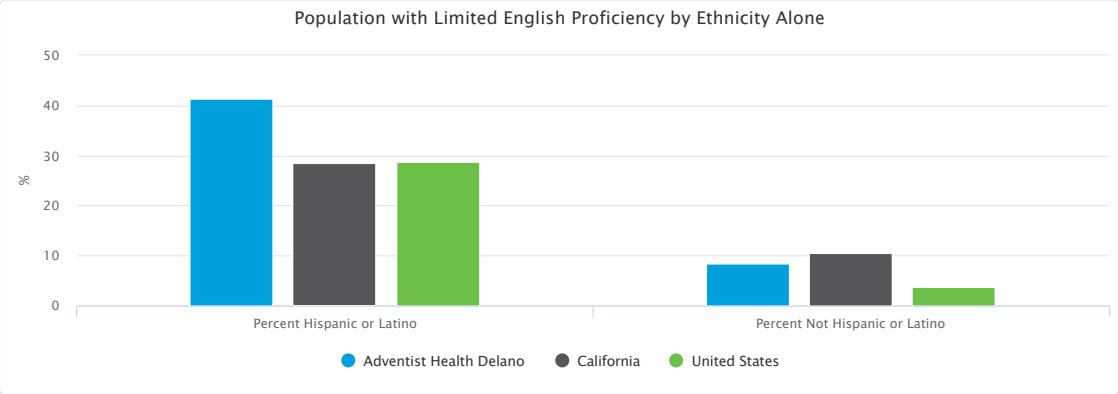
Report Area	Spanish	Other Indo-European Languages	Asian and Pacific Island Languages	Other Languages
Adventist Health Delano	112,418	1,831	4,920	806
Kern County, CA	132,707	5,906	9,618	1,554
Tulare County, CA	105,904	1,866	4,558	766
California	4,083,013	499,656	1,720,073	129,360
United States	15,949,582	3,422,525	4,886,876	1,053,041



Population with Limited English Proficiency by Ethnicity Alone

This indicator reports the total population aged 5 and older who speak a language other than English at home and speak English less than "very well" by ethnicity alone in the report area.

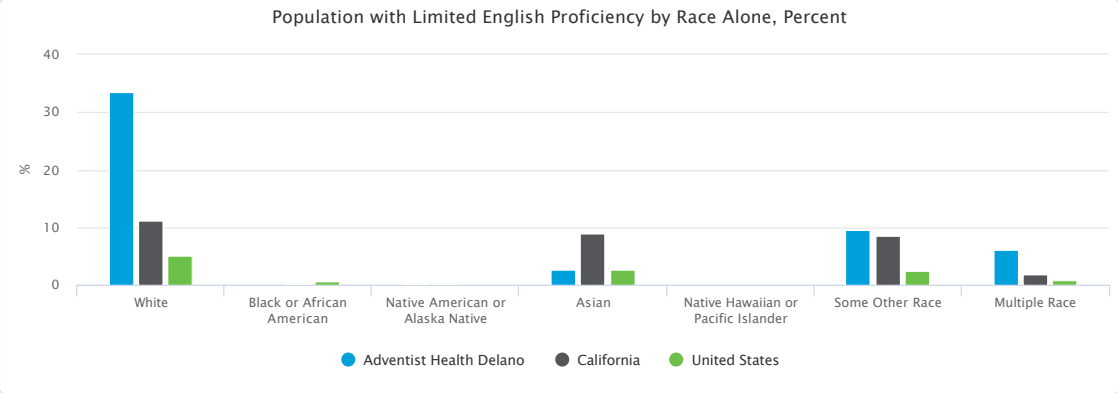
Report Area	Total Hispanic or Latino	Total Not Hispanic or Latino	Percent Hispanic or Latino	Percent Not Hispanic or Latino
Adventist Health Delano	112,355	7,620	41.31%	8.48%
Kern County, CA	132,205	17,580	30.35%	4.53%
Tulare County, CA	105,642	7,452	38.59%	4.86%
California	4,048,196	2,383,906	28.56%	10.47%
United States	15,590,137	9,721,887	28.69%	3.85%



Population with Limited English Proficiency by Race Alone, Percent

This indicator reports the percentage of the population aged 5 and older who speak a language other than English at home and speak English less than "very well" by race alone in the report area.

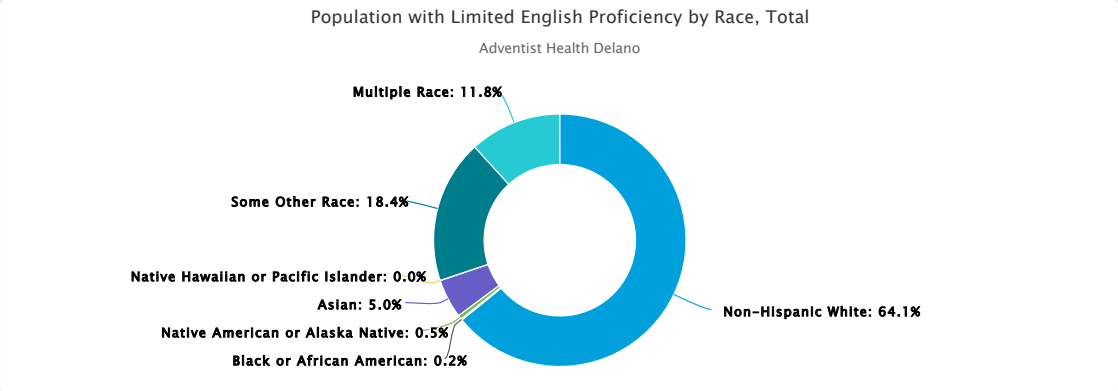
Report Area	White	Black or African American	Native American or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
Adventist Health Delano	33.51%	0.08%	0.28%	2.62%	0.01%	9.60%	6.15%
Kern County, CA	15.71%	0.07%	0.15%	2.50%	0.01%	5.73%	2.66%
Tulare County, CA	24.37%	0.08%	0.20%	1.76%	0.02%	9.77%	3.34%
California	11.14%	0.23%	0.21%	8.84%	0.08%	8.58%	1.77%
United States	5.12%	0.55%	0.09%	2.55%	0.03%	2.48%	0.82%



Population with Limited English Proficiency by Race, Total

This indicator reports the total population aged 5 and older who speak a language other than English at home and speak English less than "very well" by race alone in the report area.

Report Area	Non-Hispanic White	Black or African American	Native American or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
Adventist Health Delano	76,925	194	649	6,009	28	22,048	14,122
Kern County, CA	87,716	369	819	13,956	45	32,005	14,875
Tulare County, CA	69,713	236	565	5,027	53	27,958	9,542
California	2,323,258	47,356	43,331	1,842,890	17,098	1,788,369	369,800
United States	11,134,122	1,196,004	202,081	5,545,968	71,524	5,388,974	1,773,351


Population with Limited English Proficiency by Race, Total
Adventist Health Delano
Multiple Race: 11.8%
Some Other Race: 18.4%
Native Hawaiian or Pacific Islander: 0.0%
Asian: 5.0%
Native American or Alaska Native: 0.5%
Black or African American: 0.2%
Non-Hispanic White: 64.1%

D. Financial Stability

Numerous factors create a culture of financial instability in Delano, which, in turn, creates barriers to accessing insurance coverage, healthcare services, healthy food, and other necessities that contribute to a better quality of life. A lower percent of the population of Delano (57%) participates in the labor force as compared to California (63.29%) and the United States (63%). The unemployment rate in Delano is higher than the California average by 5% and is nearly double the national average.

In Delano, 33.82% of children aged 0-17 are living in poverty, an alarmingly higher percentage than in California and the rest of the United States (17.48%). Poverty is impacting some populations children at higher rates, with 53.41% of African American children and 8.749% of Native Hawaiian or Pacific Islander children in Delano living in poverty. This can contribute to generational health and well-being challenges.

The median household income of $38,237 in Delano is only around half of the California median and around $25,000 below the United States average, which is an enormous difference. The high cost of living in California represents a major financial barrier for Delano households. Over a third of the population has debt in collections, and 44% spend more than 30% of their income on housing. Both of these numbers are quite a bit larger than what is normally seen across the country. The percentage of income spent on housing numbers are particularly noteworthy since being above the 30% mark is a sign of significant financial risk.

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PRIMARY COMMENTS

FOCUS GROUPS

- Focus group participants said low wages for hourly jobs make it very difficult for many to afford to live in the area.
- Daily expenses like food, gas, car, and clothing items are seen as difficult for many to afford.
- Limited employment opportunities, and higher unemployment, leave residents feeling hopeless, they said.
- There are not enough childcare services. Interviewees noted most childcare is found within one's community, family, or friends.
- Underserved communities are most at-risk, interviewees stated.
- Farmworkers are seen as often having to rely on family or friends for childcare since daycare operating hours don't line up well with their work schedules.
- Rents are believed to have increased substantially.
- Programs are seen as only focusing on paying rent rather than having a place to live.
- Financial struggles are believed to require people to choose which priorities they can pay for.
- In some cases, interviewees noted, people don't qualify for food stamps because they are working.

KEY INFORMANT COMMENTS

- One of the things that key informants see as affecting healthcare is the high poverty rate. One in three kids is believed to live below the poverty level.
- Poverty makes it harder to access healthcare and healthy food options, community leaders that were interviewed stated.
- Affordable housing is seen as something that only the wealthy can manage.
- It was suggested that housing rates should be calculated as a portion of Supplemental Security Income for those receiving that support.
- Lower income, lower education community members are more significantly impacted by financial challenges in an adverse way in the eyes of interviewees.
- The community doesn't see a lot of opportunities to get out of poverty.
- Lower wages and a high cost of living make recruiting professionals very difficult, interviewees noted.

Secondary Data Summary

Financial Stability

Employment - Unemployment

According to the most recent American Community Survey estimates, total unemployment in the report area is 17,157, or 10.59% of the civilian non-institutionalized population age 16 and older. This indicator is relevant because unemployment creates financial instability and barriers to access including insurance coverage, health services, healthy food, and other necessities that contribute to poor health status.

Report Area	Labor Force	Number Unemployed	Unemployment Rate
Adventist Health Delano	162,021	17,157	**10.59%**
Kern County, CA	381,634	34,847	9.13%
Tulare County, CA	204,090	20,214	9.90%
California	19,875,973	1,229,079	6.18%
United States	164,759,496	8,870,516	5.38%

Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2016-20. Source geography: Tract

View larger map

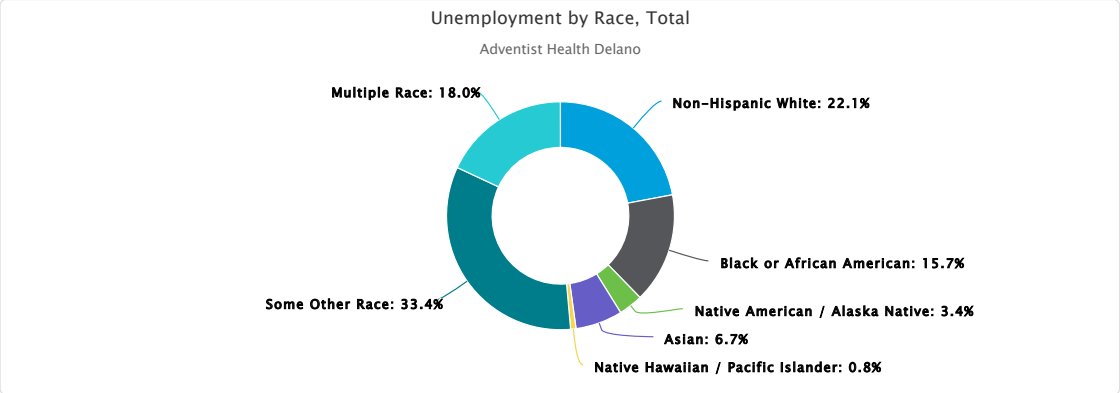
Unemployed Workers, Percent by Tract, ACS 2016-20

- Over 12.0%
- 8.1 - 12.0%
- 4.1 - 8.0%
- Under 4.1%
- No Data or Data Suppressed
- Adventist Health Delano

Unemployment by

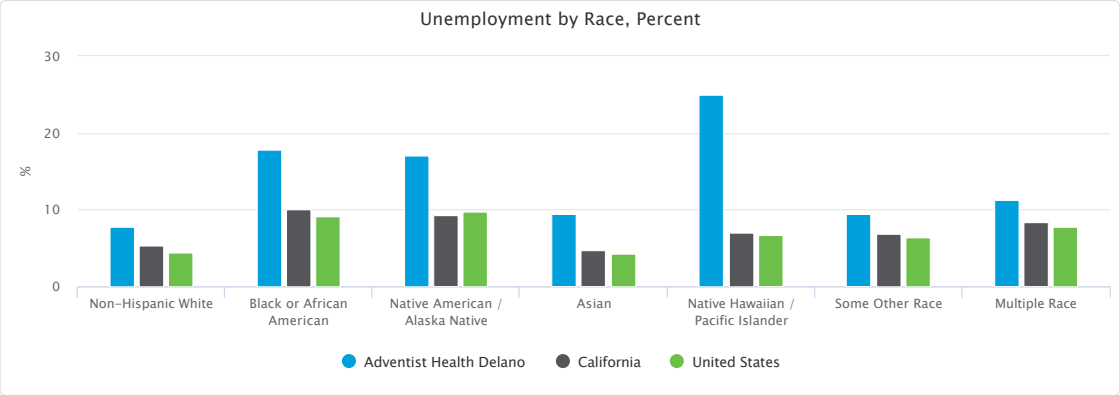
Data Source: US Census Bureau, American Community Survey. 2016-20. Source geography: Tract

Report Area	Non-Hispanic White	Black or African American	Native American / Alaska Native	Asian	Native Hawaiian / Pacific Islander	Some Other Race	Multiple Race
Adventist Health Delano	362,472	257,392	56,429	109,454	12,596	548,537	296,375
Kern County, CA	10,913	2,903	414	1,091	131	4,859	2,578
Tulare County, CA	3,910	224	313	545	43	4,139	1,590
California	402,121	110,197	13,728	144,492	5,681	193,399	115,127
United States	4,432,807	1,853,375	115,397	421,021	20,879	541,963	564,122



Unemployment by Race, Percent

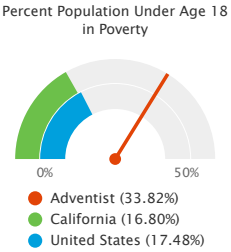
Report Area	Non-Hispanic White	Black or African American	Native American / Alaska Native	Asian	Native Hawaiian / Pacific Islander	Some Other Race	Multiple Race
Adventist Health Delano	7.71%	17.85%	17.01%	9.39%	24.97%	9.44%	11.21%
Kern County, CA	8.24%	15.31%	13.16%	5.44%	24.81%	9.47%	8.94%
Tulare County, CA	6.66%	6.91%	13.81%	6.97%	14.93%	10.60%	10.11%
California	5.36%	10.08%	9.25%	4.65%	7.04%	6.79%	8.32%
United States	4.38%	9.20%	9.70%	4.26%	6.76%	6.43%	7.76%



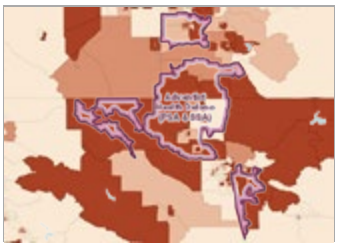
Income - Childhood Poverty Rate

In the report area 33.82% or 41,393 children aged 0-17 are living in households with income below the Federal Poverty Level (FPL). This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.

Report Area	Total Population	Population Under Age 18	Population Under Age 18 in Poverty	Percent Population Under Age 18 in Poverty
Adventist Health Delano	376,293	122,396	41,393	**33.82%**
Kern County, CA	861,063	253,369	70,291	27.74%
Tulare County, CA	457,738	140,267	41,096	29.30%
California	38,589,882	8,815,673	1,480,649	16.80%
United States	318,564,128	72,065,774	12,598,699	17.48%



Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2016-20. Source geography: Tract



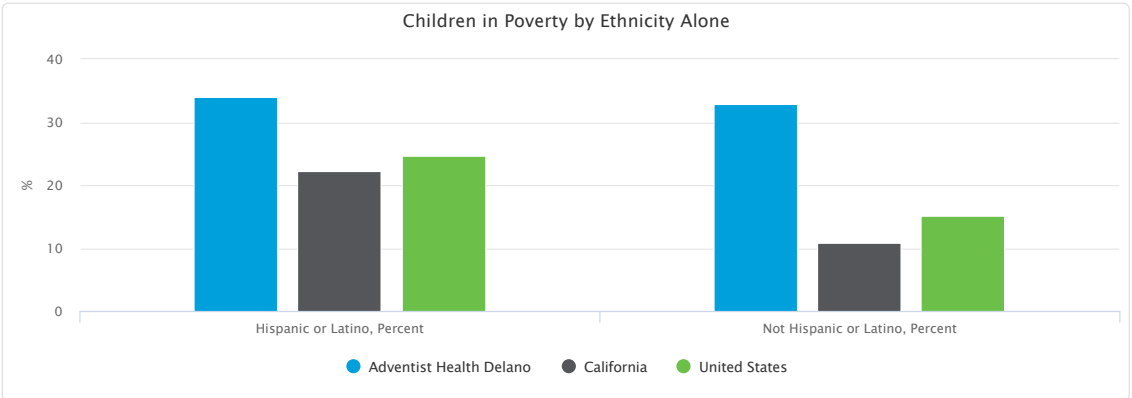
Population Below the Poverty Level, Children (Age 0-17), Percent by Tract, ACS 2016-20

- Over 30.0%
- 22.6 - 30.0%
- 15.1 - 22.5%
- Under 15.1%
- No Population Age 0-17 Reported
- No Data or Data Suppressed
- Adventist Health Delano

Children in Poverty by Ethnicity Alone

This indicator reports children aged 0-17 living in households with income below the federal poverty level by ethnicity alone.

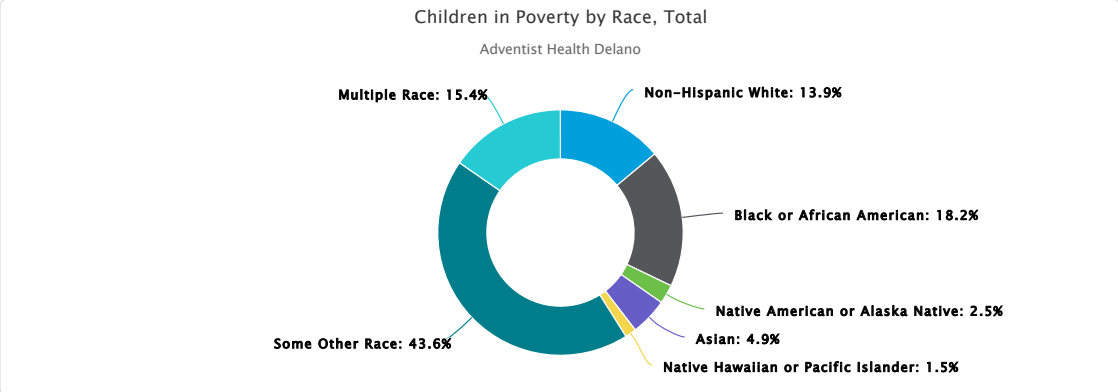
Report Area	Hispanic or Latino	Not Hispanic or Latino	Hispanic or Latino, Percent	Not Hispanic or Latino, Percent
Adventist Health Delano	6,675,685	1,341,039	33.94%	32.95%
Kern County, CA	51,951	18,340	31.27%	21.03%
Tulare County, CA	36,142	4,954	33.70%	15.01%
California	1,013,787	466,862	22.32%	10.92%
United States	4,487,018	8,111,681	24.68%	15.05%



Children in Poverty by Race, Total

This indicator reports the total children aged 0-17 living in households with income below the federal poverty level by race alone.

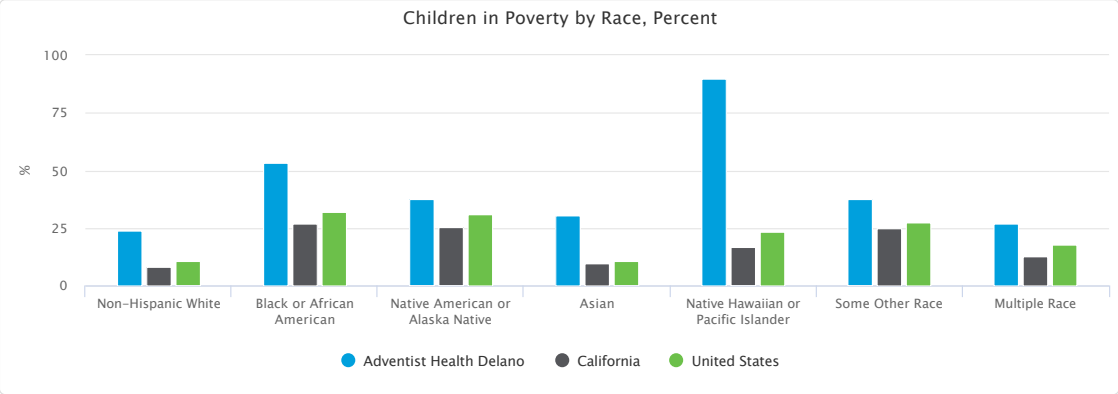
Report Area	Non-Hispanic White	Black or African American	Native American or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
Adventist Health Delano	506,321	661,238	91,193	179,317	53,649	1,583,499	558,127
Kern County, CA	9,705	5,767	953	2,026	289	11,330	6,263
Tulare County, CA	2,941	861	855	1,084	142	10,185	2,761
California	182,435	124,650	17,742	106,168	5,141	378,293	149,598
United States	3,805,465	3,169,873	214,829	388,057	34,982	1,282,237	1,163,442



Children in Poverty by Race, Percent

This indicator reports percent of children aged 0-17 living in households with income below the federal poverty level by race alone.

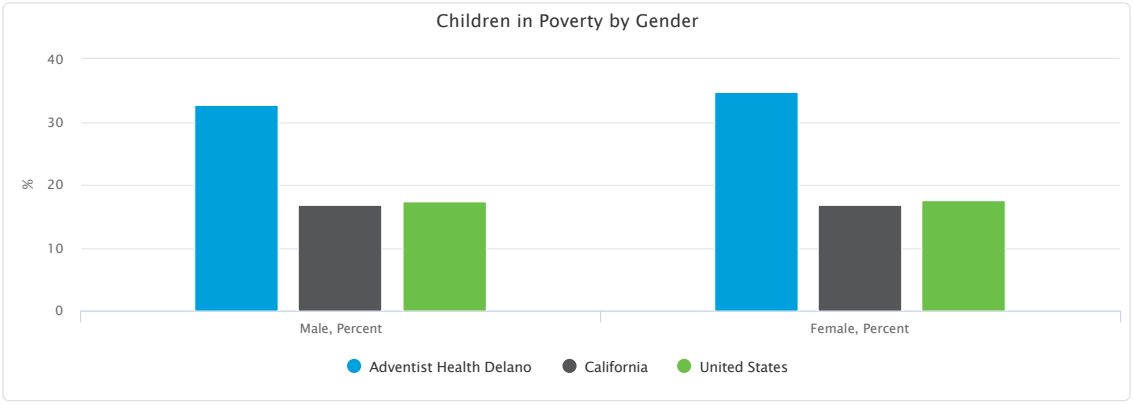
Report Area	Non-Hispanic White	Black or African American	Native American or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
Adventist Health Delano	23.83%	53.41%	37.77%	30.37%	89.74%	37.31%	26.94%
Kern County, CA	16.92%	45.32%	35.85%	20.29%	72.07%	32.96%	22.68%
Tulare County, CA	12.52%	34.89%	47.63%	22.29%	87.12%	36.69%	20.29%
California	8.30%	27.13%	25.30%	9.84%	16.73%	24.94%	12.86%
United States	10.58%	31.80%	31.16%	10.58%	23.24%	27.24%	17.63%



Children in Poverty by Gender

This indicator reports children aged 0-17 living in households with income below the federal poverty level by gender.

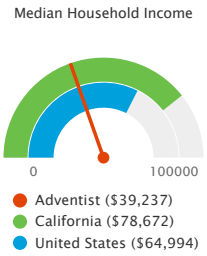
Report Area	Male	Female	Male, Percent	Female, Percent
Adventist Health Delano	3,944,911	4,071,813	32.72%	34.79%
Kern County, CA	34,789	35,502	27.08%	28.42%
Tulare County, CA	21,641	19,455	30.21%	28.35%
California	753,182	727,467	16.73%	16.87%
United States	6,414,903	6,183,796	17.43%	17.54%



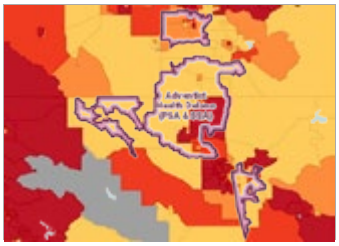
Income - Median Household Income

This indicator reports median household income based on the latest 5-year American Community Survey estimates. This includes the income of the householder and all other individuals 15 years old and over in the household, whether they are related to the householder or not. Because many households consist of only one person, average household income is usually less than average family income. There are 104,600 households in the report area, with an average income of $57,351 and median income of $39,237.

Report Area	Total Households	Average Household Income	Median Household Income
Adventist Health Delano	104,600	$57,351	**$39,237**
Kern County, CA	273,556	$75,161	$54,851
Tulare County, CA	139,044	$72,092	$52,534
California	13,103,114	$111,622	$78,672
United States	122,354,219	$91,547	$64,994



Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2016-20. Source geography: Tract



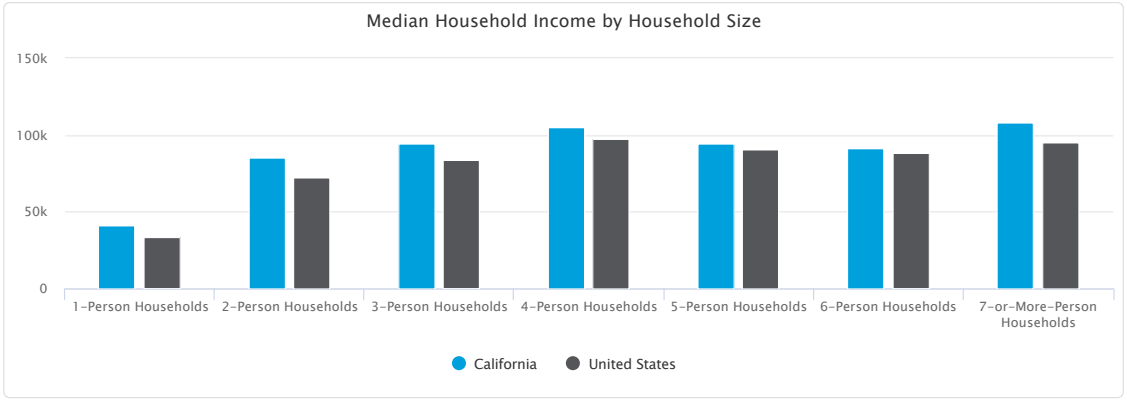
Median Household Income by Tract, ACS 2016-20

- Over $70,000
- $60,001 - $70,000
- $50,001 - $60,000
- Under $50,001
- No Data or Data Suppressed
- Adventist Health Delano

Median Household Income by Household Size

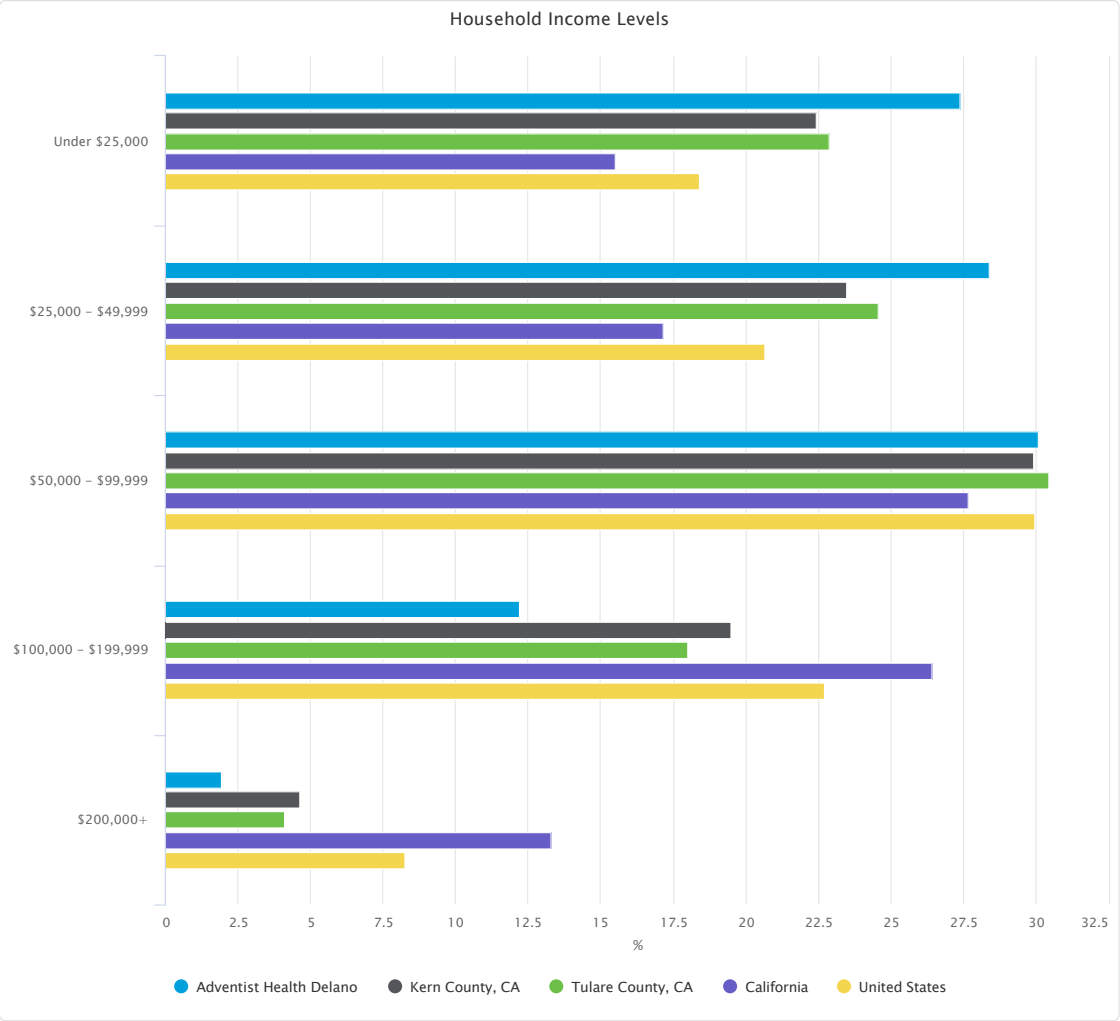
This indicator reports the median household income of the report area by household size.

Report Area	1-Person Households	2-Person Households	3-Person Households	4-Person Households	5-Person Households	6-Person Households	7-or-More-Person Households
Adventist Health Delano	No data	No data	No data	No data	No data	No data	No data
Kern County, CA	$27,830	$57,137	$63,370	$68,559	$68,468	$63,451	$69,368
Tulare County, CA	$29,089	$54,093	$55,115	$64,006	$56,943	$56,975	$85,947
California	$40,788	$85,056	$94,221	$104,973	$94,232	$91,578	$107,797
United States	$33,265	$72,238	$84,033	$97,660	$90,979	$88,413	$94,924



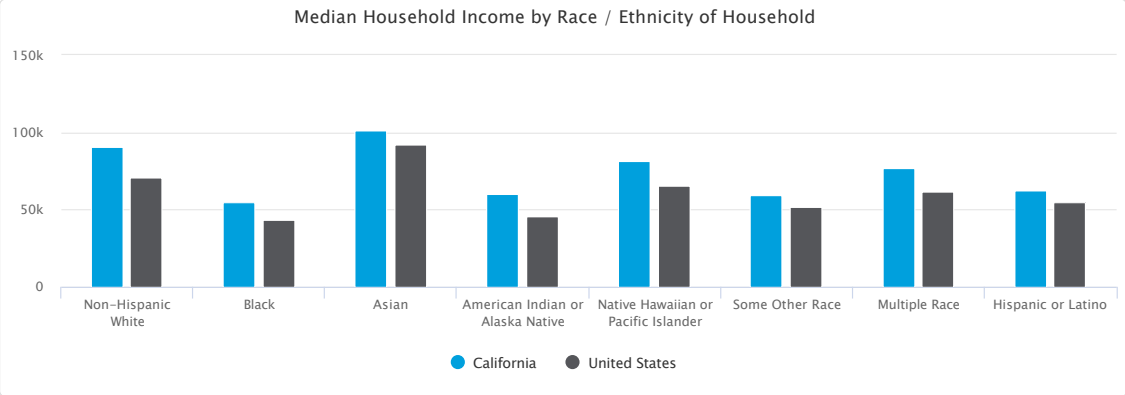
Household Income Levels

Report Area	Under $25,000	$25,000 - $49,999	$50,000 - $99,999	$100,000 - $199,999	$200,000+
Adventist Health Delano	27.38%	28.41%	30.09%	12.21%	1.92%
Kern County, CA	22.45%	23.48%	29.94%	19.48%	4.65%
Tulare County, CA	22.87%	24.57%	30.46%	18.00%	4.11%
California	15.51%	17.14%	27.66%	26.42%	13.27%
United States	18.41%	20.64%	29.95%	22.73%	8.26%



This indicator reports the median household income of the report area by race / ethnicity of household

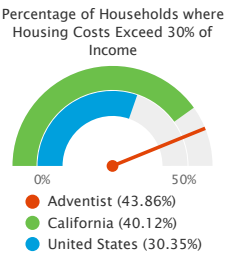
Adventist Health Delano	No data	No data	No data	No data	No data	No data	No data	No data
Tulare County, CA	$64,453	$44,708	$67,396	$37,632	No data	$47,520	$62,159	$46,063
United States	$70,843	$43,674	$91,775	$45,877	$65,804	$51,900	$61,870	$54,632



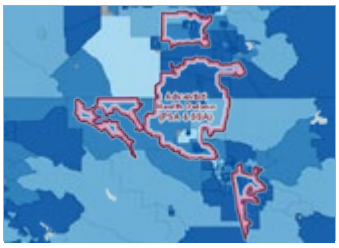
Security - Housing Cost Burden (30%)

This indicator reports the percentage of the households where housing costs are 30% or more of total household income. This indicator provides information on the cost of monthly housing expenses for owners and renters. The information offers a measure of housing affordability and excessive shelter costs. The data also serve to aid in the development of housing programs to meet the needs of people at different economic levels. Of the 104,600 total households in the report area, 45,881 or 43.86% of the population live in cost burdened households.

Report Area	Total Households	Cost Burdened Households (Housing Costs Exceed 30% of Income)	Cost Burdened Households, Percent
Adventist Health Delano	104,600	45,881	**43.86%**
Kern County, CA	273,556	102,314	37.40%
Tulare County, CA	139,044	52,667	37.88%
California	13,103,114	5,256,527	40.12%
United States	122,354,219	37,128,748	30.35%



Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2016-20. Source geography: Tract



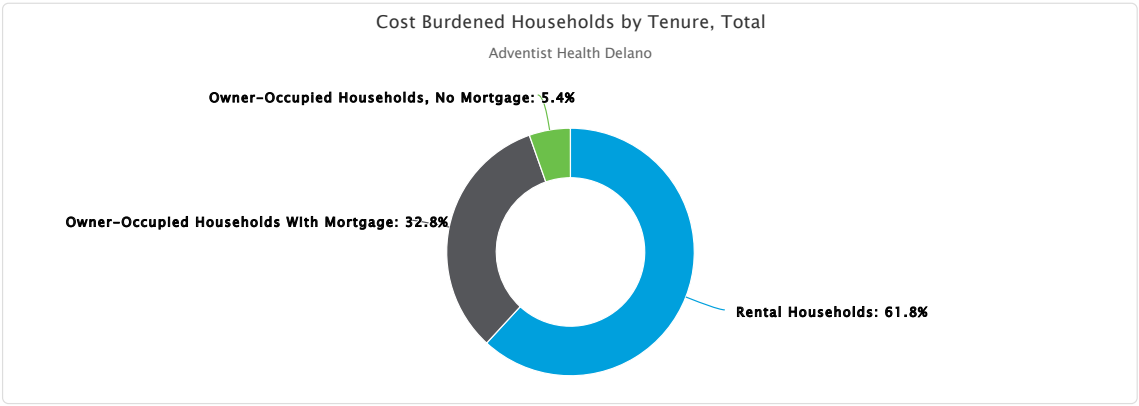
Cost Burdened Households (Housing Costs Exceed 30% of Household Income), Percent by Tract, ACS 2016-20

- Over 35.1%
- 28.1 - 35.0%
- 21.1 - 28.0%
- Under 21.1%
- No Data or Data Suppressed
- Adventist Health Delano

Cost Burdened Households by Tenure, Total

These data show the number of households that spend more than 30% of the household income on housing costs. In the report area, there were 45,881 cost burdened households according to the U.S. Census Bureau American Community Survey (ACS) 2016-2020 5-year estimates. The data for this indicator is only reported for households where household housing costs and income earned was identified in the American Community Survey.

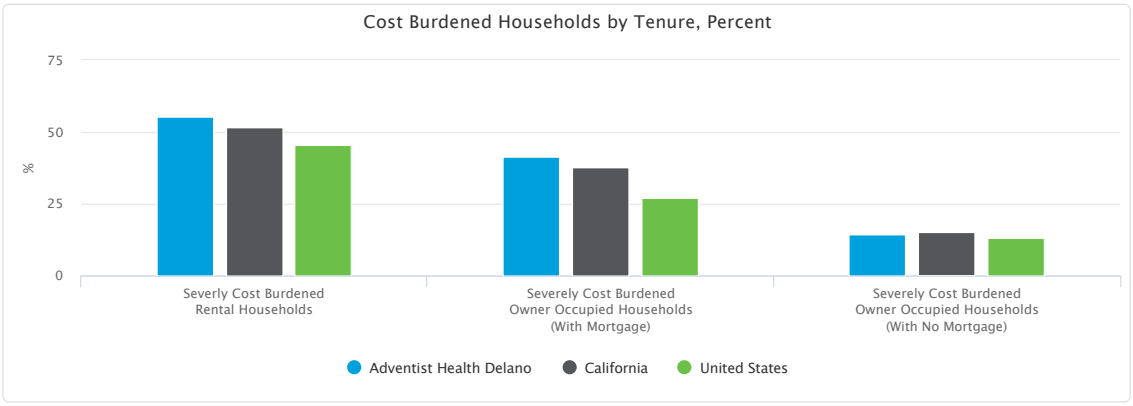
Report Area	Cost Burdened Households	Cost Burdened Rental Households	Cost Burdened Owner Occupied Households (With Mortgage)	Cost Burdened Owner Occupied Households (With No Mortgage)
Adventist Health Delano	45,881	28,374	15,033	2,474
Kern County, CA	102,314	57,143	38,121	7,050
Tulare County, CA	52,667	28,894	20,601	3,172
California	5,256,527	3,019,235	1,906,204	331,088
United States	37,128,748	19,886,052	13,344,089	3,898,607



Cost Burdened Households by Tenure, Percent

These data show the percentage of households by tenure that are cost burdened. Cost burdened rental households (those that spent more than 30% of the household income on rental costs) represented 55.41% of all of the rental households in the report area, according to the U.S. Census Bureau American Community Survey (ACS) 2016-2020 5-year estimates. The data for this indicator is only reported for households where tenure, household housing costs, and income earned was identified in the American Community Survey.

Report Area	Rental Households	Percentage of Rental Households that are Cost Burdened	Owner Occupied Households (With Mortgage)	Percentage of Owner Occupied Households w/ Mortgages that are Cost Burdened	Owner Occupied Households (No Mortgage)	Percentage of Owner Occupied Households w/o Mortgages that are Cost Burdened
Adventist Health Delano	51,204	55.41%	36,284	41.43%	17,112	14.46%
Kern County, CA	112,443	50.82%	109,460	34.83%	51,653	13.65%
Tulare County, CA	59,691	48.41%	54,387	37.88%	24,966	12.71%
California	5,861,796	51.51%	5,035,650	37.85%	2,205,668	15.01%
United States	43,552,843	45.66%	48,974,364	27.25%	29,827,012	13.07%



E. Health Conditions

Health conditions, especially chronic conditions, can undermine a person's quality of life and lead to extensive healthcare service needs over time. Several health factors in the community highlight the need for intervention in Delano. 37.28% of Delano's adult population meets the medical criteria for obesity, which is nearly 10% higher than the state average and 6% higher than the national average. Delano also had a higher heart disease mortality rate than California and the nation by a substantial degree, with 3,373 persons dying of heart disease between 2016 and 2020. Delano's lung disease death rate is also higher in California and the United States. Similarly, liver disease death rates are higher in Delano than in California and the nation to a significant degree.

Scan QR Code for more information on the full Report

PRIMARY COMMENTS

FOCUS GROUPS

- The large number of fast-food restaurants in the community is seen as a driver towards unhealthy eating.
- Obesity is seen as a leading factor in other health issues, and the rate is seen as high in Kern County.
- Interviews think that this area has a high rate of mortality due to diabetes.
- One interview noted that previous statistics showed that close to half of the population were pre-diabetic and didn't know it.
- More than 60% of full families are believed to be obese/overweight).
- People have noted that many other health issues feed off of obesity due to food habits and the lack of education within high schools and the community at large.
- The consequences of poor diet and overweight/obesity have been seen in the community for many years, focus group members said.
- Childhood obesity is on the rise. Those aged 10+ have a BMI greater than 28, one interviewee reported.
- Some noted cultural beliefs and generational habits that can negatively impact eating habits.

KEY INFORMANT COMMENTS

- Increased cancer screening opportunities are viewed as important.
- The lack of easily accessible public exercise spaces was identified as a major barrier for many in the community.
- "If I were to pick one disease that affects our community most, it would be diabetes. I think there's a need for comprehensive diabetes centers as opposed to individual primary care doctors. We have very few endocrinologists in our community, we are very understaffed, but if we were to comprehensively deal with it, you could cut the amputations rate by 50%, cut heart disease, cut blindness. There's a limited relationship to cancer but a huge relationship to heart disease."
- There are believed to be very high obesity rates in the county for youth and adults and the related health conditions that are impacted by high obesity rates. Also, high rates of diabetes, high blood pressure, heart disease and that further impacts the specialty need for care. Much of this is seen as being related to the lack of doctors.
- When a patient presents as being morbidly obese, doctors may focus on this factor rather than seeing the full set of the patient's medical needs.
- Interviewees noted a high incidence of heart disease locally.

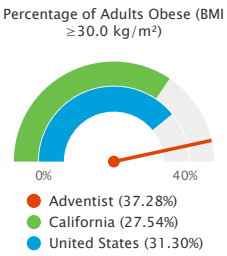
Secondary Data Summary

Health Conditions

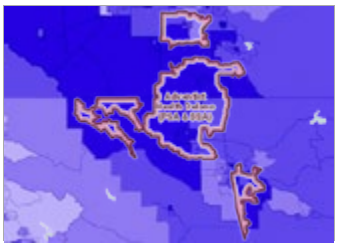
Obesity & Diabetes - Obesity

This indicator reports the number and percentage of adults age 18 and older who are obese, defined as having a body mass index (BMI) ≥30.0 kg/m², calculated from self-reported weight and height.

Report Area	Total Population (2019)	Adult Obesity (BMI ≥30.0 kg/m²) (Crude)	Adult Obesity (BMI ≥30.0 kg/m²) (Age-Adjusted)
Adventist Health Delano	383,586	**37.28%**	No data
Kern County, CA	900,202	35.00%	35.50%
Tulare County, CA	466,195	35.20%	35.70%
California	39,512,223	27.54%	27.71%
United States	328,239,523	31.30%	31.30%



Note: This indicator is compared to the state average.
Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2019. Source geography: Tract



Obese (BMI >= 30), Prevalence Among Adults Age 18+ by Tract, CDC BRFSS PLACES Project 2019

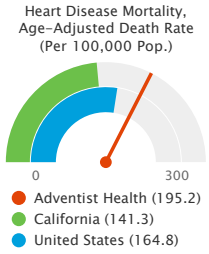
- Over 37.0%
- 30.1% - 37.0%
- 25.1% - 30.0%
- Under 25.1%
- No Data or Data Suppressed
- Adventist Health Delano

Heart Disease & Stroke - Heart Disease & Stroke Mortality

This indicator reports the 2016-2020 five-year average rate of death due to heart disease (ICD10 Codes I00-I09, I11, I13, I20-I151) per 100,000 population. Figures are reported as crude rates, and as rates age-adjusted to year 2000 standard. Rates are resummarized for report areas from county level data, only where data is available. This indicator is relevant because heart disease is a leading cause of death in the United States.

Within the report area, there are a total of 3,273 deaths due to heart disease. This represents an age-adjusted death rate of 195.2 per every 100,000 total population.
Note: Data are suppressed for counties with fewer than 20 deaths in the time frame.

Report Area	Total Population, 2016-2020 Average	Five Year Total Deaths, 2016-2020 Total	Crude Death Rate (Per 100,000 Population)	Age-Adjusted Death Rate (Per 100,000 Population)
Adventist Health Delano	396,244	3,273	165.2	**195.2**
Kern County, CA	895,247	7,407	165.5	197.7
Tulare County, CA	465,133	3,824	164.4	187.7
California	39,444,803	315,849	160.1	141.3
United States	326,747,554	3,294,101	201.6	164.8



Note: This indicator is compared to the state average.
Data Source: Centers for Disease Control and Prevention, CDC - National Vital Statistics System. Accessed via CDC WONDER. 2016-2020. Source geography: County

Heart Disease Mortality, Age Adj. Rate (Per 100,000 Pop.) by County, CDC NVSS 2016-20

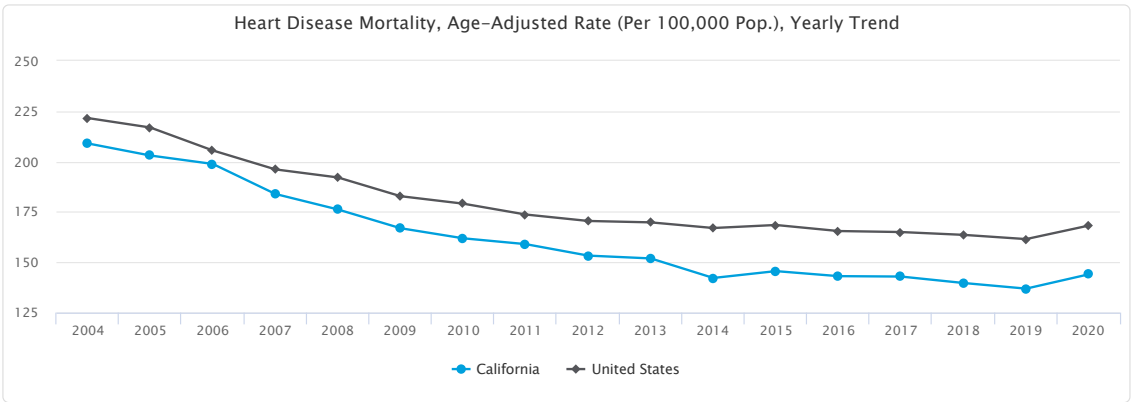
- Over 240.0
- 200.1 - 240.0
- 160.1 - 200.0
- Under 160.1
- Data Suppressed (<20 Deaths)
- Adventist Health Delano

Heart Disease Mortality, Age-Adjusted Rate (Per 100,000 Pop.), Yearly Trend

This indicator reports age-adjusted rate of death due to heart disease per 100,000 people over time.

