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December 20, 2022

Via Messenger Service

Neli N. Palma, Supervising Deputy Attorney General
Office of Attorney General
Healthcare Rights and Access, California Department of Justice
1300 I Street, 12th Floor
Sacramento, California 95814

Re: Beverly Community Hospital Association, Montebello Community Health Services, Inc., and Adventist Health System/West: Written Notice and Request for Attorney General Consent to the Affiliation (Corp. Code § 5920 / 11 C.C.R. 999.5)

Dear Ms. Palma:

This letter and all attachments hereto shall serve as written notice (this "Notice") to the Office of Attorney General (the "Attorney General") of the proposed affiliation (the "Affiliation") among Beverly Community Hospital Association d/b/a Beverly Hospital, a California nonprofit public benefit corporation ("Beverly"), Montebello Community Health Services, Inc., a California nonprofit public benefit corporation ("Montebello" and with Beverly, each a "Beverly Entity" and together, the "Beverly Entities"), and Adventist Health System/West d/b/a Adventist Health, a California nonprofit religious corporation ("Adventist Health"), and a request for written consent from the Attorney General for approval of the Affiliation.

California Corporations Code Section 5920 requires that any nonprofit corporation that operates or controls a health facility, as defined in Section 1250 of the Health and Safety Code, provides written notice to, and obtains the written consent of, the Attorney General prior to entering into any agreement that transfers control, responsibility, or governance of a material amount of assets or the operations of the nonprofit corporation to another nonprofit corporation. Pursuant to these requirements, Beverly, as a nonprofit corporation that operates a health facility, provides this Notice to obtain the Attorney General's written consent prior to the finalization of the Affiliation.

The Beverly Entities and Adventist Health have entered into an Affiliation Agreement, dated December 15, 2022 (the "Affiliation Agreement") under which Adventist Health will become the sole corporate member or sole controlling entity of each Beverly Entity. As a result, Beverly will join Adventist Health's health system as one of its member hospitals, and the Affiliation will provide Beverly with the support of an integrated health system and allow the Beverly community to continue to have access to critical healthcare services. The Affiliation reflects the espousal of each organization's longstanding mission to provide high quality, accessible, and affordable healthcare services to underserved communities.

As addressed below, this letter summarizes the events leading up to and the terms of the Affiliation. Section I provides an introduction to the parties. Section II describes the developments during the negotiations of the Affiliation and material terms of the Affiliation. Finally, Section III includes the anticipated timing, culminating in the closing of the Affiliation.

I. BACKGROUND INFORMATION

Beverly Community Hospital Association d/b/a Beverly Hospital. Beverly is a nonprofit public benefit corporation that owns and operates a 202-bed general acute care hospital located at 309 W. Beverly Boulevard, Montebello, California, 90640, which has a mission of providing quality driven, compassionate, and patient-centric care for its community of over 700,000 residents. Through approximately 1,000 employees and a medical staff with over 400 physicians, Beverly provides a full range of inpatient and outpatient care, including a 32-bed Emergency Care Center; general acute care services that include an intensive care unit, medical/surgical care, telemetry care, obstetrics/gynecology, NICU (level I) and pediatrics; diagnostic and interventional imaging center equipped with an interventional radiology lab; 24/7 laboratory and pathology services; comprehensive cardiac services with two catheterization labs and an open heart surgery program; orthopedic services; urology services; and a Wound Care and Hyperbaric Medicine Center.

As a safety net hospital provider, Beverly delivers crucial healthcare services and represents a vital resource and asset for its patient community, of which over 80% of individuals speak a language other than English in their household, almost 50% of households live below 200% of the Federal Poverty Level, and over one-third of adults do not have a high school diploma or equivalency. Further, over 75% of the patients served by Beverly are Medicare or Medi-Cal beneficiaries. In sum, Beverly provides critical healthcare services to populations that, without Beverly's presence, are vulnerable to patient access and quality of care issues.

Over the past several years, Beverly has faced significant financial and operational challenges that have been amplified by issues arising under the COVID-19 pandemic, and as a result, Beverly's fiscal and operational sustainability is under an unprecedented threat. In the absence of sizable reserves to address the current fiscal year's negative cash flow and EBITDA situation, Beverly is facing an imminent threat of bond default and insolvency in the near future. In particular, Beverly's operating margin does not generate adequate capital funding necessary to address its aging physical plant and equipment (including replacements/upgrades), competitive wages and benefits for clinical and non-clinical workforce recruitment and retention, empower Beverly to negotiate an attractive payor mix for specialty physician recruitment and retention, make information technology upgrades for its electronic health records and related software, and provide sufficient capital resources to comply with California's 2030 seismic requirements. In addition, Beverly has not been able to maintain adequate financial reserves to address the ever-present challenges facing community hospitals operating in the current market conditions. As a result, Beverly's financial position has inhibited its ability to identify a willing healthcare provider partner in an effort to better serve the needs of its patient community and remain a competitive

organization in a service area that includes a number of hospitals owned and operated by larger health systems. Without a health system partner or form of financial support from a third party, Beverly will have to consider ceasing its operations in the very near future, which will be to the severe detriment to the community it serves.

Montebello Community Health Services, Inc. Montebello is a California nonprofit public benefit corporation, which operates exclusively for the benefit of Beverly and its affiliates. Specifically, Montebello provides managerial support and financial planning, operates healthcare education programs, and promotes the delivery of healthcare services in the Montebello community. Montebello owns medical office buildings and other healthcare facilities, which are leased to third party providers.

Adventist Health System/West d/b/a Adventist Health. Adventist Health is nonprofit religious corporation founded on Seventh-day Adventist heritage and values that provides care through an integrated health system with operations in California, Hawaii, and Oregon. Adventist Health operates its hospitals through separate legal entities of which Adventist Health (or one of its affiliates) is the sole corporate member or sole controlling entity, including White Memorial Medical Center d/b/a Adventist Health White Memorial Hospital, a California nonprofit religious corporation ("AHWM"), which operates a 353-bed teaching hospital that delivers a full range of inpatient, outpatient, emergency, and diagnostic services to downtown Los Angeles and its surrounding communities. Founded in 1913, AHWM is now one of Southern California's leading nonprofit hospitals.

II. NEGOTIATIONS AND SUMMARY OF AFFILIATION

Beverly's Evaluation of Potential Closure and Necessity of Affiliation for Continued Operations.

In light of the pervasive financial and operational challenges that Beverly has and continues to experience, in 2018, the Board of Directors of Beverly ("Beverly Board") ultimately determined that Beverly's operations as an independent, community hospital were not financially sustainable, and in fact, were in severe jeopardy. Accordingly, the Beverly Board considered all possible alternatives to secure Beverly's future as a healthcare facility that would enable it to continue to deliver critical healthcare services to its community.

The Beverly Board determined that an affiliation with a larger health system would best preserve and strengthen Beverly's legacy as a community-focused healthcare provider. Due to the urgency surrounding Beverly's financial position, the Beverly Board evaluated and considered all potential options, approached multiple potential partners, and engaged with all organizations that expressed interest in affiliating with Beverly.

In securing an affiliation, the Beverly Board was interested in potential health system partners that would help preserve critical healthcare services in the community and provide

Beverly with access to additional resources to support its current and anticipated financial needs. Although Beverly engaged in preliminary, confidential discussions with a limited number of partners regarding a potential affiliation, these discussions did not proceed because of the other party's lack of interest or inability to move forward with the transaction based on Beverly's financial condition. Thus, despite Beverly's good-faith efforts to find alternatives, its financial and operational challenges combined with macroeconomic conditions affecting nonprofit hospitals ultimately resulted in Beverly's negotiations moving forward with Adventist Health as the only potential partner. The Beverly Board concluded that, without a health system partner or form of financial support from a third party, Beverly would have to consider ceasing its operations. The Beverly Board concluded that Adventist Health proved to the ideal organization based upon its culture, vision, and goals for the future, including its commitment to serving as safety net community hospital that provides innovative and high-quality care to the Greater East Los Angeles area. Thus, the Beverly Board determined that the Affiliation with Adventist Health, which will permit Beverly to maintain community access to essential healthcare services, was in the best interest of Beverly and its community.

Letter of Intent. Beverly and Adventist Health signed the letter of intent on June 15, 2022 (the "Letter of Intent"). In accordance with the Letter of Intent, Beverly's officers, along with Beverly's legal counsel, under the oversight of the Beverly Board, proceeded with the negotiation of a definitive Affiliation Agreement and related documents to effectuate the transaction.

Entrance into the Affiliation Agreement. On December 15, 2022, the parties executed the Affiliation Agreement. The Affiliation Agreement provides that Adventist Health will become the sole corporate member or sole controlling entity of each Beverly Entity. The Beverly Entities will retain all of their assets and liabilities under the Affiliation. In addition, all endowment and donor funds will remain unchanged as to both control and charitable use. A more detailed summary of the Affiliation Agreement is provided for in Section 999.5(d)(1)(A) of this Notice and the full Affiliation Agreement with all Schedules and Exhibits is included as Exhibit 1 to Section 999.5(d)(1)(A).

III. TIMING AND ANTICIPATED CLOSING

Timing and Anticipated Closing. The parties executed the Affiliation Agreement December 15, 2022. This Notice and other consents necessary to close the Affiliation, as required under the Affiliation Agreement, are ongoing at this time. Beverly is submitting the Notice immediately after signing of the Affiliation Agreement to help expedite approval by the California Attorney General. Pursuant to the Affiliation Agreement, the closing of the Affiliation will occur upon satisfaction of each party's respective closing conditions, which we anticipate to occur during the second quarter of 2023.

Anticipated Post-Closing Events.

The parties believe that the Affiliation will allow both parties to work cooperatively to adapt to the changing healthcare environment and best serve their communities. Following the closing of the Affiliation, Beverly and Adventist Health intend to maximize operational efficiencies arising from the parties' ability to provide services at each of the Beverly and AHWM campuses, which are located in the same general service areas along with many other healthcare providers. The Affiliation will enable healthcare services to be located at either of the two facilities to facilitate appropriate access to healthcare services for all patients in the communities. As part of the Affiliation, within three years of the closing, Adventist Health intends to effectuate a corporate restructuring of Beverly so that it is operated under a single hospital license with AHWM.

We remain hopeful that the Attorney General will provide written consent to the Affiliation as described above. We are prepared to provide any additional information or documentation which you may require. Please feel free to contact me at your convenience. We appreciate your consideration of this request and look forward to your response.

Sincerely,

Jill H. Gordon
Partner

JHG:ab

Enclosures

NOTICE OF PROPOSED SUBMISSION AND REQUEST FOR CONSENT BY

BEVERLY COMMUNITY HOSPITAL ASSOCIATION
D.B.A.
BEVERLY HOSPITAL
A CALIFORNIA NONPROFIT PUBLIC BENEFIT CORPORATION,

AND

MONTEBELLO COMMUNITY HEALTH SYSTEM, INC.,
A CALIFORNIA NONPROFIT PUBLIC BENEFIT CORPORATION

IN CONNECTION WITH ITS AFFILIATION AGREEMENT

ADVENTIST HEALTH SYSTEM/WEST D.B.A. ADVENTIST HEALTH
A CALIFORNIA NONPROFIT RELIGIOUS CORPORATION

PREPARED FOR THE OFFICE OF THE ATTORNEY GENERAL

CALIFORNIA DEPARTMENT OF JUSTICE
CHARITABLE TRUSTS DIVISION

December 20, 2022

Title 11, California Code of Regulations, § 999.5(d)(1)

DESCRIPTION OF THE TRANSACTION

11 Cal. Code Reg. Section 999.5(d)(1)(A)

A full description of the proposed agreement and transaction

This summarizes the proposed transaction between the following parties: Beverly Community Hospital Association d/b/a Beverly Hospital, a California nonprofit public benefit corporation ("Beverly"), Montebello Community Health Services, Inc., a California nonprofit public benefit corporation ("Montebello" and together with Beverly, each a "Beverly Entity" and collectively, the "Beverly Entities"), Adventist Health System/West d/b/a Adventist Health, a California nonprofit religious corporation ("Adventist Health"), under which Adventist Health will become the sole corporate member or the sole controlling entity of each Beverly Entity (the "Affiliation") pursuant to a definitive agreement (the "Affiliation Agreement") (*See* **Exhibit 1**, attached to Section 999.5(d)(1)(B), including all exhibits and schedules thereto, with certain of such schedules submitted to the Attorney General on a confidential basis pursuant to 11 Cal. Code Reg. § 999.5(c)(3)). Beverly submits this notice to the California Attorney General under Corporations Code Section 5920 in accordance with the requirements of Title 11 of the California Code of Regulations, Section 999.5(a) (this "Notice").

I. The Parties

A. Beverly Community Hospital Association d/b/a Beverly Hospital

Beverly is a nonprofit public benefit corporation that owns and operates a 202-bed general acute care hospital located at 309 W. Beverly Boulevard, Montebello, California, 90640. Beverly was founded by a group of 18 physicians in 1949 with the goal of creating a community-based hospital with a mission of providing quality driven, compassionate, and patient-centric care for its community, which includes over 700,000 residents. Beverly is one of the only remaining standalone, community hospital facilities in the Greater East Los Angeles area (which includes Montebello, Pico Rivera, East Los Angeles, and surrounding communities). In response to the health needs of its community, over the past several decades, Beverly has expanded its services and facilities to include approximately 1,000 employees and a medical staff with over 400 physicians.

Beverly provides a full range of inpatient and outpatient care, including a 32-bed Emergency Care Center; general acute care services that include an intensive care unit, medical/surgical care, telemetry care, obstetrics/gynecology, NICU (level I) and pediatrics; diagnostic and interventional imaging center equipped with an interventional radiology lab; 24/7 laboratory and pathology services; comprehensive cardiac services with two catheterization labs and an open heart surgery program; orthopedic services; urology services; and a Wound Care and Hyperbaric Medicine Center.

Beverly is a safety-net acute care hospital and emergency care provider serving vulnerable populations who, without Beverly's presence, would be at risk of inadequate access to quality care. Specifically, Beverly serves a largely diverse population and its patient community includes the following demographics: over 80% of individuals that speak a language other than English in their household, almost 50% of households that live below 200% of the Federal Poverty Level (FPL), and over one-third of adults that do not have a high school diploma or equivalency. Over 75% of the patients served by Beverly are Medicare or Medi-Cal

beneficiaries, and Beverly receives less than 25% of its revenue from commercial health plans and other payors.

Beverly, which has a primary service area that includes a number of competitor hospitals owned and operated by larger health systems, faces ongoing operating losses due to a number of historical payor mix challenges that have been amplified by new challenges arising from the COVID-19 pandemic. In particular, Beverly's operating margin does not generate adequate capital funding necessary to address its aging physical plant and equipment (including replacements/upgrades), to offer competitive wages and benefits for clinical and non-clinical workforce recruitment and retention, to empower Beverly to attract and develop a payor mix that would support specialty physician recruitment and retention, information technology upgrades for its electronic health records and related software, and provide sufficient capital resources to comply with California's 2030 seismic requirements. These issues have been aggravated by a decline of Beverly's operating margin resulting from the rising costs of hospital operations, as well as the fact that there have been minimal increases, if any, to Beverly's commercial and government payor reimbursement rates, which fail to adequately address increased costs attributable to clinical staffing costs. Moreover, federal and state funding that Beverly currently receives—Disproportionate Share Hospital (DSH) payments and payments under the Hospital Quality Assurance Fee Program (QAF)—are at risk of being cut, meaning that Beverly cannot rely on these funding sources to augment its revenues into the future.

As a result, Beverly's fiscal and operational sustainability is under an unprecedented threat. Compounding factors include excessive labor premiums (averaging $1.5 million per month) due to nurse staffing shortages, inability to recruit and retain nursing workforce to mitigate registry usage, stagnant or near zero rate increases in 85% of the patient days (Medi-Cal and Medicare) over the past ten years, lack of specialty physicians to cover the emergency department on-call panel, and lack of sizable reserves to provide cash flow for basic capital improvements. Beverly's predicament is further evidenced by macroeconomic financial pressures, reflected in a growing number of hospitals in Beverly's service area filing for Chapter 11 bankruptcy and Fitch Ratings downgrading the entire nonprofit hospital sector to "deteriorating" for the remainder of 2022. It is critical that Beverly Hospital joins with a health system that has the capacity and capability to sustain Beverly's future, and more importantly, a partner with an aligned community mission and commitment to high quality of care to continue Beverly's founding principle.

With respect to the organization and governance of Beverly, Beverly currently does not have any corporate members. The governance of Beverly is set forth under its Bylaws, which provides governing authority to a Board of Directors that consists of 17 board members (the "Beverly Board").

Beverly's services to the community are supported by Beverly Hospital Foundation, a California nonprofit public benefit corporation (the "Foundation"), of which Beverly is the sole corporate member. As a separate legal entity, the Foundation is governed by its own, separate Board of Trustees, which is not required to have overlapping membership with the Beverly Board and consists of 21 to 31 members. The Foundation engages in fundraising and the administration of such funds and property that have been donated for the benefit of Beverly and its programs, services, and patients.

B. Montebello Community Health Services, Inc.

Montebello is a California nonprofit public benefit corporation, which operates exclusively for the benefit of Beverly and its affiliates. Specifically, Montebello provides managerial support and financial planning, operates healthcare education programs, and promotes the delivery of healthcare services in the Montebello community. Montebello owns certain medical office buildings and other healthcare facilities, which are leased to third party providers.

With respect to the organization and governance of Montebello, Montebello currently does not have any corporate members. The governance of Montebello is set forth under its Bylaws, which provides governing authority to a Board of Directors that consists of 17 board members that are the same individuals appointed to the Beverly Board (the "Montebello Board").

C. Adventist Health System/West d/b/a Adventist Health

Adventist Health is nonprofit religious corporation founded on Seventh-day Adventist heritage and values that provides care through an integrated health system comprised of 23 hospitals, 379 clinics, 14 home care agencies, eight hospice agencies, one continuing care retirement community, and three joint venture retirement centers throughout California, Hawaii, and Oregon. Adventist Health employs approximately 34,000 individuals across its health system.

Adventist Health operates its hospitals through separate legal entities of which Adventist Health (or one of its affiliates) is either the sole corporate member or exerts control through a "mirror" board of directors, including White Memorial Medical Center d/b/a Adventist Health White Memorial Hospital, a California nonprofit religious corporation ("AHWM"), which operates a 353-bed teaching hospital that delivers a full range of inpatient, outpatient, emergency, and diagnostic services to downtown Los Angeles and its surrounding communities. Founded in 1913, AHWM is now one of Southern California's leading nonprofit hospitals, providing services including cardiac and vascular care, intensive and general medical care, oncology, orthopedic care, rehabilitation, specialized and general surgery, and women's and children's services. In addition, as an established teaching hospital, AHWM plays a key role in training physicians, nurses, and other medical professionals to deliver critical healthcare services in the community.

With respect to governance of Adventist Health, Adventist Health maintains Board of Directors (the "Adventist Board") made up of no more than 15 members. As the governing body of Adventist Health, the Adventist Board provides strategic oversight and governance over all of the clinical care activities provided under the health system.

II. Overview of the Transaction: Affiliation Agreement

In order to remain operational as a healthcare facility in the Greater East Los Angeles community, Beverly plans to affiliate with Adventist Health, which will occur through the addition of Beverly as a member hospital of Adventist Health's health system under Adventist Health's control. In addition, Adventist Health will become the sole corporate member or the sole controlling entity of Montebello. Without the Affiliation, Beverly will be forced to consider, as a result of its financial condition, shutting down its operations. Thus, the Affiliation is the only

remaining avenue for Beverly to maintain community access to essential healthcare services to its community. Adventist Health views the Affiliation as an extension of its mission to transform the health experience of its communities by making care more accessible and affordable, and is committed to maintaining health facilities that deliver care to underserved communities.

The parties intend that the Affiliation will fulfill community needs for expanded access to high-quality health services for residents in Beverly's service area and surrounding communities through the creation of a regionally-integrated healthcare delivery system. As safety net hospitals that provide a substantial portion of their respective services to uninsured patients and Medi-Cal or Medicare beneficiaries, both Beverly and Adventist Health view the provision of high quality, healthcare services to underserved communities as a critical pillar of their respective missions and visions of care delivery. As a result, both parties agree that the Affiliation, which will join Beverly to Adventist Health's health system and provide Beverly with the support of an integrated health system, will enhance the Beverly's community continued access to healthcare services. In connection with the parties' objectives, the Affiliation will also provide the parties a way to explore opportunities to develop, implement, and expand clinical program integration, physician alignment, network development, and educational and teaching programs.

A. Key Provisions of Affiliation

1. New Governance Structure under the Affiliation

The Affiliation will result in Adventist Health becoming the sole corporate member or the sole controlling entity of each Beverly Entity on the closing (the "Closing") of the Affiliation Agreement and in accordance with its terms. To effectuate certain terms of the Affiliation, including designating Adventist Health as the controlling entity of each Beverly Entity, the following will occur: Beverly's Articles of Incorporation and Bylaws will be amended and restated, and Montebello's Articles of Incorporation and Bylaws will be amended and restated (collectively, the "New Beverly Organizational Documents"). Upon the Closing, the Beverly Board and the Montebello Board will be replaced in order to have a Beverly Board and Montebello Board that mirror the composition of the Adventist Board. In addition, the Beverly Board will appoint a newly created "Community Board" that will have delegated authority from the Beverly Board, consistent with the applicable New Beverly Organizational Documents.

As required under the current governance documents of each Beverly Entity, the following approvals were obtained in order to give effect to the New Beverly Organizational Documents:

- On September 27, 2022 and October 25, 2022, the Beverly Board approved the amendment and restatement of Beverly Articles of Incorporation and amendment and restatement of the Beverly Bylaws (*See* **Exhibit 2** and **Exhibit 4** attached to Section 999.5(d)(1)(B)), which will be filed with the California Secretary of State and will be adopted at Closing, respectively.

- On September 27, 2022 and October 25, 2022, the Montebello Board approved an amendment and restatement of the Montebello Articles of Incorporation and amendment and restatement of the Montebello Bylaws (*See* **Exhibit 3** and **Exhibit 5**, attached to Section 999.5(d)(1)(B)), which will be

filed with the California Secretary of State and will be adopted at Closing, respectively.

2. Operations

Upon Closing, as part of the integrated Adventist Health system, Adventist Health will use commercially reasonable efforts to provide Beverly access to or to further support and enhance the following operational functions at Beverly to enhance care delivery, improve quality, promote access to high quality care services, and reduce unnecessary costs:

- Physician Alignment and Network Development. Implement a physician network strategy focused on alignment and network development of providers.

- Payor Relations. Implement a Medi-Cal and Quality Assurance Fees strategy to improve value and access for residents of the communities served by Beverly and AHWM.

- Medical Staff and Physician Coverage. Combine the medical staff of Beverly and AHWM to expand Beverly's medical staff coverage by more than 800 primary care and specialist physicians.

- GME. Extend graduate medical education activities across both campuses to enable resident physicians to provide coverage at Beverly and further enhance access to care for patients of the facilities.

- Quality and Patient Safety. Enhance Beverly's quality and patient safety programs as part of the integrated Adventist Health system with access to Adventist Health's clinical protocols, care coordination, analytics, tools, leadership, and other supporting programs and infrastructure for value-based services and quality mandates.

- Revenue Cycle Management. Provide access to Adventist Health's revenue cycle management tools and infrastructure, including in connection with management of claims denials, group purchasing, and maintenance of inventories.

- Information Technology Systems. Support Beverly's IT capabilities including (i) ambulatory/clinic data integration, (ii) clinical analytic capabilities, (iii) virtual/digital health platform opportunities, and (iv) enhanced cyber security.

As long as Beverly operates as a general acute care hospital, Adventist Health will provide for typical hospital-based services, including maintaining an emergency department at Beverly. Through the Affiliation, Beverly and Adventist Health further intend to maximize operational efficiencies arising from the parties' ability to provide services at either of the Beverly and AHWM campuses. AHWM currently operates at capacity in certain service lines and typically turns away approximately ten patients per day due to capacity limits, in comparison with Beverly, which generally has excess capacity. The flexibilities resulting from the integration of Beverly into Adventist Health's health system will enable healthcare services to be located at either of the member hospitals (i.e., Beverly and AHWM) to allow the patients of such facilities appropriate access to healthcare services in the community and to provide sufficient medical staff coverage and support for all inpatient care services in each facility. As part of the

Affiliation, within three years of the Closing, Adventist Health intends to effectuate a corporate restructuring of Beverly so that it is operated under a single hospital license with AHWM.

Following the Closing, if Adventist Health determines it needs to cease operating Beverly as a general acute care hospital, the Affiliation Agreement requires that Adventist Health utilize Beverly's net assets (calculated in accordance with the terms of the Affiliation Agreement) for charitable health care purposes for the local community.

3. Employees; Medical Staff

Employees of Beverly and Montebello will remain employees of their respective organization at Closing.

The physicians on the medical staff of Beverly who are in good standing will be retained as of the Closing. As described above, following the Closing, Adventist Health anticipates taking the steps necessary to combine the medical staff members of Beverly with the AHWM medical staff to mitigate ongoing medical staff challenges at Beverly and to expand medical staff coverage.

4. Financial Commitments and Resources

Following the Closing, Adventist Health will develop an annual operating and capital budget for each Beverly Entity in accordance with Adventist Health's policies and procedures for its budgets and capital commitments for Adventist Health's member-hospitals and organizations. As a foundational element of the Affiliation and Adventist Health's decision to bring Beverly into the Adventist Health system, Beverly and Adventist Health agreed that Beverly's future net revenues must fund both its operations and any routine or strategic capital expenditures, including any capital expenditures necessary to maintain compliance with applicable laws, including the Alfred E. Alquist Hospital Seismic Safety Act of 1983, without any supplemental capital commitment from the Adventist Health system. Beverly's capital budgets, which will be developed in accordance with Adventist Health's policies, will provide for an annual capital budget of up to 70% of Beverly's EBITDA as a reinvestment of earnings into Beverly's ongoing capital needs, and will be determined by Adventist Health in its sole and absolute discretion.

5. Charity and Community Care

Beverly will adopt the Adventist Health policies on charity and indigent care (See **Exhibit 26** to Section 999.5(d)(9)) (the "AH Charity Care Policy"), which will require that Beverly continues to provide care through community-based 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 Beverly's service area. Notwithstanding Beverly's adoption of the AH Charity Care Policy, the parties have agreed that any charity care patient or discounted care patient of Beverly as of the Closing shall finish his or her course of treatment under the same financial arrangement as existed with Beverly prior to the Closing.

6. Beverly Foundation

As of the Closing, in accordance with applicable laws, charitable donations that the Foundation receives will be distributed and expended according to the terms of such donations. The Affiliation Agreement provides that Adventist Health shall maintain the current status of the mission of the Foundation and shall retain the Foundation board of directors for no less than twelve months.

11 Cal. Code Reg. Section 999.5(d)(1)(B)

A complete copy of all proposed written agreements or contracts to be entered into by the applicant and the transferee that relate to or effectuate any part of the proposed transaction

Attached to this Section are the following documents:

- **Exhibit 1**, a copy of the Affiliation Agreement, including all exhibits, schedules, and attachments thereto, provided that certain of such schedules are submitted to the Attorney General on a confidential basis pursuant to 11 Cal. Code Reg. § 999.5(c)(3).

- **Exhibit 2**, a copy of the Amended and Restated Articles of Incorporation of Beverly, pursuant to which Adventist Health will have governance control over Beverly and to be adopted as of the Closing.

- **Exhibit 3**, a copy of the Amended and Restated Articles of Incorporation of Montebello, pursuant to which Adventist Health will have governance control over Montebello and to be adopted as of the Closing.

- **Exhibit 4**, a copy of the current Amended and Restated Bylaws of Beverly, pursuant to which Adventist Health will have governance control over Beverly and to be adopted as of the Closing.

- **Exhibit 5**, a copy of the current Amended and Restated Bylaws of Montebello, pursuant to which Adventist Health will have governance control over Montebello and to be adopted as of the Closing.

- **Exhibit 6,** a copy of the Bylaws for the Community Board of Beverly, to be adopted as of the Closing.

EXHIBIT 1

AFFILIATION AGREEMENT

Execution Version

AFFILIATION AGREEMENT

by and among

BEVERLY COMMUNITY HOSPITAL ASSOCIATION
DBA
BEVERLY HOSPITAL
a California nonprofit public benefit corporation,

and

MONTEBELLO COMMUNITY HEALTH SYSTEM, INC.,
a California nonprofit public benefit corporation

and

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

TABLE OF CONTENTS

TABLE OF CONTENTS (CONTINUED)

TABLE OF CONTENTS (CONTINUED)

TABLE OF CONTENTS (CONTINUED)

PAGE

AFFILIATION AGREEMENT

THIS AFFILIATION AGREEMENT (this "***Agreement***") is made and entered into effective as of December 15, 2022 (the "***Execution Date***") by and among Adventist Health System/West, d.b.a. Adventist Health, a California nonprofit religious corporation on behalf of itself and any Affiliate designated pursuant to this Agreement (collectively, "***Adventist Health***"), Beverly Community Hospital Association d/b/a Beverly Hospital, a California nonprofit public benefit corporation ("***Beverly***"), and Montebello Community Health Services, Inc., a California nonprofit public benefit corporation ("***Montebello***" and together with Beverly, each a "***Beverly Entity***" and collectively, the "***Beverly Entities***"). Adventist Health, Beverly, and Montebello may be referred to herein individually as a "***Party***" and collectively as the "***Parties***."

R E C I T A L S

WHEREAS, Beverly is a California nonprofit public benefit corporation that currently has no member and that owns and operates an acute care hospital located at 309 West Beverly Blvd., Montebello, CA 90640, and provides various outpatient services in the Beverly Service Area (as defined below);

WHEREAS, Montebello is a California nonprofit public benefit corporation organized to support Beverly and its affiliates, including through the provision of administrative and managerial support, operation of medical and public health education programs, and promotion of the efficient delivery and financing of healthcare in the Beverly Service Area;

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 the Beverly Entities to affiliate with Adventist Health on the terms and conditions set forth in this Agreement (the "***Affiliation***") to develop a regionally-integrated healthcare delivery system to improve the quality of care of healthcare within Adventist Health's and Beverly's communities, and to further the Parties' mission of advancing quality of care in a manner consistent with the Parties' charitable missions and purposes; and

WHEREAS, once the Affiliation takes effect, it is the Parties' desire to grow the integrated healthcare delivery system created by the Affiliation where such growth is strategically and economically feasible and appropriate.

NOW, THEREFORE, the Parties agree as follows:

ARTICLE I
VISION AND DEFINITIONS

1.1 Vision. The Parties intend to fulfill community need for expanded access to high-quality health services for residents in the Beverly Service Area and surrounding communities through the creation of a regionally-integrated healthcare delivery system.

1.2 Definitions. As used in this Agreement, 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) "***Adventist Health Due Diligence Request***" means that certain Due Diligence Request list originally provided by Adventist Health to Beverly and all supplemental diligence requests made by Adventist Health prior to the Closing Date.

(c) "***Adventist Health Financial Statements***" means the balance sheet and income statement of Adventist Health as of and for the year ended December 31, 2021, and the interim balance sheet and income statement of Adventist Health as of September 30, 2022.

(d) "***Adventist Health's Knowledge***" means: (i) the actual knowledge of the Chief Executive Officer, Chief Financial Officer, and Chief Operating Officer of Adventist Health and (ii) the knowledge which could have been acquired by any of the individuals listed immediately above after making such due inquiry and exercising such due diligence as a prudent business person in their actual capacity would have made or exercised in the management of his, her or its business affairs in light of all of the circumstances applicable thereto.

(e) "***Adventist Health Material Adverse Change***" 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 an effect or consequence that individually or in the aggregate results in the loss of a dollar amount, consideration, or other value that is equal to or exceeds two percent (2%) of the net revenue of Adventist Health, measured based on Adventist Health's fiscal year immediately prior to the Execution Date, on the business, assets, liabilities, financial condition or results of Adventist Health Operations regardless of whether such effect is or would be realized before or after the Closing. An Adventist Health Material Adverse Change 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 healthcare facilities; (iii) general business, industry or economic conditions, including such conditions related to Adventist Health; (iv) local, regional, national or international political or social conditions, including (A) the engagement by the United States in hostilities, whether or not pursuant to the declaration of a national emergency or war; (B) plague, epidemic, pandemic, outbreak of infectious disease or any other public health emergency recognized by an applicable Governmental Entity; or (c) 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 ("***GAAP***").

(f) *"**Affiliate**"* means any Person that directly, or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with another Person. 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.

(g) "***Beverly Assets***" means any and all assets used in the ordinary course of the Beverly Operations taken as a whole or in the individual operations of the Beverly Entities, including: (i) the Beverly Real Property (as defined below), (ii) all tangible personal property owned by the Beverly Entities and used in connection with the Beverly Operations, of every kind and nature, including all furniture, fixtures, equipment, machinery, vehicles, and owned or licensed computer systems, (iii) all inventories of useable supplies, drugs, food, janitorial and office supplies, maintenance and shop supplies, and other disposables and consumables owned by the Beverly Entities and used in connection with the Beverly Operations, and (iv) 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 Beverly Operations.

(h) "***Beverly Board of Directors***" means the Board of Directors of Beverly.

(i) "***Beverly's EBITDA***" means Beverly's consolidated net income for the applicable fiscal year of Beverly before any reduction for interest, income taxes, depreciation or amortization, as reflected on Beverly's financial statements prepared in conformity with the accounting method adopted and used by Adventist Health for the preparation of Beverly's financial statements following the Closing.

(j) "***Beverly 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, or other employee or fringe benefit plan, program, policy, practice, agreement or arrangement, whether written or oral, formal or informal, legally binding or not (including, but not limited to, 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 Beverly or any ERISA Affiliate, (ii) under which any current or former employee or director of Beverly has any present or future right to benefits, and (iii) with respect to which Beverly has any liability.

(k) "***Beverly Financial Statements***" means the balance sheet and income statement of each Beverly Entity as of and for the year ended December 31, 2021, and the interim balance sheet and income statement of each Beverly Entity as of August 31, 2022.

(l) "***Beverly Foundation***" shall mean Beverly Hospital Foundation, a California nonprofit public benefit corporation, of which Beverly is the sole corporate member.

(m) "***Beverly Healthcare Service***" means any licensed or license-exempt healthcare service provided by Beverly.

(n) "***Beverly's Knowledge***" means: (i) the actual knowledge of the Chief Executive Officer, Chief Financial Officer, Chief Strategy Officer, Chief Operations Officer or Chief Compliance Officer, or a position equivalent to any of the foregoing held by an individual at each of Beverly and Montebello, and (ii) the knowledge which could have been acquired by any of the individuals listed immediately above at each of Beverly and Montebello after making such due inquiry and exercising such due diligence as a prudent businessperson in their actual capacity would have made or exercised in the management of his, her or its business affairs in light of all of the circumstances applicable thereto.

(o) "***Beverly Material Adverse Change***" 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 an effect or consequence that individually or in the aggregate results in the loss of a dollar amount, consideration, or other value that is equal to or exceeds Ten Million Dollars ($10,000,000), on the business, assets, liabilities, financial condition or results of Beverly Operations regardless of whether such effect is or would be realized before or after the Closing. A Beverly Material Adverse Change 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 healthcare facilities; (iii) general business, industry or economic conditions, including such conditions related to the Beverly Entities; (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 GAAP.

(p) "***Beverly Operations***" means any and all operations conducted by the Beverly Entities, including, without limitation, all Beverly Healthcare Services.

(q) "***Beverly Real Property***" means all real property interests owned by the Beverly Entities, and all of the respective Beverly Entity's interests therein, and all right, title and interest of the Beverly Entities in all appurtenances, options, easements, servitudes, rights-of-way and other rights associated therewith.

(r) "***Beverly Service Area***" means the thirty (30) mile radius surrounding Beverly.

(s) "***Closing Date***" means the date of the Closing that is no more than seven (7) days after satisfaction or waiver of the conditions set forth in Sections 8.1 and 8.2.

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

(u) "***Control***" (including, with correlative meanings, the terms "controlled by" and "under common control with") means the power or possession of the power, direct or indirect,

to direct or cause the direction of the management and policies of an entity, whether through the ownership of securities, election or appointment of directors, by contract or otherwise.

(v) "***Effective Time***" means 12:01 a.m. (Pacific Time) on the day immediately following the Closing Date.

(w) "***Employee Welfare Benefit Plan***" shall have the meaning set forth in Section 3(1) of ERISA.

(x) "***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.

(y) *"**Environmental Claim**"* means any written or threatened, claim, action, cause of action, investigation or notice by any Person alleging potential liability arising out of, based on or resulting from (i) the presence, release, or threatened release, of any Hazardous Materials at or adjacent to any location owned or operated by a Beverly Entity or Adventist Health, as applicable, or (ii) circumstances forming the basis of any violation or alleged violation of any Environmental Law.

(z) "***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.

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

(bb) "***ERISA Affiliate***" means any person or entity that directly controls, is controlled by, or is under common control with 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).

(cc) "***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, contractor, 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.

(dd) "***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.

(ee) "***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.

(ff) "***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***").

(gg) "***Law***" or "***Laws***" means all laws, codes, regulations, rules, orders, common law and ordinances including, but not limited to: state corporate practice of medicine Laws and regulations, state professional fee-splitting laws and regulations, the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Affordability Reconciliation 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), and any other local, state or federal law, regulation, guidance document, manual provision, program memorandum, opinion letter, or other public issuance.

(hh) "***Lookback Period***" means the six (6) year period ending on the Execution Date.

(ii) "***Material Contract***" means all commitments, contracts, leases, licenses, agreements and understandings, written or oral, 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, and bonds, mortgages and other loan agreements (i) with a book value of Fifty Thousand Dollars ($50,000) annually or One Hundred Thousand Dollars ($100,000) in the aggregate or (ii) that is not terminable by the applicable Beverly Entity within thirty (30) days at the applicable Beverly Entity's sole and absolute discretion.

(jj) "***Montebello Board of Directors***" means the Board of Directors of Montebello.

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

(ll) "***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.

(mm) "***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*.).

(nn) "***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 Material 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 state, local or foreign Law) or otherwise.

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

ARTICLE II
BEVERLY MEMBERSHIP AND GOVERNANCE

2.1 Issuance of Membership. The Affiliation shall initially be effected by Adventist Health or a designated Affiliate becoming the sole corporate member or the sole controlling entity of each of Beverly and Montebello on the Closing Date, effective as of the Effective Time (the "***Membership Issuance***"). On the Closing Date and effective as of the Effective Time, the applicable Beverly Entity shall have: (a) adopted and filed with the California Secretary of State an amended and restated articles of incorporation of each of Beverly and Montebello in the forms attached hereto as Attachment 2.1(a)(1) and Attachment 2.1(a)(2), respectively, (b) adopted the amended and restated bylaws of each of Beverly and Montebello in the forms attached hereto as Attachment 2.1(b)(1) and Attachment 2.1(b)(2), respectively, and (c) adopted the bylaws of the Community Board (as defined below) in the form attached hereto as Attachment 2.1(c) (collectively the "***New Beverly Organizational Documents***"), making Adventist Health the sole corporate member or sole controlling entity of each of Beverly and Montebello with all governance and economic control over Beverly and Montebello as set forth in the New Beverly Organizational Documents and the applicable Nonprofit Corporation Law of the State of California (the "***State***").

2.2 Corporate Restructuring of Beverly Operations. The Parties acknowledge that following the Closing, Adventist Health, in its sole and absolute discretion may merge Beverly or Montebello or both of the Beverly Entities with and into any Adventist Health Affiliate so that the Beverly Operations can be consolidated with Adventist Health's operations at White Memorial Medical Center ("***AHWM***").

2.3 Governance. Pursuant to the New Beverly Organizational Documents:

(a) Beverly and Montebello shall each have a legal board of directors (the "***Corporate Board***") that is the board of directors ultimately responsible for the actions of each of Beverly and Montebello under the Laws of the State. Effective on the Closing Date, the members of the Corporate Board shall be reconstituted to mirror the composition of the then-current Adventist Health board of directors.

(b) Beverly shall have an advisory committee tasked with oversight responsibilities of Beverly Operations (the "***Community Board***") as set forth in the New Beverly Organizational Documents. The members serving on the Beverly Board of Directors immediately prior to the Closing shall be the initial members of the Community Board. Following the restructuring of Beverly Operations set forth in Section 2.2 above, the Community Board shall continue as provided for in the New Beverly Organizational Documents.

2.4 Beverly Foundation. Upon the Closing, Adventist Health shall cause Beverly to maintain the current status of the mission of Beverly Foundation immediately prior to the Closing. Adventist Health shall retain the Beverly Foundation Board for no less than twelve (12) months. Further, in accordance with applicable Laws, charitable donations that Beverly Foundation receives that are restricted for use at Beverly will be distributed and expended accordingly.

ARTICLE III
REPRESENTATIONS AND WARRANTIES OF THE BEVERLY ENTITIES

Except as otherwise set forth on the schedules prepared by the Beverly Entities, dated as of the Execution Date and updated pursuant to Section 5.2(a) (collectively, "***Beverly Schedules***"), Beverly and Montebello each represent and warrant to Adventist Health as of the Execution Date, as follows:

3.1 Organization, Power, Absence of Conflicts.

(a) Organization; Good Standing. Each Beverly Entity is a 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 respective business in the State and to own or lease and operate the Beverly Assets and other properties at and where now owned or leased and operated by it. Neither Beverly nor Montebello 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 Beverly Asset, or the conduct or nature of the Beverly Operations, makes such licensing, qualification or admission necessary.

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

(i) Each Beverly Entity has all requisite corporate power and authority to conduct its businesses 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 any Beverly Entity, as may be required under Law. No other corporate or other proceeding on the part of the respective Beverly Entity is necessary to authorize this Agreement and the Affiliation contemplated hereby. This Agreement has been duly executed and delivered by each Beverly Entity and is a legal, valid and binding obligation of such Beverly Entity, enforceable against each Beverly 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 Beverly Entity is necessary to approve this Agreement or the Affiliation contemplated hereby.

(ii) The execution and delivery by each Beverly Entity of this Agreement does not, and the consummation of the Affiliation contemplated hereby will not, (A) result in any material breach or contravention of, or permit the acceleration of the maturity of, any Material Encumbrances of the Beverly Entities, (B) to Beverly's Knowledge result in the creation of any Material Encumbrances on the Beverly 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 the Beverly Entities, as amended to date, or (D) to Beverly's Knowledge 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 the Beverly Entities.

3.2 Third-Party Rights; Transactions.

(a) Other than the Beverly Entities, no Affiliate of either of the Beverly Entities conducts any Beverly Operations and neither Beverly Entity has any subsidiaries or other interests in any Persons that conduct any Beverly Operations. Except for this Agreement, there are no Material Contracts with, or rights of, any Person to acquire, directly or indirectly, any Beverly Assets, or any interest therein.

(b) Since January 1, 2021, no Beverly Entity has sold, gifted, transferred or leased any Beverly Asset with a book value of One Hundred Thousand Dollars ($100,000) or more, individually or in the aggregate (if more than a single Beverly Asset was sold, gifted, transferred or leased in a single transaction) ("***Material Beverly Asset***"), to any Affiliate of any Beverly Entity or to any other Person, other than sales, gifts, transfers or leases between Beverly Entities themselves.

3.3 Legal Compliance.

(a) Each of the Beverly Entities is and, during the Lookback Period, has been in all material respects, in compliance with all Laws and, to the Beverly Entities' Knowledge, has timely filed all reports, data and other information required to be filed with Governmental Entities. No Beverly 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. No Beverly 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 Beverly Operations.

(b) Each applicable Beverly Entity has (i) developed and implemented a compliance plan for being in compliance with the Health Information Laws, and (ii) used its reasonable efforts to implement those provisions of such compliance plan in all material respects necessary to ensure that the applicable Beverly Operations are in compliance with the Health Information Laws.

(c) Each Beverly Entity has (i) 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 and (ii) 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 Beverly Entity is a party or otherwise bound.

(d) During the Lookback Period, (i) no Beverly Entity has received any written 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 Beverly 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 each Beverly Entity and (ii) to Beverly's Knowledge, its "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).

(e) Beverly and each Beverly Healthcare Service 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, as applicable. No Beverly Entity nor any of their respective officers, directors, employees, agents or contractors has been or is currently excluded from participation in any Government Payment Program.

(f) There are no Government Payment Program recoupments or recoupments of any third-party payor being sought, requested, claimed, or threatened in writing against any Beverly Entity. There is no Action, pending or threatened in writing against any Beverly Entity that relates in any way to a violation of any Law pertaining to the Government Payment Programs or which could reasonably be expected to result in the imposition of material penalties on or the exclusion of any Beverly Entity or any of the Beverly Operations from participation in any Government Payment Programs. No Beverly Entity or, to Beverly's Knowledge, 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. No Beverly 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.

(g) Each Beverly Entity is in compliance in all material respects 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. Each Beverly Entity's contracted providers are properly licensed and hold appropriate clinical privileges, as applicable, for the services which they provide at the Beverly Operations, 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.

(h) All material reports, data, and information required to be filed by any Beverly Entity in connection with any Government Payment Program have been timely filed and were true and complete in all material respects at the time filed (or were corrected in or supplemented by a subsequent filing). There are no Actions or appeals pending (and no Beverly 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 Beverly 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. During the Lookback Period, no validation review or program integrity review related to any Beverly Entity or any of the Beverly Operations has been conducted by any Governmental Entity in connection with any Government Payment Program and no such reviews are scheduled, pending, or threatened in writing against or affecting any Beverly Entity or any of the Beverly Operations.

(i) Each Beverly Entity holds all material licenses, permits, authorizations, certifications, accreditations, registrations and franchises (collectively, the "***Licenses***") that are necessary for its respective Beverly Operations. The Beverly Schedules contain an accurate list of all Licenses. Further, each facility owned or operated by a Beverly Entity holds all Licenses required by the appropriate state or federal agencies and any and all ancillary services operated or provided at each such facility that is required to be separately licensed holds all Licenses required by (or such Licenses have been applied for) the appropriate state or federal agencies. All such Licenses are in good standing (to the extent granted) or have been applied for and, to Beverly's Knowledge, are not subject to any current or threatened Action. To Beverly's Knowledge, the Beverly Operations and Beverly Healthcare Services are in compliance in all material respects with all applicable licensing requirements. There are no provisions in any Material Contracts or Material Contracts relating to any Licenses which would preclude or limit any Beverly Entity from conducting the Beverly Operations and using all the beds of Hospitals as they are currently classified (other than those beds held in suspense). Beverly has made available to Adventist Health complete and genuine copies of the current Licenses, survey results, reports, deficiency lists, statements of deficiency, plans of correction and similar materials related to the Beverly

Operations. All violations set forth in such reports, if any, have been corrected in all respects by Beverly.

3.4 Beverly Financial Statements. Attached as Schedule 3.4 are copies of the Beverly Financial Statements. Except as set forth on Schedule 3.4, the Beverly Financial Statements fairly and accurately present in all material respects the financial condition and results of operations of the Beverly 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 a Beverly Material Adverse Change) and the absence of notes; and the Beverly Financial Statements reflect the consistent application of GAAP throughout the periods involved.

3.5 Absence of Material Change. Since the date of the last Beverly Financial Statements, no Beverly Material Adverse Change has occurred in the financial condition, assets, liabilities, income or prospects of Beverly. To Beverly's Knowledge, there has not been any event, change, occurrence or circumstance that has had or could reasonably be expected to have a Beverly Material Adverse Change.

3.6 Real Property; Personal Property and Inventory and Supplies.

(a) Each of the Beverly Entities owns fee simple title to the Beverly Real Property, free and clear of any Encumbrances, other than those Encumbrances listed on Schedule 3.6(a).

(b) The Beverly Real Property listed on Schedule 3.6(b) comprises all of the real property owned or leased by the Beverly Entities.

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

(d) Except for those tenants in possession of the Beverly Real Property under Material Contracts as set forth on Schedule 3.6(d), to Beverly's Knowledge there are no Persons in possession of, or claiming any possession, adverse or not, to or other interest in, any portion of the Beverly Real Property other than the Beverly Entities, 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 Beverly Real Property, including all amendments and guarantees. No tenants have asserted nor are there any defenses or offsets to rent accruing after the Closing Date and no material default or breach exists on the part of any tenant. No Beverly Entities have received any written notice of any material default or breach on the part of the landlord under any lease of Beverly Real Property which has not been cured, nor does there exist any such default or breach on the part of the landlord.

(e) Since January 1, 2020, except in the ordinary course consistent with past practice, no Beverly Entity has sold or otherwise disposed of any personal property related to the Beverly Operations (the "***Beverly Personal Property***") (except obsolete Beverly Personal Property not in use) having an original cost in excess of Two Hundred Fifty Thousand Dollars ($250,000) except with a comparable replacement thereof. To Beverly's Knowledge, all Beverly Personal Property material to the Beverly Operations is in good working order. A Beverly Entity owns and

holds good and valid title or leasehold interest, as the case may be, to all Beverly Personal Property material to the Beverly Operations free and clear of any Encumbrances.

(f) Items of inventory related to the Beverly Operations (the "***Beverly 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 Beverly Financial Statements. The quantities of all Beverly Inventory are reasonable and consistent with the normal conduct of the Beverly Operations.

3.7 Environmental Matters.

(a) To Beverly's Knowledge, (i) neither of the Beverly Entities is subject to any Action or any other material liability arising under any Environmental Laws, and (ii) no circumstances exist that are reasonably expected to prevent material compliance with Environmental Laws by the Beverly Entities. During the Lookback Period, neither of the Beverly Entities has received any written communication (or reduced to writing any oral communication) from any Person alleging that such Beverly Entity is not in full compliance with Environmental Laws. The applicable Beverly Entity has or has applied for all material permits, licenses, approvals and authorizations required under applicable Environmental Laws to conduct the Beverly Operations ("***Environmental Licenses***"). The Beverly Entities have made available to Adventist Health complete and genuine copies of all Environmental Licenses currently held by any Beverly Entity or related to the Beverly Operations and the Beverly Real Property pursuant to the Environmental Laws.

(b) During the Lookback Period, there has been no Material Environmental Claim pending or, to Beverly's Knowledge, 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 Beverly Entity.

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

3.8 Employment Matters.

(a) Employee and Employee Relations. Following the Execution Date and subject to the terms of this Section 3.8(a), Beverly will make available to Adventist Health a true and complete list of all employees of each Beverly Entity ("***Beverly Employees***"), which 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; (vi) a description of the employee benefits provided to each such individual as of the date hereof; and (vii) if covered by a collective bargaining agreement or obligation. As

of the Execution Date, all compensation, including wages, commissions, and bonuses, payable to all Beverly 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 will be paid or accrued in accordance with Beverly's normal payroll and similar practices.

(i) There is no pending or, to Beverly's Knowledge, threatened employee strike, work stoppage or slowdown, labor dispute or unfair labor practices in connection with the Beverly Operations.

(ii) Except as set forth on Schedule 3.8(a)(ii), (A) there are no employees of either Beverly Entity who are represented by, or have made demand for recognition of, a labor union or employee organization with respect to their work at the Beverly Operations, or (B) to Beverly's Knowledge, there is no other union organizing or collective bargaining activities by or with respect to any employees of either Beverly Entity with respect to such employment.

(iii) Beverly has complied with all material obligations and liabilities under any Plant Closure Laws during the Lookback Period and as a result of (A) the Beverly Operations on or prior to the Closing Date, and/or (B) the consummation of the Affiliation.

(b) Pending Proceedings. There are no active, pending or, to Beverly's Knowledge, threatened Action 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 either Beverly Entity. No employee or independent contractor of a Beverly Entity is entitled to receive any compensation, payment, or remuneration from any Person as a result of the execution and delivery of this Agreement or the occurrence of the Closing.

3.9 Employee Benefit Plans.

(a) Schedule 3.9 sets forth a true, correct and complete list of each Beverly Employee Benefit Program. No Beverly Employee Benefit Program is maintained outside the jurisdiction of the United States, or covers any employee working for a Beverly Entity outside the United States.

(b) Each Beverly Employee Benefit Program that is intended to qualify under Section 401(a) of the Code has received a favorable determination or opinion letter from the IRS regarding its qualification thereunder, and during the Lookback Period no event has occurred and no condition exists that would reasonably be expected to result in the loss of such tax-qualified status or the imposition of any liability, penalty or tax under ERISA, the Code or any other Laws. With respect to each Beverly Employee Benefit Program, 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 Beverly Employee Benefit Program, have been filed or furnished on a timely basis.

(c) With respect to each Beverly Employee Benefit Program, Beverly has provided to Adventist Health, and has caused Beverly to provide to Adventist Health (in each case, if applicable to such Beverly Employee Benefit Program): (i) all documents embodying or governing such Beverly Employee Benefit Program, and any funding medium for the Beverly Employee Benefit Program (including plan documents, trust agreements and amendments thereto); (ii) the most recent IRS determination letter with respect to such Beverly Employee Benefit Program under Code Section 401(a); and (iii) any insurance policy related to such Beverly Employee Benefit Program.

(d) Each Beverly Employee Benefit Program has been established, operated, and administered in all material respects in accordance with the requirements of Law, including ERISA and the Code, 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 penalties imposed by Law, including penalty taxes. No Beverly Employee Benefit Program is subject to Title IV of ERISA or is a Multiemployer Plan, within the meaning of ERISA Section 3(37) and during the Lookback Period neither Beverly Entity nor any ERISA Affiliate has sponsored, maintained, contributed to or had any liability in respect to any employee benefit plan subject to Title IV of ERISA or any Multiemployer Plan.

(e) Neither any Beverly Employee Benefit Program fiduciary nor any Beverly Employee Benefit Program has engaged in any transaction in violation of Section 406 of ERISA or any "prohibited transaction" (as defined in Section 4975(c)(1) of the Code), which transaction is not exempt under Section 4975(d) of the Code or Section 408 of ERISA and which could reasonably be expected to result in material liability under ERISA or the Code. Neither Beverly Entity nor any ERISA Affiliate or any Person appointed or otherwise designated to act on behalf of Beverly or such ERISA Affiliate, has engaged in any transactions in connection with any Beverly 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.

(f) No Action by the DOL, the PBGC, the Internal Revenue Service or any other Governmental Entity is pending, with respect to any Beverly Employee Benefit Program. There is no pending, or to Beverly's Knowledge, threatened Action other than routine claims for benefits, concerning any of the Beverly Employee Benefit Programs, or, any fiduciary or service provider thereof. Neither Beverly Entity has liability by virtue of its being a member of a controlled group with a person who has liability under the Code or ERISA.

(g) Each Employee Welfare Benefit Plan which is a group health plan (within the meaning of Section 5000(b)(1) of the Code) complies in all material respects with and has been maintained and operated in all material respects in accordance with each of the requirements of Section 4980B of the Code and Part 6 of Subtitle B of Title I of ERISA. Except as set forth in Schedule 3.9(g), no Beverly 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.

(h) Each Beverly Employee Benefit Program that is a "nonqualified deferred compensation plan" (as defined under Section 409A of the Code) has been operated and administered in good faith compliance with Section 409A of the Code, and no compensation shall be includable in the gross income of any current or former employee, officer, director or consultant of Beverly or any ERISA Affiliate as a result of the operation of Section 409A of the Code with respect to any applicable arrangements or agreements in effect prior to the Closing.

3.10 Litigation. There are no material Actions pending or, to Beverly's Knowledge, threatened against either Beverly Entity or with respect to any Beverly Assets. To Beverly's Knowledge, there exist no facts known to Beverly that might form the basis of any such Action. There is no pending or, to Beverly's Knowledge, threatened Action involving either Beverly Entity or Beverly 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.

3.11 Certain Affiliations. Except as set forth on Schedule 3.11, no officer or director of either Beverly Entity, nor any child, spouse, parent or sibling or any other family member of any such officer or director of either Beverly Entity (i) directly or indirectly owns, in whole or in part, any property, asset or right of material significance, used in connection with the Beverly Operations; or (ii) directly or indirectly has an interest in or is party to any Material Contract to which the respective Beverly Entity is a party.

3.12 Beverly Operations. To Beverly's Knowledge, the Beverly Assets constitute all assets, properties, goodwill and businesses necessary to conduct the Beverly Operations, in the aggregate and with respect to each Beverly Healthcare Service, in all material respects in the manner in which the Beverly Operations are currently conducted.

3.13 Intellectual Property. Except for customary licensing and maintenance fees payable under the Material Contracts, each Beverly Entity has the right to use, free and clear of any royalty or other payment obligations, claims of infringement or other liens, (a) all Beverly Intellectual Property (as defined below) used by such Beverly Entity, and (b) all software, hardware, application programs and similar systems owned by or licensed under Material Contracts to such Beverly Entity; and to Beverly's Knowledge, such Beverly Entity is not in conflict with or in violation or infringement of, nor has any Beverly Entity received a notice in writing alleging any conflict with or violation or infringement of, any rights of any other Person with respect to any such Beverly Intellectual Property or software, hardware, application programs or similar systems. For purposes of this Agreement, "***Beverly Intellectual Property***" means, for each Beverly Entity: (a) all fictional business names, trade names, registered and unregistered trademarks, service marks and applications for same; (b) all patents and patent applications; (c) all copyrights in both published works and unpublished works; (d) all rights in mask works; and (e) all know-how, trade secrets, confidential information, customer lists, software, technical information, data, process technology, plans, drawings and blueprints and other intellectual property rights owned, used or licensed by the Beverly Entity as licensee or licensor. To Beverly's Knowledge, no other Person is in conflict with or in violation or infringement of such Beverly Entity's rights in such Beverly

Intellectual Property or software, hardware, application programs or similar systems. To Beverly's Knowledge, there are no current restrictions or conditions that would result in each Beverly Entity not being entitled to make use of all Beverly Intellectual Property subsequent to the Closing Date in the same manner as currently used by a Beverly Entity in accordance with the Material Contracts related thereto and without further action or the payment of additional fees, royalties or other compensation to any Person, except for customary licensing and maintenance fees payable under the Material Contracts.

3.14 Insurance. Schedule 3.14 includes a list of all insurance policies (including the policy type, carrier, retention, term and claim limits) to which a Beverly Entity is a party and that provide coverage to either Beverly Entity or the Beverly Operations, or any director, manager or officer of a Beverly Entity (the "***Beverly Insurance Policies***"). The Beverly Entities have made available to Adventist Health copies of all Beverly Insurance Policies. All Beverly Insurance Policies are, now and until the Closing, (i) valid, outstanding, and enforceable, and (ii) sufficient for compliance in all material respects with all applicable Material Contracts to which such Beverly Entity is a party. During the Lookback Period, no Beverly Entity has been denied, or reduced the amount of, any insurance or indemnity bond coverage.

3.15 Government Programs. Each Beverly Entity and facility related to the Beverly Operations that provides health care services to beneficiaries of Government Payment Programs is qualified for participation in and has current and valid provider agreements with the Government Payment Programs and/or their fiscal intermediaries or paying agents and, to Beverly's Knowledge, complies, and has complied during the Lookback Period, in all material respects with the conditions of participation therein. Each Beverly Entity referenced in the preceding sentence receives payment under the Government Payment Programs for services rendered to qualified beneficiaries and during the Lookback Period, has received or applied for all approvals or qualifications necessary for capital reimbursement on the Beverly Assets (if applicable). Except to the extent liabilities and contractual adjustments of each Beverly Entity under the Government Payment Programs have been properly reflected and adequately reserved in the Beverly Financial Statements, during the Lookback Period, no Beverly Entity has received or submitted any claim for payment in excess of the amount provided by law or any applicable Material Contract and no Beverly Entity has received written notice of any Action by any Governmental Entity or other Person regarding the Government Payment Programs or participation therein.

3.16 Material Contracts. Schedule 3.16 sets forth each Beverly Entity's Material Contracts. The Material Contracts: (a) are in full force and effect, and (b) are valid, legal and binding upon the parties thereto, 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. To Beverly's Knowledge, no event has occurred and no state of facts exists which may result in the termination or limitation of the rights of any Beverly Entity under any of the Material Contracts, except for a natural termination or expiration of a Material Contract pursuant to the terms thereof or as set forth on Schedule 3.16. Each Beverly Entity and, to Beverly's Knowledge, each other party to the Material Contracts have performed all material obligations required to be performed by them under such Material 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.

3.17 Taxes.

(a) Each Beverly Entity has filed all Tax Returns required to be filed relating to the Beverly Operations. All Tax Returns are complete and genuine in all material respects, and each Beverly Entity has paid or made provision in the Financial Statements for the payment of all Taxes due and has made provision in the Financial Statements for the payment of all Taxes not yet due. No claim provided to a Beverly Entity in writing by a Governmental Entity is pending against any Beverly Entity for failure to file Tax Returns. There are no Encumbrances on any Beverly Assets that arose in connection with any failure (or alleged failure) to pay any Tax.

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

(c) To Beverly's Knowledge, no Governmental Entity intends to assess any additional Taxes of any Beverly Entity for any period for which Tax Returns have been filed. There is no Action pending or threatened in writing against any Beverly Entity concerning any Tax liability.

(d) Each Beverly Entity is a California nonprofit public benefit corporation and is exempt from federal and state income taxation. Each Beverly Entity has made available to Adventist Health copies of each Beverly Entity's favorable letters of determination from the IRS and the State regarding such Tax status.

3.18 Medical Staff; Physician Relations. Beverly has made available to Adventist Health complete and genuine copies of the bylaws, policies, rules and regulations of the Beverly medical staffs and Schedule 3.18 sets forth the current medical staff roster and the names of current medical staff members in respect of whom Beverly 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.

3.19 Experimental Procedures and Research Studies. To Beverly's Knowledge, no member of the Beverly medical staff has conducted or otherwise participated in any clinical trials, experimental procedures or research studies at Beverly or as part of the Beverly Operations within the prior three (3) years, in each case, for which Beverly was a sponsor.

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

3.21 Brokers and Finders. Beverly has not entered into any Material Contract 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.

3.22 Material Misstatements or Omissions. Subject to qualifications expressly set forth in this Article III regarding Beverly's Knowledge, the representations and warranties of the Beverly Entities in this Article III, together with the disclosures set forth in the Beverly 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 the Beverly Entities in this Article III not misleading in any material respect.

3.23 Due Diligence. Each Beverly Entity has provided all items responsive to the Adventist Health Due Diligence Request and such items, either individually or in the aggregate, do not, to Beverly's Knowledge, contain any untrue statement of fact or omit to state any fact that is reasonably expected to be material to Adventist Health's decision regarding the Affiliation. In addition, each Beverly Entity 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 Adventist Health Due Diligence Request.

3.24 No Other Representations. Adventist Health acknowledges and agrees that, except as expressly set forth in this Agreement, the New Beverly Organizational Documents, and the New Beverly Bylaws, the Beverly Entities and their officers, directors, attorneys, financial advisors, agents or other representatives (collectively "***Representatives***") are not making any representation or warranty, express or implied, with respect to such Beverly Entity.

3.25 Survival of Representations and Warranties. The representations and warranties of Beverly set forth in this Article III shall not survive the Closing Date.

ARTICLE IV
REPRESENTATIONS AND WARRANTIES OF ADVENTIST HEALTH

Except as otherwise set forth on the schedules prepared by Adventist Health, dated as of the Execution Date and updated pursuant to Section 5.2(b) (collectively, "***Adventist Health Schedules***"), Adventist Health represents and warrants to Beverly as of the Execution Date as follows:

4.1 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 in any jurisdiction 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 businesses 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 Adventist Health, as may be required under Law. No other corporate or other proceeding on the

part of Adventist Health is necessary to authorize this Agreement and the Affiliation contemplated hereby. This Agreement has been duly executed and delivered by Adventist Health and is a legal, valid and binding obligation of Adventist Health, enforceable against it 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 Adventist Health is necessary to approve this Agreement or the Affiliation contemplated hereby.

(ii) The execution and delivery by Adventist Health of this Agreement does not, and the consummation of the Affiliation contemplated hereby will not, (A) to Adventist Health's Knowledge 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) 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 Adventist Health, or (C) conflict with, or result in any violation or breach of any applicable Law.

4.2 Adventist Health Financial Statements. The Adventist Health Financial Statements fairly and accurately present in all material respects the financial condition and results of operations of Adventist Health as of the respective dates thereof and for the period therein referred to, and reflect the consistent application of GAAP throughout the periods involved, 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.

4.3 Absence of Material Adverse Change. Since the date of the last Adventist Health Financial Statements, no Adventist Health Material Adverse Change has occurred in the financial condition, assets, liabilities, income or prospects of Adventist Health. To Adventist Health's Knowledge, there has not been any event, change, occurrence or circumstance that has had or is reasonably expected to have a Adventist Health Material Adverse Change.

4.4 Litigation. There is no pending or, to Adventist Health's Knowledge, threatened, litigation, arbitration, investigation or other proceeding involving Adventist Health 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.

4.5 Tax Exempt Status. Adventist Health is a California religious corporation exempt from federal and state income taxation.

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

Health's own due diligence and analysis of materials and information provided or made available by the Beverly Entities.

4.7 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.

4.8 No Other Representations. The Beverly Entities acknowledge and agree that, except as expressly set forth in this Agreement, Adventist Health is not making any representation or warranty, express or implied, with respect to Adventist Health.

4.9 Survival of Representations and Warranties. The representations and warranties of Adventist Health set forth in this Article IV shall not survive the Closing Date

ARTICLE V
PRE-CLOSING COVENANTS

5.1 Consents and Approvals.

(a) California Attorney General. Within fifteen (15) days after the Execution Date or as soon as reasonably practicable, Beverly shall notify the California Attorney General (the "***Attorney General***") in writing of the proposed Affiliation in accordance with Sections 5914 et seq. of the California Corporations Code ("***Section 5914***"). As of the Execution Date, Adventist Health and Beverly hereby agree that Adventist Health has reviewed and approved Beverly's proposed written notice to the Attorney General, and that Beverly shall submit to the Attorney General the written notice in substantially the same form as reviewed and approved by Adventist Health. The Beverly Entities shall use commercially reasonable efforts to 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. As used in this Agreement, "***commercially reasonable efforts***" means, with respect to the efforts to be expended by a Party with respect to any objective under this Agreement, reasonable, diligent, good faith efforts, as determined in that Party's sole and absolute discretion, to accomplish such objective as a similarly situated Person would normally use to accomplish a similar objective as expeditiously as reasonably possible under similar circumstances exercising reasonable business judgment. Notwithstanding the foregoing, "commercially reasonable efforts" will not require a Person to make payments to third parties, to incur non-de minimis liabilities to third parties or to grant any non-de minimis concessions or accommodations. Adventist Health shall provide such information and communications to the Attorney General as Beverly may reasonably request and shall otherwise cooperate with Beverly in obtaining the Attorney General's approval of the Affiliation.

(b) Participation; No Consent. 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. If the Attorney General challenges, objects to, prohibits, enjoins, places conditions upon or fails to provide any consent or approval required to complete the transaction contemplated by this Agreement, the Parties shall meet in good faith to confer on: (i) the acceptance or negotiation of any conditions imposed on the Affiliation by the Attorney

General, (ii) the decision to pursue any remedies a Party may have against the Attorney General, or (iii) the decision to contest or appeal the Attorney General's challenge, objection to, prohibition, enjoyment of, or failure to approve the Affiliation. If Adventist Health agrees to take any action set forth in the foregoing sentence, Adventist Health shall bear all costs and expenses pertaining thereto, including without limitation attorneys' fees. If Adventist Health does not agree to accept or negotiate conditions by the Attorney General, pursue any remedy a Party may have against the Attorney General, or contest or appeal an action by the Attorney General, then Adventist Health may, in its sole discretion and as its sole remedy, terminate this Agreement by giving written notice of such termination to the Beverly Entities.

(c) Material Contracts. For those Material Contracts to which Beverly or Montebello is a Party, Beverly and Montebello shall each use commercially reasonable efforts to obtain prior to Closing all required consents and approvals necessary from each Material Contract's parties to ensure that each Material Contract remains in full force and effect following the Closing Date.

5.2 Notification of Certain Matters.

(a) Beverly Schedule Amendments. From time to time prior to the Closing, Beverly may promptly supplement or amend the Beverly Schedules in Article III in order to keep such information therein timely, complete and accurate, and each supplement to or amendment of the Beverly Schedules made after the Execution Date pursuant to this Section 5.2(a) shall be deemed to amend the Beverly Schedules as of the date the Beverly Schedule is accepted by Adventist Health; *provided*, *however*, that if any material supplement or amendment is not acceptable to Adventist Health, and Adventist Health notifies Beverly of same within fifteen (15) days of Adventist Health receiving the amended Beverly Schedule(s), the Parties shall work together in good faith to resolve the matter. If the Parties cannot resolve the matter satisfactorily to all 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 the Beverly Entities within seven (7) days after the Parties determine they cannot resolve the matter.

(b) Adventist Health Schedule Amendments. From time to time prior to the Closing, Adventist Health may promptly supplement or amend the Adventist Health Schedules in Article IV in order to keep such information therein timely, complete and accurate, and each supplement to or amendment of the Schedules made after the Execution Date pursuant to this Section 5.2(b) shall be deemed to amend the Adventist Health Schedules as of the date the Adventist Health Schedule is accepted by Beverly; *provided*, *however*, that if any material supplement or amendment is not acceptable to Beverly, and Beverly notifies Adventist Health of same within fifteen (15) days of Beverly receiving the amended Adventist Health Schedule(s), the Parties shall work together in good faith to resolve the matter. If the Parties cannot resolve the matter satisfactorily to all Parties, then the Beverly Entities may, in their sole discretion and as their sole remedy, terminate this Agreement by giving written notice of such termination to Adventist Health within seven (7) days after the Parties determine they cannot resolve the matter.

5.3 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 the Beverly Entities 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 the Beverly Entities.

5.4 Negative Covenants of Beverly. From the Execution Date until the earlier of the Closing or the termination of this Agreement, neither of the Beverly Entities shall (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.

5.5 Conduct of the Beverly Operations. After the Execution Date and until the earlier of the Closing or the termination of the Agreement, 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, Beverly shall conduct, and shall cause each Beverly Entity to conduct, the Beverly Operations in the ordinary course of business consistent with past practices. Without limiting the generality of the foregoing, except as expressly contemplated by this Agreement, each Beverly Entity shall:

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

(b) use commercially reasonable efforts to maintain the Beverly Inventory at levels not materially less than or greater than those usually maintained to provide Beverly Healthcare Services;

(c) pay in full before material 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 Beverly 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 Beverly Personal Property in good working order, ordinary wear and tear excepted;

(e) not mortgage, pledge or otherwise allow any Encumbrances to be placed on any of the Beverly Assets, except liens for taxes not yet due, except in the ordinary course of business consistent with past practice;

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

(g) not renew, extend, terminate or amend any Material Contract (excluding any agreement 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 any Material Contracts, or enter into any Material Contract, except in the ordinary course consistent with past practices or as otherwise required herein; provided, however, the Beverly Entities shall use commercially reasonable efforts to retain the services of each Beverly Entity's employees who are not in breach of their employment obligations and, provided further, that the Beverly Entities shall have no obligation to provide additional or enhanced compensation or benefits to any Beverly Entity Employees;

(h) not agree, whether in writing or otherwise, to do any of the foregoing actions specified in this Section;

(i) except in the ordinary course following consultation with Adventist Health, not enter into a new, or extend, renew or materially amend any Material Contract with a physician, medical group or other physician services provider;

(j) keep in full force and effect present insurance policies or other comparable insurance benefiting the Beverly Assets and the conduct of the Beverly Operations and maintain sufficient liquid reserves reasonably estimated to be sufficient to meet all deductible, self-insurance and copayment requirements under such policies;

(k) not sell, assign, transfer, distribute or otherwise transfer or dispose of any Material Beverly Asset except in the ordinary course of the Beverly Operations with comparable replacement thereof or except obsolete equipment not in use;

(l) not materially alter the manner of keeping of Beverly's books, accounts or records of the Beverly Operations or the accounting practices therein reflected, unless required to do so by Law or GAAP;

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

(n) not to enter into or materially change the terms of any employment agreement with the Chief Executive Officer, Chief Strategy Officer, Chief Operating Officer, Chief Financial Officer, Chief Nursing Officer, and Chief Medical Officer of each of the Beverly Entities (collectively, the "***Executive Team***"), or increase the compensation, bonus or benefits of Executive Team, except in the ordinary course of business consistent with past practice; and

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

5.6 Access and Information; Due Diligence. From the Execution Date until the Closing Date, the Beverly Entities shall give to Adventist Health and its Representatives, reasonable access

during normal business hours to each Beverly Entity's corporate, financial, litigation, insurance and personnel files, books, accounts, records and all other relevant documents and information as Representatives of Adventist Health may request from time to time for any purpose related to its due diligence review of the Beverly Entities in connection with Affiliation, all in such manner as to not unduly disrupt normal business activities and in compliance with Law, including, without limitation antitrust laws. Such access may include consultations with the personnel of any Beverly Entity (including physicians), provided that Adventist Health shall provide reasonable advance notice to the Beverly Entity, and such consultations shall not unreasonably interfere with the duties and responsibilities of such personnel. From the Execution Date until the earlier of Closing Date or the termination of this Agreement, the Beverly Entities shall make the Beverly Real Property and Beverly Personal Property reasonably available for inspection by Adventist Health and its Representatives during normal business hours upon prior written request and any contractual obligations relating to confidentiality. 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 Mutual Nondisclosure Agreement between Adventist Health and Beverly dated as of July 16, 2021 and that certain Clean Team Confidentiality Agreement dated April 25, 2022.

5.7 No Negotiation.

(a) Without prior written notice to Adventist Health as provided in subsection 5.7(b) below, until the earlier of the Closing or the termination of this Agreement, the Beverly Entities shall not, and shall cause their respective representatives to not, hold any discussions with any third party or negotiate the change of control of either of the Beverly Entities. As used in this Section 5.7, "change in control" means, as applicable, (i) the sale, lease or other transfer of substantially all of either of the Beverly Entity's assets or (ii) the transfer of voting control or management of the operations of either of the Beverly's Entities whether by merger, consolidation, substitution of corporate member or otherwise.

(b) If either of the Beverly Entities is in discussions with a third party and such discussions have progressed to the point that the Beverly Entities will begin a due diligence process with a third party, which includes making available to that third party information or documents provided to Adventist Health in the Beverly Entities due diligence rooms or requested by Adventist Health during the Adventist Health due diligence process, including collecting, exchanging, providing, or reviewing any confidential or nonpublic documents/information, or public documents/information compiled from multiple sources, then the applicable Beverly Entity shall provide prompt written notice to Adventist Health that describes the parties involved and the proposed material terms of the proposed change in control transaction to the extent known. During the pendency of any discussions with a third party identified in a notice to Adventist Health consistent with this Section, the Beverly Entities shall provide periodic updates regarding the status of the discussions and an update regarding any proposed material terms.

(c) Until the earlier of the Closing or the termination of this Agreement, neither Beverly Entity will enter into a letter of intent or a definitive agreement related to a change in control transaction. The Parties acknowledge that nothing in this Section 5.7 is intended to alter or modify the obligations of the Beverly Entities set forth under Section 5.5.

5.8 Medical Staff. Following the Execution Date, Beverly shall use commercially reasonable efforts to facilitate communications with the Beverly medical staff regarding the Affiliation and the combination of the medical staffs of Beverly and AHWM after the Closing, with or without reorganizing under a single license.

5.9 Beverly's Efforts to Close. The Beverly Entities shall use commercially reasonable efforts to satisfy all of the conditions precedent set forth in Article VIII to the Parties' obligations under this Agreement to the extent that Beverly's action or inaction can control or influence the satisfaction of such conditions.

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

ARTICLE VI
ADDITIONAL COVENANTS AND AGREEMENTS

6.1 Government Authorizations. The Beverly Entities shall promptly apply for and use good faith efforts to obtain, as promptly as practicable, all Government Authorizations that are necessary to consummate the proposed transaction as set forth in this Agreement. For purposes of the preceding, "***Government Authorizations***" means all Licenses, consents or approvals of any Governmental Entity which are required for Beverly to continue operating all material aspects of the Beverly Operations after Adventist Health becomes Beverly's sole member.

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

6.3 Line of Credit; Temporary Sale. The Parties acknowledge that Beverly will require a line of credit or other access to cash up to $18 million to support continuing operations until the Closing. Beverly may elect to either (i) obtain such line of credit from a third party lender or enter into a sale of its unencumbered real estate with a repurchase option with a third party (collectively, the "***Interim Financing***"), the final terms and conditions of which will be subject to the advance written approval of Adventist Health, which consent shall not be unreasonably withheld or delayed or (ii) negotiate such Interim Financing with Adventist Health; provided that the Parties acknowledge that any such Interim Financing must be commercially reasonable at market interest rates and terms, be secured by unencumbered assets of the Beverly Entities and covered by a title

insurance policy relating to any Beverly real property collateral. The Parties further acknowledge and agree that any sale of the Beverly Entities' unencumbered real estate must include commercially reasonable terms including that (i) the Beverly Entity maintains the right to repurchase the unencumbered real estate from the third party for at least one (1) calendar year from the sale closing date and (ii) such repurchase option gives the Beverly Entity the right to repurchase such unencumbered real estate for an amount equal to the sale price plus a reasonable rate of return consistent with then-current market conditions. The Parties agree to negotiate such Interim Financing in good faith promptly following the execution of the Agreement, which may be comprised of one or multiple transactions up to a total principal amount of $18 million. In the event that Adventist Health does not grant its consent for Beverly to obtain Interim Financing, in whole or in part, with a third party hereunder, Beverly shall have the ability to terminate this Agreement.

6.4 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 VII
TERMINATION OF AGREEMENT

7.1 Term. The term of this Agreement shall commence upon the Execution Date and shall continue until the Effective Time.

7.2 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 Beverly Entity. This Agreement may be terminated by Adventist Health at any time prior to the Closing if a Beverly Entity has materially breached any of its covenants, representations or warranties prior to the Closing, or if any representation or warranty of a Beverly Entity set forth in this Agreement is determined to have been materially inaccurate or misleading when made.

(ii) Breach By Adventist Health. This Agreement may be terminated by Beverly at any time prior to the Closing if Adventist Health has materially breached any of its covenants, representations or warranties prior to the Closing, or if any representation or warranty of Adventist Health set forth in this Agreement is determined to have been materially inaccurate or misleading when made.

(c) Failure of Closing Condition. This Agreement may be terminated by Adventist Health or the Beverly Entities if the Closing has not occurred on or before September 30, 2023 (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 that was Adventist Health's responsibility to fulfill; and (ii) the Beverly Entities 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 the Beverly Entities or the failure of a condition which was the Beverly Entities' responsibility to fulfill.

(d) Regulatory Consent or Approval. This Agreement may be terminated pursuant to the provisions of Section 5.1(b).

(e) Disclosure Schedule Amendments. This Agreement may be terminated pursuant to the provisions of Section 5.2.

(f) Consent for Line of Credit. Pursuant to Section 6.3 of this Agreement, for a period of fourteen (14) days from the receipt by the Beverly Entities of Adventist Health's notice of non-consent to the proposed terms for Interim Financing, unless mutually extended by written agreement of the Parties, the Beverly Entities may terminate this Agreement by delivering a written notice of termination to Adventist Health.

7.3 Return of Information. Upon the termination of this Agreement prior to the Closing Date, each Party 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 VIII
CONDITIONS TO CLOSING

8.1 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 that are waived in writing by Adventist Health:

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

(b) Attorney General Approval. The consent of the Attorney General with respect to the Affiliation, including both the Membership Issuance and the post-closing restructuring, shall have been obtained and each condition imposed by the Attorney General with respect to the Affiliation has been approved by Adventist Health, in Adventist Health's sole discretion.

(c) Material Contracts. The required consents and approvals necessary to ensure that each Material Contract of the Beverly Entities remains in full force and effect following the Closing Date.

(d) Performance of Covenants and Agreements. Each Beverly Entity shall have performed in all material respects all covenants and agreements contained in this Agreement required to be performed by such Beverly Entity before the Closing.

(e) Licenses and Other Government Authorizations. Any Government Authorizations required for Adventist Health to become the sole corporate member or the sole controlling entity of Beverly and Montebello and or to consummate any of the terms set forth in this Agreement shall have been obtained.

(f) Third Party Approvals. The consents and approvals of third parties required for Adventist Health to become the sole corporate member or sole controlling entity of Beverly and Montebello and or to consummate any of the terms set forth in this Agreement shall have been obtained.

(g) No Litigation. No court order shall have been issued and no Action shall be pending against the Beverly Entities or Adventist Health that prohibits the consummation of the Affiliation or could reasonably be expected to have a material adverse effect on the Beverly Entities or Adventist Health as a result of the consummation of the Affiliation.

(h) Officers Certificates. The Beverly Entities shall deliver to Adventist Health, in forms reasonably acceptable to Adventist Health, (i) a closing and incumbency certificate of an officer of each Beverly Entity, (ii) resolutions of the Beverly Board of Directors and Montebello Board of Directors, each authorizing the execution and delivery of this Agreement and the performance by Beverly and Montebello of its respective obligations hereunder, and (iii) a bring-down certificate to the effect of Section 8.1(a) (collectively, the "***Beverly Certificates***").

(i) Beverly Material Adverse Change. There has been no Beverly Material Adverse Change with respect to the Beverly Entities since the Execution Date.

(j) Due Diligence Investigation. Adventist Health shall be fully satisfied, in its sole and absolute discretion (which shall not be unreasonably withheld), with the results of its due diligence investigation of Beverly conducted by Adventist Health prior to the Closing Date.

(k) New Organizational Documents. Each Beverly Entity shall have adopted and taken any actions reasonably necessary to reconstitute the Board of Directors of each Beverly entity to mirror the then-current Board of Director of Adventist Health and delivered to Adventist Health the applicable New Beverly Organizational Documents contemplated hereunder.

(l) Deliveries at Closing. All of the deliverables described in Section 9.2 shall have been provided to Adventist Health or waived by Adventist Health.

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

(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) Attorney General Approval. The consent of the Attorney General with respect to the 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) No Litigation. No Action shall be pending or threatened against the Beverly Entities or Adventist Health in relation to or affecting the consummation of the Affiliation contemplated by this Agreement.

(e) Officers Certificates. Adventist Health shall each deliver to Beverly, in forms reasonably acceptable to Beverly, (i) a closing and incumbency certificate of an officer of Adventist Health, (ii) resolutions of the Adventist Health Board of Directors authorizing the execution and delivery of this Agreement and the performance by Adventist Health of their obligations hereunder, and (iii) a bring-down certificate to the effect of Section 8.2(a) (collectively, the "***Adventist Health Certificates***").

(f) Adventist Health Material Adverse Change. There has been no Adventist Health Material Adverse Change with respect to Adventist Health since the Execution Date.

(g) Deliveries at Closing. All of the deliverables described in Section 9.3 shall have been provided to the Beverly Entities or waived by Beverly.

ARTICLE IX
CLOSING

9.1 Closing, Closing Date and Effective Time. Subject to the provisions of this Article IX, the closing of the Affiliation (the "***Closing***") shall take place remotely via exchange of documents and signature pages on the date that is as promptly as practical but no later than the Closing Date. The Membership Issuances and Affiliation contemplated by the Parties pursuant to this Agreement shall occur at the Effective Time. All proceedings to take place at the Closing shall take place simultaneously.

9.2 Deliveries by Beverly. At the Closing, Beverly and Montebello shall deliver to Adventist Health the following:

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

(b) Good Standing Certificates. For each Beverly Entity, original Certificates of Status, or comparable status, 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.

(c) 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.

9.3 Deliveries by Adventist Health. At the Closing, Adventist Health shall deliver to the Beverly Entities the following:

(a) Adventist Health Certificates. Certified copies of the Adventist Health Certificates.

(b) Good Standing Certificates. Adventist Health's original Certificates of Status, or comparable status, 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.

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

ARTICLE X
CONFIDENTIALITY

10.1 Confidentiality and Announcements. Prior to the date on which notice to the Attorney General is filed by Beverly pursuant to Section 5.1(a), no 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. Additionally, the Parties shall mutually develop a plan in conjunction with this Agreement providing for the processes and requirements of any internal and external communications with respect to the terms of this Agreement, which the Parties shall comply with prior to the Closing. The Parties shall mutually agree on any announcements pertaining to the Affiliation made by a Party or its affiliates or Representatives, including internal announcement prior to the date on which notice to the Attorney General is filed by Beverly pursuant to Section 5.1(a).

ARTICLE XI
POST-CLOSING RIGHTS AND OBLIGATIONS

11.1 Licensure. The Parties anticipate that, within three (3) years of the Closing and as part of the Affiliation, Adventist Health may effectuate a corporate restructuring of Beverly so that it is operated under a single hospital license with AHWM to promote access, efficiencies and to mitigate ongoing medical staff challenges at Beverly.

11.2 Continued Funding of Health Care in Beverly Service Area. At any time following the Closing, in the event that Beverly ceases to operate as a general acute care hospital, the "net assets" of the Beverly Entities as of such date (the "***Transition Date***") shall be earmarked to be used for charitable health care purposes for the local community in the Beverly Service Area, where "net assets" shall be defined as the appraised value of the Beverly Real Property and other assets of the Beverly Entities as of the Transition Date (excluding any capital contributions, cash transfers, operational subsidies or other funding by Adventist Health contributed to the Beverly Entities as of the Transition Date) less liabilities (including accounts payable) as of the Transition Date.

11.3 Maintenance of Clinical Services; Clinical Program Integration.

(a) As long as Beverly operates as a general acute care hospital, Adventist Health will provide for typical hospital-based services, including maintaining an emergency department at Beverly.

(b) Adventist Health will maximize efficiency and access by having flexibility to provide clinical service lines at the Beverly campus or to move and integrate clinical service lines to another location. Integration of clinical service lines may include, without limitation, cardiology (surgical and rehabilitation), neurology (medical, interventional and surgical) and pediatrics (NICU). Beverly acknowledges that Adventist Health will have the flexibility post-Closing to open or close any clinical service line or center of excellence based on quality measures or the financial results of operations in Adventist Health's sole and absolute discretion.

11.4 Physician Alignment and Network Development. Adventist Health will use commercially reasonable efforts to implement a physician network strategy focused on alignment and network development of providers in the Beverly Service Area.

11.5 Payor Relations. Adventist Health will implement a Medi-Cal and Quality Assurance Fees strategy to improve value and access for residents in the Beverly Service Area. Implementation will include partnering with key payors, including employer-based payors and payors that offer Medicare Advantage products.

11.6 Medical Staff and Physician Coverage. Following the Closing, each of the Beverly medical staff members in good standing as of the Closing Date medical may be combined with the AHWM medical staff resulting in the expansion of Beverly's medical staff coverage through a combined medical staff with AHWM, which has over 800 primary care and specialist physicians on its medical staff.

11.7 GME. Adventist Health will use commercially reasonable efforts to extend Adventist Health's graduate medical education ("***GME***") activities across both campuses enabling resident physicians to provide coverage at Beverly that will further enhance access and coverage and increase the physician base and expand access to care throughout the Beverly Service Area.

11.8 Services and Operations. After the Closing, Adventist Health will use commercially reasonable efforts to undertake the following:

(a) Quality and Patient Safety.

(i) Enhance Beverly's quality and patient safety programs as part of the integrated Adventist Health system by bringing its clinical protocols, care coordination, analytics, tools, leadership, and other supporting programs and infrastructure for value-based services and quality mandates, in order to enhance care delivery, improve quality, reduce variations in care and unnecessary costs of care; and

(ii) Operate Beverly with a commitment to quality, safety and patient satisfaction, including maintaining appropriate accreditation, and with a commitment to improving population health and participation in all commercial, Medicare Advantage, Medicare, and Medi-

Cal programs, subject to any changes in any of those programs after Closing that materially and adversely financially impact, hinder, or preclude participation by Beverly or Adventist Health.

(b) Revenue Cycle Management. Provide Beverly access to its revenue cycle management tools and infrastructure, including in connection with management of claims denials, group purchasing, and maintenance of inventories.

(c) Information Technology Systems. Support Beverly's IT capabilities including (i) ambulatory/clinic data integration, (ii) clinical analytic capabilities, (iii) virtual/digital health platform opportunities, and (iv) enhanced cyber security.

11.9 Capital. Adventist Health allocates its capital resources based upon facility performance and the overall financial objectives of the Adventist Health system, in furtherance of Adventist Health's mission and the health care needs of the communities served by Adventist Health facilities. After the Closing, Adventist Health will develop an annual operating and capital budget for each Beverly Entity in accordance with Adventist Health's policies and procedures for its budgets and capital commitments for Adventist Health's member-hospitals and organizations, which shall provide for an annual capital budget of up to 70% of Beverly's EBITDA. Beverly acknowledges that (i) Beverly's net revenues must fund both its operations and any routine or strategic capital expenditures, including any necessary capital expenditures necessary to improve Beverly's facilities to maintain compliance with applicable laws, including the Alfred E. Alquist Hospital Seismic Safety Act of 1983, and (ii) such capital expenditures will be determined by Adventist Health in its sole and absolute discretion.

11.10 Executive Team Retention. Following the Closing Date, Adventist Health may, but shall not be required to, retain the individuals serving as the Executive Team as of the Closing Date, respectively, subject to each member of the Executive Team meeting Adventist Health's standard conditions for employment and successfully passing a satisfactory background screening that is acceptable to Adventist Health.

11.11 Charity and Community Care. Effective upon the Closing Date, Adventist Health shall cause Beverly to adopt the Adventist Health policies on charity and indigent care, as set forth in Attachment 11.11 (the "***AH Charity Policy***"), as may be modified by Adventist Health system-wide from time to time. Beverly shall follow Adventist Health's procedures for implementing, maintaining and adhering to the AH Charity Policy. Adventist Health shall ensure that Beverly reasonably continues to provide care through community-based 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 Beverly Service Area. If Beverly has a charity care patient or discounted care patient as of the Effective Time, Beverly shall finish the course of treatment for such patient under the same financial arrangement as existed with Beverly prior to the Effective Time.

11.12 Registered Nurses Union. Pursuant to that certain Collective Bargaining Agreement by and among Beverly Hospital Registered Nurses Association, United Nurses Associations of California/Union of Health Care Professionals (collectively, the "***Union***"), and Beverly Community Hospital Association, dated January 1, 2022, Adventist Health will cause Beverly to comply with the terms and conditions under the Collective Bargaining Agreement.

ARTICLE XII
REMEDIES

12.1 Remedies on or Prior to the Closing Date. The Parties acknowledge and agree that the sole and exclusive remedy of the Parties hereto arising out of: (a) any breach of, or any inaccuracy in, any representation or warranty made by a Party in this Agreement that occurs on or prior to the Closing Date or (b) any breach of any covenant, obligation or agreement of a Party in this Agreement that occurs on or prior to the Closing Date, shall be the right to terminate this Agreement pursuant to Article VII; *provided*, *however*, that nothing contained in this Section 12.1 shall in any way limit or restrict the right of any Party to bring a cause of action based on actual fraud or knowing and willful misrepresentation.

ARTICLE XIII
MISCELLANEOUS

13.1 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, (a) when personally delivered, or (b) three (3) days after delivery to a nationally recognized overnight courier service for next 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 Adventist Health:	Adventist Health 1 Adventist Health Way Roseville, California 95661 Attention: Kerry Heinrich, President and Chief Executive Officer
With a copy to:	Adventist Health System 1 Adventist Health Way Roseville, California 95661 Attn: Meredith Jobe, Vice President, General Counsel
	Jones Day 555 S. Flower Street 50th Floor Los Angeles, California 90071 Attention: Catherine A. Ehrgott
To Beverly:	Beverly Community Hospital Association 309 W. Beverly Blvd. Montebello, California 90640 Attn: Alice Cheng, President and Chief Executive Officer
With a copy to:	Nixon Peabody LLP 300 South Grand Avenue Suite 4100

Los Angeles, California 90071
Attention: Jill H. Gordon, Esq.

To Montebello: Montebello Community Health Services, Inc.
309 W. Beverly Blvd.
Montebello, California 90640
Attn: Alice Cheng, President and Chief Executive Officer

With a copy to: Nixon Peabody LLP
300 South Grand Avenue
Suite 4100
Los Angeles, California 90071
Attention: Jill H. Gordon, Esq.

13.2 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. The Parties may deliver executed signature pages to this Agreement by facsimile, electronic mail (including pdf or any electronic signature complying with the U.S. federal ESIGN Act of 2000, *e.g.*, www.docusign.com) or other transmission method.

13.3 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.

13.4 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.

13.5 Time of Essence. The time of making payments and keeping the agreements made herein is specifically made of the essence of this Agreement.

13.6 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.

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

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

13.9 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.

13.10 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.

13.11 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.

13.12 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.

13.13 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]

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

ADVENTIST HEALTH SYSTEM/WEST DBA ADVENTIST HEALTH, a California nonprofit religious corporation

By: [redacted]
Name: Kerry Heinrich
Title: President and Chief Executive Officer

BEVERLY COMMUNITY HOSPITAL ASSOCIATION, a California nonprofit public benefit corporation

By: [redacted]
Name: Alice Cheng
Title: President and Chief Executive Officer

MONTEBELLO COMMUNITY HEALTH SERVICES, INC., a California nonprofit public benefit corporation

By: [redacted]
Name: Alice Cheng
Title: President and Chief Executive Officer

Beverly Schedules

BEVERLY DISCLOSURE SCHEDULES

TO THE

AFFILIATION AGREEMENT

by and among

BEVERLY COMMUNITY HOSPITAL ASSOCIATION

DBA

BEVERLY HOSPITAL

a California nonprofit public benefit corporation,

and

MONTEBELLO COMMUNITY HEALTH SYSTEM, INC.,

a California nonprofit public benefit corporation

and

ADVENTIST HEALTH SYSTEM/WEST D.B.A. ADVENTIST HEALTH

a California nonprofit religious corporation

dated December 15, 2022

BEVERLY DISCLOSURE SCHEDULES

The following are the Beverly Schedules ("***Beverly Schedules***") to the Affiliation Agreement (the "***Agreement***") by and among **Adventist Health System/West, d.b.a. Adventist Health**, a California nonprofit religious corporation on behalf of itself and any Affiliate designated pursuant to this Agreement ("***Adventist Health***"), **Beverly Community Hospital Association d/b/a Beverly Hospital**, a California nonprofit public benefit corporation ("***Beverly***"), and **Montebello Community Health Services, Inc.**, a California nonprofit public benefit corporation ("***Montebello***" and together with Beverly, each a "***Beverly Entity***" and collectively, the "***Beverly Entities***").

Notwithstanding anything to the contrary set forth in the Agreement, no information contained in any portion of the Beverly Schedules shall be deemed to be an admission by any party to any third Person of any matter whatsoever, including an admission of any violation of any law or breach of any contract. The Beverly Schedules shall constitute formal disclosure to Parent of the facts and circumstances which are, or may be, inconsistent with the representations and warranties referred to in Article 4 of the Agreement. Such facts and circumstances shall be deemed to qualify such representations and warranties. The Beverly Schedules are arranged in sections corresponding to the sections contained in the Agreement merely for convenience, and the disclosure of an item in one section of the Beverly Schedules as an exception to a particular representation or warranty will be deemed adequately disclosed as an exception with respect to all other representations and warranties to the extent that the relevance of such item to such other representations or warranties is reasonably apparent on the face of such disclosure, notwithstanding the presence or absence of a specific cross reference thereto.

Capitalized terms used in these Beverly Schedules have the meanings assigned to them in the Agreement.

Table of Contents

Schedule 3.1(b)(ii)

Termination of Material Contracts

The Parties agree that as of the Effective Date, Schedule 3.16 includes a comprehensive list of the contracts of the Beverly Entities, which includes the Material Contracts of the Beverly Entities. Prior to the Closing Date, the Beverly Entities shall update this Schedule 3.1(b)(ii) in accordance with Section 5.2(a) of the Agreement in order to identify the Material Contracts for which the Affiliation will give rise to a right of termination or amendment, as required under Section 3.1(b)(ii) of the Agreement.

Schedule 3.3(i)

Licenses

Licensee Name	License Information
State of California Department of Public Health General Acute Care Hospital License – Beverly Hospital	License #: 930000389 Effective: 105/04/2022 Expires: 04/30/2023 Licensed Capacity: 202
College of American Pathologists Certificate of Accreditation Beverly Hospital Laboratory Montebello, California Robert A. Orlando, MD, PhD	CAP #: 2281401 AU-ID: 1187510 CLIA #: 05D0552242
Center for Medicare & Medicaid Services Clinical Laboratory Improvement Amendments Certificate of Accreditation	Laboratory Name and Address: Beverly Hospital Clinical Laboratory 309 West Beverly Boulevard Montebello, CA 90640 Laboratory Director: Robert A. Orlando, M.D. CLIA ID #: 05D0552242 Effective Date: 02/28/2021 Expiration Date: 02/27/2023
DNV-GL Healthcare USA, Inc. Primary Stroke Center Beverly Hospital 309 W. Beverly Blvd. Montebello, CA 90640	Certificate #: 216528-PSCC-2020 Initial Date: 09/02/2020 Valid Until: 09/02/2023
County of Los Angeles Public Health Permit Beverly Community Hospital Association 309 W. Beverly Blvd. Montebello, CA 90640	PR #: PR0192566 Program ID: Beverly Hospital Kitchen & Café Description: Licensed Health Care Food Facility (4000-9999 SF) High Risk FY 2022/2023 Valid Until: 6/30/2023
California Department of Public Health Clinical and Public Health Laboratory License Beverly Hospital Labor and Delivery Suites 309 W. Beverly Blvd. Montebello, CA 90640-4308	STATE ID: CLP-00330330 Effective Date: 11/06/2021 Expiration Date: 11/05/2022 Owner: Beverly Community Hospital Association License Type: Clinical Laboratory Registration CLIA ID: 05D1010353 Director: Stephen Lee
DNV Healthcare USA Inc. Medicare Recertification	Program: Hospital CCN: 050350 Survey Type: Medicare Recertification/DNV Reaccreditation Certificate #: 10000515395-MSC-CMS-USA Survey Dates: November 9-11, 2021 Accreditation Decision: Fully Accredited Date Acceptable Plan of Correction Received: 12/09/2021 Effective Date of Accreditation: 3/12/2022

Licensee Name	License Information
	Expiration Date of Accreditation: 3/12/2025
California Department of Public Health Clinical and Public Health Laboratory License Beverly Hospital Clinical Laboratory 309 W. Beverly Blvd. Montebello, CA 90640	STATE ID: CDF-00000128 Effective Date: 9/13/2022 Expiration Date: 9/12/2023 Owner: Beverly Community Hospital Association License Type: Clinical Laboratory License Certificate of Deemed Status Director: Robert A. Orlando; Cyrus Parsa
California Board of Pharmacy Sterile Compounding License Beverly Hospital 309 W. Beverly Blvd B17ABCD Montebello CA, 90640	License No. LSC 101399 Issuance Date: 9/5/2019 Expiration Date: 3/1/2023 License Type: Sterile Compounding License
California Board of Pharmacy Hospital Pharmacy License Beverly Hospital Pharmacy 309 W. Beverly Blvd Montebello CA, 90640	License No. HSP 18720 Issuance Date: 7/11/1963 Expiration Date: 3/1/2023 License Type: Hospital Pharmacy License

Schedule 3.3

Legal Compliance

(a)

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(d)

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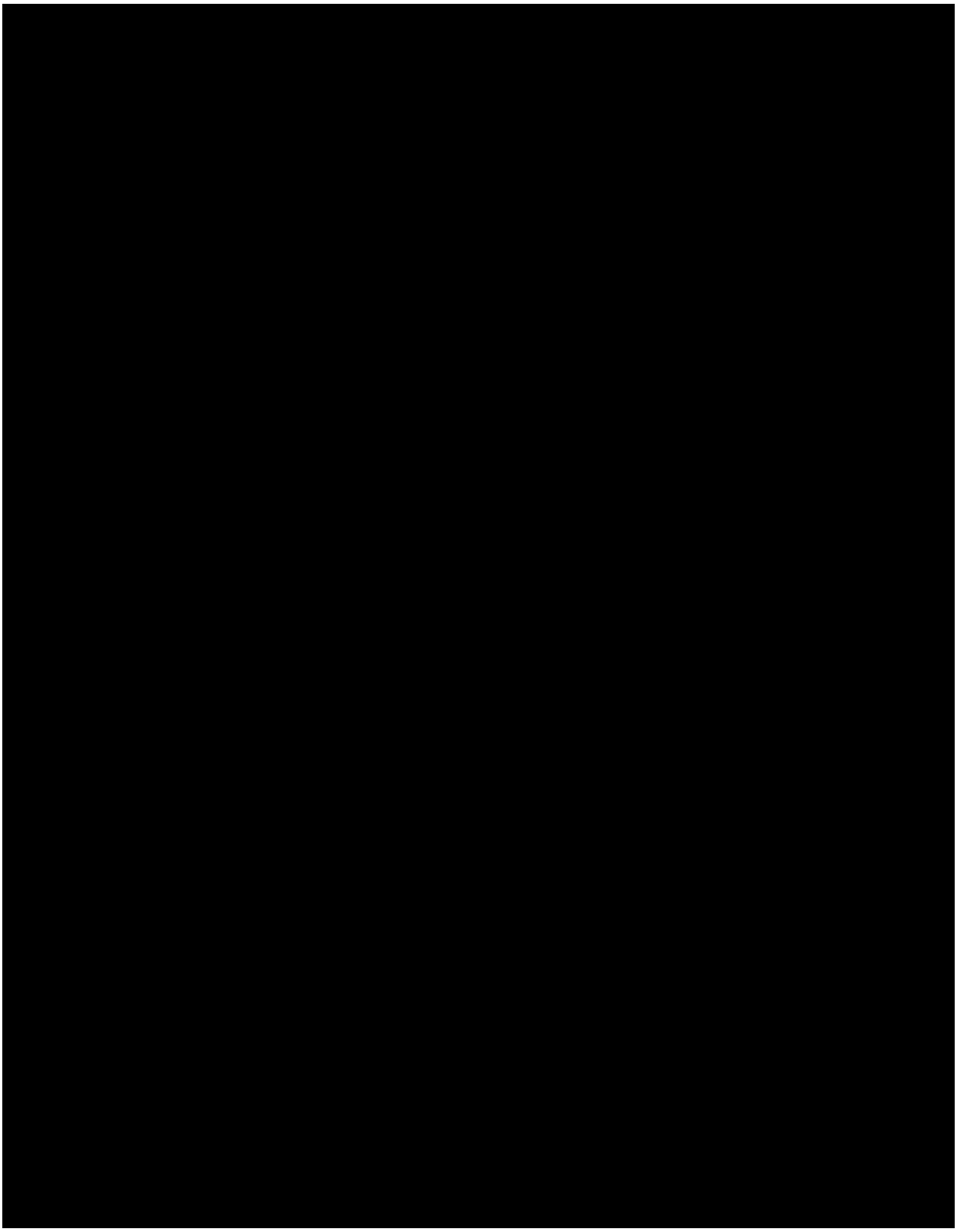
(i)



Schedule 3.4

Financial Statements

The following Beverly Financial Statements, as described below, are attached hereto:

1. Balance Sheet and Income Statement of Beverly for year ending December 31, 2021.
2. Balance Sheet and Income Statement of Montebello for year ending December 31, 2021.
3. Balance Sheet and Income Statement of Beverly as of August 1, 2022.
4. Balance Sheet and Income Statement of Montebello as of August 1, 2022.

REPORT OF INDEPENDENT AUDITORS AND
CONSOLIDATED FINANCIAL STATEMENTS
WITH SUPPLEMENTARY INFORMATION

BEVERLY COMMUNITY HOSPITAL ASSOCIATION

December 31, 2021 and 2020

MOSSADAMS

Table of Contents

MOSSADAMS

Report of Independent Auditors

The Board of Directors
Beverly Community Hospital Association

Report on the Audit of the Financial Statements

Opinion

We have audited the consolidated financial statements of Beverly Community Hospital Association (the "Hospital"), which comprise the consolidated balance sheets as of December 31, 2021 and 2020, and the related consolidated statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

In our opinion, the accompanying consolidated financial statements present fairly, in all material respects, the financial position of Beverly Community Hospital Association as of December 31, 2021 and 2020, and the results of their operations and their cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

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

Responsibilities of Management for the Financial Statements

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

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

Auditor's Responsibilities for the Audit of the Financial Statements

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

In performing an audit in accordance with GAAS, we:

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

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

Supplementary Information

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The consolidating schedules listed in the foregoing table of contents are presented for purposes of additional analysis and are not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Moss Adams LLP

Los Angeles, California
April 29, 2022

ASSETS

	December 31, 2021	December 31, 2020
CURRENT ASSETS		
Cash and cash equivalents	$ 44,317,000	$ 43,371,000
Patient accounts receivable	19,469,000	21,371,000
Due from third-party payors, current	19,243,000	21,530,000
Inventories of drugs and supplies	3,244,000	3,548,000
Prepaid expenses and other assets	3,481,000	3,086,000
Total current assets	89,754,000	92,906,000
DUE FROM THIRD-PARTY PAYORS, less current portion	12,415,000	12,822,000
ASSETS LIMITED AS TO USE	3,542,000	3,033,000
PROPERTY AND EQUIPMENT, net	99,077,000	99,795,000
OTHER ASSETS	8,246,000	7,938,000
	$ 213,034,000	$ 216,494,000

LIABILITIES AND NET ASSETS

CURRENT LIABILITIES		
Accounts payable	$ 11,315,000	$ 8,850,000
Accrued expenses and other liabilities	8,651,000	9,147,000
Medical claims liabilities	4,562,000	5,101,000
Shared risk liability	8,011,000	2,810,000
Current portion of accrued self-insurance claims reserves	2,070,000	2,547,000
Current portion of Medicare advance payment	10,925,000	4,795,000
Current maturities of long-term debt	1,418,000	1,354,000
Current maturities of lease obligations	2,808,000	2,922,000
Total current liabilities	49,760,000	37,526,000
OTHER LONG-TERM LIABILITIES	-	1,176,000
ACCRUED SELF-INSURANCE CLAIMS RESERVES, less current portion	5,168,000	5,038,000
MEDICARE ADVANCE PAYMENT, less current portion	-	10,178,000
REVOLVING LOAN	10,000,000	10,000,000
LONG-TERM DEBT, net	58,199,000	59,677,000
LEASE OBLIGATIONS, less current maturities	5,546,000	5,019,000
Total liabilities	128,673,000	128,614,000
NET ASSETS		
Without donor restrictions	82,647,000	86,326,000
With donor restrictions	1,714,000	1,554,000
Total net assets	84,361,000	87,880,000
	$ 213,034,000	$ 216,494,000

See accompanying notes.

Beverly Community Hospital Association
Consolidated Statements of Operations

	Years Ended December 31,	
	2021	2020
UNRESTRICTED REVENUES, GAINS, AND OTHER SUPPORT		
Net patient service revenue	$ 145,515,000	$ 138,743,000
Premium revenue	24,204,000	27,248,000
In-kind contributions	3,019,000	-
Grant revenue – Provider Relief Funds	798,000	12,396,000
Other operating revenue	2,902,000	2,616,000
Net assets released from restrictions	190,000	450,000
Total unrestricted revenues, gains, and other support	176,628,000	181,453,000
EXPENSES		
Salaries and employee benefits	73,285,000	71,426,000
Supplies	22,474,000	21,838,000
Capitated medical services	18,571,000	24,403,000
Quality assurance fee	16,451,000	18,349,000
Other purchased services	14,736,000	15,565,000
Professional fees	12,711,000	10,230,000
Depreciation and amortization	9,764,000	9,454,000
Interest	3,073,000	3,086,000
Utilities	2,599,000	2,375,000
Rentals	2,406,000	3,912,000
Insurance	2,186,000	2,426,000
Other	2,051,000	1,636,000
Total expenses	180,307,000	184,700,000
Deficiency of revenues over expenses	$ (3,679,000)	$ (3,247,000)

See accompanying notes.

Beverly Community Hospital Association
Consolidated Statements of Changes in Net Assets

	Years Ended December 31,	
	2021	2020
NET ASSETS WITHOUT DONOR RESTRICTIONS		
Deficiency of revenues over expenses	$ (3,679,000)	$ (3,247,000)
Decrease in net assets without donor restriction	(3,679,000)	(3,247,000)
NET ASSETS WITH DONOR RESTRICTIONS		
Contributions	350,000	576,000
Net assets released from restrictions used for operations	(190,000)	(450,000)
Increase in net assets with donor restrictions	160,000	126,000
Decrease in net assets	(3,519,000)	(3,121,000)
NET ASSETS, beginning of year	87,880,000	91,001,000
NET ASSETS, end of year	$ 84,361,000	$ 87,880,000

See accompanying notes.

Beverly Community Hospital Association
Consolidated Statements of Cash Flows

	Years Ended December 31, 2021	2020
CASH FLOWS FROM OPERATING ACTIVITIES		
Decrease in net assets	$ (3,519,000)	$ (3,121,000)
Adjustments to reconcile decrease in net assets to net cash provided by (used in) operating activities		
Depreciation and amortization	9,764,000	9,454,000
Amortization of premiums and debt issuance costs	(58,000)	32,000
In-kind contributions	(3,019,000)	-
Changes in operating assets and liabilities		
Patient accounts receivable	1,902,000	766,000
Due from third-party payors	2,694,000	3,440,000
Inventories, prepaid expenses, and other assets	(399,000)	(415,000)
Accounts payable, accrued expenses, and other liabilities	793,000	(3,559,000)
Medical claims liabilities	(539,000)	(1,082,000)
Shared risk liability	5,201,000	(164,000)
Accrued self-insurance claims reserves	(347,000)	31,000
Medicare advance payment	(4,048,000)	14,973,000
Net cash provided by operating activities	8,425,000	20,355,000
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchases of assets limited as to use, net	(509,000)	(128,000)
Purchases of property and equipment	(2,823,000)	(2,125,000)
Net cash used in investing activities	(3,332,000)	(2,253,000)
CASH FLOWS FROM FINANCING ACTIVITIES		
Borrowings under revolving loan	35,000,000	17,500,000
Payments on revolving loan	(35,000,000)	(17,500,000)
Principal payments of long-term debt	(1,356,000)	(953,000)
Principal payments of finance lease obligations	(2,791,000)	(2,149,000)
Net cash used in financing activities	(4,147,000)	(3,102,000)
NET INCREASE IN CASH AND CASH EQUIVALENTS	946,000	15,000,000
CASH AND CASH EQUIVALENTS, beginning of year	43,371,000	28,371,000
CASH AND CASH EQUIVALENTS, end of year	$ 44,317,000	$ 43,371,000

See accompanying notes.

	Years Ended December 31,	
	2021	2020
SUPPLEMENTAL DISCLOSURE OF CASH FLOW INFORMATION		
Cash paid for interest, net of capitalized interest	$ 3,123,000	$ 3,032,000

Note 1 – Nature of Business

Organization – Beverly Community Hospital Association (the "Hospital") operates a 202-bed acute care hospital in Montebello, California. The Hospital is the sole corporate member of Beverly Hospital Foundation (the "Foundation") and is affiliated with Montebello Community Health Services ("MCHS") through a common board of directors.

MCHS was established for the exclusive benefit of the Hospital, which may include performing activities for, or providing services to, the Hospital and organizations affiliated with the Hospital. MCHS operates a medical office building, a health center, and certain rental properties.

The Foundation is organized to engage in the solicitation, receipt, and administration of funds for the benefit of the Hospital.

Note 2 – Summary of Significant Accounting Policies

Basis of consolidation – The consolidated financial statements include the accounts of the Hospital, MCHS, and the Foundation (collectively the "Corporation"). All intercompany transactions have been eliminated in consolidation.

Basis of presentation – The accompanying consolidated financial statements have been prepared on the accrual basis of accounting in accordance with accounting principles generally accepted in the United States (U.S. GAAP).

Use of estimates – The preparation of consolidated financial statements in accordance with U.S. GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from these estimates.

Cash and cash equivalents – Cash and cash equivalents include investments in highly liquid debt instruments with a maturity of three months or less, excluding those amounts that are limited for use by board designation or other arrangements under trust agreements or with third-party payors. Money market funds are included in cash and cash equivalents in the amount of $25,317,000 and $31,559,000 as of December 31, 2021 and 2020, respectively.

Patient accounts receivable – The Hospital carries its accounts receivable at billed amounts less uncollectible amounts. The Hospital does not accrue interest on its receivables. On a periodic basis, the Hospital evaluates its patient accounts receivable and establishes implicit and explicit price concessions based on contractual arrangements, history of past write-offs, collections, and current credit conditions. The Hospital's policy for writing off receivables as uncollectible varies based on the payor arrangements and management's estimate of the customer's ability to pay.

Inventories – Inventories are recorded at cost using the first-in, first-out method, which is not in excess of net realizable value.

Note 2 – Summary of Significant Accounting Policies (continued)

Assets limited as to use – Assets limited as to use include investments pledged to collateralize the outstanding letters of credit for workers' compensation self-insurance policies (see Note 5) and investments restricted by donors.

Investments in equity securities with readily determinable fair values and all investments in debt securities are measured at fair value in the consolidated balance sheets. Fair value is established based on quoted prices from recognized securities exchanges. Management determines the appropriate classification of all marketable securities at the date of purchase and reevaluates such designations at each balance sheet date. The Corporation determined that all debt investments held as of December 31, 2021 and 2020, are designated as held-to-maturity. Accordingly, unrealized gains or losses on investments are included in the consolidated statements of operations.

Income or loss on investments included in net assets with donor restriction, including realized and unrealized gains and losses on investments, interest, and dividends, is reported in the consolidated statements of operations unless the income or loss is restricted by donor or law.

Fair value of financial instruments – The Corporation's consolidated balance sheets include the following financial instruments: cash and cash equivalents, assets limited as to use, patient accounts receivable, accounts payable, accrued expenses and other liabilities, long-term debt, and lease obligations. The Corporation considers the carrying amounts of current assets and liabilities in the consolidated balance sheets to approximate the fair value of these financial instruments because of the relatively short period of time between origination of the instruments and their expected realization or payment. All investments are carried at fair value. The fair value of the Corporation's long-term debt is based on current market rates for debt of the same risk and maturity (see Note 9).

Property and equipment – Property and equipment are stated at cost. Major renewals are charged to the property and equipment accounts while replacements, maintenance, and repairs, which do not improve or extend the respective lives of the assets, are expensed currently. Depreciation is provided over the estimated useful life of each class of depreciable asset, ranging from three to forty years, and is computed using the straight-line method. Interest cost incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets. Total interest incurred amounted to $3,133,000 and $3,136,000 for the years ended December 31, 2021 and 2020, respectively. Total interest capitalized amounted to $60,000 and $50,000 as of December 31, 2021 and 2020, respectively. Total interest expense amounted to $3,073,000 and $3,086,000 for the years ended December 31, 2021 and 2020, respectively.

Equipment under finance lease obligations is amortized in the manner consistent with the policy for owned assets or over the lease term, whichever is shorter.

Note 2 – Summary of Significant Accounting Policies (continued)

The Hospital accounts for the costs incurred to obtain software for internal use in accordance with Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC), *Intangibles-Goodwill and Other – Internal-Use Software (Topic 350-40)*. Costs incurred in obtaining computer software for internal use, which include costs of configuration, installation, and testing, are capitalized by the Hospital. Costs incurred during the preliminary project along with post-implementation stages of internal use computer software are expensed as incurred. Capitalized development costs are amortized over a period of ten years. The capitalization and ongoing assessment of recoverability of computer software costs require considerable judgment with respect to certain external factors, including, but not limited to, technological and economic feasibility and estimated economic life.

Gifts of long-lived assets such as land, buildings, or equipment are reported as unrestricted support and are included in the consolidated statements of operations unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted support. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

Leases – Leases with durations greater than 12 months are recognized on the consolidated balance sheets through recognition of a liability for the discounted present value of future fixed lease payments and a corresponding right-of-use (ROU) asset. The ROU asset recorded at commencement of the lease represents the right to use the underlying asset over the lease term in exchange for the lease payments. Leases with an initial term of 12 months or less that do not have an option to purchase the underlying asset that is deemed reasonably certain to be exercised are not recorded on the consolidated balance sheets; rather, rent expense for these leases is recognized on a straight-line basis over the lease term or when incurred if a month-to-month lease. When readily determinable, the Corporation uses the interest rate implicit in a lease to determine the present value of future lease payments. For leases where the implicit rate is not readily determinable, the Corporation's incremental borrowing rate is utilized. The Corporation calculates its incremental borrowing rate on a quarterly basis using a financial model that estimates the rate of interest the Corporation would have to pay to borrow an amount equal to the total lease payments on a collateralized basis over a term similar to the lease. The Corporation's lease agreements do not contain any material residual value guarantees or material restrictive covenants.

The Corporation uses the package of practical expedients provided in FASB ASC, *Leases (Topic 842),* whereby an entity need not reassess expired contracts for lease identification or classification as a finance or operating lease, or for the reassessment of initial direct costs. Certain of the Corporation's lease agreements have lease and non-lease components, which, for most leases, the Corporation accounts for separately when the actual lease and non-lease components are determinable. For equipment leases with immaterial non-lease components incorporated into the fixed rent payment, the Corporation accounts for the lease and non-lease components as a single lease component in determining the lease payment. Additionally, for certain individually insignificant equipment leases such as copiers, the Corporation applies a portfolio approach to effectively record the operating lease liability and ROU asset.

Note 2 – Summary of Significant Accounting Policies (continued)

Equipment under finance and operating lease obligations is amortized in the manner consistent with the policy for owned assets or over the lease term, whichever is appropriate based on the type of lease.

The Corporation leases property and equipment under finance and operating leases. For leases with terms greater than 12 months, the Corporation records the related ROU assets and ROU obligations at the present value of lease payments over the term.

Generally, the Corporation uses estimated incremental borrowing rates to discount the lease payments based on information available at lease commencement, as most of the leases do not provide a readily determinable implicit interest rate.

Unamortized debt issuance costs – Debt issuance costs are amortized using the effective interest method over the life of the bonds. Amortization of debt issuance cost is included in interest expense. Accumulated amortization on the debt issuance costs was approximately $360,000 and $302,000 as of December 31, 2021 and 2020, respectively. Unamortized costs are presented net of long-term debt on the accompanying consolidated balance sheets.

Estimated self-insurance costs – The provision for estimated self-insurance costs for medical malpractice, workers' compensation, and employee health insurance claims includes estimates of the ultimate costs for both reported claims and claims incurred but not reported. The Hospital estimates claims liabilities without consideration of insurance recoveries in accordance with FASB ASC, *Health Care Entities – Contingencies (Topic 954-450),* and records insurance recoveries separately within other assets on the consolidated balance sheets.

Net assets classification – Based on the existence or absence of donor-imposed restrictions, the Hospital classifies net assets into two categories: without donor restrictions and with donor restrictions.

Without donor restrictions – Net assets that are not subject to donor-imposed restrictions and may be expended for any purpose in performing the primary objectives of the Hospital. These net assets may be used at the discretion of the Corporation's management and Board of Directors.

With donor restrictions – Net assets subject to stipulations imposed by donors and grantors. Some donor-imposed restrictions are temporary in nature, such as those that will be met by the passage of time or other events specified by the donor. Other donor-imposed restrictions are perpetual in nature, where the donor stipulates that resources be maintained in perpetuity. Donor-imposed restrictions are released when a restriction expires; that is, when the stipulated time has elapsed, when the stipulated purpose for which the resource was restricted has been fulfilled, or both.

Expiration of donor-imposed restrictions – Net assets are released from restrictions by incurring expenses satisfying the restricted purposes and by occurrence of events specified by the donors, including the passage of time. Donor restrictions on long-lived assets or cash to construct or acquire long-lived assets are considered to have expired when the assets are placed in service or expenditures exceed the amount of the gift.

Note 2 – Summary of Significant Accounting Policies (continued)

Patient service revenue – Patient service revenue is reported at the amount that reflects the consideration to which the Hospital expects to be entitled in exchange for providing patient care. These amounts are due from patients, third-party payors (including health insurers and government programs), and others and include variable consideration for retroactive revenue adjustments due to settlement of audits, reviews, and investigations. Generally, the Hospital bills the patients and third-party payors several days after the services are performed or the patient is discharged from the facility. Revenue is recognized as performance obligations are satisfied.

Performance obligations are determined based on the nature of the services provided by the Hospital. Revenue for performance obligations satisfied over time is recognized pro rata based on actual charges incurred in relation to total expected (or actual) charges. The Hospital believes that this method provides a reasonable depiction of the transfer of services over the term of the performance obligation based on the services provided to satisfy the obligation. Generally, performance obligations satisfied over time relate to patients in the hospital receiving inpatient acute care services. The Hospital measures the performance obligation from admission into the Hospital, or the commencement of an outpatient service, to the point when it is no longer required to provide services to that patient, which is generally at the time of discharge or completion of the outpatient services. Revenue for performance obligations satisfied at a point in time is generally recognized when services are provided, and the Hospital does not believe it is required to provide additional services to the patient.

Because all of its performance obligations relate to contracts with a duration of less than one year, the Hospital has elected to apply the optional exemption provided in FASB ASC, *Revenue from Contracts with Customers – Disclosure (Topic 606-10-50)*; therefore, is not required to disclose the aggregate amount of the transaction price allocated to performance obligations that are unsatisfied or partially unsatisfied at the end of the reporting period. The unsatisfied or partially unsatisfied performance obligations referred to previously are primarily related to inpatient acute care services at the end of the reporting period. The performance obligations for these contracts are generally completed when the patients are discharged, which generally occurs within days or weeks of the end of the reporting period.

The Hospital determines the transaction price based on standard charges for goods and services provided, reduced by contractual adjustments provided to third-party payors, discounts provided to uninsured patients in accordance with the Hospital's policy, and/or implicit price concessions provided to uninsured patients. The Hospital determines its estimates of explicit price concessions based on contractual agreements, its discount policies, and historical experience. The Hospital determines its estimate of implicit price concessions based on historical collection experience with this class of patients.

Agreements with third-party payors provide for payments at amounts less than established charges. A summary of the payment arrangements with major third-party payors follows:

Medicare – Certain inpatient acute care services are paid at prospectively determined rates per discharge based on clinical, diagnostic, or other factors. Certain services are paid based on a cost reimbursement methodology subject to certain limits. Physical services are paid based upon established fee schedules. Outpatient services are paid using prospectively determined rates.

Note 2 – Summary of Significant Accounting Policies (continued)

Medicaid – Reimbursements for Medicaid services are generally paid at prospectively determined rates per discharge, per occasion of services, or per covered member.

Other – Payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations provide for payment using prospectively determined rates per discharge, discounts from established charges, and prospectively determined daily rates.

Laws and regulations concerning government programs, including Medicare and Medicaid, are complex and subject to varying interpretation. As a result of investigations by governmental agencies, various health care organizations have received requests for information and notices regarding alleged noncompliance with those laws and regulations, which, in some instances, have resulted in organizations entering into significant settlement agreements. Compliance with such laws and regulations may also be subject to future government review and interpretation as well as significant regulatory action, including fines, penalties, and potential exclusion from the related programs. There can be no assurance that regulatory authorities will not challenge the Hospital's compliance with these laws and regulations, and it is not possible to determine the impact, if any, such claims or penalties would have upon the Hospital. In addition, the contracts the Hospital has with commercial payors also provide for retroactive audit and review of claims.

Settlements with third-party payors for retroactive adjustments due to audits, reviews, or investigations are considered variable consideration and are included in the determination of the estimated transaction price for providing patient care in the period the related services are provided or when results of audits and appeals can reasonably be determined or finalized. These settlements are estimated based on the terms of the payment agreement with the payor, correspondence from the payor, and the Hospital's historical settlement activity, including an assessment to ensure that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustment is subsequently resolved. Estimated settlements are adjusted in future periods as adjustments become known; that is, new information becomes available or as years are settled or are no longer subject to such audits and reviews. Adjustments arising from a change in the transaction price were not significant for the years ended December 31, 2021 or 2020.

Generally, patients who are covered by third-party payors are responsible for related deductibles and coinsurance, which vary in amount. The Hospital also provides services to uninsured patients and offers those uninsured patients a discount, either by policy or law, from standard charges. The Hospital estimates the transaction price for patients with deductibles and coinsurance and from those who are uninsured based on historical experience and current market conditions. The initial estimate of the transaction price is determined by reducing the standard charge by any explicit and implicit price concessions. Subsequent changes to the estimate of the transaction price are generally recorded as adjustments to patient service revenue in the period of the change. For the years ended December 31, 2021 and 2020, revenue reductions of approximately $1,628,000 and $731,000, respectively, were recognized due to changes in its estimates of implicit price concessions for performance obligations satisfied in prior years. Subsequent changes that are determined to be the result of an adverse change in the patient's ability to pay are recorded as bad debt expense. Bad debt expense for the years ended December 31, 2021 and 2020, was not significant.

Note 2 – Summary of Significant Accounting Policies (continued)

Consistent with the Hospital's mission, care is provided to patients regardless of their ability to pay. Therefore, the Hospital has determined it has provided implicit price concessions to uninsured patients and patients with other uninsured balances (for example, copays and deductibles). The implicit price concessions included in estimating the transaction price represent the difference between amounts billed to patients and the amounts the Hospital expects to collect based on its collection history with those patients.

Patients who meet the Corporation's criteria for charity care are provided care without charge or at amounts less than established rates. Such amounts determined to quality as charity care are not reported as revenue.

Net patient service revenue by major payor source is as follows:

	Years Ended December 31,			
	2021		2020	
Medicare	$ 26,120,000	18%	$ 24,581,000	18%
Medicare managed care	35,994,000	25%	27,342,000	20%
Medi-Cal	5,607,000	4%	7,161,000	5%
Medi-Cal managed care	16,671,000	11%	17,820,000	13%
Medi-Cal hospital fee and DSH	44,853,000	31%	43,511,000	31%
Other third party and commercial	13,979,000	10%	16,369,000	12%
Self pay	2,291,000	1%	1,959,000	1%
	$ 145,515,000	100%	$ 138,743,000	100%

The administrative procedures related to the cost reimbursement programs in effect generally preclude final determination of amounts due to the Hospital until cost reports are audited or otherwise reviewed and settled upon with the applicable administrative agencies. Normal estimation differences between final settlements and amounts accrued in previous years are reported as adjustments of the current year's net patient service revenue. In the opinion of management, adequate provision has been made for adjustments, if any, that might result from subsequent review. During the years ended December 31, 2021 and 2020, the Hospital updated anticipated final settlement amounts on previously filed Medicare and Medi-Cal cost reports and supplemental payment programs. The effect of these changes in estimates to net patient service revenue for the years ended December 31, 2021 and 2020, was an increase of $1,711,000 and $217,000, respectively.

To ensure accurate payments to providers, the Tax Relief and Healthcare Act of 2006 mandated the Centers for Medicare & Medicaid Services (CMS) to implement a Recovery Audit Contractor (RAC) program on a permanent and nationwide basis no later than 2010. The program uses RAC to search for potentially improper Medicare payments that may have been made to health care providers that were not detected through existing CMS program integrity efforts, which have occurred at least one year ago but not longer than three years ago. RAC assessment against the Hospital began during 2012. During the years ended December 31, 2021 and 2020, settlements repaid to CMS were immaterial.

Note 2 – Summary of Significant Accounting Policies (continued)

The Hospital is reimbursed for services provided to patients under certain programs administered by governmental agencies. Revenues from the Medicare and Medi-Cal programs including Hospital Fee (see Note 4) and Disproportionate Share Hospital (DSH) program (see Note 4) accounted for approximately 22% and 9%, respectively, for the year ended December 31, 2021, and 21% and 10%, respectively, for the year ended December 31, 2020, of the Hospital's net patient service revenue. Laws and regulations governing the Medicare and Medi-Cal programs are complex and subject to interpretation. The Hospital believes that it is in compliance with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing. While no such regulatory inquiries have been made, compliance with such laws and regulations can be subject to future government review and interpretation, as well as significant regulatory action, including fines, penalties, and exclusion from the Medicare and Medi-Cal programs.

Premium revenue and capitated medical services – The Hospital has agreements with various Health Maintenance Organizations (HMOs) to provide medical services to subscribing participants. Under these agreements, the Hospital receives monthly capitation payments based on the number of each HMO's participants, regardless of services actually performed by the Hospital. Revenue from monthly premiums is recognized in the month in which the Hospital is required to provide services. The amounts are included as premium revenue in the accompanying consolidated statements of operations. Liabilities for services provided to enrollees by service providers outside the Hospital are accrued in the month the services are rendered to enrollees based in part on estimates, including an accrual for services incurred but not reported to the Hospital. The Hospital retains an independent actuary to perform an annual review of the actuarial projections. Amounts for claims payment incurred related to prior years vary from previously estimated liabilities as the claims ultimately are settled. Liabilities of $4,562,000 and $5,101,000 as of December 31, 2021 and 2020, respectively, have been accrued in the accompanying consolidated balance sheets. In management's opinion, these accruals are adequate to cover ultimate claims expenses under the program. Normal estimation differences between the estimates and amounts finally paid to service providers are reflected in claims expense in the current period. These differences resulted in a decrease of $1,800,000 and increase of $1,919,000 in capitated medical services expense during the years ended December 31, 2021 and 2020, respectively.

Certain HMO contracts contain risk-sharing programs whereby the Hospital participates in the surplus and deficit of the risk-sharing program. The Hospital's partner physician groups also share in the proceeds of risk-sharing programs. Estimated settlements are accrued based upon the performance of the risk-sharing contracts in the period the Hospital was obligated to provide the services to the enrollees and adjusted in the future periods as final settlements are determined.

Grant revenue – The Hospital receives grants from various federal, state, and local agencies. Revenues from grants are recognized when all eligibility requirements are met.

In-kind contributions – Contributions of donated services are recognized if the services received: (a) create or enhance long-lived assets; or (b) require specialized skills, are provided by individuals possessing those skills, and would typically need to be purchased if not provided by donation.

Note 2 – Summary of Significant Accounting Policies (continued)

Excess of revenues over expenses – The consolidated statements of operations include excess of revenues over expenses. Changes in unrestricted net assets without donor restriction, which are excluded from excess of revenues over expenses, consistent with industry practice, include unrealized gains and losses on investments other than trading securities, permanent transfers of assets to and from subsidiaries for other than goods and services, and contributions of long-lived assets, including assets acquired using contributions which by donor restriction were to be used for the purpose of acquiring such assets.

Charity care – The Hospital provides care to patients who lack financial resources and are deemed to be medically indigent based on criteria established under the Hospital's charity care policy. This care is provided without charge or at amounts less than its established rates. Because the Hospital does not pursue collection of amounts determined to qualify as charity care, such amounts are not reported as revenue. The Hospital maintains records to identify and monitor the level of charity care provided. These records include the amount of direct and indirect costs for services and supplies furnished under its charity care policy. The direct and indirect costs related to this care totaled approximately $1,211,000 and $1,174,000 for the years ended December 31, 2021 and 2020, respectively. Direct and indirect costs for providing charity care are estimated by calculating a ratio of cost to gross charges and then multiplying that ratio by the gross uncompensated charges associated with providing care to charity patients. In addition, the Hospital provides services to other medically indigent patients under the state Medicaid programs. The state program pays amounts less than the cost of the services provided to the recipients.

Income taxes – The Hospital, MCHS, and the Foundation are not-for-profit entities organized under the laws of the state of California. All have been determined to be exempt from income taxes under Section 501(c)(3) of the Internal Revenue Code and Section 23701(d) of the state of California Revenue and Taxation Code by the Internal Revenue Service and Franchise Tax Board, respectively. The Hospital is recognized as a public charity under sections 509(a)(1) and 170(b)(1)(A)(iii) of the Internal Revenue Code.

The Corporation recognizes the tax expense or provision from uncertain tax positions only if it is more-likely-than-not that the tax positions will be sustained on examination by the tax authorities, based on the technical merits of the position. The tax benefit is measured based on the largest benefit that has a greater than 50% likelihood of being realized upon ultimate settlement.

Concentrations of credit risk – Financial instruments which potentially subject the Corporation to concentrations of credit risk consist primarily of cash, patient accounts receivable, and assets limited as to use.

Cash deposits are maintained in financial institutions that may exceed the amounts insured by the United States government. Nonperformance by these institutions could expose the Corporation to losses for amounts in excess of the insured balances. The Corporation monitors the financial condition of these institutions on an ongoing basis and does not believe significant risks exist at this time.

Note 2 – Summary of Significant Accounting Policies (continued)

Significant concentrations of net patient accounts receivable are as follows:

	December 31,	
	2021	2020
Medicare	9%	13%
Medicare managed care	45%	40%
Medi-Cal	4%	8%
Medi-Cal managed care	29%	23%
Other third party and commercial	8%	14%
Self pay	5%	2%
	100%	100%

The investment portfolio of assets limited as to use is managed by an outside investment firm within the guidelines established by the Board of Directors which, as a matter of policy, limit the amounts which may be invested in any one issuer.

Long-lived asset impairment – The Corporation reviews long-lived assets for impairment when events or changes in business conditions indicate that their carrying value may not be recoverable. The Corporation considers assets to be impaired and writes these down to fair value if expected associated cash flows are less than the carrying amounts. Fair value is the present value of the associated cash flows. The Corporation has determined that no long-lived assets are impaired as of December 31, 2021 and 2020.

Going concern – In connection with the preparation of the consolidated financial statements for the year ended December 31, 2021, the Corporation conducted an evaluation as to whether there were conditions and events, considered in the aggregate, which raised substantial doubt as to the Corporation's ability to continue as a going concern within one year after the date of the consolidated financial statements were available for issuance. Management determined that there were no conditions or events that raised substantial doubt about the Corporation's ability to continue as a going concern.

Legal proceedings – The Corporation is a defendant in certain legal actions arising from the normal conduct of business. Management believes that the ultimate resolution of these proceedings will not have a material adverse effect upon the Corporation's consolidated financial position but could be material to consolidated results of operations and cash flows of a particular future year, if resolved unfavorably.

During the year ended December 31, 2014, the Corporation made a disclosure to the Centers for Medicare and Medicaid Services under the Self-Referral Disclosure Protocol. This disclosure concerns Medicare referrals made to the Corporation by physicians who have financial arrangements with the Corporation that may have been prohibited. An estimate of the range of loss in this matter cannot currently be made with the available information.

Note 2 – Summary of Significant Accounting Policies (continued)

Subsequent events – Subsequent events are events or transactions that occur after the consolidated balance sheet date but before the consolidated financial statements were issued. The Corporation recognizes in the consolidated financial statements the effects of all subsequent events that provide additional evidence about conditions that existed at the date of the consolidated balance sheet, including the estimates inherent in the process of preparing the consolidated financial statements. The Corporation's consolidated financial statements do not recognize subsequent events that provide evidence about conditions that did not exist at the date of the consolidated balance sheets but arose after the consolidated balance sheet date and before the consolidated financial statements were issued.

Management has evaluated events that have occurred subsequent to April 29, 2022, the date on which the consolidated financial statements were issued.

Note 3 – Liquidity and Availability

The Hospital has financials assets available within one year of the consolidated balance sheet date of December 31, 2021, to meet cash needs for general expenditure as follows:

Financial assets as of December 31, 2021	
Cash and cash equivalents	$ 44,317,000
Patient accounts receivable	19,469,000
Due from third-party payors, current	19,243,000
Financial assets available to meet cash needs for general expenditures within one year	$ 83,029,000

The Hospital has $83,029,000 of financial assets available within one year of the statement of financial position date to meet cash needs for general expenditure. None of the financial assets are subject to donor or other contractual restrictions that make them unavailable for general expenditure within one year of the balance sheet date. The Corporation has a policy to structure its financial assets to be available as its general expenditures, liabilities, and other obligations come due.

Note 4 – Supplemental Payments

SB1100 (previously SB855) – During the years ended December 2021 and 2020, the Hospital was eligible to participate in the DSH program, which entitles the Hospital to supplemental payment adjustments from the California Department of Health Care Services (DHCS). Included in due from third-party payors in the accompanying consolidated balance sheets are receivable from DHCS of $607,000 as of December 31, 2021, and deferred revenue of $443,000 as of December 31, 2020. The Hospital recognized approximately $12,519,000 and $11,321,000 within net patient service revenue for the years ended December 31, 2021 and 2020, respectively, in the accompanying consolidated statements of operations.

Note 4 – Supplemental Payments (continued)

SB1100 (previously SB1255) – The Hospital met the eligibility criteria for funds available from the state of California's Emergency Services and Supplemental Payment Fund as of December 31, 2021 and 2020. Included in due from third-party payors in the accompanying consolidated balance sheets are deferred revenue from DHCS of $13,000 and $25,000 as of December 31, 2021 and 2020, respectively. The Hospital recognized approximately $1,440,000 and $2,390,000 within net patient service revenue for the years ended December 31, 2021 and 2020, respectively, in the accompanying consolidated statements of operations.

Hospital fee program – The California Hospital Fee Program (the "Program") is comprised of multiple laws enacted by the state of California. The most recent laws cover the periods from January 1, 2017 through June 30, 2019 (the "QAF V Program"), and July 1, 2019 through December 31, 2021 (the "QAF VI Program"). The Program requires a Quality Assurance Fee ("QA Fee") to be paid by certain hospitals to a state fund established to accumulate the assessed QA Fees in order to receive matching federal funds. QA Fees and corresponding matching federal funds are then paid to participating hospitals in two supplemental payment methodologies: a fee-for-service methodology and a managed care plan methodology. The Hospital recognizes Program-related revenue and expense ratably over the Program period. In relation to the Program, the Hospital has consistently recognized revenues and expenses based on reasonable estimates of what will ultimately be realized, considering among other things adjustments associated with regulatory reviews, audits, investigations, and other proceedings. Under the original legislation, uncertainty of the Program's approval resulted in deferral of revenue and expense recognition until reasonable approval of the Program had been made by CMS. Since the inception of the Program in 2010, CMS has continued to approve funding, and no portion of the applications by the state to CMS for matching has been rejected or overturned.

CMS approved the tax waiver for the fee-for-service and managed care plan methodologies for the QAF V Program as of December 14, 2017. From the inception of the QAF V Program on January 1, 2017 through December 31, 2021, the Hospital recognized $82,658,000 in net patient service revenues and $36,839,000 in QA fee expenses with a net benefit of $45,819,000. The Hospital has recorded the entirety of the revenues and expenses of the QAF V Program as of December 31, 2021.

CMS approved the tax waiver for the fee-for-service and managed care plan methodologies for the QAF VI Program. From the inception of the QAF VI Program on July 1, 2019 through December 31, 2021, the Hospital recognized $78,457,000 in net patient service revenues and $40,907,000 in QA fee expenses with a net benefit of $37,550,000.

As of December 31, 2021 and 2020, a net receivable for the Program of $28,458,000 and $31,358,000, respectively, is included within due from third-party payors on the accompanying consolidated balance sheets. The net amount includes a receivable for the Program that totaled approximately $43,654,000 and $44,894,000 for the years ended December 31, 2021 and 2020, respectively, offset by accrued fees for the Program that totaled approximately $15,196,000 and $13,536,000 for the years ended December 31, 2021 and 2020, respectively. The Hospital recognized expenses of approximately $16,451,000 and $18,349,000 and revenues of approximately $30,894,000 and $29,800,000 during the years ended December 31, 2021 and 2020, respectively. The Program revenue is included as a component of net patient service revenue in the accompanying consolidated statements of operations.

Note 5 – Self-Insurance

The Hospital self-insures against professional and general liability claims, workers' compensation claims, and certain employee group health and dental benefits. The Hospital purchases claims-made malpractice insurance coverage from a closely held insurance company, of which the Hospital is a 3% shareholder. Commercial insurance has been purchased for losses in excess of the closely held insurance company's coverage limits. The investment in the insurance company of $298,000 is included in other assets and is accounted for under the cost method. If the Hospital decides to cancel or not renew its policy with this insurance company, the Hospital must offer its shares for redemption and the insurance company must purchase the shares at the lower of either the original purchase price paid or the fair market value at the date of sale.

The Hospital's malpractice liability risks vary by accident year, as follows:

Coverage Period	Self-Insured Risks
October 1, 2003 to September 30, 2007	$25,000 per occurrence
October 1, 2007 to December 31, 2021	$50,000 per occurrence

Accruals for uninsured malpractice claims and claims incurred but not reported are actuarially estimated based upon the Hospital's claims experience and are discounted at a 2.25% rate. Liabilities of $2,553,000 and $2,418,000 as of December 31, 2021 and 2020, respectively, have been accrued in the accompanying consolidated balance sheets, included in accrued self-insurance claims reserves. In management's opinion, these accruals are adequate to cover ultimate claims expenses.

The Hospital's workers' compensation risks vary by accident year, as follows:

Coverage Period	Self-Insured Risks
March 1, 2004 to December 31, 2021	$250,000 per occurrence / $2,180,000 in aggregate

Accruals for the self-insured periods for workers' compensation claims and claims incurred but not reported are actuarially estimated based on the Hospital's claims experience and are discounted at a 2.25% rate. Liabilities of $3,861,000 and $4,207,000 as of December 31, 2021 and 2020, respectively, have been accrued in the accompanying consolidated balance sheets, included in accrued self-insurance claims reserves. In management's opinion, these accruals are adequate to cover ultimate claims expenses. As of December 31, 2021 and 2020, the Corporation had standby letters of credit of $1,828,000 and $1,479,000, respectively, available with a bank to collateralize payment of workers' compensation claims.

On January 1, 2017, the Hospital became self-insured against claims for employee group health benefits. The Hospital is self-insured for up to a retention of $250,000 per covered person. Liabilities of $824,000 and $960,000 as of December 31, 2021 and 2020, respectively, have been accrued in the accompanying consolidated balance sheets (included in accrued self-insurance claims reserves).

Note 5 – Self-Insurance (continued)

Total accrued workers' compensation, professional liability, and group health claims reserves and related insurance receivables as of December 31 were as follows:

	2021	
	Assets	Liabilities
	Insurance Receivable	Claims Liabilities
Current portion	$ 607,000	$ 2,070,000
Long-term portion	3,148,000	5,168,000
Total	$ 3,755,000	$ 7,238,000

	2020	
	Assets	Liabilities
	Insurance Receivable	Claims Liabilities
Current portion	$ 898,000	$ 2,547,000
Long-term portion	3,014,000	5,038,000
Total	$ 3,912,000	$ 7,585,000

Note 6 – Assets Limited as to Use

A summary of the limitations as to the use of assets, stated at fair value, consisted of the following as of December 31:

	2021	2020
Pledged deposit held by bank to collateralize outstanding letters of credit	$ 1,828,000	$ 1,479,000
Assets with donor restrictions	1,714,000	1,554,000
	$ 3,542,000	$ 3,033,000

Note 7 – Fair Value Measurement

The Corporation measures and reports the fair value of its financial assets and liabilities in accordance with FASB ASC, *Fair Value Measurements and Disclosures (Topic 820).* Topic 820 defines fair value as the price that would be received to sell an asset or transfer a liability in an orderly transaction between market participants at the measurement date. Topic 820 also establishes a fair value hierarchy which requires an entity to maximize the use of observable inputs and minimize the use of unobservable inputs when measuring fair value. Three levels of inputs that may be used to measure fair value are established.

Level 1 – Quoted prices in active markets for identical assets or liabilities.

Level 2 – Observable inputs other than Level 1 prices, such as quoted prices for similar assets or liabilities; quoted prices in markets that are not active; or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities.

Level 3 – Unobservable inputs that are supported by little or no market activity and that are significant to the fair value of the assets or liabilities.

In determining fair value, the Corporation utilizes valuation techniques that maximize the use of observable inputs and minimize the use of unobservable inputs to the extent possible as well as considers counterparty credit risk in its assessment of fair value.

The following is a description of the valuation methodologies used for instruments measured at fair value.

Certificates of deposit – Valued based on original cost, plus accrued interest which approximates fair value.

Equity securities – Fair value of equity securities has been determined by the Corporation from observable market quotations.

Corporate bonds – Valued using pricing models maximizing the use of observable inputs for similar securities, which includes basing value on yields currently available on comparable securities of issuers with similar credit ratings.

Alternative investments – The alternative investments consist of six funds which are invested in commodities, real estate, and reinsurance. These investments are in mutual fund format and hedge fund strategies.

- Mutual funds – valued at Net Asset Value (NAV) of shares held at year end using prices quoted by relevant pricing agents and are classified within Level 1 of the valuation hierarchy for fair value measurements.

- Hedge funds – valued at NAV using prices quoted by relevant fund managers and are excluded from the valuation hierarchy for fair value measurements.

Note 7 – Fair Value Measurement (continued)

The following tables present the fair value measurements of assets recognized in the accompanying consolidated balance sheets measured at fair value on a recurring basis and the level within the Topic 820 fair value hierarchy in which the fair value measurements fall as of December 31:

	2021		
	Fair Value	Level 1	Level 2
ASSETS			
Assets limited as to use			
Certificates of deposit	$ 1,828,000	$ -	$ 1,828,000
Corporate bonds	432,000	-	432,000
Equity securities	1,140,000	1,140,000	-
	3,400,000	$ 1,140,000	$ 2,260,000
Alternative investments measured using NAV as practical expedient			
Hedge funds	142,000		
	$ 3,542,000		

	2020		
	Fair Value	Level 1	Level 2
ASSETS			
Assets limited as to use			
Certificates of deposit	$ 1,479,000	$ -	$ 1,479,000
Corporate bonds	415,000	-	415,000
Equity securities	987,000	987,000	-
Mutual funds	99,000	99,000	-
	2,980,000	$ 1,086,000	$ 1,894,000
Alternative investments measured using NAV as practical expedient			
Hedge funds	53,000		
	$ 3,033,000		

Note 8 – Property and Equipment

Property and equipment were comprised of the following as of December 31:

	2021	2020
Depreciable assets		
Buildings and land improvements	$ 157,725,000	$ 153,440,000
Equipment	45,530,000	41,931,000
Computer software	15,652,000	15,329,000
	218,907,000	210,700,000
Less: accumulated depreciation and amortization	(129,068,000)	(120,981,000)
	89,839,000	89,719,000
Non-depreciable assets		
Land	8,279,000	8,279,000
Construction-in-progress (cost to complete at December 31, 2021, is approximately $1,875,000)	959,000	1,797,000
	9,238,000	10,076,000
	$ 99,077,000	$ 99,795,000

For the years ended December 31, 2021 and 2020, depreciation and amortization expense amounted to $9,764,000 and $9,454,000, respectively. Of this amount, depreciation and amortization expense from financing leases for the years ended December 31, 2021 and 2020, amounted to $2,350,000 and $2,245,000, respectively. Capitalized cost of equipment under financing lease obligations as of December 31, 2021 and 2020, totaled $21,312,000 and $17,234,000, respectively. Related accumulated amortization on equipment under financing lease obligations as of December 31, 2021 and 2020, totaled $12,153,000 and $9,804,000, respectively.

Note 9 – Revolving Loan and Long-Term Debt

Revolving loan – On August 1, 2019, the Hospital entered into a revolving loan agreement that allows for draws and repayments with a maximum draw of $10,000,000 and a maturity date of January 3, 2024, which classifies the balance as long-term at December 31, 2021. The interest rate is the greater of 1.75% or Prime minus 2%. The amount outstanding as of December 31, 2021 and 2020, was $10,000,000. The interest rate was 1.75% at December 31, 2021.

Note 9 – Revolving Loan and Long-Term Debt (continued)

Long-term debt – On December 2, 2015, the Corporation issued California Statewide Communities Development Authority Revenue Bonds Series 2015 ("2015 Bonds") at the par amount of $39,725,000 with stated fixed interest rates of 4% for maturity dates between 2019 and 2025 and 5% for maturity dates between 2026 and 2045. The 2015 Bonds sold at a premium of $2,043,000, which is being amortized over the life of the bonds using the effective interest rate method. The effective interest rates range between 2.14% and 4.46%. The 2015 Bonds are secured by certain assets of the Corporation. Interest is payable in arrears semi-annually on February 1 and August 1 of each year. As of December 31, 2021 and 2020, the estimated fair value of the 2015 Bonds, based on Level 2 inputs, was $39,465,000 and $37,797,000, respectively.

On May 9, 2017, the Corporation issued California Statewide Communities Development Authority Revenue Bonds Series 2017 ("2017 Bonds") at the par amount of $19,840,000 with stated fixed interest rates ranging from 3% to 5% with maturity dates between 2021 and 2048. The 2017 Bonds sold at a premium of $1,158,000, which is being amortized over the life of the bonds using the effective interest rate method. The effective interest rates range between 2.66% and 4.14%. The 2018 Bonds are secured by certain assets of the Corporation. Interest is payable in arrears semi-annually on May 1 and November 1 of each year. As of December 31, 2021 and 2020, the estimated fair value of the Bonds, based on Level 2 inputs, were $20,983,000 and $19,164,000, respectively.

The 2015 Bonds and the 2017 Bonds require the Corporation to maintain compliance with certain financial and non-financial covenants including the maintenance of day's cash on hand and debt service coverage. As defined in the master indenture agreement, the Corporation agrees to manage its business such that day's cash on hand calculated as of the end of each fiscal year will not be less than 60 days on hand for such fiscal year (the "Consultant Level"). If at the end of any fiscal year day's cash on hand is less than the Consultant Level, the Corporation covenants to retain promptly an Independent Consultant to make recommendations to increase day's cash on hand for the following fiscal year. If the Corporation retains and substantially complies with the recommendations of the independent consultant, the Corporation will be deemed to have complied with the day's cash on hand covenant, provided that day's cash on hand for any fiscal year is not less than 40 days' cash on hand (the "Minimum Level"). Failure to have day's cash on hand as of the end of any fiscal year in amount at least Minimum Level for such fiscal year is an event of default under the master indenture agreement. As of December 31, 2021, the Corporation was above the required Consultant Level for both day's cash on hand and debt service coverage.

On August 13, 2020, the Corporation entered into a loan agreement in the amount of $1,834,000 with an unrelated party to finance the purchase of patient monitors, bearing interest at 6.07% per annum. As of December 31, 2021 and 2020, the equipment loan payable was $1,348,000 and $1,666,000, respectively, and is included in long-term debt in the consolidated balance sheets. With the exception of the first installment payment of $100,000, the Corporation shall pay monthly installments of $34,000, inclusive of principal and interest, through September 1, 2025.

Note 9 – Revolving Loan and Long-Term Debt (continued)

The balance of long-term debt consists of the following as of December 31:

	2021	2020
2015 CSCDA Revenue Bonds	$ 37,365,000	$ 38,185,000
2017 CSCDA Revenue Bonds	19,625,000	19,840,000
Equipment Loan Payable	1,348,000	1,669,000
Total	58,338,000	59,694,000
Add: unamortized premium and less debt issuance costs	1,279,000	1,337,000
Less: current portion	(1,418,000)	(1,354,000)
Long-term debt, net of current portion	$ 58,199,000	$ 59,677,000

Future maturities of long-term debt are as follows:

Years Ending December 31,	
2022	$ 1,418,000
2023	1,485,000
2024	1,552,000
2025	1,488,000
2026	1,270,000
Thereafter	51,125,000
	$ 58,338,000

Note 10 – Net Assets with Donor Restrictions

Net assets with donor restrictions are available for the purpose of nursing education and for the purchase of equipment.

As of December 31, 2021 and 2020, net assets were released from donor restrictions by satisfying the restricted purpose of nursing education, construction, and equipment in the amount of $190,000 and $450,000, respectively.

As of December 31, 2021 and 2020, approximately $1,137,000 of the net assets with donor restrictions are to be held in perpetuity, the income from which is expendable to support unrestricted purposes (see Note 11).

Note 11 – Endowment

Interpretation of relevant law – The Board of Directors has interpreted the California Prudent Management of Institutional Funds Act (CPMIFA) as requiring the preservation of the fair value of the original gift as of the date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. As a result of this interpretation, the Foundation has classified as permanently restricted net assets (1) the original value of gifts donated to the permanent endowment, (2) the original value of subsequent gifts to the permanent endowment, and (3) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. Donor-restricted endowment income and accumulated gains are classified as net assets with donor restrictions until those amounts are appropriated for expenditure by the Foundation in a manner consistent with the standard of prudence prescribed by CPMIFA.

In accordance with CPMIFA, the Foundation considers the following factors in making a determination to appropriate or accumulate endowment funds:

- The duration and preservation of the fund
- The purpose of the Foundation's donor-restricted endowment fund
- General economic conditions
- The possible effect of inflation and deflation
- The expected total return from income and the appreciation of investments
- Other Foundation resources
- The investment policies of the Foundation

Return objectives and risk parameters – The Foundation has adopted investment and spending policies for endowment assets that attempt to provide a predictable stream of funding to programs supported by its endowment while seeking to maintain the purchasing power of the endowment assets. Endowment assets include those assets of donor-restricted funds that the Foundation must hold in perpetuity or for a donor-specified period(s). Under this policy, as approved by the Board of Directors, the endowment assets are invested in a manner that is intended to produce results that exceed inflation and a custom benchmark composed of a benchmark for each asset class, while assuming a low level of investment risk.

Strategies employed for achieving objectives – To satisfy its long-term rate-of-return objectives, the Foundation relies on a total return strategy in which investment returns are achieved through both capital appreciation, realized and unrealized, and current yield, interest and dividends. The Foundation targets a diversified asset allocation that places a greater emphasis on equity-based investments to achieve its long-term return objectives within prudent risk constraints.

Spending policy and how investment objectives relate to spending policy – The Foundation has a policy of spending all investment earnings each year, as recommended by the Board of Directors, and under no circumstances should any fund's market value fall below its corpus value or as specified by donor instructions. In establishing this policy, the Foundation considered the long-term expected return on its endowment.

Note 11 – Endowment (continued)

Endowment funds with deficits – Endowment funds with deficits are fair value of assets associated with individual donor-restricted endowment funds that fall below the value of the initial and subsequent donor gift amounts. When donor endowment deficits exist, they are classified as a reduction of net assets without donor restriction. There were no funds with deficits at December 31, 2021 and 2020. Per the terms of the agreement, these funds are to be invested with the income to be used as follows:

Catherine P. and George R. Hensel endowment fund – Per the terms of the agreement, these funds are to be invested and all income generated will be unrestricted and used to further the charitable health care purposes of the Hospital.

Changes in endowment net assets are as follows:

Balance at December 31, 2019	$	1,000,000
Investment income		24,000
Additions		137,000
Net realized and unrealized investment gains		330,000
Appropriation of endowment assets for expenditure		(354,000)
Balance at December 31, 2020		1,137,000
Investment income		29,000
Additions		-
Net realized and unrealized investment gains		141,000
Appropriation of endowment assets for expenditure		(170,000)
Balance at December 31, 2021	$	1,137,000

Note 12 – Seismic Regulation

The California Hospital Facilities Safety Act (SB 1953) specifies certain requirements that must be met at various dates in order to increase the probability that hospitals could maintain uninterrupted operations following major earthquakes. By January 1, 2013, all general acute care buildings must be life safe. In June 2012, the California Legislative passed Senate Bill 90 (SB 90). SB 90 provides for further extension of the January 1, 2013 deadline for achieving compliance for up to seventeen years. The Hospital has filed applications for SB 90 extensions. By January 1, 2030, all general acute care inpatient buildings must be operational after an earthquake. Management believes that the Hospital will be in compliance with the requirements of SB 1953.

Note 12 – Seismic Regulation (continued)

These upgrades may include asbestos abatement, which is an asset retirement obligation (ARO). ASC 410-20-25 requires an entity to recognize a liability for the fair value of conditional asset retirement obligations if the fair value of the liability can be reasonably estimated. The fair value of a liability for conditional ARO must be recognized when incurred, generally upon acquisition, construction, or development and/or through the normal operation of the asset. The Corporation is currently evaluating its renovation and replacement need for the Hospital to comply with California's seismic safety standards. Because the Corporation's plans for renovation are not complete and the date and amounts for which the ARO could be settled are unknown, the Corporation concluded that it could not reasonably estimate the fair value of a liability, and no liability has been recorded. However, the Corporation may record a liability in a future period in which the fair value can be reasonably estimated.

Note 13 – Leases

The following table presents the Corporation's lease-related assets and liabilities as of December 31:

Component of Lease Balance	Consolidated Balance Sheets Classification	2021	2020
Assets			
Operating leases	Property and equipment, net	$ 590,000	$ 827,000
Finance leases	Property and equipment, net	9,159,000	7,430,000
Total lease assets		$ 9,749,000	$ 8,257,000
Current liabilities			
Operating leases	Current maturities lease obligations	$ 370,000	$ 498,000
Finance leases	Current maturities lease obligations	2,438,000	2,424,000
		2,808,000	2,922,000
Non current liabilities			
Operating leases	Lease obligations, less current maturities	417,000	594,000
Finance leases	Lease obligations, less current maturities	5,129,000	4,425,000
		5,546,000	5,019,000
Total lease liabilities		$ 8,354,000	$ 7,941,000

Note 13 – Leases (continued)

The following table presents certain information related to lease expense for finance and operating leases for the year ended December 31:

Component of Lease Expense	Consolidated Statements of Operations Classification	2021	2020
Finance lease expense			
Amortization of leased assets	Depreciation and amortization	$ 2,350,000	$ 2,245,000
Interest on leased assets	Interest expense	361,000	258,000
Total finance lease expense		2,711,000	2,503,000
Operating lease expense	Rentals expense	1,520,000	2,796,000
Variable and short-term lease expense	Rentals expense	886,000	1,116,000
Total rental expense		2,406,000	3,912,000
Total lease expense		$ 5,117,000	$ 6,415,000

As of December 31, 2021, future minimum lease payments under non-cancelable operating leases (with an initial or remaining lease term in excess of one year) and future minimum finance lease payments are as follows:

	Finance Leases	Operating Leases	Total
Years Ending December 31,			
2022	$ 2,676,000	$ 383,000	$ 3,059,000
2023	1,930,000	239,000	2,169,000
2024	1,771,000	215,000	1,986,000
2025	1,154,000	-	1,154,000
2026	525,000	-	525,000
Thereafter	98,000	-	98,000
Total minimum lease payments	8,154,000	837,000	8,991,000
Less: imputed interest	587,000	50,000	637,000
Total lease obligations	7,567,000	787,000	8,354,000
Less: current obligations under leases	2,438,000	370,000	2,808,000
Long-term lease obligations	$ 5,129,000	$ 417,000	$ 5,546,000
Weighted-average remaining lease term (in years)	3.61	2.52	
Weighted-average discount rate	4.02%	3.50%	

Note 13 – Leases (continued)

During the years ended December 31, 2021 and 2020, the Hospital had the following cash and noncash activities associated with the leases:

	2021	2020
Cash paid for amounts included in the measurement of lease liabilties		
Operating cash flows from operating leases	$ 1,520,000	$ 2,796,000
Operating cash flows from finance leases	361,000	258,000
Financing cash flows from finance leases	2,791,000	2,149,000
ROU assets obtained in exchange for new operating lease liabilties	-	-
ROU assets obtained in exchange for new finance lease liabilties	3,508,000	2,537,000

Note 14 – Retirement Plans

The Corporation has a Defined Contribution Retirement Plan that meets the requirements of Section 401(a) of the Internal Revenue Code. Contributions to the plan were made solely by the Corporation based on a specified percentage of the participants' annual compensation. The Corporation notified its employees in October 2006 that the defined contribution retirement plan would be frozen as of December 31, 2006. On December 11, 2006, the Corporation adopted a Matching Savings Plan, effective on April 1, 2007. This plan is intended to meet the requirements of Section 403(b) of the Internal Revenue Code. The Corporation may match 100% of the first 3% of an employee's base salary. The Corporation began matching 25% of the first 3% of employee's base salary at January 1, 2017. Eligible employees can begin salary deferrals immediately upon becoming an employee and begin receiving any matching contribution after a period of 12 consecutive months during which an employee has at least 1,000 hours of qualifying service. Contribution expense for the plan for the years ended December 31, 2021 and 2020, was approximately $335,000 and $289,000, respectively, and is included in salaries and employee benefits on the consolidated statements of operations.