Report Area	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
California	209.0	203.0	198.8	183.9	176.2	166.9	161.9	159.0	153.3	151.9	142.2	145.6	143.1	142.9	139.7	136.9	144.0
United States	221.6	216.9	205.5	196.1	192.1	182.8	179.1	173.7	170.5	169.8	167.0	168.5	165.5	165.0	163.6	161.5	168.2

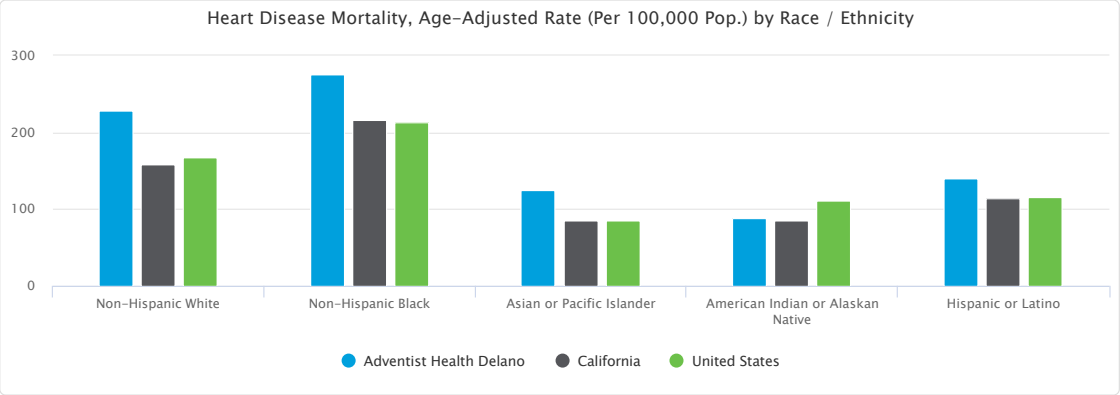
Note: No county data available. See data source and methodology for more details.



Heart Disease Mortality, Age-Adjusted Rate (Per 100,000 Pop.) by Race / Ethnicity

This table reports the age-adjusted rate of death due to heart disease per 100,000 people by race and Hispanic origin.

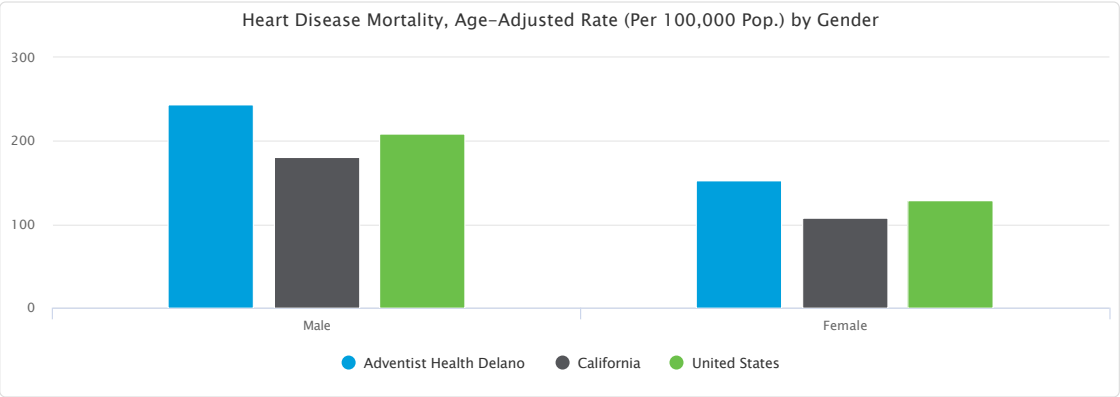
Report Area	Non-Hispanic White	Non-Hispanic Black	Asian or Pacific Islander	American Indian or Alaskan Native	Hispanic or Latino
Adventist Health Delano	228.0	275.9	124.4	88.4	139.9
Kern County, CA	229.0	279.8	121.4	84.9	141.4
Tulare County, CA	224.8	233.2	135.8	98.2	136.4
California	158.4	216.6	86.0	85.3	114.0
United States	168.2	212.6	85.6	111.7	115.3



Heart Disease Mortality, Age-Adjusted Rate (Per 100,000 Pop.) by Gender

This table reports the age-adjusted rate of death due to heart disease per 100,000 people by gender.

Report Area	Male	Female
Adventist Health Delano	244.6	153.1
Kern County, CA	247.5	155.4
Tulare County, CA	235.9	146.8
California	181.0	108.6
United States	208.9	128.8

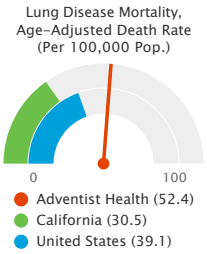


Asthma & COPD - Lung Disease Mortality

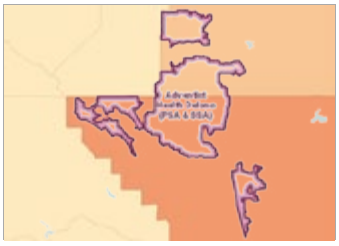
This indicator reports the 2016-2020 five-year average rate of death due to chronic lower respiratory disease per 100,000 population. Figures are reported as crude rates, and as rates age-adjusted to year 2000 standard. Rates are resummarized for report areas from county level data, only where data is available. This indicator is relevant because lung disease is a leading cause of death in the United States.

Within the report area, there are a total of 868 deaths due to lung disease. This represents an age-adjusted death rate of 52.4 per every 100,000 total population.
Note: Data are suppressed for counties with fewer than 20 deaths in the time frame.

Report Area	Total Population, 2016-2020 Average	Five Year Total Deaths, 2016-2020 Total	Crude Death Rate (Per 100,000 Population)	Age-Adjusted Death Rate (Per 100,000 Population)
Adventist Health Delano	396,244	868	43.8	**52.4**
Kern County, CA	895,247	2,086	46.6	56.4
Tulare County, CA	465,133	831	35.7	40.7
California	39,444,803	67,228	34.1	30.5
United States	326,747,554	783,919	48.0	39.1



Note: This indicator is compared to the state average.
Data Source: Centers for Disease Control and Prevention, CDC - National Vital Statistics System. Accessed via CDC WONDER. 2016-2020. Source geography: County



Lung Disease Mortality, Age Adj. Rate (Per 100,000 Pop.) by County, CDC NVSS 2016-20

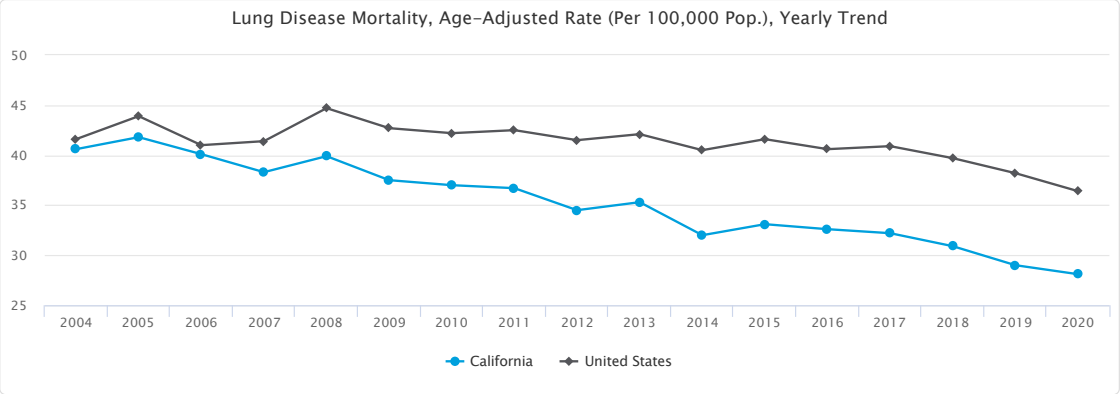
- Over 60.0
- 50.1 - 60.0
- 40.1 - 50.0
- Under 40.1
- Data Suppressed (<10 Deaths)
- Adventist Health Delano

Lung Disease Mortality, Age-Adjusted Rate (Per 100,000 Pop.), Yearly Trend

This indicator reports the age-adjusted rate of death due to lung disease per 100,000 people over time.

Report Area	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
California	40.6	41.8	40.1	38.3	39.9	37.5	37.0	36.7	34.5	35.3	32.0	33.1	32.6	32.2	30.9	29.0	28.1
United States	41.6	43.9	41.0	41.4	44.7	42.7	42.2	42.5	41.5	42.1	40.5	41.6	40.6	40.9	39.7	38.2	36.4

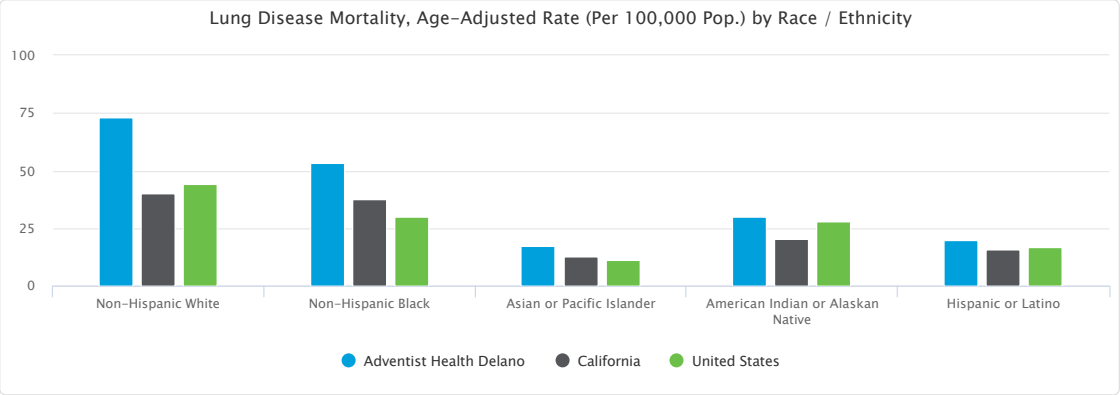
Note: No county data available. See data source and methodology for more details.



Lung Disease Mortality, Age-Adjusted Rate (Per 100,000 Pop.) by Race / Ethnicity

This table reports the age-adjusted rate of death due to lung disease per 100,000 people by race and Hispanic origin.

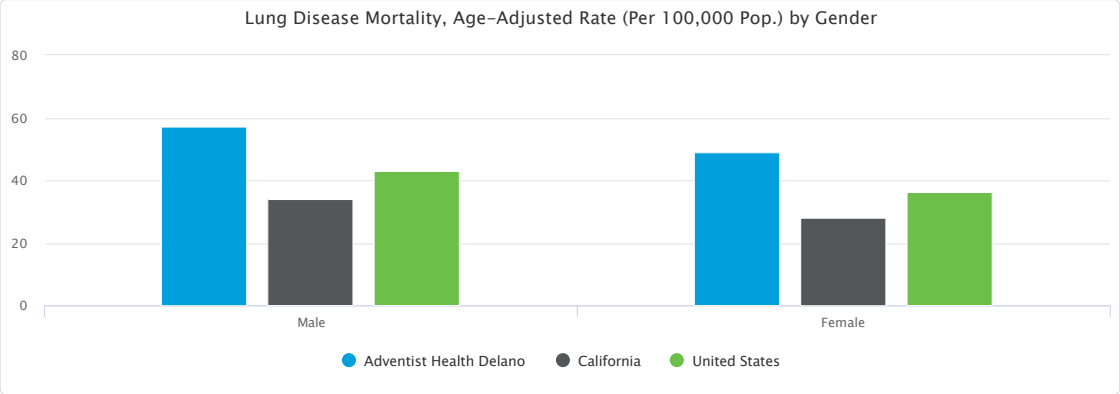
Report Area	Non-Hispanic White	Non-Hispanic Black	Asian or Pacific Islander	American Indian or Alaskan Native	Hispanic or Latino
Adventist Health Delano	73.2	53.1	17.5	30.0	19.6
Kern County, CA	77.1	53.1	17.5	30.0	20.8
Tulare County, CA	59.5	No data	No data	No data	16.6
California	40.1	37.8	12.6	20.4	15.5
United States	44.4	29.9	11.3	27.9	16.6



Lung Disease Mortality, Age-Adjusted Rate (Per 100,000 Pop.) by Gender

This table reports the age-adjusted rate of death due to lung disease per 100,000 people by gender.

Report Area	Male	Female
Adventist Health Delano	57.2	49.0
Kern County, CA	61.2	53.0
Tulare County, CA	45.1	37.7
California	33.9	27.9
United States	43.0	36.3

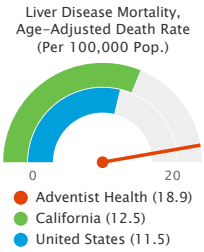


Kidney & Liver Diseases - Liver Disease Mortality

This indicator reports the 2016-2020 five-year average rate of death due to liver disease per 100,000 population. Figures are reported as crude rates, and as rates age-adjusted to year 2000 standard. Rates are resummarized for report areas from county level data, only where data is available. This indicator is relevant because liver disease is a leading cause of death in the United States.

Within the report area, there are a total of 354 deaths due to liver disease. This represents an age-adjusted death rate of 18.9 per every 100,000 total population.
Note: Data are suppressed for counties with fewer than 20 deaths in the time frame.

Report Area	Total Population, 2016-2020 Average	Five Year Total Deaths, 2016-2020 Total	Crude Death Rate (Per 100,000 Population)	Age-Adjusted Death Rate (Per 100,000 Population)
Adventist Health Delano	396,244	354	17.8	**18.9**
Kern County, CA	895,247	749	16.7	17.5
Tulare County, CA	465,133	490	21.1	22.7
California	39,444,803	27,757	14.1	12.5
United States	326,747,554	221,126	13.5	11.5



Note: This indicator is compared to the state average.
Data Source: Centers for Disease Control and Prevention, CDC - National Vital Statistics System. Accessed via CDC WONDER. 2016-2020. Source geography: County

F. Written Comments

We value your input in our community health needs assessment and invite you to submit comments on this CHNA to community.benefit@ah.org. At the time of this CHNA report development, no written comments about the previous CHNA Report or adopted implementation strategy were received.

G. Data Limitations

Focus group and key informant interviews were conducted solely with volunteers, which could affect the representativeness of the information collected. Broad-scale community engagement is difficult in geographically large, rural communities and large, high-population areas. Some of the secondary data sets used in this needs assessment were collected prior to COVID-19. The survey only sampled registered voters, leaving out a fully representative sample. As a result, it is not possible to know the full impact COVID-19 has had on the lives of the communities studied or the impact it had on data collection. It is likely sensitivity to COVID-19 affected focus group participation at a minimum. Despite these limitations, the data provided can be seen as an accurate reflection of community health needs.

Scan the QR code for the full Secondary Data Report

IV. Identification of Community's Priority Health Needs

A. Criteria and Process Used for Prioritization of Health Needs

The local Steering Committee (membership found in Section I. E) was responsible for identifying the community health needs to include in the new CHNA. To facilitate this process, a series of meetings were held in each community to 1) present the results of the CHNA data collection process and 2) prioritize the significant identified health needs.

The first part of this series involved Adventist Health System staff and a consultant presenting the primary and secondary data analysis findings to the Steering Committee. The primary data collection included focus groups, key informant interviews, and a community survey, while the secondary data collection included a review of 120 metrics used to determine factors having the greatest impact on community health. Each Steering Committee received a 90-minute data presentation of these results, highlighting the top five needs for each data source and the supporting data that led to their inclusion (see Section V for methodology). A conversation about the findings was a part of these data reviews, but the determination of priority needs was not included, the main goal of these meetings being the provision of information to drive the data-driven decision-making required for the high priority needs selection. At the end of the meeting the Steering Committee was provided with two prioritization tools, data slides and a robust secondary data report to review before the next meeting. The committee members were also asked to discuss the data with their colleagues and organizational leadership and to complete a brief poll a few days prior to the prioritization meeting. The poll allowed them to identify the three-to-five needs they viewed as most important, based on the criteria provided during the 90-minute data presentation to the CHNA steering committee (see Prioritization Tools #1 and #2).

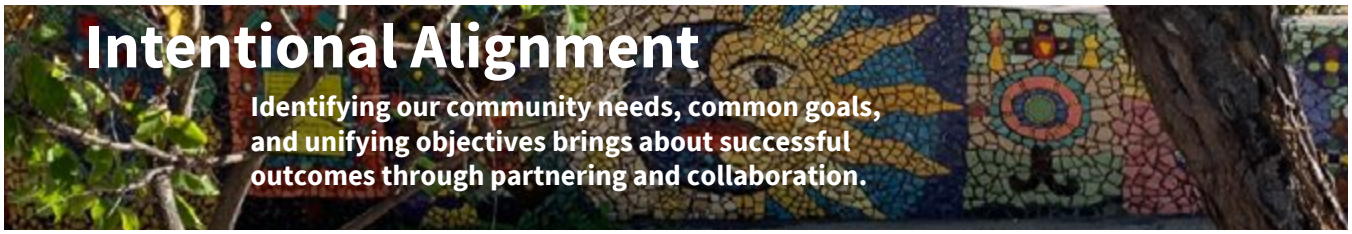
The prioritization meetings were designed to build consensus around the high priority community health needs identified by the steering committee members. The meetings were facilitated by Adventist Health System staff and relied on the CHNA data presented at the prior meeting, the poll results, and an extensive conversation between members. Each meeting concluded with committee members prioritizing the list of significant identified needs (with typically three-to-five needs selected as high-priority).

B. Next Steps

The next step in our CHNA process includes the development of the Community Health Implementation Strategy (CHIS). The CHIS implementation consists of a long-term community health improvement plan that strategically identifies and implements evidence-based solutions and programs to address our priority needs.

We believe the power of community transformation lies in the hands of the community. The voices we have heard have an impact and influence the next steps of creating a strategy to improve the health needs of the community for all. If you would like to learn more, share ideas or stay connected, please contact us at community.benefit@ah.org.

PRIORITIZATION TOOL #1



Intentional Alignment

Identifying our community needs, common goals, and unifying objectives brings about successful outcomes through partnering and collaboration.

CRITERIA FOR CONSIDERING WHICH HEALTH NEED TO ADDRESS

Operations

'Quick Wins' through collaboration

Political willingness

Partners Resources Assets

Existing orgs/programs

Need

CBO's are focused on this Need

Community willingness

Finance

Gov. or public funding available when applying

Available grants for this *Need*

Need meets the vision/mission of Gov. or philanthropic orgs

Equity

Current Orgs/programs

Everyone will benefit

Addressing *Need* could lessen absenteeism at work/school

PRIORITIZATION TOOL #2

Feasibility: High feasibility means there is alignment and/or resources in place to take actional steps to address this Need in a 1-3 year timeframe. Low feasibility means it will take more than 3 years to show a community benefit by addressing this Need.

Impact: High impact means the most community members, or the community members most in need, will benefit from addressing this Need. Low impact means this priority will not benefit a large part of the community, or that the people who will benefit are not in need.

example

	Less Impact	High Impact
High Feasibility	Community Vitality	Education Food Security Housing
Less Feasibility	Environment & Infrastructure	Mental Health

V. Process and Methods to Conduct the CHNA

A. Secondary Data Methodology

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Introduction

Since the passage of the 2010 Patient Protection and Affordable Care Act, non-profit hospitals are required to complete a community health needs assessment (CHNA) at least every three years. The purpose of the CHNA is to better align the community benefit functions of non-profit hospitals with the needs of the communities which they serve. To this end, requirements for completing a CHNA are broadly defined by the Internal Revenue Service (IRS)[1] to include "identifying and prioritizing community health needs" (Pennel, 2015), which must involve the input from "broad interests of that community" (IRS). Best practices for CHNAs as defined by the CDC, the AHA Community Health Improvement (AHCI) and others all specify the inclusion of both primary and secondary data (Barnett, 2012; Institute of Medicine, 2010; Stoto & Ryan-Smith, 2015; AHCI, 2017). In practice, however, there is little consensus on how this data is used to define community health needs.

While much research exists on the subject of population health measurement, research findings specific to quantitative analysis in Community Health Needs Assessments are limited. Among the existing literature, authors find "wide-ranging diversity in CHNA approaches and report quality".

Best practices for utilizing secondary data

One reason for this is the lack of guidelines or even requirements for incorporating secondary data into an assessment of community needs. Despite this, evaluators agree that utilizing both primary and secondary data to prioritize community health needs is a "best practice".

Several common issues with secondary data which hinder its ability to define health priorities have been defined in the literature. These include the lack of data availability at the appropriate levels of disaggregation (both geographic and for population subgroups), the lack of real-time or current data, and the lack of appropriate benchmarks (Stoto, Davis, & Atkins, 2019).

This document describes the methodological approach used to identify health needs using secondary data.

Basic Approach

Health needs scores for target communities in each of 12 priority areas (categories) were determined using quantitative analysis of secondary data from standard, national sources. First, metrics were selected which best represented each category based on a review of multiple health measurement frameworks. Next, metrics were scored based on three criteria relevant to the mission of "helping people live longer, better." These criteria include: impact on short-term health (well-being); impact on long-term health (life expectancy); and severity within the reference community relative to state benchmarks. Final health needs scores for each priority area were developed with possible scores ranging from 1 to 100. Higher health needs scores indicate 1) a comparatively high degree of correlation between the underlying metrics within the health needs category and the outcome variables (well-being

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and life expectancy), and 2) a high level of need in the community compared to other areas of the state. Figure 1 depicts this process, which is further described below.

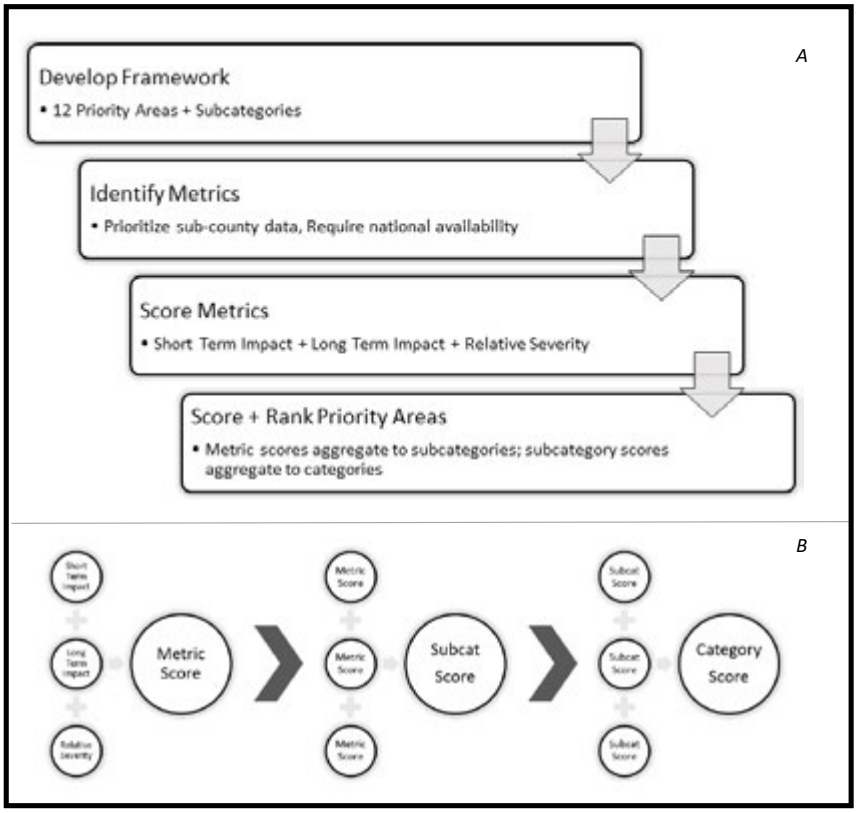

Figure 1. A. Approach to framework and scoring methodology development. B. Diagram of scoring approach.

Framework Development

A set of 12 priority conceptual areas were identified from a review of past cycle CHNAs. In order to generate a score or rank for these priority needs areas, our first task was to operationalize them by selecting appropriate data by which to measure each one. To this end, a landscape scan of available data was performed by evaluating existing population health measurement frameworks. Four primary frameworks were evaluated:

- Well-Being in the Nation (WIN) Measurement Framework
- National Committee for Vital and Health Statistics (NCVHS) Measurement Framework for Community Health & Well-Being
- County Health Rankings & Roadmaps

[1] https://www.irs.gov/charities-non-profits/community-health-needs-assessment-for-charitable-hospital-organizations-section-501r3

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- Healthy People 2030 Leading Health Indicators

Attributes for each indicator within the frameworks were identified, including data source, geographic level, extent, time period, and update frequency. Next, indicators were filtered and removed from the list based on our inclusion criteria: ability to represent the reference community (e.g., geographic scale), recency, update frequency, and source reliability. Indicators from each framework were assigned to each of the 12 categories, with some indicators assigned to multiple categories. Indicators which did not correspond into the 12 categories were not included in the analysis. Additionally, indicators representing similar concepts (e.g., poverty, childhood poverty, household poverty) were reduced to a single metric.

Next, indicators were grouped into subcategories within each priority health needs category. The final framework consists of more than 100 individual metrics across the 12 categories, each with a minimum of two subcategories (CARES, 2022).

Metric Scoring

Scores are generated for metrics (e.g., obesity prevalence) to represent the criteria mentioned above (length of life, quality of life, and severity). To operationalize the first two criteria, we measure the degree of correlation between each metric and two outcome variables: a short-term goal (well-being, measured by physical and mental health status[2]) and a long-term goal (length of life, measured by life expectancy at birth[3]). This approach was adopted in part to reflect the hospital system's mission of "helping people live longer, better".

Metrics with strong negative relationships with the outcome variables (scoring below -.40) were removed from the framework[4].

To address the third criterium, we calculate the relative severity of each metric for each target community using a z-score. A z-score is a measure which quantifies the position of a raw data value (e.g., the value for one metric for a community) in relationship to the mean and distribution of all values (e.g., the value for one metric for all other areas). For this work, the calculated value for each community for a metric (e.g., obesity) is compared against the value for all counties within the community state (e.g., obesity rates for all counties in California). In this way, communities can be compared against geographic areas with similar geographic size and heterogeneity. Furthermore, z-scores for a given community are compared against a fixed number and definition of geographic areas, which exist independent of the number of communities or hospitals assessed within a state.

[2] Source: BRFSS PLACES 2018 Poor Mental Health Days + Poor Physical Health Days
[3] Source: CDC NCHS USA LEEP
[4] Removal was preferred over inverting the score direction since indicators were selected which theoretically represented conditions for good health. One example of this removal occurred with the metric "access to grocery stores", where a lower density of grocery stores correlated with a higher life expectancy and well-being. It is predicted that this relationship is due to confounding factors or a limitation of the measurement definition selected, and not an indication that a higher density of grocery stores causes worse health.

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Transformation of Correlation Scores

To aid in interpretability, correlation scores within a single health need category and outcome category were converted to percentiles, such that the score for a single metric represents the percent of the total scores for all metrics.

Category Scores

Scores for each metric are based on three separate values as represented in Equation 1 below. Short-term and long-term health impact scores are identical for all communities, while the relative severity score is unique. To generate a *final* score for each metric, we calculate the weighted average of the short-term and long-term score and apply the z-score as an adjustment factor.

$$M_c = (ST_s + LT_s) * Z_{cs}$$

Equation 1. Metric scores. ST_s is the state-specific correlation score between the metric and the short-term outcome variable (self-reported health status), LT_s is the state-specific correlation score between the metric and the long-term outcome variable (life expectancy), and Z_{cs} is the area-specific relative severity score (z-score).

In this way, communities which perform better than average for a metric will see scores adjusted down (lower priority), and communities which perform worse than average will see scores adjusted up (higher priority).

Next, metric scores are aggregated to produce subcategory and category scores. Subcategory scores are calculated as the average of all final metric scores within a category. Finally, category scores are calculated as the average of all subcategory scores within a category.

$$SubC_c = \sum_c \frac{SubC}{n} \qquad Cat_c = \sum \frac{SubC}{n}$$

Presentation of Results

All final subcategory and category scores are transformed to a 100-point scale for ease of interpretation, where 100 is the maximum possible value (highest priority) and 1 is the lowest theoretical possible value (lowest priority).

Subcategory scores are transformed *independently* of category scores. The maximum "real" subcategory score may be as high as 7.0, which would transform to ~100, whereas the highest category score is only about 4.0, which also transforms to ~100. Therefore, subcategory scores can be compared with other subcategory scores, category scores may be compared with category scores; however subcategory scores and category scores cannot be compared.

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Limitations

This approach is subject to several limitations. First, the final selection of priority areas is heavily dependent on the structure of the measurement framework. In this work, the top-level framework was determined by the hospital system based on prior assessments; metrics were assigned to categories and grouped based on expert knowledge. However, changes to the organization of metrics within top-level categories, including the addition or removal of metrics or the reorganization of metrics within subcategories, are major drivers of category scores and results. A data-driven method for selecting a measurement framework would therefore improve the applicability of these results outside of the example health system.

Next, despite best efforts to identify relevant metrics at the community-level, availability of data to represent some priority health need concepts are limited. For example, data on the prevalence of overall homelessness is not available for small (e.g., sub-county) geographic areas. Without data sets that accurately represent prevalence within a community, the ability to score impact on health and well-being is limited.

An additional limitation is the flexibility of metric correlation scores with the outcome variables. Data analysis found scores to be influenced by the geographic scale and the geographic universe (e.g., state, region, or US total) at which relationships were assessed, and rescaling methods used to standardize data. Changes to one or more of these decisions produce a range of correlation scores. Ideally, relationships would be consistent across multiple geographic levels or groupings.

Finally, secondary data are hampered by lag in reporting. At the time assessments were performed (Spring, 2022), the latest available data on health behaviors, outcomes, and social determinants represented the 2019 calendar year, and in some cases, data were older still. Since the first aim of this work is to measure the *relationship* between certain factors and well-being and life expectancy, this temporal lag is of less importance. However, the significant events of 2020 and 2021 (e.g., the COVID-19 pandemic) are largely unrepresented in these data.

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B. Survey Methodology and Questions

The Berkeley IGS Poll is a regularly scheduled non-partisan survey of California public opinion conducted by the Institute of Governmental Studies (IGS) at the University of California, Berkeley. A component of the University of California system's flagship Berkeley campus, IGS is the oldest organized research unit in the UC system and the state's oldest public policy research center.

METHODOLOGY: The poll is administered online by distributing email invitations to stratified random samples of California registered voters. The invitation provides respondents with a short summary of the poll's purpose, its sponsorship, how long the survey is likely to take and how the recipient's email was obtained.

The statistical tabulations in this volume are based on a Berkeley IGS Poll completed online in English and Spanish July 18-24, 2021, among 5,795 California registered voters by the Institute of Governmental Studies (IGS) at the University of California, Berkeley. Funding for the poll was provided in part by the Los Angeles Times.

The survey distributed email invitations to stratified random samples of the state's registered voters. Each email invited voters to participate in a non-partisan survey conducted by the University and provided a link to the IGS website where the survey was housed. Reminder emails were distributed to non-responding voters, and an opt-out link was offered to voters not wishing to participate and not wanting to receive further email invitations.

Samples of registered voters with email addresses were provided to IGS by Political Data, Inc., a leading supplier of registered voter lists in California. The email addresses of voters were derived from information contained on the state's official voter registration rolls. Prior to the distribution of the emails, the overall sample was stratified by age and gender in an attempt to obtain a proper balance of survey respondents across all major segments of the registered voter population.

To protect the anonymity of survey respondents, voters' email addresses and all other personally identifiable information derived from the original voter listing were purged from the data file and replaced with a unique and anonymous identification number during data processing. In addition, post-stratification weights were applied to align the overall sample of the registered voters to population characteristics of the state's registered voters.

The sampling error associated with the results from the survey is difficult to calculate precisely due to the effects of sample stratification and the post-stratification weighting. Nevertheless, it is likely that the results from the overall sample of registered voters are subject to a sampling error of approximately +/- 2 %age points at the 95% confidence level.

The survey question response options were based on the community health needs framework that also defined this work's secondary and primary data collection. In addition, survey response language was adjusted to be accessible to all community members.

The following list shows how response options correspond to the community needs framework.

SURVEY QUESTION

Please choose the five things from this list that make it hard for you and others in your community to be healthy.

- Not being able to see a doctor or go to a hospital
- Not enough good jobs
- Lack of transportation
- Lack of senior care
- Poor schools
- Not enough affordable housing
- Limited affordable, healthy food
- COVID-19
- Homelessness
- Mental Health
- Cost of Living

NEEDS CROSSWALK

- Access to Care-Primary Care
- Financial Stability-Employment
- Environment & Infrastructure-Transportation
- Access to Care-Senior Care
- Education
- Housing-Cost
- Food Security
- COVID
- Housing-Unhoused
- Mental Health
- Financial Stability-Cost of Living

C. Focus Group and Key Informant Methodology and Guide

Primary data collection was designed to gather first-person input on community health needs directly from community members. Between October 2021 – January 2022, focus groups were conducted with community service providers and service recipients, and key informant interviews were conducted with community leaders. Focus group members participated in 1.5-hour virtual and/or in-person sessions, and key informant interviewees participated in 1-hour individual virtual interviews. Steering committee members were responsible for identifying participants and scheduling both types of interviews. Any social service provider in the community was eligible for inclusion in the focus groups, and any social service director or other community leader was eligible for key informant interview involvement. An emphasis was placed on hearing from underserved and minority populations whenever possible.

The semi-structured interview guides (see Section V) used for both types of interviews were nearly identical. All focus groups and interviews began with participants identifying up to five high priority community health needs from their perspective, chosen from a standard list provided by the facilitator. This standard list was comprised of common community health needs based on the larger framework of social determinants of health used for secondary data collection (see Section V). The facilitators — a team of Adventist Health System staff and a consultant — then moved through a series of questions for each identified need, focusing on depth of need, examples of the impact of the need, attempts at addressing the need historically, barriers to reducing the need, and reasonable improvement goals over three years. The only variation in the focus group and key informant interview guides was the inclusion of additional prompts for key informants allowing for greater depth of response. A notetaker was present for each focus group and key informant interview, and all interviews were recorded. Note documents and audio recordings were provided to the qualitative analysis team, which were Adventist Health System staff and a consultant, to facilitate analysis. Focus groups were conducted in teams of two, with a lead facilitator and a notetaker. All focus groups were conducted in English or Spanish. In some cases, the facilitator was provided by a Steering Committee member, either due to language needs, expertise with a specific community group, or both.

Deductive analysis of all focus groups and key informant interview data was performed by coding all available data to a social determinants of health framework developed by Adventist Health and CAREs. This framework contains twelve major categories and over 52 common community health needs subcategories. Open coding, combining all relevant codes, was done at the category and subcategory level utilizing Dedoose coding software. Focus group and key informant data were analyzed and coded into single or multiple subcategories. The number of subcategory comments were rolled up to the major category level. Axial coding, where common and highly relevant data codes were combined into themes, was conducted on all category and subcategory data, and major themes were developed for each of the top five-to-six categories/subcategories based on relative importance determined by the number of total codes and the review by the axial coding team.

Once major themes were identified, the primary data team, comprised of both facilitators and qualitative data analysts, reviewed themes and supporting data to determine the final community needs to include in the Steering Committee data reveal. The final needs were the themes that occurred most frequently, both in terms of the number of times specific needs were identified and the urgency, frequency, and intensity of the related comments. Combined with the identified survey and secondary data needs (the five largest needs of the 12 on which secondary data was collected), these themes represented the findings the Steering Committee used to determine (described in Section IV) the final set of high priority health needs included in this CHNA report. Primary interview data was presented as identified needs, a summary of the need, and supporting data taken from the qualitative analysis. Wherever possible, the supporting data was provided in the form of direct quotes from participants.

FOCUS GROUP FACILITATOR'S SCRIPT

WELCOME

- Warmly introduce yourself and note taker
  - We're from Community Benefit Solutions.
  - If site host is present, thank them for bringing everyone together.
- Duration
  - Spend the next 90 minutes together (focus group).
  - Spend the next 60 minutes together (key informant).
- Share the "why" they are here and "what" we're asking of them
  - You're here today because we want to hear your opinions about the health needs of your community.
  - Every community has things that help people be healthy and things that make it harder to stay healthy.
  - This is part of a larger plan and your input will be put together with comments from others in your community into a Community Health Needs Assessment report. This will help your community organizations and leaders as they work toward identifying the challenges and barriers you're seeing so they can work to fix the problems you're facing in trying to stay healthy.
- More about a Community Health Needs Assessment report
  - The Community Health Needs Assessment is a public document and represents the collaborative work between community agencies and the local hospital(s), partnering to identify, gather and analyze the health needs of their community. This process provides communities a way to prioritize health needs, assess local resources and plan to address key community health needs.
- Your Acknowledgment
  - We'll be asking you questions today and you're free to answer only the questions you're comfortable with.
  - Please know that notable quotes/comments from today's meeting could appear in the CHNA and will be labeled as an Anonymous Community Quote – please rest assured that we won't share any names.
  - *"Today's Focus Group is being recorded to ensure we capture all the concerns, thoughts and ideas about the health and well-being of your community. Some comments might be highlighted in the CHNA report and will not list the individual's name."*
  - We want to hear from everyone, so please understand if we move from one comment to the next – we want to make sure everyone is heard.
  - Does anyone have any questions about this?
  - How about any problems being involved in this group?

ACTIVITY EXPLANATION

- We're going to do a brief exercise to start that will tell us what the biggest problems you see are.
  - Then we'll ask you questions about those problems.
  - As you look around the room, you'll see three posters on the wall.
  - They show photos of common problems people face, many of them related to health. (Editorial note: these photos portrayed social determinants of health, for participants to select from. In some cases participants were given printed versions of the photos when they requested them. This allowed all participants to be involved regardless of mobility.
  - Please take a few minutes to vote with the stickers you were given when you walked in.
  - *Place a sticker underneath the photo that shows problems that you think are the biggest difficulties in your community.*
  - *Which of these things causes the most problems for you or others who live here?*
  - *We're specifically interested in learning about things that make it hard for you or your family and friends to have good physical and mental health, and a good quality of life.*
  - Some of the descriptions are one word and really meant for you to share more with us about that – for instance, doctor - it could be, I can't get an appointment, there isn't a pediatrician near me.
  - We'll give you 10 minutes to walk around.

TALLY RESPONSES:

- Visually tally the votes and clearly call out the top five issues that were identified for the notetaker and audience to hear.
- Spend around 15 minutes going through these questions and the topic-specific follow-up questions.
- Repeat for as many problems as time allows, leaving five minutes to wrap-up at the end.
- Use the same prompting questions for each of the five identified issues.

Question Prompters

1. One of the topics that many people identified is _____. For those of you that think this is a health problem in your community:
2. Another topic many people identified is _____. For those of you that think this is a health problem in your community:
3. People also said that _____ is a problem. For those of you that think this is a health problem in your community:

QUESTIONS:

- Why is this a big concern?
- How do you see it affecting people around you?
- What have people tried to do to address this problem?
- What else do you think should be done?
- What are the biggest barriers to fixing this problem?
- If this problem got better, how would your community look different in 3 years?
- How has this problem been affected by COVID-19?
- Do you think this problem affects everyone in your community equally?

  If not, why is that?

  Who is most affected by this?

CLOSING QUESTION:

- Are there other important health needs in your community that we have not already addressed?
- (Let audience introduce and talk through topics with any remaining time. If related to our categories, you can use topic-specific prompts below.)

CONCLUSION:

- Thank you all very much for your time today. The information you provided is very helpful for us, and we'll use it to help improve the health of your community.
- Next year, we will publish the Community Health Needs Assessment, summarizing our findings and action plans identified with the community.

  If you would like us to send you a text or email with a link to that report, just provide us with your information on the way out.
- As a thank you to you all, we have a gift card for you as you leave. **Good Health to you all!**

TOPIC-SPECIFIC PROMPTS

ACCESS TO CARE

What are the main things that stop people from seeing the doctor when they need to?

CHRONIC CONDITIONS/PHYSICAL HEALTH

What are the most common medical conditions that people have in your community?

How do you know?

HEALTH RISK BEHAVIORS

Personal choices can affect people's health at times. These can include not exercising enough, an unhealthy diet, smoking, drug use, unsafe driving habits, and many others.

What risky health behaviors do you think might affect your community?

MENTAL HEALTH

How can you tell that mental health problems are showing up in your community?

FOOD SECURITY

What examples have you seen of people struggling to have enough food to eat?

How common of a problem do you think this is?

What is being done to help?

INFRASTRUCTURE

What transportation barriers exist in your community?

COMMUNITY VITALITY

What are the best things about living here?

PHYSICAL ENVIRONMENT

What kind of access do you have to nature?

What limits people's access to the outside world?

COMMUNITY SAFETY

What are the biggest threats to your safety in your community?

What is being done to address these safety concerns?

HOUSING

What are the biggest housing problems facing your community?

What impact do these problems cause?

FINANCIAL STABILITY

What kind of job opportunities are there around here?

EDUCATION

How would you describe the educational opportunities for kids?

What about for people going to college or going back to school?

INCLUSION & EQUITY

How culturally diverse is your community?

How well does your community embrace this diversity?

What examples are there of times when diversity issues were not handled well?

D. Adventist Health Delano 2019 Implementation Strategy Evaluation of Impact

Scan QR Code to read more about the full Community Health Plan Update

E. Purpose of the Community Health Needs Assessment (CHNA) Report

The Community Health Needs Assessment (CHNA) is a public document and represents the collaborative work between community stakeholders and the local hospital(s), partnering to identify, gather and analyze the health needs of their community. This process provides communities a way to prioritize health needs, assess local resources and plan to address key community health needs.

The Patient Protection and Affordable Care Act (ACA), enacted on March 23, 2010, included new requirements for nonprofit hospitals in order to maintain their tax-exempt status. The provision was the subject of final regulations providing guidance on the requirements of section 501(r) of the Internal Revenue Code. Included in the new regulations is a requirement that all nonprofit hospitals must conduct a community health needs assessment (CHNA) and develop an implementation strategy (IS) every three years (https://www.govinfo.gov/content/pkg/FR-2014-12-31/pdf/2014-30525.pdf). The required written IS plan is set forth in a separate written document.

F. CHNA Consultants Used to Conduct the Assessment

IDENTITY AND QUALIFICATIONS

ADVENTIST HEALTH COMMUNITY WELL-BEING TEAM

The Adventist Health Community Well-Being Team coordinated the data collection, analysis and writing for these reports. The Community Well-Being team members listed below encompass highly relevant and diverse experience in healthcare, philanthropy and foundation, Medicaid managed care and quality improvement, public health and community health, consumer insights research and community benefit reporting. Those team members include:

Samantha Gomez, MPH, CHES®:
Project Manager

Amanjit "Amy" Lasher:
Administrative Director

Jesus Mora-Castro:
Public Health Intern

Janelle Ringer:
Project Manager

Paul Sandman, MBA, CPA:
Community Integration Analyst

Susan Passalacqua:
Project Manager

Jade Tuleu:
Project Manager

Lisa Wegley:
Project Manager

BERKELEY INSTITUTE OF GOVERNMENTAL STUDIES (IGS)

Berkley IGS promotes research, educational activities, and public service in the areas of American and California politics and broad domains of public policy. The Berkeley IGS Poll is a periodic survey of California public opinion on important matters of politics, public policy, and public issues. The poll, which is disseminated widely, seeks to provide a broad measure of contemporary public opinion, and to generate data for subsequent scholarly analysis.

The Matsui Center provides students with internships and real-world learning opportunities. The faculty-led research groups develop and support state-of-the-art research on critical issues facing the nation today. The Berkeley IGS Poll provides accurate, unbiased information on what California residents think and vote on.

UC Berkeley remains central to the most important governance actions and conversations unfolding today. American democracy faces deep and systemic challenges; by training the next generation of leaders and citizens, incubating policy-relevant research, and elevating critical public discussions IGS is determined to be a part of the solution.

G. Cristina Mora & Eric Schickler...IGS
Co-Directors
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510-642-4465

Mark Di Camillo
Berkeley IGS Poll Director
mdicamillo@berkeley.edu

www.igs.berkeley.edu/about

CARES

Founded in 1992, the University of Missouri Extension Center for Applied Research and Engagement Systems (CARES) develops and supports mapping, reporting, and collaboration systems that enable public, private, and nonprofit sector organizations to effectively address issues across topics like agriculture, the environment, business, community, health, safety, and youth. The CARES team integrates data, mapping, visualizations, and engagement tools to better serve communities and regions across the US, including vulnerable, rural, and underserved populations. CARES web-based technologies help organizations and policy makers make more informed decisions about access, address issues of equity, and support the allocation of public and private resources.

CARES staff have backgrounds in data science, Geographic Information System (GIS), database and geodatabase management, web design and user experience (UX), spatial analysis, programming, systems implementation and administration, and web-based content management. Additionally, significant experience in project management, user training and support, data documentation, and client design sessions directly support the wide variety of projects at CARES.

Chris Barnett (barnettc@missouri.edu) serves as director for CARES.

Angela Johnson (johnsonange@missouri.edu) serves as assistant director and lead research project analyst for CARES.

For more information, please visit careshq.org/about/

CENTER FOR BEHAVIORAL HEALTH INTEGRATION

The Center for Behavioral Health Integration is a small collaborative of mental health professionals and researchers providing evaluation, training, and program implementation support to human service organizations.

www.c4bhi.org
Project Lead: Patrick Kinner
Evaluation Consultant
Oct 2018 - Present 3 years 8 months
New England

Providing evaluation, research, writing, and strategic planning support throughout the world of human services.

Patrick Kinner joins Adventist Health as an Evaluation Consultant with more than 10 years of experience helping organizations collect high-quality data to improve their services and share their successes. He holds a vast background working with large health systems, state public health offices, and with innovative entrepreneurs and organizations to improve systems and services across the human service spectrum. Every passionate and committed organization has a gap between what they hope to accomplish and what they actually accomplish. As an evaluation consultant, Kinner identifies those gaps to collect data to understand the causes and help you use that data to change minds and turn heads. This can take the form of small-scale internal evaluation projects or long-term research efforts to test, validate, and publish your theory of change. His work has been instrumental in helping organizations secure additional funding and partnerships, and in making major structural changes in initiatives when necessary.

Project Lead: Keren Meital Kinner
Evaluation Consultant
January 2019 - Present
New England

Providing evaluation, data analysis and visualization services to human service organizations.

Keren's experience in the fields of mental health, education, and software development intersect as she helps organizations collect, understand, and act upon performance and cultural improvement data. In her role as a program evaluator, she focuses on quantitative and qualitative data analysis as well as data visualization through Tableau. With the help of regular and timely data visualization cycles, she helps organizations easily access and understand the latest information, inspect progress and back draw, and help identify new themes, gaps, learnings, and enhancements. Keren regularly works with universities, hospitals, health centers, and innovative entrepreneurs.

VI. Glossary of Terms, Definition of Health Needs

Glossary of Terms

ACCESS TO CARE:

Accessing care with reliable transportation at the right time and location is often a challenge. In addition, not having access to insurance, low-cost care, interpreters, and programming prevents many people from getting treatment. Helping families secure insurance, transportation and access through mobile health options can help them find the care they need.

COMMUNITY SAFETY:

Being safe in your neighborhood is key to developing a real sense of community: where neighbors engage and work toward the common goal of safety and friendship. This may include a formal neighborhood watch program with local police, or simply an ongoing awareness of what's happening, to ensure safe homes, safe people and safe children.

COMMUNITY VITALITY:

A sense of belonging, a place where people feel connected, where neighbors are encouraged to participate in their community across socioeconomic status, physical ability, race/ethnicity or other differences, and where businesses can thrive … this is the definition of community vitality. These are a few of the aspects of what makes a community a community, with neighbors supporting neighbors and preserving the quality of life for all to share.

EDUCATION:

Educational opportunities can deeply impact choices, quality of life and life span, from children to adults. Studies have documented that educational attainment affects health and develops a healthy sense of empowerment. As school-aged children grow in knowledge, so can parents – touching multiple generations with opportunities. Whether it is a kindergartener or a newcomer to the United States, education can improve futures.

ENVIRONMENT & INFRASTRUCTURE:

Clean water, clean air and accessible walkways and streets are key to healthy neighborhoods. Walking and biking requires safe sidewalks and roads. In a digital world where access to high-speed internet provides opportunities to attend school, work, go to a doctor and conduct daily tasks, high-speed internet access is also an infrastructure necessity.