Note 15 – Expenses

Expenses by function and nature consist of the following for the year ended December 31, 2021:

	Healthcare Services	Management and General	Total
Salaries and employee benefits	$ 60,451,000	$ 12,834,000	$ 73,285,000
Supplies	22,265,000	209,000	22,474,000
Capitated medical services	17,154,000	1,417,000	18,571,000
Quality assurance fee	16,451,000	-	16,451,000
Other purchased services	9,068,000	5,668,000	14,736,000
Professional fees	11,256,000	1,455,000	12,711,000
Depreciation and amortization	2,525,000	7,239,000	9,764,000
Interest	-	3,073,000	3,073,000
Utilities	-	2,599,000	2,599,000
Rentals	2,007,000	399,000	2,406,000
Insurance	246,000	1,940,000	2,186,000
Other	313,000	1,738,000	2,051,000
Total operating expenses	$ 141,736,000	$ 38,571,000	$ 180,307,000

Expenses by function and nature consist of the following for the year ended December 31, 2020:

	Healthcare Services	Management and General	Total
Salaries and benefits	$ 57,102,000	$ 14,324,000	$ 71,426,000
Supplies	21,694,000	144,000	21,838,000
Capitated medical services	22,705,000	1,698,000	24,403,000
Quality assurance fee	18,349,000	-	18,349,000
Other purchased services	10,302,000	5,263,000	15,565,000
Professional fees	8,600,000	1,630,000	10,230,000
Depreciation and amortization	2,285,000	7,169,000	9,454,000
Interest	-	3,086,000	3,086,000
Utilities	-	2,375,000	2,375,000
Rentals	2,819,000	1,093,000	3,912,000
Insurance	154,000	2,272,000	2,426,000
Other	333,000	1,303,000	1,636,000
Total operating expenses	$ 144,343,000	$ 40,357,000	$ 184,700,000

Note 16 – Union Contract

The Hospital has a contract with the United Nurses Associations of California/Union of Health Care Professionals; National Union of Hospital and Health Care Employees; American Federation of State, County and Municipal Employees; and American Federation of Labor and Congress of Industrial Organizations to represent all regular full-time, part-time, and per diem non-management registered nurses employed at the Hospital as their union representative. Negotiations for a contract between management and the bargaining unit were completed and ratified by both the union and the Board of Directors of the Hospital in February 2022. The union contract expires on April 30, 2025.

Note 17 – COVID-19 Pandemic Impact

During 2020, the World Health Organization declared the novel coronavirus (COVID-19) outbreak a public health emergency. The COVID-19 outbreak in the United States resulted in a temporary suspension of non-urgent elective surgeries at various times during 2020 due to government mandate.

During 2021 and 2020, the Corporation received a payment of approximately $798,000 and $12,396,000, respectively, through the Coronavirus Aid, Relief, and Economic Security Act (“CARES Act”) Provider Relief Fund (PRF). The United States Senate passed the CARES Act in March 2020 and it included a relief fund for hospitals and other health care providers on the front lines of the coronavirus response. This funding is used to support health care-related expenses or lost revenue attributable to COVID-19 and to ensure uninsured Americans can get testing and treatment for COVID-19. The Corporation was required to sign attestations agreeing to the terms and conditions prior to receiving the funds. Documentation is required to ensure that these funds are to be used for health care-related expenses or lost revenue attributable to COVID-19, limitations of out-of-pocket payments from certain patients, and the acceptance of several other reporting and compliance requirements. The U.S. Department of Health and Human Services (HHS) and the Office of the Inspector General will monitor and audit the compliance requirements. HHS may issue more specific guidance in the future on how the funding is used, which may result in modification to management's estimates in the future. Based on the current guidance, the Corporation has recognized approximately $798,000 and $12,396,000 of the grant revenue received in the consolidated statements of operations during the years ended December 31, 2021 and 2020, respectively.

In April 2020, the Corporation received an advance payment for future services to be provided to Medicare patients of approximately $14,973,000 through the Accelerated and Advance Payment Program. CMS expanded their current Accelerated and Advance Payment Program to increase cash flow to providers of services and suppliers impacted by the COVID-19 pandemic. There is no repayment requirement for the first 12 months of receipt. From months 13 through 23, Medicare will automatically recoup 25% of the Medicare payments. From months 24 through 29, Medicare will automatically recoup 50% of the Medicare payments. If the loan has not been fully paid off after the 29th month, Medicare will issue a demand letter to request payment for the remaining balance and will need to be paid 30 days from the date of the letter. Recouped amounts totaled $4,048,000 for the year ending December 31, 2021. The Corporation recorded approximately $10,925,000 as current and $0 as long-term liability in the consolidated balance sheets as of December 31, 2021, and approximately $4,795,000 as current and $10,178,000 as long-term liability in the consolidated balance sheets as of December 31, 2020.

Note 17 – COVID-19 Pandemic Impact (continued)

During February 2021, the Corporation received assistance from the U.S. Army Corps of Engineers to expand patient care during patient surges in response to the COVID-19 pandemic. Construction commenced in February 2021 and was completed in March 2021. The costs associated with the construction are paid for by California Governor's Office of Emergency Services. The maintenance, operation, and any potential deconstruction costs are the responsibility of the Corporation. Management determined that the estimated fair value of the assistance received was approximately $3,019,000 and recorded the amount as in-kind contributions on the consolidated statement of operation for the year ended December 31, 2021.

Supplementary Information

Beverly Community Hospital Association
Consolidating Balance Sheet
December 31, 2021

ASSETS

	Hospital	MCHS	Foundation	Eliminations	Consolidated
CURRENT ASSETS					
Cash and cash equivalents	$ 41,737,000	$ 2,070,000	$ 510,000	$ -	$ 44,317,000
Patient accounts receivable	19,469,000	-	-	-	19,469,000
Due from third-party payors, current	19,243,000	-	-	-	19,243,000
Due from affiliates	3,362,000	3,647,000	34,000	(7,043,000)	-
Inventories of drugs and supplies	3,244,000	-	-	-	3,244,000
Prepaid expenses and other assets	2,198,000	208,000	1,075,000	-	3,481,000
Total current assets	89,253,000	5,925,000	1,619,000	(7,043,000)	89,754,000
DUE FROM THIRD-PARTY PAYORS, less current portion	12,415,000	-	-	-	12,415,000
ASSETS LIMITED AS TO USE	1,828,000	-	1,714,000	-	3,542,000
PROPERTY AND EQUIPMENT, net	90,830,000	8,247,000	-	-	99,077,000
BENEFICIAL INTEREST IN FOUNDATION	3,333,000	-	-	(3,333,000)	-
OTHER ASSETS	8,246,000	-	-	-	8,246,000
	$ 205,905,000	$ 14,172,000	$ 3,333,000	$ (10,376,000)	$ 213,034,000

See report of independent auditors.

LIABILITIES AND NET ASSETS

	Hospital	MCHS	Foundation	Eliminations	Consolidated
CURRENT LIABILITIES					
Accounts payable	$ 11,315,000	$ -	$ -	$ -	$ 11,315,000
Accrued expenses and other liabilities	8,475,000	176,000	-	-	8,651,000
Medical claims liabilities	4,562,000	-	-	-	4,562,000
Shared risk liability	8,011,000	-	-	-	8,011,000
Due to affiliates	3,696,000	3,347,000	-	(7,043,000)	-
Current portion of accrued self-insurance claims reserves	2,070,000	-	-	-	2,070,000
Medicare advance payment	10,925,000	-	-	-	10,925,000
Current maturities of long-term debt	1,418,000	-	-	-	1,418,000
Current maturities of lease obligations	2,808,000	-	-	-	2,808,000
Total current liabilities	53,280,000	3,523,000	-	(7,043,000)	49,760,000
ACCRUED SELF-INSURANCE CLAIMS RESERVES, less current portion	5,168,000	-	-	-	5,168,000
REVOLVING LOAN	10,000,000	-	-	-	10,000,000
LONG-TERM DEBT, net	58,199,000	-	-	-	58,199,000
LEASE OBLIGATIONS, less current maturities	5,546,000	-	-	-	5,546,000
Total liabilities	132,193,000	3,523,000	-	(7,043,000)	128,673,000
NET ASSETS					
Without donor restrictions	73,712,000	10,649,000	1,619,000	(3,333,000)	82,647,000
With donor restrictions	-	-	1,714,000	-	1,714,000
Total net assets	73,712,000	10,649,000	3,333,000	(3,333,000)	84,361,000
	$ 205,905,000	$ 14,172,000	$ 3,333,000	$ (10,376,000)	$ 213,034,000

Beverly Community Hospital Association
Consolidating Balance Sheet (Continued)
December 31, 2020

ASSETS

	Hospital	MCHS	Foundation	Eliminations	Consolidated
CURRENT ASSETS					
Cash and cash equivalents	$ 40,752,000	$ 1,781,000	$ 838,000	$ -	$ 43,371,000
Patient accounts receivable	21,371,000	-	-	-	21,371,000
Due from third-party payors, current	21,530,000	-	-	-	21,530,000
Due from affiliates	3,782,000	3,833,000	-	(7,615,000)	-
Inventories of drugs and supplies	3,548,000	-	-	-	3,548,000
Prepaid expenses and other assets	2,641,000	166,000	279,000	-	3,086,000
Total current assets	93,624,000	5,780,000	1,117,000	(7,615,000)	92,906,000
DUE FROM THIRD-PARTY PAYORS, less current portion	12,822,000	-	-	-	12,822,000
ASSETS LIMITED AS TO USE	1,479,000	-	1,554,000	-	3,033,000
PROPERTY AND EQUIPMENT, net	91,710,000	8,085,000	-	-	99,795,000
BENEFICIAL INTEREST IN FOUNDATION	2,767,000	-	-	(2,767,000)	-
OTHER ASSETS	7,488,000	-	450,000	-	7,938,000
	$ 209,890,000	$ 13,865,000	$ 3,121,000	$ (10,382,000)	$ 216,494,000

See report of independent auditors.

LIABILITIES AND NET ASSETS

	Hospital	MCHS	Foundation	Eliminations	Consolidated
CURRENT LIABILITIES					
Accounts payable	$ 8,850,000	$ -	$ -	$ -	$ 8,850,000
Accrued expenses and other liabilities	9,038,000	109,000	-	-	9,147,000
Medical claims liabilities	5,101,000	-	-	-	5,101,000
Shared risk liability	2,810,000	-	-	-	2,810,000
Due to affiliates	3,833,000	3,428,000	354,000	(7,615,000)	-
Current portion of accrued self-insurance claims reserves	2,547,000	-	-	-	2,547,000
Current portion of Medicare advance payment	4,795,000	-	-	-	4,795,000
Current maturities of long-term debt	1,354,000	-	-	-	1,354,000
Current maturities of lease obligations	2,922,000	-	-	-	2,922,000
Total current liabilities	41,250,000	3,537,000	354,000	(7,615,000)	37,526,000
OTHER LONG-TERM LIABILITIES	1,176,000	-	-	-	1,176,000
ACCRUED SELF-INSURANCE CLAIMS RESERVES, less current portion	5,038,000	-	-	-	5,038,000
MEDICARE ADVANCE PAYMENT, less current portion	10,178,000	-	-	-	10,178,000
REVOLVING LOAN	10,000,000	-	-	-	10,000,000
LONG-TERM DEBT, net	59,677,000	-	-	-	59,677,000
LEASE OBLIGATIONS, less current maturities	5,019,000	-	-	-	5,019,000
Total liabilities	132,338,000	3,537,000	354,000	(7,615,000)	128,614,000
NET ASSETS					
Without donor restrictions	77,552,000	10,328,000	1,213,000	(2,767,000)	86,326,000
With donor restrictions	-	-	1,554,000	-	1,554,000
Total net assets	77,552,000	10,328,000	2,767,000	(2,767,000)	87,880,000
	$ 209,890,000	$ 13,865,000	$ 3,121,000	$ (10,382,000)	$ 216,494,000

See report of independent auditors.

Beverly Community Hospital Association
Consolidating Statement of Operations
Year Ended December 31, 2021

	Hospital	MCHS	Foundation	Eliminations	Consolidated
UNRESTRICTED REVENUES, GAINS, AND OTHER SUPPORT					
Net patient service revenue	$ 145,515,000	$ -	$ -	$ -	$ 145,515,000
Premium revenue	24,204,000	-	-	-	24,204,000
Beneficial interest in Foundation	566,000	-	-	(566,000)	-
In-kind contributions	3,019,000	-	-	-	3,019,000
Grant revenue - Provider Relief Funds	798,000	-	-	-	798,000
Other operating revenue	1,131,000	1,657,000	641,000	(527,000)	2,902,000
Net assets released from restrictions	-	-	190,000	-	190,000
Total unrestricted revenues, gains, and other support	175,233,000	1,657,000	831,000	(1,093,000)	176,628,000
EXPENSES					
Salaries and employee benefits	73,101,000	-	184,000	-	73,285,000
Supplies	22,459,000	15,000	-	-	22,474,000
Capitated medical services	18,571,000	-	-	-	18,571,000
Quality assurance fee	16,451,000	-	-	-	16,451,000
Other purchased services	14,386,000	323,000	27,000	-	14,736,000
Professional fees	12,693,000	18,000	-	-	12,711,000
Depreciation and amortization	9,561,000	203,000	-	-	9,764,000
Interest	3,073,000	-	-	-	3,073,000
Utilities	2,328,000	271,000	-	-	2,599,000
Rentals	2,620,000	123,000	-	(337,000)	2,406,000
Insurance	1,950,000	236,000	-	-	2,186,000
Other	1,880,000	147,000	24,000	-	2,051,000
Program support	-	-	190,000	(190,000)	-
Total expenses	179,073,000	1,336,000	425,000	(527,000)	180,307,000
(Deficiency) excess of revenues over expenses	(3,840,000)	321,000	406,000	(566,000)	(3,679,000)
NET ASSETS WITHOUT DONOR RESTRICTIONS, beginning of year	77,552,000	10,328,000	1,213,000	(2,767,000)	86,326,000
NET ASSETS WITHOUT DONOR RESTRICTIONS, end of year	$ 73,712,000	$ 10,649,000	$ 1,619,000	$ (3,333,000)	$ 82,647,000

See report of independent auditors.

Beverly Community Hospital Association
Consolidating Statement of Operations
Year Ended December 31, 2020

	Hospital	MCHS	Foundation	Eliminations	Consolidated
UNRESTRICTED REVENUES, GAINS, AND OTHER SUPPORT					
Net patient service revenue	$ 138,743,000	$ -	$ -	$ -	$ 138,743,000
Premium revenue	27,248,000	-	-	-	27,248,000
Beneficial interest in Foundation	58,000	-	-	(58,000)	-
Grant revenue – Provider Relief Funds	12,396,000	-	-	-	12,396,000
Other operating revenue	1,577,000	1,551,000	398,000	(910,000)	2,616,000
Net assets released from restrictions	-	-	450,000	-	450,000
Total unrestricted revenues, gains, and other support	180,022,000	1,551,000	848,000	(968,000)	181,453,000
EXPENSES					
Salaries and employee benefits	71,247,000	-	179,000	-	71,426,000
Supplies	21,832,000	6,000	-	-	21,838,000
Capitated medical services	24,403,000	-	-	-	24,403,000
Quality assurance fee	18,349,000	-	-	-	18,349,000
Other purchased services	15,119,000	409,000	37,000	-	15,565,000
Professional fees	10,209,000	21,000	-	-	10,230,000
Depreciation and amortization	9,259,000	195,000	-	-	9,454,000
Interest	3,086,000	-	-	-	3,086,000
Utilities	2,150,000	225,000	-	-	2,375,000
Rentals	4,011,000	112,000	-	(211,000)	3,912,000
Insurance	2,183,000	243,000	-	-	2,426,000
Other	1,531,000	104,000	1,000	-	1,636,000
Program support	-	-	700,000	(700,000)	-
Total expenses	183,379,000	1,315,000	917,000	(911,000)	184,700,000
(Deficiency) excess of revenues over expenses	(3,357,000)	236,000	(69,000)	(57,000)	(3,247,000)
NET ASSETS WITHOUT DONOR RESTRICTIONS, beginning of year	80,909,000	10,092,000	1,282,000	(2,710,000)	89,573,000
NET ASSETS WITHOUT DONOR RESTRICTIONS, end of year	$ 77,552,000	$ 10,328,000	$ 1,213,000	$ (2,767,000)	$ 86,326,000

See report of independent auditors.

Beverly Community Hospital Association

Consolidating Balance Sheet

31-Aug-22

	Hospital	MCHS	Foundation	Eliminations	Consolidated
Assets					
Current assets:					
Cash and cash equivalents	21,614,686	631,878	710,772	-	22,957,336
Patient accounts receivable, net	18,730,927		-	-	18,730,927
Due from third-party payors	31,196,244		-	-	31,196,244
Due from affiliates	3,410,029	5,019,617	-	(8,429,646)	-
Inventories of drugs and supplies	3,074,632		-	-	3,074,632
Prepaid expenses and other assets	2,437,915	259,149	-	-	2,697,064
Total current assets	80,464,433	5,910,644	710,772	(8,429,646)	78,656,203
Other assets:					
Assets limited as to use	2,129,208	-	1,417,519	-	3,546,727
Property and equipment, net	89,351,733	8,416,588	-	-	97,768,321
Beneficial interest in Foundation	2,636,608	-	-	(2,636,608)	-
Other assets	8,874,586	3	601,272	-	9,475,861
Total assets	183,456,568	14,327,236	2,729,563	(11,066,254)	189,447,112
Liabilities and net assets					
Current liabilities:					
Accounts payable	14,623,599			(6,288)	14,617,311
Accrued expenses and other liabilities	7,577,574	194,139	-	-	7,771,712
Medical claims liabilities	6,185,852				6,185,852
Shared risk liability	3,306,926				3,306,926
Due to affiliates	5,019,572	3,310,832	92,955	(8,423,359)	-
Current portion of accrued self-insurance claims reserves	2,280,975	-	-	-	2,280,975
Current portion of medicare advance payment	5,164,507				5,164,507
Revolving lines of credit	-	-			-
Current maturities of long-term debt	1,688,445	-	-	-	1,688,445
Current maturities of lease obligations	2,402,825	-			2,402,825
Total current liabilities	48,250,274	3,504,971	92,955	(8,429,647)	43,418,553
Other long term liabilities	-				-
medicare advance payment, less current portion	-				-
Long-term debt, less current maturities	56,823,778	-	-	-	56,823,778
Revolving Loan	9,500,000				9,500,000
lease obligations, less current maturities	7,268,772	-	-	-	7,268,772
Accrued self-insurance claims less current portion	5,493,774	-	-	-	5,493,774
Net assets:					
Unrestricted	56,119,970	10,822,265	1,219,090	(2,636,607)	65,524,718
Temporarily restricted	-	-	280,318	-	280,318
Permanently restricted	-	-	1,137,200	-	1,137,200
Total net assets	56,119,970	10,822,265	2,636,608	(2,636,607)	66,942,236
Total liabilities and net assets	183,456,568	14,327,236	2,729,563	(11,066,254)	189,447,113

Beverly Community Hospital Association

Consolidating Statement of Operations

8 months ending
31-Aug-22

	Hospital	MCHS	Foundation	Eliminations	Consolidated
Unrestricted revenues, gains and other suppor:					
Net patient service revenue	$ 107,859,418	$ –	$ –	$ –	$ 107,859,418
Provision for bad debts	(15,687,893)	–	–	–	(15,687,893)
Net patient service revenue less provision for bad debts	92,171,525	–	–	–	92,171,525
Premium revenue	16,620,995	–	–	-	16,620,995
Beneficial interest in Foundation	(696,450)	–	–	696,450	–
Other operating revenue	717,734	1,069,517	(262,023)	(650,533)	874,695
Net assets released from restrictions	–	–	427,476		427,476
Total unrestricted revenues, gains and other suppor	108,813,804	1,069,517	165,453	45,917	110,094,691
Expenses:					
Salaries and employee benefits	49,932,032	(4,790)	115,837	-	50,043,079
Professional fees	14,635,540	15,875	–	-	14,651,415
Supplies and other	13,815,653	5,048	1,837	-	13,822,538
Capitated medical services	14,124,749		–	-	14,124,749
Other purchased services	9,685,609	228,091	26,655	-	9,940,355
Utilities	1,486,065	220,301	–	-	1,706,366
Insurance	1,312,970	173,236	–	-	1,486,206
Rentals	1,007,787	80,104	–	(223,057)	864,834
Depreciation and amortization	6,679,164	138,735	–	-	6,817,899
Interest	2,151,186	–	–	–	2,151,186
Program support	–	–	427,476	(427,476)	–
Quality assurance fee	10,128,256	–	–	–	10,128,256
Other	1,446,786	27,279	(7,708)	–	1,466,357
Total expenses	126,405,797	883,880	564,096	(650,533)	127,203,241
Excess of (expenses over revenues) revenues over expenses	(17,591,993)	185,636	(398,643)	696,450	(17,108,550)
Transfers from (to) affiliates, net	–	–	–	–	–
Increase (decrease) in unrestricted net assets	(17,591,993)	185,636	(398,643)	696,450	(17,108,550)
Unrestricted net assets (deficit) at December 31, 2021	73,711,963	10,636,629	1,617,733	(3,333,057)	82,633,268
Unrestricted net assets (deficit) at August 31, 2022	$ 56,119,970	$ 10,822,265	$ 1,219,090	$ (2,636,607)	$ 65,524,718

Schedule 3.6(a)

Encumbrances

Beverly Entities:

1. That certain Master Trust Indenture dated as of December 1, 2015, by and between Beverly Community Hospital Association, Beverly Hospital Foundation, Montebello Community Health Services, Inc., and U.S. Bank National Association, including all amendments and supplements thereto, and all associated loan agreements, bond indentures, ancillary agreements, financing statements and other related documents.

2. That certain Master Trust Indenture dated as of May 1, 2017, by and between Beverly Community Hospital Association, Beverly Hospital Foundation, Montello Community Health Services, Inc., and U.S. Bank National Association, including all amendments and supplements thereto, and all associated loan agreements, bond indentures, ancillary agreements, financing statements and other related documents.

3. *See* leases set forth on Schedule 3.6(d), incorporated herein by reference.

Beverly:

1. Chicago Title Insurance Company and Beverly Community Hospital Association, dated and recorded September 30, 2015.

2. Second Supplemental Master Indenture effective May 1, 2017, by and between Beverly Community Hospital Association, and U.S. Bank National Association.

3. Deed of Trust, Assignment of Rents, Security Agreement and Fixture Filing by and between Beverly Community Hospital Association and Chicago Title Company for the benefit of U.S. Bank of National Association, dated December 1, 2015.

4. Request for Full Conveyance is by and between Hanmi Bank and Beverly Community Hospital Association, dated September 30, 2015.

Schedule 3.6(b)

Beverly Real Property

Owned Beverly Real Property (Montebello):

1. Beverly Hospital – 309 W. Beverly Blvd., Montebello, CA 90640-4308.
2. Beverly Medical Plaza – 101 E. Beverly Blvd., Montebello, CA 90640-4300.
3. Center for Wound Care and Hyperbaric Medicine – 413 Poplar Ave., Montebello, CA 90640-4419.
4. 344 N. First St., Montebello, CA 90640-4405.
5. Beverly Hospital Guild – 100-102 West Harding, Montebello, CA 90640-4411.
6. Beverly Care – 1920 W. Whittier Blvd., Montebello, CA 90640-4009.
7. 208-224 W. Beverly Blvd., Montebello, CA 90640-4307.
8. 3rd and Beverly Blvd., Montebello, CA 90640.
9. 208 W. Beverly Blvd., Montebello, CA 90640-4307.
10. 108-116 W. Beverly Blvd., Montebello, CA 90640-4308.
11. 312-320 W. Beverly Blvd., Montebello, CA 90640-4308.
12. 509 & 509 ½ N. 3rd St., Montebello, CA 90640.
13. 517 & 517 ½ N. 3rd St., Montebello, CA 90640.
14. 519 & 519 ½ N. 3rd St., Montebello, CA 90640.
15. 521 & 521 ½ N. 3rd St., Montebello, CA 90640.
16. 523 & 523 ½ N. 3rd St., Montebello, CA 90640.
17. 105 W. Beverly Blvd., Montebello, CA 90640-4304.

Owned Beverly Real Property (Beverly):

None.

Leased Beverly Real Property (Montebello):

1. Lease by and between GGF Pico Rivera, LLC and Montebello Community Health Services, Inc.: 8862 E. Whittier Blvd., Pico Rivera, CA 90660.

Leased Beverly Real Property (Beverly):

None.

Schedule 3.6(d)

Real Property Under Contracts

Montebello:

1. Premises Lease Agreement, by and between Montebello Community Health Services and Beverly Care, effective October 1, 2018 through September 30, 2021, for premises located at 1920 Whittier Blvd.

2. Premises Sublease Agreement, by and between Montebello Community Health Services, Inc. and Beverly Care, effective September 1, 2019 through August 31, 2024, for premises located at 8862 E. Whittier Blvd.

3. Premises Lease Agreement, by and between Montebello Community Health Services, Inc. and Beverly Care, effective January 1, 2021 through June 30, 2021, for premises located at 101 E. Beverly Blvd., Suite 307.

4. Premises Lease Agreement, by and between Montebello Community Health Services, Inc. and Beverly Care, effective December 17, 2020 through May 31, 2021, for premises located at 101 E. Beverly Blvd., Suite 102.

5. Premises Lease Agreement, by and between Montebello Community Health Services, Inc. and Beverly Care, effective August 15, 2018, amendment effective May 13, 2021 through June 30, 2024, for premises located at 101 E. Beverly Blvd., Suite 303.

6. Premises Lease Agreement, by and between Montebello Community Health Services, Inc. and Beverly Care, effective November 1, 2018 through October 31, 2021, for premises located at 101 E. Beverly Blvd., Suite 104A.

7. Premises Lease Agreement, by and between Montebello Community Health Services, Inc. and Beverly Care, effective July 1, 2019 through June 30, 2022, for premises located at 101 E. Beverly Blvd., Suite 301.

8. Lease Agreement by and between Montebello Community Health Services, Inc. and AME Management Firm, Inc., effective October 1, 2018, for premises located at 401 W. Beverly Blvd., Montebello, California 90640.

9. Premises Lease Agreement, by and between Montebello Community Health Services, Inc. and Barua Himu, effective October 1, 2020 through September 30, 2022, for premises located at 312 W. Beverly Blvd.

10. Premises Lease Agreement, by and between Montebello Community Health Services, Inc. and Alignment Healthcare USA, LLC, effective December 1, 2018 through November 30, 2021, for premises located at 101 E. Beverly Blvd., Suite 100A.

11. Premises Lease Agreement, by and between Montebello Community Health Services, Inc. and Beverly Plaza RX, Inc., effective December 30, 2021 through December 29, 2026, for premises located at 101 E. Beverly Blvd., Suite 101.

12. Premises Lease Agreement, by and between Montebello Community Health Services, Inc. and Comprehensive Cardiovascular Specialist Group, effective August 1, 2018 through July 31, for premises located at 101 W. Beverly Blvd., Suite 103.

13. Premises Lease Agreement, by and between Montebello Community Health Services, Inc. and TOI management, LLC, effective October 1, 2020 through September 30, 2023, for the premises located at 101 E. Beverly Blvd., Suite 200/203A.

14. Premises Lease Agreement, by and between Montebello Community Health Services, Inc. and BonLaVie Inc., effective January 1, 2020 through December 31, 2022, for the premises located 101 W. Beverly Blvd., Suite 201.

15. Premises Lease Agreement, by and between Montebello Community Health Services, Inc. and Victor M Wassily, MD, Inc., effective July 15, 2015 through July 31, 2020, for the premises located at 101 E. Beverly Blvd., Suite 202.

16. Premises Lease Agreement, by and between Montebello Community Health Services, Inc., and Abdul M. Alaama, M.D., Inc. and Abdul M. Alaama, M.D., effective April 1, 2016 through March 31, 2009, for the premises located at 101 E. Beverly Blvd., Suite 204.

17. Premises Lease Agreement, by and between Montebello Community Health Services, Inc. and Fernando Ibarra MD, effective April 1, 2019 through March 31, 2022, for the premises located 101 W. Beverly Blvd., Suite 203.

18. Premises Lease Agreement, by and between Montebello Community Health Services, Inc. and Dr. Stephen Lee, M.D., effective January 1, 2021 through September 30, 2023, for the premises located 101 E. Beverly Blvd., Suite 300.

19. Premises Lease Agreement, by and between Montebello Community Health Services, Inc. and Suda Govindarajan, M.D., effective August 1, 2018 through July 31, 2021, for the premises located 101 W. Beverly Blvd., Suite 302.

20. Premises Lease Agreement, by and between Montebello Community Health Services, Inc. and Kidney Specialists, Inc., effective August 1, 2018 through July 31, 2021, for the premises located 101 W. Beverly Blvd., Suite 304.

21. Premises Lease Agreement, by and between Montebello Community Health Services, Inc. and Stanley Wijesekera, M.D., effective January 1, 2004, amendment effective December 31, 2010 through December 31, 2013, for the premises located 101 E. Beverly Blvd., Suite 305.

22. Premises Lease Agreement, by and between Montebello Community Health Services, Inc. and Krishna Narayanan, M.D., Inc., effective September 1, 2004, amendment effective November 1, 2013 through October 31, 2016, for the premises located 101 E. Beverly Blvd., Suite 306.

23. Premises Lease Agreement, by and between Montebello Community Health Services, Inc. and Eliseo Mills Jr., M.D., effective August 1, 2018 through July 31, 2021, for the premises located 101 W. Beverly Blvd., Suite 400.

24. Premises Lease Agreement, by and between Montebello Community Health Services, Inc. and Mohammad Chaudhry, M.D., effective May 1, 2007, amendment effective April 30, 2010 through April 30, 2013, for the premises located 101 E. Beverly Blvd., Suite 401.

25. Premises Lease Agreement, by and between Montebello Community Health Services, Inc. and Stephanee Hethumuni, M.D., effective August 1, 2018 through July 21, 2021, for the premises located 101 W. Beverly Blvd., Suite 404.

26. Premises Lease Agreement, by and between Montebello Community Health Services, Inc. and Southern California Heart and Vascular Center, effective April 1, 2022 through March 31, 2027, for the premises located 101 W. Beverly Blvd., Suite 405.

27. Premises Lease Agreement, by and between Montebello Community Health Services, Inc. and Iftikhar A. Khan, M.D., effective August 1, 2018 through July 31, 2021, for the premises located 101 W. Beverly Blvd., Suite 406.

28. Premises Lease Agreement, by and between Montebello Community Health Services, Inc. and Kamalakar Rambhatla, M.D., Inc., effective July 1, 2015 through June 30, 2020, assigned to Savitri

Rambhatla, M.D., effective April 18, 2016, for the premises located 101 E. Beverly Blvd., Suite 407.

29. Premises Lease Agreement, by and between Montebello Community Health Services, Inc. and Mir-Basharat Ali, M.D., effective November 1, 2007, amendment effective October 31, 2010 through October 31, 2013, for the premises located 101 E. Beverly Blvd., Suite 407.

30. Premises Lease Agreement, by and between Montebello Community Health Services, Inc. and Agility Ortho MSO, Inc., effective January 1, 2022 through February 28, 2027, for the premises located 101 E. Beverly Blvd., Suite 205.

Beverly:

1. Premises Lease Agreement, by and between Masao Ishihama & Asako Ishihama Revocable Trust and Jacob Zulalyan, effective June 1, 2001, for premises located at 316 W. Beverly Blvd, assigned to and assumed by Beverly Community Hospital Association on October 26, 2004.

Schedule 3.6(e)

Beverly Personal Property

Prior to the Closing Date, the Beverly Entities shall update this Schedule 3.6(e) in accordance with Section 5.2(a) of the Agreement in order to identify the Beverly Personal Property to be set forth on this Schedule, as required under Section 3.6(e) of the Agreement.

Schedule 3.8(a)(ii)

Labor Union or Employee Organization Employees

1. Collective Bargaining Agreement by and between Beverly Community Hospital Association dba Beverly Hospital and United Nurses Associations of California/Union of Health Care Professionals (UNAC/UHCP), NUHHCE, AFSCME, AFL-CIO, effective January 1, 2022, as supplemented by that Wage Increase Letter dated October 4, 2022.

Schedule 3.8(b)

Pending Proceedings

1. *See* item 3 set forth on Schedule 3.3, subsection (d), incorporated herein by reference

2. *See* items 1-16 set forth on Schedule 3.10, incorporated herein by reference.

Schedule 3.9(a)

Employee Benefit Programs

2022 Employee Benefits

Medical Plans

- Anthem Blue Cross – EPO Select
- Anthem Blue Cross – EPO Plus
- Anthem Blue Cross – Traditional PPO

Prescription Drug Coverage

- Express Scripts

Dental Plans

- DeltaCare USA - HMO Dental Plan
- Delta Dental – PPO Dental Plan

Vision Plan

- VSP

Insurance (different offerings based on employee level)

- Reliance Standard – Basic Life/ADD Insurance
- Reliance Standard – Voluntary Life/ADD Insurance
- Reliance Standard – Voluntary Long Term Disability
- Trustmark – Voluntary Universal Life Insurance with Long Term Care
- Trustmark – Critical Illness/Cancer Insurance
- Trustmark – Accident Insurance
- Trustmark – Short Term Disability Insurance
- Nationwide – Pet Insurance

Anthem Blue Cross Employee Assistance Program

Health Savings Accounts

- Igoe - Flexible Spending Account

MERP

- Catilize Health

Retirement Accounts

- 401(k) Retirement Savings Plan – Transamerica Retirement Solutions

Vacation/Sick Time/Leaves

- Paid Time Off (PTO) Program (includes California Sick Time)
- Sick Leave Reserve
- Bereavement Leave

- Jury Duty
- Military Leave
- Personal Leave
- Voting Time
- Witness Leave

Transportation

- Free Parking

Miscellaneous

- Credit Union
- Direct Deposit
- Cafeteria Discount
- Local Area Attractions Discount

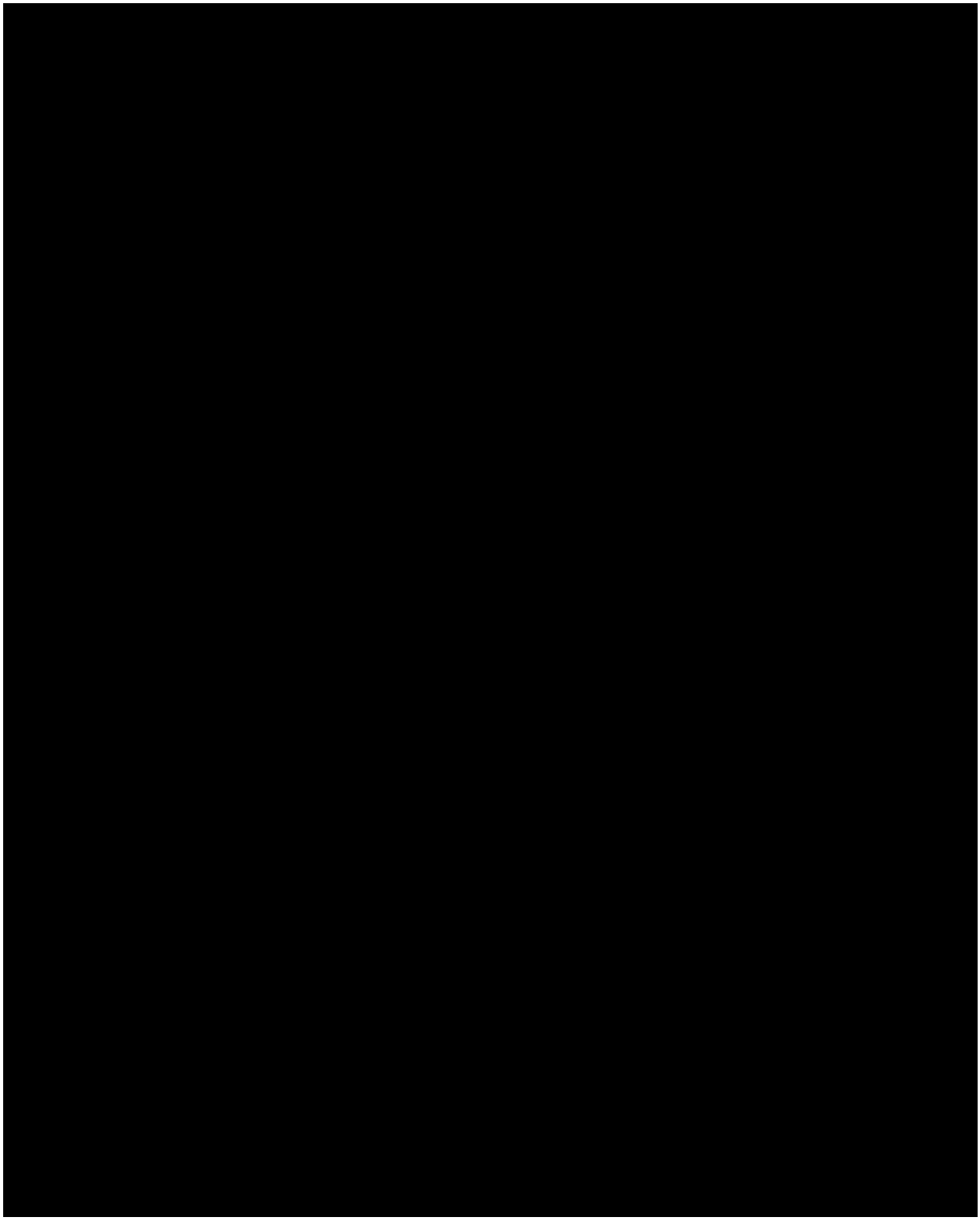
Schedule 3.9(g)

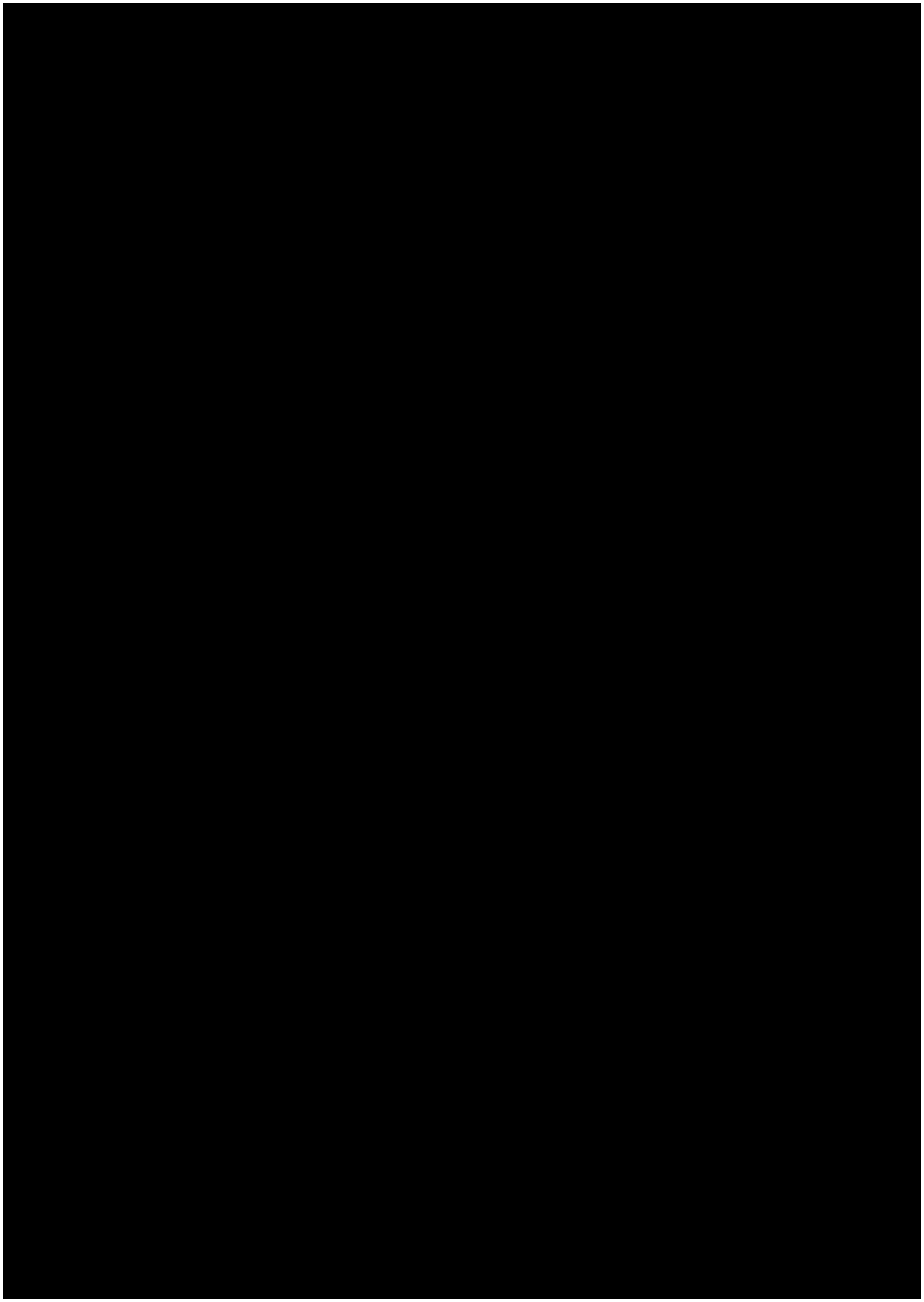
Employee Health or Welfare Benefits

None.

Schedule 3.10

Litigation





Schedule 3.11

Certain Affiliations

1. Employment Agreement by and between Beverly Community Hospital Association, and Alice Shu Jen Cheng, dated January 1, 2016, as amended on January 1, 2021, March 15, 2021, and January 1, 2022.

2. Loan Agreement by and between Beverly Community Hospital Association and Alice Shu Jen Cheng, dated August 4, 2021.

3. Retention Bonus Agreement by and between Beverly Community Hospital Association and Houshang Abd, effective December 13, 2021.

4. Employment Agreement by and between Beverly Community Hospital Association and Charlene Chu, dated April 1, 2021, as amended on December 13, 2021.

5. Employment Agreement by and between Beverly Community Hospital Association and Mark Lueken, dated April 1, 2021, as amended on December 13, 2021.

6. Employment Agreement by and between Beverly Community Hospital Association and Lester Fujimoto, dated April 1, 2021, as amended on December 13, 2021.

7. Employment Agreement by and between Beverly Community Hospital Association and Nancy Lee, dated April 1, 2021, as amended on December 13, 2021.

8. Employment Agreement by and between Beverly Community Hospital Association and George Holtz, dated April 1, 2021, as amended on December 13, 2021.

9. Employment Agreement by and between Beverly Community Hospital Association and Sridhar Chadalavada, dated April 1, 2021, as amended on December 13, 2021.

10. Employment Agreement by and between Beverly Community Hospital Association and James V. Mathew, dated July 1, 2021.

11. Retention Bonus Agreement by and between Beverly Community Hospital Association and Daniel Way, effective December 13, 2021.

12. Retention Bonus Agreement by and between Beverly Community Hospital Association and Kathleen Curran, effective December 13, 2021.

13. Chief Medical Officer Agreement by and between Beverly Community Hospital Association and Kenneth Lawrence Cohen, M.D., effective July 1, 2016.

Schedule 3.14

Insurance

1. Healthcare Professional and General Liability Insurance Policy, insured by California Healthcare Insurance Company, effective October 1, 2022 to October 1, 2023, with $5,000,000/$15,000,000 aggregate limit and $50,000 deductible, Policy No. HP 00842.

2. Healthcare Employment Practices Liability Insurance Policy, insured by California Healthcare Insurance Company, effective October 1, 2022 to October 1, 2022, with $5,000,000 per claim limit and $50,000 Retention, Policy No. HP 00842.

3. Directors & Officers (Primary Layer) Insurance Policy, insured by California Healthcare Insurance Co., Inc., effective October 01, 2022 to October 01, 2023, with a $5,000,000 aggregate limit and $75,000 per claim deductible, Policy No. HP00842.

4. Fiduciary Duty Liability Insurance, insured by California Healthcare Insurance Co., Inc., effective October 01, 2022 to October 01, 2023, with $3,000,000 aggregate limit and $1,000 per each loss, Policy No. HP00842.

5. Healthcare Entity Excess Liability (1st Excess), insured by Admiral Insurance Company, effective October 01, 2022 to October 01, 2023, with $20,000,000 aggregate limit, Policy No. CEL-CA-10245-1016-07.

6. Healthcare Entity Excess Liability (2nd Excess), insured by Endurance American Specialty Insurance Company, effective October 01, 2022 to October 01, 2023, with $5,000,000 aggregate limit, Policy No. #HLC10015252201.

7. Directors & Officers (1st Excess) Insurance Policy, insured by ACE American Insurance Company, effective October 01, 2022 to October 01, 2023, with $10,000,000 aggregate limit and including underlying insurance for California Healthcare Insurance Co., Inc. of $5,000,000, Policy No. G25780565 008.

8. Side A Difference In Condition and Additional Defense Limit Insurance Policy, insured by ACE American Insurance Company, effective October 01, 2022 to October 01, 2023, with a $1,000,000 aggregate limit and $2,000,000 aggregate limit, respectively, Policy No. G25780565 008.

9. Directors & Officers (2nd Excess) Insurance Policy, insured by Starr Indemnity & Liability Company, effective October 01, 2022 to October 01, 2023, with a $5,000,000 aggregate limit, Policy No. 1000623620221.

10. Side A Difference In Condition and Additional Defense Limit Insurance Policy, insured by Starr Indemnity & Liability Company, effective October 01, 2022 to October 01, 2023, with a $1,000,000 aggregate limit and $2,000,000 aggregate limit, respectively, Policy No. 1000623620221.

11. Commercial Auto Insurance Policy, insured by Berkley Regional Insurance Company, effective October 01, 2022 to October 01, 2023, with $1,000,000 liability, $5,000 medical payment, and $1,000,000 uninsured motorist's limits, which includes non-owned liability & hired Auto Liability and a $500 deductible on comprehensive & collision, Policy No. 5047547-14.

12. Cyber Liability Insurance Policy, insured by AIG Specialty Insurance Company, effective October 01, 2022 to October 01, 2023, with $5,000,000 aggregate limit and the following deductibles: $100,000 deductible for a Specialty Risk Protector or Media Content claim; $250,000 for a Security and Privacy Liability or Regulatory Action Claim; $250,000 for a Network Interruption Claim, Event Management or Cyber Extortion Claim, Policy No. 01-592-51-47.

13. Storage Tank System Third Party Liability & Cleanup (Underground Storage Tank) Insurance Policy, insured by Ace American Insurance Company, effective October 01, 2022 to October 01, 2023 (for 309 W. Beverly Blvd.), with $3,000,000 aggregate limit for all claims that includes: $1,000,000 aggregate limit for an Underground Storage Tank or Third Party Liability Claim; $2,000,000 aggregate limit for a Bodily Injury/Property Damage Claim; $1,000,000 aggregate limit for a Legal Defense Expense Claim; and with $25,000 deductible per Storage Tank Incident, Policy No. UST G71184808 005.

14. Premises Pollution Liability Policy (Standalone), insured by Illinois Union Insurance Company, effective October 01, 2022 to October 01, 2023 (for 309 W. Beverly Blvd.), with $2,000,000 aggregate limit that includes $1,000,000 limit per Pollution Condition, with a $10,000 deductible per Pollution Condition, Policy No. PPI G24540571 012.

15. Premises Pollution Liability Policy (Excess), insured by Interstate Fire & Casualty Insurance Company, effective July 01, 2022 to July 01, 2023 (for 309 W. Beverly Blvd.), with $2,000,000 aggregate limit that includes $2,000,000 limit per Pollution Condition and Indoor Environmental Condition, with a $50,000 deductible per Pollution Condition or Indoor Environmental Condition, Policy No. [TBD].

16. All Risk Property Insurance Policy, insured by Alliant Insurance Services, Inc. and Hospital All Risk Property Program, effective July 1, 2022 to July 1, 2023, with $500,000,000 property limit, $282,684,999 TIV limit, and $100,000,000 boiler and machinery limit and the following deductibles: (1) $40,000 for property and (2) $750,000 for water damage, and (3) $10,000 for boiler and machinery, Policy No. PPROP2223 / PBOILER223.

17. Crime Insurance Policy, insured by National Union Fire Insurance Company of Pittsburgh, PA, effective July 01, 2022 to July 01, 2023, with the following terms: $1,500,000 limit and $15,000 deductible for employee theft; $1,500,000 limit and $15,000 deductible for clients property; $1,500,000 limit and $15,000 deductible for forgery or alteration; $1,500,000 limit and $15,000 deductible for theft of money and securities; $1,500,000 limit and $15,000 deductible for robbery/safe burglary of Other Property; $1,500,000 limit and $15,000 deductible for outside premises; $1,500,000 limit and $15,000 deductible for computer fraud; $1,500,000 limit and $15,000 deductible for funds transfer fraud; and $1,500,000 limit and $15,000 deductible for money orders and counterfeit paper currency, Policy No. 01-335-54-67.

18. Workers' Compensation, insured by Safety National, effective March 1, 2022 to March 1, 2023, with statutory limits on workers' compensation and a $1,000,000 on Employer's Liability, and a deductible of $250,000 per claim, Policy No. LDC4043759.

Schedule 3.15

Government Programs

Prior to the Closing Date, the Beverly Entities shall update this Schedule 3.15 in accordance with Section 5.2(a) of the Agreement to identify the particular items required to be disclosed hereunder pursuant to Section 3.15 of the Agreement.

Schedule 3.16

Material Contracts; Termination of Material Contracts

The Parties agree that as of the Effective Date, this Schedule 3.16 includes a comprehensive list of the contracts of the Beverly Entities, which includes the Material Contracts of the Beverly Entities. Prior to the Closing Date, the Beverly Entities shall update this Schedule 3.16 in accordance with Section 5.2(a) of the Agreement in order to limit the list set forth below such that this Schedule 3.16 only sets forth the Material Contracts of each Beverly Entity, as required under Section 3.16 of the Agreement.

Termination of Material Contracts:

[redacted]

Material Contracts:

1. Services Agreement by and between Beverly Community Hospital Association and Physician Assistant Specialist-California, Inc., effective July 1, 2018.
2. Hospitalist Services Agreement by and between Beverly Community Hospital Association and Hospitalists Group of Montebello, effective August 1, 2019.
3. Hospital Emergency Department Agreement by and between Beverly Community Hospital Association and California Emergency Physicians Medical Group, effective July 1, 2009 and as amended on July 1, 2018.
4. Amendment #1 to Medical Directorship Agreement by and between Beverly Community Hospital Association and Comprehensive Cardiovascular Specialists, effective as of July 1, 2007 and as amended on August 1, 2019.
5. Directorship Agreement by and between Beverly Community Hospital Association and Abdulomouti Alaama, M.D, effective January 1, 2017.
6. Amendment to Medical Directorship Agreement by and between Beverly Community Hospital Association and Abdulomouti Alaama, M.D., effective January 1, 2017 and amended as of July 1, 2020.
7. Medical Director Services Agreement by and between Beverly Community Hospital Association and Babak Dadvand, M.D., effective December 1, 2011.
8. Medical Directorship Agreement by and between Beverly Community Hospital Association and Kamalakar S. Rambhatla, M.D., Inc., effective July 1, 2021.
9. Medical Directorship Agreement, by and between Beverly Community Hospital Association and Leo Li, M.D, effective October 1, 2015.
10. Coverage and Directorship Agreement by and between Beverly Community Hospital Association and MLH, effective October 1, 2010.
11. Coverage and Directorship Agreement by and between Beverly Community Hospital Association and Neurology Consultants Medical Group, effective January 1, 2016.

12. Medical Directorship Agreement by and between Beverly Community Hospital Association and San Gabriel Valley Perinatal Medical Group, Inc., effective October 1, 2021.

13. Telemedicine Services Agreement by and between Beverly Community Hospital Association and CEP America Telehealth, PC, dated June 1, 2017.

14. Sixth Amendment to the Management Services Agreement by and between Restorix Health, Inc., and Beverly Community Hospital Association, dated June 1, 2004 and as amended as of April 11, 2019.

15. Anesthesiology Coverage Agreement by and between Beverly Community Hospital Association and Core Anesthesia Associates, dated July 1, 2014 and as amended on July 1, 2021 and October 1, 2021.

16. Medical Directorship Agreement by and between Beverly Community Hospital Association and Oana Maria Penciu, M.D., effective August 1, 2019.

17. Anesthesia Service Coverage On-Call Agreement by and between Beverly Community Hospital Association and H.P. Chang, MD, Inc., effective July 1, 2021.

18. Anesthesia Service Coverage On-Call Agreement by and between Beverly Community Hospital Association and Advanced Anesthesia Consultant, Inc., effective July 1, 2021.

19. Anesthesia Service Coverage On-Call Agreement by and between Beverly Community Hospital Association and Cho-Ying David Wu MD, Inc., effective January 1, 2022.

20. Anesthesiology Coverage Agreement by and between Beverly Community Hospital Association and Medstar Anesthesia Service, Inc., effective July 1, 2022.

21. Emergency Room On-Call Agreement by and between Beverly Community Hospital Association and Jackson C. Ma, M.D., effective July 1, 2016.

22. Emergency Room On-Call Agreement by and between Beverly Community Hospital Association and Steve S. Bae, M.D., effective March 1, 2022.

23. Anesthesiology Coverage Agreement by and between Beverly Community Hospital Association and Weiji Xu, MD, Inc., effective July 1, 2021.

24. Anesthesiology Coverage Agreement by and between Beverly Community Hospital Association and Yiping Wu MD, Inc., effective July 1, 2021.

25. Intensivist Services Agreement by and between Beverly Community Hospital Association and Prestige Pulmonary Consultants, Inc., effective April 13, 2020.

26. Emergency Department On Call Coverage Agreement by and between Beverly Community Hospital Association and Daniel Choo, M.D., dated July 1, 2008.

27. Emergency Room On-Call Agreement by and between Beverly Community Hospital Association and Khetan M. Umakant, M.D., dated January 1, 2017.

28. Emergency Room Neurosurgery Agreement by and between Beverly Community Hospital Association and Arthur Po-Fe Chou MD Inc., undated.

29. Emergency Room On-Call Agreement by and between Beverly Community Hospital Association and Abdulomouti Alaama, M.D., dated November 1, 2010.

30. Emergency Room On-Call Agreement by and between Beverly Community Hospital Association and Moksha Ranasinghe, M.D., dated September 1, 2020.

31. Emergency Room On-Call Agreement by and between Beverly Community Hospital Association and Krishna Narayanan, M.D., effective March 1, 2014.

32. Emergency Room On-Call Agreement by and between Beverly Community Hospital Association and David A. Duarte, M.D., effective March 1, 2014.

33. Emergency Department Call Coverage by and between Beverly Community Hospital Association and Minimally Invasive Surgical Services Inc., effective May 1, 2018.

34. Anesthesia Service Coverage On-Call Agreement by and between Beverly Community Hospital Association and Cho-Ying David Wu MD, Inc., effective January 1, 2022.

35. Emergency Room On-Call Agreement by and between Beverly Community Hospital Association and Fernando Ibarra, M.D., effective November 1, 2010.

36. Emergency Room On-Call Agreement by and between Beverly Community Hospital Association and Donald J. Portocarrero, D.O., Inc., effective September 1, 2016.

37. Emergency Room On-Call Agreement by and between Beverly Community Hospital Association and Atef L. Yacoub, M.D., effective January 1, 2017.

38. Emergency Room On-Call Agreement by and between Beverly Community Hospital Association and Antonio Alarcon, M.D., effective January 1, 2017.

39. Emergency Room On-Call Agreement by and between Beverly Community Hospital Association and Lydia Aguilera, M.D., effective September 1, 2010.

40. Emergency Room On-Call Agreement by and between Beverly Community Hospital Association and Stephen Lee, M.D., effective September 1, 2010.

41. Emergency Room On-Call Agreement by and between Beverly Community Hospital Association and Kenneth R. Purdom, II, M.D., effective September 1, 2010.

42. Pathology Services Agreement by and between Beverly Community Hospital Association and Pathology and Laboratory Medical Group, Inc., effective June 1, 2014.

43. Radiology Services Agreement by and between Beverly Community Hospital Association and Focus Medical Imaging, A Medical Group, Inc., effective July 1, 2017.

44. Service Agreement by and between Park Place International and Beverly Community Hospital Association, effective June 26, 2014.

45. Google Cloud Platform Terms of Service by and between Google and Beverly Community Hospital Association, undated.

46. Master Service Agreement by and between Cyber Korp Inc. and Beverly Community Hospital Association, effective May 11, 2016.

47. Health Care Information System Software Agreement by and between Medical Information Technology, Inc. and Beverly Community Hospital Association, effective April 24, 2008.

48. Health Care Information System Software Agreement by and between Medical Information Technology, Inc. and Beverly Community Hospital Association, effective May 31, 2008.

49. Health Care Information System Software Agreement by and between Medical Information Technology, Inc. and Beverly Community Hospital Association, effective July 22, 2009.

50. Health Care Information System Software Agreement by and between Medical Information Technology, Inc. and Beverly Community Hospital Association, effective December 2, 2009.

51. Health Care Information System Software Agreement by and between Medical Information Technology, Inc. and Beverly Community Hospital Association, effective March 29, 2011.

52. Health Care Information System Software Agreement by and between Medical Information Technology, Inc. and Beverly Community Hospital Association, effective June 30, 2011.

53. Health Care Information System Software Agreement by and between Medical Information Technology, Inc. and Beverly Community Hospital Association, effective January 31, 2013.

54. Health Care Information System Software Agreement by and between Medical Information Technology, Inc. and Beverly Community Hospital Association, effective October 30, 2012.

55. Health Care Information System Software Agreement by and between Medical Information Technology, Inc. and Beverly Community Hospital Association, effective September 11, 2013.

56. Health Care Information System Software Agreement by and between Medical Information Technology, Inc. and Beverly Community Hospital Association, effective January 14, 2016.

57. Contract Supplement to License Agreement No. 13009 by and between McKesson Health Solutions LLC and Beverly Community Hospital Association, effective December 11, 2007.

58. IMO Enhanced Terminology Platform Addendum to License Agreement by and between Beverly Community Hospital Association and Intelligence Medical Objects, Inc., effective April 28, 2016.

59. Amendment to Master Service Agreement by and between DrFirst.com, Inc. and Beverly Community Hospital Association, effective December 31, 2021

60. Agreement by and between GE Healthcare and Beverly Community Hospital Association, effective November 7, 2017.

61. Addendum to Quotations by and between GE Healthcare and Beverly Community Hospital Association, effective July 7, 2014.

62. Copy Rental Agreement by and between Beverly Community Hospital Association and Kyocera Document Solutions, effective September 19, 2019.

63. Agreement by and between TIAA Commercial Finance, Inc. and Beverly Community Hospital Association, effective October 7, 2019.

64. Hospital eMeasures Agreement by and between Medisolv, Inc. and Beverly Community Hospital Association, effective April 28, 2020.

65. Healthcare Master Agreement by and between Nuance Communications, Inc. and Beverly Community Hospital Association, effective March 30, 2016.

66. IMO License Agreement by and between and Intelligent Medical Objects, Inc., dated December 10, 2012.

67. Agreement by and between Zynx Health Incorporated and Beverly Community Hospital Association, effective August 15, 2010.

68. Order by and between Beverly Community Hospital Association and Nuance Communications, Inc., effective August 1, 2016.

69. Agreement by and between Summit Healthcare Services, Inc. and Beverly Community Hospital Association, undated.

70. Agreement by and between Kyocera Document Solutions West, LLC and Beverly Community Hospital Association, dated January 27, 2020.

71. Customer Support Maintenance Agreement by and between Beverly Community Hospital Association and Bridgehead Software, Inc., effective August 1, 2018.

72. Customer Account Agreement by and between American Messaging Services, LLC and Beverly Community Hospital Association, and Amendment No. 1 to Customer Account Agreement, effective July 6, 2017.

73. Professional Services Agreement by and between Nesbitt Solutions LLC and Beverly Community Hospital Association, effective January 12, 2022.

74. End-User License/ Contract Agreement by and between FormFast, Inc. and Beverly Community Hospital Association, dated May 19, 2009.

75. Master Services Agreement by and between ConvergeOne, Inc. and Beverly Community Hospital Association, effective December 4, 2017.

76. Renewal Content License Order by and between Truven Health Analytics LLC, an IBM Company; and Beverly Community Hospital Association, effective June 1, 2017.

77. Order by and between Truven Health Analytics Inc., an IBM Company; and Beverly Community Hospital Association, effective August 25, 2016.

78. Purchase Order by and between Beverly Community Hospital Association and Insight Direct USA Inc., effective August 11, 2020.

79. Amendment to the Master Agreement for EPCS Gold with PDMP Access by and between Dr.First.com, Inc. and Beverly Community Hospital Association, dated September 30, 2018.

80. Maintenance Renewal by and between Beverly Community Hospital Association and Digital Telecommunications Corp., dated August 24, 2021.

81. Addendum to Master Agreement by and between DrFirst.com, Inc. and Beverly Community Hospital Association, dated October 18, 2017.

82. Addendum #1 to FormFast Agreement by and between FormFast, Inc. and Beverly Community Hospital Association, effective October 28, 2015.

83. Merchant Processing Agreement by and between EVO Merchant Services, LLC and Beverly Community Hospital Association, effective October 25, 2019.

84. End-User License/Contract Agreement by and between FormFast, Inc. and Beverly Community Hospital Association, dated May 19, 2009.

85. Service Agreement by and between Beverly Community Hospital Association and Insight Direct USA Inc., effective March 1, 2021.

86. Change Health Care Add-On Order Terms and Conditions by and between Beverly Community Hospital Association and Change Healthcare Technologies, LLC, effective December 11, 2018.

87. Purchase Order by and between ConvergeOne Inc. and Beverly Community Hospital Association, undated.

88. Master Service Agreement for Information Technology Services by and between Advanced Networks and Beverly Community Hospital Association, effective September 28, 2021.

89. Electronic Health Exchange Information Data Exchange Participation Agreement by and between The Los Angeles Network for Enhanced Services and Beverly Community Hospital Association, effective May 1, 2019.

90. Amendment to Electronic Health Exchange Information Data Exchange Participation Agreement by and between The Los Angeles Network for Enhanced Services and Beverly Community Hospital Association, effective October 20, 2021.

91. Form Order Letter by and between IBM and Beverly Community Hospital Association, dated June 25, 2020.

92. Online Services Terms Agreement by and between Microsoft Corporation and Beverly Community Hospital Association, undated.

93. Software Product License Agreement Addendum by and between Iatric Systems, Inc. and Beverly Community Hospital Association, effective November 4, 2009.

94. Software Product Master Maintenance Agreement Addendum by and between Iatric Systems, Inc. and Beverly Community Hospital Association, effective November 8, 2009.

95. Order Terms and Conditions by and between National Decision Support Company, Inc. and Beverly Community Hospital Association, effective June 12, 2018.

96. Interbit Data, Inc. Software Agreement Amendment by and between Interbit Data, Inc. and Beverly Community Hospital Association, effective February 6, 2017.

97. Statement of Understanding by and between Nth Generation Computing, Inc. and Beverly Community Hospital Association, effective February 10, 2021.

98. Purchase Order/Solution Quote between Beverly Community Hospital Association and ConvergeOne, Inc., undated.

99. Purchase Order/Solution Quote between Beverly Community Hospital Association and ConvergeOne, Inc., undated.

100. Purchase Order/Solution Quote Renewal between Beverly Community Hospital Association and ConvergeOne, Inc., undated.

101. SecureDocs Terms of Service is entered into by and between SecureDocs, Inc. and Beverly Community Hospital Association, dated February 14, 2019.

102. Contract Supplement and License Agreement by and between McKesson Health Solutions LLC and Beverly Community Hospital Association, effective December 11, 2013.

103. Purchase Order/Print Quote by and between Beverly Community Hospital Association and PCM Sales, undated.

104. Customer License Agreement by and between Micromedex, a business of Thomson Reuters Inc. and Beverly Community Hospital Association, effective May 9, 2011.

105. Order Form by and between Zoom Video Communications Inc. and Beverly Community Hospital Association, effective January 25, 2021.

106. Telecommunications Account Agreement by and between U.S. TelePacific Corp. and Beverly Community Hospital Association, dated May 9, 2014.

107. Service Agreement by and between U.S. TelePacific Corp. and Beverly Community Hospital Association, dated April 22, 2015.

108. Retail Installment Contract by and between T-Mobile Financial LLC and James Jaworski (on behalf of Beverly Community Hospital Association), dated March 31, 2020.

109. Retail Installment Contract by and between T-Mobile Financial LLC and Rudy Silva (on behalf of Beverly Community Hospital Association), dated August 20, 2020.

110. Service Agreement by and between TPx Communications and Beverly Community Hospital Association, dated July 18, 2018.

111. Service Agreement by and between TPx Communications and Beverly Community Hospital Association, dated October 29, 2019.

112. Master Service Agreement by and between U.S. TelePacific Corp. and/or its affiliated companies and Beverly Community Hospital Association, dated October 29, 2019

113. Equipment Addendum by and between TPx Communications and Beverly Community Hospital Association, dated October 29, 2019.

114. Service Agreement by and between TPx Communications and Beverly Community Hospital Association, effective August 13, 2018.

115. Health Care Information System Software Agreement by and between Medical Information Technology, Inc. and Beverly Community Hospital Association, effective December 20, 2007.

116. Ancillary Services Agreement by and between Beverly Community Hospital Association and Angel's Smile Hospice, Inc., effective September 1, 2020.

117. Provider Agreement by and between Beverly Community Hospital Association and Apria Healthcare LLC, effective May 1, 2019.

118. Medical Transport Services Agreement by and between EastWestProto, Inc. and Beverly Community Hospital Association, dated September 1, 2020.

119. Consulting Services Agreement by and between Beverly Community Hospital Association and Posner Healthcare Consulting, effective April 26, 2021.

120. Services Agreement by and between Beverly Community Hospital Association and Hunn Group LLC and AltaMed Health Services Corporation, undated.

121. Lobby Agreement by and between the Beverly Community Hospital Association and Noteware & Rosa Government Relations, dated January 1, 2020.

122. Engagement Letter by and between Doyle & Schafer LLP and Beverly Community Hospital Association, effective April 1, 2014.

123. Engagement Letter by and between J. Richard Eichman, CPA and Beverly Community Hospital Association, dated May 10, 2019.

124. Contract for Performance Services by and between Beverly Community Hospital Association and Hunn Group, LLC, dated November 1, 2018.

125. Agreement for Legal Services by and between Nixon Peabody LLP and Montebello Community Health Services, Inc., Beverly Community Hospital Association, dated January 13, 2021.

126. Lobbying Agreement by and between Beverly Community Hospital Association and NL Short Public Affairs, dated November 20, 2021.

127. Amendment to Letter Agreement by and between Health Care Advisory Board and Nursing Executive Center and Beverly Community Hospital Association, dated January 30, 2019.

128. Search Agreement by and between Beverly Community Hospital Association and ALIGN Executive Search LLC, dated January 14, 2018.

129. Security Professional Service Agreement by and between Universal Protection Service, LP, and Beverly Community Hospital Association, effective January 1, 2022.

130. Letter Agreement between AMC Financial LLC and Beverly Community Hospital Association, dated December 15, 2018.

131. Service Mark License Agreement by and between Beverly Community Hospital Association and AME Management Firm, Inc., effective October 1, 2018.

132. American Red Cross Blood Services Agreement by and between The American National Red Cross, Southern California Region and Beverly Community Hospital Association, effective January 1, 2013.

133. Purchase Order by and between Beverly Community Hospital Association and ANG Public Relations and Marketing, dated January 12, 2021.

134. Person Protective Equipment Decontamination Services Agreement by and between Battelle and Beverly Community Hospital Association, undated.

135. Master Subscription Agreement by and between Binary Fountain, Inc. and Beverly Community Hospital, effective September 18, 2020.

136. Amendment #2 to Agreement by and between Coffey Communications and Beverly Community Hospital Association, dated November 15, 2018 and as amended on February 1, 2022.

137. California Universal Patient Information Discovery Software and Training Agreement by and between SpeedTrack, Inc. and Beverly Community Hospital Association, dated June 4, 2021.

138. Engagement Letter by and between Beverly Community Hospital Association and Squire Patton Boggs, dated August 5, 2015.

139. Master Biomedical Waste Services Agreement by and between Stericycle, Inc. and Beverly Community Hospital Association, dated February 1, 2010.

140. Letter Agreement by and between Health Care Advisory Board and Nursing Executive Center and Beverly Community Hospital Association, dated January 30, 2019.

141. Cost per Copy Agreement by and between Xerox Financial Services and Beverly Community Hospital Association, dated February 24, 2017.

142. License Agreement by and between 3M Health Information Systems Inc. and Beverly Community Hospital Association, dated March 19, 2018.

143. 2018 Data Files End User Internal Use License Agreement and Product Amendment by and between the American Medical Association and Beverly Community Hospital Association, effective August 10, 2017.

144. Management Agreement by and between Beverly Community Hospital Association and Sodexo America, LLC, dated March 30, 2022.

145. Supplemental Staffing Services Agreement by and between Beverly Community Hospital Association and 24-Hour Medical Staffing Services, LLC, effective January 25, 2009.

146. Supplemental Staffing Services Agreement by and between Beverly Community Hospital Association and Advanced Care Services, effective January 25, 2009.

147. Supplemental Staffing Services Agreement by and between Beverly Community Hospital Association and Advanced Medical Personnel Services, Inc., effective January 25, 2009.

148. Services Agreement by and between Aerotek Scientific, LLC and its affiliated entity Aerotek, Inc. and Beverly Community Hospital Association, dated November 27, 2018.

149. Staffing Agreement by and between All Source Recruiting Group, Inc. and Beverly Community Hospital Association, effective February 19, 2018.

150. Supplemental Staffing Agreement for Healthcare Professional by and between Aya Healthcare Inc. and Beverly Community Hospital Association, effective April 9, 2015.

151. Supplemental Staffing Services Agreement by and between Beverly Community Hospital Association and Career Staff Unlimited, effective April 14, 2016.

152. Supplemental Staffing Services Agreement by and between Beverly Community Hospital Association and Clinical Staffing Services, effective May 19, 2009.

153. Supplemental Staffing Services Agreement by and between Beverly Community Hospital Association and Core Medical Group, effective February 4, 2009.

154. Supplemental Staffing Services Agreement by and between Beverly Community Hospital Association and Emerald Health Services, effective January 25, 2009.

155. Supplemental Staffing Services Agreement by and between Beverly Community Hospital Association and EPS Systems, LLC, effective January 12, 2016.

156. Supplemental Staffing Services Agreement by and between Beverly Community Hospital Association and EZ Staffing, effective January 25, 2009.

157. Supplemental Staffing Services Agreement by and between Beverly Community Hospital Association and FlexCare Medical Staffing, effective November 10, 2015.

158. Supplemental Staffing Services Agreement by and between Beverly Community Hospital Association and GQR Global, effective August 12, 2020.

159. Supplemental Staffing Services Agreement by and between Beverly Community Hospital Association and HealthOne Staffing, LLC, effective February 14, 2011.

160. Supplemental Staffing Services Agreement by and between Beverly Community Hospital Association and Hospital Stafflink Network, effective February 12, 2009.

161. Supplemental Staffing Services Agreement by and between Beverly Community Hospital Association and Integrated Healthcare Staffing, LLC, effective August 23, 2016.

162. Supplemental Staffing Services Agreement by and between Beverly Community Hospital Association and Nightingale Nurses LLC, effective January 25, 2009.

163. Supplemental Staffing Services Agreement by and between Beverly Community Hospital Association and Maxim Healthcare Services, Inc., effective June 1, 2018.

164. Supplemental Staffing Services Agreement by and between Beverly Community Hospital Association and MDM Staffing, effective January 25, 2009.

165. Supplemental Staffing Services Agreement by and between Beverly Community Hospital Association and Med-Link Services, effective February 4, 2009.

166. Supplemental Staffing Services Agreement by and between Beverly Community Hospital Association and Medical Solutions, LLC, effective February 1, 2018.

167. Supplemental Staffing Services Agreement by and between Beverly Community Hospital Association and MGA Healthcare California, Inc., effective January 25, 2009.

168. Supplemental Staffing Services Agreement by and between Beverly Community Hospital Association and Nightingale's List, LLC, effective February 10, 2016.

169. Supplemental Staffing Services Agreement by and between Beverly Community Hospital Association and PHS Staffing, effective January 25, 2009.

170. Supplemental Staffing Services Agreement by and between Beverly Community Hospital Association and Preferred Healthcare Registry, Inc., effective December 23, 2015.

171. Supplemental Staffing Services Agreement by and between Beverly Community Hospital Association and ProCare One Nurses, effective January 25, 2009.

172. Supplemental Staffing Services Agreement by and between Beverly Community Hospital Association and PROCEL Corporation, effective January 25, 2009.

173. Supplemental Staffing Services Agreement by and between Beverly Community Hospital Association and Quincy MD, LLC, effective April 10, 2018.

174. Supplemental Staffing Services Agreement by and between Beverly Community Hospital Association and Rehababilties Inc., effective March 17, 2009.

175. Supplemental Staffing Services Agreement by and between Beverly Community Hospital Association and Tailored Healthcare Staffing, effective November 10, 2015.

176. Supplemental Staffing Services Agreement by and between Beverly Community Hospital Association and Travel Nurse Across America, LLC, effective January 22, 2016.

177. Supplemental Staffing Services Agreement by and between Beverly Community Hospital Association and Trustaff Travel Nurses, effective August 20, 2010.

178. Supplemental Staffing Services Agreement by and between Beverly Community Hospital Association and United Staffing Solutions, Inc., effective February 1, 2018.

179. Supplemental Staffing Services Agreement by and between Beverly Community Hospital Association and Westways Staffing Services Inc., effective January 25, 2009.

180. Beverly Community Hospital Association 457(F) Executive Deferred Compensation Plan for the Benefit of Alice Shu Jen Cheng by and between Beverly Community Hospital Association and Alice Shu Jen Cheng, effective January 1, 2016.

181. Promissory Note by and between Beverly MSO and Montebello Community Health Services, Inc., dated November 16, 2017.

182. Promissory Note by and between Beverly Care, Inc. and Beverly Community Hospital Association, dated November 16, 2017.

183. Stock Subscription and Purchase Agreement by and between California Hospital Insurance Company, Inc. and Beverly Community Hospital Association, dated September 14, 1992.

184. Collective Bargaining Agreement by and between Beverly Community Hospital Association, Registered Nurses Association, United Nurses Association of California, Union of Health Care Professionals, NUHHCE, AFSCME, and AFL-CIO, effective January 1, 2022.

185. Amendment to Provider Participating Agreement by and between Health Net of California, Inc. and Beverly Community Hospital Association, effective June 1, 2011.

186. Amendment to Provider Participating Agreement by and between Beverly Community Hospital Association and Health Net of California, Inc., effective July 1, 2013.

187. Amendment to Hospital Services Agreement by and between Molina Healthcare of California and Beverly Community Hospital Association, effective December 1, 2016.

188. Amendment to the Provider Participating Agreement by and between Health Net of California, Inc. and Beverly Community Hospital Association, effective June 1, 2011.

189. Amendment to the Provider Participating Agreement by and between Beverly Community Hospital Association and Health Net of California, Inc., effective July 1, 2013.

190. Amendment to Provider Participating Agreement by and between Beverly Community Hospital Association and Health Net of California, Inc., dated November 9, 2011.

191. Amendment to Provider Participating Agreement by and between Beverly Community Hospital Association and Health Net of California, Inc., dated July 29, 2013.

192. Amendment to Molina Healthcare of California Hospital Services Agreement by and between Molina Healthcare of California and Beverly Community Hospital Association, dated October 28, 2016.

193. Hospital/Network Risk Pool Agreement by and between Associated Hispanic Physicians of Southern California, Inc. and Beverly Community Hospital Association, dated May 23, 2018.

194. Amendment to Hospital/Network Risk Pool Agreement by and between Southern California Children's Healthcare Network, Inc. and Beverly Community Hospital Association, dated June 27, 2019.

195. Central Health Plan of California Hospital Services Agreement by and between Central Health Plan of California, Inc. and Beverly Community Hospital Association, dated May 23, 2007.

196. Facility Participation Agreement by and between United Health Insurance Company and PacifiCare of California; and Beverly Community Hospital Association, dated May 29, 2009.

197. Amendment to Participation Agreement by and between United Healthcare Insurance Company and PacifiCare of California; and Beverly Community Hospital Association, dated October 1, 2009.

198. Delta Health Systems, Inc. Network Provider Agreement by and between William Michael Stemler, Inc. d/b/a Delta Health Systems and Beverly Community Hospital Association, dated April 22, 2011.

199. Hospital Participation Agreement Amendment by and between Health Value Management, Inc. and Beverly Community Hospital Association, dated October 12, 2011.

200. Letter by and between Health Net of California, Inc. and Beverly Community Hospital Association, effective September 1, 2012.

201. Hospital Services Agreement by and between Prospect Health Plan, Inc. and Beverly Community Hospital Association, dated April 23, 2014.

202. Hospital Services Agreement by and between Universal Care, Inc., Universal Care Medical Group, and Beverly Community Hospital Association, dated April 7, 2014.

203. MPI Participating Facility Agreement by and between MultiPlan, Inc. and Beverly Community Hospital Association, dated July 7, 2014.

204. Fifth Amendment to Beverly Community Hospital Agreement by and between California Physicians' Service, Inc. (Blue Shield of California) and Beverly Community Hospital Association, dated February 3, 2015.

205. Hospital Agreement by and between Easy Choice Health Plan, Inc. and Beverly Community Hospital Association, dated July 21, 2017.

206. Hospital Services Agreement for Medi-Cal Services by and between Care1st Health Plan and Beverly Community Hospital Association, dated August 14, 2017.

207. Hospital Services Agreement by and between Aetna Health of California, Inc. and Beverly Community Hospital Association, dated June 7, 2017.

208. Amendment to Facility Participation Agreement by and between UnitedHealthcare Insurance Company, UHC of California, United Healthcare Benefits Plan of California; and Beverly Community Hospital Association, dated October 8, 2019.

209. Hospital Services Agreement by and between Alignment Health Plan and Beverly Community Hospital Association, dated December 12, 2018.

210. Amendment II to Hospital Services Agreement by and between DaVita Health Plan of California, Inc. and Beverly Community Hospital Association, dated April 1, 2019.

211. Professional Services Agreement by and between Clever Care of Golden State Inc. and Beverly Community Hospital Association, dated September 18, 2019.

212. Participating Hospital Agreement by and between Brandman Health Plan and Beverly Community Hospital Association, dated January 1, 2021.

213. Health Care Services Agreement by and between Kaiser Foundation Hospitals on behalf of its Southern California Region and Beverly Community Hospital Association, dated August 1, 2021.

214. Facility Provider Services Agreement by and between Align Senior Care California, Inc. and Beverly Community Hospital Association, dated January 25, 2022.

215. Amendment to the Hospital Services Agreement by and between L.A. Care Health Plan and Beverly Community Hospital Association, dated January 5, 2022.

216. Hospital Services Agreement by and between AmericasHealth Plan, Inc. and Beverly Community Hospital Association, dated December 6, 2018.

217. Renewal Letter by and between CalOptima and Beverly Community Hospital Association, dated May 26, 2020.

218. Amendment to Medicare Advantage Hospital Service Agreement by and between Beverly Community Hospital Association and CareMore Health Plan, dated December 18, 2015.