FINANCIAL STABILITY:

The definition of financial stability is broad and encompasses the ability to cover daily living expenses, allowing individuals to fully engage in life's opportunities. Things like safe housing, access to healthy foods and other necessities are impacted by financial stability. The gap between income and cost of living, along with a lack of stability, can be a barrier for individuals and families from securing the care and resources they need. Over time, the lack of financial means impacts health and physical, emotional, and social well-being.

FOOD SECURITY:

Food security is the ability of all people, at all times, to have physical, social and financial access to healthy and nutritious food. Food security also involves the ability to purchase preferred affordable healthy foods, cook and store them.

Today, that is a goal and a challenge, as costs increase, and access to finding affordable healthy options is limited.

HEALTH CONDITIONS:

Obesity, heart disease, cancer and diabetes – examples of chronic diseases – are the leading causes of death and disability in the United States. The conditions in which we live contribute to our well-being and influence our choices that can lead to potentially serious diseases. Access to clean and healthy food, water, air, safe schools, affordable housing, and reliable safety-net programs play a major role in the health and well-being of a community. These conditions can make a significant difference in combatting the leading causes of death and disability in the United States, such as obesity, heart disease, cancer and diabetes.

HEALTH RISK BEHAVIORS:

Each day, decisions are made that impact lives – directly and indirectly. These manners range from abuse of drugs and alcohol, to smoking, to misuse of medications. Relying on unhealthy food choices is another example of behavior that can be a life-threatening health risk. But life changes, such as consistent physical exercise and healthier food choices, when supported by financial stability, equitable social conditions, and a healthy natural and built environment, offer the opportunity to change direction and live healthier lives. Sometimes, it's our opportunities and choices that lead to some of these serious diseases. Often, the conditions in which we live can influence and contribute to our health. Access to healthy foods, green space for exercise, quality of our air and schools, affordable housing and the reliability of safety net programs often play a role in community health.

HOUSING:

The definition of housing varies from person to person, as individuals and families struggle to find safe housing – a place to rest and live that is affordable and in good condition. Today, families face a shortage of housing stock, long wait lists and complicated steps required to secure a place to live. Families may find that they can't afford housing, so they double up with another family or remain in a home that is too small or even unsafe. Efforts continue to address these very real concerns and to seek solutions.

INCLUSION & EQUITY:

The definition of inclusion and equity includes fairness, justice, prosperity, and opportunity – for all people of all ages to feel welcomed, with a fair chance to participate, thrive, and reach their full potential. Inclusion and equity reflect those social conditions, systems, and policies make it so all individuals in a community have equal opportunities to live good lives.

MENTAL HEALTH:

Mental health includes our psychological, social and emotional well-being. It affects how we think, feel and act, and sometimes leads to behaviors like self-harm or self-medication. Mental health is important at every stage of life, and not knowing when or where to ask for help often leaves children, teens, adults and families feeling alone and helpless.

VII. Approval Page

2022 CHNA Approval

This community health needs assessment was adopted on October 20, 2022 by the Adventist Health System/West Board of Directors. The final report was made widely available on December 31, 2022.

Thank you for reviewing our 2022 Community Health Needs Assessment. We are proud to serve our local community, and are committed to making it a healthier place for all.

Daniel Wolcott
Adventist Health Delano

AdventistHealth
Delano

COMMUNITY HEALTH NEEDS ASSESSMENT

EXHIBIT B
2025 COMMUNITY HEALTH NEEDS ASSESSMENT
See Attached.

MORE
COMMUNITY VOICES

Adventist Health
Delano

Living God's love by **inspiring health, wholeness** and hope.

IRS Section 501(r)(3) CHNA Compliance Checklist

1) A definition of the community served by the hospital facility and description of how the community was defined.	Page 8	4) A prioritized description of the significant health needs of the community identified through the CHNA, along with a description of the criteria and process used in identifying certain health needs as significant as well as prioritizing and selecting those significant health needs.	Section IV. and V.
2) A description of the process and methods used to conduct the CHNA, including identification of information gaps that limit the hospital facility's ability to assess the community's health needs.	Section V.	5) A description of the resources potentially available to address the significant health needs identified through the CHNA.	Section IV. A
3) A description of how the hospital facility solicited and took into account input received from persons who represent the broad interests of the community it serves.	Section IV. B	6) An evaluation of the impact of any actions that were taken, since the hospital facility finished conducting its immediately preceding CHNA to address the significant health needs identified in the hospital facility's prior CHNA(s).	Page 11

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You’re made for more

At Adventist Health, we’re here to help you live your life to your fullest potential. We heal hearts so they can love more, bones so they can move more, and brains so they can imagine more. We inspire **health**, **wholeness** and **hope** to help everyone we reach live all the mores they were made for. Because we believe we were all made for more.

Executive Summary

Non-profit health systems, community-based organizations and public health agencies across the country all share a similar calling: to provide public services to help improve the lives of the community members they serve. The Community Health Needs Assessment (CHNA) is conducted every three years to support this calling by helping nonprofit hospitals understand the health needs of the community. The CHNA is a public document and represents the collaborative work between community stakeholders and the local hospital(s), partnering to identify the health needs of their community. The CHNA process engages communities in identifying high priority health needs, and in aligning the resources of community-based organizations, public health services and Adventist Health to achieve improved health for all. Through this collective effort, communities collect data and identify resources to maximize their focus on meeting the most significant community health needs over the next three years.

For 2025, the following Adventist Health hospitals in Central California: Delano, Hanford, Tulare, Reedley and Selma, collaborated with community partners to create a concise report the entire community could contribute to and access, regardless of public health context or reading ability. Input was gathered from focus groups and key informants representing the broad interests of the community served by our hospital, and collaborative organizations. We intentionally prioritized gathering insights from local health officials with knowledge and expertise about community health needs, community-based organizations, medical providers, and members of medically underserved, low-income and minority populations.

Our assessment used a combination of primary and secondary data, providing the greatest understanding of community needs from the broadest range of perspectives. Primary data was collected from focus groups and key informant interviews conducted between May 2024 and July 2024. Seven significant health needs, which focused on the social determinants of health, were identified through in-depth analysis.

The local CHNA Steering Committee reviewed significant health needs, along with corresponding data, and prioritized needs based on severity, prevalence, alignment around common goals, feasibility of potential interventions and opportunities to maximize available resources over a three-year period. This collaborative effort resulted in the identification of the following high priority health needs:

Access to Care

Financial Stability

Mental Health

The following pages share opportunities where you, your family and your community can drive change for improved well-being. We hope this report is leveraged by all local partners and community members, empowering them to own the potential of healthy living for all. In addition to our comprehensive written CHNA report, please explore our living CHNA dashboard below. The entire report is published online and available in print form free of charge by contacting community.benefit@ah.org.

Scan QR Code to explore the full live data report or visit: cares.page.link/FZWG

Transforming the health experience of our **communities** by **improving** physical, mental and spiritual **health**.

Identity of Steering Committee Hospital & Partner Organizations

To all that partnered with us, we say THANK YOU. To those now joining, we welcome you. Let s work together to inspire health, wholeness and hope in our community.

We thank the Central California CHNA Steering Committee, who collaborated and partnered to create the 2025 CHNA. Through a series of three collaborative meetings, engagement of community members, and data review, each committee member brought their unique perspective as seen through their job and the work they performed during the CHNA process.

Joe Alvarez
Community Pastor, Pastor

Miriam Cardenas-Aleman
Kings Canyon Unified School District,
School Health Liaison

Rosemary Caso
United Way of Tulare County, Executive Director

Andrew Cromwell
Koinonia Church, Pastor

Jeff Garner
KCAO, Executive Director

Pawan Gill
Kern Health, Systems, Health Equity Manager

Brian Johnson
City of Hanford, City Communication Manager

Mark Mondell
City of Tulare, City Manager

Julie Mooney
Champions Recovery, Program Director

Rose Mary Rahn
Kings County Public Health, Director

Jasmine Ochoa
Kern County Public Health, Health Equity Officer

Gabriela Rodriguez
KPFP, Executive Director

Raman Singh
Adventist Health, Director of Nursing

Jan Smith
Adventist Health, Director, Community Integration

Amy Travis
First 5 Kern County, Executive Director

Nicole Zieba
City of Reedley, City Manager

A. CHNA Community Defined

Getting to Know Our Community

The Central California CHNA encompasses five hospitals: Delano, Hanford/Selma, Reedley and Tulare. One of Central California's most prized assets is our geography, a region known for its agricultural productivity that feeds the world and a short road trip away from natural wonders like the Sierra Nevada and the Central Coast. Sitting in the heart of the most productive farmland in the world, agriculture remains a major contributor to the economy and our community. According to the California Department of Food and Agriculture, more than 250 different crops, worth $30 billion per year, are grown within the Central Valley.

Research suggests that up to 80% of health outcomes can be traced back to social determinants of health (SDOH), the nonmedical factors that influence health outcomes. For additional community context, the following are a few SDOH data points:

- High school graduation rate of 89.7%.
- 23.55% of the population holds an Associate's level degree or higher, compared to 44.42% in California.
- The unemployment rate is 9.38%.
- Based on the Area Median Income, residents spend 59.27% of their income on housing and transportation alone.

We recognize the challenges we face and are optimistic about exploring opportunities to improve our health and well-being. In the following pages, we'll review lessons learned and accomplishments from the past three years. We'll dive deeper into the high priority needs, community voices and data that guided the Community Health Needs Assessment process.

For the purposes of our CHNA, we refer to the following geographic areas throughout the report:

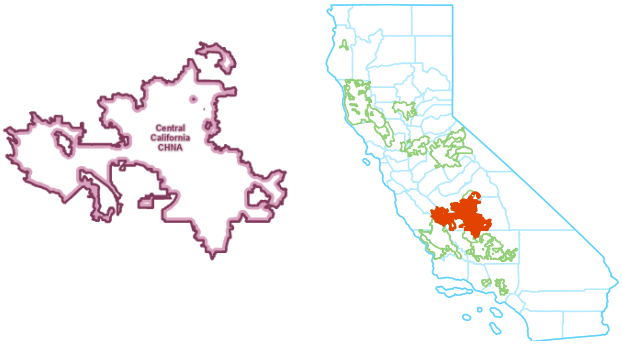
- **Central California CHNA** as the full area encompassed in this report, as defined by zip codes listed in Section I. A. Defining the Community We Serve, and is referenced in indicator graphic dials, tables and charts throughout this report..
- **Delano** as defined by city boundaries.
- **Adventist Health Delano** as the hospital facility conducting this CHNA report.

These terms are used for different purposes throughout this report, with the report data being reflective of the most exhaustive "Central California CHNA" service area. We gathered data and heard voices spanning multiple counties and across all corners of Central California.

Defining the Community We Serve

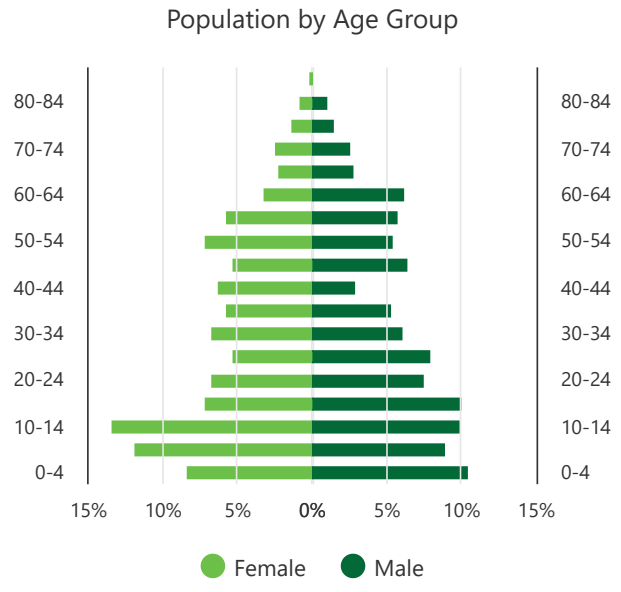
To define our community, we used the hospital's primary service area and vetted the zip codes with Steering Committee members. We also invited our Steering Committee members to expand the CHNA service area to include zip codes based on the constituents they serve.

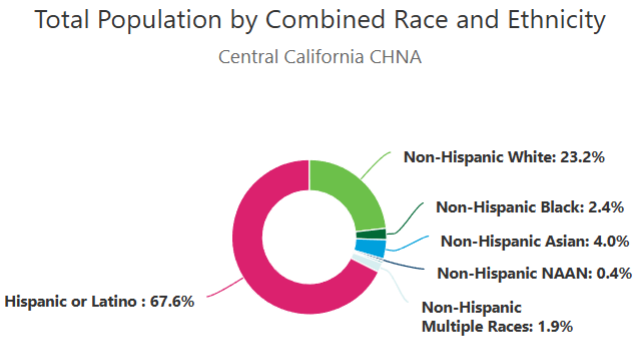
The report area is located in the state of California and includes a total population of 795,814 (based on the 2020 Decennial Census). The largest city in the report area is Visalia city, with a population of 141,384. The report area is comprised of the following ZIP codes: 93201, 93202, 93204, 93210, 93212, 93215, 93218, 93219, 93227, 93230, 93234, 93239, 93242, 93245, 93247, 93250, 93256, 93257, 93258, 93261, 93266, 93267, 93270, 93272, 93274, 93277, 93291, 93292, 93609, 93615, 93616, 93618, 93621, 93625, 93631, 93646, 93647, 93648, 93654, 93656, 93662, 93673.



Total Population
795,814

Demographic Profile





Note: NAAN = Native American or Alaska Native, NPI = Native Hawaiian or Pacific Islander.

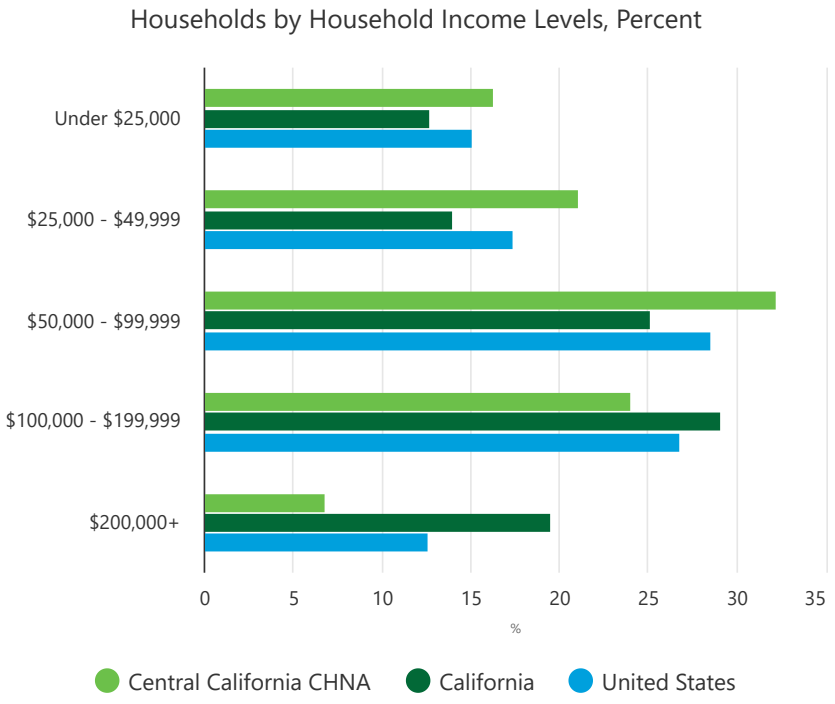
Students Experiencing Homelessness, Percent
2.59%
California: 3.96%

Associate's Degree or Higher
23.55%
California: 44.42%

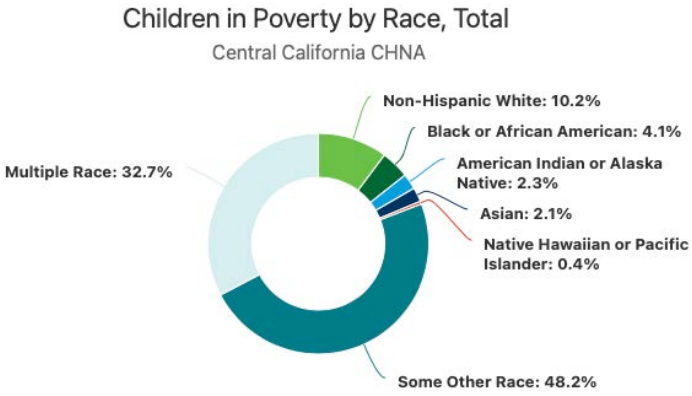
Labor Force Participation Rate
59.09%
California: 63.86%

56.83%
California: 55.79%
of the population **owns** their home

43.17%
California: 44.21%
of the population **rents** their home



Data Source: US Census Bureau, American Community Survey. 2019-23.



Childhood Poverty Rate
25.37%
California: 15.15%

II. About Us

Adventist Health

Adventist Health is a faith-based, nonprofit, integrated health system serving more than 100 communities on the West Coast and Hawai'i, with over 440 sites of care, including 27 acute care facilities. Founded on Adventist heritage and values, Adventist Health provides care in hospitals, clinics, home care agencies, hospice agencies and joint-venture retirement centers in both rural and urban communities. Our compassionate and talented team of more than 38,000 includes employees, physicians, allied health professionals and volunteers driven in pursuit of one mission: living God's love by inspiring health, wholeness and hope. Guided by our mission, Adventist Health supports purposeful work to address the social drivers of health, with a special focus on underserved members of the communities in which we operate. Together, we are transforming the healthcare experience of our communities with a whole-person focus on physical, mental, spiritual and social healing to support well-being.

Adventist Health Delano

Adventist Health Delano is a 156-bed hospital that has been providing comprehensive healthcare services in the Kern community since 1974. Our hospital is committed to delivering medical excellence, emergency care, outpatient services and wellness programs to all individuals regardless of insurance or ability to pay. Our continuum of care network of healthcare resources and expertise allow us to provide patients with seamless coordination and access to specialized services.

Specialties Brought to our Community

- Imaging
- Maternity Care
- Special Care Unit
- Rehabilitation Services
- Weight-loss Surgery
- Women's Clinic

A Look Back: Activities Since 2022 CHNA

CHNA Successes

Over the last three years, Adventist Health Delano focused on access to care, financial stability and health conditions. To document our impact, we have been monitoring and evaluating progress through annual updates and the Community Health Implementation Strategy (CHIS). In collaboration with the community, we implemented goals, actions, solutions and programs to address each high priority need.

In partnership with the Delano Union School District and the McFarland Unified School District, Adventist Health Delano increased access to care for school-aged children and their families by providing flu vaccine clinics to encourage individuals to maintain preventative wellness. During immunization clinics, participants were provided with "on-the-spot" appointments for establishing or follow-up care at a local clinic. In addition, the Adventist Health Wasco Medical Office worked with the Wasco Unified School District to provide free back-to-school immunizations and school physicals to local school-aged children. In total, 120 students were provided with services and the opportunity to establish care with medical offices with the goal of encouraging people to be proactive about their health.

We encourage future collaboration with other community organizations to build and scale the work in addressing community health needs. For a full and complete reporting of program and activities since the 2022 Community Health Needs Assessment, please visit this link: https://www.adventisthealth.org/delano/about-us/community-benefit/

A Look Forward: After the CHNA Report

The next step in our CHNA process is to complete a CHIS. The goal of the CHIS is to strategically implement programs using evidence-informed solutions that address the high priority needs identified in our 2025 CHNA. Together, Adventist Health Delano, Hanford & Selma, Tulare and Reedley along with, local public health officials, community-based organizations, medical providers, students, parents, and members of underserved, low-income and minority populations will develop a three-year strategic plan to work towards addressing the needs of our community.

We believe the power of community transformation lies in the hands of the community. We're calling for more collaboration to create intentional strategies that improve health needs for all. Everyone's voice matters, so we want to hear more of your ideas and partner closely with those who want to drive meaningful change. If you would like to learn more, share ideas or stay connected, please contact us at community.benefit@ah.org.


EXIT

The following pages **reflect high priority needs** for our community, as identified by our **diverse** CHNA Steering Committee.

III. High Priority Health Needs

Access to Care

Access to care refers to the timely use of personal health services to achieve the best health outcomes. This concept encompasses the availability, affordability and appropriateness of healthcare services, and accessibility for all individuals, regardless of income, location or social standing. Access to care directly affects population health, influencing rates of preventable diseases, overall mortality and quality of life. Ensuring equitable access to healthcare is a central public health goal, particularly in reducing health disparities among underserved populations.

In the United States, three in ten people do not have access to a reliable source of primary care (National Association of Community Health Centers) and the American Medical Association projects a shortage of 17,000 - 45,000 primary care doctors over the next decade. Additionally, factors such as being uninsured, lacking access to transportation, limited English proficiency and insufficient provider availability prevent people from receiving the services they need at the right time and place. Central California residents face similar limiting factors, often to a greater extent, making access to care a priority need.

One of the many challenges in accessing health care is ensuring that people can engage with a service provider. Key informants described the diverse agricultural communities, voicing that "[we have] more low-income migrant, maybe undocumented populations that have trouble arranging transportation and work is important to them. So, to take a day off of work means a lot." When asked about getting all the medical care needed to live a healthy life, a community survey indicated 24% of respondents did not receive the care they needed. Of the respondents, 28% attributed their lack of care to barriers like location of medical care, inconvenient hours and transportation challenges. In the Central California service area, 88.79% of the population lives in a primary care Health Professional Shortage Area (HPSA), compared to 22.59% in California. This HPSA designation identifies geographic areas and populations that lack sufficient health care professionals to meet the community's health needs.

Given that many Central California residents live in underserved areas, increasing access and reducing barriers to healthcare in our community can improve health outcomes and reduce disparities. For additional data, see the secondary data summary.

Scan QR Code to explore the full live data report on Access to Care or visit: cares.page.link/NZnq

Data Highlights

Community Voices: *exploring local perceptions, thoughts & beliefs*

"...our population is growing here in Hanford and we have one large hospital...if you're going into their emergency room or you're trying to access some type of routine medical care, there's just a longer wait and it's harder to get those services."

"...that middle range sometimes suffers because it's like you make enough that you don't qualify for programs, [but you] don't make enough so the cost of the insurance is... going to be prohibitive, a burden on your family."

"...a lot of family or people here are traveling to Mexico for treatments more affordable..."

"We see a lot of our population that unfortunately, because of their work, there is no offer of, especially in a lot of [agricultural] sectors, there's no offer of health insurance."

"Access to affordable healthcare. Even though we've got systems in place, federal, state and other, a lot of people just don't get a[n] affordable plan that's effective...for the conditions they have."

"...if you have a physician that doesn't understand that patient's culture, what could be normal in regards to a value or belief to that physician could be offensive to that patient."

"You are vulnerable and this person [medical provider] is educated and knows better, so you're taking what they're saying as truth. So there's a sense of I can't speak up for myself because they know better."

"It just compiles with people's...distrust and frustration with medical providers...there's not this sense of...empathy and really wanting to engage in you as an individual...I think that's contributing to a larger conception of I can't go there and have my problem actually solved."

"...I know in our county we really don't have a lot of specialty services..."

"...[we have] more low-income migrant, maybe undocumented populations that have trouble arranging transportation and work is important to them. So to take a day off of work means a lot..."

"There's not as much labor and delivery options for women and pregnant women in the county."

"We have a lot of families that have to work out there. They might be farm laborers, and they have to take a day off of work to then get transportation to get to where they need to be. And that's the day of work...and if everything doesn't work out with the specialist or gets cancelled [it] like derails the whole [day]. I just feel like transportation has been an issue for a while."

Community Resources

Administration for Community Living
acl.gov/programs/aging-and-disability-networks
800-677-1116

Central California Alliance for Health
thealliance.health
800-700-3874

Healthcare Enrollment Services
coveredca.com
800-300-1506

Community Health Needs Assessment Full Report

Location

Central California CHNA

Health Needs: Access to Care

Availability - Primary Care - Primary Care Shortage Areas

A **Health Professional Shortage Area (HPSA)** is a designation given by the Health Resources and Services Administration (HRSA) in the United States to identify geographic areas, populations, or facilities that lack sufficient health care professionals to meet the health needs of the community. HPSAs are categorized into three main types based on the specific type of health professional shortage:

Types of HPSA

- **Primary Care HPSA**: Areas with a shortage of primary care physicians, including family medicine, internal medicine, pediatrics, obstetrics, and gynecology.
- **Dental Health HPSA**: Areas with a shortage of dental health professionals, such as general and pediatric dentists.
- **Mental Health HPSA**: Areas with a shortage of mental health providers, including psychiatrists, clinical psychologists, clinical social workers, psychiatric nurse specialists, and marriage and family therapists.

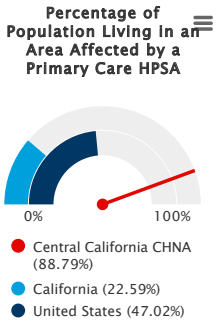
This indicator reports the total population in the report area that is living in a primary care Health Professional Shortage Area, regardless of the degree of shortage, or whether the HPSA covers the entire geographic area or a population subgroup. Indicator data are based on the following calculation:

Percentage = [HPSA Population] / [Report Area Population] * 100

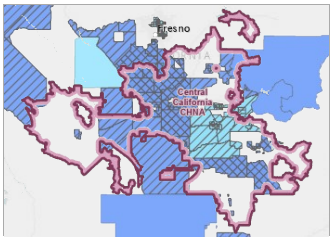
The population figures used in this calculation are from the 2019 American Community Survey 5-year Estimates.

Within the report area, there are 698,673 people living in a primary care Health Professional Shortage Area. This represents 88.79% of the total population.

Report Area	Total Population (ACS 2019 5-Year Estimates)	Population Living in an Area Affected by a Primary Care HPSA	Percentage of Population Living in an Area Affected by a Primary Care HPSA
Central California CHNA	786,914	698,673	**88.79%**
Fresno County, CA	984,521	376,423	38.23%
Kern County, CA	887,641	546,648	61.58%
Kings County, CA	150,691	150,691	100.00%
Monterey County, CA	433,410	233,240	53.82%
San Benito County, CA	60,376	60,376	100.00%
Tulare County, CA	461,898	435,256	94.23%
California	39,283,497	8,874,701	22.59%
United States	324,697,795	152,777,506	47.02%



Note: This indicator is compared to the state average.
Data Source: US Department of Health & Human Services, Health Resources and Services Administration, HRSA - Health Professional Shortage Areas Database. 2024.



View larger map

Primary Care HPSA Components, Type and Degree of Shortage by Tract / County, HRSA HPSA Database 2024

- Population Group; Over 20.0 FTE Needed
- Population Group; 1.1 - 20.0 FTE Needed
- Population Group; Under 1.1 FTE Needed
- Geographic Area; Over 20.0 FTE Needed
- Geographic Area; 1.1 - 20.0 FTE Needed
- Geographic Area; Under 1.1 FTE Needed
- Central California CHNA

Primary Care HPSA Population Underserved

This indicator reports the designated primary care HPSA population in the report area that are underserved, regardless of the degree of shortage, or whether the HPSA covers the entire geographic area or a population subgroup. Indicator data are based on the following calculation:

Percentage = [Underserved HPSA Population] / [Designated HPSA Population] * 100

Report Area	Designated Primary Care HPSA Population	Primary Care HPSA Population Underserved	Percentage of Primary Care HPSA Population Underserved
Central California CHNA	580,119	255,707	43.78%
Fresno County, CA	303,010	160,540	52.98%
Kern County, CA	476,065	281,156	59.06%
Kings County, CA	145,895	43,477	29.80%
Monterey County, CA	137,145	94,366	68.81%
San Benito County, CA	59,219	17,392	29.37%
Tulare County, CA	317,504	164,280	51.74%
California	5,988,716	2,710,171	45.23%
United States	72,823,197	37,666,041	51.65%

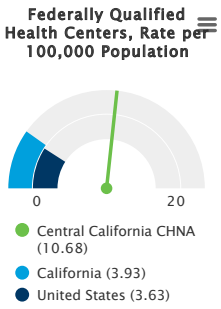
Data Source: US Department of Health & Human Services, Health Resources and Services Administration, HRSA - Health Professional Shortage Areas Database. 2024.

Availability - Hospitals & Clinics - FQHCs, Rate Per Low-Income Population

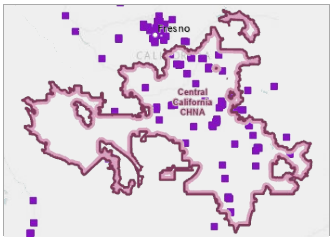
This indicator reports the number of Federally Qualified Health Centers (FQHCs) in the community. This indicator is relevant because FQHCs are community assets that provide health care to vulnerable populations; they receive extra funding from the federal government to promote access to ambulatory care in areas designated as medically underserved.

Within the report area, there are 85 Federally Qualified Heath Centers. This means there is a rate of 10.68 Federally Qualified Health Centers per 100,000 total population.

Report Area	Total Population (2020)	Number of Federally Qualified Health Centers	Rate of Federally Qualified Health Centers per 100,000 Population
Central California CHNA	795,651	85	10.68
Fresno County, CA	1,008,654	70	6.94
Kern County, CA	909,235	46	5.06
Kings County, CA	152,486	16	10.49
Monterey County, CA	439,035	21	4.78
San Benito County, CA	64,209	1	1.56
Tulare County, CA	473,117	55	11.63
California	39,538,223	1,554	3.93
United States	334,735,155	12,138	3.63



Note: This indicator is compared to the state average.
Data Source: US Department of Health & Human Services, Center for Medicare & Medicaid Services, Provider of Services File. 2024.



View larger map

Federally Qualified Health Centers, POS December 2024

Federally Qualified Health Centers, POS December 2024
Central California CHNA

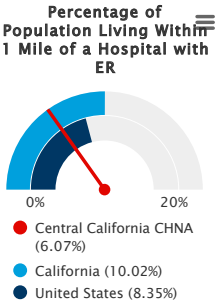
Availability - Hospitals & Clinics - Proximity to Hospitals with ER

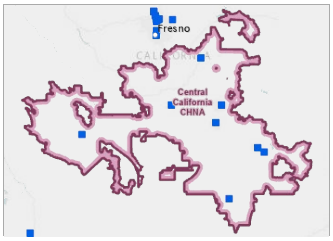
This indicator reports the percentage of the total population living within 1 mile of a hospital with an emergency room. Having good access to hospitals with an emergency room is important for community health because these hospitals play an important role in rapid and serious medical conditions.

As of 2023, of the report area's 795,651 total population, 48,260 or 6.07% live within 1 mile of a hospital with an emergency room. This is less than the state's reported rate of 10.02%.

Report Area	Total Population	Population Within 1 Mile of a Hospital with ER	Percent Within 1 Mile of a Hospital with ER
Central California CHNA	795,651	48,260	**6.07%**
Fresno County, CA	1,008,654	36,998	3.67%
Kern County, CA	909,235	64,515	7.1%
Kings County, CA	152,486	5,799	3.8%
Monterey County, CA	439,035	37,878	8.63%
San Benito County, CA	64,209	11,998	18.69%
Tulare County, CA	473,117	31,316	6.62%
California	39,538,223	3,961,644	10.02%
United States	334,735,155	27,942,571	8.35%

Note: This indicator is compared to the state average.
Data Source: US Department of Health & Human Services, Center for Medicare & Medicaid Services, Provider of Services File. 2023.





View larger map

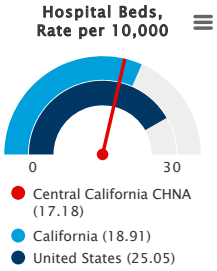
All Hospitals, POS December 2024

All Hospitals, POS December 2024
Central California CHNA

Availability - Hospitals & Clinics - Hospital Beds Per Capita

This indicator reports hospital bed availability by estimating the number of hospital beds per 10,000 population. This calculation allocates the number of hospital beds at a given hospital (location) and assigns them to ZIP codes in the hospital service area based on the proportion of patients coming from each ZIP code. This provides an estimation of how hospital capacity (beds) affects the population in ZIP codes served by the hospital.

Report Area	Hospital Beds, Total	Total Population (2020)	Hospital Beds, Rate per 10,000
Central California CHNA	1,367	795,651	**17.18**
Fresno County, CA	1,563	1,008,654	15.50
Kern County, CA	1,675	909,235	18.42
Kings County, CA	235	152,486	15.41
Monterey County, CA	756	439,035	17.22
San Benito County, CA	88	64,209	13.71
Tulare County, CA	715	473,117	15.11
California	74,762	39,538,223	18.91
United States	830,171	331,449,281	25.05

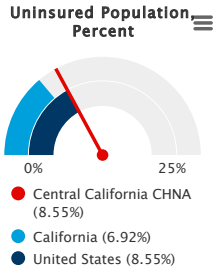


Note: This indicator is compared to the state average.
Data Source: Centers for Medicare & Medicaid Services, Hospital Service Area. 2023.

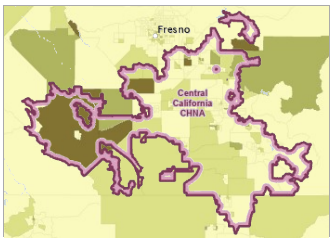
Barriers - Medical Insurance - Population without Medical Insurance

The lack of health insurance is considered a *key driver* of health status.
In the report area 8.55% of the total civilian non-institutionalized population are without health insurance coverage. The rate of uninsured persons in the report area is greater than the state average of 6.92%. This indicator is relevant because lack of insurance is a primary barrier to healthcare access including regular primary care, specialty care, and other health services that contributes to poor health status.

Report Area	Total Population (For Whom Insurance Status is Determined)	Uninsured Population	Uninsured Population, Percent
Central California CHNA	767,518	65,604	**8.55%**
Fresno County, CA	1,000,249	70,433	7.04%
Kern County, CA	888,229	69,712	7.85%
Kings County, CA	135,709	10,715	7.90%
Monterey County, CA	420,702	41,838	9.94%
San Benito County, CA	65,903	4,154	6.30%
Tulare County, CA	471,506	37,746	8.01%
California	38,761,738	2,682,732	6.92%
United States	327,425,278	28,000,876	8.55%



Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2019-23.



View larger map

Uninsured Population, Percent by Tract, ACS 2019-23

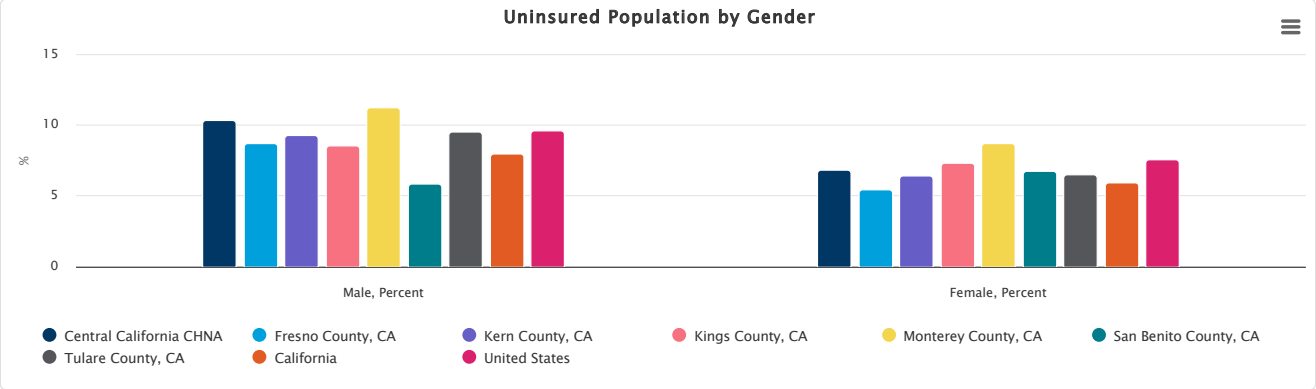
- Over 20.0%
- 15.1 - 20.0%
- 10.1 - 15.0%
- Under 10.1%
- No Data or Data Suppressed
- Central California CHNA

Uninsured Population by Gender

This indicator reports the uninsured population by gender.
The percentage values could be interpreted as, for example, *"Of all the male population within the report area, the proportion without health insurance coverage is (value)."*

Report Area	Male	Female	Male, Percent	Female, Percent
Central California CHNA	39,558	26,046	10.28%	6.81%
Fresno County, CA	43,242	27,191	8.69%	5.41%
Kern County, CA	41,040	28,672	9.26%	6.44%
Kings County, CA	5,786	4,929	8.48%	7.31%
Monterey County, CA	23,421	18,417	11.24%	8.68%
San Benito County, CA	1,942	2,212	5.85%	6.76%
Tulare County, CA	22,395	15,351	9.52%	6.50%
California	1,526,004	1,156,728	7.93%	5.92%
United States	15,443,840	12,557,036	9.59%	7.55%

Data Source: US Census Bureau, American Community Survey. 2019-23.

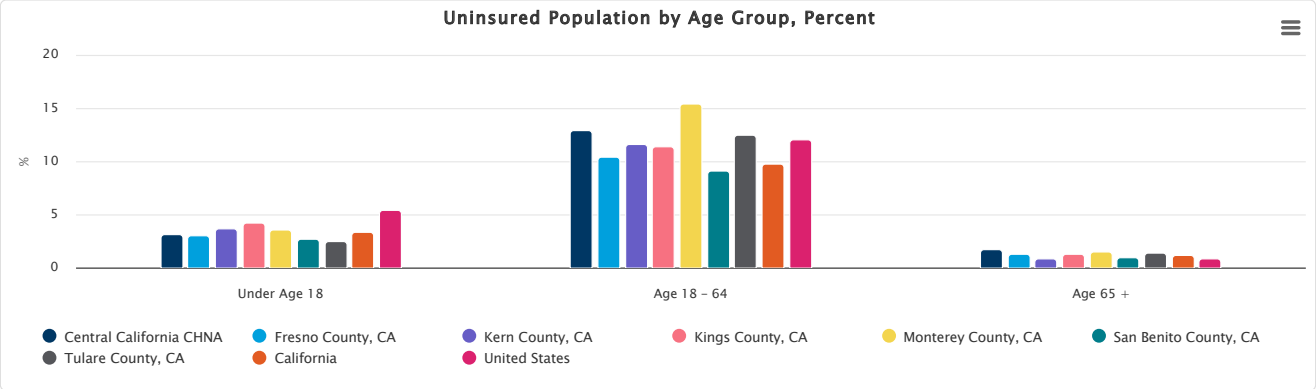


Uninsured Population by Age Group, Percent

This indicator reports the percentage of uninsured population by age group.
The percentage values could be interpreted as, for example, *"Of all the population under age 18 within the report area, the proportion without health insurance coverage is (value)."*

Report Area	Under Age 18	Age 18 - 64	Age 65 +
Central California CHNA	3.12%	12.92%	1.70%
Fresno County, CA	2.97%	10.43%	1.21%
Kern County, CA	3.68%	11.55%	0.85%
Kings County, CA	4.23%	11.31%	1.29%
Monterey County, CA	3.50%	15.34%	1.52%
San Benito County, CA	2.71%	9.11%	0.88%
Tulare County, CA	2.48%	12.48%	1.41%
California	3.35%	9.77%	1.09%
United States	5.39%	11.98%	0.83%

Data Source: US Census Bureau, American Community Survey. 2019-23.

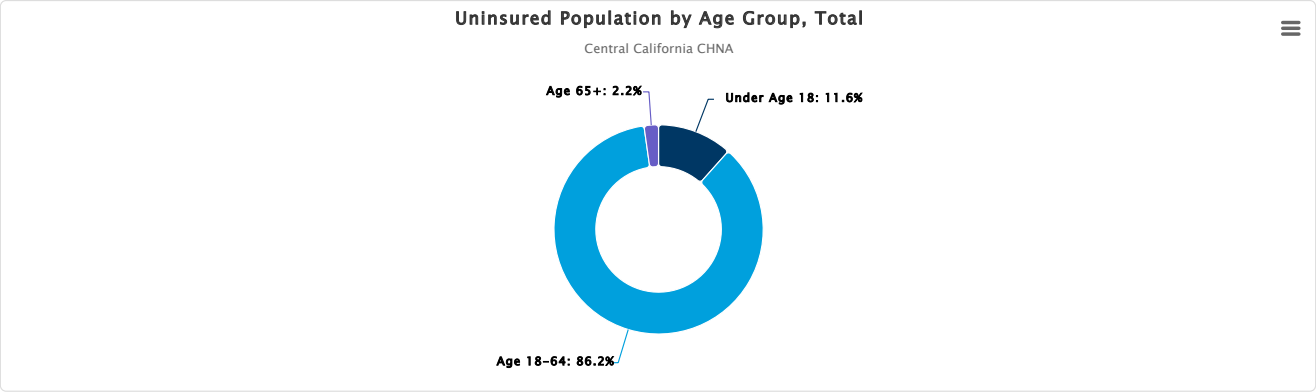


Uninsured Population by Age Group, Total

This indicator reports the total uninsured population by age group.

Report Area	Under Age 18	Age 18-64	Age 65+
Central California CHNA	7,607	56,534	1,463
Fresno County, CA	8,891	60,015	1,527
Kern County, CA	10,179	58,653	880
Kings County, CA	1,828	8,684	203
Monterey County, CA	4,176	36,718	944
San Benito County, CA	478	3,598	78
Tulare County, CA	3,724	33,251	771
California	310,351	2,307,944	64,437
United States	4,208,983	23,338,717	453,176

Data Source: US Census Bureau, American Community Survey. 2019-23.

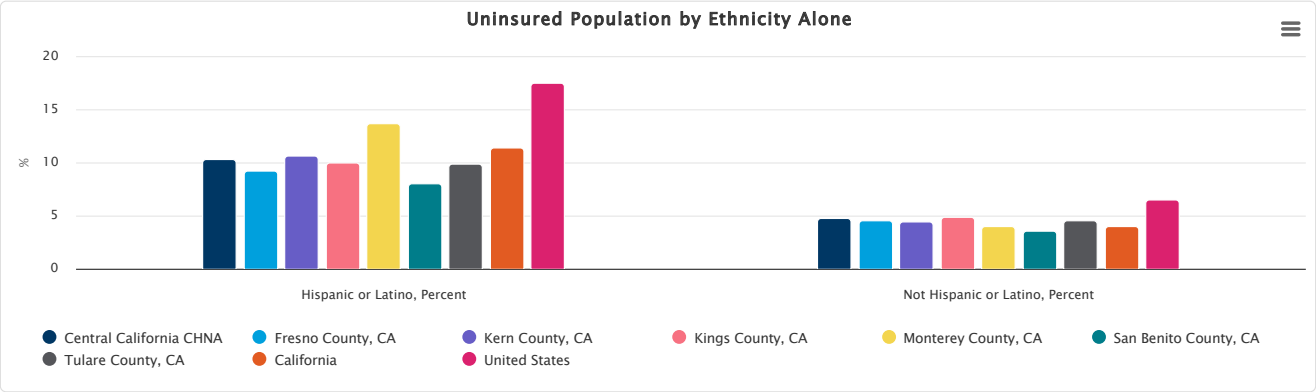


Uninsured Population by Ethnicity Alone

This indicator reports the uninsured population by ethnicity alone.
The percentage values could be interpreted as, for example, *"Of all the Hispanic population within the report area, the proportion without health insurance coverage is (value)."*

Report Area	Hispanic or Latino	Not Hispanic or Latino	Hispanic or Latino, Percent	Not Hispanic or Latino, Percent
Central California CHNA	54,236	11,368	10.32%	4.69%
Fresno County, CA	49,545	20,888	9.14%	4.56%
Kern County, CA	52,544	17,168	10.57%	4.39%
Kings County, CA	8,095	2,620	9.99%	4.79%
Monterey County, CA	35,505	6,333	13.59%	3.97%
San Benito County, CA	3,260	894	8.00%	3.55%
Tulare County, CA	30,617	7,129	9.81%	4.47%
California	1,760,029	922,703	11.37%	3.96%
United States	10,900,185	17,100,691	17.47%	6.45%

Data Source: US Census Bureau, American Community Survey. 2019-23.

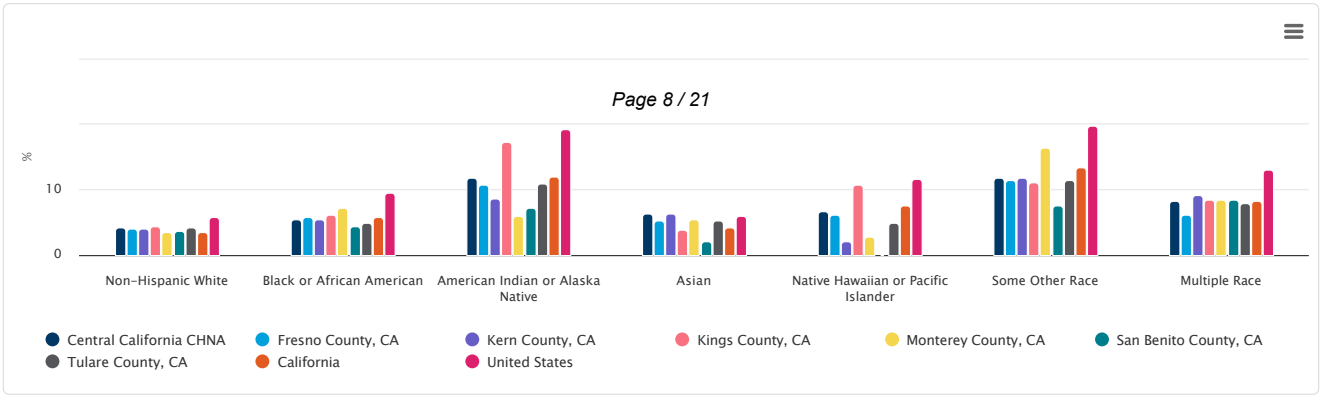


Uninsured Population by Race, Percent

This indicator reports the percentage of uninsured population by race alone.
The percentage values could be interpreted as, for example, *"Of all the non-Hispanic white population within the report area, the proportion without health insurance coverage is (value)."*

Report Area	Non-Hispanic White	Black or African American	American Indian or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
Central California CHNA	4.20%	5.47%	11.79%	6.23%	6.60%	11.70%	8.23%
Fresno County, CA	3.99%	5.75%	10.73%	5.29%	6.13%	11.33%	6.08%
Kern County, CA	3.92%	5.42%	8.54%	6.18%	2.08%	11.73%	9.03%
Kings County, CA	4.36%	6.07%	17.15%	3.76%	10.66%	11.01%	8.33%
Monterey County, CA	3.37%	7.17%	5.90%	5.39%	2.74%	16.26%	8.44%
San Benito County, CA	3.57%	4.29%	7.16%	1.97%	0.00%	7.42%	8.45%
Tulare County, CA	4.19%	4.79%	10.82%	5.25%	4.79%	11.33%	7.78%
California	3.52%	5.65%	11.90%	4.06%	7.56%	13.37%	8.27%
United States	5.71%	9.46%	19.22%	5.89%	11.59%	19.70%	12.98%

Data Source: US Census Bureau, American Community Survey. 2019-23.

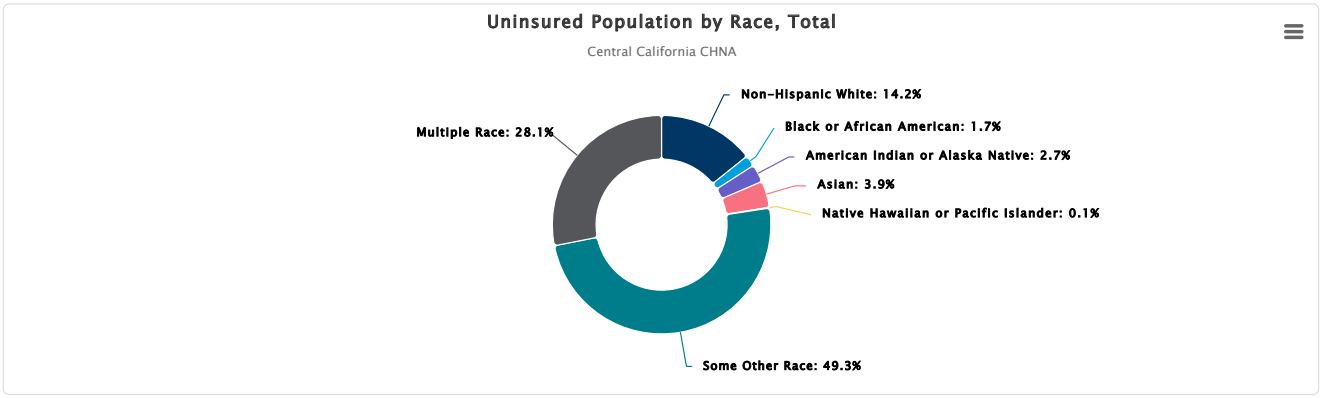


Uninsured Population by Race, Total

This indicator reports the total uninsured population by race alone.