219. Amendment to the Hospital Services Agreement by and between Cigna HealthCare of California, Inc., Cigna Health and Life Insurance Company; and Beverly Community Hospital Association, dated August 22, 2019.

220. Hospital Services Agreement by and between Providence Health Network and Beverly Community Hospital Association, dated May 1, 2020.

221. Memorandum of Understanding by and between Family Care Specialists IPA, A Medical Group, Inc. and Beverly Community Hospital Association, dated June 29, 2007.

222. Professional Services Contract Ancillary Provider by and between AltaMed Health Services Corporation and Beverly Community Hospital Association, dated September 1, 2007.

223. Ancillary Provider Services Agreement by and between AppleCare Medical Group, Inc., AppleCare Medical Group St. Francis Inc.; and Beverly Community Hospital Association, dated September 2, 2010.

224. Hospital Services Agreement by and between Heritage Provider Network, Inc. and Beverly Community Hospital Association, dated June 27, 2012.

225. Per Diem Hospital Services Agreement by and between AltaMed Health Network, Inc. and Beverly Community Hospital, dated August 7, 2013.

226. Amendment No. 1 to Hospital Services Agreement by and between Allied Physicians of California and Beverly Community Hospital Association, effective May 1, 2014.

227. Amendment 1 to Hospital Services Agreement by and between Heritage Provider Network, Inc. and Beverly Community Hospital Association, dated December 19, 2014.

228. Hospital/Network Risk Pool Agreement by and between Karing Physicians Medical Group, Inc. and Beverly Community Hospital Association, dated May 9, 2018.

229. Management Services Agreement by and between Beverly Community Hospital Association and MedPOINT Management, dated May 1, 2018.

230. Second Amendment to the Hospital Services Agreement by and between AltaMed Health Network and Beverly Community Hospital Association, dated August 5, 2020.

231. First Amendment to Hospital/Network Risk Pool Agreement by and between Southern California Children's Healthcare Network and Beverly Community Hospital Association, dated June 27, 2019.

232. Participation Agreement by and between APA ACO, Inc. and Beverly Community Hospital Association, effective July 1, 2017.

233. Hospital Services Agreement by and between AltaMed Health Services Corporation and Beverly Community Hospital Association, dated November 1, 2007.

234. Participating Ancillary Services Agreement by and between Associated Hispanic Physicians of Southern California IPA and Beverly Community Hospital Association, dated June 1, 2020.

235. Hospital/Network Risk Pool Agreement by and between Associated Hispanic Physicians of Southern California, Inc. and Beverly Community Hospital Association, dated August 1, 2018.

236. Amendment to Provider Participation Agreement by and between Beverly Community Hospital Association and Health Net of California, Inc., dated June 1, 2022.

237. Fee for Service Hospital Agreement by and between Beverly Community Hospital Association and California Physicians' Service, Inc. (Blue Shield of California), dated December 1, 2008.

238. Facility Agreement by and between Blue Cross of California and Beverly Community Hospital Association, dated September 1, 2020.

239. Hospital/Medical Group Risk Pool Agreement by and between Accountable Health Care IPA and Beverly Community Hospital Association, dated October 1, 2011.

240. Hospital/Network Risk Pool Agreement by and between Southern California Children's Healthcare Network, Inc. and Beverly Community Hospital Association, dated May 1, 2016.

241. Hospital Services Agreement by and between Molina Healthcare of California and Beverly Community Hospital Association, dated December 29, 2006.

242. Hospital Services Agreement by and between L.A. Care Health Plan and Beverly Community Hospital Association, dated May 1, 2004.

243. Amendment to Provider Participation Agreement by and between Beverly Community Hospital Association and Health Net of California, Inc., dated September 1, 2010.

244. Provider Participation Agreement by and between Beverly Community Hospital Association and Health Net of California, Inc., dated June 1, 2020.

245. Fee for Service Hospital Agreement by and between Beverly Community Hospital Association and California Physicians' Service, Inc. (Blue Shield of California), dated April 1, 2001.

246. Hospital Services Agreement by and between Cigna HealthCare of California, Inc., Connecticut General Life Insurance Company; and Beverly Community Hospital Association, dated January 1, 2008.

247. Medicare + Choice Hospital Service Agreement by and between CareMore Insurance Services, Inc. and Beverly Community Hospital Association, dated October 1, 2004.

248. Fee for Service Hospital Agreement by and between Beverly Community Hospital Association and California Physicians' Service, Inc. (Blue Shield of California), dated April 1, 2001.

249. *See* agreements set forth on Schedule 3.6(a), incorporated herein by reference

250. *See* agreements set forth on Schedule 3.6(d), incorporated herein by reference.

251. *See* agreements set forth on Schedule 3.11, incorporated herein by reference.

252. *See* agreements set forth on Schedule 3.8(a)(ii), incorporated herein by reference.

Schedule 3.18

Disciplinary Action Involving Beverly Medical Staff Members

[redacted]

Adventist Health Schedules

ADVENTIST HEALTH DISCLOSURE SCHEDULES

TO THE

AFFILIATION AGREEMENT

by and among

BEVERLY COMMUNITY HOSPITAL ASSOCIATION

DBA

BEVERLY HOSPITAL

a California nonprofit public benefit corporation,

and

MONTEBELLO COMMUNITY HEALTH SYSTEM, INC.,

a California nonprofit public benefit corporation

and

ADVENTIST HEALTH SYSTEM/WEST D.B.A. ADVENTIST HEALTH

a California nonprofit religious corporation

dated December 15, 2022

ADVENTIST HEALTH DISCLOSURE SCHEDULES

The following are the Adventist Health Schedules ("***Adventist Health Schedules***") to the Affiliation Agreement (the "***Agreement***") by and among **Adventist Health System/West, d.b.a. Adventist Health**, a California nonprofit religious corporation on behalf of itself and any Affiliate designated pursuant to this Agreement ("***Adventist Health***"), **Beverly Community Hospital Association d/b/a Beverly Hospital**, a California nonprofit public benefit corporation ("***Beverly***"), and **Montebello Community Health Services, Inc.**, a California nonprofit public benefit corporation ("***Montebello***" and together with Beverly, each a "***Beverly Entity***" and collectively, the "***Beverly Entities***").

Notwithstanding anything to the contrary set forth in the Agreement, no information contained in any portion of the Adventist Health Schedules shall be deemed to be an admission by any party to any third Person of any matter whatsoever, including an admission of any violation of any law or breach of any contract. The Adventist Health Schedules shall constitute formal disclosure to Parent of the facts and circumstances which are, or may be, inconsistent with the representations and warranties referred to in Article 4 of the Agreement. Such facts and circumstances shall be deemed to qualify such representations and warranties.

Capitalized terms used in these Adventist Health Schedules have the meanings assigned to them in the Agreement.

Disclosures related to Article IV – Representations and Warranties of Adventist Health

None.

Attachment 2.1(a)(1)

Amended and Restated Articles of Incorporation of Beverly

RESTATED ARTICLES OF INCORPORATION
OF
BEVERLY COMMUNITY HOSPITAL ASSOCIATION
(the "Corporation")

Article I

The name of this Corporation is Beverly Community Hospital Association.

Article II

This Corporation is a 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 this 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 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 Board of Directors of Adventist Health shall have sole authority to amend or repeal the Articles of Incorporation.

Article IV

A. The property of this 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. This 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 this 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 this Corporation is located where that local conference is a nonprofit religious association or a nonprofit religious corporation organized and operated exclusively for religious purposes that has established its tax-exempt status under the Code, provided, that, any use of such remaining assets distributed in accordance with the foregoing paragraph shall be subject to the requirements of the Affiliation Agreement entered into by and among the Corporation, Adventist Health, and Montebello Community Health System, Inc., dated December 15, 2022.

Article V

A. This 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 this Corporation shall consist of the carrying on or propaganda or otherwise attempting to influence legislation, nor shall this Corporation participate in, or intervene in (including the publishing or distributing of statements), any political campaign on behalf of any candidate for political office.

Article VI

This Corporation elects to be governed by all of the provisions of the Nonprofit Corporation Law effective January 1, 1980, not otherwise applicable to it under Parts 4 and 5 of Division 2 of Title 1 of the Corporation Code of the State of California.

The foregoing amendment and restatement of the Articles of Incorporation has been duly approved by the Board of Directors of the Corporation.

The foregoing amendment and restatement of the Articles of Incorporation has been duly approved by the required vote of the members of the Corporation.

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: [●], 2023

_____

_____, President

_____

_____, Secretary

Attachment 2.1(a)(2)

Amended and Restated Articles of Incorporation of Montebello

Restated Articles of Incorporation
for Montebello Community Health System, Inc.
(the "Corporation")

Article I

The name of this Corporation is Montebello Community Health System, Inc.

Article II

This Corporation is a 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 this 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 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 Board of Directors of Adventist Health shall have sole authority to amend or repeal the Articles of Incorporation.

Article IV

A. The property of this 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. This 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 this 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 this Corporation is located where that local conference is a nonprofit religious association or a nonprofit religious corporation organized and operated exclusively for religious purposes that has established its tax-exempt status under the Code, provided, that, any use of such remaining assets distributed in accordance with the foregoing paragraph shall be subject to the requirements of the Affiliation Agreement entered into by and among the Corporation, Adventist Health, and Beverly Community Hospital Association, dated December 15, 2022.

Article V

A. This 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 this Corporation shall consist of the carrying on or propaganda or otherwise attempting to influence legislation, nor shall this Corporation participate in, or intervene in (including the publishing or distributing of statements), any political campaign on behalf of any candidate for political office.

Article VI

This Corporation elects to be governed by all of the provisions of the Nonprofit Corporation Law effective January 1, 1980, not otherwise applicable to it under Parts 4 and 5 of Division 2 of Title 1 of the Corporation Code of the State of California.

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

4. The foregoing amendment and restatement of the Articles of Incorporation has been duly approved by the required vote of the members of the Corporation.

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: _____ , 2023

_____

_____, President

_____

_____, Secretary

Attachment 2.1(b)(1)

Amended and Restated Bylaws of Beverly

BYLAWS
OF
Beverly Community Hospital Association
(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 No Members. The Corporation has no members within the meaning of Section 5056 of the California Corporations Code.

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 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 of 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 personally 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 15 days, but not more than 45 days, before the time of the holding of the meeting; and (b) for special meetings, at least four days before the time of the meeting, if notice is sent by mail, and at least 48 hours before the time of the meeting, if notice is delivered personally, telephonically, or by electronic transmission. 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 be removed from office by Adventist Health.

3.11 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, understands, 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 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 treasurer. 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 treasurer 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 chief executive officer of Adventist Health shall designate the vice chair of the Board. 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. 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 Community Board (as defined in Article 6);

(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 Community 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 Treasurer. The treasurer shall keep, or cause to be kept, correct books and accounts of the Corporation's properties and transactions. The treasurer shall perform all the duties pertaining to the office of treasurer 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 treasurer will act in the place and stead of the president.

5.9 Assistant Secretaries. The treasurer 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 Treasurers. There shall be such assistant treasurers as may be designated by the Board, any of whom shall perform the duties of the treasurer in the absence of the treasurer.

Article 6
Community Board

6.1 Appointment of Community Board. The Board shall appoint the members of a committee called the "**Community Board**," with each appointment for a two-year term, and approximately one-half of the members of the Community Board appointed every year. The Community Board shall consist of from nine to 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 Community Board member or revoke any or all of the Community Board's delegated authority.

6.2 Governance Committee. The Community Board shall appoint a governance committee pursuant to its bylaws, which shall make nominations to the Board for the Board to consider in appointing Community Board members.

6.3 Bylaws. The Community Board shall have its own bylaws, which shall be adopted and may be amended by the Board, in its sole discretion, including any amendments necessary to conform to these bylaws. The Community Board shall comply with its bylaws and the resolutions of the Board.

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

(a) Shall be more than 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 Community Board. The Community Board bylaws shall specify the exact functions of the Community 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 Community Board:

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

(b) 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;

(c) 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;

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

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

(f) Organizing itself effectively so that it establishes and follows the policies and procedures necessary to discharge its responsibilities, and adopting 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 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. The chair, vice chair, president, treasurer, secretary or assistant secretary may execute, and the Board may authorize specific other persons or officers to execute, all contracts, transactions, or arrangements, and other documents related to such transactions or arrangements. These officers 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 consider any necessary revisions.

9.3 Electronic Transmission.

(a) "**Electronic transmission by the Corporation**" means a communication (1) delivered by (A) electronic mail when directed to the 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; and (2) that creates a record that is capable of retention, retrieval, and review, and that may thereafter be rendered into clearly legible tangible form.

(b) "**Electronic transmission to the Corporation**" means a communication (1) delivered by (A) electronic mail when directed to the electronic mail address that the Corporation has provided to 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 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.

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

Bylaws Certificate

I, Meredith Jobe, hereby certify that I am the Secretary of Beverly Community Hospital Association, a California nonprofit religious corporation (the "**Corporation**"), and that the foregoing bylaws are a true and correct copy of the bylaws of the Corporation as duly adopted on _____, by the vote of the Adventist Health System/West board.

Dated: _____, 2023

Beverly Community Hospital Association

By: _____

Meredith Jobe, Secretary

Attachment 2.1(b)(2)

Amended and Restated Bylaws of Montebello

BYLAWS
OF
Montebello Community Health System, Inc.
(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 No Members. The Corporation has no members within the meaning of Section 5056 of the California Corporations Code.

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 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 of 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 personally 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 8.3), 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 15 days, but not more than 45 days, before the time of the holding of the meeting; and (b) for special meetings, at least four days before the time of the meeting, if notice is sent by mail, and at least 48 hours before the time of the meeting, if notice is delivered personally, telephonically, or by electronic transmission. 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 be removed from office by Adventist Health.

3.11 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, understands, 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 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 treasurer. 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 treasurer 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 chief executive officer of Adventist Health shall designate the vice chair of the Board. 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. 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 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 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 Treasurer. The treasurer shall keep, or cause to be kept, correct books and accounts of the Corporation's properties and transactions. The treasurer shall perform all the duties pertaining to the

office of treasurer 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 treasurer will act in the place and stead of the president.

5.9 Assistant Secretaries. The treasurer 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 Treasurers. There shall be such assistant treasurers as may be designated by the Board, any of whom shall perform the duties of the treasurer in the absence of the treasurer.

Article 6
Indemnification

6.1 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.

6.2 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.

6.3 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 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 7
Legal Instruments

7.1 Execution of Legal Documents. The chair, vice chair, president, treasurer, secretary or assistant secretary may execute, and the Board may authorize specific other persons or officers to execute, all contracts, transactions, or arrangements, and other documents related to such transactions or arrangements. These officers 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.

7.2 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 8
General Provisions

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

8.2 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 consider any necessary revisions.

8.3 Electronic Transmission.

(a) "**Electronic transmission by the Corporation**" means a communication (1) delivered by (A) electronic mail when directed to the 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; and (2) that creates a record that is capable of retention, retrieval, and review, and that may thereafter be rendered into clearly legible tangible form.

(b) "**Electronic transmission to the Corporation**" means a communication (1) delivered by (A) electronic mail when directed to the electronic mail address that the Corporation has provided to 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 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.

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

Bylaws Certificate

I, Meredith Jobe, hereby certify that I am the Secretary of Montebello Community Health System, Inc., a California nonprofit religious corporation (the "**Corporation**"), and that the foregoing bylaws are a true and correct copy of the bylaws of the Corporation as duly adopted on _____, by the vote of the Adventist Health System/West board.

Dated: _____, 2023

Montebello Community Health System, Inc.

By: _____

Meredith Jobe, Secretary

Attachment 2.1(c)

Community Board Bylaws

BYLAWS OF THE COMMUNITY BOARD OF BEVERLY COMMUNITY HEALTH SYSTEM, INC.

The Board of Directors (the "**Corporate Board**") of Beverly Community Hospital Association, a California nonprofit religious corporation (the "**Corporation**") adopts these bylaws for the community board (the "**Community Board**") of Beverly Community Hospital Association and any 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 affiliated with 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 that is consistent with the philosophy, teachings, and practices of the Seventh-day Adventist Church (the "**Church**").

Article 2
Community 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 Community Board as set forth in the Corporate Bylaws and these bylaws of the Community Board (the "**Community 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 Community 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 Community Board, and the Community Board shall be responsible to the Corporate Board for, the following responsibilities and functions:

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

(b) 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;

(c) 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;

(d) 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;

(e) 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;

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

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

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

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

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

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

(l) 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;

(m) 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;

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

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

(p) 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;

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

(r) 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;

(s) Evaluating the performance of the Community Board;

(t) 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

(u) 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
Community Board Structure and Procedures

3.1 Composition of Community Board. The Community 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 Community Board shall consist of from nine to 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 Community Board shall be more than 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 Community 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 Community Board shall include the following:

1. The chief executive officer of Adventist Health (the "**Adventist Health CEO**");

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;

3. The president of this Corporation; and

4. The designated vice chair (if any) under Subsection 4.5(a).

(b) Medical Staff Physicians. The chief of staff of the medical staff may be a member of the Community Board. In addition, up to five 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 Community Board. Physicians may, at the discretion of the Community Board, provide the liaison for communication between the medical staff and the Community Board and thus function in lieu of a joint conference committee.

(c) 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 Community 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 Nominations. The Governance Committee (see Section 5.3) shall recommend to the Corporate Board candidates for election to the Community Board to replace members of the Community Board whose terms are expiring or to fill vacancies in unexpired terms on the Community Board.

3.4 Conflict of Interest Policy. Upon appointment to the Community 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 Community 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 Community Board member), shall hold office for a term of two 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 Community Board Bylaws. A member appointed to fill a vacancy shall serve for the remainder of the term of that person's predecessor. The chief of

staff may hold office on the Community 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 Community 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 Community 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 Community Board may be filled by an appointment by the Corporate Board upon a recommendation from the Community Board.

3.7 Place of Meeting. Meetings of the Community 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 Community Board. In the absence of this designation, meetings shall be held at the principal office of the Corporation. Any Community 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 Community Board, including the capacity to propose, or to interpose an objection to, a specific action to be taken by the Community Board.

3.8 Regular Meetings; Special Meetings. Regular meetings of the Community Board shall be held at least three times each year at such time as is fixed by the chair of the Community Board. Regular meetings of the Community Board shall consist of those meetings reflected on the Corporation's annual calendar. Special meetings of the Community Board for any purpose or purposes may be called at any time by the Corporation's president or the chair of the Community 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 Community 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 Community Board meetings, at least 15 days, but not more than 45 days, before the time of the holding of the meeting; and (b) for special meetings, at least four days before the time of the meeting, if notice is sent by mail, and at least 48 hours before the time of the meeting, if notice is delivered personally, telephonically, or by electronic transmission. The transaction of any meeting of the Community 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 Community 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 Community 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 Community Board Bylaws, the members present at a duly called or held Community 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 Community Board at the next meeting in which a quorum is present.

3.11 Voting; Action without a Meeting. Each Community Board member shall have one vote on each matter presented to the Community Board for action. No member may vote by proxy. Any action by the Community Board may be taken without a meeting if all members of the Community 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 Community Board.

3.12 Resignation and Removal. Any Community Board member may resign by giving written notice to the Community 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 Community Board's recommendation, may appoint a successor to take office as of the date when the resignation becomes effective. Failure to attend three consecutive meetings shall automatically be considered to be a resignation from the Community Board, unless written reasons acceptable to the Community Board chair are presented. A member of the Community Board may be removed from office, at any time, either with or without cause, by the Corporate Board.

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

3.14 Community Board Records. The Community 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 Community Board's meetings and the meetings of committees of the Community Board. Copies of any and all such minutes shall promptly be provided to the Corporate Board.

Article 4
Community Board Officers

4.1 Officers. The officers of the Community Board shall be a chair, an ex officio vice chair (as defined in Subsection 4.5(b)), and a secretary. In addition, where the Adventist Health CEO acts as chair under Section 4.4, there shall be a designated vice chair (as defined in Subsection 4.5(a)). Any number of offices may be held by the same person. Designation as an officer of the Community 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 a vice chair of the Community 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 Community Board Bylaws for regular election or appointment to such office.

4.4 Chair of the Community Board. The chair of the Community Board shall be the Adventist Health CEO or designee. The chair shall preside at all meetings of the Community Board and exercise and perform such other powers and duties as may be from time to time assigned by the Community Board.

4.5 Vice Chairs of the Community Board.

(a) When the Adventist Health CEO acts as chair, the Adventist Health CEO shall appoint a vice chair of the Community Board (the "**designated vice chair**") who shall assist the chair in the conduct of the business of the Community Board and preside at Community Board meetings in the chair's absence.

(b) The person named in Subsection 3.2(a)2 shall serve as a vice chair of the Community Board (the "**ex officio vice chair**"). The ex officio vice chair shall preside at Community Board meetings in the absence of both the chair and designated vice chair.

4.6 President. In the absence of the chair of the Community Board and both vice chairs of the Community Board, the Corporation's president shall preside at meetings of the Community Board, provided that either the chair or designated vice chair has provided prior written approval for the Corporation's president to do so. The Community 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 Community Board. The Corporation's president 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 Community Board.

4.7 Secretary. The Corporation's president shall serve as secretary of the Community Board and shall attend all meetings of the Community Board and record all the proceedings of the meetings of the Community 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 Community Board, and shall perform such duties as may be prescribed by the Community Board.

Article 5
Community Board Operations

5.1 General Functions. The Community 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 Community Board must be designated, the committee shall operate in the following manner:

(a) The Community Board, at its discretion, by resolution adopted by a majority of the authorized number of members, may designate one or more committees, each of which shall be composed of a minimum of two Community Board members, to serve at the pleasure of the Community Board. The Community Board may designate one or more members as alternate members of any committee. Additional committee members may be Community Board members, hospital or Adventist Health employees with expertise related to the committee's purpose or hospital medical staff providers. Committees designated to deliberate issues directly affecting the discharge of medical staff responsibilities shall include at least one Community Board member who is also a member of the medical staff. The committee, the committee's chair or secretary or the Community Board may from time-to-time invite outside experts to meet with committees. These individuals would not be voting members of any committee or privileged to confidential information.

(b) The Community Board may delegate to any committee, to the extent provided in the resolution, any of the Community 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 Community Board may prescribe appropriate rules, not inconsistent with these Community Board Bylaws, by which proceedings of any such committee shall be conducted. The provision of these Community Board Bylaws relating to the calling of meetings of the Community Board, notice of meetings of the Community Board and waiver of such notice, adjournments of meetings of the Community Board, written or electronic consents to Community Board meetings and approval of minutes, action by the Community 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 Community Board and action by such committees. In addition, any member of the Community Board serving as the chair or as secretary of the committee, or any two 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 Community Board or the committee.

5.3 Governance Committee. The Community Board shall appoint a Governance Committee, which shall consist of five Community Board members: the chair and vice chairs of the Community Board, the Corporation's president, and two other members of the Community Board who are

selected by the chair of the Community Board and whose terms are not expiring. The ex officio vice chair of the Community Board shall serve as chair of the Governance Committee. The Governance Committee shall be responsible for making recommendations to the Corporate Board regarding Community Board development, effectiveness, and membership and other governance issues, along with other duties as assigned by the Corporate Board from time to time.

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

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

5.6 Volunteer Program. The Community Board may establish a volunteer services department of the Hospital. If the Community Board establishes such a department, the Community 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.

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

5.8 Strategic Planning. The Community 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 Community Board, administration, medical staff, nursing, and other departments/services as appropriate or performed by the Community Board as a whole and may include the additional representatives as noted. The strategic plan must be approved by the Community Board.

5.9 Compliance with Law and Regulations. The Community 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.

5.10 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, or 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 Community 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 Community 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 Community Board medical staff bylaws and amendments thereto, which shall be effective when approved by the Community Board. Proposed medical staff bylaws changes will be presented to a meeting of the Community Board and sent to each Community Board member at least seven 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 Community Board as provided above.

6.3 Medical Staff Membership and Clinical Privileges.

(a) Delegation to the Medical Staff. The Community 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 Community Board to take informed action.

(b) Action by the Community Board. The Community 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 Community 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 Community 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 Community Board does not concur in a medical staff recommendation, it shall refer the matter to a joint committee of the Community Board and

medical staff for review and recommendation before a final decision is made by the Community Board.

(c) Criteria for Board Action. In acting on matters of medical staff membership status, the Community 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 Community 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 years.

(e) Procedure. The procedure to be followed by the medical staff and the Community 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 Community Board shall require that any adverse recommendations made by the Executive Committee of the medical staff or any adverse action taken by the Community 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 Community 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 Community Board shall be as defined in the fair hearing procedures as indicated in the medical staff bylaws.

6.5 Allied Health Professionals and Other Licensed Clinicians or Non-Physician Practitioners. The Community Board delegates to the medical staff the responsibility and authority to investigate and evaluate each category of allied health professional, other licensed clinicians or non-physician practitioner and each application by such individuals for specified services, department affiliation, and modification in the services such individuals may perform, and requires that the staff or a designated component thereof make recommendations to it for approval.

6.6 Department Chair. The Community 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 Community Board Responsibility. The Community 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 Community 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 Community 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 Community Board. Subject to the ultimate authority of the Corporate Board, the medical staff shall conduct and be accountable to the Community 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 Community 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 Community 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 Community 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 Community Board seeking indemnification under this Article of these Community 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 Community Board member is successful on the merits in defense of any proceeding, claim, or other contested matter brought against the Community Board member in connection with the Community Board member's actions or omissions in relation to the Corporation, the Corporation shall indemnify the Community 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 Community 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 Community 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 Community Board member does not qualify for this mandatory indemnification, such Community 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 Community Board member (including former Community Board members who were removed by the Corporate Board or Community 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 Community Board against any liability asserted against or incurred by that Community Board member in such capacity or arising out of the Community 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 Community Board shall establish a mechanism to evaluate its own performance on an annual basis.

9.2 Amendment of Community Board Bylaws. These Community Board Bylaws may only be amended or repealed, and new Community Board Bylaws adopted, by a vote of the Corporate Board.

9.3 Corporate Bylaws. If any provision of these Community 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 delivered by (1) electronic mail when directed to the electronic mail address for that recipient on record with the Corporation; (2) 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 (3) other means of electronic communication.

(b) "**Electronic transmission to the Corporation**" means a communication (1) delivered by (A) electronic mail when directed to the electronic mail address which the Corporation has provided to Community 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 Community 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.

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

Article 10
Initial Community Board

10.1 Appointment of Initial Community Board Members. Notwithstanding Section 3.1 above, as of the effective date of these Community Board Bylaws, the Corporation has designated _____ (__) individuals to serve on the initial Community Board: (a) ____ (__) persons appointed by the Corporation's board of directors prior to its affiliation with Adventist Health, who will serve as the initial Local Community Board Members of the Community Board; and (b) three (3) persons appointed by Adventist Health, including at least one (1) Adventist Health executive, who will serve as the initial Corporate Community Board Members of the Community Board. One half or the initial members of the Community Board shall have a term of two (2) years and the balance shall have a term of one (1) year. **[Match current board]**

10.2 Sunset. As and when the time periods in this Article 10 expire, the respective provisions in this Article 10 shall sunset. Articles 1 through 9 shall continue in effect.

10.3 Effective Date. These Community Board bylaws are to be effective at 12:01 a.m., Pacific Time, on _____, 2023.

Adopted by the Corporate Board on _____, 2023.

By: _____

Meredith Jobe, Secretary

Attachment 11.11

Adventist Health Charity Policy

Financial Assistance Policy

Disclaimer

Approvals

- Committee Approval: Nonclinical Policy Review Team - Revenue Cycle approved on 7/18/2022
- Signature: John A Beaman, Chief Finance Officer signed on 7/18/2022, 1:21:26 PM

Revision Insight

Document ID:	11927
Revision Number:	10
Owner:	Kevin Longo, Chief Compliance Officer
Revision Official Date:	7/18/2022

Revision Note:
New Revision. Only one small correction and removal of the billing and collection portion of this policy. No other changes.

Separating the Billing and Collection Policy to be separate and distinct from the FAP.

Link appropriate documents and legislation.

☒ Systemwide Standard Policy
☐ Systemwide Model Policy

Standard Policy No. 11927
Approval Pathway: Nonclinical
Department: Revenue Cycle

STANDARD POLICY: FINANCIAL ASSISTANCE POLICY

POLICY SUMMARY/INTENT:

Adventist Health facilities are built on a team of dedicated health care professionals - physicians, nurses, technicians, management, trustees, volunteers, and many other devoted health care workers. Together, these individuals serve to protect the health of their communities. Their ability to serve requires a special relationship built on trust and compassion. Through mutual trust and goodwill, Adventist Health and patients will be able to meet their responsibilities. This policy is designed to strengthen that relationship and make sure patients receive services regardless of their ability to pay.

This policy describes Adventist Health's Financial Assistance (both Charity Care and Discounted Care) policy. Adventist Health does not discriminate, and is fair in reviewing and assessing eligibility for Financial Assistance for community members who may be in need of financial help. Adventist Health provides financial assistance to patients and families when they are unable to pay, all or part, of their medical bill. This policy describes how Adventist Health reviews a patient's financial resources to determine if financial assistance can be provided.

The intent of this policy is to comply with applicable federal, state and local laws and regulations.

DEFINITIONS

1. **Allowable Medical Expenses** - All family members' medical expenses that are eligible for federal income tax deduction, even if the expenses are more than the medical expense deduction allowed by the IRS. Paid and unpaid bills may be included
2. **Amount Generally Billed (AGB)** - The amounts generally billed for emergency or other medically necessary care to individuals who have insurance covering such care. This is usually described as a percent of Gross Charges. The AGB percentages for each hospital facility are updated annually.
3. **Application Period** – The period during which Adventist Health must accept and process an application for financial assistance under its Financial Assistance Policy submitted by an individual in order to have made reasonable efforts to determine whether the individual is eligible for financial assistance under the policy. The Application Period begins on the date the care is provided and ends on the latter of the 240th day after the date that the first post-discharge billing statement for the care is provided or at least 30 days after Adventist Health provides the individual with a written notice that sets a deadline after which ECAs may be initiated.
4. **Billed Charges** - Charges for items and services provided by Adventist Health as published in the Charge Description Master (CDM) and available at www.adventisthealth.org website under Patient Resources, Healthcare Costs and Charges page.
5. **Charge Description Master** - A list of items and services, along with their individual prices and codes, used to bill for services.
6. **Charity Care** - Free or Discounted Care provided when the patient is not expected to pay a bill or is expected to pay only a small amount of the patient's payment obligation for items and services provided by Adventist Health. Charity Care is based on financial need.
7. **Discounted Care** - A deduction from the payment obligations for items and services that is given for cash, prompt, or advanced payment, or to certain categories of patients, e.g., self-pay patient or uninsured patient. A discount is usually described as a percentage of Gross Charges.
8. **Extraordinary Collection Action (ECA)** - ECAs are legal or judicial actions taken to receive payment from a patient for care covered under the hospital facility's Financial Assistance Policy. Selling a patient's debt to another company for collection purposes without adequate protections in place is also an ECA. Other examples include garnishing a patient's wages and adverse credit reporting.
9. **Emergency Medical Care** - Refers to Emergency Services and Care, as defined in the Adventist Health Emergency Medical Treatment and Labor Act policy (EMTALA) #AD-06-019-S.
10. **Essential Living Expenses (ELE)** - The following expenses are considered Essential Living Expenses: rent or house payment and maintenance, food, household supplies, laundry and cleaning, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child or spousal support, transportation and auto expenses, including insurance, gas, repairs and installment payments, and other extraordinary expenses.
11. **Family Members** –
    a. Family Members, of persons **18 years or older**, include a spouse, domestic partner, as defined by the state where the facility is licensed, and dependent children under 26 years, whether living at home or not.
    b. Family Members of **persons under 18 years** include parents, caretaker relatives, and other children of the parent or caretaker relative who are less than 26 years of age of the parent or caretaker relative.
12. **FAP** – The Adventist Health Financial Assistance Policy.
13. **Federal Income Tax Return** - The Internal Revenue Service (IRS) form/s used to report taxable income. The IRS form must be a copy of the signed and dated forms sent to the IRS.
14. **Federal Poverty Level (FPL)** - The poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services under it's statutory authority.
15. **Financial Assistance** - The reductions in payment obligation afforded to Adventist Health patients if such patients qualify for assistance under this policy.

16. **High Medical Costs** - Defined as any of the following

    a. Annual Out-of-Pocket expenses, billed to an individual by Adventist Health, , that exceeds the lesser of ten percent (10%) of the patient's current family or family income in the prior 12 months.

    b. Annual Out-of-Pocket expenses that are more than ten percent (10%) of the patient's family income, if the patient provides documentation of their medical expenses paid by the patient, or the patient's family, in the prior 12 months.

17. **Household Income** - Cumulative income of all Family Members who live in the same household as the patient, or at the home address the patient uses on income tax returns, or on other government documents. This includes the following:

    1. Gross wages, salaries, tips, etc.

    2. Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income

    3. Interest, dividends, royalties, income from rental properties, estates and trusts, alimony, child support, assistance from outside the household, and other miscellaneous sources

18. **Limited English Proficiency (LEP) Group** - A group of people whose first language is not English. The size of the group is the lesser of either 1,000 individuals, or five percent (5%) of the community served by the facility, or the non-English speaking 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 that may be affected, or encountered, by the facility.

19. **Medically Necessary** - A service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to either (a) protect life, to prevent significant illness or significant disability, (b) to alleviate severe pain, or (c) to prevent, diagnose or treat an illness, injury, condition or disease, the symptoms of an illness, injury, condition or disease, and (d) meets accepted standards of medicine.

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

21. **Patient Financial Services (PFS)** - The Adventist Health department responsible for billing, collecting, and processing payments.

22. **Payment Plan** - A series of payments, made over a period of time, to pay the patient's payment obligation for items and services provided by Adventist Health. Monthly payments cannot be more than ten percent (10%) of a patient's monthly family income, excluding deductions for Essential Living Expense.

23. **Plain Language** - Writing designed to ensure the reader understands quickly, easily, and completely as possible. Plain language strives to be easy to read, understand and use.

24. **Presumptive Financial Assistance** - When Adventist Health staff may assume a patient will qualify for 100% Financial Assistance based on information given to them, e.g., homelessness, etc.

25. **Qualifying Patient** - Patient who meets the financial qualifications for Financial Assistance as defined in Section C below.

26. **Reasonable Payment Plan** - A payment plan is a reasonable payment plan if the monthly payments are not more than 10 percent of a patient's family income for a month, excluding deductions for essential living expenses (as defined above).

27. **Self-Pay Liability** - Any balance due by the person who is responsible for payment. This could be a patient, or the patient's guarantor (not a third-party payer).

28. **Third-Party Coverage** - A policy of insurance or other prepaid coverage purchased for protection against certain events, such as health, automobile and general liability insurance, etc.

29. **Uninsured Patient** - Patients who do not have insurance to cover the services received.

30. **Underinsured Patient** - A patient who does not have enough insurance or prepaid coverage to cover the services received.

POLICY: COMPLIANCE – KEY ELEMENTS

Adventist Health is committed to providing Financial Assistance to patients who seek Emergency Medical Care, or Medically Necessary Care, but have limited, or no means, to pay for that care. Financial Assistance is comprised of both Charity Care (free care) and/or Discounted Care. Adventist Health will provide, without discrimination, Emergency Medical Care, or Medically Necessary Care as defined in this policy, to persons regardless of their ability to pay, their eligibility under this policy, or their eligibility for government assistance.

Accordingly, this written policy:

1. includes eligibility criteria for Financial Assistance – Charity Care (free) and Discounted Care (reduction in the patient's payment obligation);

2. describes the basis for how Adventist Health calculates the amount charged to patients who qualify for Financial Assistance under this policy;

3. describes how patients apply for Financial Assistance;

4. describes how the Adventist Health hospital or other Adventist Health facility will publicize this policy in the community it serves; and

5. describes how the Adventist Health hospital or other Adventist Health facility limits the amount billed to patients who qualify for Financial Assistance

6. includes a list of physician and other providers who provide ermergency or other medically necessary care in the hospital facility that specifies which providers are covered by the FAP and which are not.

Charity Care and Discounted Care are not substitutes for personal responsibility. Patients are expected to work with the facility when seeking Financial Assistance. Persons must help pay for the cost of their care based on their ability to pay. Persons with financial means to purchase health insurance will be encouraged to do so since this helps improve their access to health care services.

A. **COMMITMENT TO PROVIDE EMERGENCY MEDICAL CARE:**

1. Adventist Health provides, without discrimination, care for emergency medical conditions to individuals regardless of whether they are eligible for assistance under this policy. Adventist Health will not engage in actions that discourage individuals from seeking emergency medical care, such as by demanding that emergency department patients pay before receiving treatment for emergency medical conditions or by permitting debt collection activities that interfere with the provision, without discrimination, of emergency medical care. Emergency medical services, including emergency transfers, pursuant to EMTALA, are provided to all Adventist Health patients in a non-discriminatory manner, pursuant to each Adventist Health hospital's EMTALA policy (see AH Model Policy AD-06-109-S "EMTALA – Compliance with EMTALA").

    a. **Qualifying Care Under This Policy includes:**

        i. Emergency Medical Care, or other Medically Necessary Care, provided at Adventist Health owned and operated facilities listed in Appendix B

        ii. Emergency department physician services that the Adventist Health facility bills for on the physicians' behalf.

        iii. Note: Emergency room physicians, who provide emergency medical services in an Adventist Health general acute care facility are excluded from this policy unless listed as a "Covered Provider" in the documentation from Appendix D. California requires these physicians to have their own financial assistance policies. Patients who receive a bill from an Emergency Room physician, and are uninsured, underinsured, or have High Medical Costs, should contact that physician's office and ask about their Financial Assistance policy.

        iv. An emergency physician who provides emergency medical services at an Adventist Health hospital in California is required by law to provide discounts to uninsured patients or patients with high medical costs who are at or below 400 percent of the federal poverty level.

        v. A California rural hospital may establish eligibility levels for finanical assistance and charity care at less than 400 percent of the federal poverty level as appropriate to maintain their financial an operational integrity.

    b. **Communication of Financial Assistance**

        i. Adventist Health gives patient's information about Financial Assistance in different ways, including, but not limited to:

            I. Placing notices in Emergency Rooms, Admitting and Registration Offices, Patient Financial Services Departments, other public places and other outpatient settings, including observation units;

            II. Placing information in the Adventist Health Conditions of Registration Form;

            III. Printing information in Adventist Health Post-Discharge Billing Statement. This includes information about how patients can obtain more information about financial assistance along with the internet link for the Financial Assistance Policy;

            IV. Posting a "plain language summary" of the Financial Assistance Policy on all Adventist Health websites;

            V. Prominently displaying information on Adventist Health facility websites, with a link to the Financial Assistance Policy itself;

            VI. Placing, in a "plain language" brochure, mailings, and at other community locations.

            VII. For patients of Adventist Health's California hospitals;

                A. Providing the patient with written notice about the Financial Assistance Policy when the patient receives services. If, however, the patient is unconcious and not able to receive written notice at that time, then the notice will be provided when the patient is discharged.

                B. If the patient is not admitted, the written notice is provided when the patient leaves the facility or is mailed to the patient within 72 hours of the facility providing services to the patient.

                C. The notice includes the internet address of the Health Consumer alliance (https://healthconsumer.org) and shall explain that there are organizations that will help the patient understand the billing and payment process, as well as information regarding Covered California and Medi-Cal presumptive eligibility (if the California hospital particpates in the presumptive eligibility program).

                D. The notice shall also include the internet address for the Adventist Health Hospital's shoppable services (as per 45 CFR 180.60)

        ii. Notices and information are provided to patients in their primary language, when the patient is identified as being within a Limited English Proficiency (LEP) group. In addition to the above, Adventist Health personnel may us their discretion to give individual notice of financial assistance to patients who appear to be at risk of not being able to pay their bill. Referral of patients for financial assistance may be made by any member of the medical, or facility, staff. A request for financial assistance may also be made by the patient, his or her guardian, or family member. Requests are subject to applicable privacy laws.

            I. The written notices will contain information about availability of the hosptial's discount payment and charity care policies. This includes information about eligibility, as well as contact information for a hospital employee or office from which the person may obtain further information about these policies

        iii. Individuals can get information about the Financial Assistance Policy, a copy of our Plain Language Summary, and an application in different languages, free of charge, by:

            I. Going to the registration area

            II. Speaking with an Adventist Health facility financial counselor

            III. Going to the website for Adventist Health: https://www.adventisthealth.org/patient-resources/financial-assistance/

            IV. Calling us at 1-844-827-5047 (or local hospital – See appendix B of this policy)

            V. Writing to: Adventist Health, ATTN: Financial Assistance, P.O. Box 677000, Paradise, CA 95967

VI. Patients may get a paper copy of this Financial Assistance Policy upon request by contacting any of the five contacts listed above

c. **Eligibility Criteria for Financial Assistance**

i. Patients who are uninsured, or underinsured with High Medical Costs, and are unable to pay for their care are eligible for financial assistance if they qualify under the Financial Assistance Policy. Decisions on whether a patient will be granted financial assistance are based on a patient's financial need. Race, color, national origin, citizenship, religion, creed, gender, sexual preference, gender identity and expression, age, or disability are not considered.

ii. For patients on Medicaid (called "Medi-Cal" in California) the patient's Share of Cost (SOC) amounts are not eligible for financial assistance. The SOC amounts are set by the State. States require patients to pay the SOC as a condition of receiving Medicaid/Medi-Cal covered services.

iii. A patient may qualify for Financial Assistance under this policy, if they meet one of the following criteria:

I. Income: Household Income is at, or below, 400% of the FPL.

II. Expenses: Patients who do not meet the income criteria, may be eligible for financial assistance based on essential living expenses and resources. The following two (2) qualifications must both apply:

A. Essential Living Expenses: Exceed fifty percent (50%) of the Household Income; and

B. Resources: The patient's excess medical expenses (the amount that Allowable Medical Expenses are greater than 50% of annual Household Income) must be greater than available Qualifying Assets.

d. **Financial Assistance Levels:** Basis for Calculating Amounts Charged to Patients

i. There is a limit to the amount an individual who is eligible for Financial Assistance may be charged. That individual may not be charged more than the Amount Generally Billed (AGB) for emergency or other medically necessary care. Adventist Health does not bill or expect payment of gross charges from individuals who qualify for financial assistance under this policy. Appendix C describes the specific AGB methodology used for each Adventist Health hospital facility.

ii. Charity Care and Discounted Care: Discounts are based on Household Income. Documentation of Household income include recent pay stubs, income tax returns, and other documents.

iii. The discount amount is based on the percentages in the following tables:

I. Emergency and Medically Necessary Care for Uninsured and Insured Patients

Uninsured Patients		
Household Income	**Patient Responsibility**	**Oregon All Locations Amounts Charged**
200% or less of the Federal Poverty Level	Zero	Zero
> 200% to 300% of the Federal Poverty Level	50% of the Amount Generally Billed	25% of the Amount Generally Billed
> 300% to 350% of the Federal Poverty Level	75% of the Amount Generally Billed	50% of the Amount Generally Billed
> 350% to 400% of the Federal Poverty Level	75% of the Amount Generally Billed	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	Not covered under the Financial Assistance Policy, refer to the Uninsured Discount Policy

Patients with Commercial Insurance or Non-Contracted Managed Care Plans and High Medical Costs		
Household Income	**Amounts Charged**	**Oregon All Locations Amounts Charged**
400% or less of the Federal Poverty Level	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, the patient obligation is zero.	Any patient liability after amounts paid by the patient's insurer failed to pay AGB shall follow the FPL groupings and minimum % discounts from AGB applied as outlined in the table above for uninsured patients.
>400% of the Federal Poverty Level	Not covered under the Financial Assistance Policy, the patient is responsible for their cost sharing obligation amount.	Not covered under the Financial Assistance Policy, the patient is responsible for their Self-Pay Liability amount.

II. Non-Emergency and non-Medically Necessary Care for Uninsured and Insured Patients:

Uninsured Patients

Household Income	Amounts Charged
200% or less of the Federal Poverty Level	Zero
>200% to 400% of the Federal Poverty Level	50% 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 Plan and High Medical Costs	
Household Income	**Patient Liability**
400% or less of the Federal Poverty Level	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 obligation 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.

e. **How Patients Apply for Financial Assistance:**

i. To be considered for Financial Assistance under this policy, a patient or guarantor must:

I. Work with Adventist Health to find other sources of payment, or coverage, from public and/or private payment programs;

II. Submit a true, accurate, and complete confidential → Financial Assistance Application within the Application Period;

III. Provide a copy of patient's or guarantor's most recent pay stub (or certify that he or she is currently unemployed);

IV. Provide a copy of patient's or guarantor's most recent Federal Income Tax Return (including all schedules)

ii. The patient or guarantor is responsible for meeting the conditions of coverage of their insurance or health plan, if they have third-party insurance or health plan. Failure to do so, may result in a denial of financial assistance.

iii. Human dignity, and stewardship, are considered in the application process for deciding financial need and granting financial assistance.

iv. Adventist Health shall not use any information given by a patient regarding monetary assets, pay stubs or income tax returns, in connection with his or her application, for any collection activities of Adventist Health. Information provided by the patient about their household income will only be used to evaluate whether the patient qualifies for financial assistance under this policy.

f. **Eligibility for Other Government Programs**

i. The facility will make reasonable efforts to help the patient find insurance options including:

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

II. Medicare; or

III. The Medicaid program, the Children's Services program, or other state-funded programs designed to provide health coverage. If a patient applied or has a pending application for another health coverage program at the same time that the patient applies for a facility financial assistance program, neither application will stop eligibility for the other program.

g. **Presumptive Financial Assistance Eligibility**

i. Presumptive Financial Assistance takes place when Adventist Health staff may assume a patient will qualify for financial assistance based on information received by the facility, i.e., homelessness, etc.

I. A staff or management member of the Patient Financial Services Department will complete an internal Financial Assistance Application for a patient, to include:

A. The reason the patient, or patient's guarantor, cannot apply on his/her own behalf; and

B. The patient's documented medical or socio-economic reasons that stop the patient, or patient's guarantor, from completing the application.

II. Adventist Health staff may also assign patient accounts to be evaluated for eligibility for Charity Care or Dicsounted Care, if they think the patient may be in need of financial help paying the bill. This may occur if:

A. The patient's medical record that documents they are homeless;

B. It is verified that the patient expired with no known estate or spouse;

C. The patient is currently in jail or prison;

D. The patient qualifies for a public benefit program including Social Security, Unemployment Insurance Benefits, Medicaid, County Indigent Health, AFDC, Food Stamps, WIC, etc.;

E. The patient meets another public benefit program's requirement that are similar to Adventist Health's Financial Assistance program;

F. Adventist Health tried to get a payment from the patient, and is not able to do so;

G. The patient has not completed a Financial Assistance Application;

H. The patient does not respond to requests for documentation;

I. Any other information required by the Financial Assistance Application

ii. If the patient does not or cannot respond to the application process, then the patient's account will be screened using the presumptive eligibility information outlined above to make an individual assessment of financial need. The above information helps Adventist Health make an informed decision on the financial need of a patient by using the best estimates available if the patient does not or cannot provide the requested information.

I. Adventist Health facilities use a third-party to conduct electronic reviews of patient information to assess financial need. These reviews use a healthcare industry-recognized model that is based on public record databases. This predictive model uses public record data to calculate a socio-economic and financial capacity score. It includes estimates of income,(and for California, assets and liquidity). The electronic technology compares each patient using standards that are analogous to the standards in the formal application process.

II. Electronic technology will be used after all other eligibility, and payment sources, have been tried before a patient account is considered bad debt and turned over to a collection agency. This ensures Adventist Health facilities screen all patients for Financial Assistance before taking any collection actions.

III. The electronic eligibility review data that supports the financial need to qualify at 200% FPL, or less, will only be applied to past patient balances.

iii. Patient accounts granted presumptive eligibility will be reclassified under the Financial Assistance policy, Adventist Health will not:

I. send them to collection agencies, debt buyers, or other assignees that is not a subsidiary or affiliate of Adventist Health;

II. subject them to further collection actions;

III. notify them of their qualification; or

IV. include them in the facility's bad debt expense

h. **Eligibility Period**

i. The Financial Assistance adjustment will be applied to all eligible patient account balances, including those received before the application approval date.

ii. The financial assistance approval is good for180 days after the approval is granted.

iii. For bills received after 180 days from when the financial assistance is approved, a separate Financial Assistance Application will need to be filled out if the patient is seeking financial assistance to pay those bills

i. **Appeal Regarding Application of This Policy**

i. Patients may submit a written a request for reconsideration to the Finance Officer (FO) of the Adventist Health Facility at which they received services when:

I. they believe their Financial Assistance Application was not approved according to this policy; or

II. they disagree with the way the policy was applied to their case

ii. The FO will be the final level of appeal.

iii. Appeal must be submitted within 90 days of the date of the decision letter.

j. **Agreements with other Parties** - If Adventist Health sells or refers and individual's debt related ot care to another party, Adventist Health will enter into a legally binding written agreement with the party that is reasonably desinged to ensure that no ECAs are taken to obtain payment for the care until reasonable efforts have been made to determine whether the individual is FAP-eligible for the care. At a minimum such an agreement must provide the following:

i. if the individual submits a FAP application after the referral or sale of the debt but before the end of the application period, the party will suspend ECAs to obtain payment for the care as described in Paragraph A(j)(iii)(1) of the Financial Assitance Policy

ii. if the individual submits a FAP application after the referral or sale of the debt but before the end of the application period and is determined to be FAP-eligible for the care, the party will do the following in a timely manner:

I. Adhere to procedures specified in the agreement that ensure that the individual does not pay, and has not obligation to pay, the party and the Adventist Health facility together more than the individual is required to pay for the care as a FAP-eligible individual

II. if applicable and if the party (rather than the hospital facility) has the authority to do so, take all reasonably available mesures to reverse any ECA (other than the sale of a debt or a lien that a hospital facility is entitled to assert under state law on the proceeds of a judgment, settlement, or compromise owed to an individual (or his or her representative) as a result of personal injuries for which the hospital facility provided care) taken against the individual as described in Paragraph A(j)(iii)(III)(C) of the Financial Assistance Policy

iii. if the individual submits a FAP application after the referral or sale of the debt but before the end of the application period, the party will suspend ECAs to obtain payment for the care as described in Paragraph A(j)(iii)(1) of the Financial Assistance Policy.

iv. The party shall be required to comply with Adventist Health's definition and application of a reasonable payment plan, as that

term is defined in the Financial Assistance Policy

v. If the party refers or sells the debt to yet another party during the Application Period, the party will obtain a written agreement from that other party including all of the other elements described in this Paragraph k.

k. **Documentation**

i. Confidential Financial Assistance Application

l. **List of Covered Providers**

i. The list of Covered and Non-covered Providers who deliver Emergency Medical Care, and other Medically Necessary Care will be updated at least quarterly.

ii. See Appendix D of the Policy for a link to the lists of Covered and Non-covered Providers

iii. See Appendix B of the Policy for the physical address where to get a free copy of the Covered and Non-covered Providers list.

iv. Section B of the Policy describes how this list will be made available.

m. **Authorized Body**

i. Adventist Health Finance Cabinet will review any subsequent changes to this policy and recommend approval to the Adventist Health Board of Directors.

APPENDIX A

2022 FEDERAL POVERTY LEVELs (FPL)

Persons in Family	48 Contiguous States and the District of Columbia	Alaska	Hawaii
1	$13,590	$16,990	$15,630
2	$18,310	$22,890	$21,060
3	$23,030	$28,790	$26,490
4	$27,750	$34,690	$31,920
5	$32,470	$40,590	$37,350
6	$37,190	$46,490	$42,780
7	$41,910	$52,390	$48,210
8	$46,630	$58,290	$53,640
For each additional person, add	$4,720	$5,900	$5,640

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

APPENDIX B

Covered Facility List

List of Adventist Health facilities covered under this policy:

Doing Business As (DBA)	Address	Phone Number
Adventist Health Bakersfield	2615 Chester Avenue Bakersfield, CA 93301	661-395-3000
Adventist Health Castle	640 Ulukahiki Street Kailua, HI 96374	808-263-5500
Adventist Health Clear Lake	15630 18th Avenue Clearlake, CA 95422	707-994-6486
Adventist Health Delano	1401 Garces Highway Delano, CA 93215	661-725-4800
Adventist Health Feather River	5125 Skyway Road Paradise, CA 95969	530-872-2000

Adventist Health Glendale	1509 Wilson Terrace Glendale, CA 91206e	818-409-8000
Adventist Health Hanford	115 Mall Drive Hanford, CA 93230	559-582-9000
Adventist Health Howard Memorial	1 Marcela Drive Willits, CA 95490	707-459-6801
Adventist Health Lodi Memorial	975 S. Fairmont Avenue Lodi, CA 95240	209-334-3411
Adventist Health Mendocino Coast	700 River Drive Fort Bragg, CA 95437	707-961-1234
Adventist Health Physicians Network or Adventist Health Medical Foundation Clinics	Please use contact address for the nearest AH facility	Please use phone listed for nearest AH Facility
Adventist Health Portland	10123 S. E. Market Street Portland, OR 97216	503-257-2500
Adventist Health Reedley	372 W. Cypress Avenue Reedley, CA 93654	559-638-8155
Adventist Health Rideout	726 4th Street Marysville, CA 95901	530-749-4300
Adventist Health Selma	1141 Rose Avenue Selma, CA 93662	559-891-1000
Adventist Health Simi Valley	2975 North Sycamore Drive Simi Valley, CA 93065	805-955-6000
Adventist Health Sonora	1000 Greenley Road Sonora, CA 95370	209-536-5000
Adventist Health St. Helena	10 Woodland Road St. Helena, CA 94574	707-963-3611
Adventist Health Tehachapi Valley	1100 Magellan Drive Tehachapi, CA 93561	661-823-3000
Adventist Health Tillamook	1000 Third Street Tillamook, OR 97141	503-842-4444
Adventist Health Tulare	869 N. Cherry Street Tulare, CA 93274	559-688-0821
Adventist Health Ukiah Valley	275 Hospital Drive Ukiah, CA 95482	707-462-3111
Adventist Health Vallejo	525 Oregon Street Vallejo, CA 94590	707-648-2200

Adventist Health White Memorial	1720 East Cesar E. Chavez Ave. Los Angeles, CA 90033	323-268-5000
Adventist Health Home Care	Please Call for the Information	844-827-5047

APPENDIX C

Amount Generally Billed (AGB) for facilities in California:

AGB Table #1:

The method used to calculate the AGB is the Look-Back Method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a 12-month period (as defined by Treasury Regulations under section 501(r) of the Internal Revenue Code of 1986, as amended). A single average percentage of gross charges, or multiple percentages for separate categories of care or separate items or services may apply, as set forth in the chart below. The AGB rate will be updated annually on January 1st of each year and implemented within 120 days of any AGB rate change.

Facility Abbreviation	Facility	Service	Effective	AGB
AHBD	Adventist Health Bakersfield	All services	5/1/2022	19%
AHCL	Adventist Health Clear Lake	All services	5/1/2022	42%
AHDL	Adventist Health Delano	All services	5/1/2022	34%
AHGL	Adventist Health Glendale	All services	5/1/2022	16%
AHHF	Adventist Health Hanford	All services	5/1/2022	18%
AHHM	Adventist Health Howard Memorial	All services	5/1/2022	32%
AHLM	Adventist Health Lodi Memorial	All services	5/1/2022	16%
AHMC	Adventist Health Mendocino Coast	All services	5/1/2022	51%
AHRD	Adventist Health Reedley	All services except Rural Health Clinics – See Appendix D	5/1/2022	18%
AHRO	Adventist Health and Rideout	All services	5/1/2022	28%
AHSV	Adventist Health Simi Valley	All services	5/1/2022	21%
AHSR	Adventist Health Sonora	All services	5/1/2022	17%
AHSH	Adventist Health St. Helena	All services	5/1/2022	17%
AHTV	Adventist Health Tehachapi Valley	All services	5/1/2022	38%
AHTR	Adventist Health Tulare	All Services	5/1/2022	18%
AHUV	Adventist Health Ukiah Valley	All services	5/1/2022	27%
AHWM	Adventist Health White Memorial	All services	5/1/2022	12%
AHPN	Adventist Health Physician Network	All Services	5/1/2022	45%

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

AGB Table #2

The method used to calculate the AGB is the Look-Back Method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a 12-month period (as defined by Treasury Regulations under section 501(r) of the Internal Revenue Code of 1986, as amended). A single average percentage of gross charges, or multiple percentages for separate categories of care or separate items or services may apply, as set forth in the chart below. The AGB rate will be updated annually on January 1st of each year and implemented within 120 days of any AGB rate change.

Facility Abbreviation	Facility	Service	Effective	AGB
AHCS	Adventist Health Castle	All services except Physician Clinics - See Below Table 3	5/1/2022	42%
AHPL	Adventist Health Portland	All Services	5/1/2022	32%
AHTM	Adventist Health Tillamook	All Services	5/1/2022	56%

AGB Table #3

The method used to calculate the AGB is the Look-Back Method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a 12-month period (as defined by Treasury Regulations under section 501(r) of the Internal Revenue Code of 1986, as amended). A single average percentage of gross charges, or multiple percentages for separate categories of care or separate items or services may apply, as set forth in the chart below. The AGB rate will be updated annually on January 1st of each year and implemented within 120 days of any AGB rate change.

Facility Abbreviation	Facility	Service	Effective	AGB
AHHC	Adventist Health Home Care	All Services	5/1/2022	75%

APPENDIX D

Sliding Scale – Adventist Health Reedley – Rural Health Clinics

A completed Sliding Scale attestation must be submitted, and any qualification is valid for 90 days from the date of qualification.

Adventist Health Reedley – RHC Visit			
Nominal Amounts	**$30.00**	**$45.00**	**$60.00**
Family Size	50% of nominal amount	75% of nominal amount	100% of nominal amount
	100% of the 2022 FPL	150% of the 2022 FPL	200% of the 2022 FPL
1	$13,590	$20,385	$27,180
2	$18,310	$27,465	$36,620
3	$21,960	$34,545	$46,060
4	$27,750	$41,625	$55,500
5	$32,470	$48,705	$64,940
6	$37,190	$55,785	$74,380
7	$40,120	$62,865	$83,820
8	$46,630	$69,945	$93,260
Additional Person	$4,720	$7,080	$9,440

APPENDIX E

Covered and Noncovered Provider's List

The list of Covered and Noncovered Providers who provide Emergency Medical Care or other Medically Necessary Care, in each Adventist Health hospital facility, is maintained in the supplemental document called, PFS-112 Financial Assistance Covered and Noncovered Physicians List". This list is updated quarterly and is published on the Adventist Health website at the links in the following table.

Patients may get a free hard copy of the "PFS-112 Financial Assistance Covered and Noncovered Physicians List" at the facility addresses listed in Appendix B, above.

Below are the links to the lists of Covered and Non-Covered Providers included in this supplemental document:

Facility Abbreviation	Facility

Adventist Health Bakersfield	https://www.adventisthealth.org/documents/financial-assistance/financial-assistance-providers/AHBD-501R-FAP-Providers.pdf
Adventist Health Castle	https://www.adventisthealth.org/documents/financial-assistance/financial-assistance-providers/AHCS-501R-FAP-Providers.pdf
Adventist Health Clear Lake	https://www.adventisthealth.org/documents/financial-assistance/financial-assistance-providers/AHCL-501R-FAP-Providers.pdf
Adventist Health Delano	https://www.adventisthealth.org/documents/financial-assistance/financial-assistance-providers/AHDL-501R-FAP-Providers.pdf
Adventist Health Glendale	https://www.adventisthealth.org/documents/financial-assistance/financial-assistance-providers/AHGL-501R-FAP-Providers.pdf
Adventist Health Hanford	https://www.adventisthealth.org/documents/financial-assistance/financial-assistance-providers/AHHF-501R-FAP-Providers.pdf
Adventist Health Howard Memorial	https://www.adventisthealth.org/documents/financial-assistance/financial-assistance-providers/AHHM-501R-FAP-Providers.pdf
Adventist Health Lodi Memorial	https://www.adventisthealth.org/documents/financial-assistance/financial-assistance-providers/AHLM-501R-FAP-Providers.pdf
Adventist Health Mendocino Coast	https://www.adventisthealth.org/documents/financial-assistance/financial-assistance-providers/AHUV-501R-FAP-Providers.pdf
Adventist Health Physician Network	To be determined
Adventist Health Portland	https://www.adventisthealth.org/documents/financial-assistance/financial-assistance-providers/AHPD-501R-FAP-Providers.pdf
Adventist Health and Rideout	https://www.adventisthealth.org/documents/financial-assistance/financial-assistance-providers/AHRO-501R-FAP-Providers.pdf
Adventist Health Simi Valley	https://www.adventisthealth.org/documents/financial-assistance/financial-assistance-providers/AHSV-501R-FAP-Providers.pdf
Adventist Health Sonora	https://www.adventisthealth.org/documents/financial-assistance/financial-assistance-providers/AHSR-501R-FAP-Providers.pdf
Adventist Health Tehachapi Valley	https://www.adventisthealth.org/documents/financial-assistance/financial-assistance-providers/AHTV-501R-FAP-Providers.pdf
Adventist Health Tillamook	https://www.adventisthealth.org/documents/financial-assistance/financial-assistance-providers/AHTM-501R-FAP-Providers.pdf
Adventist Health Ukiah Valley	https://www.adventisthealth.org/documents/financial-assistance/financial-assistance-providers/AHUV-501R-FAP-Providers.pdf
Adventist Health Home Care Services	To be determined
Adventist Health White Memorial	https://www.adventisthealth.org/documents/financial-assistance/financial-assistance-providers/AHWM-501R-FAP-Providers.pdf

MANUAL(S):

ATTACHMENTS:
(REFERENCED BY THIS DOCUMENT)

www.ftc.gov
http://www.aspe.hhs.gov/poverty/
www.ftc.gov
www.adventisthealth.org
Financial Assistance Policy - Facility Application Letter (English)
EMTALA - Compliance With EMTALA
Charity Care/Financial Assistance Application Form - Confidential (English)
Charity Discount Application - ENG
Charity Discount Application - SPN
CA Health and Safety Code Sec. 127405 (a)(1)(B), as amended by AB 1020 (2021)
ORS 442.612(7)
IRS Section 501(r)
CA Health & Safety Code Sec. 127410 (b) by AB 532

OTHER DOCUMENTS:
(WHICH REFERENCE THIS DOCUMENT)

Self Pay Billing and Collection Policy

FEDERAL REGULATIONS:

Other

https://www.irs.gov/charities-non-profits/charitable-organizations/requirements-for-501c3-hospitals-under-the-affordable-care-act-section-501r

ACCREDITATION:	
CALIFORNIA:	**https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB1020; https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB532**
HAWAII:	**No specific state requirements noted. Corporate policy applies as written.**
OREGON:	**https://olis.leg.state.or.us/liz/2018R1/Downloads/MeasureDocument/HB4020, https://olis.leg.state.or.us/liz/2019R1/Downloads/MeasureDocument/HB3076**
WASHINGTON:	**No specific state requirements noted. Corporate policy applies as written.**
REFERENCES:	**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)) 3/1/2017 DISTRIBUTION: PFS Directors, CFOs**
ADVENTIST HEALTH SYSTEM/WEST POLICY OWNER:	**Kevin K Longo - Chief Compliance Officer**
ENTITY POLICY OWNER:	**Not applicable**
COLLABORATION:	**Adam M Cain - Manager, E-Learning Alyssa M Joyner - Director, Privacy Amy K Miller - Director, Revenue Cycle Compliance Cheryl A Brooksher - Director, Business Intelligence Claudia G Kanne - Regional Director, Compliance Colleen A Fiore - Sr. Application Analyst Jacalyn Liebowitz - System Chief Nursing Officer Jessica M Hoops - Legal Support Assistant Joan S Dillon - Program Manager, Nonclinical Policies & Procedures Jodi L Oldes - Regulatory Specialist Kathy J Leppanen - Program Manager, Regulatory Lori Esquivel - Director, Patient Access Mona A Snyder - Director, Revenue Cycle-Home Care CBO Sarah M Janosz - Program Manager, Polices and Procedures Serena L Avila - Administrative Coordinator Shelly J Williams - Financial Analyst**
APPROVED BY:	
ADVENTIST HEALTH SYSTEM/WEST:	**(06/22/2022) Nonclinical Policy Review Team - Revenue Cycle**
ADVENTIST HEALTH SYSTEM/WEST INDIVIDUAL:	**(07/18/2022 01:21PM PST) John A Beaman, Chief Finance Officer**
ENTITY:	**Not applicable**
ENTITY INDIVIDUAL:	**Not applicable**
REVIEW DATE:	
REVISION DATE:	**05/02/2019, 05/10/2019, 04/20/2020, 04/22/2020, 04/24/2020, 10/14/2020, 05/03/2021, 06/06/2021, 01/05/2022, 05/02/2022, 07/18/2022**
NEXT REVIEW DATE:	**07/17/2024**
APPROVAL PATHWAY:	**Nonclinical**

EXHIBIT 2

AMENDED AND RESTATED ARTICLES OF INCORPORATION OF BEVERLY

RESTATED ARTICLES OF INCORPORATION
OF
BEVERLY COMMUNITY HOSPITAL ASSOCIATION
(the "Corporation")

Article I

The name of this Corporation is Beverly Community Hospital Association.

Article II

This Corporation is a 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 this 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 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 Board of Directors of Adventist Health shall have sole authority to amend or repeal the Articles of Incorporation.

Article IV

A. The property of this 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. This 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 this 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 this Corporation is located where that local conference is a nonprofit religious association or a nonprofit religious corporation organized and operated exclusively for religious purposes that has established its tax-exempt status under the Code, provided, that, any use of such remaining assets distributed in accordance with the foregoing paragraph shall be subject to the requirements of the Affiliation Agreement entered into by and among the Corporation, Adventist Health, and Montebello Community Health System, Inc., dated December 15, 2022.

Article V

A. This 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 this Corporation shall consist of the carrying on or propaganda or otherwise attempting to influence legislation, nor shall this Corporation participate in, or intervene in (including the publishing or distributing of statements), any political campaign on behalf of any candidate for political office.

Article VI

This Corporation elects to be governed by all of the provisions of the Nonprofit Corporation Law effective January 1, 1980, not otherwise applicable to it under Parts 4 and 5 of Division 2 of Title 1 of the Corporation Code of the State of California.

The foregoing amendment and restatement of the Articles of Incorporation has been duly approved by the Board of Directors of the Corporation.

The foregoing amendment and restatement of the Articles of Incorporation has been duly approved by the required vote of the members of the Corporation.

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: [●], 2023

_____

_____, President

_____

_____, Secretary

EXHIBIT 3

AMENDED AND RESTATED ARTICLES OF INCORPORATION OF MONTEBELLO

Restated Articles of Incorporation
for Montebello Community Health System, Inc.
(the "Corporation")

Article I

The name of this Corporation is Montebello Community Health System, Inc.

Article II

This Corporation is a 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 this 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 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 Board of Directors of Adventist Health shall have sole authority to amend or repeal the Articles of Incorporation.

Article IV

A. The property of this 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. This 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 this 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 this Corporation is located where that local conference is a nonprofit religious association or a nonprofit religious corporation organized and operated exclusively for religious purposes that has established its tax-exempt status under the Code, provided, that, any use of such remaining assets distributed in accordance with the foregoing paragraph shall be subject to the requirements of the Affiliation Agreement entered into by and among the Corporation, Adventist Health, and Beverly Community Hospital Association, dated December 15, 2022.

Article V

A. This 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 this Corporation shall consist of the carrying on or propaganda or otherwise attempting to influence legislation, nor shall this Corporation participate in, or intervene in (including the publishing or distributing of statements), any political campaign on behalf of any candidate for political office.

Article VI

This Corporation elects to be governed by all of the provisions of the Nonprofit Corporation Law effective January 1, 1980, not otherwise applicable to it under Parts 4 and 5 of Division 2 of Title 1 of the Corporation Code of the State of California.

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

4. The foregoing amendment and restatement of the Articles of Incorporation has been duly approved by the required vote of the members of the Corporation.

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: _____ , 2023

_____

_____, President

_____

_____, Secretary

EXHIBIT 4

AMENDED AND RESTATED BYLAWS OF BEVERLY

BYLAWS
OF
Beverly Community Hospital Association
(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 No Members. The Corporation has no members within the meaning of Section 5056 of the California Corporations Code.

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 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 of 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 personally 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 15 days, but not more than 45 days, before the time of the holding of the meeting; and (b) for special meetings, at least four days before the time of the meeting, if notice is sent by mail, and at least 48 hours before the time of the meeting, if notice is delivered personally, telephonically, or by electronic transmission. 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 be removed from office by Adventist Health.

3.11 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, understands, 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 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 treasurer. 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 treasurer 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 chief executive officer of Adventist Health shall designate the vice chair of the Board. 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. 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 Community Board (as defined in Article 6);

(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 Community 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 Treasurer. The treasurer shall keep, or cause to be kept, correct books and accounts of the Corporation's properties and transactions. The treasurer shall perform all the duties pertaining to the office of treasurer 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 treasurer will act in the place and stead of the president.

5.9 Assistant Secretaries. The treasurer 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 Treasurers. There shall be such assistant treasurers as may be designated by the Board, any of whom shall perform the duties of the treasurer in the absence of the treasurer.

Article 6
Community Board

6.1 Appointment of Community Board. The Board shall appoint the members of a committee called the "**Community Board**," with each appointment for a two-year term, and approximately one-half of the members of the Community Board appointed every year. The Community Board shall consist of from nine to 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 Community Board member or revoke any or all of the Community Board's delegated authority.

6.2 Governance Committee. The Community Board shall appoint a governance committee pursuant to its bylaws, which shall make nominations to the Board for the Board to consider in appointing Community Board members.

6.3 Bylaws. The Community Board shall have its own bylaws, which shall be adopted and may be amended by the Board, in its sole discretion, including any amendments necessary to conform to these bylaws. The Community Board shall comply with its bylaws and the resolutions of the Board.

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

(a) Shall be more than 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 Community Board. The Community Board bylaws shall specify the exact functions of the Community 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 Community Board:

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

(b) 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;

(c) 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;

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

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

(f) Organizing itself effectively so that it establishes and follows the policies and procedures necessary to discharge its responsibilities, and adopting 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 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. The chair, vice chair, president, treasurer, secretary or assistant secretary may execute, and the Board may authorize specific other persons or officers to execute, all contracts, transactions, or arrangements, and other documents related to such transactions or arrangements. These officers 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 consider any necessary revisions.

9.3 Electronic Transmission.

(a) "**Electronic transmission by the Corporation**" means a communication (1) delivered by (A) electronic mail when directed to the 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; and (2) that creates a record that is capable of retention, retrieval, and review, and that may thereafter be rendered into clearly legible tangible form.

(b) "**Electronic transmission to the Corporation**" means a communication (1) delivered by (A) electronic mail when directed to the electronic mail address that the Corporation has provided to 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 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.

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

Bylaws Certificate

I, Meredith Jobe, hereby certify that I am the Secretary of Beverly Community Hospital Association, a California nonprofit religious corporation (the "**Corporation**"), and that the foregoing bylaws are a true and correct copy of the bylaws of the Corporation as duly adopted on _____, by the vote of the Adventist Health System/West board.

Dated: _____, 2023

Beverly Community Hospital Association

By: _____

Meredith Jobe, Secretary

EXHIBIT 5

AMENDED AND RESTATED BYLAWS OF MONTEBELLO

BYLAWS
OF
Montebello Community Health System, Inc.
(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 No Members. The Corporation has no members within the meaning of Section 5056 of the California Corporations Code.

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 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 of 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 personally 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 8.3), 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 15 days, but not more than 45 days, before the time of the holding of the meeting; and (b) for special meetings, at least four days before the time of the meeting, if notice is sent by mail, and at least 48 hours before the time of the meeting, if notice is delivered personally, telephonically, or by electronic transmission. 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 be removed from office by Adventist Health.

3.11 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, understands, 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 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 treasurer. 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 treasurer 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 chief executive officer of Adventist Health shall designate the vice chair of the Board. 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. 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 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 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 Treasurer. The treasurer shall keep, or cause to be kept, correct books and accounts of the Corporation's properties and transactions. The treasurer shall perform all the duties pertaining to the

office of treasurer 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 treasurer will act in the place and stead of the president.

5.9 Assistant Secretaries. The treasurer 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 Treasurers. There shall be such assistant treasurers as may be designated by the Board, any of whom shall perform the duties of the treasurer in the absence of the treasurer.

Article 6
Indemnification

6.1 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.

6.2 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.

6.3 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 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 7
Legal Instruments

7.1 Execution of Legal Documents. The chair, vice chair, president, treasurer, secretary or assistant secretary may execute, and the Board may authorize specific other persons or officers to execute, all contracts, transactions, or arrangements, and other documents related to such transactions or arrangements. These officers 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.

7.2 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 8
General Provisions

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

8.2 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 consider any necessary revisions.

8.3 Electronic Transmission.

(a) "**Electronic transmission by the Corporation**" means a communication (1) delivered by (A) electronic mail when directed to the 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; and (2) that creates a record that is capable of retention, retrieval, and review, and that may thereafter be rendered into clearly legible tangible form.

(b) "**Electronic transmission to the Corporation**" means a communication (1) delivered by (A) electronic mail when directed to the electronic mail address that the Corporation has provided to 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 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.

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

Bylaws Certificate

I, Meredith Jobe, hereby certify that I am the Secretary of Montebello Community Health System, Inc., a California nonprofit religious corporation (the "**Corporation**"), and that the foregoing bylaws are a true and correct copy of the bylaws of the Corporation as duly adopted on _____, by the vote of the Adventist Health System/West board.

Dated: _____, 2023

Montebello Community Health System, Inc.

By: _____

Meredith Jobe, Secretary

EXHIBIT 6

BYLAWS FOR THE COMMUNITY BOARD OF BEVERLY

BYLAWS OF THE COMMUNITY BOARD OF BEVERLY COMMUNITY HEALTH SYSTEM, INC.

The Board of Directors (the "**Corporate Board**") of Beverly Community Hospital Association, a California nonprofit religious corporation (the "**Corporation**") adopts these bylaws for the community board (the "**Community Board**") of Beverly Community Hospital Association and any 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 affiliated with 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 that is consistent with the philosophy, teachings, and practices of the Seventh-day Adventist Church (the "**Church**").

Article 2
Community 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 Community Board as set forth in the Corporate Bylaws and these bylaws of the Community Board (the "**Community 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 Community 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 Community Board, and the Community Board shall be responsible to the Corporate Board for, the following responsibilities and functions:

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

(b) 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;

(c) 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;

(d) 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;

(e) 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;

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

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

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

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

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

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

(l) 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;

(m) 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;

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

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

(p) 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;

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

(r) 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;

(s) Evaluating the performance of the Community Board;

(t) 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

(u) 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
Community Board Structure and Procedures

3.1 Composition of Community Board. The Community 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 Community Board shall consist of from nine to 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 Community Board shall be more than 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 Community 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 Community Board shall include the following:

1. The chief executive officer of Adventist Health (the "**Adventist Health CEO**");

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;

3. The president of this Corporation; and

4. The designated vice chair (if any) under Subsection 4.5(a).

(b) Medical Staff Physicians. The chief of staff of the medical staff may be a member of the Community Board. In addition, up to five 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 Community Board. Physicians may, at the discretion of the Community Board, provide the liaison for communication between the medical staff and the Community Board and thus function in lieu of a joint conference committee.

(c) 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 Community 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 Nominations. The Governance Committee (see Section 5.3) shall recommend to the Corporate Board candidates for election to the Community Board to replace members of the Community Board whose terms are expiring or to fill vacancies in unexpired terms on the Community Board.

3.4 Conflict of Interest Policy. Upon appointment to the Community 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 Community 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 Community Board member), shall hold office for a term of two 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 Community Board Bylaws. A member appointed to fill a vacancy shall serve for the remainder of the term of that person's predecessor. The chief of

staff may hold office on the Community 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 Community 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 Community 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 Community Board may be filled by an appointment by the Corporate Board upon a recommendation from the Community Board.

3.7 Place of Meeting. Meetings of the Community 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 Community Board. In the absence of this designation, meetings shall be held at the principal office of the Corporation. Any Community 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 Community Board, including the capacity to propose, or to interpose an objection to, a specific action to be taken by the Community Board.

3.8 Regular Meetings; Special Meetings. Regular meetings of the Community Board shall be held at least three times each year at such time as is fixed by the chair of the Community Board. Regular meetings of the Community Board shall consist of those meetings reflected on the Corporation's annual calendar. Special meetings of the Community Board for any purpose or purposes may be called at any time by the Corporation's president or the chair of the Community 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 Community 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 Community Board meetings, at least 15 days, but not more than 45 days, before the time of the holding of the meeting; and (b) for special meetings, at least four days before the time of the meeting, if notice is sent by mail, and at least 48 hours before the time of the meeting, if notice is delivered personally, telephonically, or by electronic transmission. The transaction of any meeting of the Community 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 Community 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 Community 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 Community Board Bylaws, the members present at a duly called or held Community 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 Community Board at the next meeting in which a quorum is present.

3.11 Voting; Action without a Meeting. Each Community Board member shall have one vote on each matter presented to the Community Board for action. No member may vote by proxy. Any action by the Community Board may be taken without a meeting if all members of the Community 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 Community Board.

3.12 Resignation and Removal. Any Community Board member may resign by giving written notice to the Community 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 Community Board's recommendation, may appoint a successor to take office as of the date when the resignation becomes effective. Failure to attend three consecutive meetings shall automatically be considered to be a resignation from the Community Board, unless written reasons acceptable to the Community Board chair are presented. A member of the Community Board may be removed from office, at any time, either with or without cause, by the Corporate Board.

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

3.14 Community Board Records. The Community 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 Community Board's meetings and the meetings of committees of the Community Board. Copies of any and all such minutes shall promptly be provided to the Corporate Board.

Article 4
Community Board Officers

4.1 Officers. The officers of the Community Board shall be a chair, an ex officio vice chair (as defined in Subsection 4.5(b)), and a secretary. In addition, where the Adventist Health CEO acts as chair under Section 4.4, there shall be a designated vice chair (as defined in Subsection 4.5(a)). Any number of offices may be held by the same person. Designation as an officer of the Community 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 a vice chair of the Community 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 Community Board Bylaws for regular election or appointment to such office.

4.4 Chair of the Community Board. The chair of the Community Board shall be the Adventist Health CEO or designee. The chair shall preside at all meetings of the Community Board and exercise and perform such other powers and duties as may be from time to time assigned by the Community Board.

4.5 Vice Chairs of the Community Board.

(a) When the Adventist Health CEO acts as chair, the Adventist Health CEO shall appoint a vice chair of the Community Board (the "**designated vice chair**") who shall assist the chair in the conduct of the business of the Community Board and preside at Community Board meetings in the chair's absence.

(b) The person named in Subsection 3.2(a)2 shall serve as a vice chair of the Community Board (the "**ex officio vice chair**"). The ex officio vice chair shall preside at Community Board meetings in the absence of both the chair and designated vice chair.

4.6 President. In the absence of the chair of the Community Board and both vice chairs of the Community Board, the Corporation's president shall preside at meetings of the Community Board, provided that either the chair or designated vice chair has provided prior written approval for the Corporation's president to do so. The Community 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 Community Board. The Corporation's president 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 Community Board.

4.7 Secretary. The Corporation's president shall serve as secretary of the Community Board and shall attend all meetings of the Community Board and record all the proceedings of the meetings of the Community 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 Community Board, and shall perform such duties as may be prescribed by the Community Board.