Report Area	Non-Hispanic White	Black or African American	American Indian or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
Central California CHNA	7,266	843	1,353	1,995	63	25,170	14,339
Fresno County, CA	10,751	2,485	1,477	5,852	100	22,981	12,770
Kern County, CA	10,734	2,280	915	2,832	29	18,699	17,075
Kings County, CA	1,672	407	456	176	29	3,314	2,280
Monterey County, CA	3,820	521	195	1,321	58	28,387	4,847
San Benito County, CA	710	29	88	45	0	763	1,821
Tulare County, CA	5,165	333	759	877	33	15,713	7,824
California	471,187	118,238	52,186	242,128	10,982	903,127	524,941
United States	10,876,176	3,775,959	549,575	1,134,010	71,131	4,280,782	4,567,337

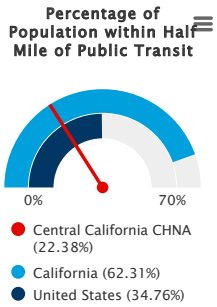
Data Source: US Census Bureau, American Community Survey. 2019-23.



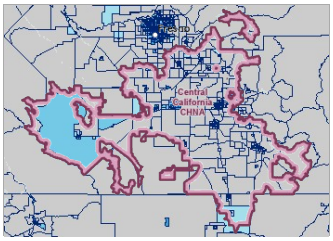
Barriers - Transportation - Distance to Public Transit

This indicator measures the proportion of the population living within 0.5 miles of a GTFS or fixed-guideway transit stop. Transit data is available from over 200 transit agencies across the United States, as well as all existing fixed-guideway transit service in the U.S. This includes rail, streetcars, ferries, trolleys, and some bus rapid transit systems.

Report Area	Total Population	Population Within 0.5 Miles of Public Transit	Percentage of Population within Half Mile of Public Transit
Central California CHNA	454,467	101,711	**22.38%**
Fresno County, CA	978,130	523,423	53.51%
Kern County, CA	883,053	390,904	44.27%
Kings County, CA	150,075	83,601	55.71%
Monterey County, CA	433,212	302,737	69.88%
San Benito County, CA	59,416	31,320	52.71%
Tulare County, CA	460,477	6,724	1.46%
California	39,148,760	24,391,714	62.31%
United States	322,903,030	112,239,342	34.76%



Note: This indicator is compared to the state average.
Data Source: Environmental Protection Agency, EPA - Smart Location Database. 2021.



View larger map

Distance to Nearest Transit Stop, (Meters) by Block Group, EPA SLD 2021

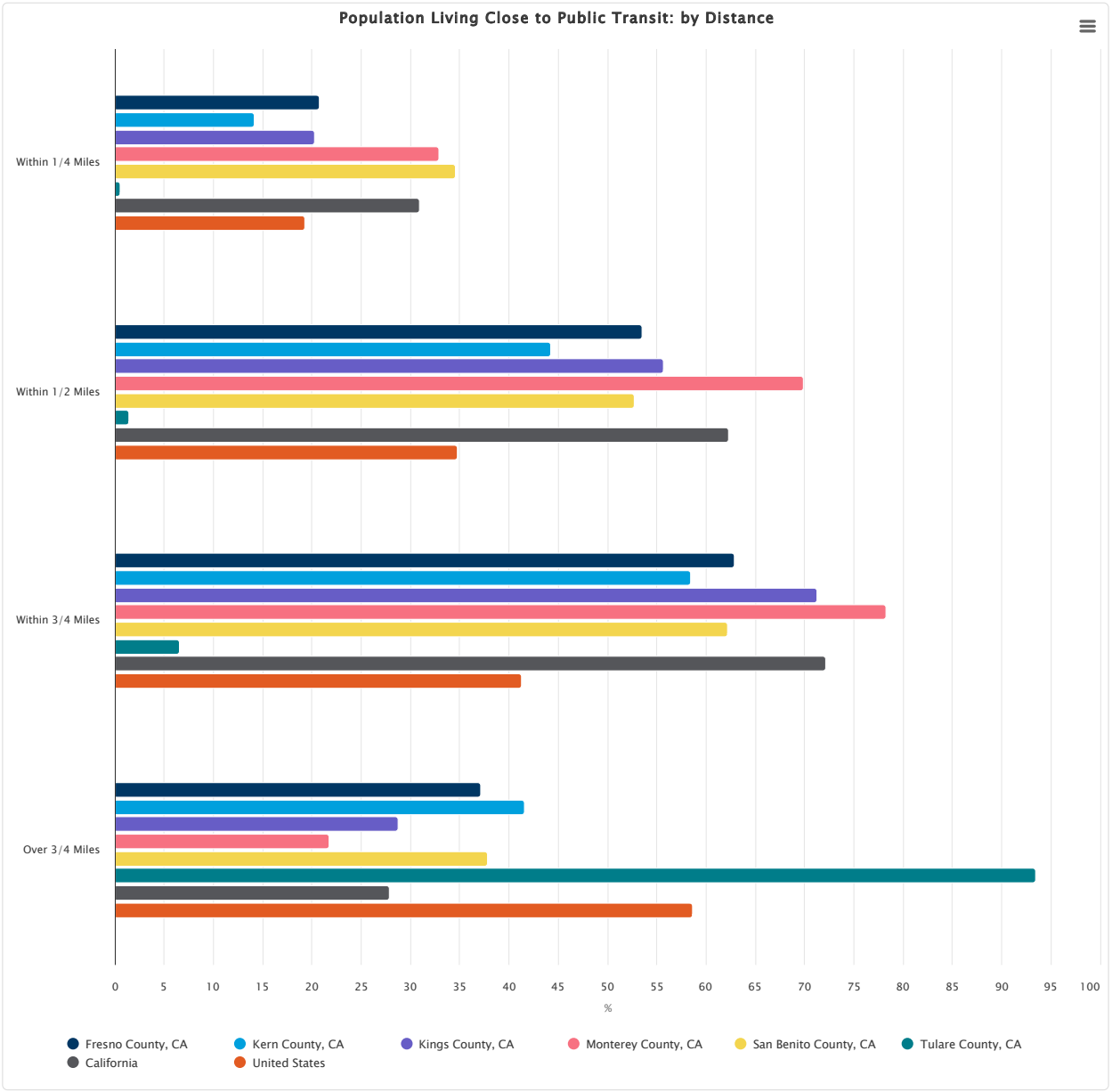
- 800 - 1200 Meters (0.5 - 0.75 Miles)
- 400 - 800 Meters (0.25 - 0.5 Miles)
- 200 - 400 Meters (0.125 - 0.25 Miles)
- Closer than 200 Meters (< 0.125 Miles)
- Further than 1200 Meters (> 0.75 Miles)
- Central California CHNA

Population Living Close to Public Transit: by Distance

This indicator reports the percentages of population living within 1/4, 1/2, 3/4, and over 3/4 miles from the nearest transit stop.

Report Area	Within 1/4 Miles	Within 1/2 Miles	Within 3/4 Miles	Over 3/4 Miles
Fresno County, CA	20.77%	53.51%	62.91%	37.09%
Kern County, CA	14.13%	44.27%	58.39%	41.61%
Kings County, CA	20.3%	55.71%	71.25%	28.75%
Monterey County, CA	32.86%	69.88%	78.27%	21.73%
San Benito County, CA	34.58%	52.71%	62.22%	37.78%
Tulare County, CA	0.56%	1.46%	6.54%	93.46%
California	30.95%	62.31%	72.11%	27.83%
United States	19.25%	34.76%	41.26%	58.64%

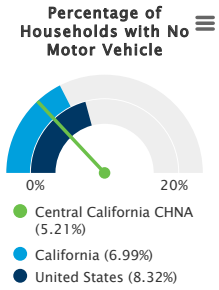
Data Source: Environmental Protection Agency, EPA - Smart Location Database. 2021.



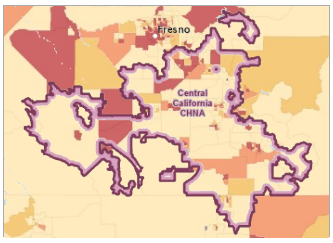
Barriers - Transportation - Households with No Vehicle

This indicator reports the number and percentage of households with no motor vehicle based on the latest 5-year American Community Survey estimates. Of the 234,087 total households in the report area, 12,196 or 5.21% are without a motor vehicle.

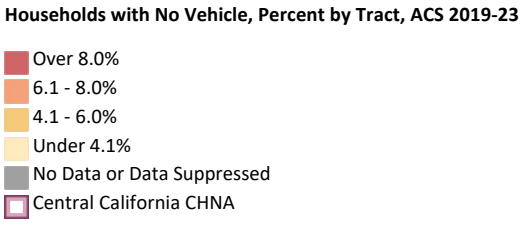
Report Area	Total Occupied Households	Households with No Motor Vehicle	Households with No Motor Vehicle, Percent
Central California CHNA	234,087	12,196	**5.21%**
Fresno County, CA	322,163	23,037	7.15%
Kern County, CA	281,416	18,305	6.50%
Kings County, CA	43,736	2,556	5.84%
Monterey County, CA	132,046	6,041	4.57%
San Benito County, CA	20,188	530	2.63%
Tulare County, CA	142,026	6,617	4.66%
California	13,434,847	939,021	6.99%
United States	127,482,865	10,602,826	8.32%



Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2019-23.



View larger map

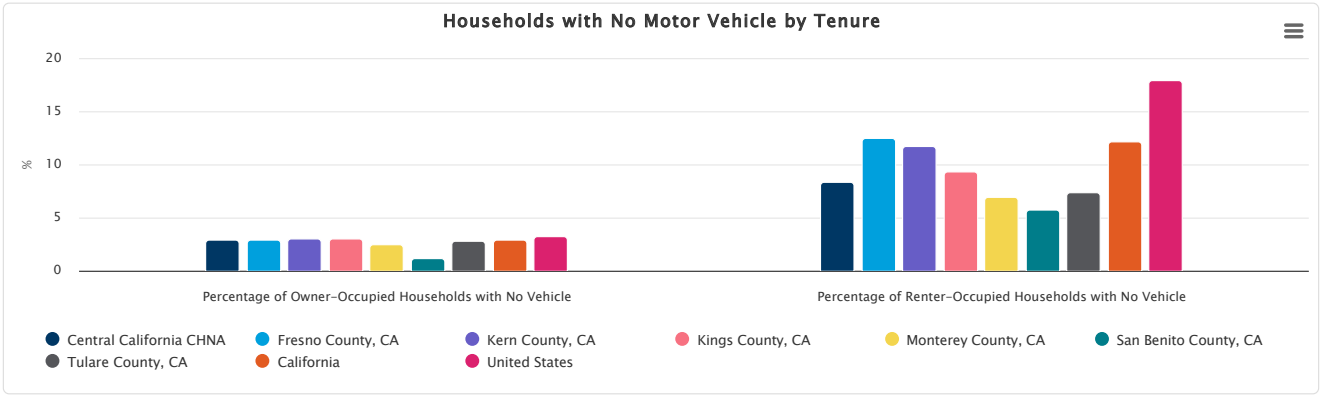


Households with No Motor Vehicle by Tenure

This indicator reports the total and percentage of households with no vehicle by tenure.
These numbers in the following table could be interpreted as (take the first two columns as an example), *"Within the report area, there are a total of (value) owner-occupied households with no vehicle. This accounts for (value) of all the owner-occupied households."*

Report Area	Owner-Occupied Households	Owner-Occupied Households, Percent	Renter-Occupied Households	Renter-Occupied Households, Percent
Central California CHNA	3,769	2.88%	8,241	8.30%
Fresno County, CA	5,218	2.92%	17,819	12.41%
Kern County, CA	5,115	3.04%	13,190	11.66%
Kings County, CA	721	3.01%	1,835	9.29%
Monterey County, CA	1,690	2.45%	4,351	6.90%
San Benito County, CA	154	1.13%	376	5.72%
Tulare County, CA	2,271	2.73%	4,346	7.39%
California	216,828	2.89%	722,193	12.16%
United States	2,636,344	3.18%	7,966,482	17.87%

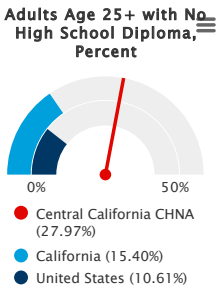
Data Source: US Census Bureau, American Community Survey. 2019-23.



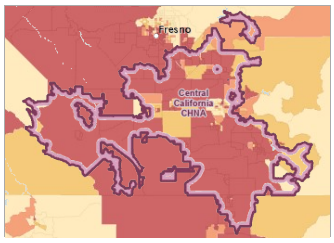
Barriers - Health Literacy - Educational Attainment

Within the report area there are 135,293 persons aged 25 and older without a high school diploma (or equivalency) or higher. This represents 27.97% of the total population aged 25 and older. This indicator is relevant because educational attainment is linked to positive health outcomes (Freudenberg & Ruglis, 2007).

Report Area	Total Population Age 25+	Adults Age 25+ with No High School Diploma	Adults Age 25+ with No High School Diploma, Percent
Central California CHNA	483,664	135,293	**27.97%**
Fresno County, CA	631,185	135,093	21.40%
Kern County, CA	558,810	127,772	22.87%
Kings County, CA	95,545	24,617	25.76%
Monterey County, CA	279,274	74,469	26.67%
San Benito County, CA	43,450	7,283	16.76%
Tulare County, CA	284,744	72,985	25.63%
California	26,941,198	4,149,146	15.40%
United States	228,434,661	24,230,217	10.61%



Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2019-23.



View larger map

Population with No High School Diploma (Age 25+), Percent by Tract, ACS 2019-23

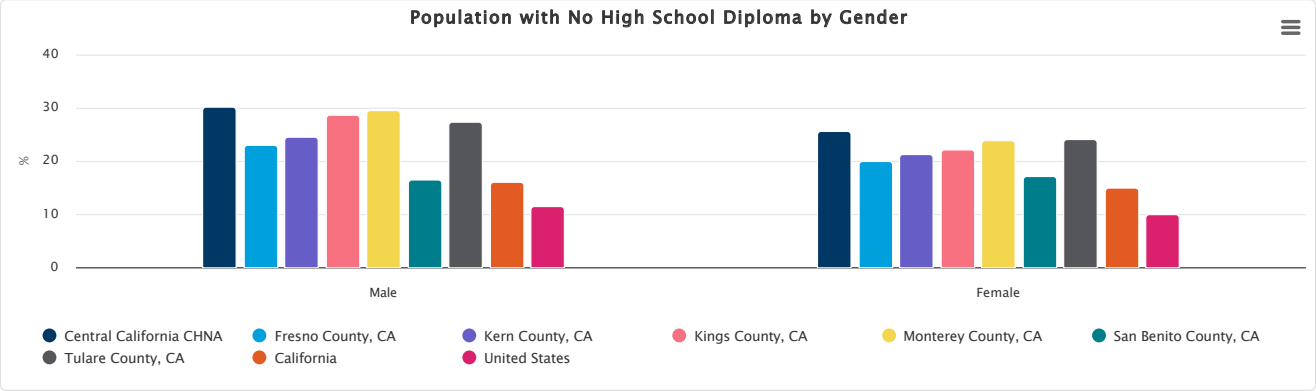
- Over 21.0%
- 16.1 - 21.0%
- 11.1 - 16.0%
- Under 11.1%
- No Data or Data Suppressed
- Central California CHNA

Population with No High School Diploma by Gender

This indicator reports the population age 25+ with no high school diploma by gender.
The percentage values could be interpreted as, of all the males age 25+ within the report area, the percentage without a high school diploma is 30.14%; of all the females age 25+ within the report area, the percentage without a high school diploma is 25.64%.

Report Area	Male	Female	Male, Percent	Female, Percent
Central California CHNA	75,613	59,680	30.14%	25.64%
Fresno County, CA	71,511	63,582	22.87%	19.96%
Kern County, CA	69,486	58,286	24.53%	21.15%
Kings County, CA	15,506	9,111	28.57%	22.07%
Monterey County, CA	41,591	32,878	29.35%	23.90%
San Benito County, CA	3,591	3,692	16.38%	17.15%
Tulare County, CA	38,430	34,555	27.27%	24.02%
California	2,111,415	2,037,731	15.87%	14.94%
United States	12,672,705	11,557,512	11.38%	9.87%

Data Source: US Census Bureau, American Community Survey. 2019-23.

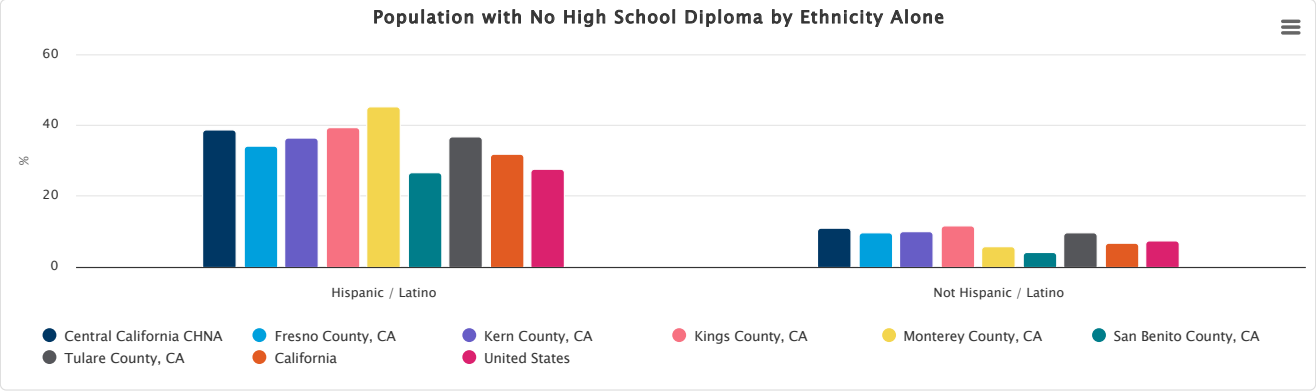


Population with No High School Diploma by Ethnicity Alone

This indicator reports the population age 25+ with no high school diploma by ethnicity alone.
The percentage values could be interpreted as, of all the Hispanic population age 25+ within the report area, the percentage without a high school diploma is 38.72%; of all the non-Hispanic population age 25+ within the report area, the percentage without a high school diploma is 10.96%.

Report Area	Hispanic or Latino	Not Hispanic or Latino	Hispanic or Latino, Percent	Not Hispanic or Latino, Percent
Central California CHNA	114,774	20,519	38.72%	10.96%
Fresno County, CA	103,605	31,488	34.13%	9.61%
Kern County, CA	99,890	27,882	36.22%	9.85%
Kings County, CA	19,299	5,318	39.20%	11.48%
Monterey County, CA	66,924	7,545	45.19%	5.75%
San Benito County, CA	6,483	800	26.65%	4.18%
Tulare County, CA	61,772	11,213	36.61%	9.67%
California	2,963,752	1,185,394	31.69%	6.74%
United States	10,132,918	14,097,299	27.46%	7.36%

Data Source: US Census Bureau, American Community Survey. 2019-23.

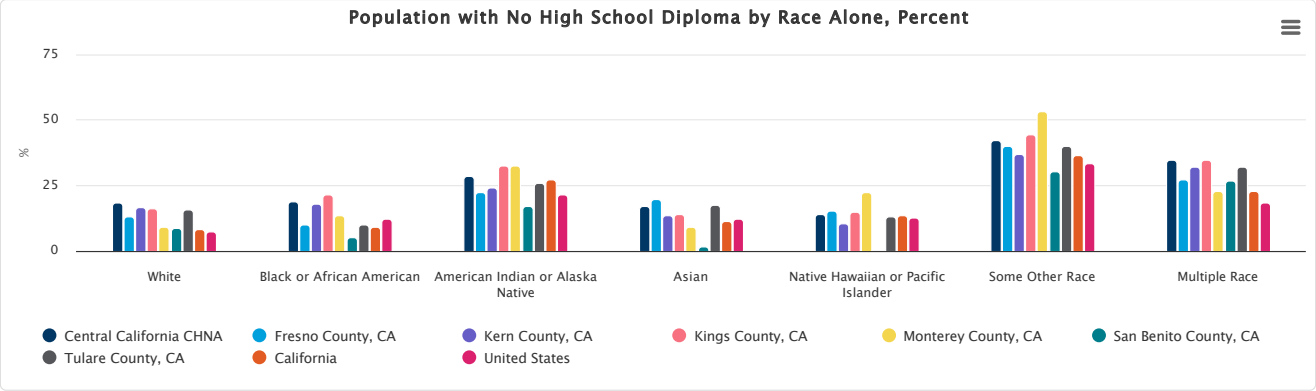


Population with No High School Diploma by Race Alone, Percent

This indicator reports the percentage of population age 25+ with no high school diploma by race alone in the report area. The percentage values could be interpreted as, for example, *"Of all the white population age 25+ in the report area, the percentage with no high school diploma is (value)."*

Report Area	White	Black or African American	American Indian or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
Central California CHNA	18.18%	18.61%	28.66%	16.88%	14.01%	42.03%	34.82%
Fresno County, CA	12.88%	9.88%	22.25%	19.45%	15.09%	40.13%	27.05%
Kern County, CA	16.69%	17.84%	24.09%	13.42%	10.48%	36.88%	31.82%
Kings County, CA	15.93%	21.54%	32.34%	14.04%	14.70%	44.15%	34.76%
Monterey County, CA	8.90%	13.48%	32.42%	8.89%	22.08%	53.15%	22.86%
San Benito County, CA	8.39%	5.21%	16.83%	1.34%	0.00%	30.21%	26.60%
Tulare County, CA	15.81%	9.71%	25.64%	17.51%	12.95%	39.99%	31.77%
California	8.28%	9.18%	26.94%	11.14%	13.33%	36.28%	22.77%
United States	7.12%	11.94%	21.51%	11.97%	12.73%	33.21%	18.36%

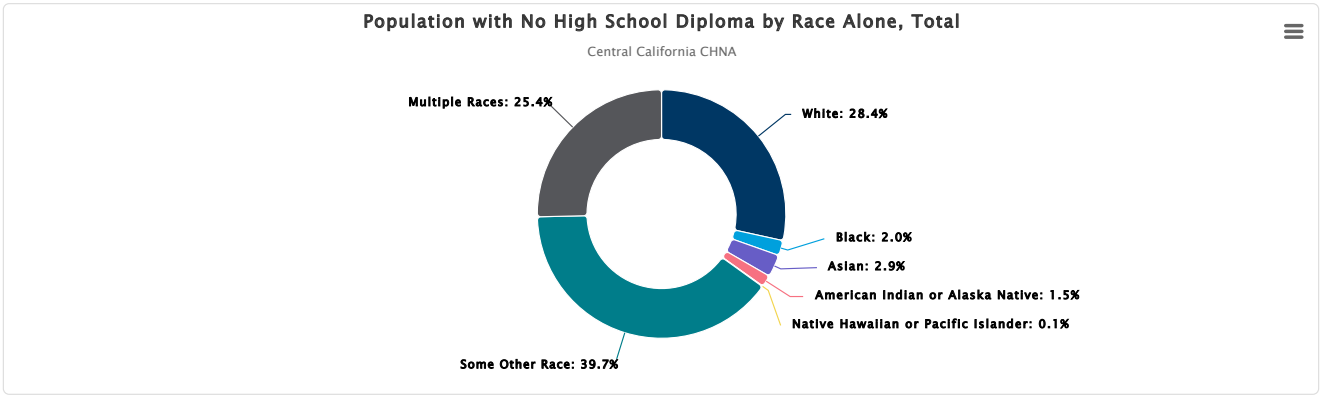
Data Source: US Census Bureau, American Community Survey. 2019-23.



Population with No High School Diploma by Race Alone, Total

Report Area	White	Black	Asian	American Indian or Alaska Native	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Races
Central California CHNA	38,475	2,675	3,929	2,075	102	53,718	34,319
Fresno County, CA	37,024	2,763	13,883	1,894	159	48,626	30,744
Kern County, CA	48,615	4,979	4,323	1,803	104	33,904	34,044
Kings County, CA	7,272	1,516	578	584	41	8,869	5,757
Monterey County, CA	10,296	965	1,712	813	340	52,459	7,884
San Benito County, CA	1,776	33	22	140	0	2,032	3,280
Tulare County, CA	20,821	403	1,958	1,168	50	31,156	17,429
California	1,050,186	139,805	495,148	79,473	13,685	1,538,790	832,059
United States	10,836,488	3,217,325	1,664,267	393,606	51,272	4,453,551	3,613,708

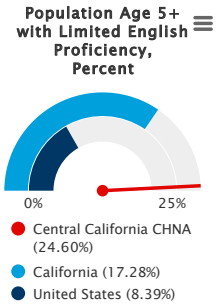
Data Source: US Census Bureau, American Community Survey. 2019-23.



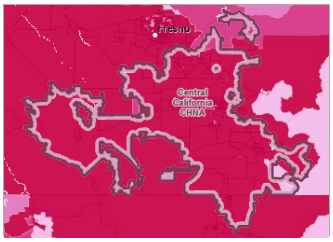
Barriers - Health Literacy - Limited English Proficiency

This indicator reports the percentage of the population aged 5 and older who speak a language other than English at home and speak English less than "very well". This indicator is relevant because an inability to speak English well creates barriers to healthcare access, provider communications, and health literacy/education. Of the 740,941 total population aged 5 and older in the report area, 182,242 or 24.60% have limited English proficiency.

Report Area	Population Age 5+	Population Age 5+ with Limited English Proficiency	Population Age 5+ with Limited English Proficiency, Percent
Central California CHNA	740,941	182,242	**24.60%**
Fresno County, CA	940,103	162,647	17.30%
Kern County, CA	844,742	146,893	17.39%
Kings County, CA	141,762	28,465	20.08%
Monterey County, CA	406,954	100,871	24.79%
San Benito County, CA	61,827	10,046	16.25%
Tulare County, CA	440,766	102,332	23.22%
California	37,028,644	6,400,397	17.28%
United States	313,447,641	26,299,012	8.39%



Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2019-23.



View larger map

Population with Limited English Proficiency, Percent by Tract, ACS 2019-23

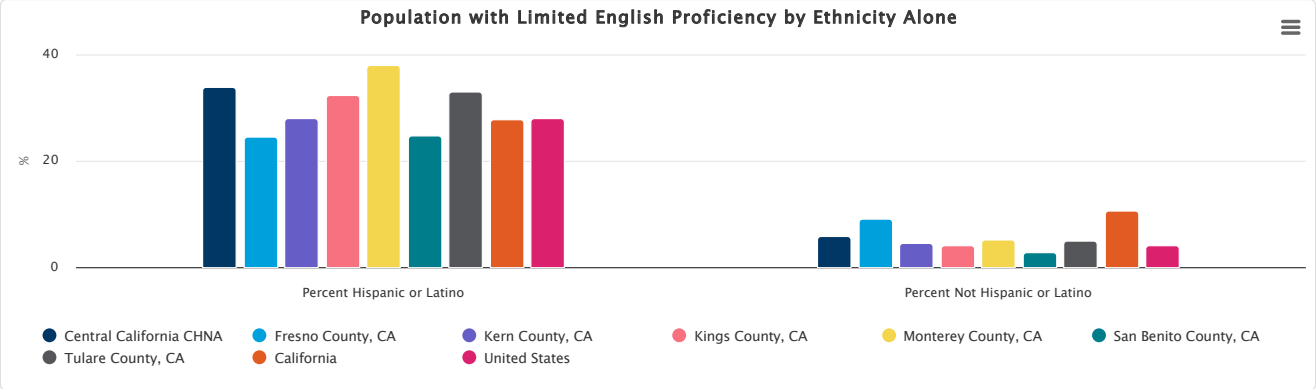
- Over 4.0%
- 2.1 - 4.0%
- 1.1 - 2.0%
- Under 1.1%
- No Data or Data Suppressed
- Central California CHNA

Population with Limited English Proficiency by Ethnicity Alone

This indicator reports the total and percentage of population aged 5 and older who speak a language other than English at home and speak English less than "very well" by ethnicity alone in the report area. The percentage values could be interpreted as, for example, *"Among the Hispanic population in the report area, the percentage of the population with limited English proficiency is (value)."*

Report Area	Total Hispanic or Latino	Total Not Hispanic or Latino	Percent Hispanic or Latino	Percent Not Hispanic or Latino
Central California CHNA	168,052	14,190	33.88%	5.79%
Fresno County, CA	122,746	39,901	24.49%	9.09%
Kern County, CA	129,776	17,117	27.85%	4.52%
Kings County, CA	26,026	2,439	32.36%	3.98%
Monterey County, CA	92,413	8,458	38.04%	5.16%
San Benito County, CA	9,395	651	24.77%	2.72%
Tulare County, CA	94,903	7,429	32.90%	4.88%
California	4,008,878	2,391,519	27.61%	10.62%
United States	16,290,980	10,008,032	28.02%	3.92%

Data Source: US Census Bureau, American Community Survey. 2019-23.

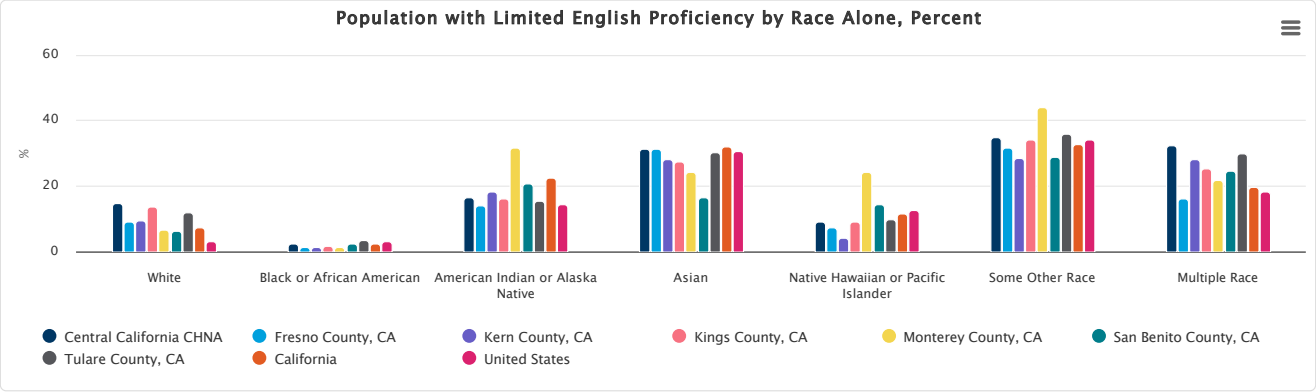


Population with Limited English Proficiency by Race Alone, Percent

This indicator reports the percentage of the population aged 5 and older who speak a language other than English at home and speak English less than "very well" by race alone in the report area.
The percentage values could be interpreted as, for example, *"Of all the white population in the report area, the percentage of population with limited English proficiency is (value)."*

Report Area	White	Black or African American	American Indian or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
Central California CHNA	14.65%	2.22%	16.39%	31.41%	9.01%	34.94%	32.15%
Fresno County, CA	9.12%	1.16%	14.08%	31.31%	7.10%	31.67%	16.16%
Kern County, CA	9.50%	1.25%	18.17%	28.07%	3.91%	28.31%	27.96%
Kings County, CA	13.51%	1.56%	15.94%	27.20%	8.84%	34.08%	25.36%
Monterey County, CA	6.46%	1.17%	31.49%	24.12%	24.10%	44.10%	21.88%
San Benito County, CA	6.13%	2.36%	20.48%	16.44%	14.17%	28.66%	24.61%
Tulare County, CA	11.75%	3.35%	15.18%	30.28%	9.79%	35.74%	29.94%
California	7.13%	2.23%	22.24%	32.04%	11.45%	32.77%	19.53%
United States	3.13%	3.11%	14.39%	30.47%	12.50%	33.93%	18.06%

Data Source: US Census Bureau, American Community Survey. 2019-23.

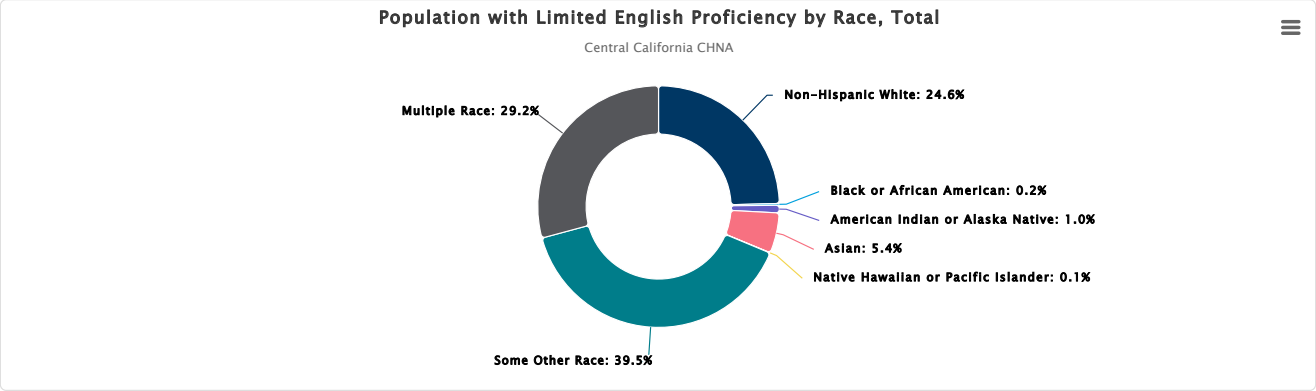


Population with Limited English Proficiency by Race, Total

This indicator reports the total population aged 5 and older who speak a language other than English at home and speak English less than "very well" by race alone in the report area.

Report Area	Non-Hispanic White	Black or African American	American Indian or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
Central California CHNA	44,792	444	1,853	9,833	96	72,020	53,204
Fresno County, CA	36,236	480	1,862	32,301	110	60,590	31,068
Kern County, CA	39,604	539	1,890	12,277	55	42,841	49,687
Kings County, CA	8,810	145	441	1,388	29	10,410	7,242
Monterey County, CA	9,768	108	1,084	5,842	534	71,746	11,789
San Benito County, CA	1,717	16	238	357	18	2,833	4,867
Tulare County, CA	22,130	226	1,036	4,805	66	46,260	27,809
California	1,171,612	46,021	93,958	1,831,952	16,068	2,097,665	1,143,121
United States	6,268,072	1,198,675	395,358	5,604,715	73,488	6,939,133	5,819,571

Data Source: US Census Bureau, American Community Survey. 2019-23.

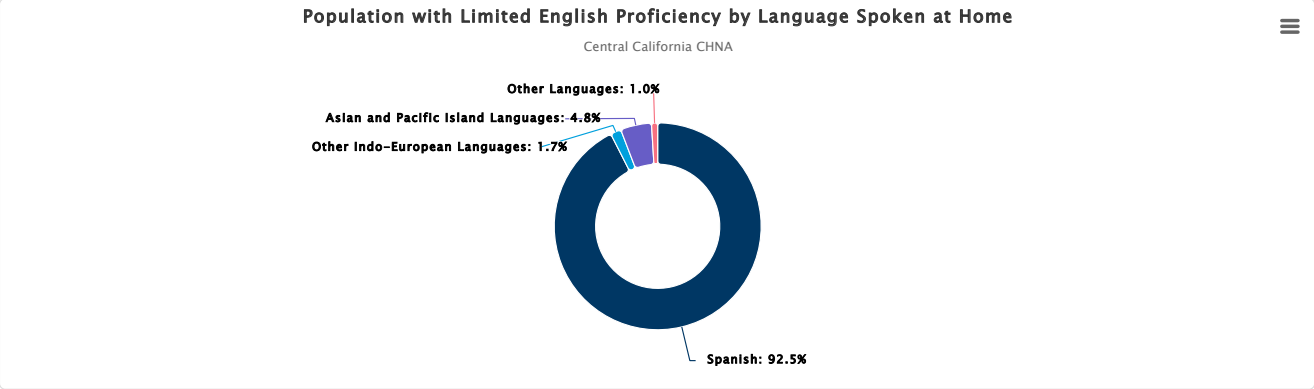


Population with Limited English Proficiency by Language Spoken at Home

This indicator reports the total population aged 5 and older who speak a language other than English at home and speak English less than "very well" by language spoken at home in the report area.

Report Area	Spanish	Other Indo-European Languages	Asian and Pacific Island Languages	Other Languages
Central California CHNA	168,610	3,035	8,837	1,760
Fresno County, CA	123,244	11,972	24,160	3,271
Kern County, CA	130,855	4,404	9,189	2,445
Kings County, CA	26,331	499	1,498	137
Monterey County, CA	92,597	1,947	5,439	888
San Benito County, CA	9,480	76	411	79
Tulare County, CA	95,244	1,684	4,390	1,014
California	4,043,207	518,139	1,705,745	133,306
United States	16,642,933	3,637,966	4,890,240	1,127,873

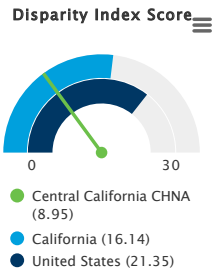
Data Source: US Census Bureau, American Community Survey. 2019-23.



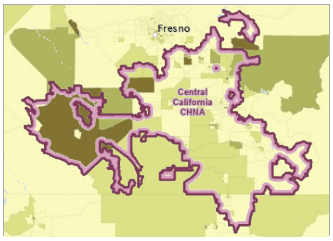
Barriers - Medical Insurance - Health Insurance Disparities

This indicator reports the percentage of the report area population that is uninsured by population race and ethnicity. The disparity index score is a relative measure which expresses the magnitude of disparity across population groups, with a score of 0 representing perfect equality, and a score of 100 representing perfect disparity.

Report Area	Non-Hispanic White	Hispanic or Latino	Non-Hispanic Black	Non-Hispanic Other Race	Disparity Index Score
Central California CHNA	4.13%	10.32%	5.39%	9.91%	**8.95**
Fresno County, CA	3.99%	9.14%	5.76%	8.01%	9.95
Kern County, CA	3.92%	10.57%	5.42%	9.73%	13.52
Kings County, CA	4.36%	9.99%	6.08%	9.61%	10.90
Monterey County, CA	3.37%	13.59%	7.17%	13.29%	12.94
San Benito County, CA	3.57%	8.00%	4.29%	7.65%	10.25
Tulare County, CA	4.19%	9.81%	4.79%	9.56%	9.49
California	3.52%	11.37%	5.65%	8.82%	16.14
United States	5.71%	17.47%	9.47%	13.32%	21.35



Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2019-23.



View larger map

Uninsured Population, Percent by Tract, ACS 2019-23

- Over 20.0%
- 15.1 - 20.0%
- 10.1 - 15.0%
- Under 10.1%
- No Data or Data Suppressed
- Central California CHNA

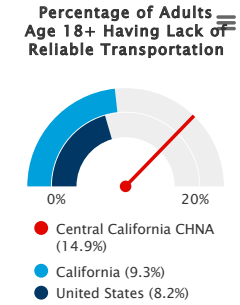
Barriers - Transportation - Lack of Reliable Transportation

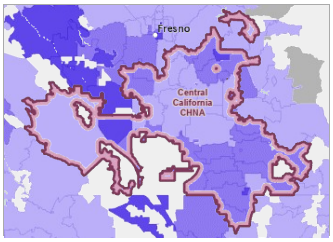
This indicator reports the percentage of adults age 18 and older who report having a lack of reliable transportation in the past 12 months.

Within the report area, there were 14.9% of adults 18 and older who rreport having a lack of reliable transportation in the past 12 months of the total population age 18 and older.

Report Area	Total Population	Adults Age 18+ Having Lack of Reliable Transportation (Crude)	Adults Age 18+ Having Lack of Reliable Transportation (Age-Adjusted)
Central California CHNA	795,651	14.9%	No data
Fresno County, CA	1,015,190	12.8%	13.0%
Kern County, CA	916,108	12.9%	12.9%
Kings County, CA	152,981	12.5%	12.3%
Monterey County, CA	432,858	11.2%	11.4%
San Benito County, CA	67,579	10.6%	10.7%
Tulare County, CA	477,544	15.1%	14.9%
California	39,029,342	9.3%	9.5%
United States	333,287,557	8.2%	8.7%

Note: This indicator is compared to the state average.
Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2022.





View larger map

Lack of Reliable Transportation, Prevalence Among Adults Age 18+ by ZCTA, CDC BRFSS PLACES Project 2022

- Over 29.1%
- 22.1% - 29.0%
- 15.1% - 22.0%
- Under 15.1%
- No Data or Data Suppressed
- Central California CHNA

Finacial Stability

Financial stability refers to having a reliable and sufficient income to meet basic needs such as housing, food, healthcare and transportation, while being able to handle unexpected expenses. Financial stability is a critical social determinant of health, as individuals with steady income are more likely to access preventive care, afford nutritious food, maintain safe living conditions and plan for the future.

However, many people face persistent financial instability which impacts their health and well-being. In the United States, 36.8 million Americans were living in poverty in 2023 (US Census Bureau), and 28% of adults went without medical care in 2022 because they could not afford it (Federal Reserve). Financial instability is linked to higher rates of chronic disease, mental health issues and shorter life expectancy due to limited access to health resources and higher exposure to stressors. In the Central California service area, the primary and secondary data confirm that financial stability is a high priority need.

With a median household income of $67,109 compared to California's $96,334, achieving financial stability in the Central California service area can be a challenge. Additionally, one in four children (25.37%) ages 0-17 live in households with income below the Federal Poverty Level. A high unemployment rate of 9.38% indicates that job conditions may be unstable.

People with steady jobs, or positions that continue for a long time with regular pay, are more likely to be healthy and less likely to have an income below the poverty level (Healthy People 2030). A key informant noted, "when people have access to great career opportunities and they're able to find permanent stable jobs, that helps provide for their stability [...] in their household, in their finances, with education, with healthcare, with transportation, with daycare."

Financial stability enables people to meet their basic needs, health needs and social needs. Interventions may include policies or programs that support employment and boost wages for parents to improve family economic stability. For additional data, see the following pages.

Scan QR Code to explore the full live data report on Financial Stability or visit: cares.page.link/NZnq

Data Highlights

Community Voices: *exploring local perceptions, thoughts & beliefs*

"I do feel…when folks do have a job and a career…the mental and the physical well being of an individual does increase…it adds…this further purpose to one's life and contribution to their community."

"Agriculture doesn't pay much…maybe 60% of the maybe 70% of the population have agriculture as their background…they're not making that much money to be able to live comfortably in a home."

"…when you compare working at minimum wage full time or not being employed and getting CalWorks and Medi-Cal…so why work?"

"…minimum wage is really not enough to live [on] in this state. And even in the smaller communities like Delano, it's really not enough."

"…it's just choices that as the rent skyrockets, health insurance goes up…people are making choices not to go to the doctor, not to take their medication…and they're making choices to adversely affect their health because they're paying other bills."

"…we don't have enough agencies local around here that has funding to help them pay their bills. And for [Kern County]…we will help pay energy and utilities…but only if we have the funding, if the grant is still there. But when we run out, we don't have it."

"And when people have access to great career opportunities and they're able to find permanent stable jobs, that helps provide for their stability…in their household, in their finances, with education, with healthcare, with transportation, with daycare…I think great jobs provide many people purpose and meaning…"

"We've got to bring in better employers to…get people better paying jobs, so that with those jobs they're in a safer work environment and they have higher incomes. And then they could have private insurance and then they could take care of themselves."

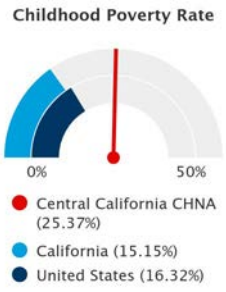
"…our responsibility is to bring in those larger employers and those industry sectors so they can create that economic diversity and then that will help fuel more of those [college] programs in our school systems."

"…we're building a business incubator right next door to City Hall. I've reserved 25% of that business incubator for immigrant businesses, so if you help, if you have a business idea and you want to start a business and you don't want to work for someone else, bring your idea to the incubator. We'll put you in the incubator and we'll wrap around you all the services you need."

Community Resources

BenefitsCal
benefitscal.com

The California Wellness Foundation
calwellness.org/money/what-we-fund/economic-security-and-dignity
818-702–1900



Community Health Needs Assessment Full Report

Location

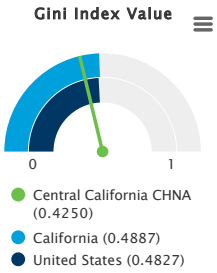
Central California CHNA

Basic Needs: Financial Stability

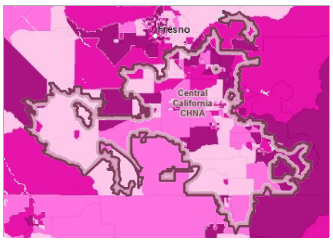
Income - Income Inequality

This indicator reports income inequality using the Gini coefficient. Gini index values range between zero and one. A value of one indicates perfect inequality where only one household has any income. A value of zero indicates perfect equality, where all households have equal income.
Note: Index values are acquired from the 2019-23 American Community Survey and are not available for custom report areas or multi-county areas.

Report Area	Total Households	Gini Index Value
Central California CHNA	234,087	**0.4250**
Fresno County, CA	322,163	0.4735
Kern County, CA	281,416	0.4645
Kings County, CA	43,736	0.4211
Monterey County, CA	132,046	0.4627
San Benito County, CA	20,188	0.4193
Tulare County, CA	142,026	0.4401
California	13,434,847	0.4887
United States	127,482,865	0.4827



Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2019-23.



View larger map

Income Inequality (GINI), Index Value by Tract, ACS 2019-23

- Over 0.460
- 0.431 - 0.460
- 0.401 - 0.430
- Under 0.401
- No Data or Data Suppressed
- Central California CHNA

Income Inequality (GINI Index) by Year

This indicator reports the GINI index from 2012-16 to 2019-23.

Report Area	2012-16	2013-17	2014-18	2015-19	2016-20	2017-21	2018-22	2019-23
Fresno County, CA	0.48	0.48	0.48	0.47	0.48	0.47	0.47	0.47
Fresno County, CA	0.45	0.45	0.45	0.44	0.44	0.44	0.45	0.45
Kern County, CA	0.42	0.41	0.45	0.43	0.42	0.42	0.43	0.41
Kern County, CA	0.46	0.46	0.46	0.47	0.47	0.46	0.47	0.46
Kings County, CA	0.45	0.44	0.43	0.43	0.41	0.41	0.41	0.42
Kings County, CA	0.51	0.54	0.53	0.54	0.57	0.55	0.49	0.47
Monterey County, CA	0.44	0.44	0.44	0.43	0.43	0.44	0.45	0.44
Monterey County, CA	0.46	0.46	0.46	0.46	0.46	0.45	0.46	0.46
San Benito County, CA	0.41	0.40	0.40	0.41	0.41	0.41	0.41	0.42
San Benito County, CA	0.58	0.60	0.61	0.61	0.55	0.57	0.56	0.55
Tulare County, CA	0.44	0.43	0.43	0.42	0.43	0.41	0.42	0.43
Tulare County, CA	0.47	0.47	0.48	0.47	0.46	0.46	0.45	0.44
California	0.49	0.49	0.49	0.49	0.49	0.49	0.49	0.49
United States	0.48	0.48	0.48	0.48	0.48	0.48	0.48	0.48

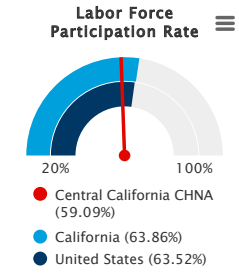
Data Source: US Census Bureau, American Community Survey. 2019-23.

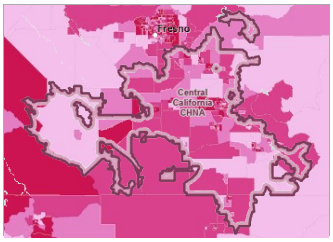
Employment - Labor Force Participation Rate

The table below displays the labor force participation rate for the report area. According to the 2019 – 2023 American Community Survey, of the 602,688 working age population, 356,134 are included in the labor force. The labor force participation rate is 59.09%.

Report Area	Total Population Age 16+	Labor Force	Labor Force Participation Rate
Central California CHNA	602,688	356,134	**59.09%**
Fresno County, CA	761,285	466,586	61.29%
Kern County, CA	677,057	398,143	58.80%
Kings County, CA	115,997	64,752	55.82%
Monterey County, CA	335,220	202,644	60.45%
San Benito County, CA	51,266	34,250	66.81%
Tulare County, CA	349,036	211,707	60.65%
California	31,545,603	20,144,078	63.86%
United States	267,393,519	169,855,626	63.52%

Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2019-23.





View larger map

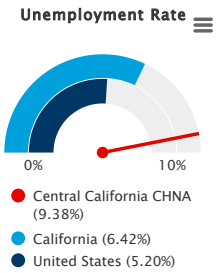
Labor Force, Participation Rate by Tract, ACS 2019-23

- Over 66.0%
- 60.1% - 66.0%
- 54.1% - 60.0%
- Under 54.1%
- No Data or Data Suppressed
- Central California CHNA

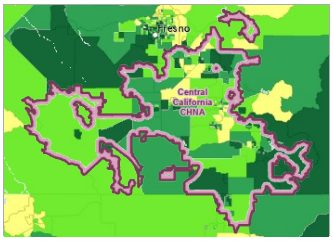
Employment - Unemployment

According to the most recent American Community Survey estimates, total unemployment in the report area is 33,391, or 9.38% of the civilian labor force. This indicator is relevant because unemployment creates financial instability and barriers to access including insurance coverage, health services, healthy food, and other necessities that contribute to poor health status.

Report Area	Labor Force	Number Unemployed	Unemployment Rate
Central California CHNA	356,134	33,391	**9.38%**
Fresno County, CA	466,586	39,771	8.55%
Kern County, CA	398,143	33,049	8.35%
Kings County, CA	64,752	5,787	9.82%
Monterey County, CA	202,644	10,068	5.13%
San Benito County, CA	34,250	2,038	5.96%
Tulare County, CA	211,707	18,688	8.85%
California	20,144,078	1,282,259	6.42%
United States	169,855,626	8,759,317	5.20%



Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2019-23.



View larger map

Unemployed Workers, Percent by Tract, ACS 2019-23

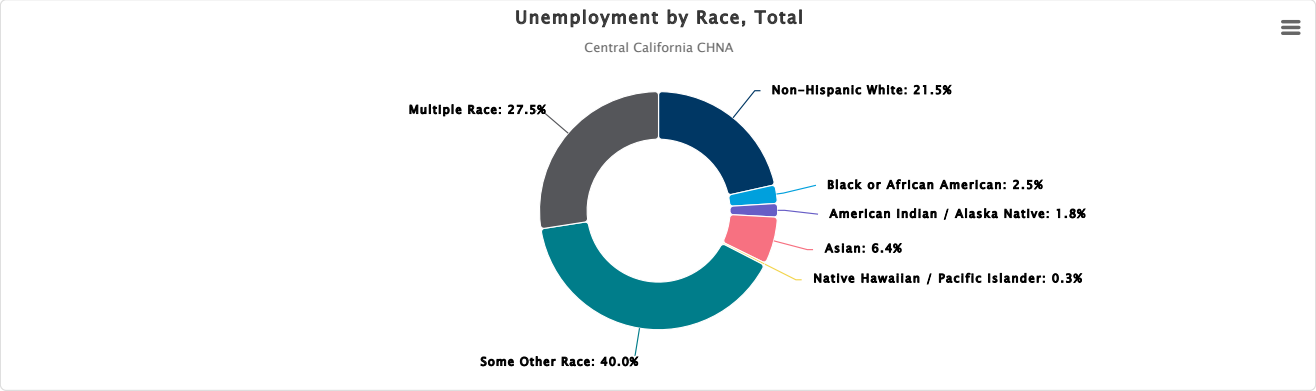
- Over 12.0%
- 8.1 - 12.0%
- 4.1 - 8.0%
- Under 4.1%
- No Data or Data Suppressed
- Central California CHNA

Unemployment by Race, Total

This indicator reports the total count of unemployed population in the report area by race.

Report Area	Non-Hispanic White	Black or African American	American Indian / Alaska Native	Asian	Native Hawaiian / Pacific Islander	Some Other Race	Multiple Race
Central California CHNA	5,700	669	489	1,695	77	10,594	7,274
Fresno County, CA	7,593	2,408	785	3,603	24	9,627	9,213
Kern County, CA	9,265	2,781	562	1,220	76	6,236	7,187
Kings County, CA	1,438	340	124	164	31	1,530	1,134
Monterey County, CA	3,091	251	129	796	164	2,733	1,622
San Benito County, CA	465	2	27	17	2	381	499
Tulare County, CA	3,834	272	357	676	31	6,417	3,890
California	413,831	106,059	18,806	158,934	6,166	236,196	227,927
United States	4,184,342	1,757,752	108,909	456,672	22,627	698,102	1,076,447

Data Source: US Census Bureau, American Community Survey. 2019-23.

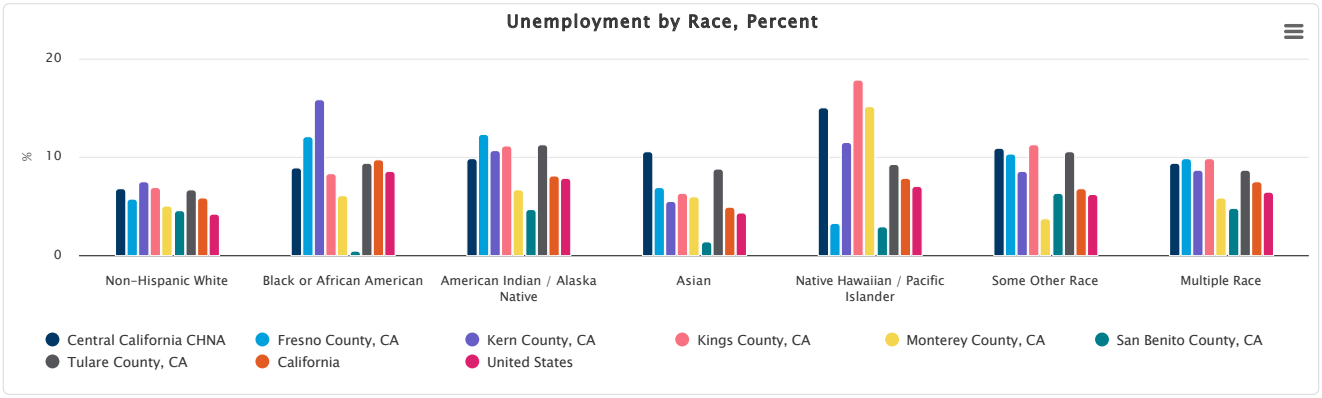


Unemployment by Race, Percent

This indicator reports the percentage of unemployed population in the report area by race. The values could be interpreted as, for example, *"Of all the Non-Hispanic White population in civilian labor force in the report area, the unemployment rate is (value)."*

Report Area	Non-Hispanic White	Black or African American	American Indian / Alaska Native	Asian	Native Hawaiian / Pacific Islander	Some Other Race	Multiple Race
Central California CHNA	6.72%	8.84%	9.82%	10.54%	15.01%	10.92%	9.38%
Fresno County, CA	5.70%	12.06%	12.30%	6.85%	3.27%	10.28%	9.81%
Kern County, CA	7.49%	15.78%	10.67%	5.45%	11.45%	8.54%	8.60%
Kings County, CA	6.92%	8.30%	11.16%	6.28%	17.82%	11.19%	9.78%
Monterey County, CA	5.03%	6.11%	6.69%	5.94%	15.12%	3.68%	5.81%
San Benito County, CA	4.50%	0.43%	4.65%	1.30%	2.90%	6.27%	4.71%
Tulare County, CA	6.64%	9.39%	11.22%	8.72%	9.28%	10.49%	8.61%
California	5.81%	9.76%	8.07%	4.88%	7.88%	6.77%	7.44%
United States	4.17%	8.58%	7.87%	4.28%	7.05%	6.21%	6.40%

Data Source: US Census Bureau, American Community Survey. 2019-23.

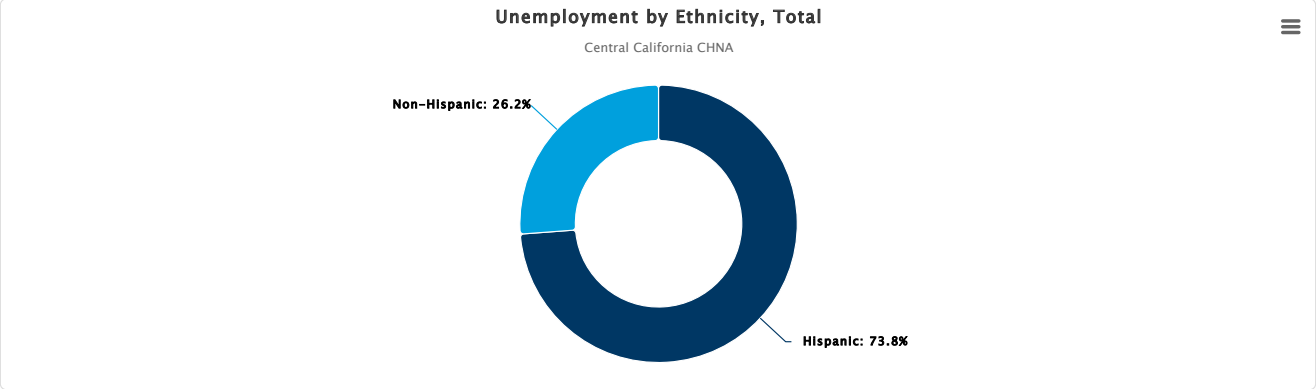


Unemployment by Ethnicity, Total

This indicator reports the total count of unemployed population in the report area by ethnicity.

Report Area	Hispanic	Non-Hispanic
Central California CHNA	24,319	8,627
Fresno County, CA	24,644	15,127
Kern County, CA	18,208	14,841
Kings County, CA	3,643	2,144
Monterey County, CA	5,342	4,726
San Benito County, CA	1,509	529
Tulare County, CA	13,663	5,025
California	537,311	744,948
United States	1,889,916	6,869,401

Data Source: US Census Bureau, American Community Survey. 2019-23.

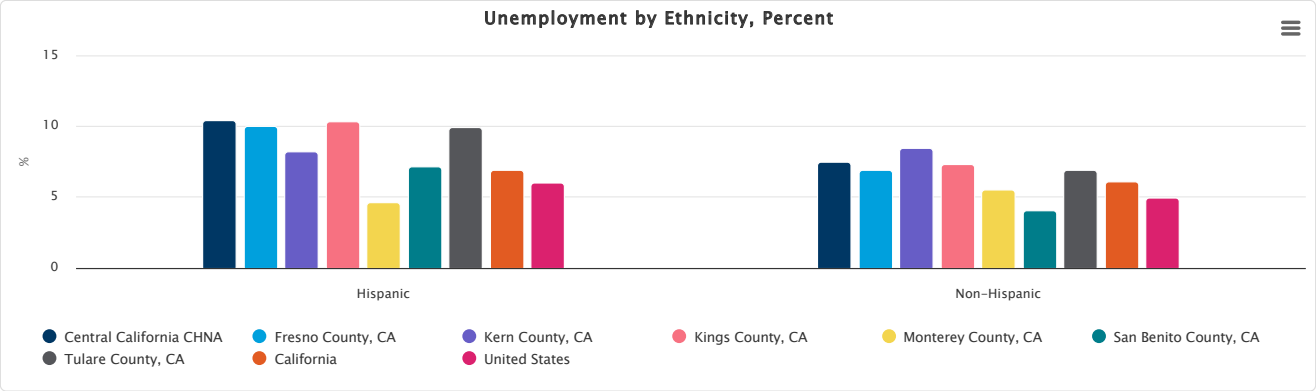


Unemployment by Ethnicity, Percent

This indicator reports the percentage of unemployed population in the report area by ethnicity. The values could be interpreted as, for example, *"Of all the Hispanic population in civilian labor force in the report area, the unemployment rate is (value)."*

Report Area	Hispanic	Non-Hispanic
Central California CHNA	10.40%	7.43%
Fresno County, CA	10.01%	6.86%
Kern County, CA	8.20%	8.42%
Kings County, CA	10.33%	7.27%
Monterey County, CA	4.58%	5.49%
San Benito County, CA	7.14%	4.04%
Tulare County, CA	9.88%	6.85%
California	6.87%	6.04%
United States	6.00%	4.97%

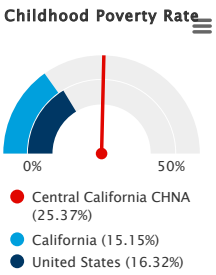
Data Source: US Census Bureau, American Community Survey. 2019-23.



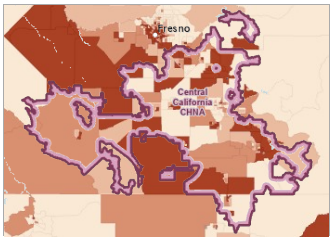
Income - Childhood Poverty Rate

In the report area 25.37% or 58,194 children aged 0-17 are living in households with income below the Federal Poverty Level (FPL). This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.

Report Area	Total Population	Population < Age 18	Population < Age 18 in Poverty	Childhood Poverty Rate
Central California CHNA	769,408	229,349	58,194	**25.37%**
Fresno County, CA	994,567	278,756	70,989	25.47%
Kern County, CA	886,335	258,663	66,762	25.81%
Kings County, CA	139,672	41,112	9,702	23.60%
Monterey County, CA	419,124	111,276	20,085	18.05%
San Benito County, CA	65,660	16,528	1,772	10.72%
Tulare County, CA	470,078	141,134	33,980	24.08%
California	38,529,452	8,590,409	1,301,440	15.15%
United States	324,567,147	72,472,636	11,829,878	16.32%



Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2019-23.



View larger map

Population Below the Poverty Level, Children (Age 0-17), Percent by Tract, ACS 2019-23

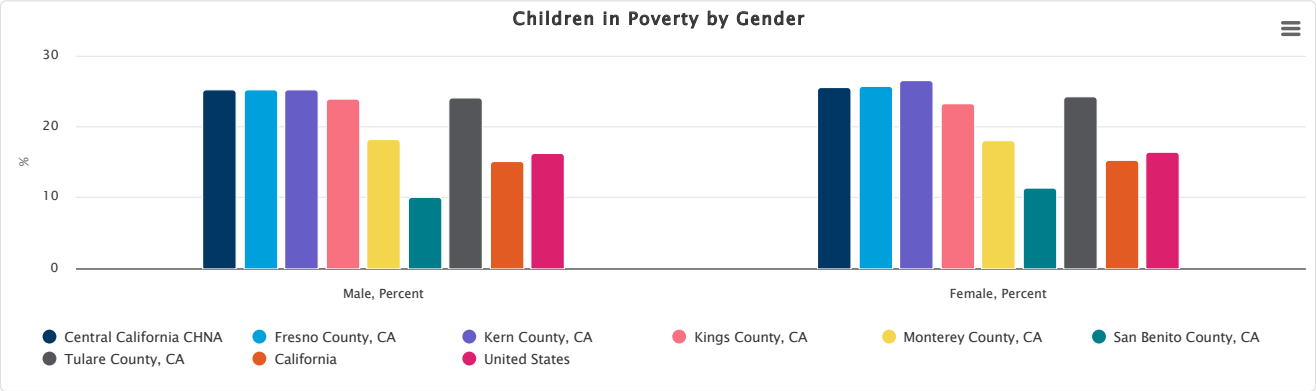
- Over 30.0%
- 22.6 - 30.0%
- 15.1 - 22.5%
- Under 15.1%
- No Population Age 0-17 Reported
- No Data or Data Suppressed
- Central California CHNA

Children in Poverty by Gender

This indicator reports children aged 0-17 living in households with income below the federal poverty level by gender. The percentage values could be interpreted as, for example, *"Of all the males under age 18 within the report area, the percentage living in households with income below the federal poverty level is (value)."*

Report Area	Male	Female	Male, Percent	Female, Percent
Central California CHNA	29,586	28,608	25.25%	25.51%
Fresno County, CA	35,804	35,185	25.20%	25.75%
Kern County, CA	33,206	33,556	25.18%	26.47%
Kings County, CA	4,983	4,719	23.96%	23.23%
Monterey County, CA	10,234	9,851	18.11%	17.99%
San Benito County, CA	833	939	10.06%	11.39%
Tulare County, CA	17,269	16,711	24.01%	24.15%
California	662,455	638,985	15.07%	15.24%
United States	6,037,616	5,792,262	16.28%	16.37%

Data Source: US Census Bureau, American Community Survey. 2019-23.

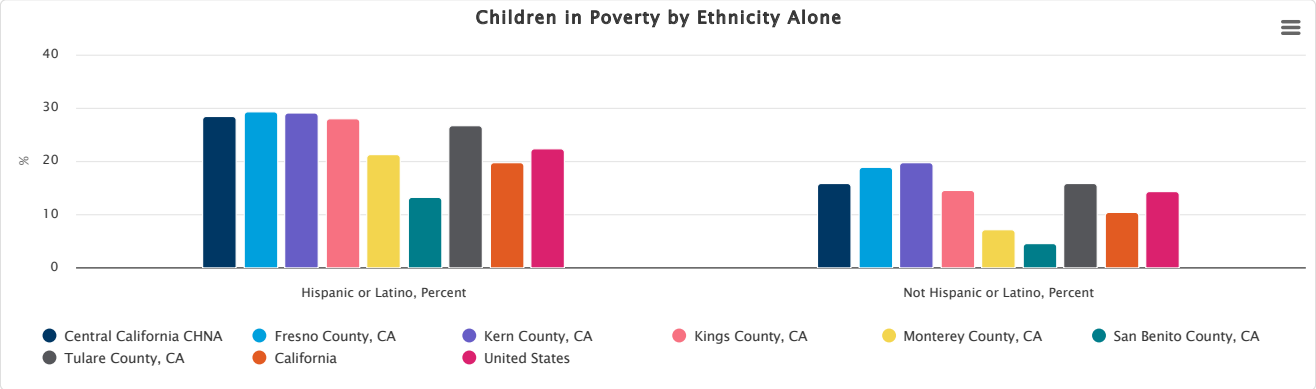


Children in Poverty by Ethnicity Alone

This indicator reports children aged 0-17 living in households with income below the federal poverty level by ethnicity alone. The percentage values could be interpreted as, for example, *"Of all the Hispanic children under age 18 within the report area, the proportion living in households with income below the federal poverty level is (value)."*

Report Area	Hispanic or Latino	Not Hispanic or Latino	Hispanic or Latino, Percent	Not Hispanic or Latino, Percent
Central California CHNA	50,229	7,965	28.31%	15.75%
Fresno County, CA	52,342	18,647	29.16%	18.78%
Kern County, CA	49,330	17,432	29.03%	19.64%
Kings County, CA	7,831	1,871	27.83%	14.42%
Monterey County, CA	18,370	1,715	21.16%	7.01%
San Benito County, CA	1,563	209	13.16%	4.49%
Tulare County, CA	28,640	5,340	26.68%	15.81%
California	872,964	428,476	19.71%	10.30%
United States	4,180,720	7,649,158	22.26%	14.25%

Data Source: US Census Bureau, American Community Survey. 2019-23.

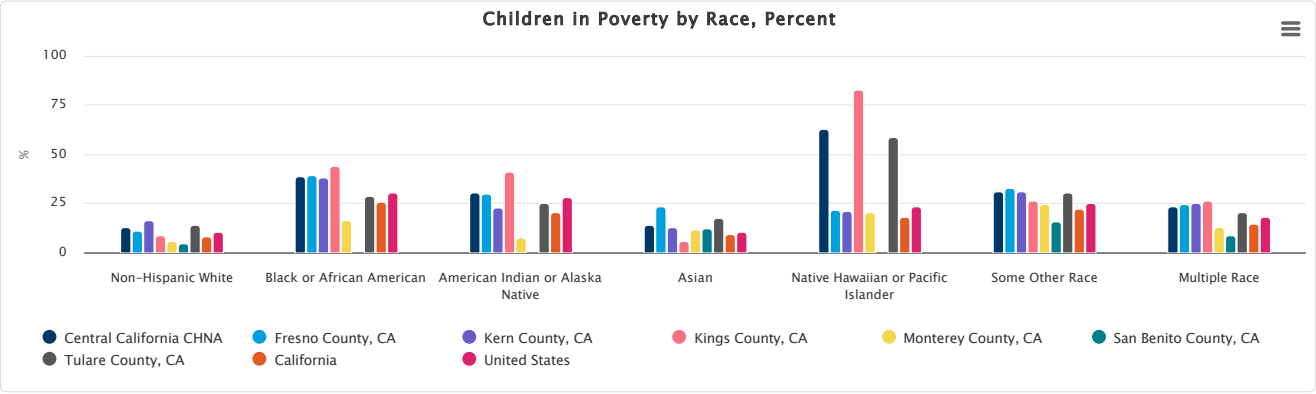


Children in Poverty by Race, Percent

This indicator reports percent of children aged 0-17 living in households with income below the federal poverty level by race. The percentage values could be interpreted as, for example, *"Of all the non-Hispanic white children under age 18 within the report area, the proportion living in households with income below the federal poverty level is (value)."*

Report Area	Non-Hispanic White	Black or African American	American Indian or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
Central California CHNA	12.68%	38.74%	30.56%	13.64%	62.50%	30.61%	23.25%
Fresno County, CA	10.67%	39.04%	29.90%	22.97%	21.59%	32.45%	24.26%
Kern County, CA	16.13%	38.16%	22.87%	12.66%	21.16%	30.87%	24.94%
Kings County, CA	8.68%	43.90%	40.59%	5.46%	82.72%	25.95%	25.96%
Monterey County, CA	5.34%	15.98%	7.51%	11.64%	20.05%	24.58%	12.61%
San Benito County, CA	4.51%	0.00%	0.00%	12.14%	0.00%	15.87%	8.38%
Tulare County, CA	14.10%	28.34%	25.08%	17.19%	58.45%	30.46%	20.52%
California	7.82%	25.58%	20.38%	9.39%	17.71%	22.10%	14.39%
United States	10.03%	30.17%	27.96%	10.09%	23.01%	24.72%	17.65%

Data Source: US Census Bureau, American Community Survey. 2019-23.

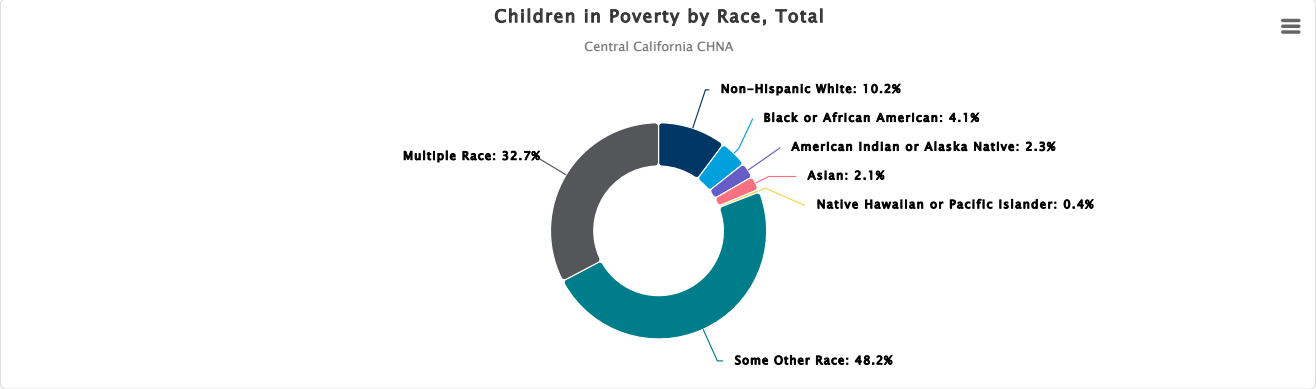


Children in Poverty by Race, Total

This indicator reports the total children aged 0-17 living in households with income below the federal poverty level by race alone.

Report Area	Non-Hispanic White	Black or African American	American Indian or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
Central California CHNA	4,378	1,770	993	895	175	20,637	14,004
Fresno County, CA	4,881	4,414	1,145	6,943	114	19,330	18,180
Kern County, CA	8,940	5,105	551	1,329	73	15,491	16,191
Kings County, CA	713	821	291	44	67	2,462	2,706
Monterey County, CA	816	214	42	447	86	14,258	2,345
San Benito County, CA	150	0	0	59	0	354	583
Tulare County, CA	3,332	608	486	717	128	13,692	7,078
California	159,032	110,186	20,317	100,971	5,448	389,279	294,258
United States	3,485,516	2,945,781	207,029	375,774	35,256	1,470,871	2,097,833

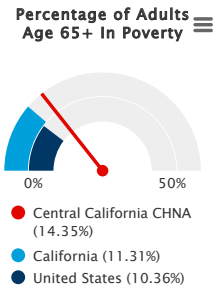
Data Source: US Census Bureau, American Community Survey. 2019-23.



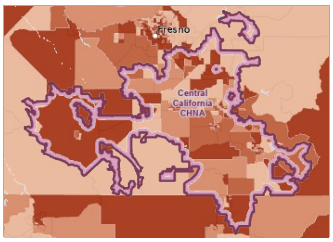
Income - Senior Poverty Rate

In the report area 14.35% or 12,336 older adults aged 65 or older are living in households with income below the Federal Poverty Level (FPL). This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.

Report Area	Total Population	Population Age 65+	Population Age 65+ in Poverty	Population Age 65+ in Poverty, Percent
Central California CHNA	769,408	85,940	12,336	**14.35%**
Fresno County, CA	994,567	126,060	18,415	14.61%
Kern County, CA	886,335	104,013	15,549	14.95%
Kings County, CA	139,672	15,728	1,657	10.54%
Monterey County, CA	419,124	62,143	6,715	10.81%
San Benito County, CA	65,660	8,815	725	8.22%
Tulare County, CA	470,078	54,607	7,240	13.26%
California	38,529,452	5,889,841	666,273	11.31%
United States	324,567,147	54,579,391	5,654,531	10.36%



Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2019-23.



View larger map

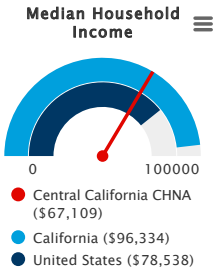
Population Below the Poverty Level, Senior (Age 65+), Percent by Tract, ACS 2019-23

- Over 17.0%
- 12.1 - 17.0%
- 7.1 - 12.0%
- Under 7.1%
- No Population Age 65+ Reported
- No Data or Data Suppressed
- Central California CHNA

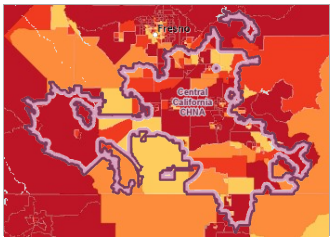
Income - Median Household Income

This indicator reports median household income based on the latest 5-year American Community Survey estimates. This includes the income of the householder and all other individuals 15 years old and over in the household, whether they are related to the householder or not. Because many households consist of only one person, average household income is usually less than average family income. There are 230,069 households in the report area, with an average income of $86,115 and a median income of $67,109.

Report Area	Total Households	Average Household Income	Median Household Income
Central California CHNA	230,069	$86,115	**$67,109**
Fresno County, CA	322,163	$97,005.29	$71,434
Kern County, CA	281,416	$91,401.00	$67,660
Kings County, CA	43,736	$86,267.72	$68,750
Monterey County, CA	132,046	$128,334.16	$94,486
San Benito County, CA	20,188	$138,188.77	$108,289
Tulare County, CA	142,026	$90,157.44	$69,489
California	13,434,847	$136,729.66	$96,334
United States	127,482,865	$110,490.58	$78,538



Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2019-23.



View larger map

Median Household Income by Tract, ACS 2019-23

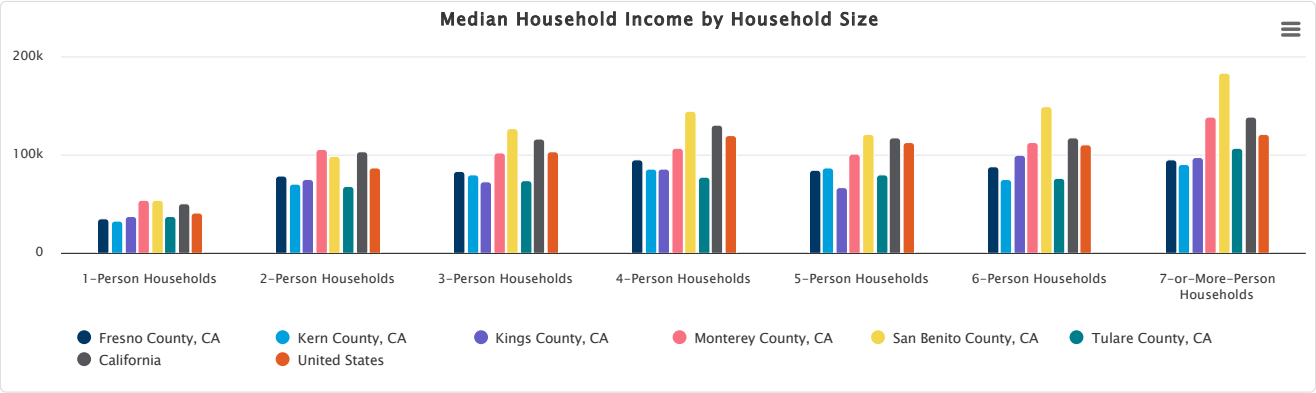
- Over $70,000
- $60,000 - $70,000
- $50,000 - $59,999
- Under $50,000
- No Data or Data Suppressed
- Central California CHNA

Median Household Income by Household Size

This indicator reports the median household income of the report area by household size.

Report Area	1-Person Households	2-Person Households	3-Person Households	4-Person Households	5-Person Households	6-Person Households	7-or-More-Person Households
Fresno County, CA	$34,448	$78,376	$83,448	$94,830	$83,873	$87,492	$94,288
Kern County, CA	$31,986	$69,492	$79,955	$85,083	$86,540	$74,976	$89,457
Kings County, CA	$37,180	$74,521	$72,511	$85,043	$66,882	$99,688	$97,109
Monterey County, CA	$53,400	$104,987	$101,318	$106,438	$100,963	$112,523	$137,696
San Benito County, CA	$53,186	$98,404	$126,250	$143,750	$120,739	$149,016	$182,917
Tulare County, CA	$36,482	$67,787	$73,101	$77,037	$79,045	$75,746	$105,966
California	$49,595	$102,789	$115,509	$129,753	$117,386	$116,568	$138,755
United States	$40,456	$86,971	$102,372	$118,913	$111,952	$109,893	$120,082

Data Source: US Census Bureau, American Community Survey. 2019-23.

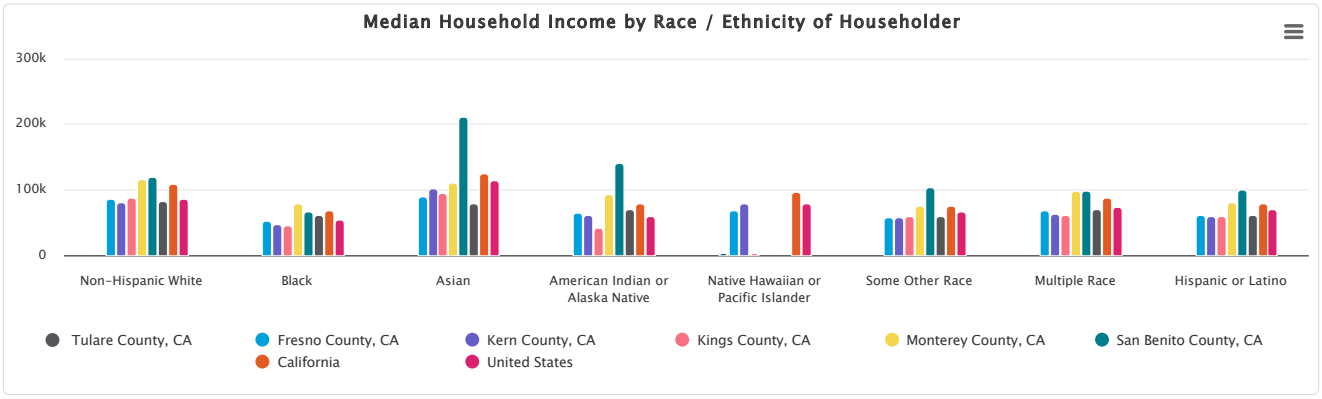


Median Household Income by Race / Ethnicity of Householder

This indicator reports the median household income of the report area by race / ethnicity of householder.

Report Area	Non-Hispanic White	Black	Asian	American Indian or Alaska Native	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race	Hispanic or Latino
Fresno County, CA	$85,064	$51,280	$88,247	$63,992	$67,868	$57,945	$67,479	$60,754
Kern County, CA	$80,401	$46,541	$101,199	$60,375	$78,125	$57,787	$62,942	$59,498
Kings County, CA	$86,480	$44,240	$95,217	$40,917	$2,499	$58,469	$61,081	$59,072
Monterey County, CA	$116,317	$78,750	$109,731	$92,361	No data	$74,717	$98,204	$79,579
San Benito County, CA	$118,801	$65,385	$210,673	$140,972	No data	$103,662	$98,696	$100,204
Tulare County, CA	$82,643	$61,105	$78,750	$69,375	No data	$58,634	$69,290	$61,418
California	$109,049	$67,365	$125,149	$78,909	$96,758	$74,377	$87,968	$78,763
United States	$84,745	$53,444	$113,106	$59,393	$78,640	$65,558	$73,412	$68,890

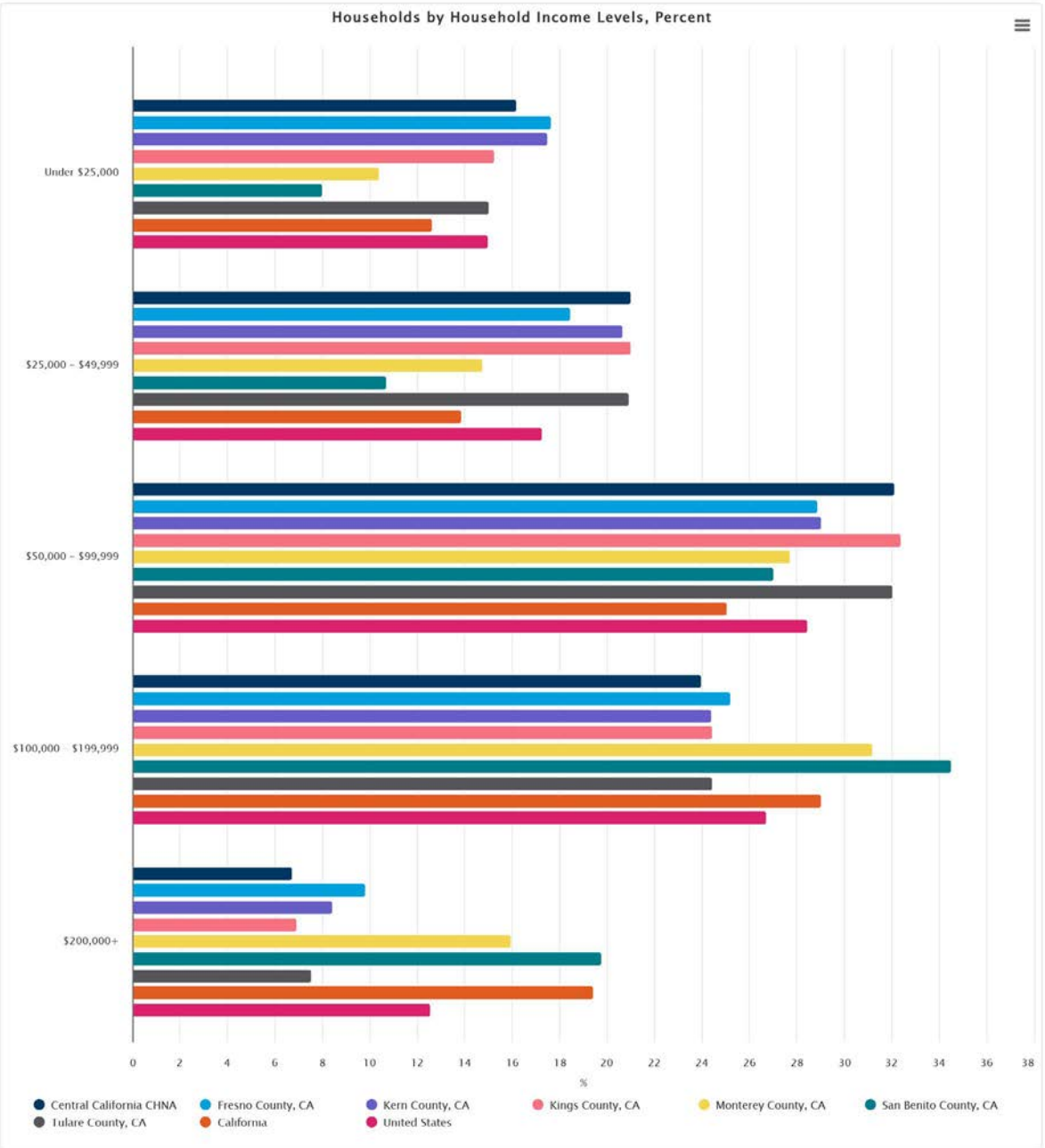
Data Source: US Census Bureau, American Community Survey. 2019-23.



Households by Household Income Levels, Percent

Report Area	Under $25,000	$25,000 - $49,999	$50,000 - $99,999	$100,000 - $199,999	$200,000+
Central California CHNA	16.17%	21.01%	32.10%	23.97%	6.75%
Fresno County, CA	17.65%	18.46%	28.87%	25.20%	9.81%
Kern County, CA	17.51%	20.64%	29.02%	24.39%	8.44%
Kings County, CA	15.25%	20.99%	32.39%	24.45%	6.93%
Monterey County, CA	10.38%	14.74%	27.72%	31.19%	15.97%
San Benito County, CA	8.02%	10.70%	27.01%	34.51%	19.76%
Tulare County, CA	15.04%	20.94%	32.03%	24.43%	7.56%
California	12.62%	13.87%	25.05%	29.03%	19.43%
United States	15.00%	17.28%	28.46%	26.70%	12.56%

Data Source: US Census Bureau, American Community Survey. 2019-23.



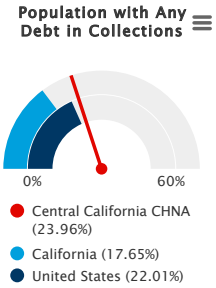
Security - Population with Debt

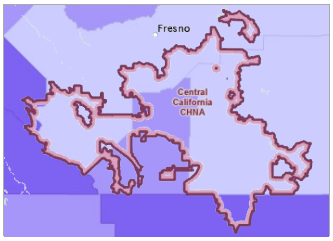
This indicator reports data from a 2 percent nationally representative panel of deidentified, consumer-level records from a major credit bureau at the national, state, and county levels for the 50 states and Washington, DC, as of 2023, compiled by the Urban Institute. The share with any debt in collections and the median debt in collections within the report area are shown as below. The Share with Any Debt in Collections is defined as the share of people with a credit bureau record who have any debt in collections. This includes past-due credit lines that have been closed and charged-off on the creditor's books as well as unpaid bills reported to the credit bureaus that the creditor is attempting to collect. The Median Debt in Collections is the median amount of all debt in collections among those with any debt in collections.

Note: Credit bureau metrics are not reported when they are based on fewer than 50 people.

Report Area	Share with Any Debt in Collections	Median Debt in Collections
Central California CHNA	**23.96%**	No data
Fresno County, CA	23.65%	$2,090
Kern County, CA	26.78%	$2,224
Kings County, CA	24.72%	$2,026
Monterey County, CA	18.25%	$2,756
San Benito County, CA	19.70%	$2,418.5
Tulare County, CA	23.34%	$1,950
California	17.65%	$2,276
United States	22.01%	$2,123

Note: This indicator is compared to the state average.
Data Source: Debt in America, The Urban Institute. 2019-24.





View larger map

Debt in Collections, Median Amount (USD) by County, UI 2023

- Over $2,000
- $1,701 - $2,000
- $1,401 - $1,700
- Under $1,401
- No Data or Data Suppressed
- Central California CHNA

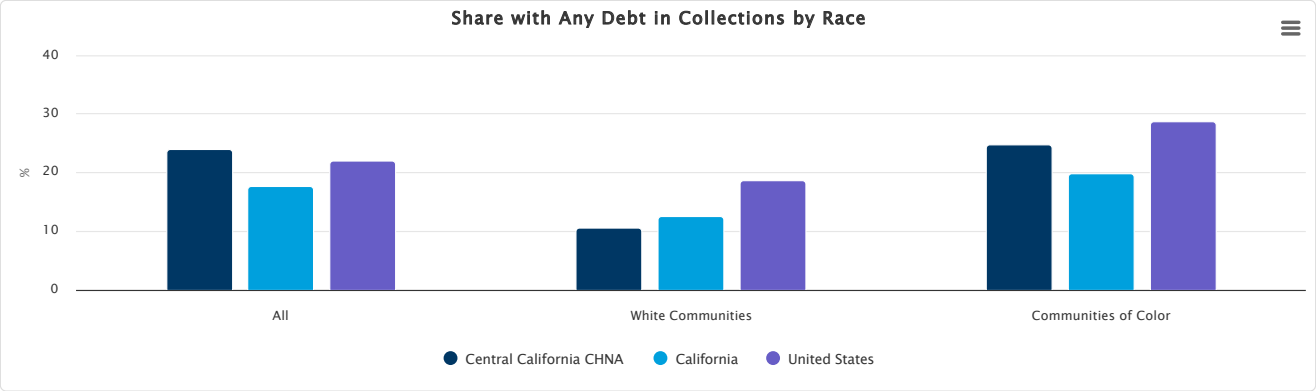
Share with Any Debt in Collections by Race

The table below reports how debt affects communities across the US in terms of race. White communities and communities of color are based on zip codes where most residents are white (at least 60 percent of the population are white) or most residents are people of color (at least 60 percent of the population are of color). As of December 2023, of all the people who have a credit bureau record in the report area, there were 23.95% that have any debt in collections. In white communites, there were 10.59% people with any debt in collections while in communities of color, this ratio is 24.65%.

Note: Credit bureau metrics are not reported when they are based on fewer than 50 people. In some cases, values for white communities and communities of color are not reported because there are no zip codes with predominantly white populations or populations of color in the county or state.

Report Area	Share with Any Debt in Collections, All	Share with Any Debt in Collections, White Communities	Share with Any Debt in Collections, Communities of Color
Central California CHNA	23.95%	10.59%	24.65%
California	17.65%	12.55%	19.74%
United States	22.01%	18.63%	28.60%

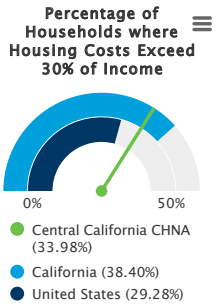
Data Source: Debt in America, The Urban Institute. 2019-24.



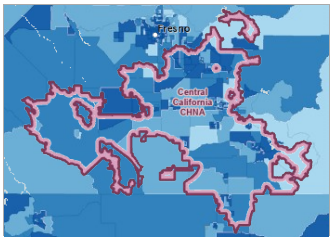
Security - Housing Cost Burden (30%)

This indicator reports the percentage of the households where housing costs are 30% or more of total household income. This indicator provides information on the cost of monthly housing expenses for owners and renters. The information offers a measure of housing affordability and excessive shelter costs. The data also serve to aid in the development of housing programs to meet the needs of people at different economic levels. Of the 230,069 total households in the report area, 78,172 or 33.98% of the population live in cost burdened households.

Report Area	Total Households	Cost-Burdened Households	Cost-Burdened Households, Percent
Central California CHNA	230,069	78,172	**33.98%**
Fresno County, CA	322,163	115,913	35.98%
Kern County, CA	281,416	102,854	36.55%
Kings County, CA	43,736	14,989	34.27%
Monterey County, CA	132,046	51,113	38.71%
San Benito County, CA	20,188	7,469	37.00%
Tulare County, CA	142,026	47,374	33.36%
California	13,434,847	5,158,482	38.40%
United States	127,482,865	37,330,839	29.28%



Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2019-23.



View larger map

Cost Burdened Households (Housing Costs Exceed 30% of Household Income), Percent by Tract, ACS 2019-23

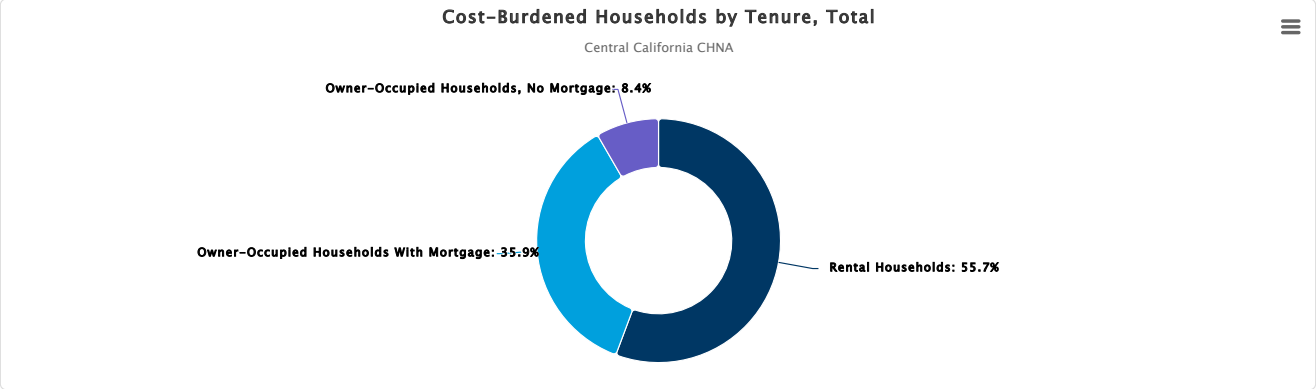
- Over 35.1%
- 28.1 - 35.0%
- 21.1 - 28.0%
- Under 21.1%
- No Data or Data Suppressed
- Central California CHNA

Cost-Burdened Households by Tenure, Total

These data show the number of households that spend more than 30% of the household income on housing costs. In the report area, there were 79,421 cost burdened households according to the U.S. Census Bureau American Community Survey (ACS) 2019-2023 5-year estimates. The data for this indicator is only reported for households where household housing costs and income earned was identified in the American Community Survey.

Report Area	Cost-Burdened Households	Cost-Burdened Rental Households	Cost-Burdened Owner-Occupied Households w/ Mortgage	Cost-Burdened Owner-Occupied Households w/o Mortgage
Central California CHNA	79,421	46,325	29,894	6,946
Fresno County, CA	115,913	74,013	38,892	8,509
Kern County, CA	102,854	58,836	39,334	9,297
Kings County, CA	14,989	9,159	5,347	1,180
Monterey County, CA	51,113	33,690	16,165	3,758
San Benito County, CA	7,469	3,084	4,237	537
Tulare County, CA	47,374	27,096	18,696	3,910
California	5,158,482	3,087,543	1,911,566	387,697
United States	37,330,839	20,909,407	13,886,916	4,391,728

Data Source: US Census Bureau, American Community Survey. 2019-23.