Article 5
Community Board Operations

5.1 General Functions. The Community 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 Community Board must be designated, the committee shall operate in the following manner:

(a) The Community Board, at its discretion, by resolution adopted by a majority of the authorized number of members, may designate one or more committees, each of which shall be composed of a minimum of two Community Board members, to serve at the pleasure of the Community Board. The Community Board may designate one or more members as alternate members of any committee. Additional committee members may be Community Board members, hospital or Adventist Health employees with expertise related to the committee's purpose or hospital medical staff providers. Committees designated to deliberate issues directly affecting the discharge of medical staff responsibilities shall include at least one Community Board member who is also a member of the medical staff. The committee, the committee's chair or secretary or the Community Board may from time-to-time invite outside experts to meet with committees. These individuals would not be voting members of any committee or privileged to confidential information.

(b) The Community Board may delegate to any committee, to the extent provided in the resolution, any of the Community 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 Community Board may prescribe appropriate rules, not inconsistent with these Community Board Bylaws, by which proceedings of any such committee shall be conducted. The provision of these Community Board Bylaws relating to the calling of meetings of the Community Board, notice of meetings of the Community Board and waiver of such notice, adjournments of meetings of the Community Board, written or electronic consents to Community Board meetings and approval of minutes, action by the Community 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 Community Board and action by such committees. In addition, any member of the Community Board serving as the chair or as secretary of the committee, or any two 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 Community Board or the committee.

5.3 Governance Committee. The Community Board shall appoint a Governance Committee, which shall consist of five Community Board members: the chair and vice chairs of the Community Board, the Corporation's president, and two other members of the Community Board who are

selected by the chair of the Community Board and whose terms are not expiring. The ex officio vice chair of the Community Board shall serve as chair of the Governance Committee. The Governance Committee shall be responsible for making recommendations to the Corporate Board regarding Community Board development, effectiveness, and membership and other governance issues, along with other duties as assigned by the Corporate Board from time to time.

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

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

5.6 Volunteer Program. The Community Board may establish a volunteer services department of the Hospital. If the Community Board establishes such a department, the Community 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.

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

5.8 Strategic Planning. The Community 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 Community Board, administration, medical staff, nursing, and other departments/services as appropriate or performed by the Community Board as a whole and may include the additional representatives as noted. The strategic plan must be approved by the Community Board.

5.9 Compliance with Law and Regulations. The Community 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.

5.10 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, or 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 Community 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 Community 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 Community Board medical staff bylaws and amendments thereto, which shall be effective when approved by the Community Board. Proposed medical staff bylaws changes will be presented to a meeting of the Community Board and sent to each Community Board member at least seven 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 Community Board as provided above.

6.3 Medical Staff Membership and Clinical Privileges.

(a) Delegation to the Medical Staff. The Community 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 Community Board to take informed action.

(b) Action by the Community Board. The Community 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 Community 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 Community 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 Community Board does not concur in a medical staff recommendation, it shall refer the matter to a joint committee of the Community Board and

medical staff for review and recommendation before a final decision is made by the Community Board.

(c) Criteria for Board Action. In acting on matters of medical staff membership status, the Community 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 Community 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 years.

(e) Procedure. The procedure to be followed by the medical staff and the Community 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 Community Board shall require that any adverse recommendations made by the Executive Committee of the medical staff or any adverse action taken by the Community 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 Community 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 Community Board shall be as defined in the fair hearing procedures as indicated in the medical staff bylaws.

6.5 Allied Health Professionals and Other Licensed Clinicians or Non-Physician Practitioners. The Community Board delegates to the medical staff the responsibility and authority to investigate and evaluate each category of allied health professional, other licensed clinicians or non-physician practitioner and each application by such individuals for specified services, department affiliation, and modification in the services such individuals may perform, and requires that the staff or a designated component thereof make recommendations to it for approval.

6.6 Department Chair. The Community 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 Community Board Responsibility. The Community 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 Community 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 Community 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 Community Board. Subject to the ultimate authority of the Corporate Board, the medical staff shall conduct and be accountable to the Community 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 Community 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 Community 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 Community 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 Community Board seeking indemnification under this Article of these Community 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 Community Board member is successful on the merits in defense of any proceeding, claim, or other contested matter brought against the Community Board member in connection with the Community Board member's actions or omissions in relation to the Corporation, the Corporation shall indemnify the Community 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 Community 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 Community 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 Community Board member does not qualify for this mandatory indemnification, such Community 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 Community Board member (including former Community Board members who were removed by the Corporate Board or Community 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 Community Board against any liability asserted against or incurred by that Community Board member in such capacity or arising out of the Community 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 Community Board shall establish a mechanism to evaluate its own performance on an annual basis.

9.2 Amendment of Community Board Bylaws. These Community Board Bylaws may only be amended or repealed, and new Community Board Bylaws adopted, by a vote of the Corporate Board.

9.3 Corporate Bylaws. If any provision of these Community 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 delivered by (1) electronic mail when directed to the electronic mail address for that recipient on record with the Corporation; (2) 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 (3) other means of electronic communication.

(b) "**Electronic transmission to the Corporation**" means a communication (1) delivered by (A) electronic mail when directed to the electronic mail address which the Corporation has provided to Community 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 Community 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.

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

Article 10
Initial Community Board

10.1 Appointment of Initial Community Board Members. Notwithstanding Section 3.1 above, as of the effective date of these Community Board Bylaws, the Corporation has designated _____ (__) individuals to serve on the initial Community Board: (a) ____ (__) persons appointed by the Corporation's board of directors prior to its affiliation with Adventist Health, who will serve as the initial Local Community Board Members of the Community Board; and (b) three (3) persons appointed by Adventist Health, including at least one (1) Adventist Health executive, who will serve as the initial Corporate Community Board Members of the Community Board. One half or the initial members of the Community Board shall have a term of two (2) years and the balance shall have a term of one (1) year. **[Match current board]**

10.2 Sunset. As and when the time periods in this Article 10 expire, the respective provisions in this Article 10 shall sunset. Articles 1 through 9 shall continue in effect.

10.3 Effective Date. These Community Board bylaws are to be effective at 12:01 a.m., Pacific Time, on _____, 2023.

Adopted by the Corporate Board on _____, 2023.

By: _____

Meredith Jobe, Secretary

11 Cal. Code Reg. Section 999.5(d)(1)(C)

A statement of all of the reasons the board of directors of applicant believes that the proposed agreement or transaction is either necessary or desirable

Beverly has been fulfilling its charitable mission of delivering healthcare services to communities in the Greater East Los Angeles area for over seventy years as a 202-licensed bed general acute care hospital in Montebello, California. However, in recent years, Beverly has incurred significant operating losses due to historical and new challenges and rising costs of patient care without adequate rates increase from its major payors, Medi-Cal and Medicare. As a result of such challenges, Beverly operates without sufficient operating capital or financial reserves needed to fund depreciation and service its debts. As a standalone facility, Beverly has been unable to achieve economies of scale that competitors operating in Beverly's primary service areas have been able to attain as a result of operating within larger health systems. Moreover, Beverly does not have additional capital resources required to remain competitive and generate growth, particularly, in order to comply with California's mandatory seismic requirements, to develop and expand outpatient networks, to recruit and retain physicians for specialty and primary care services, and to explore digital health solutions as a way to reduce costs and explore efficiencies in care delivery.

In light of the above, the Beverly Board has determined that Beverly's viability to operate as a community hospital is in severe jeopardy, and its operations are not financially sustainable. In absence of sizable reserves to address the current fiscal year's negative cash flow and EBITDA situation, Beverly is facing an imminent threat of bond default and insolvency in the immediate future.

In anticipation of its increasing financial and operational challenges, in 2018, the Beverly Board began to evaluate its ability to remain an independent community hospital and considered alternatives that would enable Beverly to continue operations. The Beverly Board sought a potential partner that would secure Beverly's continued operations as a healthcare facility and preserve Beverly's legacy as a provider of healthcare services in the Greater East Los Angeles area. The Beverly Board ultimately determined that an affiliation was critical for its survival as a healthcare provider for its community. Beverly was receptive to discussions with any party that expressed interest in an affiliation. As part of this, the Beverly Board identified potential partners that it believed would affiliate with Beverly, and approached those parties. In addition, Beverly's financial condition was known by third parties operating in the market, and as a result, Beverly was approached by additional potential partners.

As detailed further in Section 999.5(d)(11)(E) of this Notice, a portion of which has been submitted to the Attorney General on a confidential basis, one other health system initially presented itself as a potential partner for affiliation with Beverly. Although discussions with this organization resulted in the execution of a letter of intent between the parties, negotiations did not proceed beyond this initial stage because of the other party's lack of interest in moving forward with Beverly as a partnering organization. Even though the parties' negotiations identified ways to address Beverly's current financial condition and its need for significant capital for its long-term operations, including expenditures necessary to bring Beverly into compliance with California seismic requirements by 2030, the other party identified that

proceeding with an affiliation with Beverly would not be feasible from a financial and operational perspective. Specifically, the other party raised material concerns that the conditions imposed by the Attorney General (based on its review of conditions imposed on other California hospitals affiliations in 2020, 2021, and 2022), and in particular, the competitive impact conditions, would significantly impair aspects of integration between the parties that would have otherwise enabled Beverly to become competitive in the market and ensure its financial viability. As a result, the other party withdrew from negotiations and did not proceed with a potential affiliation with Beverly.

The Beverly Board worked diligently to find a partner and evaluate all possible options. However, due to Beverly's financial condition and the economic downturn caused by the pandemic, discussions with initial potential partners did not proceed in most instances, and the only potential partner that elected to move forward with negotiations was Adventist Health.

The Beverly Board concluded that, without a health system partner or form of financial support from a third party, Beverly would have to consider ceasing its operations soon. In assessing all available options, Beverly proceeded with discussions with Adventist Health. Beverly's discussions with Adventist Health proved Adventist Health to be a compatible and ideal organization based upon its culture, vision, and goals for the future, and as a result, negotiations regarding affiliation between Beverly and Adventist Health moved forward. Thus, the Beverly Board determined that affiliating with Adventist Health would allow for the continuation of Beverly's mission within a larger health system that models itself on similar long-term goals of serving underserved areas and still remain financially viable as a healthcare services organization.

A letter of intent ("Letter of Intent") was signed by Beverly and Adventist Health on June 15, 2022. Attached to this Section as **Exhibit 7** are the meeting minutes of the Beverly Board and Montebello Board, from the meetings held on September 27, 2022 and October 25, 2022, approving the proposed Affiliation with Adventist Health and the execution of the Affiliation Agreement by the applicable Beverly Entity.

EXHIBIT 7
MINUTES FROM MEETINGS OF BEVERLY BOARD AND MONTEBELLO BOARD (SEPTEMBER 27, 2022; OCTOBER 25, 2022)

BEVERLY COMMUNITY HOSPITAL ASSOCIATION
MONTEBELLO COMMUNITY HEALTH SERVICES, INC.
MINUTES
EXECUTIVE SESSION MEETING
BOARD STRATEGIC INITIATIVE-MERGER/AFFILIATION
TOWER BASEMENT CENTER (TBC) IN-PERSON & VIA ZOOM WEB CONFERENCE
SEPTEMBER 27, 2022

The Executive Session Meeting of the Board of Directors of Beverly Community Hospital Association/Montebello Community Health Services, Inc. was held in In-Person and via Zoom Web Conference in the City of Montebello, County of Los Angeles, and State of California on Tuesday, September 27, 2022 at 3:05 PM.

MEMBERS IN-PERSON: Lyla Eddington, EdD, RN, Chairperson, Board of Directors; Carlos Manuel Haro, PhD; Renee Martinez; Gautam Ganguly, MD; Richard Adams, JD; Gary Einstein; Ralph Hansen, DMD; Alma Perez, SPHR; Arthur Revueltas; Pamala Sakamoto;

MEMBERS VIA ZOOM: John Hsu, CPM; Julie France, MSN/ED, RN; Goharik Gabriel; Aziz Khan, MD; Rosemary Orozco; Monica Thornhill-Joynes, MD; George Wang, MD

MEMBERS EXCUSED: None

MEMBERS ABSENT: None

OTHERS PRESENT: Alice Cheng, President and CEO; David Tredway, Senior Counsel, Doyle Schafer McMahon *(via Zoom)*

GUESTS: Michael Hunn, President, The Hunn Group *(via Zoom)*

ITEM	AGENDA	PRESENTED BY	ACTION/RECOMMENDATION/CONCLUSION	FOLLOW-UP
I	[redacted]			
II				

BEVERLY COMMUNITY HOSPITAL ASSOCIATION
MONTEBELLO COMMUNITY HEALTH SERVICES, INC.
MINUTES
EXECUTIVE SESSION MEETING
SEPTEMBER 27, 2022

ITEM	AGENDA	PRESENTED BY	ACTION/RECOMMENDATION/CONCLUSION	FOLLOW-UP
III	[redacted]			
IV	**Executive Session** ➢ Strategic Initiative Update • Adventist Health Affiliation	L. Eddington, EdD., Chairperson Board of Directors A. Cheng President & CEO M. Hunn President, The Hunn Group	The Executive Session was convened before the General Session. [redacted]	

BEVERLY COMMUNITY HOSPITAL ASSOCIATION
MONTEBELLO COMMUNITY HEALTH SERVICES, INC.
MINUTES
EXECUTIVE SESSION MEETING
SEPTEMBER 27, 2022

ITEM	AGENDA	PRESENTED BY	ACTION/RECOMMENDATION/CONCLUSION	FOLLOW-UP
			[redacted]	
IV	**Executive Session** *(Continued...)* ➢ Strategic Initiative Update • Adventist Health Affiliation	L. Eddington, EdD., Chairperson Board of Directors A. Cheng President & CEO M. Hunn President, The Hunn Group	• LOI Exclusivity ended August 21, 2022 without further agreement to extend by Adventist Health. [redacted]	

BEVERLY COMMUNITY HOSPITAL ASSOCIATION
MONTEBELLO COMMUNITY HEALTH SERVICES, INC.
MINUTES
EXECUTIVE SESSION MEETING
SEPTEMBER 27, 2022

ITEM	AGENDA	PRESENTED BY	ACTION/RECOMMENDATION/CONCLUSION	FOLLOW-UP
IV	**Executive Session** *(Continued...)* ➢ Strategic Initiative Update • Adventist Health Affiliation	L. Eddington, EdD., Chairperson Board of Directors A. Cheng President & CEO M. Hunn President, The Hunn Group	Mr. Hunn presented a summary of the key terms of the Beverly/Adventist Health Affiliation Agreement, as outlined in the Power Point attached (Attachment A). Mr. Hunn also described the related transaction documents to carry out the terms of the Affiliation Agreement, including amendments to the Beverly and Montebello Articles of Incorporation and Bylaws, which were circulated to the Board (the "Governance Documents"). He noted that the terms and conditions outlined in the Agreement are not final. In addition, the closing of the Affiliation Agreement is subject to the approval by the AG. Mr. Hunn stated the next steps are: • Finalization and execution of the Affiliation Agreement once both entities' Board approve the Agreement • Filing of the AG approval application to obtain approval from the AG for the affiliation • The Board then discussed the proposed terms under the Affiliation Agreement. Mr. Hunn then answered questions from the committee on key terms of the affiliation, Affiliation Agreement, and Governance Documents.	

BEVERLY COMMUNITY HOSPITAL ASSOCIATION
MONTEBELLO COMMUNITY HEALTH SERVICES, INC.
MINUTES
EXECUTIVE SESSION MEETING
SEPTEMBER 27, 2022

ITEM	AGENDA	PRESENTED BY	ACTION/RECOMMENDATION/CONCLUSION	FOLLOW-UP
IV	**Executive Session** *(Continued...)* ➢ Strategic Initiative Update • Adventist Health Affiliation	L. Eddington, EdD., Chairperson Board of Directors A. Cheng President & CEO M. Hunn President, The Hunn Group	Dr. Eddington stated that the Board Strategic Working Group has been meeting every other week since January of 2022. Group members, based on the facts and information presented by Ms. Cheng and Mr. Hunn, the Board had carefully discussed, assessed, and considered all other potential options and the terms of the transaction with Adventist Health. On behalf of the Group, Dr. Eddington recommended the approval of the draft Affiliation Agreement between Beverly Hospital and Adventist Health, and once executed by both parties, the filing to the AG requesting approval for the affiliation. A motion was moved by Dr. Ganguly, seconded by Dr. T.J. and carried to approve the draft Affiliation Agreement between Beverly Hospital and Adventist Health, and the AG approval application filing.	
V	[redacted]			

[redacted]

L. Eddington, EdD., RN
Chairperson
Board of Directors

BEVERLY COMMUNITY HOSPITAL ASSOCIATION
MONTEBELLO COMMUNITY HEALTH SERVICES, INC.
MINUTES
EXECUTIVE SESSION MEETING
BOARD STRATEGIC INITIATIVE-MERGER/AFFILIATION
TOWER BASEMENT CENTER (TBC) IN-PERSON
OCTOBER 25, 2022

The Executive Session Meeting of the Board of Directors of Beverly Community Hospital Association/Montebello Community Health Services, Inc. was held in In-Person in the City of Montebello, County of Los Angeles, and State of California on Tuesday, October 25, 2022 at 3:20 PM.

MEMBERS IN-PERSON: Lyla Eddington, EdD, RN, Chairperson, Board of Directors; Carlos Manuel Haro, PhD; Renee Martinez; Gautam Ganguly, MD; John Hsu, CPM; Richard Adams, JD; Gary Einstein; Julie France, ED/RN; Goharik Gabriel; Ralph Hansen, DMD; Alma Perez, SPHR; Pamala Sakamoto; Monica Thornhill-Joynes, MD; George Wang, MD

MEMBERS EXCUSED: Aziz Khan, MD; Rosemary Orozco; Art Revueltas

MEMBERS ABSENT: **None**

OTHERS PRESENT: Alice Cheng, President and CEO; Dan Doyle, Partner, Doyle Schafer McMahon

GUESTS: Michael Hunn, President, The Hunn Group *(via Zoom)*

ITEM	AGENDA	PRESENTED BY	ACTION/RECOMMENDATION/CONCLUSION	FOLLOW-UP
I	[redacted]			
II				
III				

ITEM	AGENDA	PRESENTED BY	ACTION/RECOMMENDATION/CONCLUSION	FOLLOW-UP
IV	[redacted]			
V	**Review of Minutes** ➢ Meeting held on Tuesday, September 27, 2022 (*Exhibit 1*)	L. Eddington, EdD., Chairperson Board of Directors	Ms. Cheng presented the minutes from the Executive Session held on Tuesday, September 27, 2022 as outlined in Exhibit for approval. A motion was made by Dr. Ganguly, seconded by Mrs. Perez and carried to approve the Executive Session Minutes as presented.	
VI	**Executive Session** ➢ Beverly Hospital/Adventist Health Affiliation Update (*Exhibit 2)* • Draft Affiliation Agreement • Proposal to Submit AG Approval Application	L. Eddington, EdD., Chairperson Board of Directors A. Cheng President & CEO M. Hunn President, The Hunn Group	The Executive Session was convened before the General Session. Mr. Hunn provided the progress report on the proposed Beverly Hospital/Adventist Health Affiliation as documented in a draft Affiliation Agreement, circulated to the Board and attached as Exhibit 2. The highlights are as follows: • **Draft Affiliation Agreement**. Mr. Hunn presented the revisions to certain sections of the Affiliation Agreement (documented in the draft attached as Exhibit 2) that had been previously approved by the Board during its last meeting on September 27th: ➢ **Membership/Control**. At closing of the Affiliation Agreement, the composition of the board of directors of Beverly and Montebello will mirror	

ITEM	AGENDA	PRESENTED BY	ACTION/RECOMMENDATION/CONCLUSION	FOLLOW-UP
			Adventist Health's Corporate Board, making Adventist Health the new controlling entity. This does not require Adventist Health to become the sole corporate member of Beverly or Montebello.	
VI	**Executive Session** *(Continued...)* ➢ Beverly Hospital/Adventist Health Affiliation Update *(Exhibit 2)* • Draft Affiliation Agreement • Proposal to Submit AG Approval Application	L. Eddington, EdD., Chairperson Board of Directors A. Cheng President & CEO M. Hunn President, The Hunn Group	➢ **Pre-Closing Covenants** ✓ Conduct of the Beverly Operations (5.5e). The revised draft, attached as Exhibit 2, includes language to affirmatively allow Beverly Hospital to borrow up to $18 million of working capital from either Adventist Health or third party lender, which may encumber the Beverly Real Property in order to provide Beverly with working capital to maintain operations. ✓ Continuing Operations (11.2). The revised draft, attached as Exhibit 2, includes new language that describes that in the event that Beverly ceases to operate as a general acute care hospital, the "net assets" of the Beverly Entities as of such date shall be earmarked to be used for charitable health care purposes for the local community in the Beverly Service Area. • **Notice to the California Attorney General ("AG").** Mr. Hunn provided a summary overview of the AG approval application package, which includes: ➢ ***A Cover Letter*** outlining the background information and descriptions of the transaction, closing timeline, and anticipated post-closing activities.	

ITEM	AGENDA	PRESENTED BY	ACTION/RECOMMENDATION/CONCLUSION	FOLLOW-UP
			➢ ***Notice of Proposed Submission and Request for Consent***. The Notice includes detailed descriptions and supporting exhibits of the proposed transaction and terms, including: ✓ Description of the transaction, which includes as attachments, the fully executed Affiliation Agreement, proposed amended and restated Articles of Incorporation and Bylaws to be adopted at closing, and a description of the Board's deliberations and process to identify a potential affiliation partner.	
VI	**Executive Session** *(Continued...)* ➢ Beverly Hospital/Adventist Health Affiliation Update *(Exhibit 2)* • Draft Affiliation Agreement • Proposal to Submit AG Approval Application	L. Eddington, EdD., Chairperson Board of Directors A. Cheng President & CEO M. Hunn President, The Hunn Group	✓ Fair market value and supporting documents ✓ Inurement and self-dealing: Board and Executives ✓ Charitable use of assets ✓ Impacts on healthcare services for the community ✓ Possible effect on competition ✓ Public interests ✓ Resolutions of the Board and Statement of Board Chair ✓ Transferee information (Adventist Health) ✓ Public communications ➢ ***Confidential Materials***: ✓ Board minutes for the Board's affiliation explorations and decisions, including a description of other potential partners that engaged in initial discussions with Beverly	

ITEM	AGENDA	PRESENTED BY	ACTION/RECOMMENDATION/CONCLUSION	FOLLOW-UP
			The Board then discussed the proposed terms under the Affiliation Agreement. Mr. Hunn then answered questions from the committee on key terms of the affiliation, Affiliation Agreement, and Governance Documents.	
VI	**Executive Session** *(Continued...)* ➢ Beverly Hospital/Adventist Health Affiliation Update (*Exhibit 2)* • Draft Affiliation Agreement • Proposal to Submit AG Approval Application	L. Eddington, EdD., Chairperson Board of Directors A. Cheng President & CEO M. Hunn President, The Hunn Group	A motion was moved by Mr. Einstein, seconded by Mrs. Sakamoto and carried to approve the Affiliation Agreement attached as Exhibit 2 (including the latest proposed revisions as presented by Mr. Hunn) and for Beverly to proceed with the AG Approval Application filing once the Affiliation Agreement is executed by the parties.	
VII	[redacted]			

[redacted]

L. Eddington, EdD., RN
Chairperson
Board of Directors

Title 11, California Code of Regulations, § 999.5(d)(2)

FAIR MARKET VALUE

11 Cal. Code Reg. Section 999.5(d)(2)(A)

The estimated market value of all cash, property, stock, notes, assumption or forgiveness of debt, and any other thing of value that the applicant would receive for each health facility or facility that provides similar healthcare coverage by the proposed agreement or transaction

The Affiliation will not involve any sale, transfer, merger or other disposition of any assets of Beverly or Montebello. Pursuant to the Affiliation Agreement, Adventist Health will become the sole member or the sole controlling entity of each Beverly Entity in which no cash, property, stock, notes forgiveness of debt, or other monetary consideration is to be received by either Beverly Entity. As a result, there is no estimated market value to be provided under this Section. For information regarding each Beverly Entity's assets, liabilities, and other financial matters, see the responses to Section 999.5(d)(1)(A), Section 999.5(d)(1)(B), Section 999.5(d)(11)(F) and the referenced exhibits. Post-Closing, the assets of Beverly and Montebello will continue to be dedicated to the same charitable purpose. In the event that Adventist Health ever closes Beverly, per the terms of the Affiliation Agreement, Adventist Health has committed the net assets of Beverly and Montebello to be used for charitable health care purposes for the local community.

11 Cal. Code Reg. Section 999.5(d)(2)(B)

The estimated market value of each health facility, facility that provides similar healthcare or other asset to be sold or transferred by the applicant under the proposed agreement or transaction

The Affiliation will not involve any sale, transfer, merger or other disposition of any of the assets of the Beverly Entities at Closing. Beverly's goal in entering into an affiliation is to secure the future availability of healthcare in Beverly's community. Thus, the value of the assets at Closing was not of critical importance in determining the most advantageous partner for the Beverly Entities, which is further described in detail in Section 999.5(d)(1)(C) of this Notice. However, as an indication of value, an assessment of the value of Beverly's assets is set forth in the consolidated financial statements attached as **Exhibit 29** and **Exhibit 30** to Section 999.5(d)(11)(F).

11 Cal. Code Reg. Section 999.5(d)(2)(C)

A description of the methods used by the applicant to determine the market value of any assets involved in the proposed agreement or transaction. This description shall include a description of the efforts made by the applicant to sell or transfer each health facility or facility that provides similar healthcare that is the subject of the proposed agreement or transaction

The Affiliation provides for Adventist Health to become the sole member or the sole controlling entity of each Beverly Entity, for the ongoing continuation of Beverly's operations, and does not involve a sale, transfer merger or other disposition of any of either Beverly Entity's assets or a dedication of such assets for a different purpose. Therefore, the parties did not obtain an appraisal in connection with the proposed Affiliation. For information regarding each Beverly Entity's assets, liabilities, and other financial matters, see the response to Section 999.5(11)(F) and related exhibits.

For a description of the deliberative and extensive process that the Beverly Entities engaged in to determinate that this Affiliation is the best course of action for each Beverly Entity, and the reports, analyses, and other documents that informed this deliberative process, see the responses to Section 999.5(d)(l)(C) and Section 999.5(d)(11)(A).

11 Cal. Code Reg. Section 999.5(d)(2)(D)

Reports, analysis, Requests for Proposals and other documents that refer or relate to the valuation of any asset involved in the transaction

The Affiliation provides that Adventist Health will become the sole member or the sole controlling entity of each Beverly Entity, serving the same public with the same (or nearly the same) mission and does not involve a sale, transfer, merger or other disposition of any of the assets of the Beverly Entities. As a result, the parties did not obtain an appraisal in connection with the proposed Affiliation. The Beverly Entities did, however, engage in a deliberate and extensive process to determine that the entrance into an affiliation would be the best option to pursue in order to allow Beverly to continue to operate and deliver critical healthcare services to its community, particularly in light of the financial condition of Beverly which, without a partnership with a larger health system, would result in the imminent closure of Beverly. Thus, in exploring Beverly's ability to remain a viable hospital, Beverly aimed to ensure that any affiliation would help preserve critical healthcare services in the community and provide Beverly with access to additional resources to support its current and anticipated financial needs. The Beverly Board believes that Adventist Health will maximize these objectives going forward.

For more information regarding the deliberative process of the Beverly Entities in selecting Adventist Health as an affiliation partner, see the responses to Section 999.5(d)(l)(C) and Section 999.5(d)(l l)(A).

For more information regarding the value of the assets of the Beverly Entities, please see the response to Section 999.5(d)(l l)(F).

11 Cal. Code Reg. Section 999.5(d)(2)(E)

For joint venture transactions, all asset contribution agreements and related valuations, all limited liability corporation or limited liability partnership operating agreements, management contracts, and put option agreements

The proposed transaction is not a joint venture.

Title 11, California Code of Regulations, § 999.5(d)(3)

INUREMENT AND SELF-DEALING

11 Cal. Code Reg. Section 999.5(d)(3)(A)

Copies of any documents or writings of any kind that relate or refer to any personal financial benefit that a proposed affiliation between applicant and the transferee would confer on any officer, director, employee, doctor, medical group or other entity affiliated with applicant or any family member of any such person as identified in Corporations Code Section 5227(b)(2)

The proposed transaction does not confer any personal financial benefit on any individual or entities described in California Code of Regulation, Title 11, Section 999.5(d)(3)(A).

Pursuant to the Affiliation Agreement, Adventist Health will become the sole member or the sole controlling entity of each Beverly Entity, each of which will retain all of its respective assets and liabilities at Closing. These assets and liabilities include contractual arrangements Beverly has in place with officers, employees, doctors, and medical groups to provide administrative, professional and coverage services to Beverly, arrangements which Beverly does not intend the Affiliation to disrupt, although post-Closing, Adventist Health may decide and will have a right to terminate all such agreements pursuant to their terms. For more information in this regard, please see the responses to Section 999.5(d)(3)(B) and Section 999.5(d)(5)(F) of this Notice.

11 Cal. Code Reg. Section 999.5(d)(3)(B)

The identity of each and every officer, trustee or director of applicant (or any family member of such persons as identified in Corporations Code section 5227(b)(2)) or any affiliate of applicant who or which has any personal financial interest in any company, firm, partnership, or business entity (other than salary and directors'/trustees' fees) currently doing business with applicant, any affiliate of applicant, or the transferee or any affiliate of the transferee

None of the individuals described in Title 11, California Code of Regulations, Section 999.5(d)(3)(B) have any personal financial interest (other than salary and/or directors' fees) in any company, firm, partnership or business entity currently doing business with the Beverly Entities (or their affiliates), or with Adventist Health (or its affiliates), except as noted below:

1. Employment Agreement between Beverly Community Hospital Association, and Alice Shu Jen Cheng, dated January 1, 2016, as amended on January 1, 2021, March 15, 2021, and January 1, 2022.

2. Loan Agreement by and between Beverly Community Hospital Association and Alice Shu Jen Cheng, dated August 4, 2021.

3. Retention Bonus Agreement between Beverly Community Hospital Association and Houshang Abd, effective December 13, 2021.

4. Employment Agreement by and between Beverly Community Hospital Association and Charlene Chu, dated April 1, 2021, as amended on December 13, 2021.

5. Employment Agreement by and between Beverly Community Hospital Association and Mark Lueken, dated April 1, 2021, as amended on December 13, 2021.

6. Employment Agreement by and between Beverly Community Hospital Association and Lester Fujimoto, dated April 1, 2021, as amended on December 13, 2021.

7. Employment Agreement by and between Beverly Community Hospital Association and Nancy Lee, dated April 1, 2021, as amended on December 13, 2021.

8. Employment Agreement by and between Beverly Community Hospital Association and George Holtz, dated April 1, 2021, as amended on December 13, 2021.

9. Employment Agreement by and between Beverly Community Hospital Association and Sridhar Chadalavada, dated April 1, 2021, as amended on December 13, 2021.

10. Employment Agreement by and between Beverly Community Hospital Association and James V. Mathew, dated July 1, 2021.

11. Retention Bonus Agreement between Beverly Community Hospital Association and Daniel Way, effective December 13, 2021.

12. Retention Bonus Agreement between Beverly Community Hospital Association and Kathleen Curran, effective December 13, 2021.

13. Chief Medical Officer Agreement between Beverly Community Hospital Association and Kenneth Lawrence Cohen, M.D., dated July 1, 2016.

11 Cal. Code Reg. Section 999.5(d)(3)(C)

A statement describing how the board of directors of the nonprofit corporations involved in the transaction are complying with the provisions of Health and Safety Code sections 1260 and 1260.1

As further described in response to Section 999.5(d)(1)(C), the Beverly Board's and Montebello Board's exploration of all potential alternatives ultimately resulted in the Beverly Board and Montebello Board approving the Beverly Entities moving forward with this proposed Affiliation with Adventist Health.

In compliance with Health and Safety Code Sections 1260 and 1260.1, no member of the Beverly Board or Montebello Board who participated in the negotiation of the terms and conditions of the proposed transaction with Adventist Health has received or will receive (directly or indirectly), any salary, compensation, payment or other form of remuneration from Adventist Health, or any entity affiliated with Adventist Health, following consummation of the proposed Affiliation. None of the members of the Beverly Board or Montebello Board listed in Section 999.5(d)(3)(B) of this Notice participated in the negotiation of the terms and conditions of the proposed transaction with Adventist Health.

The Beverly Board delegated to the Beverly Chief Executive Officer, subject to the Beverly Board's oversight and periodic reporting, the responsibility to negotiate the Letter of Intent, the Affiliation Agreement, and the other related documents to effectuate the Affiliation. Any remarks to the Beverly Board by the Beverly Chief Executive Officer were limited to factual statements.

Title 11, California Code of Regulations, § 999.5(d)(4)

CHARITABLE USE OF ASSETS

11 Cal. Code Reg. Section 999.5(d)(4)(A)

The applicant's articles of incorporation and all amendments thereto and current bylaws, any charitable trust restrictions, and any other information necessary to define the charitable trust purpose of the applicant's assets

Attached to this Section are the following:

- **Exhibit 8**, a copy of Beverly's current Articles of Incorporation;
- **Exhibit 9**, a copy of Beverly's current Bylaws;
- **Exhibit 10**, a copy of Montebello's current Articles of Incorporation; and
- **Exhibit 11**, a copy of Montebello's current Bylaws.

Copies of Beverly's Amended and Restated Articles of Incorporation and Beverly's Amended and Restated Bylaws are attached as **Exhibit 2** and **Exhibit 4**, respectively, to Section 999.5(d)(1)(B), to be adopted as of the Closing. Copies of Montebello's Amended and Restated Articles of Incorporation and Montebello's Amended and Restated Bylaws are attached as **Exhibit 3** and **Exhibit 5**, respectively, to Section 999.5(d)(1)(B), to be adopted as of the Closing.

Beverly's mission and services to its community is supported through the Foundation. The Foundation engages in fundraising, donation, philanthropic efforts and the administration of such funds and property for the benefit of Beverly and its programs, services, and patients. Pursuant to the Foundation's governance documents and Affiliation Agreement, in accordance with applicable laws, charitable donations that the Foundation receives will be distributed and expended according to the terms of such donations. The Affiliation Agreement provides that Adventist Health shall maintain the current status of the mission of the Foundation and shall retain the Foundation board of directors for no less than twelve months. As of August 31, 2022, the net assets of the Foundation were approximately $710,772.

EXHIBIT 8

CURRENT ARTICLES OF INCORPORATION OF BEVERLY

ARTICLES OF INCORPORATION

OF

BEVERLY HOSPITAL FOUNDATION

KNOW ALL MEN BY THESE PRESENTS:

That we, the undersigned, all of whom are residents of the State of California, have this day voluntarily associated ourselves together for the purpose of forming a corporation under the laws of the State of California; that the corporation is organized pursuant to Part 1 of Division 2 of Title 1 of the Corporations Code, and we do hereby certify:

I.

NAME

The name of the corporation is Beverly Hospital Foundation.

II.

DURATION

The period of the corporation's duration is perpetual.

III.

PURPOSES AND POWERS

3.1 Specific and Primary Purpose. The specific and primary purpose for which the corporation is formed is to engage in the solicitation, receipt and administration of property and from time to time to disburse such property and the income therefrom to, or for the benefit of, Beverly Community Hospital Association, for hospital, scientific, educational and charitable uses, including research in such fields.

3.2 General Purposes and Powers. The general purposes for which the corporation is formed are:

3.2.a. To obtain and administer funds to be used for Beverly Community Hospital Association for charitable purposes.

3.2.b. To receive and administer funds in furtherance of the charitable, educational and scientific objectives and purposes mentioned above, and to that end, in addition to and not in limitation of, the general powers conferred by the laws of the State of California, to take and hold by bequest, devise, gift, grant, purchase, lease or otherwise, either absolutely or jointly with any other person, persons, or corporation, any property, real, personal, tangible, or intangible, or any undivided interest therein, without limitation as to amount or value required for its purpose, to sell, convey, or otherwise dispose of any such property and to invest, reinvest or deal with the principal or the income thereof in such manner as in the judgment of the Board of Trustees will best promote its purposes, without limitations, except such limitations, if any, as may be contained in the instrument under which such property is received, the Articles of Incorporation, the by-laws of the corporation, or any laws applicable thereto.

3.2.c. To engage in and conduct charitable activities.

3.2.d. To act as trustee under any trust or endowment incidental to the principal objectives of the corporation, and in connection therewith to receive, hold, administer and expend funds and real and personal property of every kind and character whatsoever subject to such trust or endowment.

3.2.e. To acquire by purchase, exchange, subscription or otherwise, and to receive, mortgage, pledge, sell, assign, transfer, exchange or otherwise dispose of shares of stock of, or voting trust certificates for shares of the stock of, or any bonds or other securities, evidences of indebtedness or obligations created by, any other corporation or corporations organized under the laws of the State of California or of any other state, or of any country, nation or government, and

to pay therefor, in whole or in part, with cash or other property or with bonds or other obligations of this corporation, and while the owner or holder of any such shares, or voting trust certificates for shares, or bonds or other securities or evidences of indebtedness or obligations of any such other corporation or corporations, to possess and exercise in respect thereof all the rights, powers and privileges of ownership, including the right to vote thereon and to consent in respect thereof for any and all purposes.

3.2.f. To borrow or raise moneys for any of the purposes of this corporation without limit as to amount, and, from time to time, to issue bonds, debentures, notes or other obligations, secured or unsecured, of this corporation for moneys so borrowed, or in payment for property acquired, or for any of the other objectives or purposes of this corporation or in connection with its business; to secure such bonds, debentures, notes and other obligations by mortgage or mortgages, or deed or deeds of trust, or pledge or other lien upon any or all of the property, rights, privileges or franchises of this corporation, wheresoever situated, acquired or to be acquired, and to pledge, sell or otherwise dispose of any or all of such bonds, debentures, notes and other obligations of this corporation for its corporate purposes.

3.2.g. To do all other acts necessary or expedient for the administration of the affairs and attainment of the purposes of the corporation.

3.2.h. Notwithstanding any of the above statements of purposes and powers, this corporation shall not, except to an insubstantial degree, engage in any activities or exercise any powers that are not in furtherance of the primary purpose of this corporation.

The foregoing clauses shall each be construed as purposes, objectives and powers, and the matters expressed in each clause shall, except as otherwise expressly provided, be in nowise limited by reference to, or inference from the terms of any other clause, but shall be regarded as independent purposes, objectives and powers; and the enumeration

of specific purposes, objectives and powers shall not be construed to limit or restrict in any manner the meaning of the general powers of the corporation, nor shall the expression of one thing be deemed to exclude another, although it be of like nature, not expressed; provided that all of the foregoing purposes, objectives, powers and matters set forth in this Article III shall be limited to those which do not jeopardize the corporation's tax exempt status under Section 501(c)(3) of the Internal Revenue Code of 1954.

IV.

DISSOLUTION

The property of the corporation is irrevocably dedicated to hospital, scientific, educational and charitable purposes. Upon the dissolution or winding up of the corporation, after paying or adequately providing for the debts and obligations thereof, any remaining assets shall be distributed to Beverly Community Hospital Association, if it is then in existence and qualified as an exempt organization under Section 501(c)(3) of the Internal Revenue Code (1954), as amended, supplanted or revised, if amended, supplanted or revised. If Beverly Community Hospital Association is not then in existence or so qualified, than any remaining assets shall be distributed to a nonprofit corporation (selected by this corporation's Board of Trustees) which is engaged in activities substantially similar to those of this corporation and which is then qualified as an exempt organization under Section 501(c)(3) of the Internal Revenue Code (1954), as amended, supplanted or revised, if amended, supplanted or revised.

V.

PROHIBITIONS

No part of the net earnings of the corporation shall inure to the benefit of any Member, Trustee or Officer of the corporation or any private individual (except that reasonable compensation may be paid for services rendered to or for the corporation affecting one or more of its purposes). No substantial part of the activities of the corporation shall be the carrying on of propaganda, or otherwise attempting to influence legislation, and the corporation shall not participate in, or intervene in (including the publication or distribution of statements), any political campaign on behalf of any candidate for public office.

Notwithstanding any other provision of these Articles, the corporation shall not conduct or carry on any activities not permitted to be conducted or carried on by an organization exempt under Section 501(c)(3) of the Internal Revenue Code and its Regulations as they now exist or as they may hereafter be amended, or by an organization contributions to which are deductible under Section 170(c)(2) of such Code and Regulations as they now exist or as they may hereafter be amended, or the laws of the State of California as they now exist or as they may hereafter be amended.

VI.

MEMBERS

The corporation shall have one or more classes of Members and one or more Members in each class. The designation of each class and the number, manner of selection, rights and qualifications of the Members of each class shall be prescribed from time to time by the by-laws. The by-laws may enlarge, limit or deny the voting rights of Members otherwise prescribed by statute.

VII.

PRINCIPAL OFFICE

The principal office for the transaction of the business of this corporation is to be located in the County of Los Angeles, State of California.

VIII.

TRUSTEES

The number of Trustees of this corporation shall be four (4), which number shall constitute the authorized number of Trustees until changed by amendment to these Articles of Incorporation or by a by-law adopted by the Members. The names and addresses of the persons who are to act in the capacity of Trustees until the selection of their successors are:

NAME	ADDRESS
Roy W. McDiarmid	16958 Lake Terrace Way, Yorba Linda, Calif.
Robert E. Pellissier	7239 So. Washington Ave., Whittier, Calif.
Robert Ellenburg, M.D.	433 No. 4th Street, Montebello, California
Donald Peters	901 W. Whittier Blvd., Montebello, Calif.

IN WITNESS WHEREOF, we have hereunto set our hands all as of the 5th day of February, 1974.

[redacted]

Roy W. McDiarmid

[redacted]

Robert Pellissier

[redacted]

Robert Ellenburg, M.D.

[redacted]

Donald Peters

STATE OF CALIFORNIA)
) ss.
COUNTY OF LOS ANGELES)

On this 5 th day of February, 1974, before me, the undersigned, a Notary Public, personally appeared Roy McDiarmid, Robert Ellenburg, M.D., Robert E. Pellissier, and Donald Peters, known to me to be the persons whose names are subscribed to these Articles of Incorporation, and acknowledged to me that they executed them.

(Seal)

[redacted]
Notary Public for the State of California

236121 A475323

FILED
In the office of the Secretary of State
of the State of California

APR 29 1996

[redacted]
BILL JONES, Secretary of State

CERTIFICATE OF AMENDMENT
OF
ARTICLES OF INCORPORATION
OF
BEVERLY COMMUNITY HOSPITAL ASSOCIATION

W.W. Wilkinson, M.D. and William W. Hung, M.D. certify that:

1. They are the President and the Secretary, respectively of Beverly Community Hospital Association, a California public benefit corporation;

2. The sixth article of the articles of incorporation of this corporation is amended to read as follows:

SIXTH: This corporation shall have no members.

3. The foregoing amendment of articles of incorporation has been duly approved by the board of directors.

4. The foregoing amendment of articles of incorporation has been duly approved by the required vote of members of the corporation.

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.

Dated: 4/25/96

[redacted]
W.W. Wilkinson, M.D.
President

[redacted]
William W. Hung, M.D.
Secretary

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031896

EXHIBIT 9

CURRENT BYLAWS OF BEVERLY

BYLAWS

OF

BEVERLY COMMUNITY HOSPITAL ASSOCIATION

FEBRUARY 12, 1980

Revised	November 17, 1981
Reviewed	January 19, 1982
Revised	July 20, 1982
Revised	March 15, 1983
Revised	June 21, 1983
Revised	November 20, 1984
Revised	October 20, 1987
Revised	October 16, 1990
Revised	May 24, 1994
Revised	February 27, 1996
Revised	March 26, 1996
Revised	July 27, 1999
Revised	January 25, 2000
Revised	October 22, 2002
Revised	July 22, 2003
Revised	December 16, 2003
Revised	November 7, 2004
Revised	February 22, 2005
Revised	September 25, 2007
Revised	June 24, 2008
Revised	November 24, 2009
Revised	November 16, 2010
Revised	July 24, 2012
Revised	May 27, 2014

TABLE OF CONTENTS Page

TABLE OF CONTENTS Page

TABLE OF CONTENTS Page

TABLE OF CONTENTS Page

BYLAWS
OF
BEVERLY COMMUNITY HOSPITAL ASSOCIATION

ARTICLE I
PURPOSES OF THE CORPORATION

This Corporation is established for the purposes set forth in the Articles of Incorporation (a copy of which is attached). Specifically, the Corporation shall furnish its services and facilities without regard to age, race, national origin, color, creed, religion, sex, sexual orientation, disability, or, to the extent of its financial ability to do so, ability to pay, and shall manage its services and facilities so as to retain accreditation pursuant to the standards promulgated by the Joint Commission or any other accrediting agency selected by the Board of Directors of the Corporation (sometimes referred to hereinafter as the "Board").

ARTICLE II
OFFICES AND SEAL

Section 1 - OFFICES. The principal office for the transaction of the business of the Corporation shall be in the County of Los Angeles, State of California. The Corporation may also have an office or offices within or without the State of California as the Board may from time to time establish.

Section 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 word "California."

ARTICLE III
MEMBERSHIP

Section 1 - NO MEMBERS. The Corporation shall have no members within the meaning of Section 5056 of the California Corporations Code.

Section 2 - DEDICATION OF ASSETS. This Corporation's assets are exclusively and irrevocably dedicated to charitable and hospital purposes. No part of the net earnings, properties, or assets of the Corporation, on dissolution or otherwise, shall inure to the benefit of any private person or individual, or to any Director or Officer of the Corporation.

ARTICLE IV
BOARD OF DIRECTORS

Section 1 - POWERS. Except as otherwise provided by the Articles of Incorporation or these Bylaws, the powers of the Corporation shall be exercised, its property controlled and its affairs conducted by or under the direction of the Board.

The specific powers of the Board shall include, but shall not be limited to, the following, which powers may be more fully delineated in other sections of these Bylaws:

a. The selection and removal of the Officers of the Corporation including, but not limited to, the selection, evaluation, and removal of the President and Chief Executive Officer of the Corporation.

b. The appointment of Committees of the Board.

c. The development and approval of strategic and/or long-range plans for hospital services provided by the Corporation.

d. The review and approval of the annual budget of the Corporation, as developed by the Officers of the Corporation.

Section 2 - NUMBER AND QUALIFICATIONS.

a. The Board shall consist of no less than nine (9) members and no more than seventeen (17) members (sometimes hereinafter referred to individually as "Director" or collectively as "Directors"). A majority of Directors shall be persons other than practitioners of the healing arts in active practice. Directors who are practitioners of the healing arts ("Physician Directors") shall be licensed by the State of California to practice medicine and surgery. The Chief of Staff shall be included among the Physician Directors.

Two (2) members of the Board shall be Trustees of the Beverly Hospital Foundation. These two positions shall be filled by appointment by the Board of Directors. The positions filled by Trustees shall be for two (2) year terms. One position shall be a voting member of the Board. The second position shall be an ex officio representative and entitled to attend meetings of the Board of Directors and to participate in deliberations but shall not be entitled to vote and shall not be included among the Directors' membership criteria. Trustees who will serve as Directors shall be nominated by the Governance Committee.

b. The Chief of Staff-Elect of the Medical Staff shall be entitled to attend meetings of the Board and to participate in deliberations but shall not be entitled to vote and shall not be included among the Directors membership criteria of no more than seventeen (17) members. Directors shall be nominated by the Governance Committee as provided in Article V, Section 5. The Governance Committee selected by the Board, as described in Section 5 of Article V hereof, shall utilize such criteria as set forth in said Section and such additional criteria and qualifications as the Board may specify from time to time for the nomination of persons to serve as Directors.

c. No more than forty-nine percent (49%) of the persons serving on the Board may be "interested persons" as defined in California Corporations Code Section 5227, as amended, and by the Internal Revenue Services ("IRS"). An interested person is (1) any person compensated by the Corporation for services rendered by such person within the previous twelve (12) months, whether as a full-time or part-time employee, independent contractor, or otherwise, excluding any reasonable compensation paid to a Director as Director; and (2) any brother, sister, ancestor, descendant, spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, or father-in-law of such person. Notwithstanding the above, any violation of this paragraph shall not affect the validity or enforceability of transactions entered into by the Corporation.

Section 3 - TERM, TENURE AND ELECTION. Directors shall be elected or reelected at the annual meeting of the Board, which shall be held in November of each calendar year or at a special meeting held for the purpose of electing Directors. The term of office of a Director shall be three (3) years except as provided otherwise in Article IV, Section 2, and shall commence on the first day of the month subsequent to the meeting in which he or she was elected, unless otherwise specified by the Board. There is no maximum tenure limit for a Director. A directorship shall terminate automatically upon a Director's failure to qualify for the Board as specified herein.

Section 4 - RESIGNATION. Any Director may resign at any time, either by oral tender of resignation at any meeting of the Board or by giving written notice thereof to the Secretary of the Corporation. Such resignation shall take effect at the time specified therefor and, unless otherwise specified with respect thereto, the acceptance of such resignation shall not be necessary to make it effective. Failure of any Director to remain qualified as provided in these Bylaws shall be deemed a resignation. Except upon notice to the Attorney General, no Director may resign where the Corporation would then be left without a duly elected Director or Directors in charge of its affairs.

Section 5 - REMOVAL. Any Director may be removed for cause from the Board upon approval by two-thirds (2/3) of the Board in the following circumstances:

a. the Director fails to attend more than two-thirds (2/3) of the duly noticed Board meetings per calendar year without being excused by the Secretary before such meetings; or

b. the Director has been declared of unsound mind by a final order of court, or convicted of a felony, or been found by a final order or judgment of any court to have breached any duty under Article 3 (commencing with Section 5230) of the Nonprofit Corporation Law.

Any director may also be removed without cause from the Board upon approval by two-thirds (2/3) of the Board.

Section 6 - VACANCIES. Vacancies on the Board may be filled by approval of the Board or, if the number of Directors then in office is less than a quorum, by (1) the unanimous written consent of the Directors then in office, (2) the affirmative vote of a majority of the Directors then in office at a meeting held according to notice or waivers of notice complying with California Corporations Code Section 5211, or (3) a sole remaining Director.

ARTICLE V
MEETINGS OF BOARD OF DIRECTORS

Section 1 - PLACE OF MEETINGS. Regular or special meetings of the Board may be held at any place within or outside California that the Board may designate or, if not so designated, meetings shall be held at the Corporation's principal office. Notwithstanding the foregoing, a regular or special meeting of the Board may be held at any place consented to in writing by all Board members, either before or after the meeting. All such consents shall be filed with the Minutes of the meeting.

Section 2 - ANNUAL MEETING OF THE BOARD OF DIRECTORS. The annual meeting of the Board shall be held in November of each calendar year at such time and place as the Board shall fix from time to time for the purpose of electing Officers and for the transactions of such other business as may come before the meeting.

Section 3 - REGULAR MEETINGS. Regular meetings of the Board shall be held on the fourth Tuesday of each month at such time and place as the Board may fix by resolution from time to time.

Section 4 - SPECIAL MEETINGS. Special meetings of the Board may be called by or at the request of:

a. four (4) or more Directors; or

b. the Chair of the Board.

Notice of these meetings shall be in accordance with Section 5 of this Article V.

Section 5 - NOTICE OF MEETINGS. No notice of annual or regular meetings of the Board need be given, except that in the event the Board desires to hold a regular meeting at a time other than as set forth in Section 3, Article V, the Board shall provide notice of such changed time at the preceding regular meeting. Notice of the time and place of all special meetings shall be delivered personally or by telephone to each Director and the President and Chief Executive Officer, sent by first class mail or telegram, charge prepaid, addressed to each Director and the President and Chief Executive Officer at that person's address as it is shown on the records of the Corporation or by electronic transmission in compliance with Section 9, Article XII of these Bylaws. In case the notice is mailed, it shall be deposited in the United States mail at least seven (7) days before the time of the holding of the meeting. In case the notice is delivered personally, by telephone or telegram, or by electronic transmission, it shall be delivered personally, by telephone or to the telegraph company, or by electronic transmission at least forty-eight (48) hours before the time of the holding of the meeting. Any oral notice given personally, by telephone or telegram, or by electronic transmission may be communicated either to the Director or to a person at the office of the Director who the person giving the notice has reason to believe will promptly communicate it to the Director. The notice need not specify the purpose of the meeting nor the place if the meeting is to be held at the principal office of the Corporation. Notice shall not be given by electronic transmission if the Corporation is unable to deliver two consecutive notices to a Director by that means, or if the inability to deliver the notice becomes known to the Secretary or other person responsible for giving such notice.

Section 6 - QUORUM AND VOTING. A majority of the Board shall constitute a quorum for the transaction of business at any meeting of the Board, but if less than a majority thereof is present at the meeting, a majority of the Directors present may adjourn and reconvene the meeting from time to time without further notice, unless the meeting is adjourned for more than twenty-four (24) hours, in which case notice of the time and place shall be given before the time of the adjourned meeting to the Directors who were not present at the time of the adjournment. Unless otherwise provided by the Articles of Incorporation, these Bylaws, or by applicable law, every act or decision made by a majority of the Directors present at a duly held meeting at which a quorum is present is an act of the Board, subject to the more stringent provisions of the California Nonprofit Public Benefit Corporation Law, including, without limitation, those provisions relating to (1) approval of contracts or transactions in which a Director has a direct or indirect material financial interest, (2) approval of certain transactions between corporations having common directorships, (3) creation of and appointments to committees of the Board, and (4) indemnification of Directors. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of Directors, if any action taken is approved by at least a majority of the required quorum for that meeting.

Section 7 - SUPERMAJORITY APPROVAL. Notwithstanding the provisions of Section 6, Article V, the following actions require the approval of two-thirds of the directors then in office:

a. A decision to sell all or substantially all of the Corporation's assets;

b. A decision to authorize a merger of the Corporation with another nonprofit entity;

c. A decision on behalf of the Corporation to file a petition in bankruptcy, enter into an assignment for the benefit of creditors, or enter into any transaction constituting a reorganization or conversion of the Corporation;

d. A decision to dissolve and wind up the affairs of the Corporation; or

e. A decision to amend these Bylaws.

Section 8 - VALIDATION OF MEETING. The transactions of the Board at any meetings, however called or noticed, or wherever held, shall be as valid as though had at a meeting duly held after call and notice if a quorum be present and if, either before or after the meeting, each Director not present signs a written waiver of notice or a consent to the holding of such a meeting or an approval of the minutes thereof. All such waivers, consents, or approvals shall be filed with the corporate records and made a part of the minutes of the meeting.

Section 9 - ADJOURNMENT. A majority of the Directors present, whether or not constituting a quorum, may adjourn any meeting to another time and place. Notice of the time and place of holding an adjourned meeting need not be given, unless the meeting is adjourned for more than twenty-four (24) hours, in which case notice of the time and place shall be given before the time of the adjourned meeting to the Directors who were not present at the time of the adjournment.

Section 10 - ACTION WITHOUT MEETING. Any action required or permitted to be taken by the Board under any provision of law, the Articles of Incorporation or these Bylaws may be taken without a meeting if all Directors shall individually or collectively consent in writing to such action. Such written consent or consents shall be filed with the minutes of the proceedings of the Board. Such action by written consent shall have the same force and effect as a unanimous vote of the Directors. Any certificate or other document filed on behalf of this Corporation relating to an action taken by the Board without a meeting shall state that the action was taken by a unanimous written consent of the Board without a meeting, and that the Bylaws of the Corporation authorize its Directors to so act.

Section 11 - TELECOMMUNICATIONS EQUIPMENT. Any Board meeting may be held by conference telephone, electronic video screen communication, or other electronic transmission by and to the Corporation. Participation in a meeting through use of conference telephone or electronic video screen communication constitutes presence in person at that meeting so long as all Directors participating in the meeting are able to hear one another. Participation in a meeting through use of electronic transmission by and to the Corporation, other than conference telephone and electronic video screen communication, 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.

b. Each Director is provided the means of participating in all matters before the Board, including, without limitation, the capacity to propose, or to interpose an objection to, a specific action to be taken by the Corporation.

Section 12 - COMPENSATION. The Directors shall receive no compensation for their services as Directors.

Section 13 - CONTRACTS WITH DIRECTORS. No Director of this Corporation nor any other corporation, firm, association, or other entity in which one or more of this Corporation's Directors are directors or have a material financial interest, shall be interested, directly or indirectly, in any contract or transaction with this Corporation unless (1) the material facts regarding that Director's financial interest in such contract or transaction or regarding such common directorship, officership, or financial interest are fully disclosed in good faith and noted in the minutes; (2) such contract or transaction is authorized in good faith by a Committee or other body of the Board excluding the interested Directors and then ratified by the Board excluding the interested Directors; (3) before authorizing or approving the transaction, the Board considers, and in good faith decides after reasonable investigation that the Corporation could not obtain a more advantageous arrangement with reasonable effort under the circumstances; (4) concurrently with its consideration of such contract or transaction, the Board documents the information that it considers and the process it follows before authorizing or approving the transaction; and (5) the Corporation for its own benefit enters into the transaction, which is fair and reasonable to the Corporation at the time the transaction is entered into. This Section shall not apply to a transaction that is part of an educational, religious or charitable program of this Corporation if it (1) is approved or authorized by the Corporation in good faith and without unjustified favoritism and (2) results in a benefit to one or more Directors or their families because they are in the class of persons intended to be benefited by the educational, religious or charitable program of this Corporation.

Section 14 - DIRECTORS' INSPECTION RIGHTS. Every Director shall have the right at any reasonable time to inspect the Corporation's books, records, and documents of every kind, and to inspect the physical properties of the Corporation. The inspection may be made in person or by the Director's agent or attorney. The right of inspection includes the right to copy and make extracts of books, records, and documents of every kind.

ARTICLE VI
COMMITTEES

Section 1 - COMMITTEES GENERALLY. Except as otherwise provided by these Bylaws, the Board may, by resolution or resolutions passed by a majority of the members thereof, appoint standing or special Committees for any purpose and, if such Committees are comprised solely of Directors, delegate to such Committees any of the powers and authority of the Board, except the power and authority to adopt, amend or repeal these Bylaws, or such other powers as may be prohibited by law. Such Committees shall have power to act only in intervals between meetings of the Board and shall at all times be subject to the control of the Board. The Board, or if the Board does not act, the Committees, shall establish Rules and Regulations for meetings and shall meet at such times as is deemed necessary, provided that notice of all meetings shall be given to Committee members in the manner provided in Section 5 of Article IV and provided that the provisions of Section 12 of this Article VI entitled "Quorum" shall apply to all Committee meetings. No act of a Committee shall be valid unless approved by the vote or written consent of a majority of said Committee's members. Committees shall keep regular minutes of proceedings and report

the same to the Board from time to time, as the Board may require. Persons who are not Directors may be appointed to committees. Any committee composed of one or more persons whom are not Directors, shall act solely in an advisory capacity to the Board, and may in no respect bind or obligate the Board or the Corporation. All committees shall have a majority of disinterested Directors and/or persons (as defined in Section 1(c) of Article IV of these Bylaws). There shall be Medical Staff representation on any Committee deliberating the discharge of Medical Staff responsibilities. The Board may at any time assume any or part of the duties of any standing or special Committee, in which case those duties shall be temporarily removed from such Committee's responsibilities, until such time as the Board determines that such duties should be restored to such Committee's responsibilities.

Section 2 - EXECUTIVE COMMITTEE.

a. The Executive Committee shall be comprised of no more than seven (7) persons and shall be elected by a majority of the Directors in office. Each member of the Executive Committee shall be a Director of the Corporation. The Executive Committee shall include the following persons if they are Directors: the Chair of the Board, the senior ranking Vice Chair, the ranking Vice Chairs, the Treasurer, the Secretary, and the Chief of Staff. At least one member of the Executive Committee shall be a member of the Medical Staff of Beverly Hospital (the "Hospital").

b. Between meetings of the Board, the Executive Committee shall have and exercise authority of the Board in the management of the Corporation, excepting as to matters concerning which the full Board is required to act by law or by the Articles of Incorporation or by these Bylaws. The Executive Committee shall have and exercise such specific powers and perform such specific duties as prescribed by these Bylaws or as the Board shall from time to time prescribe or direct.

Section 3 - AUDIT AND FINANCE COMMITTEE. The Audit and Finance Committee shall consist of a minimum of three (3) Directors, including the Chief of Staff. The primary duty of the Audit and Finance Committee shall be to determine the financial feasibility of proposed short- and long-term corporate projects. It shall review the annual budget of the Corporation, review the monthly financial statements of the Corporation, review the Corporation's operating performance, counsel the Officers of the Corporation on both current and long-term fiscal affairs, and perform such other duties as may be assigned to it by the Board. The Audit and Finance Committee is charged with the following specific tasks:

a. Monitor assets and investments of the Corporation;

b. Verify the credibility of financial statements and internal controls;

c. Ensure that management's use of corporate financial resources is prudent;

d. Monitor operating budget variances;

e. Examine major capital expenditures;

f. Review, approve and recommend annual and longer-term Corporation budgets;

g. Provide recommendations to the Board on policies governing financial affairs of the Corporation;

h. Exercise oversight trusteeship, as directed by the Board, to verify that funds are used for intended purposes;

i. Receive and review periodical financial reports;

j. Determine and recommend the content and duration of Chief Financial Officer's ("CFO") report to the Board;

k. Provide oversight with respect to the Corporation's other expenditures;

l. Regularly review and evaluate the Corporation's Human Resources and Compensation Policies;

m. Oversee any independent audit that the Corporation chooses or is required to undertake, including without limitation: (i) assisting the Board in choosing an independent auditor and recommending termination of the auditor, if necessary, (ii) negotiating the auditor's compensation, (iii) conferring with the auditor regarding the Corporation's financial affairs, and (iv) reviewing and accepting or rejecting the audit.

Section 4 - STRATEGIC PLANNING COMMITTEE. The Strategic Planning Committee shall consist of a minimum of three (3) Directors, including the Chief of Staff-Elect of the Medical Staff. The primary duty of the Strategic Planning Committee shall be to assist the Board in the development, approval and implementation of a mission statement that will determine the course of action the Board will follow in its achieving its specific goals and objectives. In addition, it shall guide the development and implementation of vital and meaningful short and long-range strategic plans that will respond to environmental change and the evolving healthcare needs of the Corporation and the community, assume the ongoing responsibilities of regular evaluation and assessment of the strategic plan's currency and relevance, evaluate all proposed acquisitions of land, buildings, and equipment related to accepted strategic planning, assist in the development of plans for additions and improvements to the Corporation's buildings and grounds, report its recommendations with respect to selection of architects, engineers, or contractors, report its recommendations with respect to proposed construction contracts and keep advised of all construction work in progress, and perform such other duties as may be assigned to it by the Board.

Section 5 - GOVERNANCE COMMITTEE. The Governance Committee shall consist of a minimum of five (5) Directors including at least one (1) Physician Director, each of whom shall be designated by the Board. The primary duty of the Governance Committee shall be to assist the Board in developing and monitoring the effectiveness of the corporate structure and its existing members.

The Governance Committee is charged with the following special tasks:

a. Periodically review and make recommendation to the Board regarding the Bylaws;

b. Serve as liaison for and to assist in coordinating the efforts of the Board and the various auxiliary groups, whether incorporated or unincorporated which shall have been or which may be organized and operated for the support and assistance of the Corporation;

c. Propose one or more persons to fill vacancies on the Board. Whenever a person serving as a Director is elected Chief of Staff or Chief of Staff-Elect, the vacancy thereby created among

the Directors shall be filled as provided herein. In considering candidates for Director, the Governance Committee shall take into account: position description; willingness and ability to carry out the responsibilities of a Director; areas of interest and expertise; and experience in community organizations and services. The Board may, from time to time, identify other qualifications and/or criteria for nominees to the Board.

d. Develop and recommend to the Board a Performance Evaluation Tool for evaluating the President and Chief Executive Officer of the Corporation.

e. Propose one or more persons to fill each office.

f. Ensure the continued growth and development of the Directors.

g. Develop and implement an ongoing Recruitment and Orientation Program, a process by which Directors are made aware of key health issues facing the Corporation and community, as well as the process by which the Directors can utilize evaluation as a means of improving their overall effectiveness as individual Directors.

h. Ensure the Corporation has adopted and implemented policies and procedures which will require the Corporation and its employees to act in full compliance with all applicable laws, regulations, and policies.

i. Assist in the Board in fulfilling its responsibilities relating to accounting policies, financial reporting practices, and the quality and integrity of the Corporation's financial reporting.

j. Address and review matters concerning or relating to the Corporate Compliance Program.

k. Oversee and make recommendations to the Board on policies and procedures of the Corporation pertaining to the compliance of all rules, regulations, and requirements imposed by federal, state, and local governments relating to the operations and conduct of hospitals and providers of medical treatment to the public.

l. Perform such other duties as may be assigned to it by the Board.

Section 6 - QUALITY COMMITTEE. The Committee shall consist of five (5) Directors and at least two physicians, including the Chief of Staff. Its primary duty shall be to assess patient safety and the delivery of quality patient care throughout the Hospital. The Committee shall assist in determining the need for policies and procedures which result in the achievement, through continuous quality improvement, of the maximum benefit to patients in the Hospital in a customer-oriented and cost-effective manner.

The Quality Committee is charged with the following specific tasks:

a. Recommend policies and procedures which enable the medical staff to process applications and reappointments and the granting of clinical privileges in a timely and appropriate manner.

b. Monitor the performance of the medical staff in carrying out its responsibilities for evaluating and improving patient care.

c. Monitor the performance of all Hospital programs in developing and implementing quality improvement responsibilities and review to assure that the organization remains nationally accredited and locally respected for its quality of care.

d. Review periodic trend reports which reflect the overall performance of the Hospital in providing quality care in a customer-focused, cost-effective manner.

e. Ensure that the quality of services and their quantification is a Hospital-wide expectation of all operating units. Quality is defined through the objective answering of the following question: Was the proper service provided at the proper time, by the proper people, utilizing proper resources, with a proper outcome based on predetermined expectations?

f. Ensure that all operating programs develop a specific plan of implementing the concept of continuous quality improvement through individual and team initiatives. This includes implementation, evaluation and oversight processes within the appropriate medical/administrative/ governance structures.

g. Assist in the development of the process and the outcomes of identifying, reviewing and continuously improving and ensuring value throughout the Hospital through a Quality Committee.

Section 7 - ADVANCEMENT COMMITTEE shall comprise of 6-8 individuals who will assist in the planning and evaluation of the fundraising activities of the Hospital and Foundation. It is a representative group that includes up to two members each from the Board of Directors, Board of Trustees, senior administrative staff and medical staff of Beverly Hospital. Members should be willing to set an example of giving financial support, time and participation in the advancement of the Hospital's culture of philanthropy.

The specific responsibilities of the Advancement Committee members are to:

a. Serve as the primary advancement liaison between the Board of Trustees and Board of Directors.

b. Attend regular committee meetings.

c. Develop annual and ancillary fundraising objectives.

d. Review and give input on fundraising plans.

e. Monitor the success of all fundraising activities.

f. Maintain 100% participation by staff and volunteer leadership.

Section 8 - PRESIDENT/CEO EVALUATION COMMITTEE. The President/CEO Evaluation Committee shall consist of the Chair of the Board and the Chairs of the Audit and Finance, Governance, Quality, and Strategic Planning Committees. The Chair of the Board shall appoint a Physician Director to the committee if there is no Physician Member on this Committee. This Committee will be chaired by the Chair of the

Board. The primary duty of the President/CEO Evaluation Committee is to evaluate the President and Chief Executive Officer on an annual basis, using the Performance Evaluation Tool recommended by the Governance Committee and approved by the Board. The Committee shall recommend and regularly review a policy for succession, selection, and annual evaluation of the Chief Executive Officer of the Corporation. The President and Chief Executive Officer will be evaluated annually using the Performance Evaluation Tool recommended by the Governance Committee and approved by the Board.

Section 9 - SPECIAL COMMITTEES. Special committees and their chairpersons may be appointed by resolution adopted by a majority of the Directors then in office for such special tasks as circumstances warrant. All special committees shall limit their activities solely to the accomplishment of their tasks for which they are appointed and shall have no power to act except as specifically conferred by action of the Board. Upon completion of their tasks for which they were appointed, all such special committees shall stand discharged.

Section 10 - APPOINTMENT AND TERM OF OFFICE. Members of each Committee set forth in this Article VI shall, unless otherwise provided by these Bylaws, be appointed by the Board. The Chair of each Committee shall be designated by the Chair of the Board and shall be a Director. The Chair and each member of each Committee shall serve until the end of the fiscal year for which appointed or until his successor is appointed, or until such Committee is sooner terminated, or until he is removed, resigns, or otherwise ceases to qualify as a Chair or member, as the case may be, of the Committee. Chair and members of Special Committees shall serve for the life of the Committee unless they are sooner removed, resign, or cease to qualify as a Chair or member as the case may be.

Section 11 - QUORUM. A majority of the members of a Committee shall constitute a quorum except five (5) members shall constitute a quorum of the Executive Committee, and any transaction of a Committee shall require a majority vote of the quorum present at any meeting. Each member of a Committee, including the person presiding at the meetings, shall be entitled to one (1) vote.

Section 12 - REMOVAL OF MEMBERS OF COMMITTEES. The Board may, by resolution adopted by a majority of the Directors then in office, remove any member or members of any committee, at any time, with or without cause.

Section 13 - MEETINGS. Members of Committees, other than the Executive Committee, shall meet not less frequently than once a year, and in any event, at the call of the Chair of the Board, the Chair of the particular Committee or two (2) Committee members at such place as he, she, or they shall designate. The provisions of Sections 5, 8, 9, 10, and 11 of Article IV shall apply to all Committee meetings. Each Committee shall keep minutes of its proceedings and make a written report to the Board of its action within a reasonable time subsequent thereto.

ARTICLE VII
OFFICERS

Section 1 - OFFICERS. The Officers of the Corporation shall be a Chair of the Board, a President and Chief Executive Officer, a Vice Chair, a Secretary, a Treasurer, and a Chief Financial Officer. The Corporation may also have, at the discretion of the Board, one or more additional Vice Chairs, one or more Assistant Secretaries, one or more Assistant Treasurers, and such other Officers as the Board may

authorize. Any person may hold more than one office, except that the Chair of the Board may not serve concurrently as the Secretary or Chief Financial Officer.

Section 2 - ELECTION OF OFFICERS. All Officers of the Corporation shall be elected by the Board and shall serve at the pleasure of the Board, subject to the rights, if any, or any officer under any contract of employment.

Section 3 - TENURE OF OFFICERS. The tenure for Officers of the Corporation shall be limited to six (6) years maximum per office.

Section 4 - REMOVAL OF OFFICERS. Any Officer may be removed either with or without cause by a majority of the Directors then in office at any regular or special meeting of the Board. Should a vacancy occur in any office as a result of death, resignation, removal, disqualification or any other cause, the Board may delegate the powers and duties of such office to any Officer or to any Director until such time as a successor for such office has been selected.

Section 5 - CHAIR OF THE BOARD OF DIRECTORS. The Chair of the Board shall serve as an ex-officio member of all standing Committees, except the Governance Committee, and report annually to the Board on the current state of the Corporation. The Chair of the Board shall discharge all other duties as may be required by these Bylaws and from time to time may be assigned by the Board.

Section 6 - VICE CHAIR. In the absence or removal of the Chair of the Board, the Vice Chair, or the Vice Chairs in order of their rank as fixed by the Board, or if not ranked, the Vice Chair designated by the Board, shall perform all the duties of the Chair of the Board and when so acting shall have all of the powers of and be subject to all of the restrictions upon the Chair of the Board. The Chair of the Board, the Vice Chair, or the Vice Chairs shall perform such other duties as may from time to time be prescribed by the Board.

Section 7 - PRESIDENT AND CHIEF EXECUTIVE OFFICER. The President and Chief Executive Officer shall be the Chief Executive Officer of the Corporation and shall, subject at all times to the order and direction of the Board, be charged with the duty of consultation with proper Officers and Committees, the initiation and administration of the activities of the Corporation, and shall, unless otherwise ordered by the Board, attend all meetings of the Board. The President and Chief Executive Officer shall be qualified for the position by education and experience. The authority and duties of the President and Chief Executive Officer, as well as his qualifications, shall be more specifically defined in a written job description adopted by the Board. The President and Chief Executive Officer shall at all times conduct the business operated by this Corporation to conform with all national, state and municipal laws and ordinances and shall promptly respond to reports and recommendations from planning, regulatory and inspecting agencies.

Section 8 - SECRETARY. The Secretary shall keep or cause to be kept a book of the minutes at the principal office or at such other place as the Board may order of all meetings of the Board and the Executive Committee with the time and place of holding, whether regular or special, and if special how authorized, the notice thereof given, the names of those present, and the proceedings. The Secretary shall also keep or cause to be kept at the principal office, or such other place as the Board may order, a register showing the names of the members of the Board, and the members of the Executive Committee, and the address of each. The Secretary shall give or cause to be given notice of all the meetings of the Board, and of the Executive Committee required by these Bylaws or by law to be given, and shall keep the seal of the

Corporation in safe custody and have such other powers and perform such other duties as may be prescribed by the Board, the Executive Committee, or by these Bylaws.

Section 9 - TREASURER. The Treasurer shall not be an interested person as defined in these Bylaws. The Treasurer shall cause to be kept and maintained adequate and correct accounts of the properties and business transactions of the Corporation, including accounts of its assets, liabilities, receipts, disbursements, gains and losses. The books of account shall at all times be open to inspection by any member of the Board. The Treasurer shall have such other powers and perform such other duties as may be prescribed by the Board, the Executive Committee or by these Bylaws.

Section 10 - CHIEF FINANCIAL OFFICER. If required by the Board, the Chief Financial Officer ("CFO") of the Corporation shall give a bond for the faithful discharge of his duties in such form and with such surety or sureties as the Board shall determine. The CFO shall have charge and custody of all the funds of the Corporation and shall keep or cause to be kept, in books belonging to the Corporation, full and accurate accounts of all receipts and disbursements, and shall deposit all money and other valuable effects in the name of the Corporation in such depositories as may be designated for that purpose by the Board. The CFO shall disburse the funds of the Corporation as may be ordered by the Board, taking proper vouchers for such disbursements, and shall render to the Chair of the Board and Directors at the meetings of the Board whenever requested by them an account of all his transactions as CFO and of the financial condition of the Corporation.

Section 11 - ADDITIONAL OFFICERS. Officers and assistant Officers, in addition to those herein above described, who are elected or appointed by the Board, shall perform such duties as shall be assigned to them by the Chair of the Board, the Board, or the Executive Committee.

Section 12 - COMPENSATION AND EXPENSES. Officers shall serve without salary unless they are also employees of the Corporation. Expenses incurred in connection with performance of their official duties may be reimbursed to Officers upon approval of the Board.

ARTICLE VIII
MEDICAL STAFF

Section 1 - ORGANIZATION. The Board shall cause to be created a medical staff organization, to be known as the Medical Staff of the Hospital, whose membership shall be comprised of all physicians, dentists, and podiatrists, who are privileged to attend patients in the Hospital. Membership in this medical staff organization shall be a prerequisite to the exercise of clinical privileges in the Hospital, except as otherwise specifically provided in the Medical Staff Bylaws. No practitioner shall admit patients to the Hospital unless he is a member of the Medical Staff and has admitting privileges. Further, a Medical Staff member shall provide medical services to patients only within the scope of his clinical privileges or temporary privileges he is granted in accordance with the procedures in the Medical Staff Bylaws. In addition, the general medical condition of each patient in the Hospital will be the responsibility of a qualified physician member of the Medical Staff.

Subject to the oversight responsibility and ultimate authority of the Board, the organized Medical Staff shall be self-governing with respect to the professional work performed in the Hospital, and shall elect its own officers to direct Medical Staff activities and perform Medical Staff functions as set forth in the Medical Staff Bylaws.

Section 2 - MEDICAL STAFF BYLAWS RULES AND REGULATIONS.

a. Purpose. The Medical Staff shall propose and adopt by majority vote Bylaws, Rules, and Regulations for its internal governance, which shall be effective only when approved by the 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 Board. The Medical Staff Bylaws, Rules and Regulations shall state the purposes, 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.

b. Procedures. The Medical Staff shall have the initial responsibility to formulate, adopt, and recommend to the Board Medical Staff Bylaws and amendments thereto which shall be effective when approved by the Board. Neither the Medical Staff nor the Board may unilaterally amend the Medical Staff Bylaws, Rules & Regulations. No Medical Staff Bylaws or amendments shall become effective without approval by the Board as herein above provided. If the Medical Staff fails to exercise this responsibility in good faith and in a reasonable, timely, and responsible manner, and after written notice from the Board to such effect, including a reasonable period of time for a response, the Board may formulate or amend the Medical Staff Bylaws. In such event, Medical Staff recommendations and views shall be carefully considered by the Board during its deliberations and in its actions.

c. Minimum Requirements. The Medical Staff Bylaws shall address, at a minimum:

(1) The structure of the Medical Staff;

(2) The processes used to review credential (and re-credential) and delineate clinical privileges of physicians, and all other types of practitioners authorized by the Board to provide professional services at the Hospital;

(3) The responsibilities and qualifications for Medical Staff membership, and the process for appointment and re-appointment to membership on the Medical Staff;

(4) The duties and prerogatives of each category of membership on the Medical Staff;

(5) A listing of all of the officer positions for the Medical Staff, with their responsibilities and qualifications, and the process for selecting and/or electing and removing the officers;

(6) The qualifications and roles and responsibilities of the chairs of departments, as defined by the Medical Staff;

(7) The organization of the quality assurance activities of the Medical Staff as well as the mechanism used to conduct, evaluate, and revise such activities in conjunction with the Board;

(8) The indications and processes by which membership on the Medical Staff and clinical privileges may be terminated, revoked, restricted, automatically suspended, summarily suspended or limited;

(9) The mechanism for fair hearing and appeal procedures, which at a minimum, shall include the process for scheduling and conducting hearings and appeals, including for creating a fair hearing committee;

(10) Acceptable standards of conduct for Medical Staff members, applicants and other credentialed practitioners such as Allied Health Professionals;

(11) A delineation of which Medical Staff members shall have the right to vote on Medical Staff matters;

(12) The requirements for completing and documenting medical histories and physical examinations;

(13) The Medical Executive Committee's function, composition, and duties, as determined by the Medical Staff and approved by the Board;

(14) The authority delegated to the Medical Executive Committee by the Medical Staff to act on its behalf, within the scope of responsibilities as defined by the Medical Staff, and how such authority is delegated and removed;

(15) The process, as determined by the Medical Staff and approved by the Board, for selecting and/or electing and removing all members of the Medical Executive Committee;

(16) The process for adopting and amending the Medical Staff Bylaws and Rules and Regulations;

(17) The process by which individual members or groups of Medical Staff members may raise directly with the Board, issues, and/or submit to the Board proposals for or amendments to Medical Staff Bylaws, Rules and Regulations and Medical Staff Policies, in the absence of support from the Medical Executive Committee; and

(18) The process by which the Medical Executive Committee shall resolve any conflicts over Bylaws, Rules, and/or Policies with groups of or individual Medical Staff members.

Section 3 - MEDICAL STAFF MEMBERSHIP AND CLINICAL PRIVILEGES.

a. Delegation to the Medical Staff. The Board shall delegate 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 shall require that the Staff adopt and forward to its specific written recommendations with appropriate supporting documentation that will allow the Board to take informed action.

b. Action by the Board After Medical Staff Recommendation. Final action on all matters relating to Medical Staff membership status, clinical privileges, and corrective action shall be taken by the Board within a reasonable period of time as specified in and in accordance with the provisions of the Medical Staff Bylaws after considering the recommendations of the Medical Staff, except as otherwise provided in this Article. Whenever the Board does not concur in the Medical Staff recommendation relative to Medical Staff membership or the granting or revision of clinical privileges following the conclusion of the

practitioner's exercise of fair hearing rights, it shall refer the matter to an Ad Hoc Committee consisting of three (3) members of the Medical Staff selected by the Chief of Staff, and three (3) non-physician members of the Board selected by the Chair of the Board, for review and recommendation before a final decision is made by the Board. The Ad Hoc Committee shall make a recommendation to the Board regarding the matter before it and the Board shall make a final decision within a reasonable period of time.

c. Unilateral Action by the Board of Directors.

(1) Action on Application. If the Medical Staff fails to make a recommendation to the Board regarding an application for membership or clinical privileges, within the times specified in the Medical Staff Bylaws, the Board shall request the Executive Committee to act on the application within thirty (30) days. If the Medical Staff fails to act on the application by the end of that period, the Board may act on the application. Such Board action shall be based on a documented investigation and evaluation of the applicant's current ability, judgment, and character, and the Board shall confer with the Medical Executive Committee, if possible, prior to taking final action on the application.

(2) Corrective Action. In those instances in which the Executive Committee of the Medical Staff fails to investigate or to initiate disciplinary action, and when such failure is contrary to the weight of the evidence, the Board shall have the authority to direct the Executive Committee of the Medical Staff to initiate an investigation or a disciplinary action, but only after consultation by the Board with the Executive Committee of the Medical Staff. No such action shall be taken by the Board in an unreasonable manner.

In the event the Executive Committee of the Medical Staff fails to take action in response to such a direction from the Board, the Board shall have authority to take corrective action against a Medical Staff member. Such action shall only be taken after written notice to the Executive Committee of the Medical Staff and shall fully comply with the procedures and rules applicable to peer review as set forth in Articles VII and VIII of the Medical Staff Bylaws.

d. Summary Suspension. The Board or its designees may summarily restrict or suspend a practitioner's clinical privileges only if:

(1) Neither the Chief of Staff, the Executive Committee of the Medical Staff, nor the Chair of the department in which the practitioner holds privileges, or their designees, are available to summarily suspend the practitioner's clinical privileges despite a reasonable attempt to contact such persons or Committee; and

(2) The Board or its designee determines that failure to summarily restrict or suspend the practitioner's clinical privileges may result in imminent danger to the health of any individual. Any such summary suspension or restriction by the Board or its designee is subject to ratification by the Executive Committee of the Medical Staff, and if not so ratified within two (2) working days, excluding weekends and holidays, the summary suspension or restriction shall terminate automatically.

e. Criteria for Board Action. When acting on matters of Medical Staff membership status, the Board shall consider the Staff's recommendations, the supporting information on which they are based, the Hospital's and the community's needs, 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 Board shall consider the Staffs recommendations, the supporting information on which they

are based, the Hospital's and community's needs, and such additional criteria as are set forth in the Medical Staff Bylaws. In reaching its decision, the Board shall give great weight to the recommendations of the Executive Committee of the Medical Staff, except when a judicial review Committee has rendered a recommendation to the Board and the Executive Committee has not appealed that recommendation, the Board shall give great weight to recommendation of the judicial review Committee. In no event shall the Board act in an arbitrary or capricious manner. 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, or on the basis of any other criterion unrelated to good patient care at the Hospital, to professional qualifications, to the Hospital's purposes, needs and capabilities, or to community needs.

f. 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 an individual appointment. Appointments to the Medical Staff may be for a maximum term of two (2) years.

g. Procedure. The procedures to be followed by the Medical Staff and the Board in acting on matters of membership status, clinical privileges, and corrective action shall be as specified in the Medical Staff Bylaws.

Section 4 - FAIR HEARING PROCEDURES. The Board shall require that any potential or actual adverse action recommended or taken by the Board or the Executive Committee of the Medical Staff with respect to a practitioner's Staff appointment, reappointment, department affiliation, Staff category, admitting prerogatives or clinical privileges shall be accomplished in accordance with the procedures set forth in the Medical Staff Bylaws as approved by the Board.

Such procedures shall, at a minimum, be those required by law. For the purposes of this Section, a potential or actual adverse action shall be as defined in Article VIII of the Medical Staff Bylaws.

Section 5 - SPECIFIED PROFESSIONAL PERSONNEL. The Board shall delegate to the Medical Staff the responsibility and authority to investigate and evaluate each application by a specified health professional for specified services, department affiliation, and modification in the services such specified professional personnel may perform, and shall require that the Staff or a designated component thereof make recommendation to it or to its designee thereon.

Section 6 - DEPARTMENT CHAIRS. The Board shall delegate to the Medical Staff the responsibility and authority to evaluate and nominate candidates to serve as chairs for each basic and supplemental medical service in accordance with the procedure and for the terms specified in the Medical Staff Bylaws, and shall require that the Medical Staff, or a component or Committee thereof, make recommendations of candidates to the Board for final approval.

Section 7 - EFFECT OF PROVISIONS ON CONTRACTUAL RELATIONSHIPS. The provisions of this Article and the fair hearing procedures of the Medical Staff Bylaws shall not apply to a practitioner who is under contract with the Hospital, and the clinical privileges and Medical Staff membership of such a practitioner shall instead be subject to the terms of the practitioner's contract; provided, however, that the provisions of this Article and the fair hearing procedures of the Medical Staff Bylaws shall apply when either (1) Staff membership status or clinical privileges independent of a practitioner's contract are to be limited or

terminated, or (2) the limitation or termination is for a medical disciplinary cause or reason, as that term is defined in Article VIII of the Medical Staff Bylaws.

Section 8 - ALLIED HEALTH PROFESSIONALS. The Board shall delegate to the Medical Staff the responsibility and authority to investigate and evaluate each application by an Allied Health Professional for specified services, department affiliation (if any), and modification in the services such Allied Health Professional may perform, and shall require that the staff or a designated component thereof make recommendation to it or to its designee thereon. Further, the Board, upon recommendation from the Medical Staff, shall determine which categories of Allied Health Professionals may practice at the Hospital, as shall be set forth in the Medical Staff Bylaws.

Section 9 - DISPUTE RESOLUTION. In the event of a dispute between the Medical Staff and the Board that cannot be resolved informally, the Medical Executive Committee or the Board, or both, may, upon its or their own initiative, invoke the formal dispute resolution process established herein and in the Medical Staff Bylaws. In addition, the dispute resolution process shall be invoked upon written request to the Medical Executive Committee of twenty-five (25%) of the voting members of the Medical Staff. In the event the Medical Executive Committee declines to invoke formal dispute resolution, such process shall also be invoked upon written petition to the Board of fifty percent (50%) of the voting members of the Medical Staff.

Where a formal dispute resolution has been invoked, the procedure described in Section 16.2 of the Medical Staff Bylaws (Dispute Resolution Forum) shall be followed.

ARTICLE IX
QUALITY OF PROFESSIONAL SERVICES

Section 1 - BOARD OF DIRECTORS' RESPONSIBILITY. The Board shall require: (a) that the Medical and Administrative Staffs prepare and maintain adequate and accurate medical records for all patients and (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 Board. All such policies and procedures, bylaws, rules and regulations shall be reviewed at least every three (3) years unless a more frequent review cycle is mandated by applicable law, regulation or accrediting standard.

The Board shall further require, after considering the recommendations of the Medical Staff, the conduct of specific review and evaluation activities to assess, preserve, and improve the overall quality and efficiency of patient care in the Hospital. The Board shall also require the Medical Staff to develop and maintain mechanisms to assure that (a) one level of patient care is provided in the Hospital, and that (b) all patients with the same health problem receive the same level of care in the Hospital, and such mechanisms shall be approved by the Board.

The Board shall provide whatever administrative assistance is reasonably necessary to support and facilitate the implementation and the ongoing operation of these review and evaluation activities, and that (c) on at least an annual basis, there shall be submitted for review to the Board a report on staff competence, for all persons providing services in the Hospital, including contract staff, who are not subject to the Medical Staff clinical privilege delineation process.

The Board shall require, further, that: (1) Policies are adopted and enforced to assure that Hospital employees, Medical Staff members and other patient care providers observe all rights of patients guaranteed under California and Federal law; and (2) Policies are adopted and enforced to assure that all

Hospital employees, Medical Staff members and other patient care providers are familiar with and abide at all times the confidentiality requirements for patient health information, and that the specific requirements of California and Federal law (including, but not limited to the Health Insurance Portability and Accountability Act -- "HIPAA") are adhered to by all personnel providing services at the Hospital.

Section 2 - MEDICAL STAFF ACCOUNTABILITY TO BOARD OF DIRECTORS. The Medical Staff shall conduct and be accountable to the 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. The conduct of periodic meetings at regular intervals to review and evaluate the quality of patient care (generally on a retrospective basis) through a valid and reliable patient care audit procedure based upon a review of patient medical records;

b. Ongoing monitoring of patient care practices through the defined functions of the Medical Staff;

c. Definition of the clinical privileges which may be appropriately granted within the Hospital and within each department, delineation of clinical privileges for members of the Medical Staff commensurate with individual credentials and demonstrated ability and judgment, and assignment of patient care responsibilities to other health care professionals consistent with the individual licensure, qualifications and demonstrated ability;

d. Provision of continuing professional education, shaped primarily by the needs identified through the review and evaluation activities;

e. Review of utilization of the Hospital's medical resources to provide for their allocation to meet the needs of the patients;

f. The preparation and maintenance of a complete and accurate medical record for each patient;

g. Such other measures as the 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; including but not limited to preparing jointly with the Hospital's Administration, an annual review of and recommendations for the comprehensiveness and integration of a Hospital-wide quality improvement program; and

h. Implement, and report to the Board on, the activities and mechanisms for monitoring and evaluating the quality of patient care, for identifying and resolving problems, and for identifying opportunities to improve patient care. The Chief of Staff and the Hospital's quality assessment director shall report to the Board on a regular basis during Board meetings regarding the Medical Staff's program of monitoring, reviewing and appraising the quality of professional care rendered in the Hospital, and shall report on any specific problems identified by Administration and the Medical Staff, respectively, and how such problems are being resolved. The Board, through the Chief Executive Officer and the Chief of Staff, shall support and advise the Medical Staff's activities and processes for monitoring, reviewing, and appraising the quality of patient care.

Section 3 - DOCUMENTATION. The Board shall require, receive, consider, and act upon the findings and recommendations emanating from the activities required by Section 2 of this Article IX. All such findings and recommendations shall be in writing, signed by the person responsible for conducting the review activities and supported and accompanied by appropriate documentation upon which the Board can take informed action.

ARTICLE X
INDEMNIFICATION AND INSURANCE

Section 1 - RIGHT OF INDEMNIFICATION. To the fullest extent permitted by law, this Corporation shall indemnify its Directors and Officers, and may indemnify employees and other persons described in California Corporations Code Section 5238(a), including persons formerly occupying any such positions, against all expenses, judgments, fines, settlements, and other amounts actually and reasonably incurred by them in connection with any "proceeding," as that term is used in that Section, and including an action by or in the right of the Corporation, by reason of the fact that the person is or was a person described in that Section. "Expenses," as used in this bylaw, shall have the same meaning as in that Section of the Corporations Code.

On written request to the Board by any person seeking indemnification under California Corporations Code Section 5238(b) or Section 5238(c), the Board shall promptly decide under California Corporations Code Section 5238(e) whether the applicable standard of conduct set forth in California Corporations Code Section 5238(b) or Section 5238(c) has been met and, if so, the Board shall authorize indemnification. If the Board cannot authorize indemnification, because the number of Directors who are parties to the proceeding with respect to which indemnification is sought prevents the formation of a quorum of Directors who are not parties to that proceeding, the person seeking indemnification must seek authorization from the court in which the proceeding is or was pending, in accordance with Section 5238(e)(3).

To the fullest extent permitted by law and except as otherwise determined by the Board in a specific instance, expenses incurred by a person seeking indemnification under this Section in defending any proceeding covered by this Section 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.

Section 2 - INSURANCE. This Corporation shall have the right, and shall use its best efforts, to purchase and maintain insurance to the full extent permitted by law on behalf of its Officers, Directors, employees, and other agents, to cover any liability asserted against or incurred by any Officer, Director, employee, or agent in such capacity or arising from the Officer's, Director's, employee's, or agent's status as such.

ARTICLE XI
AUXILIARY ORGANIZATIONS

Section 1 - GENERAL. From time to time, the Corporation may establish adjunct organizations, including advisory boards and Hospital auxiliaries. Each such group shall establish its own Constitution or Articles of Incorporation, Bylaws and Rules and Regulations and present them to the Board for approval, and all amendments thereto shall also be subject to the approval of the Board. These Bylaws and the Articles of

Incorporation of this Corporation shall prevail over the documents and actions of such adjunct and subordinate groups.

ARTICLE XII
GENERAL PROVISIONS

Section 1 - CONTRACTS. The Board or the Executive Committee may authorize any Officer or Officers, agent or agents, to enter into any contract or execute or deliver any instrument in the name of and on behalf of the Corporation, and such authority may be general or confined to specific instances.

Section 2 - DEPOSITS. All funds of the Corporation not otherwise employed shall be deposited from time to time to the credit of the Corporation in such banks, trust companies or other depositories as the Board or the Executive Committee may select.

Section 3 - CHECKS. All checks, drafts or other orders for the payment of money, notes, or other evidences of indebtedness issued in the name of the Corporation shall be signed by such Officer or Officers, agent or agents, of the Corporation and in such manner as shall from time to time be determined by resolution of the Board or the Executive Committee.

Section 4 - LOANS. No loans shall be made by or to this Corporation and no evidences of indebtedness shall be issued in this name unless authorized by a resolution of the Board or the Executive Committee. Such authority may be general or confined to specific instances; provided, however, that no loans shall be made by the Corporation to its Directors, or Officers.

Section 5 - VOTING SHARES. The Corporation may vote any and all shares held by it in any other Corporation by such officer, agent or proxy as the Board may appoint, or in default of any such appointment, by its Chair or by any Vice Chair and, in such case, such officers, or any of them, may likewise appoint a proxy to vote said shares.

Section 6 - CONFLICT OF INTEREST. As further and more specifically provided in the Corporation's Statement of Policy Concerning Conflicts of Interest which is incorporated herein), any director, officer, committee member or employee influencing the actions of the Corporation, who has a material personal, professional, or business interest in a position that directly or indirectly, relate to a contract or other transaction presented to the Board, or a committee thereof, for authorization, approval, or ratification, shall disclose the nature and extent of that person's financial interest to the Board or committee prior to its taking any action on such contract or transaction. Such person shall not vote on nor attempt to influence any vote related to such contract or transaction; nor shall such person participate (other than to respond to questions of the Board) in the discussions or deliberations with respect to such contract or transaction. Such person may be counted in determining the existence of a quorum at any meeting where the contract or transaction is under discussion or is being voted upon.

Section 7 - NON-DISCRIMINATION. The Corporation shall operate in all respects, on a completely non-discriminatory basis, without regard to age, race, national origin, color, creed, religion, sex, or sexual orientation. All facilities of the Hospital shall be generally available to employees, the public and patients on an equal, non-discriminatory basis, including, but not limited to, waiting rooms, toilets, locker rooms, dining facilities and therapeutic services. Accommodation assignments of patients shall be made without regard to age, race, national origin, color, creed, religion, sex, or, sexual orientation. The Corporation shall

not discriminate as to hiring, firing, compensation, terms, conditions, or privileges of employment on the basis of age, race, national origin, color, creed, religion, sex, sexual orientation, or disability.

Section 8 - ANNUAL REPORT. The Board shall cause an annual report to be sent to Directors within 120 days after the end of the Corporation's fiscal year. That report shall contain the following information, in appropriate detail:

a. The assets and liabilities, including the trust funds, of the Corporation as of the end of the fiscal year;

b. The principal changes in assets and liabilities, including trust funds;

c. The Corporation's revenue or receipts, both unrestricted and restricted to particular purposes;

d. The Corporation's expenses or disbursements for both general and restricted purposes;

e. Any information required by Section 6322 of the California Corporations Code; and

f. An independent accountants' report or, if none, the certificate of an authorized officer of the Corporation that such statements were prepared without audit from the Corporation's books and records.

Section 9 - ANNUAL STATEMENT REGARDING INTERESTED PERSON TRANSACTIONS. As part of the annual report, or as a separate document if no annual report is issued, the Corporation shall, within 120 days after the end of the Corporation's fiscal year, annually prepare and furnish to each Director a statement of any transaction or indemnification of the following kind: (1) Any transaction (a) in which the Corporation was a party, (b) in which an "interested person" had a direct or indirect material financial interest, and (c) that involved more than $50,000 or was one of several transactions with the same interested person involving, in the aggregate, more than $50,000. For this purpose, an "interested person" is any Director or officer of the Corporation or its parent, or its subsidiary; or (ii) any holder of more than 10 percent of the voting power of the Corporation, its parent, or its subsidiary. The statement shall include a brief description of the transaction, the names of interested persons involved, their relationship to the Corporation, the nature of their interest in the transaction, and, if practicable, the amount of that interest, provided that if the transaction was with a partnership in which the interested person is a partner, only the interest of the partnership need be stated. (2) Any indemnifications or advances aggregating more than $10,000 paid during the fiscal year to any officer or Director of the Corporation under these Bylaws, unless that indemnification has already been approved by the Board under California Corporations Code Section 5238(e)(2).

Section 10 - ELECTRONIC TRANSMISSION. Subject to any guidelines and procedures that the Board may adopt from time to time, the terms "written", and "in writing" as used in these Bylaws include any form of recorded message in the English language capable of comprehension by ordinary visual means and may include electronic transmissions, such as facsimile or email, provided (i) for electronic transmissions from the Corporation, the Corporation has obtained an unrevoked written consent from the recipient to the use of such means of communication; (ii) for electronic transmissions to the Corporation, the Corporation has in effect reasonable measures to verify that the sender is the individual purporting to have sent such

transmission; and (iii) the transmission creates a record that can be retained, retrieved, reviewed, and rendered into clearly legible tangible form.

ARTICLE XIII
ACCOUNTING YEAR AND TAX AUDIT

Section 1 - ACCOUNTING YEAR. The accounting year of the Corporation shall be the calendar year unless otherwise changed by the Board.

Section 2 - AUDIT. At the end of the accounting year the books of the Corporation shall be closed and audited by a certified public accountant selected by the Audit and Finance Committee. The financial report of the auditor shall be promptly mailed to each Director.

ARTICLE XIV
AMENDMENTS

The Bylaws of the Corporation may be altered, amended or repealed and new Bylaws adopted only by the vote of two-thirds (2/3) of the members of the Board of the Corporation.

CERTIFICATE

This is to certify that the attached Bylaws of **BEVERLY COMMUNITY HOSPITAL ASSOCIATION** have been duly adopted and approved as amended by the Board of Directors of said Corporation at a meeting of said Board of Directors held on July 24, 2012.

IN WITNESS WHEREOF, the undersigned, duly elected and acting as Secretary of this Corporation, has signed this Certificate and affixed a seal of this Corporation hereto this 24th day of July 2012.

Rosemary Orozco Secretary
Secretary, Board of Directors

[SEAL]

EXHIBIT 10

CURRENT ARTICLES OF INCORPORATION OF MONTEBELLO

1169543

ARTICLES OF INCORPORATION

OF

MONTEBELLO COMMUNITY HEALTH SERVICES, INC.

I

The name of this corporation is MONTEBELLO COMMUNITY HEALTH SERVICES, INC.

II

This corporation is a nonprofit public benefit corporation and is not organized for the private gain of any person. It is organized under the California Nonprofit Public Benefit Corporation Law for charitable purposes.

III

A. The general purpose for which this corporation is formed is to plan, develop, coordinate, direct, and control

a system of health care entities exclusively for the benefit of, and supervised or controlled in connection with, BEVERLY COMMUNITY HOSPITAL ASSOCIATION, a California nonprofit corporation.

B. The specific purposes of this corporation include:

(a) providing managerial support and guidance;

(b) engaging in financial planning;

(c) operating medical and public health education programs;

(d) engaging in long-range health care planning; and

(e) promoting the efficient delivery and financing of health care in the Montebello community;

to, or for, BEVERLY COMMUNITY HOSPITAL ASSOCIATION and other organizations affiliated with BEVERLY COMMUNITY HOSPITAL ASSOCIATION which may be controlled by this corporation.

IV

A. This corporation shall have no members.

B. The number, manner of selection, rights and qualifications of the directors of this corporation shall be provided in the Bylaws.

V

The name and address in the State of California of this corporation's initial agent for service of process is:

Wayne J. Miller
McDermott & Trayner
615 South Flower Street
Suite 1900
Los Angeles, California 90017

VI

A. This corporation is organized and operated exclusively: (a) for charitable purposes within the meaning of Section 501(c)(3) of the Internal Revenue Code, and (b) for the benefit of organizations which are other than private foundations within the meaning of Sections 509(a)(1) and 509(a)(2) of the Internal Revenue Code.

B. Notwithstanding any other provision of these articles, this corporation shall not carry on any other activities not permitted to be carried on (a) by a corporation exempt from federal income tax under Section 501(c)(3) of the Internal Revenue Code, (b) by a corporation contributions to which are deductible under Section 170(c)(2) of the Internal Revenue Code, or (c) by a corporation other than a private foundation within the meaning of Section 509(a)(3) of the Internal Revenue Code.

C. No substantial part of the activities of this corporation shall consist of carrying on propaganda, or otherwise attempting to influence legislation, and this corporation shall not participate or intervene in any

political campaign (including the publishing or distribution of statements) on behalf of any candidate for public office.

VII

A. The property of this corporation is irrevocably dedicated to charitable purposes and no part of the net income or assets of this corporation shall inure to the benefit of any director, officer, or member thereof or to the benefit of any private person.

B. Upon the dissolution or winding up of the corporation, its assets remaining after payment or provision for payment of all debts and liabilities of this corporation, shall be distributed to BEVERLY COMMUNITY HOSPITAL ASSOCIATION, if it is then in existence and qualified as an exempt organization under Section 501(c)(3) of the Internal Revenue Code and an organization other than a private foundation within the meaning of Sections 509(a)(1) or 509(a)(2) of the Internal Revenue Code, for use in furtherance of the purposes of this corporation as set forth in Article III of these Articles of Incorporation. If BEVERLY COMMUNITY HOSPITAL ASSOCIATION is not then in existence, or so qualified, then any remaining assets shall be distributed to a nonprofit fund, foundation, or corporation selected by this corporation's Board of Directors which is then qualified as an charitable organization within the meaning Section 501(c)(3) of the Internal Revenue Code and as an organization other than a

private foundation within the meaning of Sections 509(a)(1) or 509 (a)(2) of the Internal Revenue Code.

VIII

Any reference in these articles to a section of the Internal Revenue Code shall be interpreted to include a reference to the corresponding provisions of any applicable future United States Internal Revenue law.

Dated: February 18, 1983

[redacted]

Wayne J. Miller
Incorporator

I hereby declare that I am the person who executed the foregoing Articles of Incorporation, which execution is my act and deed.

[redacted]

Wayne J. Miller
Incorporator

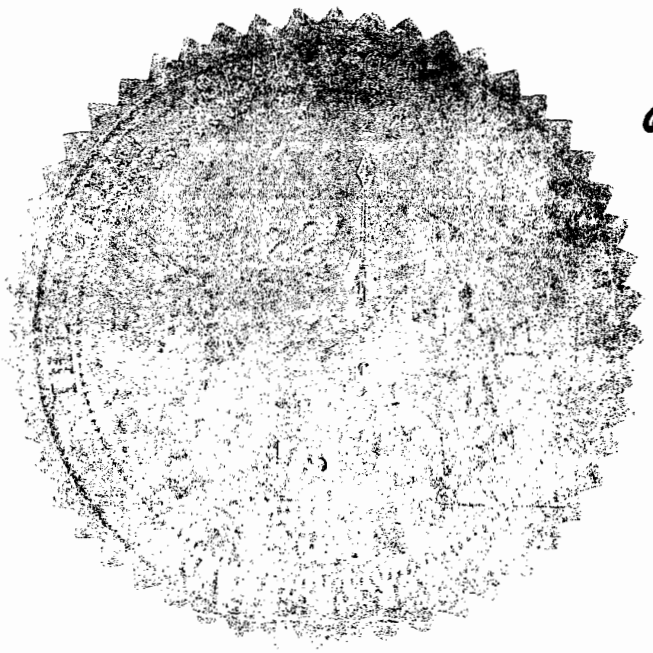
State of California

Office of the
Secretary of State

I, FRANK M. JORDAN, Secretary of State of the State of California, hereby certify:

That I have compared the annexed transcript with the RECORD *on file in my office, of which it purports to be a copy, and that the same is a full, true and correct copy thereof.*

IN WITNESS WHEREOF, *I hereunto set my hand and affix the Great Seal of the State of California this* 9th day of May, 1949.



Frank M. Jordan
Secretary of State

By _____
Deputy

STATE OF CALIFORNIA

OFFICE OF THE
SECRETARY OF STATE

(PHOTOCOPY CERTIFICATION)

I, *EDMUND G. BROWN JR.*, Secretary of State of the State of California, hereby certify:

That the photographic reproduction hereunto annexed was prepared by and in this office from the record on file of which it purports to be a copy, and that it is full, true and correct.

IN WITNESS WHEREOF, I execute this certificate and affix the Great Seal of the State of California this

Edmund G. Brown Jr.

Secretary of State

EXHIBIT 11

CURRENT BYLAWS OF MONTEBELLO

MONTEBELLO COMMUNITY HEALTH SERVICES, INC.

RESTATED

BYLAWS

OF

MONTEBELLO COMMUNITY HEALTH SERVICES, INC.

Revised: October 20, 1987
July 20, 1993
September 28, 1999
October 22, 2002
July 22, 2003
December 16, 2003
November 7, 2004
September 25, 2007
June 24, 2008
November 24, 2009
November 16, 2010
Revised May 27, 2014

MONTEBELLO COMMUNITY HEALTH SERVICES, INC.

BYLAWS
OF
MONTEBELLO COMMUNITY HEALTH SERVICES, INC.

ARTICLE I

PURPOSES OF THE CORPORATION

The corporation is a charitable corporation organized and operated pursuant to the California nonprofit Public Benefit Corporation law, and is supervised or controlled in connection with, within the meaning of Section 509(a)(3) of the Internal Revenue Code of 1954, as amended, and of Section 1.509(a)-4(h)(1) of the United States Treasury Regulations, Beverly Community Hospital Association, a nonprofit charitable organization organized and operated pursuant to the California Nonprofit Public Benefit Corporation law. The corporation shall further such purposes as are not or may hereafter be specified in its Articles of Incorporation for the exclusive benefit of Beverly Community Hospital Association, which may include performing activities for, or providing services to, Beverly Community Hospital Association, and organizations affiliated with Beverly Community Hospital Association, which the corporation may control.

ARTICLE II

OFFICES AND SEAL

Section 1. OFFICES. The principal office for the transaction of the business of the corporation shall be in the County of Los Angeles, State of California. The corporation may also have an office or offices within or without the State of California as the Board of Directors (sometimes referred to hereinafter as either "Board" or "Board of Directors") may from time to time establish.

Section 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 word "California".

ARTICLE III

MEMBERSHIP

Section 1. NO MEMBERS. The corporation shall have no members within the meaning of Section 5056 of the California Corporations Code.

ARTICLE IV

BOARD OF DIRECTORS

Section 1. POWERS. Except as otherwise provided by the Articles of Incorporation or these Bylaws, the powers of the corporation shall be exercised, its property controlled and its affairs conducted by the Board of Directors.

The specific powers of the Board of Directors shall include, but shall not be limited to, the following, which powers may be more fully delineated in other sections of these Bylaws:

(a) The selection and removal of the Officers of the corporation including, but not limited to, the selection, evaluation and removal of the President and Chief Executive Officer of the corporation. The President and Chief Executive Officer will be evaluated annually using the Performance Evaluation Tool recommended by the Personnel Committee and approved by the Board of Directors.

(b) The appointment of Committees of the Board of Directors.

(c) [Reserved.]

(d) The review and approval of the annual budget of the corporation, as developed by the officers of the corporation.

Section 2. NUMBER AND QUALIFICATIONS. The Board of Directors shall consist of no less than **nine (9)** members and no more than **seventeen (17)** members (sometimes hereinafter referred to individually as "Director" or collectively as "Directors"), and shall be composed of the duly elected members of the Board of Directors of Beverly Community Hospital Association.

The Chief of Staff-Elect of the medical staff (the "Medical Staff") of Beverly Hospital shall be entitled to attend meetings of the Board and to participate in deliberations but shall not be entitled to vote and shall not be included among the Directors membership criteria of no more than **seventeen (17)** members. Directors shall be nominated by the Governance Committee as provided in Article V, Section 6. The Governance Committee selected by the Board of Directors, as described in Section 6 of Article V hereof, shall utilize such criteria as set forth in said Section and such additional criteria and qualifications as the Board of Directors may specify from time to time for the nomination of persons to serve as Directors.

Section 3. TERM, TENURE AND ELECTION. The Board of Directors shall be elected or reelected tri-annually at the annual meeting of the Board of Directors, which shall be held in November of each calendar year. The term of office of a Director shall be three (3) years, except as provided otherwise in Article IV, Section 2 of the Bylaws of Beverly Community Hospital Association. There is no maximum tenure limit for a Director.

Section 4. RESIGNATION. Any Director may resign at any time, either by oral tender of resignation at any meeting of the Board of Directors or by giving written notice thereof to the Secretary of the corporation. Such resignation shall take effect at the time specified therefor and, unless otherwise specified with respect thereto, the acceptance of such resignation shall not be necessary to make it effective. Failure of any Director to remain qualified as provided in these Bylaws shall be deemed a resignation. Except upon notice to the Attorney General, no Director may resign where the corporation would then be left without a duly elected Director or Directors in charge of its affairs.

Section 5. REMOVAL. A Director may be removed, with or without cause, by action of a vote of two-thirds (2/3) of the Directors on the Board of Directors. Grounds for removal shall in any event include failure to attend two-thirds of the duly noticed meetings of the Board in any one-year and any other grounds provided by law.

Section 6. VACANCIES. Any vacancy occurring in the Board of Directors shall be filled by the remaining members of the Board of Directors.

Section 7. ANNUAL MEETING OF THE BOARD OF DIRECTORS. The annual meeting of the Board of Directors shall be held in November of each calendar year at such time and place as the Board shall fix from time to time for the purpose of electing Officers and for the transactions of such other business as may come before the meeting.

Section 8. REGULAR MEETINGS. Regular meetings of the Board of Directors shall be held on the fourth Tuesday of each month at such time and place as the Board may fix by resolution from time to time.

Section 9. SPECIAL MEETINGS. Special meetings of the Board of Directors may be called by or at the request of:

(i) four (4) or more Directors; or
(ii) the Chairman.

Section 10. NOTICE OF MEETINGS. No notice of annual or regular meetings of the Board need be given. Notice of the time and place of all special meetings shall be delivered personally or by telephone to each Director and the President and Chief Executive Officer or sent by first class mail or telegram, charge prepaid, addressed to each Director and the President and Chief Executive Officer at that persons address as it is shown on the records of the corporation. In case the notice is mailed, it shall be deposited in the United States mail at least days before the time of the holding of the meeting. In case the notice is delivered personally, or by telephone or telegram, it shall be delivered personally or by telephone or to the telegraph company at least forty-eight (48) hours before the time of the holding of the meeting. Any oral notice given personally or by telephone may be communicated either to the Director or to a person at the office of the Director who the person giving the notice has reason to believe will promptly communicate it to the Director. The notice need not specify the purpose of the meeting nor the place if the meeting is to be held at the principal office of the corporation.

Section 11. QUORUM AND VOTING. A majority of the Board of Directors shall constitute a quorum for the transaction of business at any meeting of the Board of Directors, but if fewer than a majority thereof are present at the meeting, a majority of the Directors present may adjourn and reconvene the meeting from time to time without further notice. Unless otherwise provided by the Articles of Incorporation, these Bylaws, or by applicable law, every act or decision made by a majority of the Directors present at a duly held meeting at which a quorum is present is an act of the Board of Directors. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of Directors, if any action taken is approved by at least a majority of the required quorum for that meeting.

Section 12. VALIDATION OF MEETING. The transactions of the Board of Directors at any meetings, however called or noticed, or wherever held, shall be as valid as though had at a meeting duly held after call and notice if a quorum be present and if, either before or after the meeting, each Director not present signs a written waiver of notice or a consent to the holding of such a meeting or an approval of the minutes thereof. All such waivers, consents or approvals shall be filed with the corporate records and made a part of the minutes of the meeting.

Section 13. ACTION WITHOUT MEETING AND CONFERENCE TELEPHONE MEETINGS.

(a) **Written Consent**. Any action required or permitted to be taken by the Board of Directors under any provision of law, the Articles of Incorporation or these Bylaws may be taken without a meeting if all Directors shall individually or collectively consent in writing to such action. Such written consent or consents shall be filed with the minutes of the proceedings of the Board. Such action by written consent shall have the same force and effect as a unanimous vote of the Directors. Any certificate or other document filed on behalf of this corporation relating to an action taken by the Board of Directors without a meeting shall state that the action was taken by a unanimous written consent of the Board without a meeting, and that the Bylaws of the corporation authorize its Directors to so act.

(b) **Conference Telephone**. The Directors may participate in a meeting through use of conference telephone or similar communications equipment, provided that all Directors participating in such meeting can hear one another. Participation in a meeting pursuant to this paragraph constitutes presence in person at such meeting.

Section 14. COMPENSATION. The Directors shall receive no compensation for their services as Directors.

ARTICLE V

COMMITTEES

Section 1. COMMITTEES GENERALLY. Except as otherwise provided by these Bylaws, the Board of Directors may, by resolution or resolutions passed by a majority of the members thereof, appoint standing or special Committees for any purpose and, if such Committees are comprised solely of Directors, delegate to such Committees any of the powers and authority of the Board, except the power and authority to adopt, amend or repeal these Bylaws, or such other powers as may be prohibited by intervals between meetings of the Board, and shall at all times be subject to the control of the Board. The Board of Directors, or if the Board does not act, the Committees, shall establish Rules and Regulations for meetings and shall meet at such times as is deemed necessary, provided that notice of all meetings shall be given to Committee members in the manner provided in Section 14 of this Article V. No act of a Committee shall be valid unless approved by the vote or written consent of a majority of said Committee's members. Committees shall keep regular minutes of proceedings and report the same to the Board from time to time, as the Board of Directors may require. Any Committee composed of persons, one or more of whom are not Directors may act solely in an advisory capacity to the Board.

Section 2. EXECUTIVE COMMITTEE.

(a) The Executive Committee shall be comprised of no more than seven (7) persons and shall be elected by a majority of the Directors in office. Each member of the Executive Committee shall be a Director of the Corporation. The Executive Committee shall include the following persons if they are Directors: the Chairman, the senior ranking Vice Chairman, the ranking Vice Chairmen, the Treasurer, the Secretary, and the Chief of Staff. At least one member of the Executive Committee shall be a member of the Medical Staff of the Hospital.

(b) Between meetings of the Board of Directors, the Executive Committee shall have and exercise authority of the Board of Directors in the management of the corporation, excepting as to matters concerning which the full Board of Directors is required to act by law or by the Articles of Incorporation or by these Bylaws. The Executive Committee shall have and exercise such specific powers and perform such specific duties as prescribed by these Bylaws or as the Board of Directors shall from time to time prescribe or direct.

Section 3. AUDIT AND FINANCE COMMITTEE. The Audit and Finance Committee shall consist of a minimum of three (3) Directors, including the Chief of the Medical Staff. The primary duty of the Audit and Finance Committee shall be to determine the financial feasibility of proposed short- and long-term corporate projects. It shall review the annual budget of the corporation, review the monthly financial statements of the corporation, appraise the corporation's operating performance, counsel the Officers of the corporation on both current and long term fiscal affairs, and perform such other duties as may be assigned to it by the Board of Directors.

The Audit and Finance Committee is charged with the following specific tasks:

(1) Monitor assets and investments of the corporation;

(2) Verify the credibility of financial statements and internal controls;

(3) Ensure that management's use of corporate financial resources is prudent;

(4) Monitor operating budget variances;

(5) Examine major capital expenditures;

(6) Review, approve and recommend annual and longer-term corporation budgets;

(7) Provide recommendations to the Board of Directors on policies governing financial affairs of the corporation;

(8) Exercise oversight trusteeship, as directed by the Board of Directors, to verify that funds are used for intended purposes;

(9) Receive and review periodical financial reports;

(10) Determine and recommend the content and duration of Chief Financial Officer's ("CFO") report to the Board of Directors; and

(11) Provide oversight with respect to the corporation's other expenditures.

(12) Regularly review and evaluate the corporation's Human Resources and Compensation Policies.

Section 4. STRATEGIC PLANNING COMMITTEE. The Strategic Planning Committee shall consist of a minimum of three (3) Directors, including the Chief of Staff-Elect of the Medical Staff. The primary duty of the Strategic Planning Committee shall be to assist the Board of Directors in the development, approval and implementation of a mission statement that will determine the course of action the Board of Directors will follow in its achieving its specific goals and objectives. In addition, it shall guide the development and implementation of vital and meaningful short and long-range strategic plans that will respond to environmental change and the evolving healthcare needs of the corporation and the community, assume the ongoing responsibilities of regular evaluation and assessment of the strategic plan's currency and relevance, evaluate all proposed acquisitions of land, buildings, and equipment related to accepted strategic planning, assist in the development of plans for additions and improvements to the corporation's buildings and grounds, report its recommendations with respect to selection of architects, engineers, or contractors, report its recommendations with respect to proposed construction contracts and keep advised of all construction work in progress, and perform such other duties as may be assigned to it by the Board of Directors.

Section 5. GOVERNANCE COMMITTEE. The Governance Committee shall consist of a minimum of five (5) Directors including at least one (1) Physician Director, each of whom shall be designated by the Chairman of the Board. The primary duty of the Governance Committee shall be to assist the Board of Directors in developing and monitoring the effectiveness of the corporate structure and its existing members.

The Governance Committee is charged with the following special tasks:

(a) Periodically review and make recommendation to the Board regarding the Bylaws.

(b) To serve as liaison for and to assist in coordinating the efforts of the Board of Directors and the various auxiliary groups, whether incorporated or unincorporated which shall have been or which may be organized and operated for the support and assistance of the corporation.

(c) Shall propose one or more persons to fill vacancies on the Board. Whenever a person serving as a Director is elected Chief of Staff or Chief of Staff-Elect, the vacancy thereby created among the Directors shall be filled as provided herein. In considering candidates for Director, the Governance Committee shall take into account: position description; willingness and ability to carry out the responsibilities of a Director; areas of interest and expertise; and experience in community organizations and services. The Board of Directors may, from time to time, identify other qualifications and/or criteria for nominees to the Board of Directors.

(d) Shall propose one or more persons to fill each office.

(e) Shall ensure the continued growth and development of the Directors.

(f) Shall develop and implement an ongoing Recruitment and Orientation Program, a process by which Directors are made aware of key health issues facing the Corporation and community, as well as the process by which the Directors can utilize evaluation as a means of improving their overall effectiveness as individual Directors.

(g) Shall ensure the corporation has adopted and implemented policies and procedures which will require the corporation and its employees to act in full compliance with all applicable laws, regulations, and policies.

(h) Shall assist in the Board in fulfilling its responsibilities relating to accounting policies, financial reporting practices, and the quality and integrity of Montebello Community Health Services Inc.'s financial reporting.

(i) It shall address and review matters concerning or relating to the Corporate Compliance Program.

(j) It shall maintain communication between the Board, the corporation's legal counsel, the independent auditors, any internal auditors, the financial management and other senior management of Montebello Community Health Services Inc.

(k) Shall also perform such other duties as may be assigned to it by the Board of Directors.

Section 6. QUALITY COMMITTEE. The Committee shall consist of five (5) Directors from the corporation’s Board, at least two physicians, including the Chief of the Medical Staff. Its primary duty shall be to assess patient safety and the delivery of quality patient care throughout the corporation. The Committee shall assist in determining the need for policies and procedures which result in the achievement, through continuous quality improvement, of the maximum benefit to the customers of the corporation in a customer-oriented and cost-effective manner.

The Quality Committee is charged with the following specific tasks:

(a) Recommend policies and procedures which enable the medical staff to process applications and reappointments and the granting of clinical privileges in a timely and appropriate manner.

(b) Monitor the performance of the medical staff in carrying out its responsibilities for evaluating and improving patient care.

(c) Monitor the performance of all corporate programs in developing and implementing quality improvement responsibilities and review to assure that the organization remains nationally accredited and locally respected for its quality of care.

(d) Review periodic trend reports which reflect the overall performance of the corporation in providing quality care in a customer-focused, cost-effective manner.

(e) Ensure that the quality **of** services and their quantification is a corporation-wide expectation of all operating units. Quality is defined through the objective answering of the following question: Was the proper service provided at the proper time, by the proper people, utilizing proper resources, with a proper outcome based on predetermined expectations?

(f) Ensure that all operating programs develop a specific plan of implementing the concept of continuous quality improvement through individual and team initiative. This includes implementation, evaluation and oversight processes within the appropriate medical/administrative/governance structures.

(g) Assist in the development of the process and the outcomes of identifying, reviewing and continuously improving and ensuring value throughout the corporation through a Quality Committee.

Section 7. ADVANCEMENT COMMITTEE shall comprise of 6-8 individuals who will assist in the planning and evaluation of the fundraising activities of the Hospital and Foundation. It is a representative group that includes up to two members each from the Board of Directors, Board of Trustees, senior administrative staff and medical staff of Beverly Hospital. Members should be willing to set an example of giving financial support, time and participation in the advancement of the Hospital's culture of philanthropy.

The specific responsibilities of the Advancement Committee members are to:

(a) Serve as the primary advancement liaison between the Board of Trustees and Board of Directors.

(b) Attend regular committee meetings.

(c) Develop annual and ancillary fundraising objectives.

(d) Review and give input on fundraising plans.

(e) Monitor the success of all fundraising activities.

(f) Maintain 100% participation by staff and volunteer leadership.

Section 8. PRESIDENT/CEO EVALUATION COMMITTEE. The President/CEO Evaluation Committee shall consist of the Chairman of the Board and the Chairmen of the Audit and Finance Committee, Governance Committee, Quality Committee, and Strategic Planning Committees. The Chairman of the Board of Directors shall appoint a Physician Member of the Board of Directors to the committee if there is no Physician Member on this committee. This committee will be chaired by the Chairman of the Board of Directors. The primary duty of the President/CEO Evaluation Committee is to evaluate the President and Chief Executive Officer on an annual basis, using the Performance Evaluation Tool recommended by the Governance Committee and approved by the Board of Directors. Shall recommend and regularly review a policy for succession, selection and annual evaluation of the Chief Executive Officer of the corporation.

Section 9. APPOINTMENT AND TERM OF OFFICE. Members of each Committee set forth in this Article V shall, unless otherwise provided by these Bylaws, be appointed by the Chairman of the Board, subject to approval by the Board. The Chairman of each Committee shall be designated by the Chairman of the Board and shall be a Director. The Chairman and each member of each Committee shall serve until the end of the fiscal year for which appointed or until his successor is appointed, or until such Committee is sooner terminated, or until he is removed, resigns, or otherwise ceases to qualify as a Chairman or member, as the case may be, of the Committee. Chairman and members of special Committees shall serve for the life of the Committee unless they are sooner removed, resign or cease to qualify as a Chairman or member as the case may be.

Section 10. QUORUM. A majority of the members of a Committee shall constitute a quorum except five (5) members shall constitute a quorum of the Executive Committee, and any transaction of a Committee shall require a majority vote of the quorum present at any meeting. Each member of a Committee, including the person presiding at the meetings, shall be entitled to one (1) vote.

Section 11. REMOVAL OF MEMBERS OF COMMITTEES. The body or person that appointed the Committee may remove at any time, with or without cause, a member or members of that particular Committee.

Section 12. MEETINGS. Members of Committees, other than the Executive Committee, shall meet not less frequently than once a year, and in any event, at the call of the Chairman of the Board, the Chairman of the particular Committee or two (2) Committee members at such place as he or they shall designate. The provisions of Sections 10, 12, and 13 of Article IV shall apply to all

Committee meetings. Each Committee shall keep minutes of its proceedings and make a written report to the Board of Directors of its action within a reasonable time subsequent thereto.

ARTICLE VI

OFFICERS

Section 1. OFFICERS. The Officers of the corporation shall be a Chairman of the Board of Directors, President and Chief Executive Officer, a Vice Chairman, a Secretary, a Treasurer and a Chief Financial Officer. The corporation may also have, at the discretion of the Board of Directors, one or more additional Vice Chairman, one or more Assistant Secretaries and one or more Assistant Treasurers. Any person may hold more than one office, except that the Chairman of the Board of Directors may not serve concurrently as the Secretary or Chief Financial Officer.

Section 2. ELECTION OF OFFICERS. The Officers of the corporation shall be elected annually by the Board of Directors, and each shall hold his office until he shall resign or shall be removed, or otherwise disqualified to serve, or his successor shall be elected.

Section 3. TENURE OF OFFICERS. The tenure for Officers of the corporation shall be limited to 6 years maximum per office.

Section 4. SUBORDINATE OFFICERS. The Board of Directors may elect or authorize the appointment of such other Officers than those herein before mentioned as the business of the corporation may require, each of whom shall hold office for such period, have such authority and perform such duties as are provided in these Bylaws or as the Board of Directors from time to time may authorize.

Section 5. REMOVAL OF OFFICERS. Any Officer may be removed either with or without cause by a majority of the Directors then in office at any regular or special meeting of the Board. Should a vacancy occur in any office as a result of death, resignation, removal, disqualification or any other cause, the Board may delegate the powers and duties of such office to any Officer or to any Director until such time as a successor for such office has been selected.

Section 6. CHAIRMAN OF THE BOARD OF DIRECTORS. The Chairman of the Board of Directors shall serve as an ex-officio member of all standing Committees, except the Governance Committee, and report annually to the Board of Directors on the current state of the corporation. The Chairman of the Board of Directors shall discharge all other duties as may be required by these Bylaws and from time to time may be assigned by the Board of Directors.

Section 7. PRESIDENT AND CHIEF EXECUTIVE OFFICER. The President and Chief Executive Officer shall be the Chief Executive Officer of the corporation and shall, subject at all times to the order and direction of the Board of Directors, be charged with the duty of consultation with proper Officers and Committees, the initiation and administration of the activities of the corporation, and shall, unless otherwise ordered by the Board of Directors, attend all meetings of the Board of Directors. The authority and duties of the President and Chief Executive Officer, as

well as his qualifications, shall be more specifically defined in a written statement adopted by the Board of Directors. The President and Chief Executive Officer shall at all times conduct the business operated by this corporation to conform with all national, state and municipal laws and ordinances.

Section 8. VICE CHAIRMAN. In the absence or removal of the Chairman of the Board of Directors, the Vice Chairman, or the Vice Chairmen in order of their rank as fixed by the Board of Directors, or if not ranked, the Vice Chairman designated by the Board of Directors, shall perform all the duties of the Chairman of the Board of Directors and when so acting shall have all of the powers of and be subject to all of the restrictions upon the Chairman of the Board of Directors. The Chairman of the Board of Directors, the Vice Chairman, or the Vice Chairmen shall perform such other duties as may from time to time be prescribed by the Board of Directors.

Section 9. SECRETARY. The secretary shall keep or cause to be kept the minutes of the meeting of the Board of Directors and the Executive Committee in one or more books provided for that purpose, will see that all notices are duly given in accordance with the provisions of these Bylaws, the Articles of Incorporation or as required by law, be custodian of the corporation's records and of the seal of the corporation, and in general perform all duties as from time to time may be prescribed by the Chairman of the Board of Directors, the Board of Directors or the Executive Committee.

Section 10. TREASURER. The Treasurer shall perform such duties as shall be assigned by the Board of Directors or the Chairman of the Board of Directors.

Section 11. CHIEF FINANCIAL OFFICER. If required by the Board of Directors, the Chief Financial Officer ("CFO") of the corporation shall give a bond for the faithful discharge of his duties in such form and with such surety or sureties as the Board of Directors shall determine. The CFO shall have charge and custody of all the funds of the corporation and shall keep or cause to be kept, in books belonging to the corporation, full and accurate accounts of all receipts and disbursements, and shall deposit all money and other valuable effects in the name of the corporation in such depositories as may be designated for that purpose by the Board of Directors. The CFO shall disburse the funds of the corporation as may be ordered by the Board of Directors, taking proper vouchers for such disbursements, and shall render to the Chairman of the Board and Directors at the meetings of the Board of Directors whenever requested by them an account of all his transactions as CFO and of the financial condition of the corporation.

Section 12. ADDITIONAL OFFICERS. Officers and assistant Officers, in addition to those herein above described, who are elected or appointed by the Board of Directors, shall perform such duties as shall be assigned to them by the Chairman of the Board of Directors, the Board of Directors or the Executive Committee.

Section 13. COMPENSATION AND EXPENSES. Officers shall serve without salary unless they are also employees of the corporation. Expenses incurred in connection with performance of their official duties may be reimbursed to Officers upon approval of the Board of Directors.

ARTICLE VII

[RESERVED.]

ARTICLE VIII

[RESERVED.]

ARTICLE IX

AUXILIARY ORGANIZATIONS

Section 1. GENERAL. From time to time, the corporation may establish adjunct organizations, including advisory boards and hospital auxiliaries. Each such group shall establish its own Constitution or Articles of Incorporation, Bylaws and Rules and Regulations and present them to the Board of Directors for approval, and all amendments thereto shall also be subject to the approval of the Board of Directors. These Bylaws and the Articles of Incorporation of this corporation shall prevail over the documents and actions of such adjunct and subordinate groups.

Section 2. HONORARY BOARD MEMBERS. The Board of Directors may from time to time within its discretion grant honorary memberships to persons who have performed outstanding service to this corporation. Such members shall have the right to attend any meetings of the Board of Directors, but shall have no right to vote. Such membership may be terminated at any time at the discretion of the Board.

Section 3. EMERITUS BOARD MEMBERS. Persons who have served actively and faithfully on the Board of Directors of this corporation and who wish to continue their relationship with the corporation may be elected Emeritus Board Members by a two-thirds (2/3) affirmative vote of the Directors. Such members shall hold that position for life and shall have the right to attend any meetings of the Board of Directors, but shall have no right to vote.

ARTICLE X

GENERAL PROVISIONS

Section 1. INDEMNIFICATION AND INSURANCE. The corporation shall have the power to indemnify its Directors, Officers and agents who are or were parties or who are threatened to be made parties to any proceedings against expenses, judgments, fines, settlements and other amounts actually and reasonably incurred in connection with such proceeding in accordance with and subject to the limitations prescribed by the California Nonprofit Public Benefit Corporation Law and by the Articles of Incorporation of this corporation.

Subject also to the provisions of said law and said Articles of Incorporation, the corporation shall also have the power to purchase and maintain insurance on behalf of its Directors, Officers and agent against any liability asserted against or incurred by them in their capacity as such Director, Officer or agent, or arising out of their status as such, whether or not the corporation would have the power to indemnify against such liability.

Section 2. CONTRACTS. The Board of Directors or the Executive Committee may authorize any Officer or Officers, agent or agents, to enter into any contract or execute or deliver any instrument in the name of and on behalf of the corporation, and such authority may be general or confined to specific instances.

Section 3. DEPOSITS. All funds of the corporation not otherwise employed shall be deposited from time to time to the credit of the corporation in such banks, trust companies or other depositories as the Board of Directors or the Executive Committee may select.

Section 4. CHECKS. All checks, drafts or other orders for the payment of money, notes or other evidences of indebtedness issued in the name of the corporation shall be signed by such Officer or Officers, agent or agents, of the corporation and in such manner as shall from time to time be determined by resolution of the Board of Directors or the Executive Committee.

Section 5. LOANS. No loans shall be made by or to this corporation and no evidences of indebtedness shall be issued in this name unless authorized by a resolution of the Board of Directors or the Executive Committee. Such authority may be general or confined to specific instances; provided, however, that no loans shall be made by the corporation to its Directors, or Officers.

Section 6. INSPECTION OF CORPORATE RECORDS. The books of account and minutes of proceedings of the Directors shall be open to inspection upon the written demand of any Director, made personally or through an authorized representative, at any reasonable time and for any purpose reasonably related to his interest as a Director. Such inspection may be made by the Director personally or by an agent or attorney appointed by Director and shall include the right to make extracts. Demand for inspection shall be made in writing, addressed to the President or Secretary of the Corporation.

Section 7. VOTING SHARES. The corporation may vote any and all shares held by it in any other corporation by such officer, agent or proxy as the Board of Directors may appoint, or in default of any such appointment, by its Chairman or by any Vice Chairman and, in such case, such officers, or any of them, may likewise appoint a proxy to vote said shares.

ARTICLE XI

ACCOUNTING YEAR AND TAX AUDIT

Section 1. ACCOUNTING YEAR. The accounting year of the corporation shall be the calendar year unless otherwise changed by the Board of Directors.

Section 2. AUDIT. At the end of the accounting year the books of the corporation shall be closed and audited by a certified public accountant selected by the Board of Directors. The financial report of the auditor shall be promptly mailed to each Director.

ARTICLE XII

AMENDMENTS

The Bylaws of the corporation may be altered, amended or repealed and new Bylaws adopted only by the vote of two-thirds (2/3) of the members of the Board of Directors of the Corporation.

CERTIFICATE

This is to certify that the attached Restated Bylaws of **MONTEBELLO COMMUNITY HEALTH SERVICES, INC.** have been duly adopted and approved as amended by the Board of Directors of said corporation at a meeting of said Board of Directors held on May 27, 2014.

IN WITNESS WHEREOF, the undersigned, duly elected and acting as Secretary of this corporation, has signed this Certificate and affixed a seal of this corporation hereto this 27th day of May 2014. .

Rosemary Orozco
Secretary, Board of Directors

[SEAL]

BYLAWS OF MONTEBELLO COMMUNITY HEALTH SERVICES, INC.

TABLE OF CONTENTS

TABLE OF CONTENTS

11 Cal. Code Reg. Section 999.5(d)(4)(B)

Applicant's plan for use of the net proceeds after the close of the proposed transaction together with a statement explaining how the proposed plan is as consistent as possible with existing charitable purposes and complies with all applicable charitable trusts that govern use of applicant's assets. The plan must include any proposed amendments to the articles of incorporation or bylaws of the applicant or any entity related to the applicant that will control any of the proceeds from the proposed transfer

The Affiliation does not involve any sale, transfer, merger or other disposition of any of the assets of the Beverly Entities at Closing, and accordingly, the Affiliation will not result in the receipt of any net proceeds by the Beverly Entities. Rather, pursuant to the Affiliation Agreement, Adventist Health will become the sole member or the sole controlling entity of each Beverly Entity. Although the Affiliation requires each Beverly Entity to amend its Articles of Incorporation so that Adventist Health becomes the sole member or the sole controlling entity of each Beverly Entity, the Affiliation Agreement requires that each Beverly Entity will be operated operate exclusively for the benefit of the community in accordance with the mission and charitable purposes within the meaning of Internal Revenue Code Section 50l(c)(3) set forth under the Beverly Articles of Incorporation and Bylaws in effect immediately prior to Closing. In addition, the Affiliation Agreement requires the parties to continue to comply with any donor restrictions applicable to charitable remainder trusts, donor restricted endowment funds, and other funds donated to Beverly or the Foundation.

Title 11, California Code of Regulations, § 999.5(d)(5)

IMPACTS ON HEALTHCARE SERVICES

11 Cal. Code Reg. Section 999.5(d)(5)(A)

A copy of the two most recent "community needs assessments" prepared by applicant for any health facility or facility that provides similar healthcare that is the subject of the agreement or transaction

Attached to this Section are the following documents:

- **Exhibit 12**, a copy of the Beverly's Community Needs Assessment for Fiscal Year 2019.

- **Exhibit 13**, a copy of the Beverly's Community Needs Assessment for Fiscal Year Ending 2022.

EXHIBIT 12

BEVERLY COMMUNITY NEEDS ASSESSMENT (2019)

Beverly Hospital

Community Health Needs Assessment 2019

Table of Contents

Executive Summary

Beverly Hospital is a 202-bed nonprofit acute care facility located in Montebello, CA. As required by state and federal law, Beverly Hospital has undertaken a Community Health Needs Assessment (CHNA). California's Senate Bill 697 and the Patient Protection and Affordable Care Act through IRS section 501(r)(3) regulations direct nonprofit hospitals to conduct a Community Health Needs Assessment and develop an Implementation Strategy every three years. The purpose of this Community Health Needs Assessment is to identify and prioritize the significant health needs of the community served by Beverly Hospital. The health needs identified in this report help to guide the hospital's community benefit activities.

Service Area

Beverly Hospital is located at 309 West Beverly Boulevard in Montebello, CA 90640. The hospital service area includes 14 ZIP Codes in 11 cities. The service area is comprised of portions of Service Planning Areas (SPAs) 3, 4 and 7 in Los Angeles County. The service area was determined from the ZIP Codes that reflect a majority of patient admissions.

Whenever possible, ZIP Code level data or city data were used to most accurately describe the service area. However, some data indicators are only available by Service Planning Area (SPA). It is important to note the SPA-level data represent a larger geographic area than the hospital's service area.

Assessment Process and Methods

Secondary and primary data were collected to complete the CHNA. Secondary data were collected from a variety of local, county and state sources to present community demographics, social determinants of health, health care access, birth characteristics, leading causes of death, acute and chronic disease, health behaviors, mental health, substance use and misuse, and preventive practices. The analysis of secondary data yielded a preliminary list of significant health needs, which then informed primary data collection. The following criteria were used to identify significant health needs:

1. The size of the problem (relative portion of population afflicted by the problem)
2. The seriousness of the problem (impact at individual, family, and community levels)

Primary data were obtained through four focus groups with community members and interviews with 14 key community stakeholders, public health, and service providers, members of medically underserved, low-income, and minority populations in the community, and individuals or organizations serving or representing the interests of

such populations. The primary data collection process was designed to validate secondary data findings, identify additional community issues, solicit information on disparities among subpopulations, ascertain community assets potentially available to address needs and discover gaps in resources.

Significant Health Needs

The community stakeholders were asked to prioritize the significant health needs according to highest level of importance in the community. The total score for each significant health need was divided by the total number of responses for which data were provided and resulted in an overall average for each health need. Access to health care, violence/community safety and mental health, were ranked as the top three priority needs in the service area. The significant health needs are listed below in priority order:

1. Access to health care
2. Violence/community safety
3. Mental health
4. Chronic diseases
5. Overweight and obesity
6. Preventive practices
7. Dental care
8. Substance use and misuse
9. Economic insecurity

Report Adoption, Availability and Comments

This CHNA report was adopted by the Beverly Hospital Board of Directors in October 2019.

This report is widely available to the public on the hospital's web site, https://www.beverly.org/about-us/in-the-community/. Written comments on this report can be submitted to Veronica Ramirez at VRamirez@beverly.org.

Introduction

Background and Purpose

Founded in 1949, Beverly Hospital is a 202-bed nonprofit acute care facility. Beverly Hospital offers a full range of services with the latest technology, diagnostic and treatment options. A medical staff of over 300 physicians, representing a wide spectrum of specialties, is supported by experienced and dedicated employees and volunteers, who strive to deliver high-tech, high-touch services, preventive education and patient care. The hospital's mission is to provide compassionate and quality health care.

Beverly Hospital (Beverly) has undertaken a Community Health Needs Assessment (CHNA) as required by state and federal law. California's Senate Bill 697 and the Patient Protection and Affordable Care Act through IRS section 501(r)(3) regulations direct nonprofit hospitals to conduct a Community Health Needs Assessment and develop an Implementation Strategy every three years.

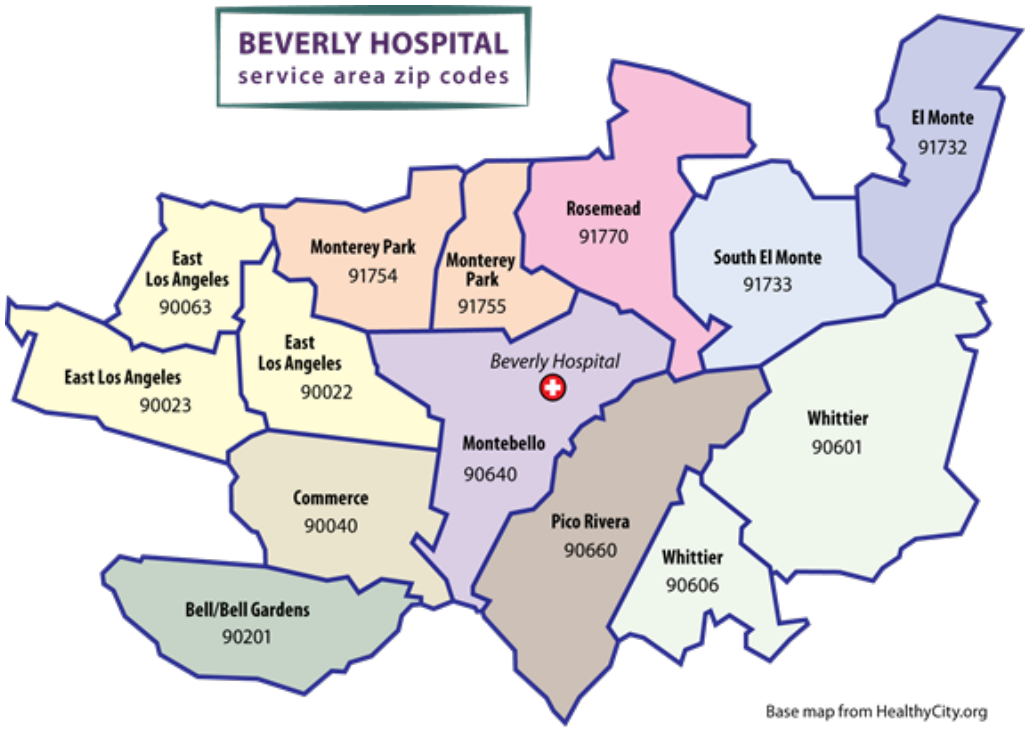
Service Area

Beverly Hospital is located at 309 West Beverly Boulevard in Montebello, CA 90640. The hospital service area includes 14 ZIP Codes in 11 cities. The service area is comprised of portions of Service Planning Areas (SPAs) 3, 4 and 7 in Los Angeles County. Given the small portion of SPA 4 included in the service area, only data from SPA 3 and SPA 7 are reported in this assessment. The hospital service area is detailed below by community and ZIP Code, and was determined from the ZIP Codes that reflect a majority of patient admissions.

Beverly Hospital Service Area

Geographic Area	ZIP Code	Service Planning Area
Bell/Bell Gardens	90201	SPA 7
Commerce	90040	SPA 7
East Los Angeles	90022, 90023, 90063	SPA 4/SPA 7
El Monte	91732	SPA 3
Montebello	90640	SPA 7
Monterey Park	91754, 91755	SPA 3
Pico Rivera	90660	SPA 7
Rosemead	91770	SPA 3
South El Monte	91733	SPA 3
Whittier	90601, 90606	SPA 7

Service Area Map



Project Oversight

The Community Health Needs Assessment process was overseen by:
Veronica Ramirez, MCM, CLE
Director, Marketing & Community Outreach

Deb DuRoff, MPA, FACHE
Administrative Director, Planning & Development

Consultant

Biel Consulting, Inc. conducted the Community Health Needs Assessment. Biel Consulting, Inc. has over 25 years' experience conducting hospital Community Health Needs Assessments and working with hospitals to develop, implement, and evaluate community benefit programs. Dr. Melissa Biel conducted the Beverly Hospital Community Health Needs Assessment. She was joined by Sevanne Sarkis, JD, MHA, MEd, and Denise Flanagan, BA. www.bielconsulting.com

Data Collection Methodology

Secondary Data Collection

Secondary data were collected from a variety of local, county and state sources to present community demographics, social determinants of health, health care access, birth characteristics, leading causes of death, acute and chronic disease, health behaviors, mental health, substance use and misuse, and preventive practices. When available, data sets are presented in the context of Los Angeles County and California to help frame the scope of an issue as it relates to the broader community.

Sources of data include: the U.S. Census American Community Survey, California Department of Public Health, California Health Interview Survey, Los Angeles County Department of Public Health, Think Health LA, County Health Rankings, California Department of Education, California Office of Statewide Health Planning and Development and California Department of Justice, among others.

Secondary data for the service area were collected and documented in data tables with narrative explanation. The tables present the data indicator, the geographic area represented, the data measurement (e.g. rate, number, or percent), county and state comparisons (when available), the data source, data year and an electronic link to the data source. Whenever possible, ZIP Code level data or city data were used to most accurately describe the service area. However, some data indicators are only available by Service Planning Area (SPA) or county. It is important to note the SPA-level data represent a larger geographic area than the hospital's service area.

Analysis of secondary data includes an examination and reporting of health disparities for some health indicators. The report includes benchmark comparison data that measure the data findings as compared to Healthy People 2020 objectives, where appropriate. Healthy People 2020 objectives are a national initiative to improve the public's health by providing measurable objectives and goals that are applicable at national, state, and local levels. Attachment 1 compares Healthy People 2020 objectives with service area data.

Primary Data Collection

Interviews and focus groups were used to gather information and opinions from persons who represent the interests of the community served by the hospital. Interview and focus group participant comments are included in the CHNA report. A list of the community respondents engaged in the primary data collection can be found in Attachment 2.

Interviews

Fourteen (14) interviews were completed from June through August 2019. Community stakeholders identified by the hospital were contacted and asked to participate in the needs assessment. Interviewees included individuals who are leaders and/or representatives of medically underserved, low-income, and minority populations, local health or other departments or agencies that have current data or other information relevant to the health needs of the community. Input was obtained from the Los Angeles County Department of Public Health.

The identified stakeholders were invited by email to participate in a phone interview. Appointments for the interviews were made on dates and times convenient to the stakeholders. At the beginning of each interview, the purpose of the interview in the context of the needs assessment was explained, the stakeholders were assured their responses would remain confidential, and consent to proceed was given.

Interview questions focused on the following topics:

- Major health issues in the community
- Socioeconomic, behavioral, or environmental factors that impact health in the community
- Who is most affected by the significant needs
- Issues, challenges and barriers experienced in the community
- Potential resources to address the identified health needs, such as services, programs and/or community efforts
- Additional comments and concerns

Focus Groups

Community focus groups were held in June, July and August, 2019 and engaged 48 persons.

Focus group questions focused on the following topics:

- Biggest health needs in the community
- Challenges and barriers faced in addressing health needs
- Prioritization of health needs
- Additional comments.

Public Comment

In compliance with IRS regulations 501(r) for charitable hospitals, a hospital Community Health Needs Assessment (CHNA) and Implementation Strategy are to be made widely available to the public and public comment is to be solicited. The previous Community

Health Needs Assessment was made widely available to the public on the website https://www.beverly.org/about-us/in-the-community/. No public comments have been received.

Identification and Prioritization of Significant Health Needs

Review of Primary and Secondary Data

Significant health needs were identified from secondary data using the size of the problem (relative portion of population afflicted by the problem) and the seriousness of the problem (impact at individual, family, and community levels). To determine size or seriousness of the problem, the health need indicators that were identified in the secondary data were measured against benchmark data; specifically, county rates, state rates and/or Healthy People 2020 objectives. Indicators related to the health needs, which performed poorly against one or more of these benchmarks met this criterion to be considered a health need.

The following significant health needs were determined:

- Access to health care
- Chronic disease (asthma, cancer, diabetes, heart disease, liver disease, kidney disease)
- Dental care
- Economic insecurity
- Mental health
- Overweight and obesity
- Preventive practices (vaccines and screenings)
- Substance use and misuse
- Violence/community safety

Priority Health Needs

The list of significant health needs informed primary data collection. The primary data collection process was designed to validate secondary data findings, identify additional community issues, solicit information on disparities among subpopulations, ascertain community assets to address needs and discover gaps in resources. Community stakeholders were used to gather input and prioritize the significant health needs.

The stakeholder interviewees and focus group participants were asked to rank order (possible score of 4) the health needs according to highest level of importance in the community. The total score for each significant health need was divided by the total number of responses for which data were provided.

Among the interviewees, access to health care violence/community safety and mental health were ranked as the top three priority needs in the service area. Calculations from

community stakeholders resulted in the following prioritization of the significant health needs.

Significant Health Needs in Priority Order	Rank Order Score (Total Possible Score of 4)
Access to health care	3.96
Violence/community safety	3.78
Mental health	3.76
Chronic diseases	3.64
Overweight and obesity	3.64
Preventive practices	3.64
Dental care	3.48
Substance use and misuse	3.46
Economic insecurity	3.35

Resources to Address Significant Health Needs

Through the interview process, community stakeholders identified resources potentially available to address the significant health needs. The identified community resources are presented in Attachment 3.

Review of Progress

In 2016, Beverly Hospital conducted the previous Community Health Needs Assessment. Significant health needs were identified from issues supported by primary and secondary data sources gathered for the CHNA. The hospital's 2016-2019 Implementation Strategy addressed access to care, chronic diseases, mental health, overweight and obesity, and preventive practices. A review of the impact of the actions to address these significant health needs can be found in Attachment 4.

Community Demographics

Population

The population of the Beverly Hospital (Beverly) service area is 711,482. From 2012 to 2017, the population increased by 1.3%, which is lower than the 2.7% increase in population countywide, during the same time period.

Total Population and Change in Population, 2012-2017

	Beverly Service Area	Los Angeles County	California
Total population	711,482	10,105,722	38,982,847
Change in population, 2012-2017	1.3%	2.7%	4.4%

Source: U.S. Census Bureau, American Community Survey, 2008-2012 & 2013-2017, DP05. http://factfinder.census.gov

Of the area population, 49.5% are male and 50.5% are female.

Population by Gender

	Beverly Service Area	Los Angeles County
Male	49.5%	49.3%
Female	50.5%	50.7%

Source: U.S. Census Bureau, American Community Survey, 2013-2017, DP05. http://factfinder.census.gov

Children and youth, ages 0-17, make up 24.4% of the population, 63.0% of the population are adults, ages 18-64, and 12.6% of the population are seniors, ages 65 and over. The service area has a higher percentage of children and youth, ages 0 to 24, and elderly, 75 and up, than the county.

Population by Age

	Beverly Service Area	Los Angeles County	California
0 – 4	6.5%	6.3%	6.4%
5 – 9	6.7%	6.1%	6.5%
10 – 14	6.6%	6.2%	6.5%
15 – 17	4.7%	3.9%	4.0%
18 – 20	4.2%	4.2%	4.2%
21 – 24	6.3%	6.0%	5.8%
25 – 34	14.9%	15.8%	14.9%
35 – 44	13.7%	13.8%	13.3%
45 – 54	12.8%	13.7%	13.3%
55 – 64	11.1%	11.5%	11.8%
65 – 74	6.7%	7.0%	7.6%
75 – 84	4.0%	3.7%	3.9%
85+	1.9%	1.8%	1.8%

Source: U.S. Census Bureau, American Community Survey, 2013-2017, DP05. http://factfinder.census.gov

In the service area, Bell/Bell Gardens (ZIP Code 90201) has the largest percentage of youth, ages 0-17 (31.3%), and the smallest percentage of seniors 65 and older (7.1%).

Monterey Park 91754 has the highest percentage of residents ages 65 and older (21.9%).

Population by Youth, Ages 0-17, and Seniors, Ages 65+

	ZIP Code	Total Population	Youth Ages 0 – 17	Seniors Ages 65+
Bell/Bell Gardens	90201	102,878	31.3%	7.1%
Commerce	90040	12,925	25.0%	14.4%
East Los Angeles	90022	67,446	26.9%	10.7%
East Los Angeles	90023	47,229	28.1%	8.7%
East Los Angeles	90063	53,556	26.8%	10.5%
El Monte	91732	63,557	23.8%	11.4%
Montebello	90640	63,547	22.3%	14.7%
Monterey Park	91754	33,114	17.6%	21.9%
Monterey Park	91755	27,942	14.7%	19.8%
Pico Rivera	90660	63,694	23.3%	14.0%
Rosemead	91770	63,981	19.2%	16.6%
South El Monte	91733	44,989	25.3%	12.4%
Whittier	90601	34,025	22.2%	14.8%
Whittier	90606	32,599	22.1%	12.9%
Beverly Service Area		**711,482**	**24.4%**	**12.6%**
Los Angeles County		**10,105,722**	**22.5%**	**12.5%**
California		**38,982,847**	**23.4%**	**13.2%**

Source: U.S. Census Bureau, American Community Survey, 2013-2017, DP05. http://factfinder.census.gov

Race/Ethnicity

In the hospital service area, 76.4% of the population is Hispanic/Latino, 17.4% are Asian, 4.8% are White, and 0.6% are Black/African American. The remaining 0.9% are American Indian/Alaskan Native, Native Hawaiian/Pacific Islander, and other or multiple races. There is a higher percentage of Latinos and Asians, and a lower percentage of Whites and Blacks/African Americans in the hospital service area than found in the county.

Race/Ethnicity

	Beverly Service Area	Los Angeles County
Hispanic/Latino	76.4%	48.4%
Asian	17.4%	14.3%
White	4.8%	26.5%
Other/Multiple	0.6%	2.5%
Black/African American	0.6%	7.9%
American Indian/Alaska Native	0.2%	0.2%
Native Hawaiian/Pacific Islander	0.1%	0.2%

Source: U.S. Census Bureau, American Community Survey, 2013-2017, DP05. http://factfinder.census.gov

Among service area cities, East Los Angeles (ZIP Codes 90022, 90023 and 90063) has the highest percentage of Hispanic or Latino residents (95.9% to 96.8%). Monterey Park (ZIP Codes 91754 and 91755) has a high percentage of Asian residents (61% and

73.6%, respectively). Commerce has the highest percentage of Black or African Americans (1.4%) in the service area. Whittier 90601 has the highest percentage of Whites (18.7%) in the service area.

Population by Race and Ethnicity and ZIP Code

	ZIP Code	Asian	Black	Latino	White
Bell/Bell Gardens	90201	0.8%	0.8%	94.4%	3.6%
Commerce	90040	0.9%	1.4%	94.9%	1.4%
East Los Angeles	90022	1.3%	0.2%	95.9%	2.1%
East Los Angeles	90023	0.8%	0.6%	96.8%	1.7%
East Los Angeles	90063	1.2%	0.3%	96.1%	1.9%
El Monte	91732	29.5%	0.5%	64.7%	4.4%
Montebello	90640	12.8%	1.2%	77.7%	7.3%
Monterey Park	91754	61.0%	0.4%	30.9%	4.7%
Monterey Park	91755	73.6%	0.2%	21.1%	3.1%
Pico Rivera	90660	3.0%	0.7%	89.5%	5.9%
Rosemead	91770	60.3%	0.2%	34.4%	4.2%
South El Monte	91733	21.7%	0.1%	74.0%	3.1%
Whittier	90601	6.3%	1.1%	72.4%	18.7%
Whittier	90606	2.0%	0.9%	87.2%	8.4%
Beverly Service Area		**17.4%**	**0.6%**	**76.4%**	**4.8%**
Los Angeles County		**14.3%**	**7.9%**	**48.4%**	**26.5%**
California		**13.9%**	**5.5%**	**38.8%**	**37.9%**

Source: U.S. Census Bureau, American Community Survey, 2013-2017, DP05. http://factfinder.census.gov

Language

In the service area, Spanish is spoken in the home among 63.5% of the population. English is spoken in the home among 20.3% of the population, 15.3% of the population speaks an Asian language, and 0.7% of the population speaks an Indo-European language.

Language Spoken at Home, Population 5 Years and Older

	Beverly Service Area	Los Angeles County
Speaks only English	20.3%	43.4%
Speaks Spanish	63.5%	39.3%
Speaks Asian/Pacific Islander language	15.3%	10.9%
Speak Indo-European language	0.7%	5.3%
Speaks other language	0.2%	1.1%

Source: U.S. Census Bureau, American Community Survey, 2013-2017, DP02. http://factfinder.census.gov

The highest percentage of Spanish speakers among area cities are found in East Los Angeles (86.5% to 90.8%) and Bell/Bell Gardens (89%). Monterey Park (49.4% to

65.3%) and Rosemead (54.1%) have high percentages of Asian language speakers. Montebello (3.4%) has the highest percentage of Indo-European languages spoken at home in the service area.

Language Spoken at Home by ZIP Code

	ZIP Code	Spanish	English	Asian/Pacific Islander	Other Indo European
Bell/Bell Gardens	90201	89.0%	9.2%	0.7%	0.1%
Commerce	90040	74.2%	24.5%	0.5%	0.1%
East Los Angeles	90022	86.5%	12.5%	0.8%	0.2%
East Los Angeles	90023	90.8%	8.3%	0.7%	0.1%
East Los Angeles	90063	88.2%	10.7%	0.8%	0.1%
El Monte	91732	54.6%	17.7%	27.1%	0.5%
Montebello	90640	57.7%	28.9%	9.8%	3.4%
Monterey Park	91754	21.4%	28.2%	49.4%	0.7%
Monterey Park	91755	14.4%	19.4%	65.3%	0.7%
Pico Rivera	90660	66.9%	30.0%	2.5%	0.6%
Rosemead	91770	26.8%	18.4%	54.1%	0.6%
South El Monte	91733	62.0%	16.1%	21.7%	0.1%
Whittier	90601	40.2%	54.8%	3.6%	1.0%
Whittier	90606	61.2%	36.8%	1.0%	0.9%
Beverly Service Area		**63.5%**	**20.3%**	**15.3%**	**0.7%**
Los Angeles County		**39.3%**	**43.4%**	**10.9%**	**5.3%**

Source: U.S. Census Bureau, American Community Survey, 2013-2017, DP02. http://factfinder.census.gov

Social Determinants of Health

Social and Economic Factors Ranking

The County Health Rankings examines social and economic indicators as a contributor to the health of a county's residents. California's 58 counties are ranked according to social and economic factors with a 1 for the best ranked to 58 for the poorest ranked counties. This ranking examines high school graduation rates, unemployment, children in poverty, social support, and other factors. Los Angeles County is ranked as 29, at the midpoint of all California counties, according to social and economic factors. The LA County ranking was 42 two years ago.

Social and Economic Factors Ranking

	County Ranking (out of 58)
Los Angeles County	29

Source: County Health Rankings, 2018. www.countyhealthrankings.org

The 2019 SocioNeeds Index is a measure of socioeconomic need that is correlated with poor health outcomes. All ZIP Codes, counties, and county equivalents in the United States, are given an Index Value from 0 (low need) to 100 (high need). To find the areas of highest need, the selected locations are ranked from 1 (low need) to 5 (high need) based on their Index Value. East Los Angeles, Bell/Bell Gardens, South El Monte, Commerce, El Monte and Rosemead all have rankings of 5, the highest Index Value (highest socioeconomic need). Whittier 90601 has a SocioNeeds ranking of 2.

SocioNeeds Index Value and Ranking

	ZIP Code	Index Value (0-100)	Ranking (1-5)
East Los Angeles	90023	98.8	5
Bell/Bell Gardens	90201	98.6	5
East Los Angeles	90063	98.2	5
East Los Angeles	90022	97.8	5
South El Monte	91733	96.4	5
Commerce	90040	96.1	5
El Monte	91732	95.0	5
Rosemead	91770	90.7	5
Pico Rivera	90660	80.8	4
Montebello	90640	80.5	4
Monterey Park	91755	79.1	4
Whittier	90606	74.2	4
Monterey Park	91754	63.1	3
Whittier	90601	35.8	2

Source: 2019 SocioNeeds Index, http://www.thinkhealthla.org

Poverty

The Census Bureau annually updates official poverty population statistics. For 2017, the Federal Poverty Level (FPL) was set at an annual income of $12,488 for one person and $24,858 for a family of four.

The service area has a slightly higher rate of poverty (19.3%) than found in the county (17%). Community poverty rates are highest among residents in Bell/Bell Gardens (28.1%), followed by East Los Angeles 90023 (26.2%). Levels of low-income (defined as earning less than 200% of the FPL) are 48.5% service-area-wide, which is higher than the county and state rates, and are highest in Bell/Bell Gardens (62.7%) and East Los Angeles 90023 (60.7%).