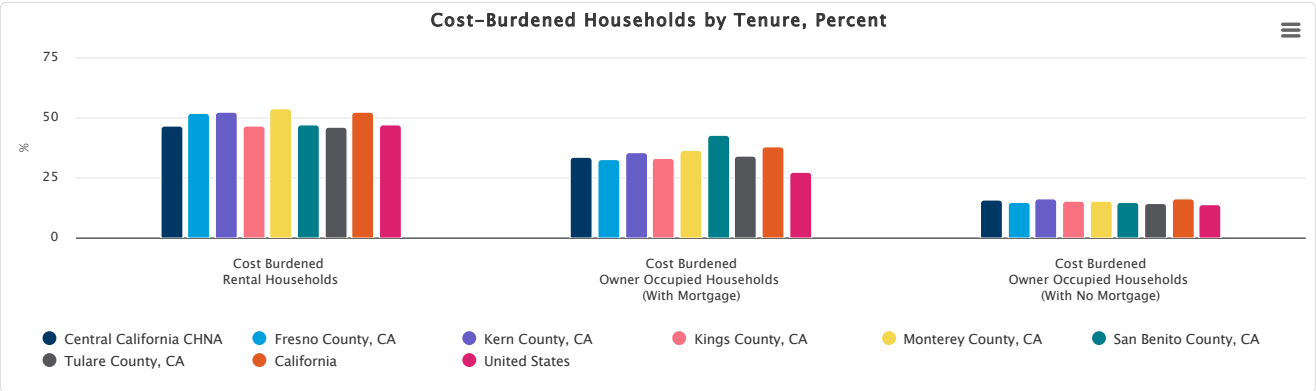


Cost-Burdened Households by Tenure, Percent

These data show the percentage of households by tenure that are cost burdened. Cost burdened rental households (those that spent more than 30% of the household income on rental costs) represented 46.29% of all of the rental households in the report area, according to the U.S. Census Bureau American Community Survey (ACS) 2019-2023 5-year estimates. The data for this indicator is only reported for households where tenure, household housing costs, and income earned was identified in the American Community Survey.

Report Area	Rental Households	Rental Households Cost-Burdened, Percent	Owner-Occupied Households w/ Mortgage	Owner-Occupied Households w/ Mortgage Cost-Burdened, Percent	Owner-Occupied Households w/o Mortgage	Owner-Occupied Households w/o Mortgage Cost-Burdened, Percent
Central California CHNA	100,076	46.29%	89,062	33.57%	44,949	15.45%
Fresno County, CA	143,630	51.53%	119,869	32.45%	58,664	14.50%
Kern County, CA	113,095	52.02%	111,333	35.33%	56,988	16.31%
Kings County, CA	19,760	46.35%	16,277	32.85%	7,699	15.33%
Monterey County, CA	63,013	53.47%	44,509	36.32%	24,524	15.32%
San Benito County, CA	6,575	46.90%	9,985	42.43%	3,628	14.80%
Tulare County, CA	58,773	46.10%	55,376	33.76%	27,877	14.03%
California	5,940,036	51.98%	5,095,484	37.51%	2,399,327	16.16%
United States	44,590,828	46.89%	50,718,449	27.38%	32,173,588	13.65%

Data Source: US Census Bureau, American Community Survey. 2019-23.

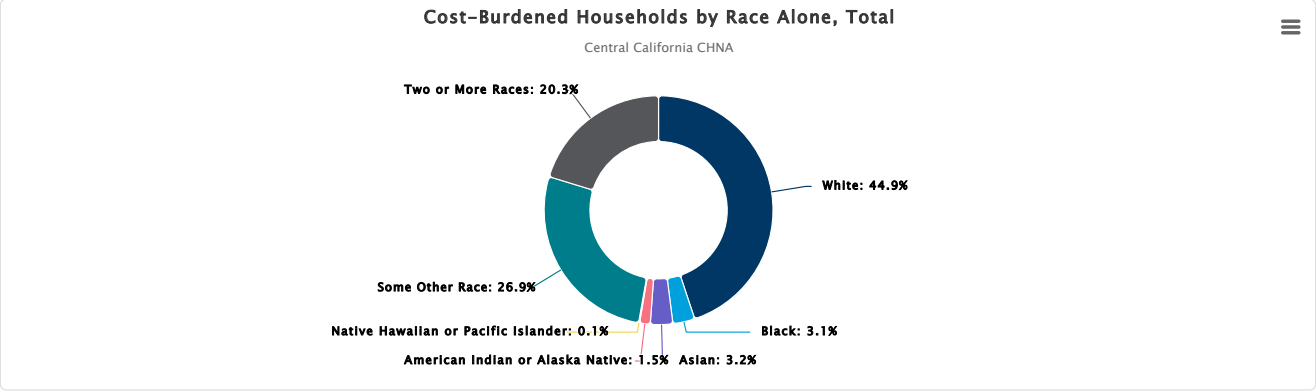


Cost-Burdened Households by Race Alone, Total

This indicator reports the number of cost-burdened households (i.e., those that spend more than 30% of their household income on housing costs) by the householder's race alone, without considering respondents' ethnicity. The data for this indicator is only reported for households where household housing costs, income earned, and race was identified in the 2019-23 American Community Survey.

Report Area	White	Black	Asian	American Indian or Alaska Native	Native Hawaiian or Pacific Islander	Some Other Race	Two or More Races
Central California CHNA	35,095	2,428	2,475	1,170	113	21,044	15,847
Fresno County, CA	52,600	7,507	10,314	1,885	297	22,065	21,245
Kern County, CA	52,858	7,603	3,721	1,548	181	16,620	20,323
Kings County, CA	7,225	1,431	472	288	17	3,040	2,516
Monterey County, CA	21,760	1,329	3,035	397	304	18,801	5,487
San Benito County, CA	4,029	203	167	60	24	997	1,989
Tulare County, CA	22,111	852	1,297	555	73	13,447	9,039
California	2,489,148	417,444	688,466	55,030	16,993	792,452	698,949
United States	22,465,807	6,393,544	1,974,714	286,541	67,283	2,530,433	3,612,517

Data Source: US Census Bureau, American Community Survey. 2019-23.

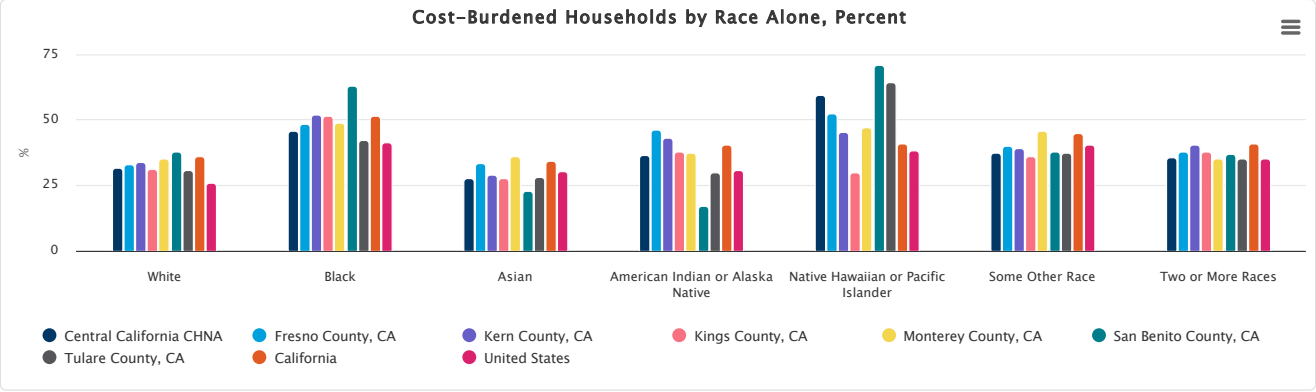


Cost-Burdened Households by Race Alone, Percent

This indicator reports the percentage of cost-burdened households (i.e., those that spend more than 30% of their household income on housing costs) by the householder's race alone, without considering respondents' ethnicity.
The percentage values could be interpreted as, for example, *"Of all occupied housing units with a white alone householder within the report area, the proportion whose housing costs exceed 30% of their household income in the past 12 months is (value)."* Note that data are only reported for households where household housing costs, income earned, and race was identified in the 2019-23 American Community Survey.

Report Area	White	Black	Asian	American Indian or Alaska Native	Native Hawaiian or Pacific Islander	Some Other Race	Two or More Races
Central California CHNA	31.52%	45.53%	27.55%	36.44%	59.47%	37.17%	35.70%
Fresno County, CA	32.92%	48.52%	33.42%	46.22%	52.11%	40.11%	37.68%
Kern County, CA	33.66%	51.99%	28.88%	42.98%	45.14%	39.20%	40.27%
Kings County, CA	31.01%	51.42%	27.73%	37.94%	29.82%	36.04%	37.55%
Monterey County, CA	34.94%	48.65%	35.93%	37.31%	46.84%	45.69%	34.90%
San Benito County, CA	37.64%	63.04%	22.54%	16.81%	70.59%	37.67%	36.96%
Tulare County, CA	30.78%	42.05%	28.23%	29.87%	64.04%	37.46%	35.16%
California	35.81%	51.44%	34.15%	40.37%	40.64%	44.89%	40.82%
United States	25.61%	41.10%	30.02%	30.74%	37.97%	40.56%	35.13%

Data Source: US Census Bureau, American Community Survey. 2019-23.



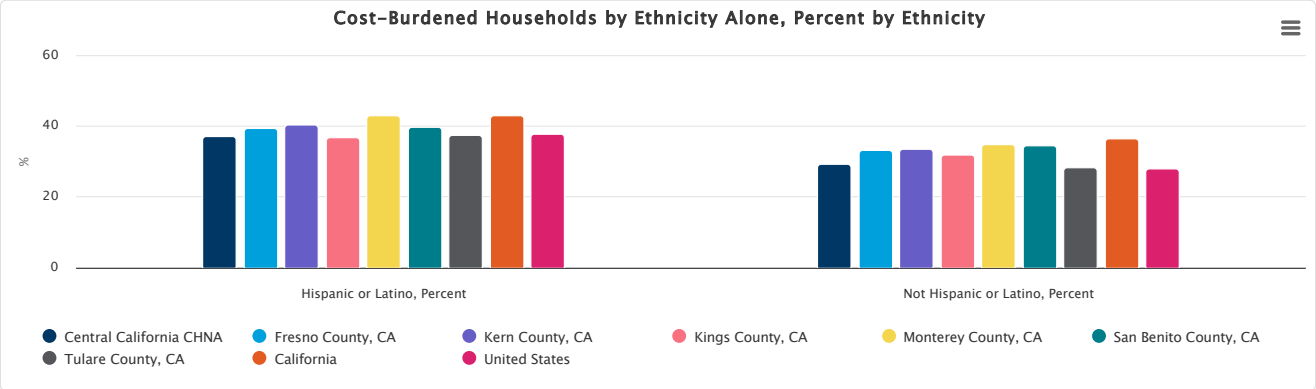
Cost-Burdened Households by Ethnicity Alone, Percent by Ethnicity

This indicator reports the percentage of households that spend more than 30% of their household income on housing costs by ethnicity alone during 2019-2023, according to the American Community Survey (ACS). Note that the data for this indicator are only reported for households where housing costs, income earned, and ethnicity were identified in the American Community Survey.

Within the report area, there were 51,097 cost-burdened households of Hispanic or Latino origin, representing 37.10% of the Hispanic or Latino households. There were 27,075 cost-burdened households of non-Hispanic or Latino origin in the report area, representing 29.32% of the total non-Hispanic households.

Report Area	Hispanic or Latino	Not Hispanic or Latino	Hispanic or Latino, Percent	Not Hispanic or Latino, Percent
Central California CHNA	51,097	27,075	37.10%	29.32%
Fresno County, CA	58,302	57,611	39.24%	33.19%
Kern County, CA	52,239	50,615	40.17%	33.44%
Kings County, CA	7,987	7,002	36.61%	31.95%
Monterey County, CA	27,135	23,978	42.92%	34.84%
San Benito County, CA	4,075	3,394	39.64%	34.26%
Tulare County, CA	29,836	17,538	37.22%	28.35%
California	1,771,076	3,387,406	43.00%	36.36%
United States	6,921,852	30,408,987	37.78%	27.86%

Data Source: US Census Bureau, American Community Survey. 2019-23.



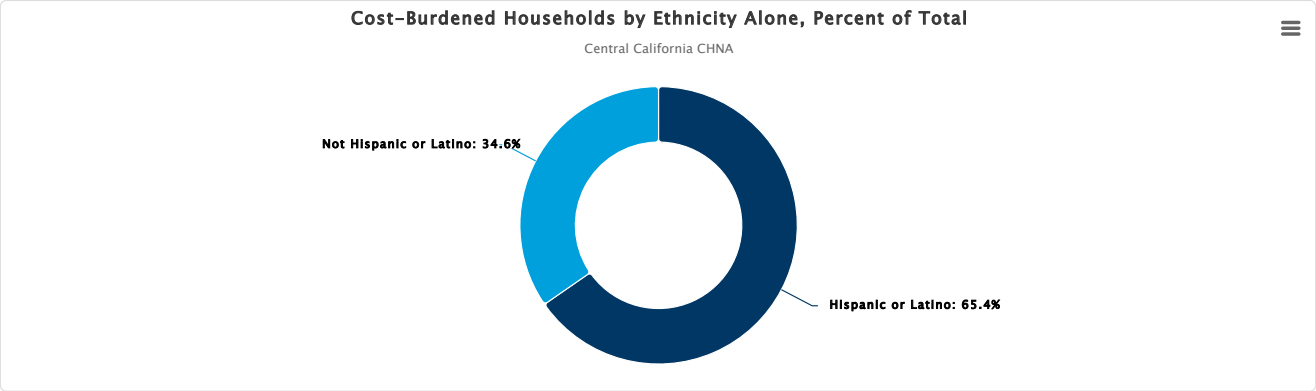
Cost-Burdened Households by Ethnicity Alone, Percent of Total

This indicator reports the percentage of households that spend more than 30% of their household income on housing costs by ethnicity alone during 2019-2023, according to the American Community Survey (ACS). Note that the data for this indicator are only reported for households where housing costs, income earned, and ethnicity were identified in the American Community Survey.

Within the report area, there were 51,097 cost-burdened households of Hispanic or Latino origin, representing 65.36% of the total cost-burdened households. There were 27,075 cost-burdened households of non-Hispanic or Latino origin in the report area, representing 34.64% of the total cost-burdened households.

Report Area	Hispanic or Latino	Not Hispanic or Latino	Hispanic or Latino, Percent	Not Hispanic or Latino, Percent
Central California CHNA	51,097	27,075	65.36%	34.64%
Fresno County, CA	58,302	57,611	50.30%	49.70%
Kern County, CA	52,239	50,615	50.79%	49.21%
Kings County, CA	7,987	7,002	53.29%	46.71%
Monterey County, CA	27,135	23,978	53.09%	46.91%
San Benito County, CA	4,075	3,394	54.56%	45.44%
Tulare County, CA	29,836	17,538	62.98%	37.02%
California	1,771,076	3,387,406	34.33%	65.67%
United States	6,921,852	30,408,987	18.54%	81.46%

Data Source: US Census Bureau, American Community Survey. 2019-23.



Mental Health

Mental health is a state of well-being where individuals cope with life's challenges, work productively and contribute to their communities. This concept goes beyond the absence of mental disorders, emphasizing the capacity for resilience, emotional stability and social well-being.

Mental health is an important component of overall health and is interdependent with social determinants such as income, education, social support and access to healthcare. Mental health conditions can increase the risk of chronic health conditions such as diabetes, heart disease and stroke. For instance, depression can lead to poor self-care which exacerbates certain health conditions (National Institute of Mental Health). Inversely, the presence of health conditions can increase the risk for mental illness as individuals with one or more chronic illnesses often experience higher levels of stress and anxiety, which can trigger mental health issues. According to the Substance Abuse and Mental Health Services Administration, 23.1% of U.S. adults (59.3 million) experienced a mental health condition in 2022. Living with a mental health condition can vary in severity, causing distress and negatively affecting personal, social and work life. For some, it can significantly impact their ability to carry out daily obligations.

The growing prevalence of mental health as an issue is affecting many community residents. People note a wide variety of factors that contribute to poor mental health, such as adverse childhood experiences and poverty. One focus group participant noted that the unhoused population with serious mental health disorders "don't have access to adequate mental health services or if they need to be on medication, they can't afford the medication because they don't have insurance." In the Central California service area, nearly one in five adults (19.6%) self-reported as having poor mental health, which can negatively impact overall health outcomes. Moreover, three out of every ten people on Medicare have been diagnosed with mental health and substance use prevalence. Focus group participants note that there is often "a waitlist for mental health providers, which if you [are] in crisis, you're going to have to call 9-1-1."

Community health and wellness can be difficult to achieve when indicators of poor mental health and the factors undermining them are prevalent. Opportunities to address mental health and improve outcomes do exist, despite increased risk factors. Securing more resources and programming, along with sharing existing opportunities, can improve overall health outcomes and reduce disparities. For additional data, see the following pages.

Scan QR Code to explore the full live data report on Mental Health or visit: cares.page.link/x1Jt

Data Highlights

Community Voices: *exploring local perceptions, thoughts & beliefs*

"...we have a wait list for mental health providers, which if you have or [are] in crisis, you're going to have to call 911...instead of actually going to your counselor."

"...that's something I've seen with youth, their depression, their anxieties...it hits them more when they're hitting eighth grade because they can't read. They're behind in math, they're not reading...because they're very distracted with social media."

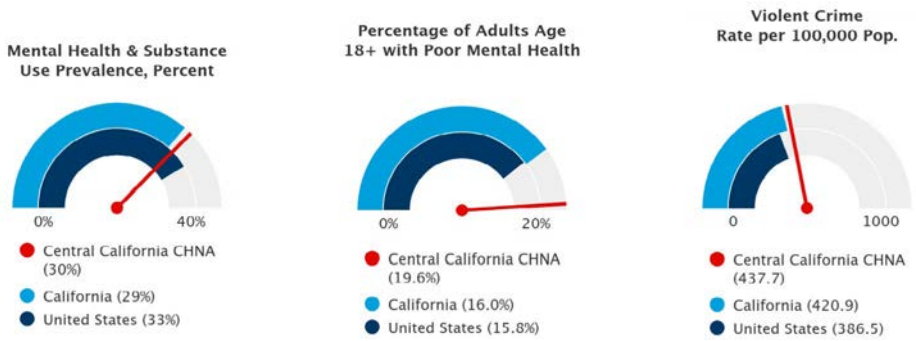
"...we know right now that a lot of kids [are] dealing with anxiety, trauma or they already tell themselves, I'm stressed."

"...serious mental health disorders really play a big part in the homeless population. And it can be really hard because...a lot of the time they don't have access to adequate mental health services or if they need to be on medication, they can't afford the medication because they don't have insurance..."

"...when you talk about the needs of mental health, you've got people who are cutters, you've got people who are bulimic...and I don't know anybody in this community that can help those specific needs."

"I think a positive trend is a focus on mental health. We do have social workers in all of our schools, so it's easier to assess somebody if a kid is having some kind of issues."

"...I do feel like the homeless population is really a symptom of a lot of other factors that we have in our community, drug use, the lack of of access and mental health early on..."



Community Resources

California Youth Crisis Hotline
800-843-5200

Central California Alliance for Health
thealliance.health/for-members/get-care/behavioral-health-care
800-700-3874

Crisis, Assessment, & Intervention Program (CAIP)
209-533-7000 or
Toll free 800-630-1130

Managing Stress & Depression
calhope.org
833-317-4673 English
833-642-7696 Spanish

Community Health Needs Assessment Full Report

Location

Central California CHNA

Health Needs: Mental Health

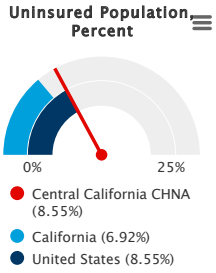
Risk Factors - Access to Care - Medical Insurance

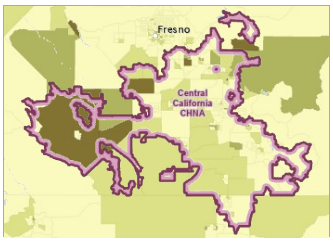
The lack of health insurance is considered a *key driver* of health status.

In the report area 8.55% of the total civilian non-institutionalized population are without health insurance coverage. The rate of uninsured persons in the report area is greater than the state average of 6.92%. This indicator is relevant because lack of insurance is a primary barrier to healthcare access including regular primary care, specialty care, and other health services that contributes to poor health status.

Report Area	Total Population (For Whom Insurance Status is Determined)	Uninsured Population	Uninsured Population, Percent
Central California CHNA	767,518	65,604	**8.55%**
Fresno County, CA	1,000,249	70,433	7.04%
Kern County, CA	888,229	69,712	7.85%
Kings County, CA	135,709	10,715	7.90%
Monterey County, CA	420,702	41,838	9.94%
San Benito County, CA	65,903	4,154	6.30%
Tulare County, CA	471,506	37,746	8.01%
California	38,761,738	2,682,732	6.92%
United States	327,425,278	28,000,876	8.55%

Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2019-23.





View larger map

Uninsured Population, Percent by Tract, ACS 2019-23

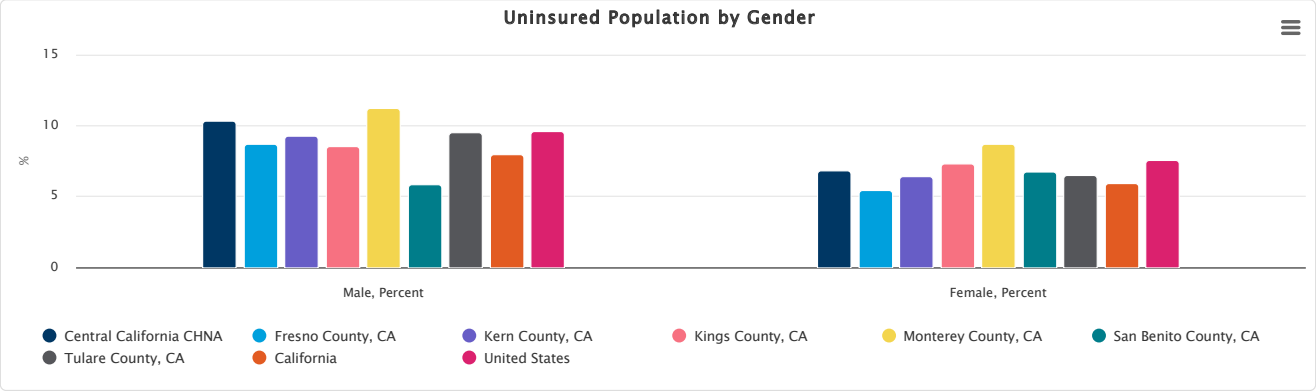
- Over 20.0%
- 15.1 - 20.0%
- 10.1 - 15.0%
- Under 10.1%
- No Data or Data Suppressed
- Central California CHNA

Uninsured Population by Gender

This indicator reports the uninsured population by gender.
The percentage values could be interpreted as, for example, *"Of all the male population within the report area, the proportion without health insurance coverage is (value)."*

Report Area	Male	Female	Male, Percent	Female, Percent
Central California CHNA	39,558	26,046	10.28%	6.81%
Fresno County, CA	43,242	27,191	8.69%	5.41%
Kern County, CA	41,040	28,672	9.26%	6.44%
Kings County, CA	5,786	4,929	8.48%	7.31%
Monterey County, CA	23,421	18,417	11.24%	8.68%
San Benito County, CA	1,942	2,212	5.85%	6.76%
Tulare County, CA	22,395	15,351	9.52%	6.50%
California	1,526,004	1,156,728	7.93%	5.92%
United States	15,443,840	12,557,036	9.59%	7.55%

Data Source: US Census Bureau, American Community Survey. 2019-23.

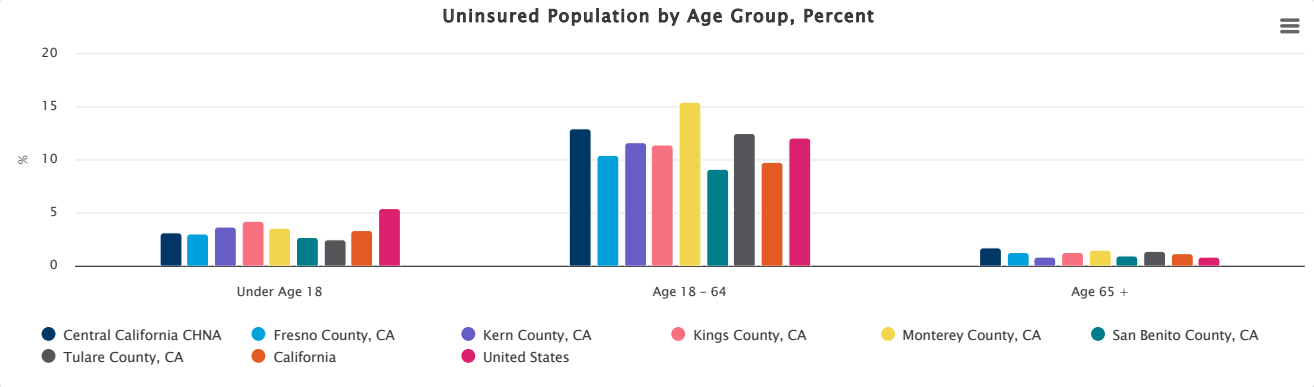


Uninsured Population by Age Group, Percent

This indicator reports the percentage of uninsured population by age group.
The percentage values could be interpreted as, for example, *"Of all the population under age 18 within the report area, the proportion without health insurance coverage is (value)."*

Report Area	Under Age 18	Age 18 - 64	Age 65 +
Central California CHNA	3.12%	12.92%	1.70%
Fresno County, CA	2.97%	10.43%	1.21%
Kern County, CA	3.68%	11.55%	0.85%
Kings County, CA	4.23%	11.31%	1.29%
Monterey County, CA	3.50%	15.34%	1.52%
San Benito County, CA	2.71%	9.11%	0.88%
Tulare County, CA	2.48%	12.48%	1.41%
California	3.35%	9.77%	1.09%
United States	5.39%	11.98%	0.83%

Data Source: US Census Bureau, American Community Survey. 2019-23.

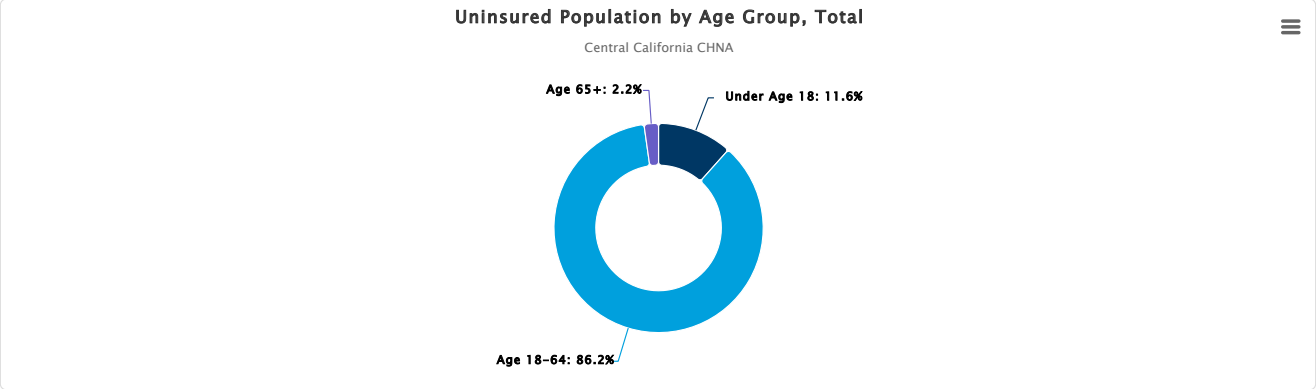


Uninsured Population by Age Group, Total

This indicator reports the total uninsured population by age group.

Report Area	Under Age 18	Age 18-64	Age 65+
Central California CHNA	7,607	56,534	1,463
Fresno County, CA	8,891	60,015	1,527
Kern County, CA	10,179	58,653	880
Kings County, CA	1,828	8,684	203
Monterey County, CA	4,176	36,718	944
San Benito County, CA	478	3,598	78
Tulare County, CA	3,724	33,251	771
California	310,351	2,307,944	64,437
United States	4,208,983	23,338,717	453,176

Data Source: US Census Bureau, American Community Survey. 2019-23.

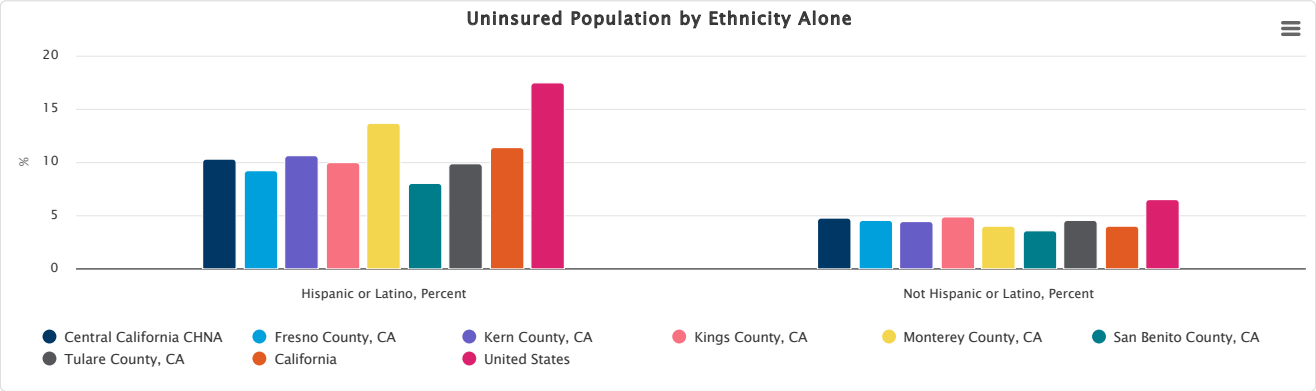


Uninsured Population by Ethnicity Alone

This indicator reports the uninsured population by ethnicity alone.
The percentage values could be interpreted as, for example, *"Of all the Hispanic population within the report area, the proportion without health insurance coverage is (value)."*

Report Area	Hispanic or Latino	Not Hispanic or Latino	Hispanic or Latino, Percent	Not Hispanic or Latino, Percent
Central California CHNA	54,236	11,368	10.32%	4.69%
Fresno County, CA	49,545	20,888	9.14%	4.56%
Kern County, CA	52,544	17,168	10.57%	4.39%
Kings County, CA	8,095	2,620	9.99%	4.79%
Monterey County, CA	35,505	6,333	13.59%	3.97%
San Benito County, CA	3,260	894	8.00%	3.55%
Tulare County, CA	30,617	7,129	9.81%	4.47%
California	1,760,029	922,703	11.37%	3.96%
United States	10,900,185	17,100,691	17.47%	6.45%

Data Source: US Census Bureau, American Community Survey. 2019-23.

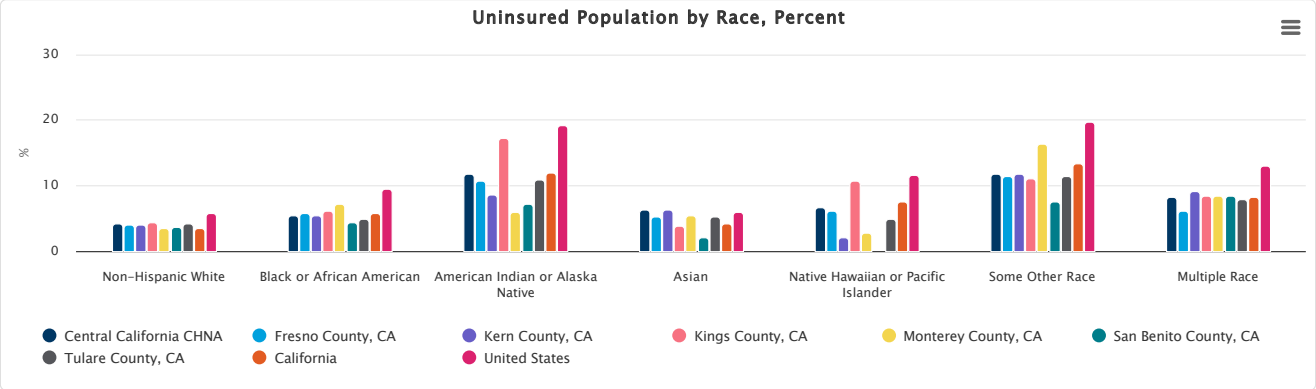


Uninsured Population by Race, Percent

This indicator reports the percentage of uninsured population by race alone.
The percentage values could be interpreted as, for example, *"Of all the non-Hispanic white population within the report area, the proportion without health insurance coverage is (value)."*

Report Area	Non-Hispanic White	Black or African American	American Indian or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
Central California CHNA	4.20%	5.47%	11.79%	6.23%	6.60%	11.70%	8.23%
Fresno County, CA	3.99%	5.75%	10.73%	5.29%	6.13%	11.33%	6.08%
Kern County, CA	3.92%	5.42%	8.54%	6.18%	2.08%	11.73%	9.03%
Kings County, CA	4.36%	6.07%	17.15%	3.76%	10.66%	11.01%	8.33%
Monterey County, CA	3.37%	7.17%	5.90%	5.39%	2.74%	16.26%	8.44%
San Benito County, CA	3.57%	4.29%	7.16%	1.97%	0.00%	7.42%	8.45%
Tulare County, CA	4.19%	4.79%	10.82%	5.25%	4.79%	11.33%	7.78%
California	3.52%	5.65%	11.90%	4.06%	7.56%	13.37%	8.27%
United States	5.71%	9.46%	19.22%	5.89%	11.59%	19.70%	12.98%

Data Source: US Census Bureau, American Community Survey. 2019-23.

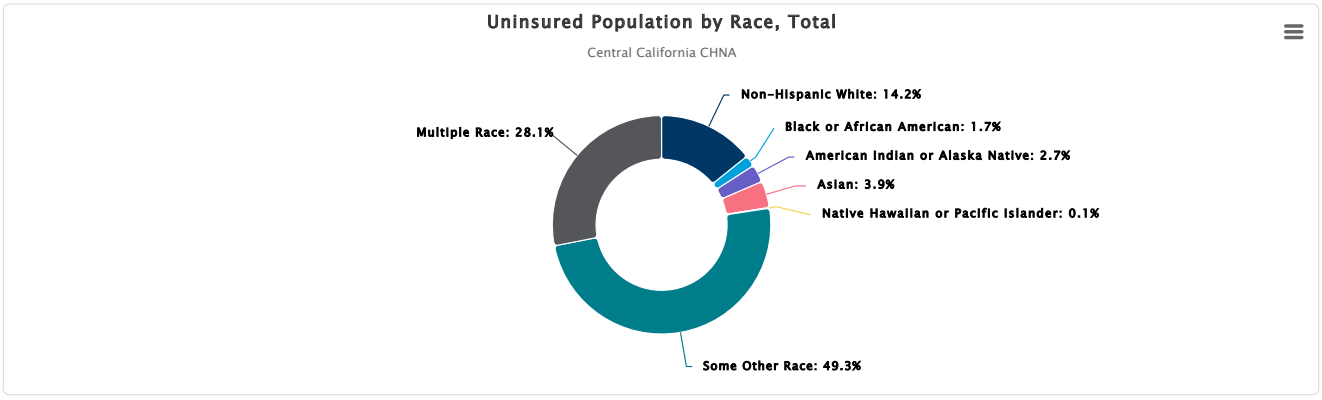


Uninsured Population by Race, Total

This indicator reports the total uninsured population by race alone.

Report Area	Non-Hispanic White	Black or African American	American Indian or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
Central California CHNA	7,266	843	1,353	1,995	63	25,170	14,339
Fresno County, CA	10,751	2,485	1,477	5,852	100	22,981	12,770
Kern County, CA	10,734	2,280	915	2,832	29	18,699	17,075
Kings County, CA	1,672	407	456	176	29	3,314	2,280
Monterey County, CA	3,820	521	195	1,321	58	28,387	4,847
San Benito County, CA	710	29	88	45	0	763	1,821
Tulare County, CA	5,165	333	759	877	33	15,713	7,824
California	471,187	118,238	52,186	242,128	10,982	903,127	524,941
United States	10,876,176	3,775,959	549,575	1,134,010	71,131	4,280,782	4,567,337

Data Source: US Census Bureau, American Community Survey. 2019-23.



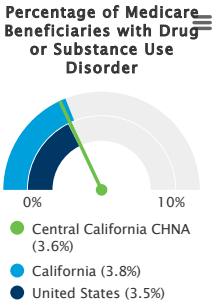
Risk Factors - Drugs & Alcohol - Substance Use Disorder

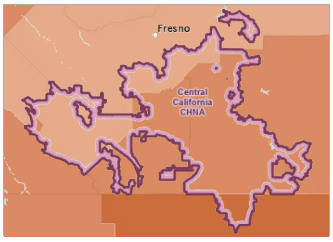
This indicator reports the percentage of the Medicare Fee-for-Service population with substance use disorder. Data are based upon Medicare administrative enrollment and claims data for Medicare beneficiaries enrolled in the Fee-for-Service program.

Within the report area, there are a total of 2,500 beneficiaries with substance use disorder. This represents a 3.6% of the Medicare Fee-for-Service beneficiaries.

Report Area	Total Medicare Fee-for-Service Beneficiaries	Beneficiaries with Drug/Substance Use Disorder	Percentage with Drug/Substance Use Disorder
Central California CHNA	69,913	2,500	3.6%
Fresno County, CA	77,958	2,247	2.9%
Kern County, CA	61,717	3,120	5.1%
Kings County, CA	12,512	403	3.2%
Monterey County, CA	53,963	1,622	3.0%
San Benito County, CA	6,717	139	2.1%
Tulare County, CA	45,846	1,703	3.7%
California	2,859,642	107,557	3.8%
United States	33,499,472	1,172,214	3.5%

Note: This indicator is compared to the state average.
Data Source: Centers for Medicare & Medicaid Services, Centers for Medicare & Medicaid Services - Chronic Conditions. 2018.





View larger map

Beneficiaries with Drug/Substance Use Disorder, Percent by County, CMS 2018

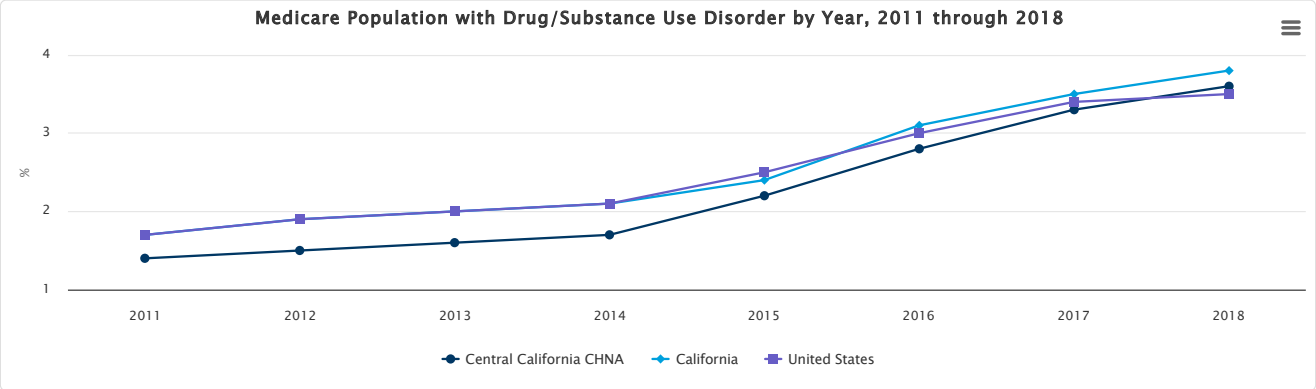
- Over 5.0%
- 3.1 - 5.0%
- 2.1 - 3.0%
- Under 2.1%
- No Data or Data Suppressed
- Central California CHNA

Medicare Population with Drug/Substance Use Disorder by Year, 2011 through 2018

This indicator reports the percentage of the Medicare Fee-for-Service population with drug or substance use disorders over time.

Report Area	2011	2012	2013	2014	2015	2016	2017	2018
Central California CHNA	1.4%	1.5%	1.6%	1.7%	2.2%	2.8%	3.3%	3.6%
California	1.7%	1.9%	2.0%	2.1%	2.4%	3.1%	3.5%	3.8%
United States	1.7%	1.9%	2.0%	2.1%	2.5%	3.0%	3.4%	3.5%

Data Source: Centers for Medicare & Medicaid Services, Centers for Medicare & Medicaid Services - Chronic Conditions. 2018.

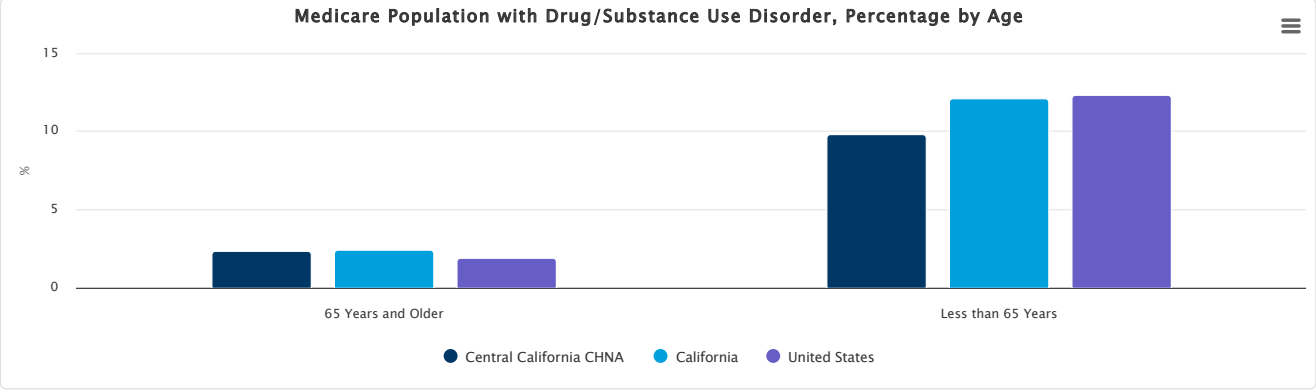


Medicare Population with Drug/Substance Use Disorder, Percentage by Age

This indicator reports the prevalence of drug or substance use disorders among Medicare beneficiaries by age.
The percentage values could be interpreted as, for example, *"Of all the Medicare beneficiaries age 65 and older within the report area, the proportion with drug or substance use disorders is (value)."*

Report Area	65 Years and Older	Less than 65 Years
Central California CHNA	2.3%	9.8%
California	2.4%	12.1%
United States	1.9%	12.3%

Data Source: Centers for Medicare & Medicaid Services, Centers for Medicare & Medicaid Services - Chronic Conditions. 2018.



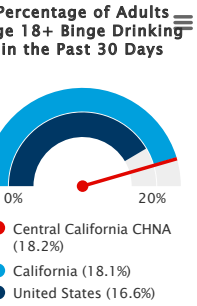
Risk Factors - Drugs & Alcohol - Binge Drinking

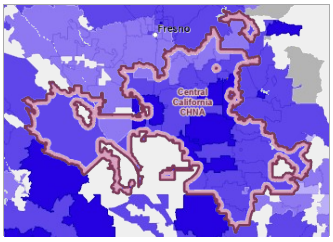
This indicator reports the percentage of adults age 18 and older who report having five or more drinks (men) or four or more drinks (women) on an occasion in the past 30 days.

Within the report area there are 18.2% adults age 18+ who reported having four or more drinks in the last month of the total population age 18+.

Report Area	Total Population	Adults Age 18+ Binge Drinking in the Past 30 Days (Crude)	Adults Age 18+ Binge Drinking in the Past 30 Days (Age-Adjusted)
Central California CHNA	795,651	**18.2%**	No data
Fresno County, CA	1,015,190	16.3%	16.2%
Kern County, CA	916,108	18.1%	17.7%
Kings County, CA	152,981	19.7%	18.8%
Monterey County, CA	432,858	17.0%	17.6%
San Benito County, CA	67,579	19.6%	19.9%
Tulare County, CA	477,544	18.9%	18.6%
California	39,029,342	18.1%	18.8%
United States	333,287,557	16.6%	18.0%

Note: This indicator is compared to the state average.
Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2022 .





View larger map

Binge Drinking, Percent of Adults Age 18+ by ZCTA, CDC BRFSS PLACES Project 2022

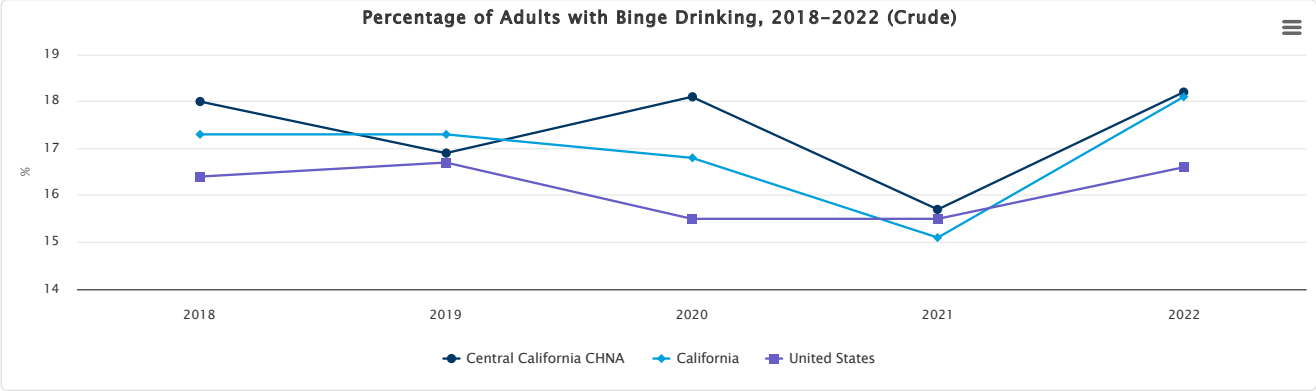
- Over 19.0%
- 16.1 - 19.0%
- 13.1 - 16.0%
- Under 13.1%
- No Data or Data Suppressed
- Central California CHNA

Percentage of Adults with Binge Drinking, 2018-2022 (Crude)

The table and chart below display annual trends in the percentage of adults age 18+ who report binge drinking.

Report Area	2018	2019	2020	2021	2022
Central California CHNA	18.0%	16.9%	18.1%	15.7%	18.2%
California	17.3%	17.3%	16.8%	15.1%	18.1%
United States	16.4%	16.7%	15.5%	15.5%	16.6%

Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2022 .

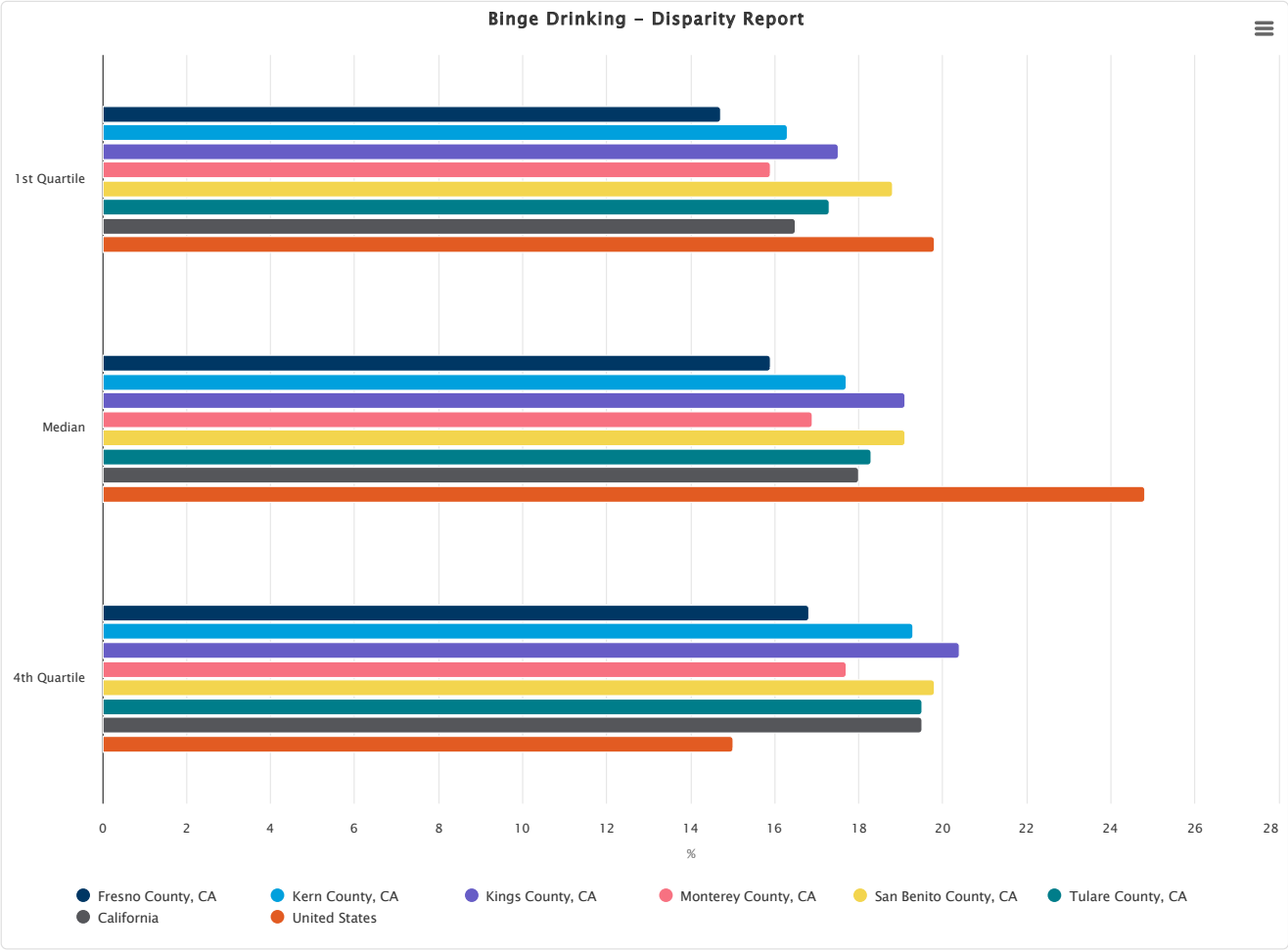


Binge Drinking - Disparity Report

The table and chart below display the median and interquartile ranges for census tract values related to the indicator.

Report Area	1st Quartile	Median	4th Quartile
Fresno County, CA	14.70%	15.90%	16.80%
Kern County, CA	16.30%	17.70%	19.30%
Kings County, CA	17.50%	19.10%	20.40%
Monterey County, CA	15.90%	16.90%	17.70%
San Benito County, CA	18.80%	19.10%	19.80%
Tulare County, CA	17.30%	18.30%	19.50%
California	16.50%	18.00%	19.50%
United States	19.80%	24.80%	15.00%

Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2022 .

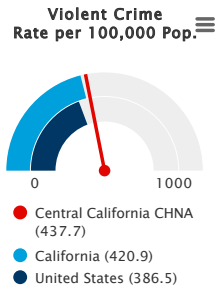


Risk Factors - Stress & Trauma - Violent Crime Rate

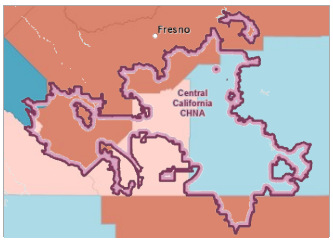
This indicator reports the rate of violent crime offenses reported by law enforcement per 100,000 residents. Violent crime includes homicide, rape, robbery, and aggravated assault. The data for this indicator are obtained from the 2022 County Health Rankings, which utilizes figures from the 2014 and 2016 FBI Uniform Crime Reports. This indicator is relevant because it assesses community safety.

In the report area, 3,388 violent crimes occurred in 2014 and 2016 (two years). The violent crime rate of 437.7 per 100,000 residents is higher than the statewide rate of 420.9 per 100,000.
Note: Data are suppressed for counties if, for both years of available data, the population reported by agencies is less than 50% of the population reported in Census or less than 80% of agencies measuring crimes reported data.

Report Area	Violent Crimes	Violent Crime Rate (Per 100,000 Pop.)
Central California CHNA	3,388	**437.7**
Fresno County, CA	5,264	541.8
Kern County, CA	4,797	545.3
Kings County, CA	668	443.4
Monterey County, CA	1,828	420.6
San Benito County, CA	176	298.7
Tulare County, CA	1,756	381.8
California	164,253	420.9
United States	1,240,534	386.5



Note: This indicator is compared to the state average.
Data Source: Federal Bureau of Investigation, FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research. 2014&2016.



View larger map

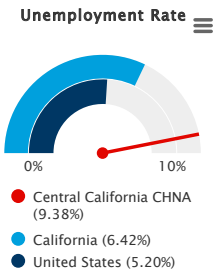
Violent Crime, Rank by County, County Health Rankings 2022

- 1st Quartile (Top 25%)
- 2nd Quartile
- 3rd Quartile
- 4th Quartile (Bottom 25%)
- Bottom Quintile (Rhode Island Only)
- No Data or Data Suppressed; -1
- Central California CHNA

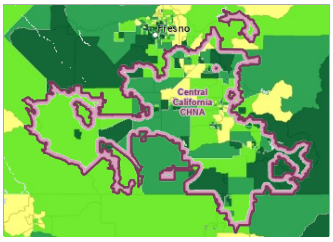
Risk Factors - Stress & Trauma - Unemployment

According to the most recent American Community Survey estimates, total unemployment in the report area is 33,391, or 9.38% of the civilian labor force. This indicator is relevant because unemployment creates financial instability and barriers to access including insurance coverage, health services, healthy food, and other necessities that contribute to poor health status.

Report Area	Labor Force	Number Unemployed	Unemployment Rate
Central California CHNA	356,134	33,391	**9.38%**
Fresno County, CA	466,586	39,771	8.55%
Kern County, CA	398,143	33,049	8.35%
Kings County, CA	64,752	5,787	9.82%
Monterey County, CA	202,644	10,068	5.13%
San Benito County, CA	34,250	2,038	5.96%
Tulare County, CA	211,707	18,688	8.85%
California	20,144,078	1,282,259	6.42%
United States	169,855,626	8,759,317	5.20%



Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2019-23.



View larger map

Unemployed Workers, Percent by Tract, ACS 2019-23

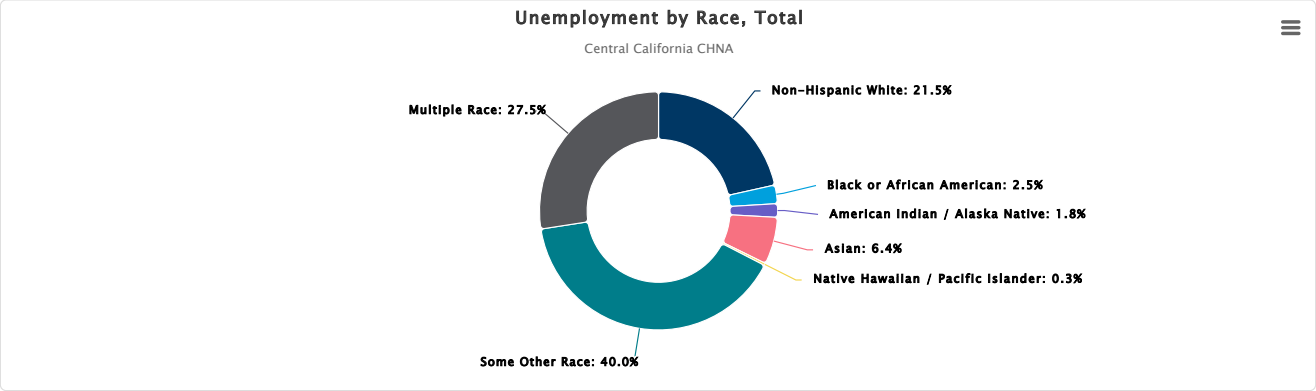
- Over 12.0%
- 8.1 - 12.0%
- 4.1 - 8.0%
- Under 4.1%
- No Data or Data Suppressed
- Central California CHNA

Unemployment by Race, Total

This indicator reports the total count of unemployed population in the report area by race.

Report Area	Non-Hispanic White	Black or African American	American Indian / Alaska Native	Asian	Native Hawaiian / Pacific Islander	Some Other Race	Multiple Race
Central California CHNA	5,700	669	489	1,695	77	10,594	7,274
Fresno County, CA	7,593	2,408	785	3,603	24	9,627	9,213
Kern County, CA	9,265	2,781	562	1,220	76	6,236	7,187
Kings County, CA	1,438	340	124	164	31	1,530	1,134
Monterey County, CA	3,091	251	129	796	164	2,733	1,622
San Benito County, CA	465	2	27	17	2	381	499
Tulare County, CA	3,834	272	357	676	31	6,417	3,890
California	413,831	106,059	18,806	158,934	6,166	236,196	227,927
United States	4,184,342	1,757,752	108,909	456,672	22,627	698,102	1,076,447

Data Source: US Census Bureau, American Community Survey. 2019-23.

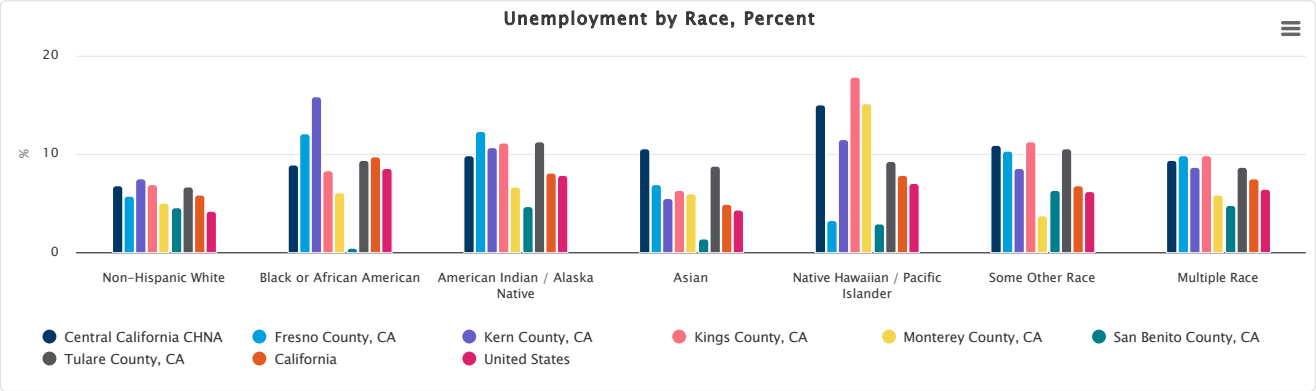


Unemployment by Race, Percent

This indicator reports the percentage of unemployed population in the report area by race. The values could be interpreted as, for example, *"Of all the Non-Hispanic White population in civilian labor force in the report area, the unemployment rate is (value)."*

Report Area	Non-Hispanic White	Black or African American	American Indian / Alaska Native	Asian	Native Hawaiian / Pacific Islander	Some Other Race	Multiple Race
Central California CHNA	6.72%	8.84%	9.82%	10.54%	15.01%	10.92%	9.38%
Fresno County, CA	5.70%	12.06%	12.30%	6.85%	3.27%	10.28%	9.81%
Kern County, CA	7.49%	15.78%	10.67%	5.45%	11.45%	8.54%	8.60%
Kings County, CA	6.92%	8.30%	11.16%	6.28%	17.82%	11.19%	9.78%
Monterey County, CA	5.03%	6.11%	6.69%	5.94%	15.12%	3.68%	5.81%
San Benito County, CA	4.50%	0.43%	4.65%	1.30%	2.90%	6.27%	4.71%
Tulare County, CA	6.64%	9.39%	11.22%	8.72%	9.28%	10.49%	8.61%
California	5.81%	9.76%	8.07%	4.88%	7.88%	6.77%	7.44%
United States	4.17%	8.58%	7.87%	4.28%	7.05%	6.21%	6.40%

Data Source: US Census Bureau, American Community Survey. 2019-23.

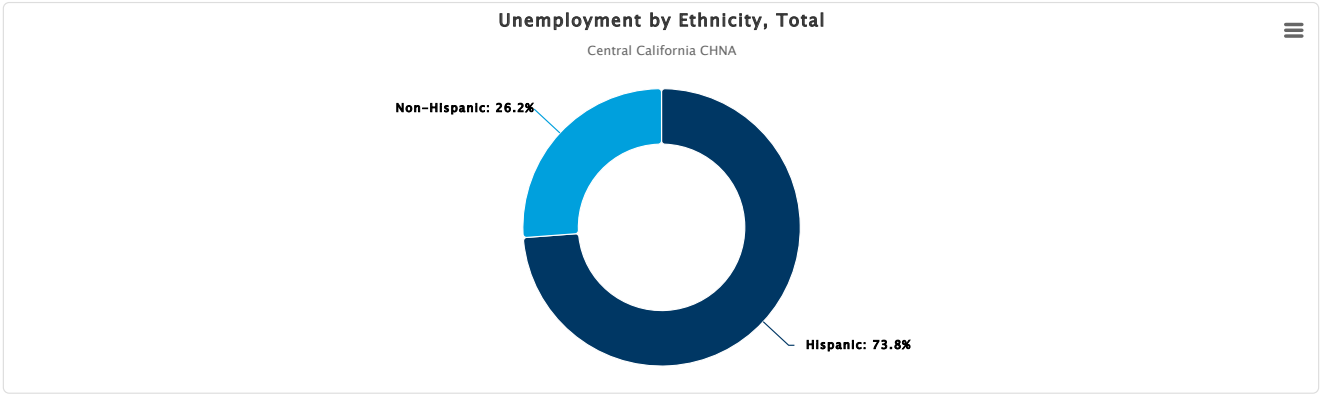


Unemployment by Ethnicity, Total

This indicator reports the total count of unemployed population in the report area by ethnicity.

Report Area	Hispanic	Non-Hispanic
Central California CHNA	24,319	8,627
Fresno County, CA	24,644	15,127
Kern County, CA	18,208	14,841
Kings County, CA	3,643	2,144
Monterey County, CA	5,342	4,726
San Benito County, CA	1,509	529
Tulare County, CA	13,663	5,025
California	537,311	744,948
United States	1,889,916	6,869,401

Data Source: US Census Bureau, American Community Survey. 2019-23.

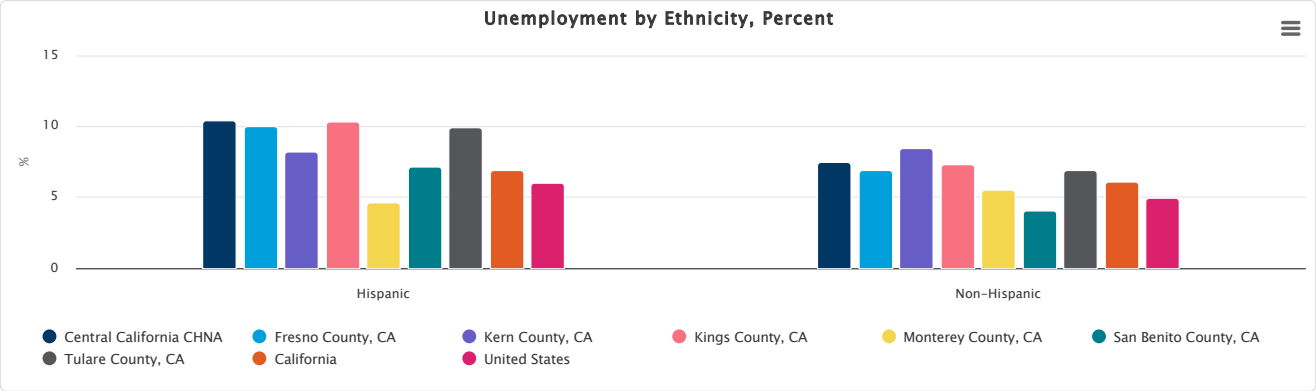


Unemployment by Ethnicity, Percent

This indicator reports the percentage of unemployed population in the report area by ethnicity. The values could be interpreted as, for example, *"Of all the Hispanic population in civilian labor force in the report area, the unemployment rate is (value)."*

Report Area	Hispanic	Non-Hispanic
Central California CHNA	10.40%	7.43%
Fresno County, CA	10.01%	6.86%
Kern County, CA	8.20%	8.42%
Kings County, CA	10.33%	7.27%
Monterey County, CA	4.58%	5.49%
San Benito County, CA	7.14%	4.04%
Tulare County, CA	9.88%	6.85%
California	6.87%	6.04%
United States	6.00%	4.97%

Data Source: US Census Bureau, American Community Survey. 2019-23.

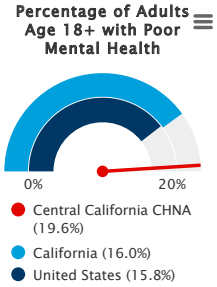


Health Outcomes - Anxiety & Depression - Poor Mental Health

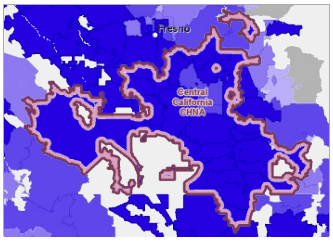
This indicator reports the percentage of adults age 18 and older who report 14 or more days during the past 30 days during which their mental health was not good.

Within the report area, there were 19.6% of adults 18 and older who reported poor mental health in the past month of the total population age 18 and older.

Report Area	Total Population	Adults Age 18+ with Poor Mental Health (Crude)	Adults Age 18+ with Poor Mental Health (Age-Adjusted)
Central California CHNA	795,651	19.6%	No data
Fresno County, CA	1,015,190	18.7%	18.6%
Kern County, CA	916,108	18.8%	18.5%
Kings County, CA	152,981	19.5%	19.0%
Monterey County, CA	432,858	17.9%	18.1%
San Benito County, CA	67,579	16.2%	16.5%
Tulare County, CA	477,544	19.5%	19.3%
California	39,029,342	16.0%	16.4%
United States	333,287,557	15.8%	16.4%



Note: This indicator is compared to the state average.
Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2022 .



View larger map

Frequent Mental Distress, Prevalence Among Adults Age 18+ by ZCTA, CDC BRFSS PLACES Project 2022

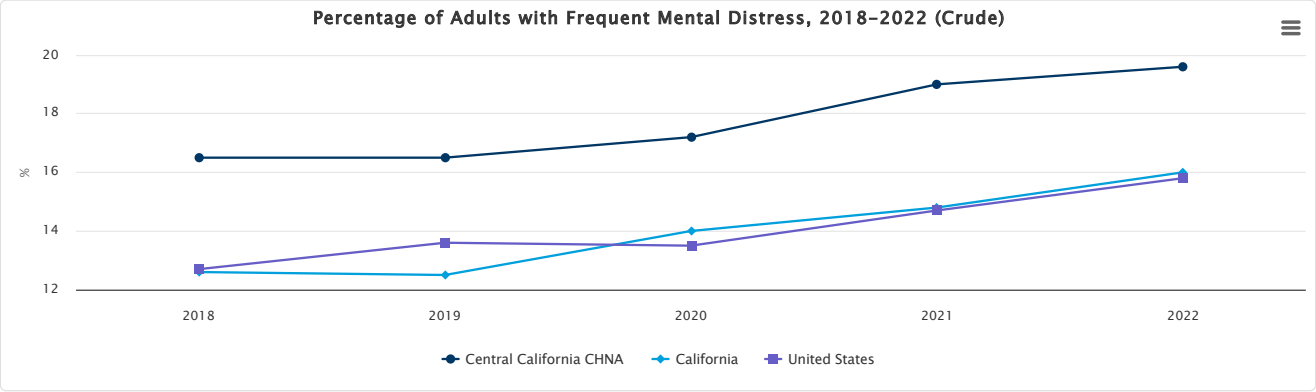
- Over 18.0%
- 16.1 - 18.0%
- 14.1 - 16.0%
- Under 14.1%
- No Data or Data Suppressed
- Central California CHNA

Percentage of Adults with Frequent Mental Distress, 2018-2022 (Crude)

The table and chart below display annual trends in the percentage of adults age 18+ whose report frequent mental distress.

Report Area	2018	2019	2020	2021	2022
Central California CHNA	16.5%	16.5%	17.2%	19.0%	19.6%
California	12.6%	12.5%	14.0%	14.8%	16.0%
United States	12.7%	13.6%	13.5%	14.7%	15.8%

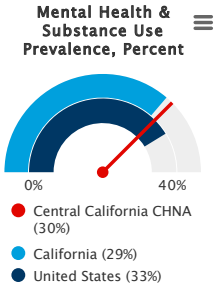
Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2022 .



Health Outcomes - Anxiety & Depression - Mental Health Diagnoses

This indicator reports the unsmoothed age-adjusted rate of mental health & substance use prevalence for Medicare FFS population in 2022. Data were obtained from the CMS Mapping Medicare Disparities tool.
Note: Data are suppressed 1) where total population is less than 11 or 2) when the count of a measure is less than 3 (rate displayed as zero for such counties.)

Report Area	FFS Beneficiaries	Mental Health & Substance Use Prevalence, Total	Mental Health & Substance Use Prevalence, Percent
Central California CHNA	65,296	19,791	**30%**
Fresno County, CA	74,538	20,871	28%
Kern County, CA	59,305	18,385	31%
Kings County, CA	11,551	3,465	30%
Monterey County, CA	54,612	14,199	26%
San Benito County, CA	6,902	1,795	26%
Tulare County, CA	42,539	13,187	31%
California	2,778,184	805,673	29%
United States	30,900,366	10,197,121	33%



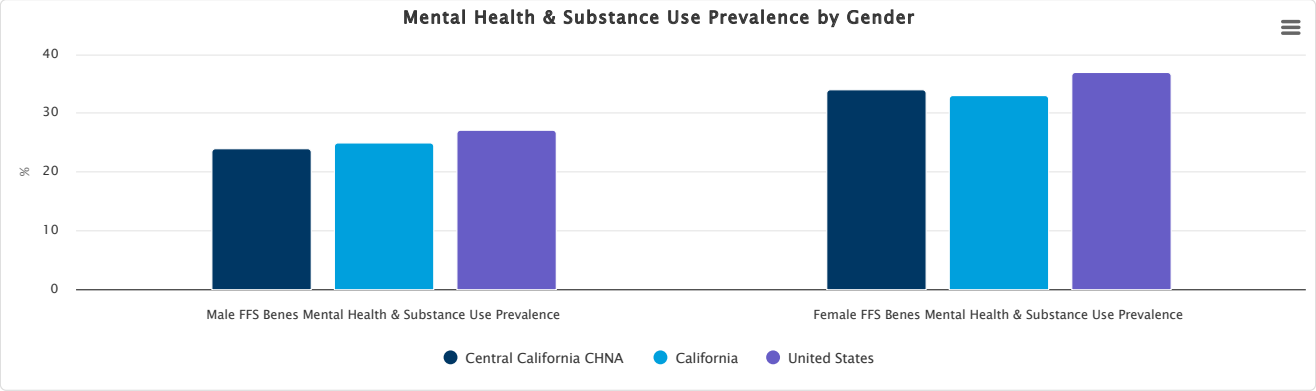
Note: This indicator is compared to the state average.
Data Source: Centers for Medicare and Medicaid Services, Mapping Medicare Disparities Tool. 2022.

Mental Health & Substance Use Prevalence by Gender

This indicator reports the unsmoothed age-adjusted rate of mental health & substance use prevalence by gender for Medicare FFS population in 2022.
Note: Data are suppressed 1) where total population is less than 11 or 2) when the count of a measure is less than 3 or greater than 0 (rate displayed as zero.)

Report Area	Male FFS Benes	Female FFS Benes	Male FFS Benes Mental Health & Substance Use Prevalence, Percent	Female FFS Benes Mental Health & Substance Use Prevalence, Percent
Central California CHNA	30,681	34,614	24%	34%
California	1,273,797	1,504,387	25%	33%
United States	14,047,306	16,853,060	27%	37%

Data Source: Centers for Medicare and Medicaid Services, Mapping Medicare Disparities Tool. 2022.

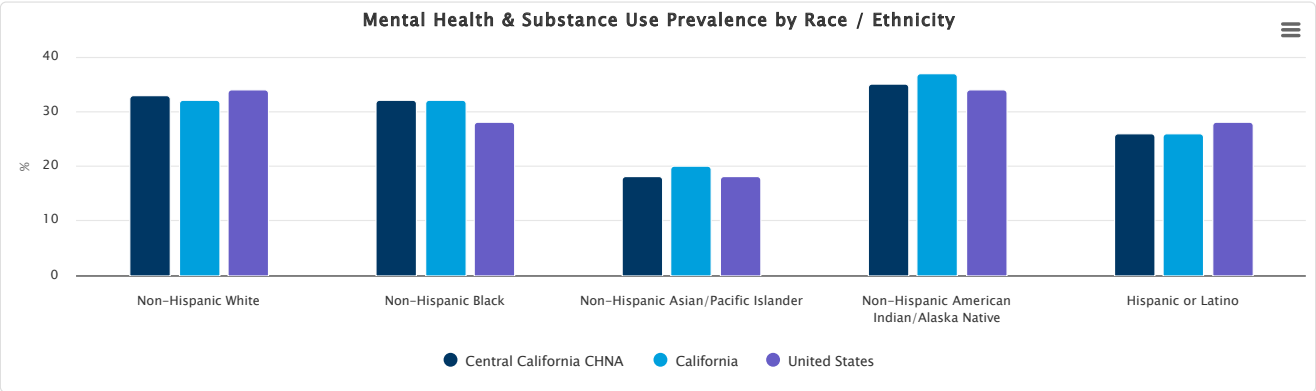


Mental Health & Substance Use Prevalence by Race / Ethnicity

This indicator reports the unsmoothed age-adjusted rate of mental health & substance use prevalence by race and ethnicity for Medicare FFS population in 2022.
Note: Data are suppressed 1) where total population is less than 11 or 2) when the count of a measure is less than 3 or greater than 0 (rate displayed as zero.)

Report Area	Non-Hispanic White	Non-Hispanic Black	Non-Hispanic Asian/Pacific Islander	Non-Hispanic American Indian/Alaska Native	Hispanic or Latino
Central California CHNA	33%	32%	18%	35%	26%
California	32%	32%	20%	37%	26%
United States	34%	28%	18%	34%	28%

Data Source: Centers for Medicare and Medicaid Services, Mapping Medicare Disparities Tool. 2022.

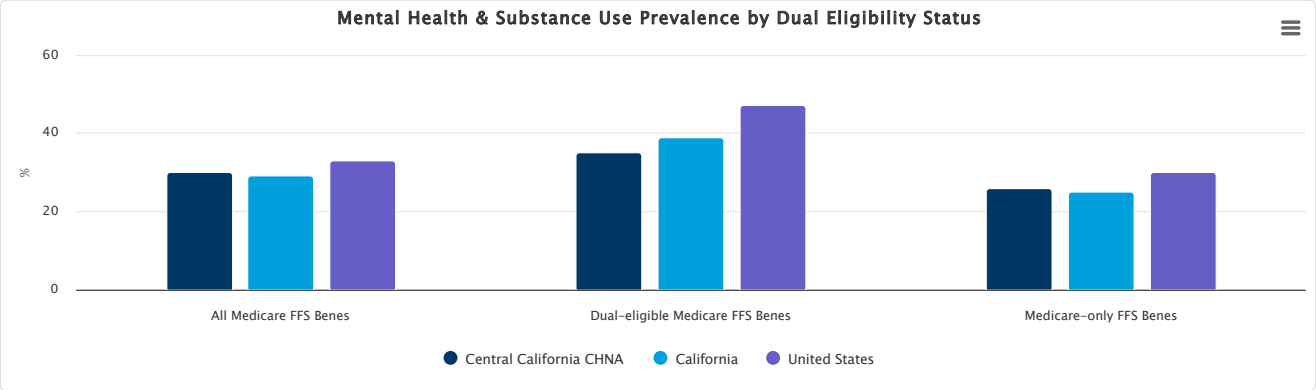


Mental Health & Substance Use Prevalence by Dual Eligibility Status

This indicator reports the unsmoothed age-adjusted rate of mental health & substance use prevalence by dual eligibility status for Medicare FFS population in 2022.
Note: Data are suppressed 1) where total population is less than 11 or 2) when the count of a measure is less than 3 or greater than 0 (rate displayed as zero.)

Report Area	All Medicare FFS Benes	Dual-eligible Medicare FFS Benes	Medicare-only FFS Benes
Central California CHNA	30%	35%	26%
California	29%	39%	25%
United States	33%	47%	30%

Data Source: Centers for Medicare and Medicaid Services, Mapping Medicare Disparities Tool. 2022.



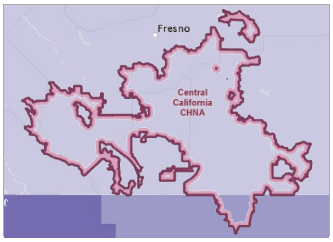
Health Outcomes - Deaths of Despair - Suicide Mortality

This indicator reports the 2019-2023 five-year average rate of death due to intentional self-harm (suicide) per 100,000 population. Figures are reported as crude rates. Rates are resummarized for report areas from county level data, only where data is available. This indicator is relevant because suicide is an indicator of poor mental health.

Within the report area, there are a total of 389 deaths due to suicide. This represents a crude death rate of 9.8 per every 100,000 total population.
Note: Data are suppressed for counties with fewer than 20 deaths in the time frame.

Report Area	Total Population, 2018-2022 Average	Five Year Total Deaths, 2018-2022 Total	Crude Death Rate (Per 100,000 Population)
Central California CHNA	796,838	389	9.8
Fresno County, CA	1,009,190	511	10.1
Kern County, CA	909,833	588	12.9
Kings County, CA	152,948	85	11.1
Monterey County, CA	433,175	233	10.8
San Benito County, CA	65,859	21	6.4
Tulare County, CA	473,788	205	8.7
California	39,222,534	21,240	10.8
United States	331,563,969	240,465	14.5

Note: This indicator is compared to the state average.
Data Source: Centers for Disease Control and Prevention, CDC - National Vital Statistics System. Accessed via CDC WONDER. 2019-2023.



View larger map

Suicide Mortality, Crude Rate (Per 100,000 Pop.) by County, CDC NVSS 2019-23

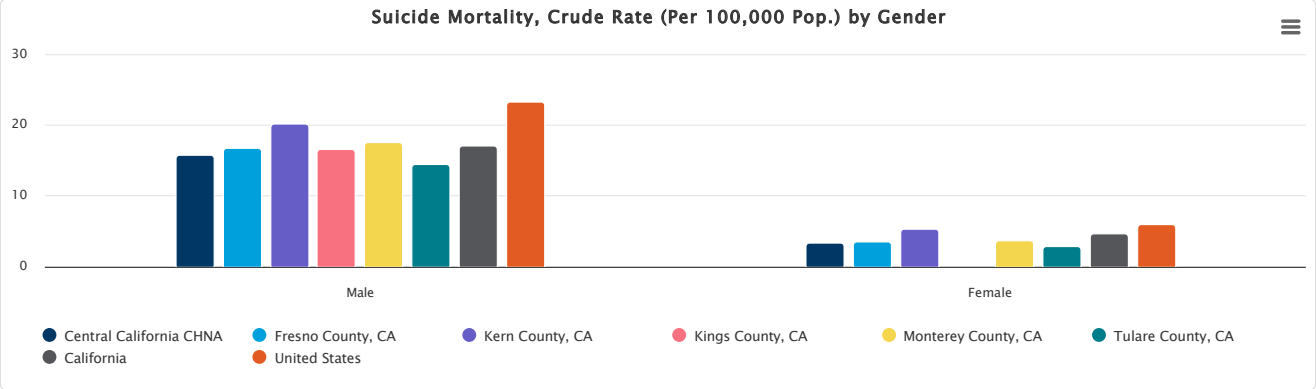
- Over 20.0
- 16.1 - 20.0
- 12.1 - 16.0
- Under 12.1
- Data Suppressed (<10 Deaths)
- Central California CHNA

Suicide Mortality, Crude Rate (Per 100,000 Pop.) by Gender

The table and chart below display crude mortality rates from deaths due to intentional self-harm (suicide) for the 5-year period 2019-2023. Rates are calculated per 100,000 population and grouped by gender.

Report Area	Male	Female
Central California CHNA	15.8	3.3
Fresno County, CA	16.7	3.5
Kern County, CA	20.2	5.3
Kings County, CA	16.6	No data
Monterey County, CA	17.6	3.7
Tulare County, CA	14.4	2.9
California	17.0	4.7
United States	23.3	6.0

Data Source: Centers for Disease Control and Prevention, CDC - National Vital Statistics System. Accessed via CDC WONDER. 2019-2023.



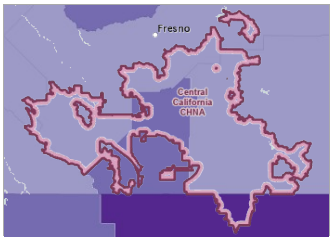
Health Outcomes - Deaths of Despair - Deaths of Despair

This indicator reports average rate of death due to intentional self-harm (suicide), alcohol-related disease, and drug overdose, also known as "deaths of despair", per 100,000 population. Figures are reported as crude rates. Rates are resummarized for report areas from county level data, only where data is available. This indicator is relevant because death of despair is an indicator of poor mental health.

Within the report area, there were 2,093 deaths of despair. This represents a crude death rate of 52.5 per every 100,000 total population.
Note: Data are suppressed for counties with fewer than 20 deaths in the time frame.

Report Area	Total Population, 2018-2022 Average	Five Year Total Deaths, 2018-2022 Total	Crude Death Rate (Per 100,000 Population)
Central California CHNA	796,838	2,093	52.5
Fresno County, CA	1,009,190	2,515	49.8
Kern County, CA	909,833	3,620	79.6
Kings County, CA	152,948	386	50.5
Monterey County, CA	433,175	1,034	47.7
San Benito County, CA	65,859	139	42.2
Tulare County, CA	473,788	1,182	49.9
California	39,222,534	100,758	51.4
United States	331,563,969	970,307	58.5

Note: This indicator is compared to the state average.
Data Source: Centers for Disease Control and Prevention, CDC - National Vital Statistics System. Accessed via CDC WONDER. 2019-2023.



View larger map

Deaths of Despair, Crude Rate (Per 100,000 Pop.) by County, CDC NVSS 2019-23

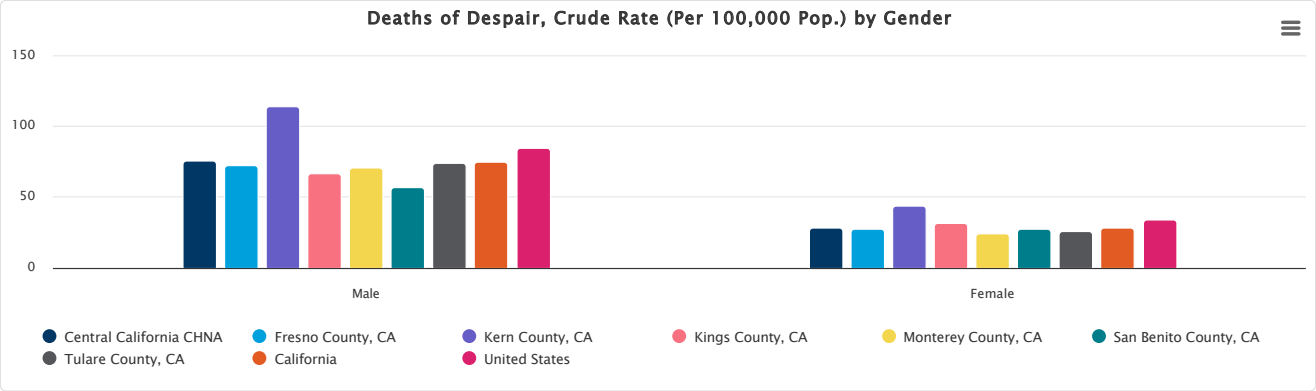
- Over 70.0
- 50.1 - 70.0
- 40.1 - 50.0
- Under 40.1
- Data Suppressed (<10 Deaths)
- Central California CHNA

Deaths of Despair, Crude Rate (Per 100,000 Pop.) by Gender

The table and chart below display crude mortality rates from deaths due to intentional self-harm (suicide), alcohol-related disease, and drug overdoses, also known as "deaths of despair" for the 5-year period 2019-2023. Rates are calculated per 100,000 population and grouped by gender.

Report Area	Male	Female
Central California CHNA	75.5	28.5
Fresno County, CA	72.3	27.3
Kern County, CA	113.8	43.8
Kings County, CA	66.1	31.2
Monterey County, CA	70.8	23.8
San Benito County, CA	56.7	27.5
Tulare County, CA	74.1	25.7
California	75.0	27.9
United States	84.0	33.7

Data Source: Centers for Disease Control and Prevention, CDC - National Vital Statistics System. Accessed via CDC WONDER. 2019-2023.



From the **list** of significant health needs, Steering Committee members **identified** the following as high priorities. The remaining lower priority needs were also identified by **Steering Committee** members as important community needs to address.

A. Identified Significant Health Needs

The following lists all significant health needs identified during the 2025 CHNA process. Also included are links to resources related to each health need.

High Priority Needs

Access to Care

Thealliance.health

Nearly nine out of ten people (88.79%) live in a primary care Health Professional Shortage Area (HPSA), compared to 22.59% in California (U.S. Department of Health and Human Services, 2024). Both focus group participants and key informants noted that access to affordable, specialty care is a community need.

Financial Stability

calwellness.org/money/what-we-fund/economic-security-and-dignity/

One in four children (25.37%) live in households below the Federal Poverty Level (U.S. Census Bureau, 2023). When asked about what makes it hard to live and be well, a community survey showed that 45.3% of respondents selected financial stability related factors.

Mental Health

thealliance.health/for-members/get-care/behavioral-health-care/

Nearly one in five adults (19.6%) self-reported as having poor mental health (Centers for Disease Control and Prevention, 2022). Focus group participants noticed that issues with anxiety and depression are more prevalent with youth and serious mental health disorders are hurting our homeless population.

Lower Priority Needs **please note web address leads to multiple 211 resources within each priority need*

Food Security

ccfoodbank.org

More than three out of four students (77.9%) are eligible for free or reduced-price lunch (National Center for Education Statistics, 2023). Key informants described that a lack of access to healthy foods disproportionately affects certain populations and areas like the central valley despite being in an agricultural region.

Housing

cdss.ca.gov/inforesources/cdss-programs/housing-programs

More than 20% of adults (22.2%) reported experiencing housing insecurity, which is associated with limited access to health care and poor outcomes (Centers for Disease Control and Prevention, 2024). Key informants described the stigma associated with homelessness and its increasing trend that points to a significant health need to address.

Health Conditions

thealliance.health/for-members/health-and-wellness/

The Central California service area performs worse than the State average for obesity, diabetes, heart disease, lung disease, kidney disease, as well as hearing and mobility disabilities. Focus group participants and key informants described many of these health conditions as especially burdensome in underserved communities.

Health Risk Behaviors

recovery.org

The Central California service area performs worse than the State average for smoking, binge drinking, chlamydia infection and teen birth rate. Focus group participants highlighted the social normalization around vaping as well as the community need for providing fentanyl test kits and Narcan.

Scan QR Code to explore the full live data report or visit: cares.page.link/FZWG

B. Description of Focus Groups & Key Informant Interviews

The CHNA Steering Committee identified vulnerable populations and worked with local organizations to coordinate focus groups and key informant interviews to ensure that minority populations — the voices of those with chronic disease, low income and the underserved were heard. See below for more details regarding focus groups and key informant interviews. Themes and quotes from focus groups and key informant interviews are available in Section III. High Priority Health Needs.

Logistics

Six (6) focus groups with twenty-six (26) people participating. Focus groups were in-person, typically running 90 minutes.

Four (4) key informant interviews. Interviews were conducted virtually, running 60 minutes.

Participating Organizations

- Champions Recovery Alternative Programs Visalia
- City of Tulare
- Community Action Partnership of Kern
- Delano Chamber of Commerce
- Delano Community Leaders
- Kings Community Action Organization
- Kings County Public Health

Represented Race/Ethnicity

- African American
- Asian
- LatinX
- White

Represented Populations

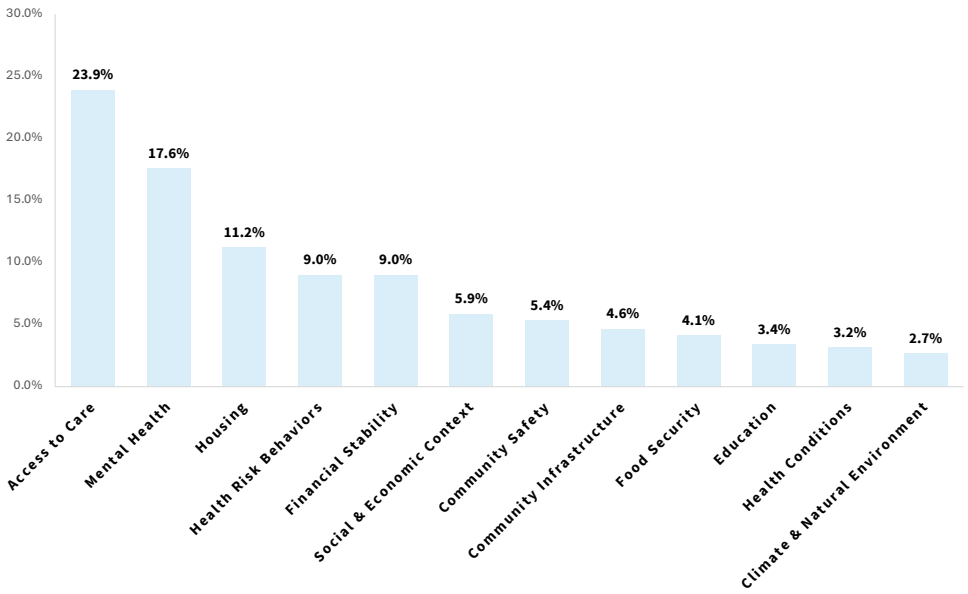
- Agricultural workers
- Civic Government
- Labor or Workforce reps
- Low-income
- LGBTQ Community
- Medically Underserved
- Minority Population
- Older Adults
- Persons with Disability
- Substance Use Disorder
- Unhoused population

C. Focus Groups & Key Informant Interviews Results

The focus group and key informant interview charts below highlight the percentage of mentions for each selected need within the Community Impact Framework. For additional details on focus group and key informant interview methodology, see Section V. Process and Methods to Conduct the CHNA.

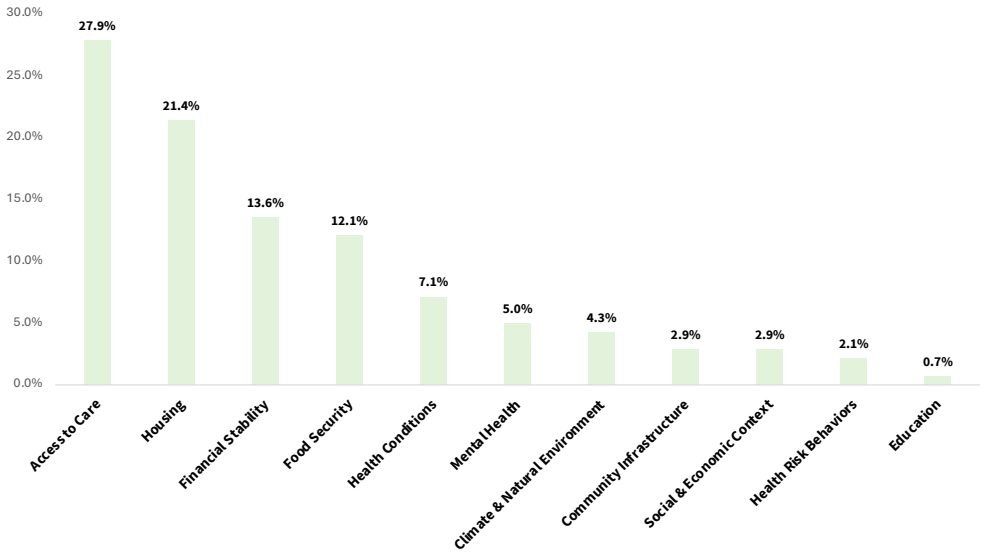
Focus Groups

The following chart details the percentage by which focus group participants mentioned or discussed the 12 categories from our Community Impact Framework.



Key Informant Interviews

The following chart details the percentage by which key informant interviews mentioned or discussed the 12 categories from our Community Impact Framework.



California: 15.15%

D. Secondary Data Results

Below are the secondary data results that rank the 12 categories from our Community Impact Framework from 1 to 100. Higher scores have the greatest impact on life expectancy and general health status. For additional information on scoring methodology see Section V. Process and Methods to Conduct the CHNA.

Priority Health Needs

Health needs in Central California CHNA were determined using quantitative analysis of data. Needs were identified based on their impact on short-term health (well-being) and long-term health (life expectancy), as well as prevalence in the market relative to state benchmarks. Priority areas are scored on a scale of 1 to 100, with higher scores indicating higher health needs.

Adults Age 18+ with Poor or Fair General Health (Crude)

27.2%

California: 18.8%

Life Expectancy at Birth (2010-2015)

78.66

California: 80.32

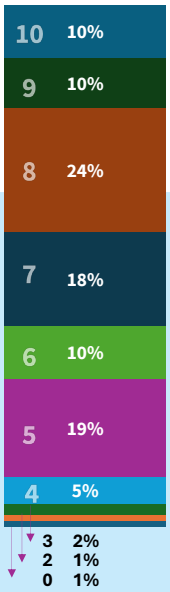
Housing	Health Risk Behaviors	Access to Care	Financial Stability	Mental Health	Social & Economic Context
76	73	73	70	64	64

Food Security	Education	Climate & Natural Environment	Health Conditions	Community Safety	Community Infrastructure
63	57	55	45	41	41

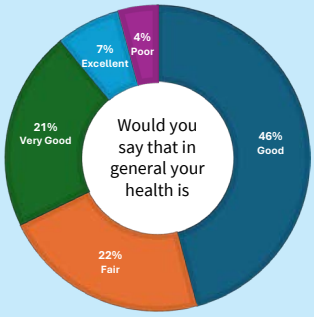
Legend: Excellent · Very Good · Good · Fair · Poor

E. Survey Results

Community surveys collect data from a broad population to understand real-time perspectives on health and well-being. Survey questions focus on gathering data related to major health issues, life satisfaction, access to medical care and community resources.



Imagine a 10-step ladder. At the top life is great, a 10. At the bottom, life is not good, a 0. Which step of the ladder are you standing on right now?

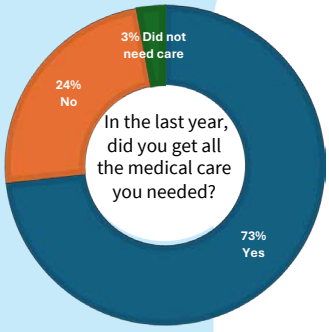


Select 3-5 things that you believe make it hard to live and be well in this community.

High cost of living	20.1%
Lack of affordable housing	14.5%
Bad air and/or water quality	13.7%
Not enough good jobs	10.7%
Access to affordable healthy food	10.1%
Can't get medical care	5.8%
Lack of safe roads, sidewalks, bike lanes	4.1%
Unsafe community	4.0%
Lack of transportation	3.8%
Limited childcare options	3.4%
Limited access to social services or me or my family members	2.4%
No friends or connections to community	2.1%
Lack of good schools	2.0%
Racism	1.9%
High risk for natural disasters (fire, floods, earthquakes)	1.4%
Grand Total	**100.0%**

Select 1-5 of the biggest health problems you're facing.