Ratio of Income to Poverty Level, by ZIP Code (<100% FPL and <200% FPL)

	ZIP Code	<100% FPL	<200% FPL
Bell/Bell Gardens	90201	28.1%	62.7%
Commerce	90040	16.3%	44.6%
East Los Angeles	90022	22.9%	56.2%
East Los Angeles	90023	26.2%	60.7%
East Los Angeles	90063	22.5%	54.8%
El Monte	91732	21.2%	52.5%
Montebello	90640	13.7%	41.4%
Monterey Park	91754	14.6%	35.3%
Monterey Park	91755	17.3%	41.2%
Pico Rivera	90660	10.7%	33.8%
Rosemead	91770	17.2%	44.5%
South El Monte	91733	22.3%	57.8%
Whittier	90601	10.5%	28.5%
Whittier	90606	9.5%	31.0%
Beverly Service Area		**19.3%**	**48.5%**
Los Angeles County		**17.0%**	**38.3%**
California		**15.1%**	**33.9%**

Source: U.S. Census Bureau, American Community Survey, 2013-2017, S1701. http://factfinder.census.gov

29.1% of service area children, under 18 years old, are living in poverty, which is higher than county and state rates. The rate is highest in East Los Angeles 90023 (39.8%) and Bell/Bell Gardens (38.9%). Among service area seniors, 15.5% are living in poverty compared to 13.4% for Los Angeles County. The highest rates are found in East Los Angeles 90023 (23.5%) and Bell/Bell Gardens (22.3%). Among Females who are Head of Household (HoH) with children, under 18 years old, 39.1% in the service area are in poverty. The highest rate is found in Bell/Bell Gardens (49.8%), followed by East Los Angeles 90023 (48.5%).

Poverty Levels of Children, Seniors, and Female Head of Household with Children

	ZIP Code	Children Under 18 Years Old	Seniors	Female HoH with Children*
Bell/Bell Gardens	90201	38.9%	22.3%	49.8%
Commerce	90040	19.3%	19.4%	47.3%
East Los Angeles	90022	33.2%	19.3%	46.3%
East Los Angeles	90023	39.8%	23.5%	48.5%
East Los Angeles	90063	31.3%	20.2%	40.8%
El Monte	91732	33.1%	14.2%	35.3%
Montebello	90640	20.1%	11.7%	29.8%
Monterey Park	91754	20.7%	14.9%	29.5%
Monterey Park	91755	23.6%	16.2%	36.8%
Pico Rivera	90660	14.3%	12.9%	26.5%
Rosemead	91770	27.3%	11.9%	42.2%
South El Monte	91733	35.3%	16.4%	42.0%
Whittier	90601	12.8%	11.9%	16.5%
Whittier	90606	13.9%	10.0%	25.4%
Beverly Service Area		**29.1%**	**15.5%**	**39.1%**
Los Angeles County		**24.0%**	**13.4%**	**36.9%**
California		**20.8%**	**10.2%**	**36.2%**

*Source: U.S. Census Bureau, American Community Survey, 2013-2017, S1701 & *S1702. http://factfinder.census.gov*

Family income has been shown to affect children's wellbeing. Compared to their peers, children in poverty are more likely to have physical health problems and are more likely to have behavioral and emotional problems. A view of children in poverty by SPA indicates that 25.7% of children in SPA 3 and 31.5% of children in SPA 7 live below the poverty level. In SPA 3, 45% of children are categorized as poverty-level or low-income (≤200% FPL), 54.6% of children in SPA 7 are living in poverty or are low-income.

Children in Poverty, Ages 0-17

	SPA 3	SPA 7	Los Angeles County	California
0-99% FPL	25.7%	31.5%	28.5%	24.2%
100-199% FPL	19.3%	23.1%	22.4%	22.3%
200-299% FPL	13.1%	16.1%	12.4%	13.0%
300% FPL and above	41.8%	29.2%	36.7%	40.6%

Source: California Health Interview Survey, 2013-2017. http://ask.chis.ucla.edu/

Unemployment

The unemployment rate in East Los Angeles is 7.5%, which is the highest unemployment rate among service area cities. The other service area cities that have unemployment rates above county (4.7%) and state (4.8%) unemployment rates are Bell (6.1%), Commerce (6.1%), Bell Gardens (5.6%) and El Monte 4.8%).

Unemployment Rate, 2017 Average

	Percent
Bell	6.1%
Bell Gardens	5.6%
Commerce	6.1%
East Los Angeles	7.5%
El Monte	4.8%
Montebello	4.3%
Monterey Park	3.9%
Pico Rivera	4.5%
Rosemead	4.3%
South El Monte	3.7%
Whittier	3.5%
Los Angeles County	**4.7%**
California	**4.8%**

Source: California Employment Development Department, Labor Market Information;
http://www.labormarketinfo.edd.ca.gov/data/labor-force-and-unemployment-for-cities-and-census-areas.html
Data available by city, therefore, ZIP Code-only areas in the service area are not listed.

Free and Reduced Price Meals

The National School Lunch Program is a federally assisted meal program that provides free, nutritionally balanced lunches to children whose families meet eligibility income requirements. Area school district eligibility ranges from 40% of students in the Lowell Joint School District to 92.1% in the El Monte City School District and 91.4% of students in Mountain View School District eligible for the program.

Free and Reduced Price Meals Eligibility

	Percent Eligible Students
Alhambra Unified School District	67.2%
East Whittier City Elementary School District	53.4%
El Monte City School District	92.1%
El Monte Union High School District	88.2%
El Rancho Unified School District	71.7%
Fullerton Joint Union High School District	49.8%
Garvey Elementary School District	81.8%
Los Angeles Unified School District (LAUSD)	81.1%
Lowell Joint School District	40.0%
Montebello Unified School District	81.4%
Mountain View School District	91.4%
Rosemead Elementary School District	79.7%
Valle Lindo Elementary School District	85.2%
Whittier City Elementary School District	75.0%
Whittier Union High School District	71.7%
Los Angeles County	**69.3%**
California	**60.1%**

Source: California Department of Education, 2017-2018.http://data1.cde.ca.gov/dataquest/

Public Program Participation

In SPA 3, 38.1% of adults, below 200% of the FPL, cannot afford food and 18.4% utilize food stamps. In SPA 7, 41.4% of residents, below 200% FPL, cannot afford food and 23.6% utilize food stamps. These rates indicate a considerable percentage of residents who may qualify for food stamps, but do not access this resource. WIC benefits are more readily accessed. Among children in SPA 3, 71% access WIC benefits and 55.1% in SPA 7 access WIC benefits. Among SPA 3 residents, 10.4% are TANF/CalWorks recipients, and 14.6% of SPA 7 residents are TANF/CalWorks recipients.

Public Program Participation

	SPA 3	SPA 7	Los Angeles County	California
Not able to afford food (<200%FPL)	38.1%	41.4%	42.6%	42.0%
Food stamp recipients	18.4%	23.6%	20.6%	20.7%
WIC usage among children, 6 years and under	71.0%	55.1%	54.1%	44.3%
TANF/CalWorks recipients	10.4%	14.6%	10.5%	9.3%

*Source: California Health Interview Survey, 2014-2016. http://ask.chis.ucla.edu/ *Statistically unstable due to sample size.*

Community Input – Economic Insecurity

Stakeholder interviews and focus groups identified the following issues, challenges and barriers related to economic insecurity.

- Parents are struggling to keep the electricity on and pay the rent and get food on the table.
- One of the things is that it is hard to find jobs. There are a lot of poor people in our area in East LA and Montebello. They just don't have enough resources. For people who qualify for Section 8 housing, it will take years for them to get their housing. So, people live with other people or they rent a room out of someone's house.
- There is a lot of economic insecurity. Rents go up but Social Security doesn't increase, or it doesn't increase enough to cover the increases in rent, food and utilities.
- Area residents suffer from higher rates of poverty and fewer opportunities for quality education, fewer employment opportunities, limited infrastructure for job development and youth development programs. There is a lot of pollution in the neighborhood
- There is a housing crisis. Many families who spend a high percent of their income on housing often live in crowded housing conditions and poor housing and that contributes to adverse health outcomes.
- A lot of families are in the low-income sector and have issues with citizenship. People may forgo going to the clinic or seeking medical attention because of their immigration status.

- Housing is one of the major ones. Also access to quality childcare. That is an issue in the community. Many times, the children we serve have behavioral problems and child care providers are not equipped to deal with that. If parents have to leave work to pick them up, they lose their job and they can't pay their rent, and they become homeless, and it becomes a ripple effect.
- Some undocumented people will not apply to receive food stamps because it will impact their residency applications.
- Our clients use the WIC program a lot. They will access that more than they do CalFresh.
- The cost of housing is an issue. And there is a wait list for senior housing. Seniors who cannot afford to live alone live with roommates, family or friends.
- Some people have problems getting jobs and they cannot afford to buy groceries. They rely on food pantries for free food.
- Transportation is an issue. Some families are completely dependent on public transportation.
- Economic stability will have a positive impact on a broad range of health outcomes.
- We are seeing high rates of food insecurity, which has risen in the last 10 years. It is going up due to the higher cost of living and greater economic insecurity, housing instability, it all contributes to food insecurity.
- People who live South of Whittier Boulevard are struggling profoundly. They are predominately the new American population who largely don't have those college degrees and have aspirations for their family and kids.
- More than anything else, what stands out as an issue in this community is homelessness.
- A lot of the seniors are on a limited income. The majority of them are on a fixed income.
- Economic insecurity is evident in so many different areas and it impacts nutrition, housing, and childcare. We are definitely seeing a lot more families facing homelessness. We are seeing more families living in housing conditions that are substandard, and multiple families living in single homes/apartments.

Food Insecurity

Food insecurity is an economic and social indicator of the health of a community. The U.S. Department of Agriculture (USDA) defines food insecurity as a limited or uncertain availability of nutritionally adequate foods or uncertain ability to acquire these foods in socially acceptable ways. The percent of households in the Beverly Hospital service area, with incomes less than 300% of the Federal Poverty Level, that are food insecure is 30.9%; this is slightly higher than the county rate of 29.2%.

Food Insecure Households, <300% FPL

	Beverly Service Area	Los Angeles County
Food insecure households, <300% FPL	30.9%	29.2%

Source: 2015 Los Angeles County Health Survey; Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health

Farmers Markets

Electronic Benefits Transfer (EBT) is how CalFresh (the California food stamp program), CalWORKs and other food and cash aid benefits are accessed in California. WIC stands for the Special Supplemental Nutrition Program for Women, Infants and Children, a federal assistance program. There are few Farmers Markets in the area, though the existing Farmers Markets accept public benefit programs (EBT or WIC).

Farmers Markets Accepting EBT or WIC

	Farmers Markets	Accepting EBT or WIC
Bell/Bell Gardens	0	0
East Los Angeles	1	1
El Monte	0	0
Montebello	0	0
Monterey Park	1	1
Pico Rivera	1	1
Rosemead	1	1
Whittier	1	1

Source: Los Angeles Department of Public Health, City and Community Health Profiles, from the Ecology Center's Farmers' Market Finder, June 2018. http://publichealth.lacounty.gov/ohae/cchp/index.htm. No data for Commerce and South El Monte.

Parks, Playgrounds and Open Spaces

The built environment influences an individuals' level of activity and ultimately their health. Youth who live in close proximity to safe parks, playgrounds, and open spaces are more physically active than those who do not live near those facilities. 87.3% of Beverly Hospital service area children, ages 1-17 years, were reported to have easy access to a park, playground or other safe place to play; this was higher than the county rate (86.8%). 51.7% of service area adults utilized walking paths, parks, playgrounds or sports fields in their neighborhood, which is higher than the county rate (47.5%).

Access to and Utilization of Parks, Playgrounds and Open Space

	Beverly Service Area	Los Angeles County
Can easily get to a park, playground, or other safe place to play, ages 1 to 17	87.3%	86.8%
Adults who use walking paths, parks, playgrounds or sports fields in their neighborhood	51.7%	47.5%

Source: 2015 Los Angeles County Health Survey; Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health

The LA County Department of Public Health has published a report showing the park space per capita in 120 cities, communities and LA City Council Districts. The report includes data on premature mortality from cardiovascular disease and diabetes, rates of childhood obesity, and an index of economic hardship. The report shows an inverse correlation between premature mortality, childhood obesity, and the amount of park space per capita.

Among area cities, Commerce has the highest amount of park space: 2.4 acres per 1,000 residents, which is 36 out of 120 ranked areas/cities in Los Angeles County. In comparison, Bell has only 0.2 acres of park space per 1,000 residents, 114 out of 120 ranked areas. El Monte also has very little park space, with 0.4 acres per 1,000 persons, and a ranking of 105 out of 120.

Park Space per Capita

	Acres per 1,000 Persons	Rank out of 120 Cities or Communities
Commerce	2.4	36
Bell Gardens	1.7	47
Monterey Park	1.5	54
Montebello	1.3	58
Pico Rivera	1.3	60
South El Monte	1.1	65
Rosemead	1.1	69
Whittier	1.0	73
East Los Angeles	0.7	85
El Monte	0.4	105
Bell	0.2	114

Source: Parks and Public Health in Los Angeles County, A Cities and Communities Report, May 2016.
http://publichealth.lacounty.gov/chronic/docs/Parks%20Report%202016-rev_051816.pdf

Transportation

Los Angeles County workers spend, on average, 30.4 minutes a day commuting to work. 73.3% of workers drive alone to work and 47.1% of solo drivers have a long commute. Few workers commute by public transportation (6.5%) or walk to work (2.8%).

Transportation/Commute to Work

	Los Angeles County	California
Mean travel time to work (in minutes)	30.4	28.4
Solo drivers with a long commute	47.1%	39.3%
Workers commuting by public transportation	6.5%	5.2%
Workers who drive alone	73.3%	73.5%
Workers who walk to work	2.8%	2.7%

Source: U.S. Census Bureau, American Community Survey, 2013-2017. Conduent Healthy Communities, www.thinkhealthla.org

Households

In the hospital service area, there are 191,411 households and 200,975 housing units. Over the last five years, the population grew by 1.3%, the number of households grew at a rate of 4.2%, housing units grew at a rate of 3.8%, and vacant units increased by 4.3%. Owner-occupied housing increased by 2.7% and renters increased by 5.5%.

Households and Housing Units, and Percent Change, 2012-2017

	Beverly Service Area			Los Angeles County		
	2012	2017	Percent Change	2012	2017	Percent Change
Households	183,656	191,411	4.2%	3,218,511	3,295,198	2.4%
Housing units	193,692	200,975	3.8%	3,441,416	3,506,903	1.9%
Owner occ.	83,132	85,340	2.7%	1,523,331	1,512,364	(-0.7%)
Renter occ.	100,524	106,071	5.5%	1,695,180	1,782,834	5.2%
Vacant	9,166	9,564	4.3%	222,905	211,705	(-5.0%)

Source: U.S. Census Bureau, American Community Survey, 2008-2012 & 2013-2017, DP04. http://factfinder.census.gov

According to the US Department of Housing and Urban Development, those who spend more than 30% of their income on housing are said to be “cost burdened.” Those who spend 50% or more are considered “severely cost burdened.” Half (50%) of owner and renter occupied households in the service area spend 30% or more of their income on housing. This percent is higher than the county rate of 48.6%, and the state rate of 43.1%. The communities where the highest percentage of households spend 30% or more of their income on housing are Bell/Bell Gardens (59.4%), East Los Angeles 90023 (54.6%), South El Monte (53.2%) and El Monte (53.1%).

Households that Spend 30% or More of Income on Housing

	ZIP Code	Percent
Bell/Bell Gardens	90201	59.4%
Commerce	90040	46.5%
East Los Angeles	90022	51.9%
East Los Angeles	90023	54.6%
East Los Angeles	90063	49.5%
El Monte	91732	53.1%
Montebello	90640	48.6%
Monterey Park	91754	45.9%
Monterey Park	91755	51.6%
Pico Rivera	90660	42.6%
Rosemead	91770	48.8%
South El Monte	91733	53.2%
Whittier	90601	41.8%
Whittier	90606	40.3%
Beverly Service Area		**50.0%**
Los Angeles County		**48.6%**
California		**43.1%**

Source: U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates DP04. http://factfinder.census.gov

Median Household Income

Household income is defined as the sum of money received in a year by all household members, 16 years and older. Median household income reflects the relative affluence and prosperity of an area. The weighted average of the median household incomes in the service area is $49,736. Median household income in the service area ranges from $39,498 in Bell/Bell Gardens to $69,740 in Whittier 90601.

Median Household Income

	ZIP Code	Median Household Income
Bell/Bell Gardens	90201	$39,498
Commerce	90040	$43,585
East Los Angeles	90022	$41,276
East Los Angeles	90023	$40,225
East Los Angeles	90063	$44,121
El Monte	91732	$48,254
Montebello	90640	$50,326
Monterey Park	91754	$58,056
Monterey Park	91755	$49,755
Pico Rivera	90660	$61,524
Rosemead	91770	$51,383
South El Monte	91733	$42,758
Whittier	90601	$69,740
Whittier	90606	$66,566
Beverly Service Area*		**$49,736**
Los Angeles County		**$61,015**
California		**$67,169**

*Source: U.S. Census Bureau, American Community Survey, 2013-2017, DP03. http://factfinder.census.gov *Weighted mean of the medians.*

Homelessness

Since 2005, the Los Angeles Homeless Services Authority (LAHSA) had conducted the annual Greater Los Angeles Homeless Count to determine how many individuals and families are homeless on a given day. Data from this survey show a large increase in homelessness from 2015 to 2018. In SPA 3, 87.2% of the homeless are single adults and 16.9% are families. In SPA 7, 85.2% of the homeless are single adults and 19.5% are families. From 2015 through 2018, the percent of sheltered homeless in SPA 3 and SPA 7 has decreased. Shelter includes cars, RVs, tents and temporary structures (e.g. cardboard), in addition to official homeless shelters. The percentage of homeless families and unaccompanied minors has decreased from 2015 to 2018.

Homeless Population*, 2015-2018 Comparison

	SPA 3		SPA 7		Los Angeles County	
	2015	2018	2015	2018	2015	2018
Total homeless	**3,093**	**3,605**	**3,571**	**4,569**	**41,174**	**49,955**
Sheltered	43.9%	22.6%	25.4%	23.2%	29.7%	24.8%
Unsheltered	56.1%	77.4%	74.6%	76.8%	70.3%	75.2%
Individual adults	81.0%	87.2%	79.3%	85.2%	81.1%	84.1%
Families/family members	24.2%	16.9%	26.8%	19.5%	18.2%	15.8%
Unaccompanied minors (<18)	0.4%	0%	0.4%	0.02%	0.7%	0.1%

Source: Los Angeles Homeless Service Authority, 2015 & 2018 Greater Los Angeles Homeless Count.
https://www.lahsa.org/homeless-count/
**These data represent the homeless counts from the LA County Continuum of Care, which does not include Glendale, Long Beach and Pasadena homeless counts.*

Among the homeless population, 33.6% in SPA 3 and 18.7% in SPA 7 are chronically homeless. Rates of serious mental illness have increased in SPA 3 and decreased in SPA 7. From 2015 to 2018, there has been an increase in the homeless population with chronic illness in SPAs 3 and 7. SPA 3 has seen an increase in homeless persons with a domestic violence experience. Substance abuse rates among the homeless have decreased across the service area SPAs from 2015 to 2018. The rates of homeless veterans have also decreased as a percentage of total homelessness in service area SPAs.

Homeless Subpopulations*

	SPA 3		SPA 7		Los Angeles County	
	2015	2018	2015	2018	2015	2018
Chronically homeless individuals	29.2%	33.6%	29.4%	18.7%	30.0%	25.7%
Chronically homeless family members	3.2%	0.2%	4.7%	8.0%	4.9%	0.9%
Brain injury	0.9%	3.9%	0.4%	2.2%	5.0%	3.5%
Chronic illness	7.3%	22.7%	0.4%	20.0%	6.7%	23.2%
Domestic violence experience	18.6%	35.0%	25.8%	25.3%	21.5%	26.8%
Persons with HIV/AIDS	8.7%	0.6%	0.2%	0.5%	1.9%	1.4%
Physical disability	18.5%	13.5%	20.7%	11.1%	19.5%	13.5%
Serious mental illness	20.3%	30.2%	30.3%	17.3%	29.6%	24.2%
Substance abuse disorder	23.9%	20.0%	43.8%	8.3%	25.2%	13.5%
Veterans	7.9%	6.4%	8.0%	6.6%	10.6%	7.1%

Source: Los Angeles Homeless Service Authority, 2015 & 2018 Greater Los Angeles Homeless Count.
*https://www.lahsa.org/homeless-count/ *These data represent the homeless counts from the LA County Continuum of Care, which does not include Glendale, Long Beach and Pasadena homeless counts.*

Educational Attainment

In the service area, 38% of the adult population has less than a high school education. This rate is higher than the county (22.3%) and the state (17.9%). 42% of the population are high school graduates and 20% have a college degree; this is a lower percentage of

college degrees than seen at the county (38.2%) or state (40.4%) level.

Educational Attainment

	Beverly Service Area	Los Angeles County	California
Population age 25 and over	**462,916**	**6,801,851**	**25,950,818**
Less than 9th grade	23.6%	12.9%	9.7%
9th to 12th grade, no diploma	14.4%	9.0%	7.8%
High school graduate	26.0%	20.7%	20.6%
Some college, no degree	16.0%	19.3%	21.5%
Associate degree	5.8%	6.9%	7.8%
Bachelor's degree	10.5%	20.4%	20.4%
Graduate or professional degree	3.8%	10.9%	12.2%

Source: U.S. Census Bureau, American Community Survey, 2013-2017, DP02. http://factfinder.census.gov

High school graduation rates are determined by dividing the number of graduates for the school year by the number of freshman enrolled four years earlier. The high school graduation rates for the area high school districts range from 76.7% in the Los Angeles Unified School District (LAUSD) to 94.6% in the Alhambra Unified School District. Three of the seven area districts with high schools do not meet the Healthy People 2020 objective of an 87% high school graduation rate: LAUSD (76.7%), Montebello Unified (84%) and El Monte Union High (85.1%).

High School Graduation Rates, 2017-2018

	Graduation Rate
Alhambra Unified School District	94.6%
El Monte Union High School District	85.1%
El Rancho Unified School District	92.6%
Fullerton Joint Union High School District	93.4%
Los Angeles Unified School District (LAUSD)	76.7%
Montebello Unified School District	84.0%
Whittier Union High School District	90.2%
Los Angeles County	**85.3%**
California	**87.3%**

Source: California Department of Education, 2017-2018. https://data1.cde.ca.gov/dataquest/

Preschool Enrollment

47% of 3 and 4-year-olds are enrolled in preschool in the hospital service area, which is lower than state (48.6%) and county (54%) rates. However, the rates range from 31.4% enrolled in El Monte and 32.5% in South El Monte, to 62% enrolled in Whittier 90606 and 61.5% enrolled in Commerce.

Children, 3 and 4 Years of Age, Enrolled in Preschool

	ZIP Code	Number	Percentage
Bell/Bell Gardens	90201	3,869	48.1%
Commerce	90040	506	61.5%
East Los Angeles	90022	1,903	42.6%
East Los Angeles	90023	1,422	55.8%
East Los Angeles	90063	1,663	54.1%
El Monte	91732	1,800	31.4%
Montebello	90640	1,638	45.7%
Monterey Park	91754	646	58.4%
Monterey Park	91755	459	49.2%
Pico Rivera	90660	1,672	44.9%
Rosemead	91770	1,525	54.6%
South El Monte	91733	1,299	32.5%
Whittier	90601	867	43.7%
Whittier	90606	550	62.0%
Beverly Service Area		**19,819**	**47.0%**
Los Angeles County		**262,258**	**54.0%**
California		**1,035,277**	**48.7%**

Source: U.S. Census Bureau, American Community Survey, 2013-2017, S1401. http://factfinder.census.gov

Reading to Children

Adults with children in their care, ages 0 to 5, were asked whether the children were read to daily by family members, in a typical week. 50.9% of adults interviewed in the hospital service area responded “yes” to this question.

Children Who Were Read to Daily by a Parent or Family Member

	Beverly Service Area	Los Angeles County
Children read to daily by parent	50.9%	56.4%

Source: 2015 Los Angeles County Health Survey; Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health

Crime

Crime negatively impacts communities through economic loss, reduced productivity, and disruption of social services. 84.4% of adults in the service area perceived their neighborhoods to be safe from crime.

Perceived Neighborhood Safe from Crime

	Beverly Service Area	Los Angeles County
Perceived neighborhood safe from crime	84.4%	84.0%

Source: 2015 Los Angeles County Health Survey; Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health

Violent crimes include homicide, rape, robbery and assault. Property crimes include burglary, larceny and motor vehicle theft. Violent crime rates increased from 2014 to

2017 in Los Angeles County and all area cities listed, with the exceptions of Bell Gardens and Pico Rivera; the rates of violent crimes reported were high in Commerce and Los Angeles. Property crime rates also increased from 2014 to 2017 in the county and area cities, with the exception of Bell; the rate of reported property crimes is high in Commerce.

Violent Crimes Rates and Property Crime Rates, per 100,000 Persons, 2014 and 2017

	Property Crimes				Violent Crimes			
	Number		Rate		Number		Rate	
	2014	2017	2014	2017*	2014	2017	2014	2017*
Bell	718	652	1,991.2	1,808.1	217	228	601.8	632.3
Bell Gardens	710	749	1,647.8	1,738.3	108	100	250.6	232.1
Commerce	965	1,174	7,404.3	9,007.9	77	106	590.8	813.3
Los Angeles (East L.A. N/A)	83,139	101,618	2,128.1	2,601.1	19,171	30,507	490.7	780.9
El Monte	2,213	2,816	1,904.1	2,423.0	333	451	286.5	388.1
Montebello	1,449	1,644	2,273.4	2,579.3	134	203	210.2	318.5
Monterey Park	1,039	1,613	1,695.4	2,632.0	91	112	148.5	182.8
Pico Rivera	1,360	1,432	2,126.0	2,238.5	275	236	429.9	368.9
Rosemead	1,186	1,327	2,166.3	2,423.8	147	173	268.5	316.0
South El Monte	647	684	3,161.5	3,342.3	120	121	586.4	591.3
Whittier	2,247	2,507	2,584.2	2,883.2	239	300	274.9	345.0
Los Angeles County*	**217,493**	**248,714**	**2,163.1**	**2,473.6**	**42,725**	**59,924**	**424.9**	**595.9**
California*	**946,682**	**1,001,380**	**2,459.0**	**2,544.5**	**151,425**	**174,701**	**393.3**	**443.9**

Source: CA Department of Justice, Office of the Attorney General, 2018. https://oag.ca.gov/crime
Source for 2014 city data (number and rate): US Bureau of Justice Statistics https://www.bjs.gov/ucrdata/Search/Crime/Crime.cfm
**State rates were provided by the CA DOJ; rates for the county were calculated based on historical population totals provided by CA Department of Finance and all 2017 rates for cities were calculated based on 2014 population coverage from bjs.gov data and are, therefore, only estimates.*

Intimate Partner Violence

5.5% of male adults and 11.7% of female adults in SPA 3 reported experiencing physical (hit, slapped, pushed, kicked, etc.) violence. Rates were somewhat higher in SPA 7, with 7.3% of males and 16.9% of females reporting physical violence. 1.6% of adult males and 6.8% of adult females in SPA 3 experienced sexual violence (unwanted sex) by an intimate partner. Rates were again higher in SPA 7, with 2.4% of males and 13.2% of females reporting sexual violence.

Intimate Partner Violence

	SPA 3	SPA 7	Los Angeles County
Women have experienced physical violence	11.7%	16.9%	16.0%
Women have experienced sexual violence	6.8%	13.2%	10.1%
Men have experienced physical violence	5.5%	7.3%	11.8%
Men have experienced sexual violence	1.6%*	2.4%*	3.3%

*Source: County of Los Angeles Public Health Department, L.A. County Health Survey, 2018; *Statistically unstable due to small sample size. http://publichealth.lacounty.gov/ha/LACHSDataTopics2018.htm*

Domestic violence calls are categorized as "with" or "without a weapon." Weapons include firearms, knives, other weapons, and fists or other parts of the body that inflict great-bodily harm. 97.2% of domestic violence calls in Whittier included a weapon while 8% of domestic violence in Bell Gardens involved a weapon.

Domestic Violence Calls

	Total	Without Weapon	With Weapon	Percent With Weapon
Bell	113	70	43	38.1%
Bell Gardens	212	195	17	8.0%
Commerce	53	11	42	79.2%
Los Angeles (East L.A. N/A)	23,197	5,876	17,321	74.7%
El Monte	146	90	56	38.4%
Montebello	178	13	165	92.7%
Monterey Park	107	95	12	11.2%
Pico Rivera	223	69	154	69.1%
Rosemead	160	73	87	54.4%
South El Monte	128	43	85	66.4%
Whittier	251	7	244	97.2%
Los Angeles County	**42,702**	**14,535**	**28,167**	**66.0%**
California	**169,362**	**94,260**	**75,102**	**44.3%**

Source: California Department of Justice, Office of the Attorney General, 2017. https://oag.ca.gov/crime Data available by city.

Community Input – Violence/Community Safety

Stakeholder interviews and focus groups identified the following issues, challenges and barriers related to violence and community safety.

- I don't know what is happening in Montebello. But we have a lot of questionable people hanging out in the alleys, hanging out in the streets, and the bars. I see it and I don't like it.
- We should have more security for our schools. There is violence in the schools.
- Seniors are concerned with safety in the community.
- This is a very high priority, even more than unintentional injury. We've seen great improvement and declines in violent homicide. Violence has many forms, with gangs and homicide, we've seen a dramatic decline because of better policing and law

enforcement, community organizations with violence prevention, and youth development programs to help keep kids from joining gangs.

- We see far too much child abuse and elder abuse. We have a taskforce on human trafficking, it's a problem in LA.
- California is a leader in regulating firearms, but it is not enough.
- Violence is a dark secret that stays hidden and is not brought out to light unless it gets out of control.
- In the communities we work in, families are scared to report what is happening. They don't want to get involved for fear of retaliation. If they are living someplace where rent is affordable, they are willing to sacrifice safety for housing.
- There are not enough opportunities for youth to participate in other activities. They have too much time on their hands and sometimes they find destructive ways of passing time.

Health Care Access

Health Insurance Coverage

Health insurance coverage is a key component to accessing health care. Barriers to care can result in unmet health needs, delays in provision of appropriate treatment, and increased costs from avoidable ER visits and hospitalizations. The Healthy People 2020 objective is 100% insurance coverage for all population groups. Among service area children, ages 0 to 17, 94.8% are insured. 85.7% of adults in the service area have health insurance.

Health Insurance Coverage

	Beverly Service Area	Los Angeles County
Insured children, ages 0-17 years	94.8%	96.6%
Insured adults, ages 18-64 years	85.7%	88.3%

Source: 2015 Los Angeles County Health Survey; Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health

In the service area, 82.8% of the population has health insurance. Whittier 90601 has the highest rate of health insurance coverage (90.9%) and South El Monte has the lowest rate of health insurance coverage (77.8%) in the service area. Health care coverage is higher among children, under 19 years of age, (93.7%). East Los Angeles 90063 has the lowest rate of health insurance coverage for children (90%) in the service area. 75.4% of adults, ages 19-64, in the service area have health insurance coverage.

Health Insurance Coverage

	ZIP Code	All Ages	0 to 18 Years	19 to 64 Years
Bell/Bell Gardens	90201	79.0%	92.9%	69.4%
Commerce	90040	82.7%	92.4%	74.6%
East Los Angeles	90022	79.5%	92.9%	70.5%
East Los Angeles	90023	78.5%	93.2%	68.9%
East Los Angeles	90063	79.6%	90.0%	71.5%
El Monte	91732	80.3%	95.5%	71.4%
Montebello	90640	83.5%	94.8%	75.7%
Monterey Park	91754	89.5%	92.8%	85.2%
Monterey Park	91755	90.4%	96.9%	86.5%
Pico Rivera	90660	86.0%	94.5%	80.1%
Rosemead	91770	88.3%	96.2%	82.9%
South El Monte	91733	77.8%	94.6%	67.0%
Whittier	90601	90.9%	94.1%	87.8%
Whittier	90606	85.8%	92.6%	81.3%
Beverly Service Area		**82.8%**	**93.7%**	**75.4%**
Los Angeles County		**86.7%**	**94.5%**	**81.5%**
California		**89.5%**	**95.3%**	**85.2%**

Source: U.S. Census Bureau, American Community Survey, 2013-2017, S2701. http://factfinder.census.gov

When the type of insurance coverage was examined for the service area, 26.3% of the population in SPA 3 and 29.4% of SPA 7 residents had Medi-Cal coverage. In SPA 3, 43.5% had employment-based insurance and in SPA 7, 38.5% had employment-based insurance.

Insurance Coverage by Type

	SPA 3	SPA 7	Los Angeles County	California
Medi-Cal	26.3%	29.4%	28.8%	25.8%
Medicare only	1.4%*	1.2%*	1.2%	1.4%
Medi-Cal/Medicare	4.4%	5.0%	4.8%	3.9%
Medicare and others	8.5%	7.0%	7.5%	8.9%
Other public	0.9%*	1.6%*	1.2%	1.3%
Employment based	43.5%	38.5%	39.8%	43.6%
Private purchase	5.6%	5.7%	6.5%	6.3%
No insurance	9.3%	11.7%	10.2%	8.8%

*Source: California Health Interview Survey, 2014-2017. http://ask.chis.ucla.edu/ *Statistically unstable due to sample size.*

Regular Source of Care

Access to a medical home and a primary care provider improve continuity of care and decrease unnecessary emergency room visits. 96.6% of children in the Beverly Hospital service area have a regular source of health care. Adults are less likely to have a regular source of health care (77.7%).

Regular Source of Health Care

	Beverly Service Area	Los Angeles County
Children, ages 0-17, with a regular source of health care	96.6%	94.3%
Adults, ages 18-64, with a regular source of health care	77.7%	77.7%

Source: 2015 Los Angeles County Health Survey; Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health

In SPA 3, 60.2% of adults access care at a doctor's office, HMO or Kaiser, and 22.9% access care at a clinic or community hospital. 55.9% of adults in SPA 7 access care at a doctor's office, HMO or Kaiser and 25% access care at a clinic or community hospital.

Sources of Care

	SPA 3	SPA 7	Los Angeles County	California
Dr. office/HMO/Kaiser	60.2%	55.9%	56.1%	59.3%
Community clinic/government clinic/ community hospital	22.9%	25.0%	25.2%	24.2%
ER/Urgent Care	1.7%*	2.2%*	2.2%	1.7%
Other	0.6%*	1.2%*	0.8%	0.8%
No source of care	14.5%	15.7%	15.6%	14.0%

*Source: California Health Interview Survey, 2014-2017.http://ask.chis.ucla.edu/ *Statistically unstable due to sample size.*

Access to primary care providers increases the likelihood that community members will have routine checkups and screenings. When access to care through a usual source of care is examined by race/ethnicity, Latinos are the least likely to have a usual source of care in SPA 3 (81.8%) and Asians are least likely to have a usual source of care in SPA 7 (81.2%).

Usual Source of Care by Race/Ethnicity

	SPA 3	SPA 7	Los Angeles County	California
African American	87.8%*	93.6%*	89.5%	89.4%
Asian	83.7%	81.2%*	82.6%	84.2%
Latino	81.8%	83.1%*	80.1%	80.8%
White	94.9%*	93.4%*	91.2%	91.1%

*Source: California Health Interview Survey, 2014-2017. http://ask.chis.ucla.edu/ *Statistically unstable due to sample size.*

19.5% of the population in SPA 3 and 24.1% of the population in SPA 7 visited an ER in the past 12 months. In SPA 3, children, 0 to 17 years old, visited the ER at the highest rates (21.6%). In SPA 7, seniors visited the ER at the highest rates (24.4%). Low-income residents tend to visit the ER at higher rates than the total population, and those living in poverty visit at the highest rates.

Use of the Emergency Room

	SPA 3	SPA 7	Los Angeles County	California
Visited ER in last 12 months	19.5%	24.1%	22.0%	21.3%
0-17 years old	21.6%	24.2%	18.3%	18.9%
18-64 years old	18.4%	23.9%	22.9%	21.6%
65 years and older	20.8%	24.4%	24.6%	23.6%
<100% of poverty level	24.0%	29.0%	24.1%	26.3%
<200% of poverty level	22.0%	27.2%	23.6%	24.7%

Source: California Health Interview Survey, 2015-2017. http://ask.chis.ucla.edu/

Access to Primary Care Community Health Centers

Community Health Centers provide primary care (including medical, dental and mental health services) for uninsured and medically underserved populations. Using ZCTA (ZIP Code Tabulation Area) data for the hospital service area and information from the Uniform Data System (UDS)[1], 50.4% of the population in the service area is categorized as low-income (200% or less than the Federal Poverty Level) and 20.5% of the population are living in poverty.

There are 14 Section 330 funded grantees (Federally Qualified Health Centers – FQHCs and FQHC Look-Alikes) serving the service area, including: AltaMed Health Services Corp., Asian Pacific Health Care Venture, Central City Community Health Center, Inc., Chinatown Service Center, Clinica Monsenor Oscar A. Romero, Community Health Alliance of Pasadena, Complete Care Community Health Center, Inc., Family Health Care Centers of Greater Los Angeles, Inc., Friends of Family Health Center, Garfield Health Center, Herald Christian Health Center, JWCH Institute, Inc., Latino Kids Health, Los Angeles Christian Health Centers, Northeast Community Clinic, Inc., Queenscare Health Centers, Southern California Medical Center, Inc., and Via Care Community Health Center, Inc.

Even with Community Health Centers serving the area, there are a significant number of low-income residents who are not served by one of these clinic providers. The FQHCs and Look-Alikes have a total of 111,420 patients in the service area, which equates to 31.4% coverage among low-income patients and 15.7% coverage among the total population. From 2015-2017, clinic providers added 11,955 patients for a 12.0% increase in patients served by Community Health Centers. However, there remain 243,651 low-income residents, approximately 68.6% of the population at or below 200% FPL, who are not served by a Community Health Center.

Low-Income Patients Served and Not Served by FQHCs and Look-Alikes

Low-Income Population	Patients served by Section 330 Grantees In Service Area	Penetration among Low-Income Patients	Penetration of Total Population	Low-Income Not Served	
				Number	Percent
355,071	111,420	31.4%	15.7%	243,651	68.6%

Source: UDS Mapper, 2017. http://www.udsmapper.org

[1] The UDS is an annual reporting requirement for grantees of HRSA primary care programs:
- Community Health Center, Section 330 (e)
- Migrant Health Center, Section 330 (g)
- Health Care for the Homeless, Section 330 (h)
- Public Housing Primary Care, Section 330 (i)

Delayed or Forgone Care

Individuals who receive services in a timely manner have greater opportunity to prevent or detect disease during earlier, treatable stages. A delay of necessary care can lead to an increased risk of complications. Residents in SPA 3 delayed or did not get medical care (10.7%) when needed at higher rates than in SPA 7 (10.4%). 6.2% of residents in SPA 3 ultimately went without needed medical care. In SPA 7 6.6% ended up having to forgo needed care. Reasons for a delay in care or going without care included the cost of care/insurance issues, personal reasons, or system/provider issues; 55.6% of SPA 3 residents and 39.9% of SPA 7 residents who delayed or went without care listed "cost/insurance Issues" as a barrier. SPA 7 residents were more likely to delay or forego prescriptions (8.5%) than were SPA 3 residents (6.3%).

Delayed Care in Past 12 Months, All Ages

	SPA 3	SPA 7	Los Angeles County	California
Delayed or did not get medical care	10.7%	10.4%	10.9%	10.5%
Had to forgo needed medical care	6.2%	6.6%	6.5%	6.2%
Delayed or did not get medical care due to cost, lack of insurance or other insurance issue	55.6%	39.9%	46.5%	45.8%
Delayed or did not get prescription meds	6.3%	8.5%	8.6%	9.0%

Source: California Health Interview Survey, 2015-2017. http://ask.chis.ucla.edu/

Lack of Care Due to Cost

4.6% of children in SPA 3 and 7.6% in SPA 7 were unable to afford a checkup or physical exam within the prior 12 months. 5.4% of children in SPA 3 and 5.8% in SPA 7 were unable to see a doctor in cases of illness. 5.5% of children in SPA 3 and 7.0% in SPA 7 were unable to afford prescription medications in the past 12 months.

Cost as a Barrier to Accessing Health Care in the Past Year for Children, Under 18 Years

	SPA 3	SPA 7	Los Angeles County
Child unable to afford medical checkup or physical exam	4.6%	7.6%	5.5%
Child unable to afford to see doctor for illness or other health problem	5.4%	5.8%	5.2%
Child unable to afford prescription medication	5.5%	7.0%	5.8%

Source: County of Los Angeles Public Health Department, Los Angeles County Health Survey, 2018; http://publichealth.lacounty.gov/ha/LACHSDataTopics2018.htm

Community Input – Access to health care

Stakeholder interviews and focus groups identified the following issues, challenges and barriers related to access to health care.

- The immigrant community and undocumented individuals are fearful about

accessing health care services.

- Language barriers interfere with health care access.
- Many people don't know what resources are available to them. They don't understand the rules for accessing Medi-Cal or Medicare.
- It is difficult for the homeless to seek out resources.
- We have a lot of families that are in the process of legalizing and they don't want to access any services they think will put them in a category of public charge.
- We have mothers who are not returning for their postpartum care visit and we haven't really figured out why. They will take their babies to their well child visits but they won't go to their own. Overall, they tend to not use preventive care and resort to ED care. They are not comfortable accessing care; they do not have a clinic or they do not have insurance.
- The more we work they cannot get away to take care of themselves.
- In this political climate, even if there is free health care and it doesn't matter about documentation, people are scared right now, so that is a barrier.
- Time is a big barrier. Also, safety and transportation to facilities. It is hard to navigate and get an appointment. Some insurance carriers have moved to an all online system, and no one is available on the phone. And once a person gets an appointment, an issue that has come up is the cultural competency of doctors.
- a lot of our seniors feel overwhelmed by the system and having to answer questions and provide information. Lack of transportation limits their ability to get to appointments.
- If people are not working or don't have Medi-Cal, they are accessing health care. If they do need care, they have to wait for hours to be seen.
- For those who are undocumented, there are problems getting specialty care and mental health care services.
- The availability of appointments is an issue. I know sometimes our staff try to arrange appointments and the next available appointment isn't for a month or two and by then, their symptoms have subsided and the next time it comes up, they are using the ED versus doctor visits.

Dental Care

Oral health is essential to a person's overall health and wellbeing. 50.3% of adults in the service area did not visit a dentist in the past year, and 12.5% of children in the service area did not obtain dental care in the past year because they could not afford it.

Delay of Dental Care

	Beverly Service Area	Los Angeles County
Adults who did not see a dentist or go to a dental clinic in the past year	50.3%	40.7%
Children, ages 3-17, who did not obtain dental care (including check-ups) in the past year because they could not afford it	12.5%	11.5%

Source: 2015 Los Angeles County Health Survey; Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health

16.7% of children in SPA 3 and 19.3% in SPA 7 had never been to a dentist; these are higher rates than seen in LA County (15.4%) and the state (15.5%). There were no teens in SPA 3 or SPA 7 who had not been to the dentist.

Delay of Dental Care among Children and Teens

	SPA 3	SPA 7	Los Angeles County	California
Children never been to the dentist	16.7%	19.3%	15.4%	15.5%
Children been to dentist less than 6 months to 2 years	80.8%*	80.1%*	83.4%*	83.7%
Teens never been to the dentist	0.0%*	0.0%*	2.8%*	1.8%
Teens been to dentist less than 6 months to 2 years	94.5%*	90.6%*	95.6%*	95.8%

*Source: California Health Interview Survey, Children 2013-2017, Teens 2013, 2014 & 2017. http://ask.chis.ucla.edu/ *Statistically unstable due to sample size*

Community Input – Dental Care

Stakeholder interviews and focus groups identified the following issues, challenges and barriers related to dental care.

- A lot of employers cover medical insurance but not dental insurance. I know so many people who have never gone to a dentist. USC Dental School has a wait list of 100 people a day when they have programs in the community. That is a testament to the need.
- The cost of dental care is a real issue.
- Parents put their babies to bed with a bottle and it causes dental decay. Also, the high intake of sugary drinks causes dental disease.
- There are not enough use of sealants and fluoride.
- Big concern in kids is tooth decay and poor oral health. It's relatively prevalent and a source of discomfort that can get in the way if learning in school and can adversely impact quality of life.
- With adults there are big deficits in the percent of those that get the dental care they need. They are not getting preventive care. They just get care when they absolutely need it, and even then, they are not sure where to go.

- Dental insurance isn't as comprehensive as health insurance and out of pocket, people can't afford it, so there are financial barriers.
- People are afraid to go to the dentist; afraid that it might be painful.

Birth Characteristics

Births

From 2014 to 2015, there were 9,887 births, or an average of 4,944 births per year in the hospital service area.

Delivery Paid by Public Insurance or Self-Pay

In the hospital service area, the rate of births paid by public insurance or self-pay was 700.5 per 1,000 live births, which is higher than county (553.4 per 1,000 live births) or state (502.6 per 1,000 live births) rates.

Delivery Paid by Public Insurance or Self-Pay, per 1,000 Live Births

	Beverly Service Area	Los Angeles County	California
Delivery paid by public insurance or self-pay	70.1%	55.3%	50.3%

Source: Calculated by Gary Bess Associates using California Department of Public Health Birth Profiles by Zip Code of Residence, 2014-2015, and U.S. Census Bureau American Community Survey, 5-Year Average 2012-2016, Table B01001.

Prenatal Care

Pregnant women in the service area entered prenatal care in the first trimester at a rate of 88%. This is higher than the county and state rates, and exceeds the Healthy People 2020 objective of 78% of women entering prenatal care in the first trimester.

Mother Received On-Time (1st Trimester) Prenatal Care

	Beverly Service Area	Los Angeles County	California
On-time prenatal care	88.0%	85.1%	83.4%

Source: Calculated by Gary Bess Associates using California Department of Public Health Birth Profiles by Zip Code of Residence, 2014-2015, and U.S. Census Bureau American Community Survey, 5-Year Average 2012-2016, Table B01001.

Teen Birth Rate

Teen births occurred at a rate of 63.5 (6.4%) per 1,000 live births in the service area. This rate is higher than the teen birth rate in the county (51.5 per 1,000 live births) and state (52.1 per 1,000 live births).

Births to Teenage Mothers (Under Age 20), 2014-2015, Percentage of Live Births

	Beverly Service Area	Los Angeles County	California
Births to teen mothers	6.4%	5.2%	5.2%

Source: Calculated by Gary Bess Associates using California Department of Public Health Birth Profiles by Zip Code of Residence, 2014-2015, and U.S. Census Bureau American Community Survey, 5-Year Average 2012-2016, Table B01001.

Premature Birth

The rate of premature births (occurring before the start of the 38th week of gestation) in the service area, is 8.3% (83.1 per 1,000 live births). This rate of premature births is lower than the county (8.6%) and state (8.4%) rates of premature births.

Premature Birth, before Start of 38th Week

	Beverly Service Area	Los Angeles County	California
Premature birth	8.3%	8.6%	8.4%

Source: Calculated by Gary Bess Associates using California Department of Public Health Birth Profiles by Zip Code of Residence, 2014-2015, and U.S. Census Bureau American Community Survey, 5-Year Average 2012-2016, Table B01001.

Low Birth Weight

Babies born at a low birth weight are at higher risk for disease, disability and possible death. The service area rate of low birth weight babies is 6.5% (65.2 per 1,000 live births). This is lower than county (7.1%) and state (6.8%) rates. The service area rate meets the Healthy People 2020 objective of 7.8% low birth weight births.

Low Birth Weight (<2,500 g), per 1,000 Live Births

	Beverly Service Area	Los Angeles County	California
Low birth weight	6.5%	7.1%	6.8%

Source: Calculated by Gary Bess Associates using California Department of Public Health Birth Profiles by Zip Code of Residence, 2014-2015, and U.S. Census Bureau American Community Survey, 5-Year Average 2012-2016, Table B01001.

Mother Smoked Regularly During Pregnancy

The service area rate of mothers who smoked regularly during pregnancy was 0.2% (2.3 per 1,000 live births), which is lower than the county rate (0.7%) and state rate (1.8%).

Mothers Who Smoked Regularly During Pregnancy, per 1,000 Live Births

	Beverly Service Area	Los Angeles County	California
Mothers smoked	0.2%	0.7%	1.8%

Source: Calculated by Gary Bess Associates using California Department of Public Health Birth Profiles by Zip Code of Residence, 2014-2015, and U.S. Census Bureau American Community Survey, 5-Year Average 2012-2016, Table B01001.

Infant Mortality

The infant (less than one year of age) mortality rate in the service area is 3.8 deaths per 1,000 live births, which is lower than the county rate of 4.1 deaths per 1,000 live births and the Healthy People 2020 objective of 6.0 deaths per 1,000 births.

Infant Death Rate, per 1,000 Live Births, 5-Year Averaged

	Beverly Service Area	Los Angeles County
Infant death rate	3.8	4.1

Source: California Department of Public Health: 2012-2016 Birth & Death Statistical File; analyzed by the Los Angeles County Department of Public Health, Maternal, Child, and Adolescent Health (MCAH) Program April 2019

Breastfeeding

Breastfeeding has been proven to have considerable benefits to baby and mother. The American Academy of Pediatrics recommends that babies are fed only breast milk for the first six months of life. Breastfeeding data are collected by hospitals on the Newborn Screening Test Form. Breastfeeding rates at Beverly Hospital indicated 89.6% of new

mothers were breastfeeding and 35.4% were exclusively breastfeeding. These rates of breastfeeding were lower than the breastfeeding rates at hospitals in the county and state.

In-Hospital Breastfeeding

	Any Breastfeeding		Exclusive Breastfeeding	
	Number	Percent	Number	Percent
Beverly Hospital	623	89.6%	246	35.4%
Los Angeles County	101,802	93.9%	67,939	62.6%
California	384,637	93.9%	285,146	69.6%

Source: California Department of Public Health, Breastfeeding Hospital of Occurrence, 2017
https://www.cdph.ca.gov/Programs/CFH/DMCAH/Breastfeeding/Pages/In-Hospital-Breastfeeding-Initiation-Data.aspx

There are ethnic/racial differences noted in breastfeeding rates of mothers who delivered at Beverly Hospital. Among White mothers, 93.8% initiated breastfeeding. Among Asian mothers, 90.7% initiated breastfeeding and 24.7% breastfed exclusively. 89.1% of Latina mothers chose to breastfeed and 38.2% breastfed exclusively. There were only 5 births in 2017 at Beverly Hospital to mothers of African-American heritage and those who listed as multiple races, so no data were available on their breastfeeding choices.

In-Hospital Breastfeeding, Beverly Hospital, by Race/Ethnicity

	Any Breastfeeding		Exclusive Breastfeeding	
	Number	Percent	Number	Percent
White	15	93.8%	<10 cases	D/S
Asian	147	90.7%	40	24.7%
Latino/Hispanic	441	89.1%	189	38.2%
African American	D/S	D/S	D/S	D/S
Multiple races	D/S	D/S	D/S	D/S
Beverly Hospital	**623**	**89.6%**	**246**	**35.4%**

Source: California Department of Public Health, Breastfeeding Hospital of Occurrence, 2017. D/S = data suppressed due to fewer than 10 births.
https://www.cdph.ca.gov/Programs/CFH/DMCAH/Breastfeeding/Pages/In-Hospital-Breastfeeding-Initiation-Data.aspx

Leading Causes of Death

Life Expectancy at Birth

Life expectancy in hospital service area cities ranged from 81.8 years in Whittier to a 86.3 years in Monterey Park.

Life Expectancy at Birth

	Years of Life Expected
Bell	85.1
Bell Gardens	82.0
East Los Angeles	82.7
El Monte	83.7
Montebello	83.0
Monterey Park	86.3
Pico Rivera	82.3
Rosemead	85.1
Whittier	81.8
Los Angeles County	**82.3**

Source: Los Angeles Department of Public Health, City and Community Health Profiles, 2016.
http://publichealth.lacounty.gov/ohae/cchp/index.htm Data not available for Commerce or South El Monte.

Leading Causes of Death

Heart disease, cancer, and stroke are the top three causes of death in the service area. Diabetes is the fourth leading cause of death and Alzheimer's disease is the fifth leading cause of death. These causes of death are reported as age-adjusted death rates. Age-adjusting eliminates the bias of age in the makeup of the populations that are compared. When comparing across geographic areas, age-adjusting is used to control the influence that population age distributions might have on health event rates.

Leading Causes of Death, Age-Adjusted Rate per 100,000 Persons, 3-Year, 2014-2015

	Beverly Service Area		Los Angeles County	California	Healthy People 2020 Objective
	Avg. Annual Deaths	Rate	Rate	Rate	Rate
Heart disease	964	128.7	149.8	143.9	No Objective
Ischemic heart disease	703	93.9	106.8	130.2	103.4
Cancer	929	127.0	138.6	143.4	161.4
Stroke	244	32.3	33.1	35.1	34.8
Diabetes	213	29.0	22.6	20.8	Not Comparable
Alzheimer's disease	167	21.5	31.4	33.3	No Objective
Chronic Lower Respiratory Disease	160	21.4	28.3	32.6	Not Comparable

	Beverly Service Area		Los Angeles County	California	Healthy People 2020 Objective
	Avg. Annual Deaths	Rate	Rate	Rate	Rate
Pneumonia and influenza	157	20.9	20.3	14.8	No Objective
Liver disease	144	19.6	13.3	12.3	8.2
Unintentional injuries	129	17.3	21.4	29.9	36.4
Kidney disease	80	10.9	10.7	8.2	Not Comparable
Homicide	45	6.2	5.6	4.8	5.5
Suicide	33	4.5	7.7	10.4	10.2
HIV	11	1.6	2.4	1.8	3.3

Source: Calculated by Gary Bess Associates using California Department of Public Health Master Death File 2014-2015 and U.S. Census Bureau American Community Survey, 5-Year Average 2012-2016, Table B01001, and using the 2000 U.S. standard million.

Heart Disease and Stroke

The age-adjusted mortality rate for ischemic heart disease (a sub-category of heart disease) was lower in the service area (93.9 deaths per 100,000 persons) than in the county (106.8 deaths per 100,000 persons) and the state (130.2 deaths per 100,000 persons). The rate of ischemic heart disease death in the service area meets the Healthy People 2020 objective of 103.4 heart disease deaths per 100,000 persons. The age-adjusted rate of death from stroke was lower in the service area (32.3 deaths per 100,000 persons) than in the county (33.1 deaths per 100,000 persons) and the state (35.1 deaths per 100,000 persons). It meets the Healthy People 2020 objective of 34.8 stroke deaths per 100,000 persons.

Heart Disease and Stroke Mortality Rates, Age-Adjusted, per 100,000 Persons

	Beverly Service Area		Los Angeles County	California
	Number	Rate	Rate	Rate
Heart disease death rate	964	128.7	149.8	143.9
Ischemic heart disease death rate	703	93.9	106.8	130.2
Stroke death rate	244	32.3	33.1	35.1

Source: Calculated by Gary Bess Associates using California Department of Public Health Master Death File 2014-2015 and U.S. Census Bureau American Community Survey, 5-Year Average 2012-2016, Table B01001, and using the 2000 U.S. standard million

Cancer

In the service area, the age-adjusted cancer mortality rate was 127.0 per 100,000 persons. This was lower than the county rate of 138.6 per 100,000 persons and the state rate of 143.4 cancer deaths per 100,000 persons. The cancer death rate in the service area meets the Healthy People 2020 objective of 161.4 cancer deaths per 100,000 persons.

Cancer Mortality Rate, Age-Adjusted, per 100,000 Persons

	Beverly Service Area		Los Angeles County	California
	Number	Rate	Rate	Rate
Cancer death rate	929	127.0	138.6	143.4

Source: Calculated by Gary Bess Associates using California Department of Public Health Master Death File 2014-2015 and U.S. Census Bureau American Community Survey, 5-Year Average 2012-2016, Table B01001, and using the 2000 U.S. standard million.

For Los Angeles County, cancer mortality rates are slightly lower, overall, than state rates. In the county, the rates of death from female breast cancer (20.5 per 100,000 women), colorectal cancer (13.8 per 100,000 persons), pancreatic cancer (10.4 per 100,000 persons), liver and bile duct cancers (8.2 per 100,000 persons), Non-Hodgkin Lymphoma (5.5 per 100,000 persons), stomach cancer (5.2 per 100,000 persons), and uterine cancers (4.8 per 100,000 women), exceed the state rates of death.

Cancer Mortality Rates, Age-Adjusted, per 100,000 Persons

	Los Angeles County	California
Cancer all sites	**142.1**	**146.6**
Lung and bronchus	28.4	32.0
Breast (female)	20.5	20.1
Prostate (males)	19.1	19.6
Colon and rectum	13.8	13.2
Pancreas	10.4	10.3
Liver and intrahepatic bile duct	8.2	7.6
Ovary (females)	7.0	7.1
Leukemia*	6.1	6.3
Non-Hodgkin lymphoma	5.5	5.4
Stomach	5.2	4.0
Uterine** (females)	4.8	4.5
Urinary bladder	3.5	3.9
Kidney and renal pelvis	3.2	3.5

*Source: The Centers for Disease Control and Prevention, National Cancer Institute, State Cancer Profiles, 2011-2015 http://www.cancer-rates.info/ca/ *Myeloid and Monocytic + Lymphocytic + "Other" Leukemias **Uterus, NOS + Corpus Uteri*

Diabetes

Diabetes is a leading cause of death and disproportionately affects minority populations and the elderly. Its incidence is likely to increase as minority populations grow and the population ages. In the service area, the diabetes death rate was 29.0 per 100,000 persons, which was higher than county and state rates.

Diabetes Mortality Rate, Age-Adjusted, per 100,000 Persons

	Beverly Service Area		Los Angeles County	California
	Number	Rate	Rate	Rate
Diabetes death rate	213	29.0	22.6	20.8

Source: Calculated by Gary Bess Associates using California Department of Public Health Master Death File 2014-2015 and U.S. Census Bureau American Community Survey, 5-Year Average 2012-2016, Table B01001, and using the 2000 U.S. standard million.

Alzheimer's Disease

Alzheimer's disease is the most common form of dementia, accounting for 50% to 80% of dementia cases. In the service area, the Alzheimer's disease death rate was 21.5 per 100,000 persons. This was lower than county and state rates.

Alzheimer's Disease Mortality Rate, Age-Adjusted, per 100,000 Persons

	Beverly Service Area		Los Angeles County	California
	Number	Rate	Rate	Rate
Alzheimer's disease death rate	167	21.5	31.4	33.3

Source: Calculated by Gary Bess Associates using California Department of Public Health Master Death File 2014-2015 and U.S. Census Bureau American Community Survey, 5-Year Average 2012-2016, Table B01001, and using the 2000 U.S. standard million.

Chronic Lower Respiratory Disease (CLRD)

Chronic Lower Respiratory Disease refers to a group of diseases that cause airflow blockage and breathing-related problems. This includes COPD (Chronic Obstructive Pulmonary Disease), chronic bronchitis and emphysema. In the service area, the CLRD death rate was 21.4 per 100,000 persons. This was lower than county and state rates.

Chronic Lower Respiratory Disease Mortality Rate, Age-Adjusted, per 100,000 Persons

	Beverly Service Area		Los Angeles County	California
	Number	Rate	Rate	Rate
CLRD death rate	160	21.4	28.3	32.6

Source: Calculated by Gary Bess Associates using California Department of Public Health Master Death File 2014-2015 and U.S. Census Bureau American Community Survey, 5-Year Average 2012-2016, Table B01001, and using the 2000 U.S. standard million.

Pneumonia and Influenza

In the service area, the pneumonia and influenza death rate was 20.9 per 100,000 persons, which was higher than the county and state rates.

Pneumonia and Influenza Mortality Rate, Age-Adjusted, per 100,000 Persons

	Beverly Service Area		Los Angeles County	California
	Number	Rate	Rate	Rate
Pneumonia/influenza death rate	157	20.9	20.3	14.8

Source: Calculated by Gary Bess Associates using California Department of Public Health Master Death File 2014-2015 and U.S. Census Bureau American Community Survey, 5-Year Average 2012-2016,Table B01001 and using the 2000 U.S. standard million.

Liver Disease

In the service area, the liver disease death rate was 19.6 per 100,000 persons. This rate was higher than county and state rates of death from liver disease.

Liver Disease Mortality Rate, Age-Adjusted, per 100,000 Persons

	Beverly Service Area		Los Angeles County	California
	Number	Rate	Rate	Rate
Liver disease death rate	144	19.6	13.3	12.3

Source: Calculated by Gary Bess Associates using California Department of Public Health Master Death File 2014-2015 and U.S. Census Bureau American Community Survey, 5-Year Average 2012-2016, Table B01001 and using the 2000 U.S. standard million.

Unintentional Injury

Major categories of unintentional injuries include motor vehicle collisions, poisonings, and falls. The age-adjusted death rate from unintentional injuries in the service area was 17.3 per 100,000 persons. The death rate from unintentional injuries easily meets the Healthy People 2020 objective of 36.4 deaths per 100,000 persons.

Unintentional Injury Mortality Rate, Age-Adjusted, per 100,000 Persons

	Beverly Service Area		Los Angeles County	California
	Number	Rate	Rate	Rate
Unintentional injury death rate	129	17.3	21.4	29.9

Source: Calculated by Gary Bess Associates using California Department of Public Health Master Death File 2014-2015 and U.S. Census Bureau American Community Survey, 5-Year Average 2012-2016, Table B01001 and using the 2000 U.S. standard million.

Kidney Disease

In the service area, the kidney disease death rate was 10.9 per 100,000 persons. This rate was higher than county and state rates of death from kidney disease.

Kidney Disease Mortality Rate, Age-Adjusted, per 100,000 Persons

	Beverly Service Area		Los Angeles County	California
	Number	Rate	Rate	Rate
Kidney disease death rate	80	10.9	10.7	8.2

Source: Calculated by Gary Bess Associates using California Department of Public Health Master Death File 2014-2015 and U.S. Census Bureau American Community Survey, 5-Year Average 2012-2016, Table B01001 and using the 2000 U.S. standard million.

Homicide

In the service area, the age-adjusted death rate from homicides was 6.2 per 100,000 persons. This rate was higher than the county and state rates for homicides, and the Healthy People 2020 objective for homicide (5.5 per 100,000 persons).

Homicide Mortality Rate, Age-Adjusted, per 100,000 Persons

	Beverly Service Area		Los Angeles County	California
	Number	Rate	Rate	Rate
Homicide	5	6.2	5.6	4.8

Source: Calculated by Gary Bess Associates using California Department of Public Health Master Death File 2014-2015 and U.S. Census Bureau American Community Survey, 5-Year Average 2012-2016, Table B01001, and using the 2000 U.S. standard million.

Suicide

In the service area, the age-adjusted death rate due to suicide was 4.5 per 100,000 persons, which is below county and state rates. The Healthy People 2020 objective for suicide is fewer than 10.2 per 100,000 persons.

Suicide Mortality Rate, Age-Adjusted, per 100,000 Persons

	Beverly Service Area		Los Angeles County	California
	Number	Rate	Rate	Rate
Suicide	33	4.5	7.7	10.4

Source: Calculated by Gary Bess Associates using California Department of Public Health Master Death File 2014-2015 and U.S. Census Bureau American Community Survey, 5-Year Average 2012-2016, Table B01001, and using the 2000 U.S. standard million

Drug Use Deaths

The age-adjusted death rate from opioid overdoses ranged from 0 deaths per 100,000 persons in Commerce and Monterey Park 91754 to 7.9 deaths per 100,000 persons in East Los Angeles 90063. The county rate was 4.1 deaths per 100,000 persons, which was lower than the state rate of 5.2 deaths per 100,000 persons. Whittier 90601 (5.2 deaths per 100,000 persons), Monterey Park 91755 (4.5 deaths per 100,000 persons) and Pico Rivera (4.2 deaths per 100,000 persons) were above the county rate.

Opioid Drug Overdose Deaths, Age-Adjusted, per 100,000 Persons

	ZIP Code	Rate
Bell/Bell Gardens	90201	3.0
Commerce	90040	0
East Los Angeles	90022	3.6
East Los Angeles	90023	2.6
East Los Angeles	90063	7.9
El Monte	91732	1.2
Montebello	90640	1.0
Monterey Park	91754	0
Monterey Park	91755	4.5
Pico Rivera	90660	4.2
Rosemead	91770	1.8
South El Monte	91733	2.6
Whittier	90601	5.2
Whittier	90606	2.6
Los Angeles County		**4.1**
California		**5.2**

Source: California Office of Statewide Health Planning and Development, via California Department of Public Health, California Opioid Overdose Surveillance Dashboard, 2017. https://discovery.cdph.ca.gov/CDIC/ODdash/

HIV

In the service area, the death rate from HIV was 1.6 per 100,000 persons. This rate was lower than the county HIV death rate (2.4 per 100,000 persons) and the state rate of HIV death (1.8 per 100,000 persons).

HIV Mortality Rate, Age-Adjusted, per 100,000 Persons

	Beverly Service Area		Los Angeles County	California
	Number	Rate	Rate	Rate
HIV death rate	11	1.6	2.4	1.8

Source: Calculated by Gary Bess Associates using California Department of Public Health Master Death File 2014-2015 and U.S. Census Bureau American Community Survey, 5-Year Average 2012-2016,Table B01001 and using the 2000 U.S. standard million.

Acute and Chronic Disease

Hospitalization Rates by Diagnoses

At Beverly Hospital, the top five primary diagnoses resulting in hospitalization were disorders of the digestive, circulatory and respiratory systems, infections, and pregnancies, not including births (which were the sixth most-common reason for hospitalization at Beverly Hospital).

Hospitalization Rates by Principal Diagnosis, Top Ten Causes

	Beverly Hospital
Digestive system	14.2%
Circulatory system	12.5%
Respiratory system	8.8%
Infections	8.5%
All pregnancies	8.4%
Births	7.3%
Injuries/poisonings	6.6%
Genitourinary system	5.8%
Endocrine diseases	5.3%
Musculoskeletal system	4.1%

Source: Healthy Communities Institute, California Office of Statewide Health Planning and Development, 2017. http://report.oshpd.ca.gov/?DID=PID&RID=Facility_Summary_Report_Hospital_Inpatient

Emergency Room Rates by Diagnoses

At Beverly Hospital, the top five primary diagnoses seen in the Emergency Room were injuries/poisonings, respiratory system, musculoskeletal system, genitourinary system, and nervous system (including eye and ear disorders) diagnoses.

Emergency Room Rates by Principal Diagnosis, Top Ten Causes

	Beverly Hospital
Injuries/poisonings	17.7%
Respiratory system	9.5%
Musculoskeletal system	9.2%
Genitourinary system	5.8%
Nervous system (including eye and ear disorders)	5.3%
Digestive system	4.9%
Mental disorders	4.1%
Skin disorders	3.6%
All pregnancies	2.0%
Circulatory system	1.7%

Source: Healthy Communities Institute, California Office of Statewide Health Planning and Development, 2017. http://report.oshpd.ca.gov/?DID=PID&RID=Facility_Summary_Report_Hospital_Inpatient

Diabetes

Among adults in SPA 3, 14.5% have been diagnosed as pre-diabetic and 9.8% have been diagnosed with diabetes. 16.1% of adults in SPA 7 reported they have been diagnosed as pre-diabetics and 13.3% have been diagnosed with diabetes. For adults

with diabetes, 58.2% in SPA 3 felt very confident that they could control their diabetes and 51.9% of adults with diabetes in SPA 7 felt very confident that they could control their diabetes.

Adult Diabetes

	SPA 3	SPA 7	Los Angeles County	California
Diagnosed pre-diabetic	14.5%	16.1%	13.7%	13.3%
Diagnosed with diabetes	9.8%	13.3%	10.3%	9.6%
Very confident to control diabetes	58.2%	51.9%	56.5%	58.7%
Somewhat confident	28.8%	39.9%	33.0%	32.9%
Not confident	13.0%*	8.2%*	10.5%	8.4%

*Source: California Health Interview Survey, 2014-2017. http://ask.chis.ucla.edu/ *Statistically unstable due to sample size.*

Among Latino adults, 12.8% in SPA 3 and 14.3% in SPA 7 have been diagnosed with diabetes. The percent of Whites with diabetes in SPA 3 (9%) and SPA 7 (12.4%) exceed the county (7.2%) and state (7.9%) rates of Whites diagnosed with diabetes. Latinos and Asians in SPA 7 exceed both county and state rates.

Adult Diabetes by Race/Ethnicity

	SPA 3	SPA 7	Los Angeles County	California
Latino	12.8%	14.3%	12.4%	11.6%
African American	11.6%*	8.5%*	15.3%	12.8%
Asian	5.1%	9.0%*	8.2%	8.8%
White	9.0%	12.4%	7.2%	7.9%

*Source: California Health Interview Survey, 2014-2017. http://ask.chis.ucla.edu/ *Statistically unstable due to sample size.*

Diabetes is an Ambulatory Care Sensitive (ACS) condition defined by the Agency for Healthcare Research and Quality as a condition resulting in hospital admissions that with improved high-quality outpatient care could have been avoided, and result in lower cost to the hospital and better quality of life for the patient. In California, diabetes-related hospitalizations occur at a rate of 17.2 per 10,000 adults, and in Los Angeles County at a rate of 19.3. Of the service area cities, Monterey Park and Rosemead had rates lower than the county and state. East Los Angeles 90023 (38.8 diabetes hospitalizations per 10,000 adults) and South El Monte (34.8 diabetes hospitalizations per 10,000 adults) had the highest rates.

Diabetes Hospitalization Rate, per 10,000 Adults, 18+

	ZIP Code	Rate
East Los Angeles	90023	38.8
South El Monte	91733	34.8
East Los Angeles	90022	30.8
East Los Angeles	90063	30.8
Whittier	90606	29.2
El Monte	91732	28.6
Bell/Bell Gardens	90201	28.1
Pico Rivera	90660	27.3
Commerce	90040	23.2
Montebello	90640	22.5
Whittier	90601	19.2
Rosemead	91770	14.4
Monterey Park	91754	14.1
Monterey Park	91755	12.3
Los Angeles County		**19.3**
California		**17.2**

Source: California Office of Statewide Health Planning and Development, 2013-2015, by Conduent Healthy Communities Institute via thinkhealthla.org.

High Blood Pressure

A co-morbidity factor for diabetes and heart disease is hypertension (high blood pressure). 23.6% of service area adults said that they have been diagnosed with hypertension. This meets the Healthy People 2020 objective to reduce the proportion of adults with high blood pressure to 26.9%.

Adults Diagnosed with Hypertension

	Beverly Service Area	Los Angeles County
Hypertension	23.6%	23.5%

Source: 2015 Los Angeles County Health Survey; Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health

Among adults in SPA 3, 38.1% of African Americans and 36.9% of Whites indicated they have high blood pressure. In SPA 7, 43.8% of Whites and 28.1% of Latinos reported high blood pressure.

Adult High Blood Pressure by Race/Ethnicity

	SPA 3	SPA 7	Los Angeles County	California
African American	38.1%	27.0%*	43.3%	40.7%
Asian	20.8%	22.4%*	24.3%	23.1%
Latino	27.0%	28.1%	26.4%	25.3%
White	36.9%	43.8%	30.3%	31.5%

*Source: California Health Interview Survey, 2014-2017. http://ask.chis.ucla.edu/ *Statistically unstable due to sample size*

Hypertension is an Ambulatory Care Sensitive (ACS) condition defined by the Agency for Healthcare Research and Quality as a condition resulting in hospital admissions that with improved high-quality outpatient care could have been avoided, and result in lower cost to the hospital and better quality of life for the patient. The rate of hypertension-related hospital admissions in Los Angeles County was 4.7 per 10,000 adults, which was higher than the state rate of 3.3 per 10,000 adults. In the service area, the cities with the highest rates were: Commerce (6.8 per 10,000 adults), South El Monte (6.7 per 10,000 adults) and Bell/Bell Gardens (6.0 per 10,000 adults).

Hypertension Hospitalization Rate, per 10,000 Adults, 18+

	ZIP Code	Rate
Commerce	90040	6.8
South El Monte	91733	6.7
Bell/Bell Gardens	90201	6.0
East Los Angeles	90023	5.4
East Los Angeles	90022	5.2
Montebello	90640	4.6
Pico Rivera	90660	4.6
Whittier	90606	4.4
East Los Angeles	90063	4.1
El Monte	91732	3.8
Rosemead	91770	2.8
Whittier	90601	2.7
Monterey Park	91754	2.3
Monterey Park	91755	2.0
Los Angeles County		**4.7**
California		**3.3**

Source: California Office of Statewide Health Planning and Development, 2013-2015, by Conduent Healthy Communities Institute via thinkhealthla.org.

Heart Disease

For adults in SPA 3, 6.2% reported they have been diagnosed with heart disease and 5.3% of SPA 7 adults reported a heart disease diagnosis. Among adults diagnosed with heart disease, 62.2% in SPA 3 were given a management care plan and 61.8% in SPA 7 were given a management care plan by a health care provider.

Adult Heart Disease

	SPA 3	SPA 7	Los Angeles County	California
Diagnosed with heart disease	6.2%	5.3%*	5.8%	6.4%
Has a management care plan	62.2%	61.8%	69.1%	72.1%

*Source: California Health Interview Survey, 2014-2017 http://ask.chis.ucla.edu/ *Statistically unstable due to sample size.*

SPA 3 has higher rates of heart disease among Whites (10.6%) and Latinos (5.4%) than were reported in the county or the state. The rate of heart disease among SPA 7 Whites (10.2%) exceeds the county and state rate of heart disease among Whites.

Adult Heart Disease by Race/Ethnicity

	SPA 3	SPA 7	Los Angeles County	California
African American	2.2%	No Data	6.7%	5.9%
Asian	4.3%*	2.9%*	4.4%	4.7%
Latino	5.4%*	4.6%*	4.6%	4.3%
White	10.6%	10.2%	8.2%	8.7%

*Source: California Health Interview Survey, 2014-2017. http://ask.chis.ucla.edu/ *Statistically unstable due to sample size.*

Asthma

In SPA 3, 13% of the population has been diagnosed with asthma. 12.4% of persons in SPA 7 have been diagnosed with asthma. Among those with asthma, 32.8% in SPA 3 and 37.8% in SPA 7 take daily medication to control their symptoms.

Asthma

	SPA 3	SPA 7	Los Angeles County
Ever diagnosed with asthma, total population	13.0%	12.4%	13.1%
Takes daily medication to control asthma, total asthmatic population	32.8%	37.8%	43.7%

Source: California Health Interview Survey, 2014-2017. http://ask.chis.ucla.edu/

In the service area, 8% of children, 17 years old or younger, have been diagnosed with asthma and currently have asthma and/or had an attack within the past year.

Asthma, Children, Ages 0 to 17

	Beverly Service Area	Los Angeles County
Diagnosed with and currently has asthma and/or had an attack in past year, 0-17 years old	8.0%	7.4%

Source: 2015 Los Angeles County Health Survey; Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health

Of the children in SPA 3 who were diagnosed with and still had asthma, 35.5% had visited an ER or Urgent Care in the past year due to asthma. 34.2%of children in SPA 7 had visited an ER or Urgent Care in the past year due to asthma.

Asthma ER Visit, Children, Ages 0-17

	SPA 3	SPA 7	Los Angeles County
ER or Urgent Care visit in past year due to asthma, 0-17 years old**	35.5%*	34.2%*	38.7%

*Source: California Health Interview Survey, 2014-2017. http://ask.chis.ucla.edu/ *Statistically unstable due to sample size.*

Pediatric asthma is an Ambulatory Care Sensitive (ACS) condition defined by the Agency for Healthcare Research and Quality as a condition resulting in hospital admissions that with improved high-quality outpatient care could have been avoided, and result in lower cost to the hospital and better quality of life for the patient. The rate of hospital admissions in Los Angeles County for pediatric asthma was 10.9 per 10,000 children, which was higher than in the state (9.8 hospitalizations per 10,000 children). In the service area, the cities with the highest rates were: El Monte (47.0 per 10,000 children) and South El Monte (42.2 per 10,000 children).

Pediatric Asthma Hospital Admissions, per 10,000 Children

	ZIP Code	Rate
El Monte	91732	47.0
South El Monte	91733	42.2
Montebello	90640	26.9
East Los Angeles	90023	20.7
Pico Rivera	90660	19.4
Whittier	90601	17.9
East Los Angeles	90022	17.1
Commerce	90040	16.0
East Los Angeles	90063	14.8
Whittier	90606	11.3
Rosemead	91770	11.0
Monterey Park	91754	10.9
Bell/Bell Gardens	90201	7.9
Monterey Park	91755	N/A
Los Angeles County		**10.9**
California		**9.8**

Source: California Office of Statewide Health Planning and Development, 2013-2015, by Conduent Healthy Communities Institute via thinkhealthla.org. N/A = Data not available

Cancer

Cancer incidence rates are available at the county level. In Los Angeles County, cancer rates are lower overall than at the state level. However, the rates of colorectal cancer (36.3 per 100,000 persons), uterine cancers, (25.9 per 100,000), thyroid cancer (13.6 per 100,000 persons), and ovarian cancer (12.0 per 100,000) exceed the state rates.

Cancer Incidence Rates, Age-Adjusted, per 100,000 Persons

	Los Angeles County	California
Cancer all sites	**375.5**	**395.2**
Breast (female)	115.0	120.6
Prostate (males)	95.2	97.1
Lung and bronchus	36.7	42.2
Colon and rectum	36.3	35.5
In situ breast (female)	26.1	28.2
Uterine** (females)	25.9	24.9
Non-Hodgkin lymphoma	17.8	18.2
Urinary bladder	15.1	16.8
Thyroid	13.6	12.8
Melanoma of the skin	13.3	21.6
Kidney and renal pelvis	13.2	13.9
Ovary (females)	12.0	11.6
Leukemia*	11.6	12.3

*Source: The Centers for Disease Control and Prevention, National Cancer Institute, State Cancer Profiles, 2011-2015 http://www.cancer-rates.info/ca/ *Myeloid & Monocytic + Lymphocytic + "Other" Leukemias **Uterus, NOS + Corpus Uteri*

The rate of newly diagnosed breast cancer in service area cities ranged from 83.4 per 100,000 females in Bell to 152.2 per 100,000 females in Whittier.

Newly Diagnosed Breast Cancer Cases, per 100,000 Females

	Rate
Whittier	152.2
Pico Rivera	130.2
Montebello	116.6
Monterey Park	111.8
East Los Angeles	107.0
Bell Gardens	97.4
Rosemead	97.1
El Monte	96.2
Bell	83.4
Los Angeles County	**140.5**

*Source: Los Angeles Department of Public Health, City and Community Health Profiles, data from University of Southern California's Cancer Surveillance Program, 2011-2015. http://publichealth.lacounty.gov/ohae/cchp/index.htm *Data not available for Commerce and South El Monte.*

The rate of newly-diagnosed colon cancer in service area cities ranged from 35.6 per 100,000 persons in East Los Angeles to 44.3 cases per 100,000 persons in Pico Rivera.

Newly Diagnosed Colon Cancer Cases, per 100,000 Persons

	Rate
Pico Rivera	44.3
Montebello	43.9
Rosemead	42.7
Monterey Park	42.0
El Monte	40.2
Whittier	39.3
East Los Angeles	35.6
Bell	N/A
Bell Gardens	N/A
Los Angeles County	**37.9**

Source: Los Angeles Department of Public Health, City and Community Health Profiles, data from University of Southern California's Cancer Surveillance Program, 2011-2015. http://publichealth.lacounty.gov/ohae/cchp/index.htm Data not available for Commerce and South El Monte. N/A = data suppressed for Bell and Bell Gardens due to privacy or statistical-validity concerns.

HIV

In the service area, the incidence of HIV (annual new cases) was 16.8 cases per 100,000 persons. This rate was less than the county rate of new HIV cases (23.3 per 100,000 persons).