Being overweight	13.6%
Aging problems (e.g. arthritis, hearing/vision loss, dementia, etc.)	13.3%
High blood pressure	11.8%
Diabetes/Kidney Disease	8.7%
Mental health problems (e.g. extreme sadness, fear, worry, anger or stress)	8.1%
Poor eating habits	7.8%
Vision/hearing problems	7.0%
Teeth problems	6.8%
Asthma/COPD	4.9%
No health problems	3.9%
Problems with mobility	3.3%
Heart disease/Stroke	3.0%
Cancer	2.3%
Illness that spreads (like flu, COVID, TB)	1.2%
Respiratory/Lung Disease	1.1%
Mother-Baby care	1.0%
Alcohol and/or drug misuse	1.0%
Learning problems	0.8%
Sexually Transmitted Diseases (STDs)	0.2%
Child/Partner Abuse	0.1%
Grand Total	**100.0%**



If you did not get all the medical care you needed, what are the reasons why?

Poor quality of doctors/nurses	17.9%
Inconvenient hours of operation	12.1%
Specialists not covered by insurance	10.7%
Getting to the clinic was too hard	9.3%
It costs too much	7.9%
I do not have health insurance	7.9%
I do not have a primary care doctor	6.4%
Location of medical care	6.4%
I did not know where to get care	5.7%
I'm uncomfortable speaking with a doctor	5.7%
Doctor or clinic (healthcare provider) did not understand my language, culture or identity	3.6%
Holistic treatments not available	3.6%
There was no doctor that accepted my insurance	2.9%
Grand Total	**100.0%**

Select the resources that your community needs more of to help you live better.

Housing Options	14.2%
Healthcare & Prescription Costs	13.9%
Utilities/Internet	11.0%
Parks, Recreation and Outdoor Activities	10.6%
Managing Stress and Depression	9.8%
Childcare or Senior Care	9.4%
Neighborhood Safety	7.7%
Social/Community Events	7.6%
Local Food Banks	6.3%
Personal Safety	4.8%
Legal Services	4.6%
Grand Total	**100.0%**

Central California Survey Responses
310

The following pages **reflect** the **process** and **methods** used to **conduct** this CHNA.

V. Process & Methods to Conduct the CHNA

A. Introduction

This Community Health Needs Assessment (CHNA) process aligns with the American Hospital Association Community Health Improvement (i.e. Healthy Communities) guidelines and was designed after an analysis of best practices for CHNAs, as defined by the Centers for Disease Control and Prevention (CDC), Community Commons, and the National Association of County & City Health Officials (NACCHO).

This CHNA was conducted using four distinct sources of primary and secondary data. This mixed methods approach is a preferred practice for needs assessments as it allows for data triangulation, providing the greatest understanding of community needs from the broadest range of perspectives. Having multiple avenues for contributing perspectives has been shown to better include the voices of all community members, particularly vulnerable and disadvantaged groups (Ravaghi et al., 2023).

For this CHNA process, a local Steering Committee was formed to help coordinate the collection of primary data, with an emphasis on incorporating the perspectives of underserved populations. Primary data collection involved focus group interviews, individual key informant interviews and surveys. Secondary data was also collected, involving a review of over 150 metrics from state and national sources which were analyzed to determine factors having the greatest impact on community health. All collected CHNA data was coded and analyzed according to a Community Impact Framework. Framework development, data types, data collection, analysis and prioritization methods are described in the following pages.

B. Community Impact Framework

To organize health findings throughout this CHNA, a multi-tiered Community Impact Framework was used to categorize data into community health needs. To develop the Community Impact Framework, an initial set of 12 conceptual health need areas were identified by reviewing an analysis of past cycle CHNAs, which was conducted by the American Hospital Association, and comparing to existing SDoH frameworks like Well-Being in the Nation (WIN) and Kaiser Family Foundation. After conducting an analysis of appropriate and available public, secondary data to measure each category, a set of sub-categories and subsequent indicators were codified to make up a systematic framework. To this end, a landscape scan of available data was performed by evaluating existing population health measurement frameworks. Four primary frameworks were evaluated:

- Well-Being in the Nation (WIN) Measurement Framework
- National Committee for Vital and Health Statistics (NCVHS) Measurement Framework for Community Health & Well Being
- County Health Rankings and Roadmaps
- Healthy People 2030 Leading Health Indicators

Attributes for each indicator within the frameworks were identified, including data source, geographic level, extent, time period and update frequency. Next, indicators were filtered and removed from the list based on our inclusion criteria: ability to represent the reference community (e.g., geographic scale), recency, update frequency and source reliability. Indicators from each framework were assigned to each of the 12 categories, with some indicators assigned to multiple categories. The final framework consists of more than 150 individual metrics across the 12 categories, each with a minimum of two subcategories (CARES, 2022). For a full glossary of terms that include all 12 categories, see Appendix A. Glossary of Terms and Definitions of Health Needs.

Health Needs	Access to Care	Availability - Hospitals & Clinics | Availability - Mental Health Care | Availability - Primary Care Availability - Specialty Care | Barriers - Health Literacy | Barriers - Medical Insurance | Barriers - Transportation
	Health Conditions	Asthma & COPD | Cancers | Chronic Brain Disorders | Heart Disease & Stroke | Kidney & Liver Diseases Obesity & Diabetes | Impairments | Preventable Death Health Status | Aging Conditions
	Health Risk Behaviors	Alc hol | Diet & Nutrition | Illicit Drugs | Physical Inactivity | Preventative Care | Reproductive Health STIs | Tobacc
	Mental Health	Health Outcomes - Anxiety & Depression | Health Outcomes - Deaths of Despair | Risk Factors - Access t Care Risk Factors - Drugs & Alc hol | Risk Factors - Stress & Trauma
Basic Needs	Food Security	Economic Security | Food Access
	Education	Achievement | Attainment | Early Childhood
	Financial Stability	Employment | Income | Security
	Housing	Homelessness | Housing Costs | Housing Quality
Social Needs	Climate & Natural Environment	Physical Environment - Air & Water | Physical Environment - Heat & Climate
	Community Safety	Injuries | Public Safety | Risk Factors
	Community Infrastructure	Access t Childcare | Community Amenities | Internet & Technology | Transportation
	Social & Economic Context	Civic Engagement | Ec nomic Vitality | Place Attachment | Social Inclusion | Socioec nomic Disadvantage

C. Data Overview: Description, Benefits & Limitations

The below information includes context related to each data source, to aid interpretation of the data included in the following sections.

Description

Key Informant Interviews

Qualitative data from semi-structured conversations with community leaders who possess specialized knowledge about a particular community. Key informants are selected based on their firsthand experience, expertise, or position within a specific community.

Focus Group

Qualitative data from structured, but fluid discussions led by a facilitator with a small group of community members who reside in that local area. Participants are chosen for their ability to represent the needs of underrepresented, underserved, or vulnerable populations within the community.

Survey

Quantitative data collected in real time for this report, representing health concerns and priorities across a broad sample of the community and patients. The survey consists of questions related to health status, health needs and resources available to the community.

Secondary Public Data

Quantitative data previously collected by government agencies, research institutions, or other organizations. This report references a pool of 150 data indicators curated by the University of Missouri Extension Center for Applied Research and Engagement Systems (CARES).

Benefits

Key Informant Interviews

- **In-depth Insight:** These interviews are designed to gather in-depth insights, perspectives and expertise that may not be readily available through other sources.
- **Contextual Understanding:** The information gathered helps our organization gain an understanding of complex health barriers and sociocultural contexts beyond what is available in quantitative data.
- **Validation:** Conducting key informant interviews can serve as a means of validating other data sources.
- **Community Engagement:** Supports collaborative efforts to address community health needs.

Focus Group

- **Interactive and In-depth Insights:** Community members are encouraged to interact with each other, which provides insights and generates discussion that uncover a range of needs and perspectives. Focus groups encourage participants to build on each other's responses, leading to richer, more detailed insights.
- **Contextual Understanding:** The information gathered helps our organization gain an understanding of complex health barriers and sociocultural contexts beyond what is available in quantitative data.
- **Validation:** Conducting focus groups can serve as a means of validating other data sources.
- **Community Engagement:** Supports collaborative efforts to address community health needs. We prioritized engaging underrepresented individuals who face negative socioeconomic or health effects, such as low-income populations, minorities and those with chronic health conditions.

Survey

- **Full Anonymity:** Personally identifiable information is not collected.
- **Wide Reach and Generalizability:** Data from a large number of respondents makes it possible to generalize findings to a larger community.
- **Cost-Effectiveness:** Surveys can be a relatively cost-effective method for reaching a large audience.

Secondary Public Data

- **Public Data:** Data is publicly available and therefore a cost-effective method for assessing health needs.
- **Diverse and Longitudinal Data:** The data includes a diverse set of 150 metrics spanning census data, economic indicators, and health statistics and publicly released survey results, allowing for the ability to conduct comparative analyses over time.
- **Wide Reach and Generalizability:** Data from a large number of respondents makes it possible to generalize findings to a larger community.

Limitations

Key Informant Interviews

- **Subjectivity and Perspective Bias:** Key informants who volunteer to participate may have their own biases or limited perspectives, which can shape their responses.
- **Limited Generalizability:** Informants may lack generalizability to the broader community since informants are selected based on involvement in specific area.

Focus Group

- **Limited Generalizability:** Findings from focus groups may not be broadly representative of the entire community due to the small sample size of volunteers.
- **Social Desirability Bias:** Participants may provide responses that they perceive as socially desirable or acceptable in a group setting, rather than fully disclosing less favorable or controversial information.

Survey

- **Sampling Bias:** Community members who choose to complete the survey may have their own biases or limited perspectives, which can shape their responses.
- **Distribution and Data Collection:** Surveys distributed digitally used a global online translation service, which may present challenges with the quality of understanding cultural nuances and word-for-word translation. Surveys were also distributed in paper form to local organizations who entered results from their constituents, which could affect the accuracy of the information collected.
- **Limited Depth of Responses:** Limited opportunity for participants to elaborate on their answers or provide context can result in responses that do not fully capture the complexities of health barriers.

Secondary Public Data

- **Timeliness:** The most recent public data that met our criteria (available across multiple states and, when possible, at the zip code level) was referenced. However, public data may not always be up-to-date or reflect real-time information.

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D. Focus Group & Key Informant Interview Methodology

Primary data collection was designed to gather first-person input on community health needs directly from community members. From May 2024 – November 2024, focus groups were conducted with community service providers and service recipients, and key informant interviews were conducted with community leaders. Focus group members participated in 1.5-hour in-person sessions, and key informant interviewees participated in 1-hour individual virtual interviews. Steering committee members were responsible for identifying participants and scheduling both types of interviews. Any social service provider in the community was eligible for inclusion in the focus groups, and any social service director or other community leader was eligible for key informant interview involvement. An emphasis was placed on hearing from underserved and minority populations whenever possible.

The semi-structured interview guides used for both types of interviews were nearly identical. The only variation between the focus group and key informant interview guides was the inclusion of additional prompting questions allowing for key informants to provide a greater depth of response.

The facilitators were a team of Adventist Health system staff who began all focus groups and key informant interviews by having participants identify up to five high priority community health needs from their perspective based on a social determinants of health framework with priority areas and subcategories. The facilitators then moved through a series of questions, focusing on depth of need, barriers, attempts at addressing the need historically, ways that different groups are affected and recent, emerging trends. Focus groups and key informant interviews were conducted in teams of two, with a lead facilitator and a notetaker, and all interviews were recorded. All focus groups were conducted in English or Spanish, with translation services provided as needed. Focus groups and key informant interviews were recorded with the consent of participating interviewees. All recordings were transcribed into English. In the spirit of collaboration, transcripts were shared with other non-profit hospitals within the same service area. To ensure the anonymity of participants was protected, all shared transcripts removed participant names. Remarks that detracted from the scope pertaining to community health needs were also removed.

E. Survey Methodology

A community survey was distributed as a primary data tool to gather real-time, quantitative data about the community's greatest health needs. To reflect the entire community, questions were designed to solicit responses at the individual, interpersonal and community levels. The selection process and criteria for the survey questions involved a rigorous review of other health systems' CHNAs, reputable government organizations such as the National Association of County and City Health Officials (NACCHO), the Centers for Medicare and Medicaid Services (CMS) Health-Related Social Needs Screening Tool, Healthy People 2030, and the Centers for Disease Control and Prevention (CDC). Additionally, the survey design was informed by interviewing techniques, collaboration with Steering Committee members from our previous CHNA cycle, a review of community health improvement toolkits, and the availability of state and national benchmarks.

The community survey comprised seven questions and took approximately five minutes to complete. To ensure accessibility, the questions were written at a fifth-grade reading level and translated into four languages using a global online translation service. The survey was distributed both in paper form and digitally via link, email, text, and QR code. Participation was voluntary, and responses were kept confidential. To maximize reach within the service area, the survey was shared with Steering Committee members, who then distributed it among their stakeholders, community-based organizations that volunteered to share it with their constituents, and patients at Adventist Health hospitals. For the full list of survey questions, see Appendix C.

F. Secondary Data Methodology

Basic Approach

Secondary data scoring comprised development of health needs index scores for each of the 12 categories included in the Community Impact framework. These index scores were determined using quantitative analysis of all secondary data referenced. Health needs scores for target communities in each of 12 priority areas (categories) were determined using quantitative analysis of secondary data from standard, national sources. First, metrics were selected that best represented each category based on a review of multiple health measurement frameworks. Next, metrics were scored based on three criteria relevant to life expectancy and quality of life. These criteria include impact on short-term health (well-being), impact on long-term health (life expectancy) and severity within the reference community relative to state benchmarks. Final health needs scores for each priority area were developed with possible scores ranging from 1 to 100. Higher health needs scores indicate 1) a comparatively high degree of correlation between the underlying metrics within the health needs category and the outcome variables (well-being and life expectancy), and 2) a high level of need in the community compared to other areas of the state. Figure 1 depicts this process, which is further described below.

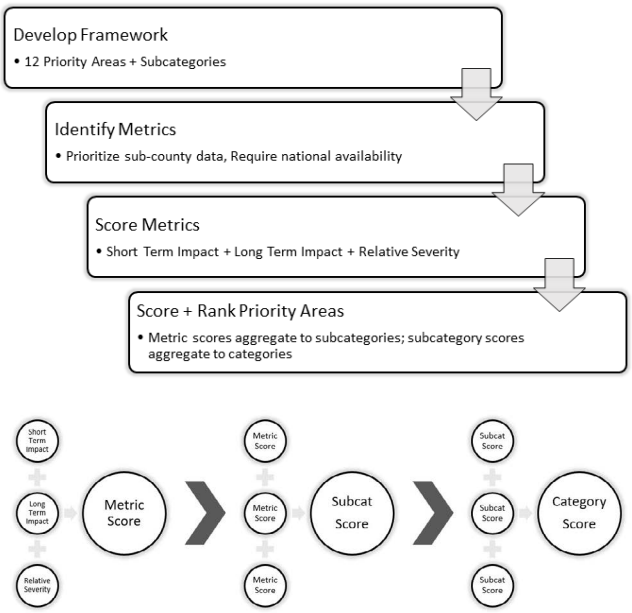

Figure 1. A. Approach to framework and scoring methodology development. B. Diagram of scoring approach.

Metric Scoring

Scores are generated for metrics (e.g., obesity prevalence) to represent the criteria mentioned above (length of life, quality of life and severity). To operationalize the first two criteria, we measure the degree of correlation between each metric and two outcome variables: a short-term goal (well-being, measured by physical and mental health status) and a long-term goal (length of life, measured by life expectancy at birth).

Metrics with strong negative relationships with the outcome variables (scoring below -.40) were removed from the framework.

To address the third criterion, we calculate the relative severity of each metric for each target community using a z-score. A z-score is a measure which quantifies the position of a raw data value (e.g., the value for one metric for a community) in relationship to the mean and distribution of all values (e.g., the value for one metric for all other areas). For this work, the calculated value for each community for a metric (e.g., obesity) is compared against the value for all counties within the community state (e.g., obesity rates for all counties in California). In this way, communities can be compared against geographic areas with similar geographic size and heterogeneity. Furthermore, z-scores for a given community are compared against a fixed number and definition of geographic areas, which exist independent of the number of communities or hospitals assessed within a state.

Transformation of Correlation Scores

To aid in interpretability, correlation scores within a single health need category and outcome category were converted to percentiles, such that the score for a single metric represents the percent of the total scores for all metrics.

Category Scores

Scores for each metric are based on three separate values, as represented in Equation 1 below. Short-term and long-term health impact scores are identical for all communities, while the relative severity score is unique. To generate a final score for each metric, we calculate the weighted average of the short-term and long-term

score and apply the z-score as an adjustment factor.

$M_c = (ST_s + LT_s) * Z_{cs}$

Equation 1. Metric scores. ST_s is the state-specific correlation score between the metric and the short term outcome variable (self-reported health status), LT_s is the state-specific correlation score between the metric and the long term outcome variable (life expectancy), and Z_{cs} is the area-specific relative severity score (z-score).

In this way, communities that perform better than average for a metric will see scores adjusted down (lower priority), and communities that perform worse than average will see scores adjusted up (higher priority).

Next, metric scores are aggregated to produce subcategory and category scores. Subcategory scores are calculated as the average of all final metric scores within a category. Finally, category scores are calculated as the average of all subcategory scores within a category.

$SubC_c = \Sigma_c SubC/n$
$Cat_c = \Sigma\ SubC/n$

Presentation of Results

All final subcategory and category scores are transformed to a 100-point scale for ease of interpretation, where 100 is the maximum possible value (highest priority) and one is the lowest theoretical possible value (lowest priority).

Subcategory scores are transformed *independently* of category scores. The maximum "real" subcategory score may be as high as 7.0, which would transform to ~100, whereas the highest category score is only about 4.0, which also transforms to ~100. Therefore, subcategory scores can be compared with other subcategory scores; category scores may be compared with category scores, however subcategory scores and category scores cannot be compared.

Limitations

This approach is subject to several limitations. First, the final selection of priority areas is heavily dependent on the structure of the measurement framework. In this work, the top-level framework was determined by the hospital system based on prior assessments; metrics were assigned to categories and grouped based on expert knowledge. However, changes to the organization of metrics within top-level categories, including the addition or removal of metrics or the reorganization of metrics within subcategories, are a major driver of category scores and results. A data-driven method for selecting a measurement framework would therefore improve the applicability of these results outside of the example health system.

Next, despite best efforts to identify relevant metrics at the community level, availability of data to represent some priority health need concepts remain limited. For example, data on the prevalence of overall homelessness is not available for small (e.g., sub-county) geographic areas. Without data that accurately represent prevalence within a community, the ability to score impact on health and well-being is limited.

An additional limitation is the flexibility of metric correlation scores with the outcome variables. Work found scores to be influenced by the geographic scale and the geographic universe (e.g., state, region, or U.S. total) at which relationships were assessed, and rescaling methods used to standardize data. Changes to one or more of these decisions produce a range of correlation scores. Ideally, relationships would be consistent across multiple geographic levels or groupings.

Finally, secondary data are hampered by lag in reporting. At the time assessments were performed (summer 2024), the latest available data on health behaviors, outcomes, and social determinants represented the 2021 and 2022 calendar years, and in some cases, data were older still. Since the first aim of this work is to measure the relationship between certain factors and well-being and life expectancy, this temporal lag is of less importance. Moreover, we incorporate a mix of other data sources to mitigate the data lag variance to take a standardized approach important for a mixed-methodology analysis.

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G. Data Analysis & Identification of Significant Health Needs

This CHNA deployed a mixed methodology combining the strengths of analyzing primary data with secondary data results. As demonstrated in steps two-four below, several actions were taken to analyze data and produce a list of significant health needs.

Preparation & Data Collection: Adventist Health staff, CARES team and CHNA Steering Committee

STEP 1: FRAMEWORK & CODEBOOK CREATION

- Map focus group and key informant interview questions to framework and codebook.
- Map secondary data indicators to framework.

STEP 2: DATA COLLECTION

- Primary Data: focus groups, key informant interviews and survey.
- Secondary Data: 150 indicators.

Data Analysis & Identification of Significant Health Needs: Adventist Health system staff and CARES team

STEP 3: AGGREGATION

- Code focus group and key informant interview groups to framework.
- Aggregate survey results per community.
- Score Secondary Data Index.

STEP 4: SYNTHESIS

- Identify list of Significant Health Needs based on:
  - Health need identified as top five across any data sources.
  - Health need is identified in two or more data sources.

EVALUATION & HEALTH NEEDS PRIORITIZATION: CHNA Steering Committee

STEP 5: EVALUATION

- Evaluate Significant Health Needs data.

STEP 6: PRIORITIZATION

- Rank "high" and "low" Priority Health Needs based on prioritization criteria.

Data Collection to Aggregation

After primary data collection, Adventist Health staff conducted a deductive coding of all focus group and key informant interview data to the Community Impact framework. Secondary public data was analyzed and index scores were created for ranking, according to the methodology outlined in Section V. Process and Methods to Conduct the CHNA.

To facilitate this coding process for focus groups and key informant interviews, as described in Step 3 of the infographic above, focus group and key informant interview transcript files were uploaded to a Microsoft AI coding solution, along with the Community Impact framework as the reference table. To generate an output, Adventist Health staff provided a written prompt to the AI solution:

You are an AI assistant tasked with analyzing and classifying provided conversational text from interviews conducted with community members regarding what they see as the top health needs in their community. The topics are related to Public Health and Social Determinants of Health (SDOH).

*Each piece of text (or excerpt) relevant to a public health need and/or social determinants of health should be classified into **all applicable** provided SDOH categories, at either the "subcategory" or "codename" levels using the following SDOH reference table: {reference table}.*

For each input text, your goal is:

*1. Identify **all relevant** (either directly or implied) SDOH-related excerpts from the provided text, based on the reference table. Use the excerpt examples, Subcategory and/or Codename Description, and code names from the SDOH reference table to assist in identifying which excerpts are relevant.*

2. Classify the excerpt under the appropriate SDOH categories. Include the entire excerpt text with accompanying context to illustrate how it corresponds with each classified category. If an excerpt cannot be coded to the code and codename level based on the reference table, use the most appropriate subcategory and leave code and codename blank. Excerpts must have two or more sentences. Excerpts must be relevant (direct or implied) to the current health needs/problems in the speaker's community.

*3. **For each classification, assign a confidence score between 0 and 1, where 1 indicates the highest confidence.***

The output was a CSV file with a list of excerpts that were coded to the category and subcategory levels of the Community Impact framework. These category and subcategory references were counted, and a percentage of excerpts coded to each category was generated to establish a ranking of top health need categories for focus groups and key informant interviews.

Data Synthesis and Identification of Significant Health Needs

Staff conducted axial coding by drawing connections between the top health needs across focus groups, key informant interviews and secondary public data. Adventist Health system staff produced a list of significant health needs and presented findings to CHNA Steering Committee, based on the following criteria:

- The health need comes up as a top five for at least one data source.
- The health need is referenced across at least two data sources.
- The health need as represented in the Community Impact framework corresponds with two or more secondary data indicators that perform worse than the CA state benchmark.

In addition to the list of significant health needs and the supporting data from axial coding of focus groups, key informant interviews and secondary public data, survey data was provided to CHNA Steering Committee for evaluation and corroboration before prioritization of significant health needs.

H. Criteria & Process Used for Identification & Prioritization of Health Need

Prioritized Criteria

The local Steering Committee was responsible for identifying and prioritizing the community health needs included in the CHNA. Steering Committee members are community stakeholders who lead and represent sectors such as local government, community-based organizations, health and human services, schools, public health and others. To facilitate the process of prioritizing health needs, Adventist Health system staff led a series of meetings held in each community to 1) present the results of the CHNA data collection process and 2) prioritize the significant identified health needs.

Prioritization Process and Selection of High Priority Needs

Following the identification of significant health needs through the analysis process, Adventist Health system staff conducted a 90-minute presentation to the Steering Committee, revealing primary and secondary data findings that led to the identification of these needs. During the presentation, staff emphasized the top five needs from each data source and the supporting data that justified their inclusion. After the data reveal meeting, Steering Committee members were provided with three prioritization tools, the presentation slides, and a secondary data report for review and discussion with organizational leadership. Additionally, members participated in a poll to identify the three to five needs they considered most critical, utilizing relevant local data sources as available.

The second part of the series involved a prioritization meeting aimed at building consensus around the community health needs identified as most critical by Steering Committee members. Steering Committee members, along with their staff, boards, and constituencies, reviewed and discussed the top five needs from each data source. They then voted to select priorities that demonstrated the greatest need based on severity and prevalence, alignment with common goals, feasibility of potential interventions, and opportunities to maximize available resources over a three-year period. The meeting concluded with committee members prioritizing the list of significant identified needs, typically selecting two to four as high-priority. See Appendix D for prioritization tools used.

I. Written Comments for 2025 CHNA

We value your input on our community health needs assessment and invite you to submit comments on this CHNA to community.benefit@ah.org. At the time of this CHNA report development, no written comments about the previous CHNA report or adopted implementation strategy were received.

J. CHNA Team Used to Conduct the Assessment

The Adventist Health Community Impact Team coordinates Community Health Needs Assessments for many of the communities we serve. The Community Impact Team convened community experts within each service area's steering committee, coordinated and/or conducted primary data collection, facilitated analysis, and wrote the report content. Team members listed below have diverse and relevant experience in healthcare, philanthropy, government, Medicaid managed care and quality improvement, public health, community health and community benefit reporting. Those team members include:

Amanjit 'Amy' Lasher
Administrative Director, Community Integration

Sarah Clair, MPA
Manager, Public Affairs

Mitchell Iwahiro, MS
Project Manager, Community Integration

Susan Passalacqua
Manager, Community Benefit Compliance

Lisa Wegley
Program Manager, Community Benefits Operations

Additionally, Adventist Health system staff supported the data collection and analysis portion of the report:

Matt Gonzales
Salesforce Administrator

Alex McFadyen, PMP
Manager, Consumer Digital Products

Philip Stanley
Digital Marketing Manager

Aldreen Venzon, Ph.D, MS, RN
Sr. Performance Analyst (System)

Cambria Wheeler
Director, Brand Engagement

CARES

Founded in 1992, the University of Missouri Extension Center for Applied Research and Engagement Systems (CARES) develops and supports mapping, reporting and collaboration systems that enable public, private and nonprofit sector organizations to effectively address issues across topics like agriculture, environment, business, community, health, safety and youth. The CARES team integrates data, mapping, visualizations and engagement tools to better serve communities and regions across the United States, including vulnerable, rural and underserved populations. CARES' web-based technologies help organizations and policy makers make more informed decisions about access, address issues of equity and support the allocation of public and private resources.

CARES staff has background in data science, Geographic Information System (GIS), database and geodatabase management, web design and user experience (UX), spatial analysis, programming, systems implementation and administration and web-based content management. Additionally, CARES holds expertise in project management, user training and support, data documentation and client design sessions that directly supports a wide variety of projects.

Angela Johnson, MPH
Assistant Director,
University of Missouri CARES
(johnsonange@missouri.edu)

Zhengting He, MPA
Research Program Analyst,
University of Missouri CARES
(hezhen@missouri.edu)

For more information, please visit
https://careshq.org/about/


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VI. APPROVAL PAGE

This Community Health Needs Assessment was adopted on September 18, 2025 by the Adventist Health System/West Board of Directors. The final report was made widely available to the public on December 31, 2025.

Thank you for reviewing our 2025 Community Health Needs Assessment. We are proud to serve our local community and are committed to making it a healthier place for all.

Jason Wells
President, Adventist Health Central California Network

Adventist Health Delano
1401 Garces Highway
Delano, CA 93215

Appendix:

A. Glossary of Terms & Definitions of Health Needs

In 2020, Adventist Health analyzed the top priorities from 2019 CHNAs across all hospitals, compared these priorities against language from CHNAs across the country, and created a set of standard nomenclature categories to promote common language, referred elsewhere in this report as "Community Impact Framework". Below is a list of these categories, organized according to this framework, with the accompanying definitions. These categories and definitions are drafted based on context summarized from public health literature, community CHNAs, and national and multi-national healthcare organizations. Sources for definitions are listed below.

Access to Care

Access to care refers to the timely use of personal health services to achieve the best health outcomes. This concept encompasses the availability, affordability and appropriateness of healthcare services, as well as the accessibility of these services to all individuals, regardless of income, location or social standing. Access to care directly affects population health, influencing rates of preventable diseases, overall mortality and quality of life. Ensuring equitable access to healthcare is a central public health goal, particularly in reducing health disparities among underserved populations.

Context/Source

Healthy People 2030. "Health Care Access and Quality"

World Health Organization (WHO). "Access to Care and Financial Protection"

Agency for Healthcare Research and Quality (AHRQ). "Access to Health Care"

Climate & Natural Environment

Climate and natural environment refers to the weather patterns, ecosystems and environmental conditions that impact the health of a community. This includes factors such as air and water quality, temperature extremes, green spaces and the frequency of natural disasters. These environmental elements shape health outcomes directly by influencing respiratory health, heat-related illnesses and exposure to pollutants, and indirectly through their effects on food security, housing stability and economic opportunities, all of which are crucial social determinants of health.

Climate change and environmental degradation can exacerbate existing health disparities, disproportionately affecting low-income communities and communities of color. Public health strategies aimed at addressing climate and environmental challenges focus on building climate resilience, reducing exposure to environmental hazards, and ensuring equitable access to resources like clean air, water and green spaces. By mitigating these environmental health risks and prioritizing sustainable practices, communities can improve both immediate health outcomes and long-term resilience in the face of climate-related impacts.

Context/Source

World Health Organization. "Climate"

National Institute of Environmental Health Sciences. "Climate Change and Human Health"

Centers for Disease Control and Prevention (CDC). "Climate and Health"

Community Infrastructure

Community infrastructure refers to the physical and organizational structures that support and enhance the health, safety and well-being of residents. This includes essential elements that people rely on every day such as transportation systems, internet access, healthcare facilities, schools, parks and water and sanitation systems. When community infrastructure is accessible, safe, and well-maintained, it supports healthier living conditions, reduces health disparities and promotes social determinants of health, such as stable housing, employment opportunities and environmental quality.

Community infrastructure is a foundation for equitable access to services and resources for a healthy lifestyle and to prevent disease. Investments in infrastructure that prioritize public health — like creating walkable neighborhoods, expanding green spaces and ensuring clean drinking water — can reduce chronic illnesses, improve mental health and enhance social connections within a community.

Context/Source

Robert Wood Johnson Foundation. "Infrastructure is Public Health"

American Public Health Association. "Strengthen Public Health Infrastructure and Capacity"

Community Safety

In public health, community safety refers to the protection and well-being of individuals in a community, reducing exposure to violence, crime, environmental hazards and other risks that impact physical and mental health. Within CHNAs, community safety is examined as a determinant of health, affecting overall quality of life and contributing to disparities in health outcomes. Ensuring community safety is seen as essential for fostering environments where individuals can thrive without fear of harm. Community safety includes violence prevention, traffic safety, safe public spaces and youth engagement.

Context/Source

Centers for Disease Control and Prevention (CDC). "About Violence Prevention"

Centers for Disease Control and Prevention (CDC). "About The Public Health Approach to Violence Prevention"

Education

Education refers to the access to quality learning opportunities that shape individuals' knowledge, skills and abilities, impacting their health and well-being. Education is a key social determinant of health because it influences health behaviors, employment opportunities and economic stability. Higher levels of education are associated with better health outcomes, including lower rates of chronic diseases, longer life expectancy and improved mental health. The link between education and health is also seen in the ability to access and understand healthcare information, which can affect decisions about diet, physical activity and preventive care.

Context/Source

American Public Health Association. "Education Health"

Centers for Disease Control and Prevention (CDC). "Education Access and Quality"

Robert Wood Johnson Foundation. "Why Education Matters to Health"

Financial Stability

Financial stability refers to having a reliable and sufficient income to meet basic needs such as housing, food, healthcare and transportation. Financial stability is a critical social determinant of health, as individuals with steady income are more likely to access preventive care, afford nutritious food and maintain safe living conditions. Financial instability and poverty are linked to higher rates of chronic disease, mental health issues and reduced life expectancy due to limited access to health resources and higher exposure to stressors.

Context/Source

Centers for Disease Control and Prevention (CDC). "Economic Stability"

Food Security

Food security refers to consistent access to sufficient, safe, and nutritious food that meets the dietary needs necessary for a healthy life. Access to healthy food is fundamental to preventing malnutrition, obesity and chronic diseases such as diabetes and heart disease. When individuals and families have reliable access to affordable, nutritious food, their overall health outcomes and quality of life improve significantly.

Food insecurity, or lack of reliable access to adequate food, disproportionately impacts low-income communities and contributes to health disparities. Public health efforts to improve food security often involve enhancing access to grocery stores, farmers' markets and community gardens, as well as supporting programs like the Supplemental Nutrition Assistance Program (SNAP). By addressing Food Security, public health initiatives aim to reduce health inequities, support economic stability and foster healthier communities.

Context/Source

World Health Organization. "Food Safety"

Centers for Disease Control and Prevention (CDC). "Diabetes and Food Insecurity"

American Public Health Association. "Food and Nutrition"

Health Conditions

Chronic health conditions are defined as long-lasting illnesses that persist for at least one year and require ongoing medical attention, lifestyle adjustments, or both. These conditions include heart disease, diabetes, cancer and chronic respiratory diseases, which are among the leading causes of death and disability worldwide. In the context of CHNAs, identifying and addressing chronic health conditions is crucial for understanding the health status of a population and guiding targeted interventions. Communities with the highest prevalence of chronic health conditions also typically face social, economic and environmental barriers that challenge prevention and management of the chronic condition, requiring interventions that focus on the complex interplay of behavioral and environmental factors described in this framework.

Context/Source

Centers for Disease Control and Prevention (CDC). "About Chronic Diseases"

World Health Organization (WHO). "Noncommunicable Diseases"

Centers for Disease Control and Prevention (CDC). "Chronic Disease Prevalence in the US: Sociodemographic and Geographic Variations by Zip Code Tabulation Area"

Health Risk Behaviors

Health risk behaviors are actions that increase the likelihood of adverse health outcomes, such as chronic disease, injury or premature death. Common examples include tobacco use, excessive alcohol consumption, physical inactivity, poor diet and risky sexual behaviors. These behaviors are significant focus areas for public health interventions because they are preventable and have broad implications for community health costs, healthcare systems and individual well-being. By identifying and targeting health risk behaviors, public health professionals aim to reduce the prevalence of diseases like heart disease, diabetes and certain cancers, promoting healthier, longer lives for populations.

For CHNAs, health risk behaviors are viewed within the context of social determinants of health, like access to resources, socioeconomic status and educational opportunities. Addressing these behaviors involves considering the social and environmental factors that make certain populations more vulnerable, such as limited access to healthy foods or safe recreational spaces. Community health approaches often implement evidence-based interventions that are culturally tailored and community-specific, recognizing that sustainable behavior change requires supportive environments and policies that mitigate risk factors and empower communities to adopt healthier lifestyles.

Context/Source

Centers for Disease Control and Prevention (CDC). "Behavioral Risk Factor Surveillance System (BRFSS)"

Centers for Disease Control and Prevention (CDC). "Health Risk Behaviors Measure Definitions PLACES: Local Data for Better Health

Centers for Disease Control and Prevention (CDC). "Sexual Risk Behaviors"

Housing

Housing refers to the availability, affordability, quality and stability of living environments. Safe, stable and affordable housing directly influences health outcomes by providing protection from physical hazards, reducing stress and enabling access to essential services. Poor housing conditions, such as overcrowding, exposure to pollutants and inadequate heating or cooling can lead to respiratory illnesses, injury risks and worsened mental health, especially among vulnerable populations.

Housing instability, including frequent moves, homelessness and the risk of eviction, contributes to health disparities by limiting access to consistent healthcare, educational opportunities and community resources.

Context/Source

Robert Wood Johnson Foundation. "Housing and Health"

American Public Health Association. "Housing and Homelessness as a Public Health Issue"

Centers for Disease Control and Prevention (CDC). "Homelessness and Health"

Mental Health

Mental health, within public health and community health frameworks, is understood as a state of well-being in which individuals can cope with life's challenges, work productively, and contribute meaningfully to their communities. This concept goes beyond the absence of mental disorders, emphasizing the capacity for resilience, emotional stability and fulfilling social connections. In public health, mental health is integral to overall health and is recognized as a critical factor influencing quality of life and socio-economic productivity, with both individual and social implications.

In the context of CHNAs, mental health is seen as interdependent with social determinants like income, education, social support, and access to healthcare. Health equity approaches prioritize the mental health of underserved communities, focusing on reducing stigma, expanding culturally appropriate services and advocating for policies that remove barriers to mental health resources. This framework recognizes that improving mental health outcomes requires collective action, community engagement and tailored support strategies that reflect the unique needs and values of diverse communities.

Context/Source

World Health Organization (WHO). "Mental Health"

Centers for Disease Control and Prevention (CDC). "Mental Health"

Substance Abuse and Mental Health Services Administration (SAMHSA). "Mental Health and Wellness"

Social & Economic Context

Social and economic context in this report refers to specific social and economic aspects of an environment that can influence health and well-being of a population-place attachment, civic engagement, social inclusion, and economic vitality. Economic stability and supportive social conditions promote healthier lifestyles, reduce stress and improve access to healthcare, positively impacting health outcomes for individuals and communities.

Social and economic contexts are closely linked to health disparities, as individuals from lower-income or underserved backgrounds often face barriers to achieving home ownership, contributing to economic health, and participating in activities which support social inclusion.

Context/Source

Centers for Disease Control and Prevention (CDC). "Social Determinants of Health (SDOH)"

World Health Organization. "Social Determinants of Health"

B. Activity Explanation: Focus Groups & Key Informant Interviews

- We're going to do a brief exercise to start that will tell us the biggest problems you see related to your and your community's health needs.
  - Then we'll ask you questions about those problems.
  - As you look around the room you'll see three (3) posters on the wall.
  - They show photos of common problems people face, many of them related to health.
  - Please take a few minutes to vote using the five (5) stickers you were given when you walked in.
- Place a sticker underneath the photo that shows problems that you think are the biggest difficulties in your community.
- You can't use all your stickers under one photo but you can use them all in one poster.
- Which of these things causes the most problems for you or others who live here?
- We're interested in learning about things that make it hard for you, your family and friends to have good physical and mental health, and a good quality of life.
  - Some of the descriptions are one word and really meant for you to share more with us.
  - We'll give you 10 minutes to walk around.

Tallying, Engaging & Asking Questions:

- For focus groups, visually tally the votes and clearly call out the top five issues that were identified for the note-taker and audience to hear.
- Spend around 15 minutes going through questions and the topic-specific follow-up questions.
- Repeat for as many problems as time allows, leaving five or so minutes to wrap-up at the end.
- Use the same "Prompting Questions" for each of the five identified issues.

ACTIVITY EXPLANATION – Key Informant Interviews

- We're going to do a brief exercise to start that will tell us what the biggest problems you see are.
  - Then we'll ask you questions about those problems.
  - Here are some photos of common problems people face, many of them related to health.
  - Please take a few minutes to select five (5) problems that you think are the biggest difficulties in your community.
- We're interested in learning about things that make it hard for your organization to provide services and/or for your constituency to have good physical and mental health, and a good quality of life.
  - Some of the descriptions are one word and really meant for you to share more with us.
  - We'll give you a few minutes to make your selection.

Engaging & Asking Questions:

- Spend around 10 minutes going through questions and the topic-specific follow-up questions.
- Repeat for as many problems as time allows, leaving five or so minutes to wrap-up at the end.
- Use the same Prompting Questions for each of the five identified issues.

B. Focus Group & Key Informant Interview: Question prompter

One of the topics that you identified is _____

Questions:

1. Why do you see ___as a problem that's related to your family/community's health?
2. What do you think creates this issue?
3. How do you see the problem affecting your local friends, family or neighbors?

   Who is most affected by this?
4. What have people tried to do to address this problem? What has worked?

   What are the biggest barriers for _____ (policy/program)?

   What makes it hard to fix this problem in your community?
5. What has changed around this concern in the last 2 - 3 years?

   Are there any new emerging trends or areas of concern in the last few years?
6. If this problem got better, how would your community look different?

Closing question:

- Are there other important health needs in your community that we have not already addressed?
- Let the audience introduce and talk through topics with any remaining time. If related to our categories, you can use topic-specific prompts below.

Conclusion:

- Thank you very much for your time today. The information you provided is very helpful for us, and we'll use it to help improve the health of your community.
- Next year we will publish the Community Health Needs Assessment that will summarize what we found, and that many people in your community will take action on.
    - If you would like us to send you a text or email with a link to that report, just provide us with your information.

Focus Groups Only: As a Thank you to you all we have a gift card for you as you leave.

C. Survey Questions:

1. **Would you say that in general your health is:**
   - Excellent
   - Very Good
   - Good
   - Fair
   - Poor

2. **Select 3 - 5 things that you believe make it hard to live and be well in this community.**
   - Can't get medical care
   - Not enough good jobs
   - Lack of affordable housing
   - Lack of good schools
   - Access to affordable healthy food
   - High cost of living
   - Unsafe community
   - Bad air and/or water quality
   - No friends or connection to community
   - High risk for natural disasters (fire, floods, earthquakes)
   - Lack of transportation
   - Lack of safe roads, sidewalks, bike lanes
   - Limited childcare options
   - Limited access to social services for me or my family members
   - Racism

3. **Select up to 5 of the biggest health problems you're facing.**
   - Aging problems (e.g. arthritis, hearing/vision loss, dementia, etc.)
   - Alcohol and/or drug misuse
   - Asthma/COPD
   - Being overweight
   - Cancer
   - Child/Partner abuse
   - Diabetes/Kidney disease
   - Heart disease/Stroke
   - High blood pressure
   - Learning problems
   - Mental health problems (e.g. extreme sadness, fear, worry, anger or stress)
   - Mother-baby care
   - Problems with mobility
   - Poor eating habits
   - Respiratory/Lung disease
   - Sexually transmitted diseases (STDs)
   - Dental problems
   - Vision/Hearing problems
   - No health problems

4. **Imagine a 10-step ladder. At the top life is great, a 10. At the bottom, life is not good, a 0. Which step of the ladder are you standing on right now?**
   - 10 (I'm living my best possible life)
   - 9
   - 8
   - 7
   - 6
   - 5
   - 4
   - 3
   - 2
   - 1
   - 0 (I'm living my worst possible life)

5. **In the last year, did you get all the medical care you needed?**
   - Yes
   - No
   - Did not need care

5b. **If you did not get all the medical care you needed, what do you think are the reasons why?**
Check all that apply.
   - Doctor or clinic (healthcare provider) did not understand my language, culture or identity
   - I'm uncomfortable speaking with a doctor
   - I do not have health insurance
   - I do not have a primary care doctor
   - There was no doctor that accepted my insurance
   - I did not know where to get care
   - Getting to the clinic was too hard
   - It costs too much
   - Inconvenient hours of operation
   - Location of medical care
   - Holistic treatments not available
   - Specialists not covered by insurance
   - Poor quality of doctors/nurses

6. **Select the resources that your community needs more of to help you live better.**
   - Childcare or senior care
   - Healthcare and prescription costs
   - Housing options
   - Legal services
   - Local food banks
   - Managing stress and depression
   - Neighborhood safety
   - Parks, recreation and outdoor activities
   - Personal safety
   - Social/Community events
   - Utilities/Internet

7. **Please enter your zip code, if you don't want to share your zip code, enter 00000.**

D. Prioritization Tools:

1. Health Need – Evaluation Worksheet

Addressing the health needs of community members is complex and often requires more than one approach with coordination across multiple sectors.

Based on the primary and secondary data presented select 3 to 5 health needs that you see as needing to be addressed.

Write the name of the need at the top, use the questions to the left to evaluate side-by-side the current resources, political will, infrastructure and shared goals/focus of each need.

Use your findings to identify the needs that, through collaboration, can be thoughtfully and intentionally addressed by multiple community sector partners.

PRIORITY NEEDS COMPARISON	1		2		3		4		5		6		7	
OPERATIONS	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Would tracked and shared progress/ data benefit multiple organizations and programs?														
Potentially, could there be 'quick wins' through collaboration and partnerships?														
Is there political willingness to act on this need?														
COMMUNITY PARTNERS/RESOURCES/ ASSETS	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Are there existing organizations/ programs addressing all or parts of this need?														
Do CBOs' goals/strategic plans list this need as an area of focus?														
Is there community willingness to act on this need?														
FINANCE	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Does this need have government/public funding streams available for those applying collaboratively?														
Are there current grants that could support some or all of this need?														
Does this need meet the vision/ mission of established government or philanthropic partners?														
EQUITY	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Are there organizations/programs focused on addressing this need with safety-net, low-income and minority populations?														
Will everyone in the community equally benefit from this need being addressed?														
Would addressing this need lessen absenteeism at work/school for everyone?														
TOTAL YES RESPONSES														

2. Questions to Consider

Do we have any unifying objectives/goals?

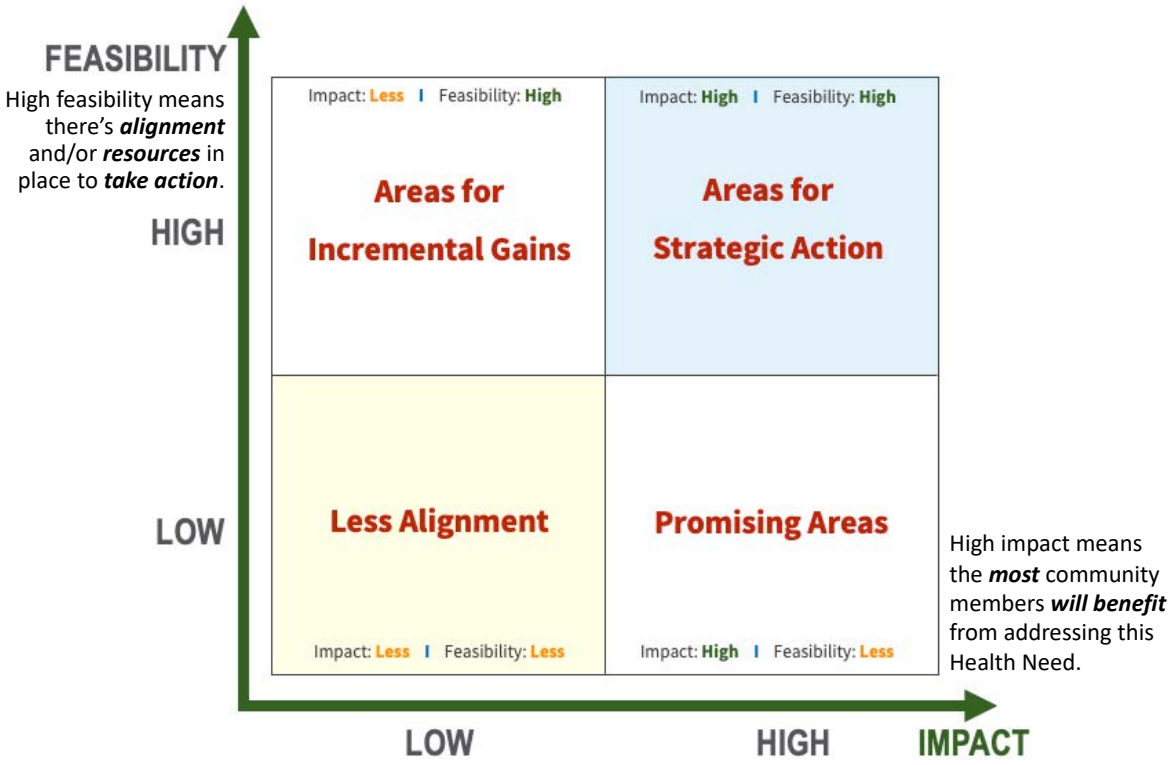
What does immediate success look like (1 - 3yrs)?

Is there available funding from grants or Quality Improvement Incentives (Payer) opportunities?

Would addressing this need free up resources for other community-wide needs?

Is this a community-wide or vulnerable population need?

3. Priority Needs Comparison



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