Incidence of HIV (Annual New Cases), Ages 13+ per 100,000 Persons

	Beverly Service Area	Los Angeles County
HIV incidence	16.8	23.3

Source: Los Angeles County Department of Public Health, Division of HIV and STD programs, HIV Surveillance System: New HIV diagnoses in 2016 as reported to the Health Department through March 2019. The numerator for the catchment area is based on provided ZIP Codes. The rate for the catchment area is based on U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates by ZCTAs. The rate for Los Angeles County is based on the July 1, 2016 Population Estimates, prepared by Hedderson Demographic Services for Los Angeles County ISD.

Community Input – Chronic Diseases

Stakeholder interviews and focus groups identified the following issues, challenges and barriers related to chronic diseases.

- Some seniors cannot afford to pay for their medications.
- A lot of people are in denial and just do not want to know if they have a chronic disease like diabetes, cancer or heart disease. They don't want to be defined by the disease or have to take medicine for the rest of their lives.
- We are seeing a rise in diabetes. A large portion of the population is pre-diabetic and many don't know this. Diabetes is strongly linked with obesity. We have a toxic food environment where we are absolutely inundated with high calorie, low nutrient food that is inexpensive, that is marketed aggressively.
- Seniors have high blood pressure and high cholesterol and diabetes and they are at risk for falls and some have pre-dementia and Alzheimer's disease.
- Diabetes is such a costly disease, and so many awful complications, major cause of heart attack and stroke, limb amputation, etc.

Health Behaviors

Health Behaviors Ranking

The County Health Rankings measures healthy behaviors and ranks counties according to health behavior data. California's 58 counties are ranked from 1 (healthiest) to 58 (least healthy) based on a number of indicators that include: adult smoking, obesity, physical inactivity, excessive drinking, sexually transmitted infections, and others. A ranking of 11 puts Los Angeles County in the top 20% of California counties for health behaviors.

Health Behaviors Ranking

	County Ranking (out of 58)
Los Angeles County	11

Source: County Health Rankings, 2018. www.countyhealthrankings.org

Health Status

Among the residents in the service area, 29.1% rate themselves as being in fair or poor health.

Adult Health status, Fair or Poor Health

	Beverly Service Area	Los Angeles County
Fair or poor health status, adults	29.1%	21.5%

Source: 2015 Los Angeles County Health Survey; Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health

Limited Activity Due to Poor Health

Adults in the service area limited their activities due to poor mental or physical health on average of 2.4 days in the previous month.

Activities Limited from Poor Mental/Physical Health, Average Days in Past Month

	Beverly Service Area	Los Angeles County
Days of limited activities from poor health	2.4	2.3

Source: 2015 Los Angeles County Health Survey; Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health

Disability

22.8% of adults in SPA 3 and 20.4% of adults in SPA 7 reported they had a physical, mental or emotional disability. The rate of disability in the county was 24.6%.

Adults with a Disability

	SPA 3	SPA 7	Los Angeles County
Adults with a disability	22.8%	20.4%	24.6%

Source: County of Los Angeles Public Health Department, Los Angeles County Health Survey, 2018
http://publichealth.lacounty.gov/ha/LACHSDataTopics2018.htm

Children with Special Health Care Needs

In the Beverly Hospital service area, 11.3% of children were reported by their caretakers to meet the criteria of having a special health care need. This rate was lower than the county level (14.5% of children).

Children with Special Health Care Needs

	Beverly Service Area	Los Angeles County
Children, 0-17, with special needs	11.3%	14.5%

Source: 2015 Los Angeles County Health Survey; Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health

Sexually Transmitted Infections

The rates of sexually transmitted infections (STIs) are lower in the service area than in the county. The rate of chlamydia was 470 per 100,000 persons in the service area, compared to 572.4 cases per 100,000 persons for the county. The rate of gonorrhea was 131 per 100,000 persons in the service area, and the rate of primary and secondary syphilis was 10 per 100,000 persons.

STI Incidence, Annual New Cases, per 100,000 Persons

	Beverly Service Area	Los Angeles County
Chlamydia	470.0	572.4
Gonorrhea	131.0	215.8
Primary and secondary syphilis	10.0	17.7

Source: 2016 STD Surveillance Database; Division of HIV and STD programs, Los Angeles County Department of Public Health

Teen Sexual History

In SPA 3, 93.7% of teens, ages of 14 to 17, whose parents gave permission for the question to be asked, reported they had never had sex. 95.2% of teens in SPA 7 reported they had never had sex. SPA 3 and SPA 7 had a higher rate of abstinence than seen at the county (88.1%) or state (82.9%) level.

Teen Sexual History, 14 to 17 Years Old

	SPA 3	SPA 7	Los Angeles County	California
Teen never had sex	93.7%*	95.2%*	88.1%*	82.9%

*Source: California Health Interview Survey, 2014-2017. http://ask.chis.ucla.edu/ *Statistically unstable due to sample size.*

Overweight and Obesity

12.1% of children in SPA 3 and 10.4% in SPA 7 are overweight. This was lower than the county rate of overweight children (13.7%). 19.2% of teens in SPA 3 and 22.5% in SPA 7 were overweight. This was higher than the county rate of overweight teens (18.8%). 34.9% of adults in SPA 3 and 32.7% pf adults in SPA 7 were overweight. The rate of overweight adults in SPA 3 was higher than the county rate (33.7%).

Overweight For Age

	SPA 3	SPA 7	Los Angeles County	California
Adults, ages 18+	34.9%	32.7%	33.7%	34.5%
Teens, ages 12-17	19.2%*	22.5%*	18.8%	16.9%
Children, ages under 12	12.1%*	10.4%*	13.7%	15.3%

*Source: California Health Interview Survey, 2015-2017. http://ask.chis.ucla.edu/ *Statistically unstable due to sample size.*

24.3% of adults in SPA 3 were obese, with a Body Mass Index of 30.0 or above. This was lower than the rate of obesity in the county (28.7%) and state (27.4%). The Healthy People 2020 objective for adult obesity is 30.5%. In SPA 7, 35.7% of adults have a BMI of 30.0 or above.

Adult Obesity

	SPA 3	SPA 7	Los Angeles County	California
Adults, ages 20+	24.3%	35.7%	28.7%	27.4%

Source: California Health Interview Survey, 2015-2017. http://ask.chis.ucla.edu/

The Healthy People 2020 objective for teen obesity is 16.1%. 21.5% of teens in SPA 3 and 9.3% of teens in SPA 7 were obese.

Teen Obesity

	SPA 3	SPA 7	Los Angeles County	California
Teens, ages 12-17	21.5%*	9.3%*	14.3%	18.1%

*Source: California Health Interview Survey, 2014-2016. http://ask.chis.ucla.edu/ *Statistically unstable due to sample size.*

In SPA 3, 79.2% of African Americans and 71.7% of Latinos are overweight and obese. In SPA 7, 70.8% of African Americans and 72.5% of Latinos are overweight and obese. Rates of overweight/obesity among Whites in SPA 3 and SPA 7 exceed county and state rates. Asians have the lowest rates of overweight/obesity in SPA 3 and SPA 7.

Adults, Overweight and Obese by Race/Ethnicity

	SPA 3	SPA 7	Los Angeles County	California
African American	79.2%	70.8%	74.9%	71.9%
Asian	34.1%	40.2%*	40.2%	42.2%
Latino	71.7%	72.5%	72.4%	72.6%
White	62.7%	67.4%	56.1%	58.4%

*Source: California Health Interview Survey, 2014-2017. http://ask.chis.ucla.edu/ *Statistically unstable due to sample size.*

The physical fitness test (PFT) for students in California schools is the FitnessGram®.

One of the components of the PFT is measurement of body composition (measured by skinfold measurement, BMI, or bioelectric impedance). Children who do not meet the "Healthy Fitness Zone (HFZ)" criteria for body composition are categorized as "needing improvement" (overweight) or "at health risk" (obese).

The area school districts with the highest percentage of 5th graders needing improvement or at health risk were Valle Lindo (55.1%) and Mountain View (53.6%). The school districts with the highest percentage of 7th graders needing improvement or at health risk were Mountain View (52.7%) and Montebello Unified (48.2%). The school districts with the highest percentage of 9th grade students not in the Healthy Fitness Zone were El Monte Union (49.7%) and Los Angeles Unified (47.2%).

5th, 7th and 9th Graders; Body Composition, 'Needs Improvement' and 'Health Risk'

School Districts	Fifth Grade		Seventh Grade		Ninth Grade	
	Needs Improvement	Health Risk	Needs Improvement	Health Risk	Needs Improvement	Health Risk
East Whittier City Elementary	21.3%	23.5%	19.3%	24.3%	N/A	N/A
El Monte City School District	19.3%	29.8%	18.7%	24.7%	N/A	N/A
Garvey Elementary	14.1%	23.2%	16.5%	15.9%	N/A	N/A
Lowell Joint	21.0%	24.0%	15.9%	18.2%	N/A	N/A
Whittier City Elementary	20.5%	28.9%	20.5%	25.0%	N/A	N/A
Mountain View	21.5%	32.1%	22.0%	30.7%	N/A	N/A
Rosemead Elementary	17.4%	20.3%	17.1%	19.3%	N/A	N/A
Valle Lindo Elementary	26.1%	29.0%	21.0%	23.0%	N/A	N/A
Garvey School District	14.1%	23.2%	16.5%	15.9%	N/A	N/A
Alhambra Unified	23.8%	16.8%	19.8%	15.4%	15.0%	14.6%
Los Angeles Unified	20.5%	29.9%	21.0%	26.7%	21.5%	25.7%
El Rancho Unified	20.4%	29.5%	20.5%	26.6%	19.6%	23.8%
Montebello Unified	26.5%	20.7%	30.9%	17.3%	27.3%	19.4%
El Monte Union High	N/A	N/A	N/A	N/A	26.8%	22.9%
Fullerton Joint Union High	N/A	N/A	N/A	N/A	16.9%	16.5%
Whittier Union High	N/A	N/A	N/A	N/A	17.8%	23.8%
Los Angeles County	**20.1%**	**24.9%**	**19.9%**	**22.7%**	**19.9%**	**20.7%**
California	**19.2%**	**21.3%**	**19.2%**	**19.8%**	**18.9%**	**18.4%**

Source: California Department of Education, Fitnessgram Physical Fitness Testing Results, 2017-2018.
http://data1.cde.ca.gov/dataquest/page2.asp?Level=District&submit1=Submit&Subject=FitTest

Community Input – Overweight and Obesity

Stakeholder interviews and focus groups identified the following issues, challenges and barriers related to overweight and obesity.

- We have a lot of obesity in the community. It is an issue tied in with depression and

a lack of transportation. A lot of people eat a lot of junk food and they do not get much exercise.
- In so many parts of our community, the sidewalks and lights are broken. Even if you want to go out, they can't. Look at the built environment and ask, does it support a healthy lifestyle?
- The availability of junk food is high in our neighborhoods. There are not a lot of healthy food choice options.
- Obesity discriminates against the poor, undereducated and new American populations.
- We have a food bank that comes here once a month but it doesn't give a lot of fresh foods. It provides dry milk and cereal, not vegetables, nothing healthy.
- It is cheaper to buy fast food versus cooking healthy food.
- Parents are working and have kids to care for and less time to cook for themselves.
- Maybe it is cultural thing, generation after generation is used to carb heavy food and has focused less on fruits and vegetables.
- People know they should eat better, but they may not know how.
- We do see obesity, even among very young children. Part of the problem is the availability of fast food and the misperceptions that healthy food is expensive. Sometimes there is the lack of healthy options in the community.

Fast Food

Adults in SPA 3, ages 18-64, consume fast food at higher rates than children or seniors. In SPA 3, 31.1% of adults, 22.4% of children and 16.5% of seniors consume fast food three or more times per week. 18.1% of adults, 21% of children and 11.7% of seniors in SPA 7 consume fast food three or more times per week. SPA 3 fast food consumption exceeds the LA County rate.

Fast Food Consumption, Three or More Times a Week

	SPA 3	SPA 7	Los Angeles County	California
Adult, ages 18-64	31.1%	18.1%	29.6%	26.5%
Children, ages 0-17	22.4%*	21.0%*	20.7%	20.2%
Seniors, ages 65+	16.5%	11.7%*	13.4%	11.6%

*Source: California Health Interview Survey, 2014-2016. http://ask.chis.ucla.edu/ *Statistically unstable due to sample size.*

Soda/Sugar-Sweetened Beverage (SSB) Consumption

41.3% of children in the service area drank at least one soda or sweetened drink a day. This was higher than the county rate of 39.2% of children who consumed a SSB daily.

Children Who Consume Soda or Sweetened Beverages Daily

	Beverly Service Area	Los Angeles County
Daily soda/SSB consumption, children	41.3%	39.2%

Source: 2015 Los Angeles County Health Survey; Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health

Adequate Fruit and Vegetable Consumption

13.6% of adults in the hospital service area consumed five or more servings of fruits and vegetables a day. This was a lower rate of daily fruit and vegetable consumption than found in the county (14.7%).

Adults Who Consume Five or More Servings of Fruits and Vegetables, Daily

	Beverly Service Area	Los Angeles County
Adults who consume 5+ servings of fruits and vegetables a day	13.6%	14.7%

Source: 2015 Los Angeles County Health Survey; Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health

71.6% of parents/guardians of children in the service area have excellent or good access to fresh fruits and vegetables in their community. The rate is lower than the county, where 75% of parents/guardians of children say they have excellent or good access to fresh fruits and vegetables in their community.

Children with Excellent or Good Access to Fruits and Vegetables

	Beverly Service Area	Los Angeles County
Children with access to fruits and vegetables	71.6%	75.0%

Source: 2015 Los Angeles County Health Survey; Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health

Physical Activity

27.9% of adults in the service area obtained the recommended amount of aerobic (75 minutes of vigorous aerobic activity or 150 minutes of moderate) and muscle-strengthening exercise (on at least two days) each week. 16.2% of children, ages 6-17, in the service area obtained the weekly recommended amount of aerobic exercise of 60 or more minutes daily and muscle-strengthening at least two days a week.

Adults and Children Meeting Aerobic Activity and Muscle Strengthening Guidelines

	Beverly Service Area	Los Angeles County
Adult physical activity	27.9%	34.1%
Child, ages 6 to 17, physical activity	16.2%	17.7%

Source: 2015 Los Angeles County Health Survey; Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health

17.3% of SPA 3 children and teens, and 15% in SPA 7, spend five hours or more in sedentary activities after school on a typical weekday. 15.6% of children and teens in SPA 3 spend 8 hours or more a day on sedentary activities on weekend days. A larger

percentage of SPA 3 teens (9%) were reported to spend no days during the week being physically active for at least one hour than were reported in SPA 7 (4.2%).

Sedentary Children and Teens

	SPA 3	SPA 7	Los Angeles County
5+ hours spent on sedentary activities after school on a typical weekday, children and teens	17.3%*	15.0%*	13.0%
8+ hours spent on sedentary activities on a typical weekend day, children and teens	15.6%*	1.8%*	8.3%
Teens, no physical activity in a typical week**	9.0%*	4.2%*	11.6%

*Source: California Health Interview Survey, 2014-2017 or **2014-2016; http://ask.chis.ucla.edu/ *Statistically unstable due to sample size*

Mental Health

Mental Health, Adults

8.8% of adults in SPA 3 and 9.1% of adults in SPA 7 have seriously thought about committing suicide. 8.6% of SPA 3 adults and 10.8% of adults in SPA 7 had experienced serious psychological distress in the past year. 7.1% of adults in SPA 3 and 7% in SPA 7 had taken a prescription medication for an emotional/mental health problem during the past year.

Mental Health Indicators, Adults

	SPA 3	SPA 7	Los Angeles County	California
Ever seriously thought about committing suicide	8.8%	9.1%	8.5%	10.4%
Adults who had serious psychological distress during past year	8.6%	10.8%	8.8%	9.0%
Adults taken prescription medicine at least 2 weeks for emotional/mental health issue in past year	7.1%	7.0%	8.6%	10.7%

Source: California Health Interview Survey, 2016-2017. http://ask.chis.ucla.edu/

11.2% of adults in the Beverly Hospital service area are at risk for major depression, which is lower than the county rate (11.8%).

Depression, Adults

	Beverly Service Area	Los Angeles County
Adults at risk for major depression	11.2%	11.8%

Source: 2015 Los Angeles County Health Survey; Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health

Mental Health Care Access, Adults

26.2% of residents in SPA 3 and 44.5% in SPA 7 reported receiving care for mental and emotional issues from primary care physicians and mental health professionals in the past year.

Type of Provider Giving Care for Mental and Emotional Issues in the Past Year

	SPA 3	SPA 7	Los Angeles County	California
Primary care physician only	23.0%	28.8%	22.6%	23.6%
Mental health professional only	50.8%	26.7%	44.1%	42.5%
Both	26.2%	44.5%	33.3%	33.9%

Source: California Health Interview Survey, 2014-2017. http://ask.chis.ucla.edu/

7.6% of residents in SPA 3 and 6.2% of SPA 7 residents had visited a professional more than three times in the past year for mental health/drug/alcohol issues.

Visits to a Professional for Mental/Drug/Alcohol Issues in Past Year

	SPA 3	SPA 7	Los Angeles County	California
0 visits	88.3%	90.6%	87.4%	87.3%
1 – 3 visits	4.1%	3.2%*	4.2%	4.8%
4 – 6 visits	2.0%	1.9%*	2.6%	2.6%
7+ visits	5.6%	4.3%	5.8%	5.2%

*Source: California Health Interview Survey, 2014-2017. http://ask.chis.ucla.edu/ *Statistically unstable due to sample size.*

Mental Health Care Access

Among adults, 15.3% in SPA 3 and 17.1% in SPA 7 needed help for an emotional/mental health problem or alcohol/drug use. Among those who needed help, 42% in SPA 3 and 47.1% in SPA 7 did not receive emotional/mental health and/or alcohol/drug use in the past year. The Healthy People 2020 objective is for 72.3% of adults with a mental disorder to receive treatment (27.7% who do not receive treatment).

Among teens in SPA 3, 22.6% needed help for an emotional/mental health problem and 20.6% received counseling. In SPA 7, 20.1% of teens needed help for an emotional/mental health problem.

Access to Mental Health Care in the Past Year

	SPA 3	SPA 7	Los Angeles County	California
Adults, needed help for emotional/mental health problem or alcohol/drug use	15.3%	17.1%	17.1%	17.1%
Adults, needed help but did not receive treatment for emotional/mental health problem or alcohol/drug use	42.0%	47.1%	41.9%	40.5%
Adults, saw any health care provider for emotional/mental health problem or alcohol/drug use	12.7%	10.5%	13.6%	13.7%
Teens, needed help for emotional/mental health problem	22.6%*	20.1%*	20.9%	20.1%
Teens, received psychological/emotional counseling in past year	20.6%*	No Data	15.2%	12.5%

*Source: California Health Interview Survey, 2014-2017. http://ask.chis.ucla.edu/ *Statistically unstable due to sample size.*

Community Input – Mental Health

Stakeholder interviews and focus groups identified the following issues, challenges and

barriers related to mental health.

- We need mental health people at the schools in the district. If not full time, then at least a couple of times a week to provide us with information about what is available in the community. We don't know where to send children and their parents for mental health care.
- One of the biggest challenges is our patients won't go for mental health care; they don't think there is anything wrong, they don't want help.
- The biggest issue is the stigma. The people who need help the most don't show up. People feel like they are broken and because of their cultures they don't believe in acknowledging mental illness.
- Substance use and mental health are tied together. And these are prominent issues with the homeless.
- There are not enough services out there for the growing population distressed mentally and emotionally.
- There is still a lot of stigma to receive mental health help and one of the solutions is to increase the use of lay people for issues like depression and anxiety.
- Depression is widespread, underrecognized, under diagnosed and the treatment service system is fragmented. There is poor coordination with medical services, especially with people who don't have great access to services already, that safety net.
- Those with mental health suffer broadly disproportionate adverse health outcomes, like living shorter lives, suffer higher rates of chronic diseases (heart disease, diabetes, cancer, stroke), have higher levels of violence and higher levels of substance use.
- One of the biggest challenges is the stigma around asking for mental health services, especially for young children. Parents fear their children will be labeled.
- There is a high turn around in mental health, so many times clients go through multiple therapists and it is hard to see progress when you are having to start over in treatment. But the population is changing and sometimes our resources and skills aren't up to date with the reality of what clients are walking in with.
- There is a societal shift in mental health issues. In general, families are isolated. Maybe there isn't as strong a sense of community, and the resilience factor for families is missing.
- We are social beings and when we are isolated in a house or apartment and do not have communication with other people, depression can kick in and caring for a young child can be very stressful. It is important that families aren't isolated.

Substance Use and Misuse

Cigarette Smoking

The Healthy People 2020 objective for cigarette smoking among adults is 12%. 17.4% of adults in the Beverly Hospital service area smoke cigarettes.

Adults who Smoke

	Beverly Service Area	Los Angeles County
Adults who smoke	17.4%	13.3%

Source: 2015 Los Angeles County Health Survey; Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health

Alcohol

Binge drinking is defined as consuming a certain amount of alcohol within a set period. For males, this is five or more drinks per occasion and for females, it is four or more drinks per occasion. In the service area, 15.2% of adults reported binge drinking in the past 30 days.

Adults who Binge Drink

	Beverly Service Area	Los Angeles County
Adults who binge drink	15.2%	15.9%

Source: 2015 Los Angeles County Health Survey; Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health

13.3% of SPA 3 teens and 16.3% of SPA 7 teens reported ever having an alcoholic drink. These were lower than county (19.8%) and state rates (22.5%).

Teen Alcohol Experience

	SPA 3	SPA 7	Los Angeles County	California
Teen ever had an alcoholic drink	13.3*	16.3%*	19.8%	22.5%

*Source: California Health Interview Survey, 2014-2016. http://ask.chis.ucla.edu/ *Statistically unstable due to sample*

Marijuana

In SPA 3, 54% of the population has tried marijuana, and 14% of the population used marijuana an average of 13.3 days in the past 30 days. In SPA 7, 41% of the population has tried marijuana, and 10% of the population used marijuana an average of 14.5 days in the past month. The average age to initiate marijuana use was 17.1 years old in SPA 3 and 17.2 years old in SPA 7.

Marijuana Use

	SPA 3	SPA 7	Los Angeles County
Ever tried marijuana, total population	54%	41%	48%
Ever tried marijuana, 12-17 years old	18%	30%	
Ever tried marijuana, 18-24 years old	59%	48%	
Ever tried marijuana, 25+	62%	38%	
Used marijuana past 30 days, total population	14%	10%	14%
Used marijuana past 30 days, 12-17	9%	13%	
Used marijuana past 30 days, 18-24	20%	20%	
Used marijuana past 30 days, 25+	15%	8%	
Avg. days used, past 30, total population	13.3	14.5	14.0
Avg. days used, past 30, users 12-17	8.9	7.9	
Avg. days used, past 30, users 18-24	11.4	11.7	
Avg. days used, past 30, users 25+	14.6	15.8	
Avg. age at initiation of use, total population	17.1	17.2	17.3
Avg. age at initiation of use, users 12-17	13.8	13.3	
Avg. age at initiation of use, users 18-24	15.9	15.3	
Avg. age at initiation of use, users 25+	17.2	17.3	

Source: County of Los Angeles Public Health, Substance Abuse Prevention and Control, Community Needs Assessment, 2017

Prescription Drug Misuse

In SPA 3, 19% of residents and 16% of SPA 7 residents had misused prescription drugs. In SPA 3, 3% of the population misused prescription drugs on an average of 8.4 days in the past 30 days. In SPA 7, 1% of the population misused prescription drugs on an average of 11.3 days in the past 30 days. The average age to initiate drug misuse was 20.7 years old in SPA 3 and 20.4 years old in SPA 7.

Prescription Drug Misuse

	SPA 3	SPA 7	Los Angeles County
Ever misused Rx meds, total population	19.%	16%	19%
Ever misused Rx meds, 12-17 years old	10%	14%	
Ever misused Rx meds, 18-24 years old	26%	18%	
Ever misused Rx meds, 25+	23%	16%	
Misused Rx meds past 30 days, total population	3%	1%	3%
Misused Rx meds past 30 days, 12-17	5%	5%	
Misused Rx meds past 30 days, 18-24	4%	2%	
Misused Rx meds past 30 days, 25+	3%	1%	
Avg. days misused, past 30, total population	8.4	11.3	9.1
Avg. days misused, past 30, users 12-17	8.7	7.2	
Avg. days misused, past 30, users 18-24	10.7	5.5	
Avg. days misused, past 30, users 25+	10.4	15.0	

	SPA 3	SPA 7	Los Angeles County
Avg. age at initiation of misuse, total population	20.7	20.4	21.4
Avg. age at initiation of misuse, users 12-17	14.3	15.3	
Avg. age at initiation of misuse, users 18-24	16.2	14.8	
Avg. age at initiation of misuse, users 25+	20.7	21.6	

Source: County of Los Angeles Public Health, Substance Abuse Prevention and Control, Community Needs Assessment, 2017

For those who had misused prescription drugs, 54% of users in SPA 3, and 52% in SPA 7 misused sedatives. Vicodin was the most likely to be misused in SPA 3 (61%).

Type of Prescription Drug Misuse

	SPA 3	SPA 7	Los Angeles County
Sedatives/sleeping pills	54%	52%	52%
Vicodin/vikings	61%	46%	49%
OxyConti/percs	36%	26%	33%
Adderall/skippy	31%	25%	25%
Don't know	5%	12%	9%

Source: County of Los Angeles Public Health, Substance Abuse Prevention and Control, Community Needs Assessment, 2017

Opioid Use

The rate of hospitalizations due to an opioid overdose was 5.6 per 100,000 persons in Los Angeles County. This is lower than the state rate (8.5 per 100,000 persons). Opioid overdose deaths in Los Angeles County were 3.2 per 100,000 persons, which was a lower death rate than found in the state (4.5 per 100,000 persons). The rate of opioid prescriptions in Los Angeles County was 388.2 per 1,000 persons. This rate is lower than the state rate of opioid prescribing (507.6 per 1,000 persons).

Opioid Use

	Los Angeles County	California
Hospitalization rate for opioid overdose (excludes heroin), per 100,000 persons	5.6	8.5
Age-adjusted opioid overdose deaths, per 100,000 persons	3.2	4.5
Opioid prescriptions, per 1,000 persons	388.2	507.6

Source: California Office of Statewide Health Planning and Development, via California Department of Public Health, California Opioid Overdose Surveillance Dashboard, 2017. https://discovery.cdph.ca.gov/CDIC/ODdash/

Community Input – Substance Use and Misuse

Stakeholder interviews and focus groups identified the following issues, challenges and barriers related to substance use and misuse.

- Middle school youth are taking Oxy and Adderall. Kids with insurance get prescriptions for medications filled and then sell those drugs at school.

- Substance use is not concentrated with low-income, less advantaged communities, it is also prevalent among persons with middle- and upper-class incomes who overuse and abuse prescription opiates. People are really hooked on pain medications.
- I have clients whose parents sold them in exchange for heroin; these are bad stories.
- There is a need for more detox centers. There are not enough services to deal with the growth in the problem.
- Legalization of recreational marijuana sends a message in the community that it is acceptable.
- In our community, there is a lot of meth and we are starting to see more heroin and definitely alcohol.
- A lot of the flavors for vaping target a younger population. There are so many edibles now that try to imitate candy, so it is attracting a younger population. Kids may start with experimenting but they end up with a substance use problem.
- One barrier is many sheriff stations that used to regularly provide safe drug take backs are now only doing them sporadically throughout year. It was costing them too much time and money. Maybe hospitals could get involved in this until new policies go into effect.

Preventive Practices

Immunization of Children

Complete vaccinations for Kindergarten students in the 2017-2018 school year ranged from 95.2% in Los Angeles Unified School District (LAUSD) to 98.7% in the Montebello Unified School District.

Up-to-Date Immunization Rates of Children Entering Kindergarten, 2017-2018

School District	Immunization Rate
Alhambra Unified	96.8%
East Whittier City Elementary	97.7%
El Monte City School District	96.9%
El Rancho Unified	97.9%
Garvey Elementary	97.4%
Los Angeles Unified (LAUSD)	95.2%
Lowell Joint	95.5%
Montebello Unified	98.7%
Mountain View	97.6%
Rosemead Elementary	98.6%
Valle Lindo Elementary	97.9%
Whittier City Elementary	98.1%
Los Angeles County*	**94.7%**
California*	**94.9%**

*Source: California Department of Public Health, Immunization Branch, 2017-2018. *For those schools where data were not suppressed due to privacy concerns over small numbers.*
https://data.chhs.ca.gov/dataset/school-immunizations-in-kindergarten-by-academic-year

Vaccines

In the Beverly Hospital service area, 66.6% of children, 6 months to 17 years, had been vaccinated for influenza. Vaccination rates among adults were lower, with 38.2% of service area adults having been vaccinated. The Healthy People 2020 objective is for 70% of the population to receive a flu shot. In the service area, only SPA 3 seniors have met this goal.

Flu Vaccination

	Beverly Service Area	Los Angeles County
Children, ages 6 months – 17 years	66.6%	55.2%
Adults, ages 18+, including seniors	38.2%	40.1%

Source: 2015 Los Angeles County Health Survey; Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health. http://www.publichealth.lacounty.gov/ha/LACHSDataTopics2015.htm

The Healthy People 2020 objective is for 90% of seniors to obtain a pneumonia vaccine. 76.5% of seniors in SPA 3, and 71.5% of SPA 7 seniors received a pneumonia vaccine.

Pneumonia Vaccine, Adults 65+

	SPA 3	SPA 7	Los Angeles County
Adults, 65+, had a pneumonia vaccine	76.5%	71.5%	72.3%

Source: County of Los Angeles Public Health Department, Los Angeles County Health Survey, 2018; http://publichealth.lacounty.gov/ha/LACHSDataTopics2018.htm

Senior Falls

Among seniors, 16.2% in the service area reported having fallen in the past year.

Adults, 65+ Years, Who Have Fallen in the Past Year

	Beverly Service Area	Los Angeles County
Seniors who have fallen	16.2%	27.1%

Source: 2015 Los Angeles County Health Survey; Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health

Among seniors who fell, 9.1% of SPA 3 seniors and 13.1% of SPA 7 seniors were injured in a fall in the previous year.

Seniors, Injured from Falls, Previous Year

	SPA 3	SPA 7	Los Angeles County
Seniors injured due to a fall	9.1%	13.1%	11.1%

Source: County of Los Angeles Public Health Department, LA County Health Survey, 2018; http://publichealth.lacounty.gov/ha/LACHSDataTopics2018.htm

Mammograms

The Healthy People 2020 objective for mammograms is 81.1% of women, ages 50-74 years, have a mammogram in the past two years. In the service area, 78.4% of women had a mammogram in the past two years.

Women, 50 to 74 Years of Age, Who Had a Mammogram in Past 2 Years

	Beverly Service Area	Los Angeles County
Mammogram	78.4%	77.3%

Source: 2015 Los Angeles County Health Survey; Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health

Pap Smears

The Healthy People 2020 objective for Pap smears is 93% of women, ages 21-65 years, be screened in the past three years. In the service area, 90.8% of women had a Pap smear in the prior 3 years.

Women, 21 to 65 Years of Age, Who Had a Pap Smear in Past 3 Years

	Beverly Service Area	Los Angeles County
Pap smear	90.8%	84.4%

Source: 2015 Los Angeles County Health Survey; Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health

Community Input – Preventive Practices

Stakeholder interviews and focus groups identified the following issues, challenges and barriers related to preventive practices.

- We do see people utilizing preventive practices.
- People's perceptions are that vaccines can cause illness. For a time, we did have challenges with parents not wanting to immunize their kids but there are a lot of public health campaigns and as a result, we've seen a big increase in parents immunizing their children.
- We need more widespread use of vaccines. Specifically, for pneumonia and flu.
- We need to a better job on screening for tobacco use. There are resources available in multiple languages to stop smoking.
- Blood pressure screenings are very important. This is a very significant problem that can be treated and the risk of stroke and heart disease can be greatly reduced with effective treatment.
- It is important for adolescents to get the HPV vaccine. This will prevent infections that predispose people to cervical cancer.
- All preventive services get done more effectively if you have a regular medical provide or medical home. And we have seen a dramatic reduction in the number of people uninsured but we are not seeing more people with a regular source of care. This means people are getting insured but they are not given the information needed to use their insurance correctly and they are less likely to get the services that are so important.
- We need more emphasis on prevention, we know how to treat someone, but it is late to treat someone after they have been diagnosed.

Attachment 1. Benchmark Comparisons

Where data were available, Beverly Hospital's health and social indicators were compared to the Healthy People 2020 objectives. The **bolded items** are Healthy People 2020 objectives that did not meet established benchmarks; non-bolded items met or exceeded the objectives.

Indicators	Service Area Data	Healthy People 2020 Objectives
High school graduation rate	**76.7% -** 94.6%	**87%**
Child health insurance rate	**93.7%**	**100%**
Adult health insurance rate	**75.4%**	**100%**
Unable to obtain medical care	**6.2% - 6.6%**	**4.2%**
Ischemic heart disease deaths	93.9 per 100,000	103.4 per 100,000
Cancer deaths	127.0 per 100,000	161.4 per 100,000
Stroke deaths	32.3 per 100,000	34.8 per 100,000
Unintentional injury deaths	17.3 per 100,000	36.4 per 100,000
Liver disease deaths	**19.6 per 100,000**	**8.2 per 100,000**
Homicides	**6.2 per 100,000**	**5.5 per 100,000**
Suicides	4.5 per 100,000	10.2 per 100,000
On-time (1st Trimester) prenatal care	88.0%	78%
Low birth weight infants	6.5% of live births	7.8% of live births
Infant death rate	3.8 per 1,000 live births	6.0 per 1,000 live births
Adult obese, ages 20+	24.3% - **35.7%**	**30.5%**
Teens obese, ages 12-17	9.3% - **21.5%**	**16.1%**
Received needed mental health care	**52.9% - 58.0%**	**72.3%**
Adults engaging in binge drinking	15.2%	24.2%
Cigarette smoking by adults	**17.4%**	**12%**
Pap smears, ages 21-65, screened in the past 3 years	**90.8%**	**93%**
Mammograms, ages 50-74, screened in the past 2 years	**78.4%**	**81.1%**
Adults, 65+, ever receiving pneumonia vaccine	**59.5% - 60.9%**	**90%**
Annual adult influenza vaccination	**38.2%**	**70%**

Attachment 2. Community Interviewees and Focus Groups

Stakeholder Interviewees

Name	Title	Organization
Julian Balderas	Director	Pico Rivera Chamber of Commerce
Maria Cerdas	Director	Potero Community Center
Susan Chan	Director	WIC Commerce
Catalina Flores	Coordinator	AltaMed Commerce
Sophie Tan Ki Hung, MPH, RDN, CLE	Supervisor	PHFE WIC Beverly
Crystal Jaimez	Community Services Coordinator	City of Montebello Recreation and Community Services Senior Center
Ann Naragry	Manager	Montebello Senior Villas
Rochio Parra, LCSW	Director of Birth to 5 Program	The Whole Child
Paul S. Parzik	Executive Director	Montebello-Commerce YMCA
Silvia Prieto, MD, MPH	Area Health Officer, Service Planning Area 7	Los Angeles County Department of Public Health
Kathy Salazar	Executive Director	MELA Counseling Services
Benjamin SaoReyes	Resident Service Coordinator	Beverly Towers
Paul Simon, MD, MPH	Chief Science Officer	Los Angeles County Department of Public Health
Christie Zamani	Executive Director	Go Day One

Focus Groups

	Focus Group Date	Participants
BeverlyCare Center, clinic patients and family members	8/21/19	15
Community members	7/20/19	15
Montebello-Commerce YMCA, women's exercise class	6/28/19	7
Senior group	7/17/19	11

Attachment 3. Resources to Address Needs

Community stakeholders and residents identified community resources potentially available to address the identified health needs. This is not a comprehensive list of all available resources. For additional resources refer to Think Health LA at www.thinkhealthla.org and 211 Los Angeles County at www.211la.org/.

Health Need	Community Resources
Access to care	Access LA Alma Family Services AltaMed CareMore Centro Maravilla Service Center LA Care Health Plan Los Angeles County Department of Public Health Lotus Blossom Therapy Center Mexican American Opportunity Fund Monrovia Health Center Montebello Senior Citizens Center
Chronic diseases	Alzheimer's Association American Cancer Society American Diabetes Association American Lung Association LA Breath Mobile Program LA Care Health Plan Los Angeles County Department of Public Health The Asthma Coalition of Los Angeles County
Dental care	AltaMed Dental Group Arroyo Vista Family Health Center Clinica Romero Denti-Cal Eisner Health First 5 LA Los Angeles Christian Health Centers Mark Taper Foundation Dental Clinic T.H.E. Clinic, Inc. USC Dental School
Economic insecurity	CalFresh California Lifeline Catholic Charities Dial-a-Ride District Office of Transition Services Los Angeles Unified GoodRx Hearts of Compassion LA Regional Food Bank Salvation Army Whittier First Day Coalition WIC
Mental health	Alma Family Services Enki Health and Research System

	Los Angeles Christian Health Centers Los Angeles Department of Mental Health NAMI
Overweight and obesity	Boy & Girls Club Department of Children and Family Services Los Angeles County Department of Public Health Schools and school districts TOPS Weight Watchers YMCA
Preventive practices	Los Angeles County Department of Public Health Los Angeles Unified School District Office of Environmental Health and Safety Potrero Heights Park Community & Senior Center
Substance use and misuse	A New Way of Life Re-entry Project Al-Anon Alcoholics Anonymous Dare You to Care Outreach Ministries First to Serve Inc. Homeless Healthcare Los Angeles LA CADA Medi Cure Health Services Inc. Salvation Army Hope Harbor Adult Rehab Center The Hills Treatment Center
Violence and community safety	Adult Protective Services LA County Office of Violence Prevention Sectors Acting for Equity (SAFE) Urban Peace Institute Youth Policy Institute

Attachment 4. Review of Progress

In 2016, Beverly Hospital conducted its previous Community Health Needs Assessment (CHNA). Significant health needs were identified from issues supported by primary and secondary data sources gathered for the Community Health Needs Assessment. In developing the hospital's Implementation Strategy, associated with the 2016 CHNA, Beverly chose to address access to care, chronic diseases, mental health, overweight and obesity, and preventive practices.

Access to Care and Preventive Practices
Insurance Enrollment – In partnership with South Bay Health and Insurance Services (SBHIS) and the Los Angeles County Department of Public Health, Beverly Hospital provides enrollment assistance to patients for no cost or low-cost health insurance coverage programs. The hospital assisted over 500 persons with enrollment and information for Medi-Cal.

Resource Center – In 2017, the Beverly Resource Center was established to create a single space where patients and community members can have access to various health resources. Services include Medi-Cal and Medicare enrollment, immunizations for children and referrals to other community partners.

Patient Transportation – Beverly Hospital offers transportation in an effort to support access to care. Patients from various hospital clinics and partnering AltaMed Clinics are eligible for transportation within a 15 mile radius of the hospital. In 2017, the hospital transportation van carried 4,487 passengers and 2,792 taxi vouchers were distributed. In 2018, the hospital transportation van provided 2,148 rides. Additionally, 4,543 taxi vouchers with a total value of $105,970 were distributed. In November 2018, the hospital began to cover Uber ride costs as another travel option for patients. $3,618 in Uber fees were covered by Beverly Hospital.

Hospital-Based Clinics – Beverly Hospital's Women's Care and Family Care Centers are staffed with Board Certified Obstetrics and Family Medicine physicians. The clinics provide medical services to low income and uninsured patients. Publicly sponsored programs are offered to teenagers, pregnant mothers, adults, and seniors. Services included family planning, chronic disease management, prenatal care, adult immunizations, and general medical treatment. During 2017, both clinics combined received 6,538 patient visits. From January 1, 2018 to September 30, 2018, both clinics served 1,800 patients. On October 1, 2018, the centers merged and became BeverlyCare Center-a separate entity from Beverly Hospital.

Breast and Cervical Cancer Screenings – Beverly Hospital offers breast and cervical cancer screenings at low and no-cost through the Family PACT and Every Woman Counts programs. In 2017, 175 women received these services at the Women's Care and Family Care Centers. Other services offered include prenatal care, comprehensive perinatal services, STD screenings, family planning, and primary care. A total of 6,538 pregnant mothers, teenagers and seniors were served through these additional services. In 2018, the hospital provided 1,886 screening mammograms and 558 diagnostics mammograms. From January 1st to September 30th, the Women's Care and Family Care Centers provided 141 cervical cancer screenings.

Preventive Screenings – The hospital presents free blood pressure and glucose screenings along with basic health education at various community sites. Some sites include: Montebello Senior Center, Pico Rivera Senior Center, Montebello Senior Villas, Potrero Heights Community Center, and St. Alphonsus Church. In 2018, 1,285 blood pressure and 213 glucose screenings for a total of 1,498 screenings were provided.

Exercise Classes for Seniors – Beverly Hospital offers specialized fitness classes for seniors led by certified training instructors. All classes are offered at no cost to participants. In 2017, 58 sessions reached 961 participants. In 2018, 63 sessions of Balance and Agility, Rock and Roll Muscles, Chair Aerobics and Zumba served 896 participants.

Community Health Fairs – Annually, the hospital participated in 12 community health fairs and provided health education, screenings and information about services. Partnerships for the health fairs include: El Rancho Unified School District, Pico Rivera Senior Center Wellness Day, APC Diabetes Health Fair, Potrero Heights Senior Health Fair, Montebello Senior Center Health Fair, Pico Rivera Expo, YMCA Senior Health Fair, Superior Markets, Montebello Expo, and others. Over 4,550 individuals were reached at the health fairs.

Breastfeeding – As part of the Baby-Friendly Hospital Initiative (BFHI), Beverly is designated as a Baby Friendly hospital. BFHI is a global program sponsored by the World Health Organization to encourage hospitals to promote breastfeeding as a best practice for newborn nutrition. The hospital has an ongoing training program that includes lactation consultants, nurse training, patient education, and support groups. In addition to providing education and support to every new mom delivering at Beverly's Hensel Maternity center, Beverly hosted 43 breastfeeding education classes and breastfeeding support groups that reached 253 breastfeeding moms.

Preventive Screenings – The hospital provides free blood pressure and glucose screenings along with basic health education at various community sites. Some sites include: Montebello Senior Center, Pico Rivera Senior Center, Montebello Senior Villas, Potrero Heights Community Center, and St. Alphonsus Church. In 2017, 1,891 screenings (1,562 blood pressure screenings and 329 blood glucose screenings) were offered at these locations. In 2018, 1,285 blood pressure and 213 glucose screenings for a total of 1,498 screenings were provided.

Influenza Immunizations – Beverly Hospital hosted flu vaccine clinics for members of the community, ages 6 months and older. In 2018, Beverly administered vaccines at local schools and at the Pico Rivera Business Expo. A total of 115 people received the flu vaccine.

Childhood Immunizations – As a Vaccine For Children (VFC) Provider, Beverly Hospital hosts monthly community vaccine clinics for infants and youth, up to age 18. SB 277 requires that children be immunized in order to enroll into public school. As a result of SB 277 and to improve overall community wellness, Beverly increased efforts to assist school aged children in becoming vaccinated. In 2017, 142 children received immunizations and in 2018, 319 immunizations were provided through these efforts.

Chronic Diseases

Diabetes Education Programs – Accredited by the American Association of Diabetes Educators, Beverly Hospital provides education on prevention, management and treatment of diabetes to the community. Through the Sweet Success Program, the center offers counseling to mothers who have developed gestational diabetes during their pregnancies. Diabetes Counseling is offered in English and Spanish. Additionally, monthly lectures are conducted during the Diabetes Wellness Hour, which teaches participants how to live a healthy lifestyle after being diagnosed with the disease. In 2017 and 2018, 242 people received information, health education, and support through these services.

Community CPR (Cardiopulmonary Resuscitation) and First Aid – CPR and First Aid classes were offered in partnership with Whittier Unified School District, Montebello School District, the Boy Scouts of Montebello, and Ramona High School in Alhambra. In June, Beverly Hospital offered “Sidewalk CPR Training” in support of National CPR Day. As a result, 730 people received CPR and/or first aid training.

Wound Care Education – The Wound Care Center provides education for wound prevention and treatment. Due to the high prevalence of diabetes in the community, physicians and staff provided community lectures and set up booths at local sites or

health fairs. At these sites or fairs, education on daily care and free foot screenings were provided to individuals living with diabetes.

Smoking Cessation – In 2017, Beverly Hospital launched a 7-week Smoking Cessation Program designed to help participants lead a smoke-free life. The program offered a logical approach to "break the chain and kick the habit" that included: effective ways to stop nicotine addiction; emphasis on changing behavior; and strategies to maintain a smoke free environment. Three sessions were held that reached 24 participants.

Preventive Health and Community Lectures – Beverly Hospital partners with its team of experts to provide monthly health and community lectures each year. In 2017, nine lectures reached 217 persons. In 2018, 17 lectures were conducted, which served 440 members of the community. Topics focused on prevention and treatment of chronic diseases.

Mental Health

Support Groups – The hospital offers support groups for bereavement and family caregivers of patients with long-term illnesses. The bereavement support group is in collaboration with VITAS Healthcare. One support group offers special emphasis on the care of family members with Alzheimer's/ Dementia. In 2017, over 637 visits were made to support groups and in FY18, 495 visits were made to monthly support groups.

NAMI Family-to-Family Education – As defined by the National Alliance on Mental Illness, (NAMI) Family-to-Family is a 12-session educational program for family, significant others, and friends of people living with mental illness. The program is designed to improve the coping and problem-solving abilities of the people closest to an individual living with a mental health condition. In 2017, Beverly Hospital hosted two 12-week sessions with 20 participants. In 2018, Beverly Hospital hosted 3 English speaking and 2 Spanish speaking 12-week sessions. There were 69 Spanish speaking participants and 203 English speaking participants for an overall 272 participants.

Mental Health Services – In partnership with BHC Alhambra Hospital, Beverly Hospital covers care for patients requiring additional mental health services. In 2017, Beverly covered the costs of necessary services for 206 patients and in FY18 for 197 patients not covered by Medicare or Medi-Cal.

Tele-Psychiatric Services – In June 2017, Beverly Hospital established a Tele-Psychiatry Program for patients requiring a psychiatric consult. It allows for timely access to care and decreases length of stay for many patients. In 2017, the service was used for approximately 10 patients a month. In 2018, the service was utilized 427 times.

Overweight and Obesity

KidsFit & TeensFit Program – The 9-week family-focused program provides children, teens, and their parents develop good nutrition and exercise habits. It is conducted in partnership with the Montebello-Commerce YMCA and is used as a resource by the Montebello Unified School District, Los Angeles County Department of Public Health and local pediatricians. The program is geared toward two age groups: kids ages 7 to 11; and adolescents ages 12 to 18. A parent or caregiver is required to attend the nutrition sessions and youth are led by a certified YMCA instructor in physical activity at the gym. In 2017, 41 children and 51 parents participated in the program. In 2018, 428 children and parents participated in the program.

EXHIBIT 13

BEVERLY COMMUNITY NEEDS ASSESSMENT (2022)

COMMUNITY HEALTH NEEDS ASSESSMENT

2022

Contents

Executive Summary

Located in Montebello, Beverly Hospital is an award-winning, nationally recognized nonprofit hospital that serves Montebello, East Los Angeles, Pico Rivera, and the surrounding communities. Our mission is to provide compassionate and quality health care.

Community Health Needs Assessment

Beverly Hospital has undertaken a Community Health Needs Assessment (CHNA). California Senate Bill 697 and the Patient Protection and Affordable Care Act through IRS section 501(r)(3) regulations direct nonprofit hospitals to conduct a CHNA every three years and develop a three-year Implementation Strategy that responds to community needs. A CHNA is one tool in this effort as it identifies unmet health needs in the service area, provides information to select priorities for action, focuses on geographical areas, and serves as the basis for community benefit programs.

Service Area

Beverly Hospital is located at 309 W. Beverly Blvd. Montebello CA, 90640. The hospital's service area encompasses 13 ZIP Codes in 11 cities or communities. The service area is served by the Los Angeles County 1st and 4th Supervisor Districts and falls within the Los Angeles County Service Planning Areas (SPAs) 3 and 7.

Beverly Hospital Service Area

	ZIP Code
Bell/Bell Gardens	90201
Commerce	90040
East Los Angeles	90022, 90023, 90063
El Monte	91732
Montebello	90640
Monterey Park	91754, 91755
Pico Rivera	90660
Rosemead	91770
South El Monte	91733
Whittier	90606

Methodology

Secondary Data

Secondary data were collected from a variety of local, county, and state sources to present community demographics, social determinants of health, health care access, birth indicators, leading causes of death, acute and chronic disease, health behaviors, mental health, substance use and preventive practices. Where available, these data are presented in the context of Los Angeles County and California.

Analysis of secondary data includes an examination and reporting of health disparities for some health indicators. The report includes benchmark comparison data that measure the data findings as compared to Healthy People 2030 objectives, where appropriate. Healthy People objectives are a national initiative to improve the public's health by providing measurable objectives that are applicable at national, state, and local levels. Attachment 1 compares Healthy People 2030 objectives with service area data.

Primary Data

Ten (10) phone interviews were conducted during April and May 2022. Community stakeholders identified by the hospital were contacted and asked to participate in the needs assessment interviews. Interview participants included a broad range of stakeholders concerned with health and wellbeing of service area residents, who spoke to issues and needs in the communities served by the hospital.

Significant Community Needs

Significant needs were identified through a review of the secondary health data and validation through stakeholder interviews. The identified significant needs included:

- Access to care
- Birth indicators
- Chronic diseases
- COVID-19
- Economic insecurity
- Education
- Housing/homelessness
- Mental health
- Overweight/obesity
- Preventive practices
- Substance use
- Violence/community safety

COVID-19

COVID-19 had an unprecedented impact on the health and well-being of the community. This CHNA identifies an increase in economic insecurity, food insecurity, housing and homelessness, mental health conditions and substance use as a direct or indirect result of the pandemic. Additionally, access to routine care, preventive screenings, disease maintenance, community safety, healthy eating and physical

activity declined as a consequence. Community stakeholder comments on the effect of COVID in the community are included in the CHNA.

Prioritization of Health Needs

The identified significant community needs were prioritized with input from the community. Interviews with community stakeholders were used to gather input on the significant needs. Mental health, housing and homelessness, chronic diseases, economic insecurity and access to health care were ranked as the top five priority needs in the service area.

Report Adoption, Availability and Comments

This CHNA report was adopted by the Beverly Hospital Board of Directors in November 2022. The report is widely available to the public on the hospital's web site and can be accessed at www.beverly.org/about-us/in-the-community/. To send comments or questions about this report, submit your feedback here: https://beverly.org/about-us/contact-us/community-health-needs-assessment-and-implementation-strategy-feedback-form /

Introduction

Background and Purpose

For Beverly Hospital, having a strong presence in our community has been critical to our success for over 73 years. The hospital has 202 licensed beds and provides a full range of inpatient and outpatient care. From emergency services and hospitalization to outpatient procedures, Beverly Hospital offers the latest technology for diagnostic and treatment options. A medical staff of over 375 physicians, representing a wide spectrum of specialties, is supported by experienced and dedicated employees and volunteers.

Beverly Hospital is accredited by Det Norske Veritas (DNV) and is an ISO 9001:2015 compliant organization. We provide services driven by the health needs of the community. Over time we have not only updated the way we deliver basic health care, but by reaching beyond the walls of our hospital and working with other like-minded organizations, we seek to continuously meet the changing needs of our community.

Services Offered

- Cardiac Care
- Emergency Care Center
- Hensel Maternity Center
- Intensive Care
- Medical and Surgical Services
- Pediatrics
- Radiology Diagnostic Services
- Senior Services
- Women's Pavilion and Breast Center
- Wound Care and Hyperbaric Medicine

The passage of California Senate Bill 697 (1994) and the Patient Protection and Affordable Care Act (2010) require tax-exempt hospitals to conduct a CHNA every three years and adopt an Implementation Strategy to meet the priority health needs identified through the assessment. A CHNA is one tool in this effort as it identifies unmet health needs in the service area, provides information to select priorities for action, focuses on geographical areas, and serves as the basis for community benefit programs. This assessment incorporates components of primary data collection and secondary data analysis that focus on the health and social needs of the service area.

Service Area

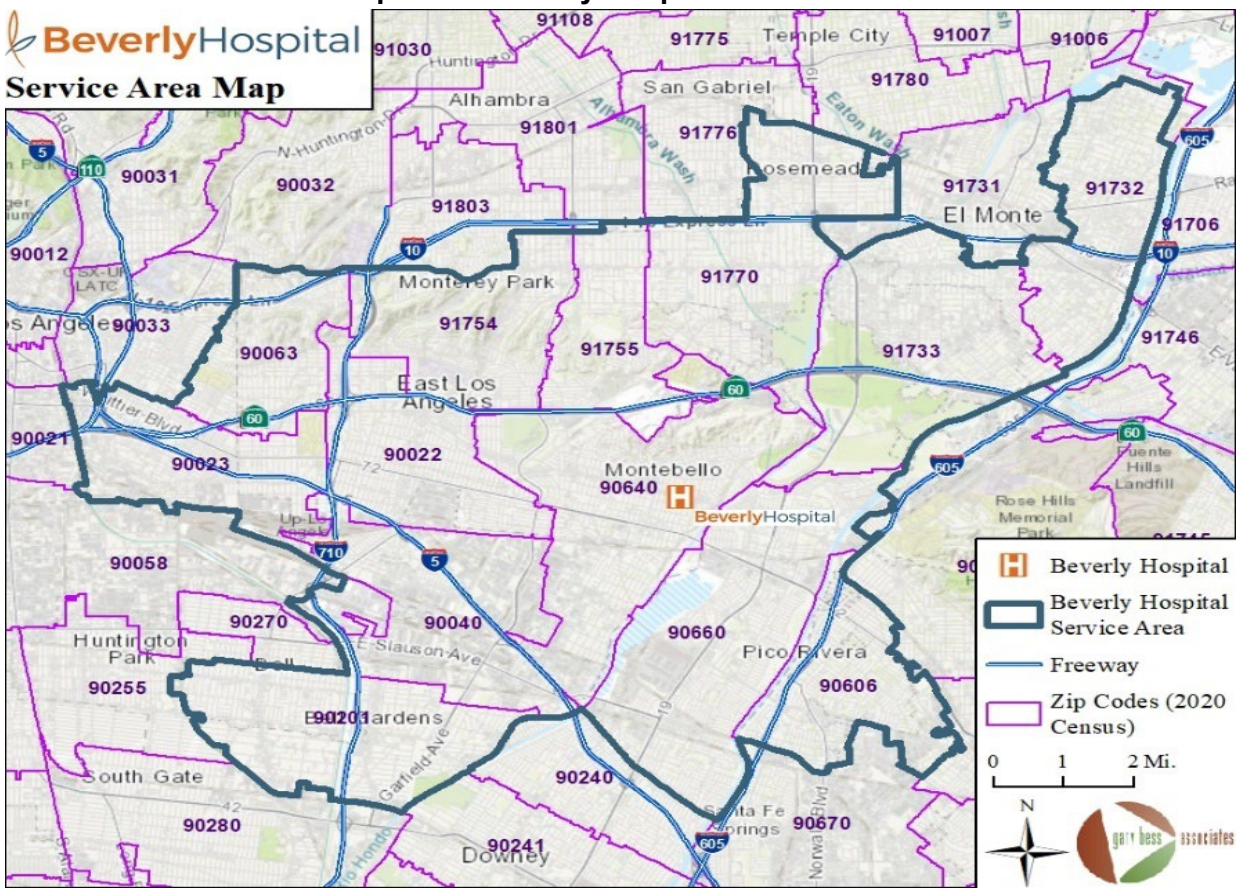
Beverly Hospital is located at 309 W. Beverly Blvd. Montebello CA, 90640. The hospital's service area encompasses 13 ZIP Codes in 11 cities or communities. The

service area is served by the Los Angeles County 1st and 4th Supervisor Districts and falls within the Los Angeles County Service Planning Areas (SPAs) 3 and 7. Beverly Hospital (Beverly) tracks ZIP Codes of origin for patient admissions. The service area was determined from the ZIP Codes that reflect a majority of patient admissions from the local geographic area.

Beverly Hospital Service Area

	Zip Code
Bell/Bell Gardens	90201
Commerce	90040
East Los Angeles	90022, 90023, 90063
El Monte	91732
Montebello	90640
Monterey Park	91754, 91755
Pico Rivera	90660
Rosemead	91770
South El Monte	91733
Whittier	90606

Map of the Beverly Hospital Service Area



Project Oversight
The Community Health Needs Assessment process was overseen by:
Kathleen Curran
Director, Business Development

Maianh Nguyen
Project Manager, Marketing
Beverly Hospital

Consultant
Biel Consulting, Inc. conducted the CHNA. Dr. Melissa Biel was joined by Sevanne Sarkis, JD, MHA, MEd, and Victoria Derrick to complete the data collection. Biel Consulting, Inc. has over 25 years of experience conducting CHNAs and working with hospitals on developing, implementing, and evaluating community benefit programs. www.bielconsulting.com

Board Approval
The Beverly Hospital Board of Directors approved this report in November 2022.

Data Collection Methodology

Secondary Data Collection

Secondary data were collected from a variety of local, county, and state sources to present community demographics, social determinants of health, access to health care, birth indicators, leading causes of death, acute and chronic disease, health behaviors, mental health, substance use and preventive practices. Where available, these data are presented in the context of Los Angeles County and California, framing the scope of an issue as it relates to the broader community.

Secondary data for the service area were collected and documented in data tables with narrative explanation. The data tables present the data indicator, the geographic area represented, the data measurement (e.g., rate, number, or percent), county and state comparisons (when available), the data source, data year and an electronic link to the data source. In some cases, data sets from public sources do not total 100%. In these cases, the data remained as reported by the data source.

Analysis of secondary data includes an examination and reporting of health disparities for some health indicators. The report includes benchmark comparison data that measure the data findings as compared to Healthy People 2030 objectives, where appropriate. Healthy People objectives are a national initiative to improve the public's health by providing measurable objectives that are applicable at national, state, and local levels.

Significant Community Needs

Initially, significant health needs were identified through a review of the secondary health data collected. The identified significant needs included:

- Access to care
- Birth indicators
- Chronic diseases
- COVID-19
- Economic insecurity
- Education
- Housing/homelessness
- Mental health
- Overweight/obesity
- Preventive practices
- Substance use
- Violence/community safety

Primary Data Collection
Beverly conducted interviews with community stakeholders to obtain input on health needs, barriers to care and resources available to address the identified health needs.

Ten (10) phone interviews were conducted during April and May 2022. Community stakeholders identified by the hospital were contacted and asked to participate in the needs assessment interviews. Interview participants included a broad range of stakeholders concerned with health and wellbeing in the service area, who spoke to issues and needs in the communities served by the hospital.

The identified stakeholders were invited by email to participate in the phone interview. Appointments for the interviews were made on dates and times convenient to the stakeholders. At the beginning of each interview, the purpose of the interview in the context of the assessment was explained, the stakeholders were assured their responses would remain confidential, and consent to proceed was given.

During the interviews, participants were asked to share their perspectives on the issues, challenges and barriers relative to the identified health needs (What makes each health need a significant issue in the community? What are the challenges people face in addressing these needs?), along with identifying known resources to address these health needs, such as services, programs and/or community efforts. Attachment 2 lists the stakeholder interview respondents, their titles and organizations. Attachment 3 provides stakeholder responses to the interview overview questions.

Public Comment
In compliance with IRS regulations 501(r) for charitable hospitals, a hospital CHNA and Implementation Strategy are to be made widely available to the public and public comment is to be solicited. The previous CHNA and Implementation Strategy were made widely available to the public on the website and can be accessed at www.beverly.org/about-us/in-the-community/. To date, no comments have been received.

Prioritization of Significant Needs

The identified significant community needs were prioritized with input from the community. Interviews with community stakeholders were used to gather input on the significant needs. The following criteria were used to prioritize the significant needs:

- The perceived severity of a health or community issue as it affects the health and lives of those in the community.
- Improving or worsening of an issue in the community.
- Availability of resources to address the need.
- The level of importance the hospital should place on addressing the issue.

Each of the stakeholder interviewees was sent a link to an electronic survey (SurveyMonkey) in advance of the interview. The stakeholders were asked to rank each identified need. The percentage of responses was noted as those that identified the need as having severe or very severe impact on the community, had worsened over time, and had a shortage or absence of resources available in the community. Not all survey respondents answered every question, therefore, the response percentages were calculated based on respondents only and not on the entire sample size. Mental health, chronic disease, COVID-19, housing and homelessness, substance use and community violence had the highest scores for severe and very severe impact on the community. Housing and homelessness and community violence were the needs with the highest scores for worsened over time. Mental health, housing and homelessness, and overweight and obesity had the highest scores for insufficient resources available to address the need.

Significant Health Needs	Severe and Very Severe Impact on the Community	Worsened Over Time	Insufficient or Absent Resources
Access to health care	62.5%	0	14.3%
Birth indicators	28.6%	16.7%	16.7%
Chronic disease	71.4%	66.7%	33.3%
COVID-19	71.4%	0	16.7%
Economic insecurity	57.2%	66.7%	50%
Education	57.2%	16.7%	33.3%
Housing and homelessness	71.4%	100%	83.3%
Mental health	85.7%	66.7%	100%
Overweight and obesity	57.2%	33.3%	66.7%
Preventive practices (vaccines and screenings)	42.9%	0	16.7%
Substance use	71.4%	66.7%	50%
Violence and community safety	71.4%	83.3%	33.3%

The interviewees were also asked to prioritize the health needs according to highest level of importance in the community. The total score for each significant need (possible score of 4) was divided by the total number of responses for which data were provided, resulting in an overall score for each significant need. Mental health, housing and homelessness, chronic diseases, economic insecurity and access to health care were ranked as the top five priority needs in the service area. Calculations resulted in the following prioritization of the significant needs.

Significant Needs	Priority Ranking (Total Possible Score of 4)
Mental health	4.00
Housing and homelessness	3.86
Chronic disease	3.83
Economic insecurity	3.71
Access to health care	3.63
Overweight and obesity	3.50
Preventive practices (vaccines and screenings)	3.50
COVID-19	3.43
Substance use	3.29
Violence and community safety	3.29
Education	3.14
Birth indicators	3.00

Community input on these health needs is detailed throughout the CHNA report.

Resources to Address Significant Needs

Community stakeholders identified community resources potentially available to address the significant community needs. The identified community resources are presented in Attachment 4.

Review of Progress

In 2019, Beverly conducted the previous CHNA. Significant needs were identified from issues supported by primary and secondary data sources gathered for the CHNA. The hospital's Implementation Strategy associated with the 2019 CHNA addressed: Access to health care, chronic diseases (including healthy eating and active living), mental health and preventive care through a commitment of community benefit programs and resources. The impact of the actions that Beverly used to address these significant needs can be found in Attachment 5.

Community Demographics

Population

The population of the Beverly service area is 672,097. From 2014 to 2019, the population decreased by 0.7%.

Total Population and Five-Year Change in Population Growth

	Beverly Service Area			Los Angeles County	California
	2014	2019	Percent Change	2014-2019 Percent Change	2014-2019 Percent Change
Total population	676,849	672,097	-0.7%	1.1%	3.1%

Source: U.S. Census Bureau, American Community Survey, 2010-2014, 2015-2019, DP05. https://data.census.gov/cedsci/

49.4% of the service area population are male and 50.6% are female.

Population, by Gender

	Beverly Service Area	Los Angeles County	California
Male	49.4%	49.3%	49.7%
Female	50.6%	50.7%	50.3%

Source: U.S. Census Bureau, American Community Survey, 2015-2019, DP05. https://data.census.gov/cedsci

Children. ages 0 to 17. make up 24.3% of the population, 62.6% are adults. ages 18 to 64, and 13.1% are adults. ages 65 and older. The service area has a higher percentage of children, ages 0-17, than the county (22%)

Population, by Age

	Beverly Service Area	Los Angeles County	California
0 – 4	6.3%	6.1%	6.2%
5 – 9	6.3%	5.9%	6.3%
10 – 14	7.3%	6.2%	6.6%
15 – 17	4.4%	3.8%	3.9%
18 – 24	10.1%	9.7%	9.6%
25 – 34	15.4%	16.1%	15.2%
35 – 44	13.2%	13.8%	13.2%
45 – 54	12.8%	13.4%	13.0%
55 – 64	11.1%	11.8%	12.0%
65 – 74	7.1%	7.5%	8.1%
75 – 84	4.0%	3.9%	4.1%
85+	2.0%	1.8%	1.8%

Source: U.S. Census Bureau, American Community Survey, 2015-2019, B01001. https://data.census.gov/cedsci

In the service area, the percentage of children, ages 0 to 17, ranged from 15.6% in Monterey Park 91755 to 29.5% in Bell/Bell Gardens. The range of senior adults, ages 65 and older, was 8.2% in Bell/Bell Gardens to 21.6% in Monterey Park 91754. The median age in the service area was 36.0 years.

Population, by ZIP Code

	ZIP Code	Total Population	Children Ages 0 – 17	Adults Ages 18-64	Adults Ages 65+	Median Age
Bell/Bell Gardens	90201	101,965	29.5%	62.3%	8.2%	29.8
Commerce	90040	12,328	23.8%	62.6%	13.5%	35.3
East Los Angeles	90022	67,014	27.0%	62.3%	10.5%	32.6
East Los Angeles	90023	46,860	28.6%	61.2%	10.2%	31.4
East Los Angeles	90063	53,980	26.9%	62.4%	10.7%	31.9
El Monte	91732	62,905	22.8%	64.8%	12.4%	36.0
Montebello	90640	62,730	22.4%	62.7%	14.9%	36.1
Monterey Park	91754	33,636	18.6%	59.7%	21.6%	43.0
Monterey Park	91755	26,083	15.6%	63.4%	21.0%	45.7
Pico Rivera	90660	63,001	22.7%	62.6%	14.7%	37.1
Rosemead	91770	62,703	19.2%	63.7%	17.1%	42.0
South El Monte	91733	45,365	24.5%	63.0%	12.5%	34.7
Whittier	90606	32,987	22.2%	64.6%	13.2%	36.8
Beverly Service Area		**672,097**	**24.2%**	**62.7%**	**13.1%**	**36.0**
Los Angeles County		**10,081,570**	**22.0%**	**64.8%**	**13.2%**	**36.5**
California		**39,283,497**	**23.0%**	**63.1%**	**14.0%**	**36.5**

Source: U.S. Census Bureau, American Community Survey, 2015-2019, B01001, DP05. https://data.census.gov/cedsci

Race/Ethnicity

In the service area, 76.9% of the population is Hispanic/Latino, followed by 17.6% Asian, 3.9% White, 0.7% Black or African American, 0.5% Two or more races, 0.2% American Indian/Alaskan Native, and 0.1% Native Hawaiian/Pacific Islander.

Race/Ethnicity

	Beverly Service Area		Los Angeles County	California
	Number	Percent	Percent	Percent
Hispanic or Latino	517,152	77.0%	48.5%	39.0%
Asian	118,173	17.6%	14.4%	14.3%
White	26,249	3.9%	26.2%	37.2%
Black or African American	4,388	0.7%	7.8%	5.5%
Two or more races/other race	3,158	0.5%	2.7%	3.2%
American Indian/Alaska Native	1,458	0.2%	0.2%	0.4%
Native Hawaiian/Pacific Islander	965	0.1%	0.2%	0.4%

Source: U.S. Census Bureau, American Community Survey, 2015-2019, DP05. https://data.census.gov/cedsci

Within the service area, the Hispanic/Latino population ranged from 23.2% in Monterey Park 91755 to 96.5% in East Los Angeles 90023. The White population ranged from 1.3% in East Los Angeles 90023 to 8.9% in Whittier 90606. The Asian population ranged from 0.4% in Commerce to 70.6% in Monterey Park 91755. The Black/African American population ranged from 0.2% in Monterey Park 91755 to 1.6% in Commerce.

Population, by Race and Ethnicity, by ZIP Code

	ZIP Codes	Hispanic/ Latino	White	Asian	Black/African American
Bell/Bell Gardens	90201	94.3%	3.6%	0.6%	1.1%
Commerce	90040	95.0%	1.5%	0.4%	1.6%
East Los Angeles	90022	95.9%	2.0%	1.1%	0.3%
East Los Angeles	90023	96.5%	1.3%	0.8%	1.2%
East Los Angeles	90063	95.7%	2.7%	1.0%	0.3%
El Monte	91732	66.0%	3.5%	28.9%	0.5%
Montebello	90640	77.4%	7.0%	13.4%	1.0%
Monterey Park	91754	32.8%	4.0%	61.0%	0.5%
Monterey Park	91755	23.2%	3.7%	70.6%	0.2%
Pico Rivera	90660	90.7%	5.3%	2.6%	0.8%
Rosemead	91770	33.2%	4.4%	60.8%	0.4%
South El Monte	91733	75.5%	2.4%	20.6%	0.3%
Whittier	90606	87.2%	8.9%	2.1%	0.6%
Beverly Service Area		**76.9%**	**3.9%**	**17.6%**	**0.7%**
Los Angeles County		**48.5%**	**26.2%**	**14.4%**	**7.8%**
California		**39.0%**	**37.2%**	**14.3%**	**5.5%**

Source: U.S. Census Bureau, American Community Survey, 2015-2019, DP05. https://data.census.gov/cedsci

Citizenship

In the service area, 42.8% of the population are foreign born. Among the foreign born, 48.1% are U.S. citizens and 51.9% are not U.S. citizens. It is important to note that not being a U.S. citizen does not indicate an illegal resident status within the U.S.

Foreign Born Residents and Citizenship

	Beverly Service Area	Los Angeles County	California
Foreign Born	42.8%	34.0%	26.8%
Naturalized U.S. citizen	48.1%	52.3%	51.7%
Not a U.S. citizen	51.9%	47.7%	48.3%

Source: U.S. Census Bureau, American Community Survey, 2015-2019, DP02. https://data.census.gov/cedsci

Language

Among the service area population, ages five and older, 65.0% speak Spanish in the home, 18.5% speak only English in the home, 15.5% speak an Asian or Pacific Islander language, 0.7% speak other Indo-European languages, and 0.3% speak other languages in the home.

Language Spoken at Home, Population, Ages 5 and Older

	Beverly Service Area	Los Angeles County	California
Speaks Spanish	65.0%	39.2%	28.7%
Speaks only English	18.5%	43.4%	55.8%
Speaks Asian/Pacific Islander languages	15.5%	10.9%	10.0%
Speaks Other Indo-European languages	0.7%	5.3%	4.5%

	Beverly Service Area	Los Angeles County	California
Speaks other languages	0.3%	1.1%	1.0%

Source: U.S. Census Bureau, American Community Survey, 2015-2019, DP02. https://data.census.gov/cedsci

In the service area, only English speakers at home ranged from 9.2% in Bell/Bell Gardens to 35.7% in Whittier. Spanish speakers in the home ranged from 15.8% in Monterey Park 91755 to 88.9% in Bell/Bell Gardens. Asian/Pacific Islander language speakers at home was highest in Monterey Park 91755 (61.4%). Indo-European language speakers at home was highest in Montebello (3.6%).

Language Spoken at Home, by ZIP Code

	ZIP Codes	English	Spanish	Asian/PI	Indo-European
Bell/Bell Gardens	90201	9.2%	88.9%	0.6%	0.2%
Commerce	90040	22.7%	76.3%	0.3%	0.0%
East Los Angeles	90022	12.0%	86.9%	0.9%	0.2%
East Los Angeles	90023	10.4%	88.6%	0.6%	0.2%
East Los Angeles	90063	12.0%	87.0%	0.7%	0.1%
El Monte	91732	17.2%	56.3%	26.0%	0.4%
Montebello	90640	26.5%	59.5%	10.2%	3.6%
Monterey Park	91754	27.7%	21.9%	49.0%	1.1%
Monterey Park	91755	21.4%	15.8%	61.4%	1.1%
Pico Rivera	90660	30.3%	66.9%	2.1%	0.6%
Rosemead	91770	19.0%	25.9%	54.4%	0.7%
South El Monte	91733	15.7%	63.3%	20.4%	0.5%
Whittier	90606	35.7%	61.8%	1.6%	0.7%
Beverly Service Area		**42.5%**	**45.7%**	**9.7%**	**1.7%**
Los Angeles County		**43.4%**	**39.2%**	**10.9%**	**5.3%**
California		**55.8%**	**28.7%**	**4.5%**	**10.0%**

Source: U.S. Census Bureau, American Community Survey, 2015-2019, DP02. https://data.census.gov/cedsci

Linguistic Isolation

Linguistic isolation is defined as the population, ages five and older, who speaks English "less than very well." In the service area, 36.8% of the population is linguistically isolated. This rate of linguistic isolation is higher than the county (23.6%) and the state (17.8%).

Linguistic Isolation, Population, Ages 5 and Older

	Beverly Service Area	Los Angeles County	California
Linguistic Isolation	36.8%	23.6%	17.8%

Source: U.S. Census Bureau, American Community Survey, 2015-2019, DP02. https://data.census.gov/cedsci/

English Learners

In local school districts, the range of students evaluated to be English Learners in academic year 2020-2021 ranged from 9.5% in the Valle Lindo School District to 49.7% in the Mountain View School District. All area school districts exceeded the county rates

of English Learners except for Valle Lindo and Whittier school districts. The 2020-2021 English Learner student enrollment counts were lower than previous years due to difficulties experienced by local educational agencies resulting from the COVID-19 pandemic. It should be noted, the Whittier Union High School District is made up of five comprehensive high schools and two non-traditional high schools; Pioneer High School is the only high school in Whittier 90606.

English Learners, by School District

	2019-2020	2020-2021
El Monte City School District	32.0%	32.8%
El Monte Union High School District	19.3%	19.8%
Garvey School District	39.2%	33.5%
Los Angeles Unified School District	20.0%	18.8%
Los Nietos School District	29.6%	23.4%
Montebello Unified School District	33.4%	31.1%
Mountain View School District	52.8%	49.7%
Rosemead School District	39.8%	37.1%
Valle Lindo School District	10.0%	9.5%
Whittier City School District	13.7%	13.3%
Whittier Union High School District (Pioneer High School)	11.9%	14.0%
Los Angeles County	**18.0%**	**16.9%**
California	**18.6%**	**17.7%**

Source: California Department of Education, 2019-2020, 2020-2021. http://data1.cde.ca.gov/dataquest/

Veterans

Among the service area civilian population, ages 18 and older, 2.0% are civilian veterans, compared to the county (3.3%) and the state (5.2%).

Veterans

	Beverly Service Area	Los Angeles County	California
Civilian veterans	2.0%	3.3%	5.2%

Source: U.S. Census Bureau, American Community Survey, 2015-2019, DP02. https://data.census.gov/cedsci

Disabled Persons

People with a disability have difficulty performing activities due to a physical, mental, or emotional condition. In the service area, 9.7% of the civilian non-institutionalized population has a disability.

Disabled Persons

	Beverly Service Area	Los Angeles County	California
Population with disabilities	9.7%	9.9%	10.6%

Source: U.S. Census Bureau, American Community Survey 2015-2019, S1810. https://data.census.gov/cedsci

The U.S. Census defines disability as the product of interactions among individuals' bodies; their physical, emotional, and mental health; and the physical and social

environment in which they live, work, or play. Disability exists where this interaction results in limitations of activities and restrictions to full participation at school, at work, at home, or in the community. In the service area, 2.5% of the population has a hearing difficulty, 2% have a vision difficulty, 3.7% have a cognitive difficulty and 5.3% have an ambulatory difficulty. Disabilities increase with age.

Disability, by Age and Condition

	Hearing Difficulty	Vision Difficulty	Cognitive Difficulty	Ambulatory Difficulty
Ages 0-17	0.3%	0.5%	2.8%	0.5%
Ages 18-64	1.2%	1.4%	2.8%	3.4%
Ages 65-74	6.5%	5.1%	5.8%	15.2%
Age 75 and older	19.6%	10.1%	17.4%	34.3%
Beverly Service Area, all ages	**2.5%**	**2.0%**	**3.7%**	**5.3%**
Los Angeles County, all ages	**2.5%**	**2.0%**	**4.1%**	**5.7%**
California, all ages	**2.9%**	**2.0%**	**4.3%**	**5.8%**

Source: U.S. Census Bureau, American Community Survey, 2015-2019, S1810. https://data.census.gov/cedsci/

Social Determinants of Health

Social and Economic Factors Ranking

The County Health Rankings order counties according to a variety of health factors. Social and economic indicators are examined as a contributor to the health of a county's residents. This ranking examines: high school graduation rates, unemployment, children in poverty, social support, and others. California's 58 evaluated counties were ranked according to social and economic factors with 1 being the county with the best factors to 58 for the county with the poorest factors. For social and economic factors, Los Angeles County is ranked 34 in 2021, showing a decrease in rank from 30 in 2019.

Social and Economic Factors Ranking

	County Ranking (out of 58)
Los Angeles County	34

Source: County Health Rankings, 2021. www.countyhealthrankings.org

Poverty

The U.S. Department of Health and Human Services annually updates official poverty levels. In 2019, the Federal Poverty Level (FPL) was an annual income of $12,490 for one person and $25,750 for a family of four. Among the service area population, 17.4% are below 100% FPL and 45.1% are below 200% FPL. Bell and Bell Gardens have the highest rates of poverty in the service area. Poverty levels in the service area are higher than the poverty levels for the county and state.

Residents Living in Poverty

	ZIP Codes	Below 100% Poverty	Below 200% Poverty
Bell/Bell Gardens	90201	26.3%	58.0%
Commerce	90040	16.0%	40.0%
East Los Angeles	90022	19.5%	50.2%
East Los Angeles	90023	24.9%	57.5%
East Los Angeles	90063	18.1%	48.9%
El Monte	91732	17.3%	47.7%
Montebello	90640	14.0%	39.4%
Monterey Park	91754	11.6%	33.1%
Monterey Park	91755	14.6%	37.3%
Pico Rivera	90660	8.8%	29.0%
Rosemead	91770	14.0%	40.3%
South El Monte	91733	19.8%	51.6%
Whittier	90606	8.9%	28.6%
Beverly Service Area		**17.4%**	**45.1%**
Los Angeles County		**14.9%**	**34.8%**
California		**13.4%**	**31.0%**

Source: U.S. Census Bureau, American Community Survey, 2015-2019, S1701. https://data.census.gov/cedsci

Among the service area population, 26.7% of children, under age 18, and 15.3% of adults, ages 65 and older, live in poverty. Poverty rates for children ranged from 10.9% in Pico Rivera to 38.8% in Bell/Bell Gardens. Poverty rates for senior adults ranged from 8.9% in Whittier 90606 to 22.0% in East Los Angeles 90023.

39.3% of female head of households (no spouse present) with related children, under age 18, live in poverty in the service area. Poverty rates for female head of household families ranged from 22.0% in Commerce to 51.9% in Bell/Bell Gardens.

Poverty Levels of Children, Older Adults, and Females Head of Household with Children

	ZIP Codes	Children, Under 18	Adults, 65 and Older	Female HoH with Children‡
Bell/Bell Gardens	90201	38.8%	20.2%	51.9%
Commerce	90040	18.6%	19.5%	22.0%
East Los Angeles	90022	29.1%	16.4%	44.2%
East Los Angeles	90023	37.8%	22.0%	47.1%
East Los Angeles	90063	25.6%	20.2%	44.5%
El Monte	91732	28.0%	13.2%	36.8%
Montebello	90640	22.5%	12.6%	31.1%
Monterey Park	91754	13.9%	12.6%	26.2%
Monterey Park	91755	19.4%	18.4%	33.5%
Pico Rivera	90660	10.9%	13.8%	22.7%
Rosemead	91770	19.0%	11.1%	33.1%
South El Monte	91733	30.8%	17.5%	38.7%
Whittier	90606	13.7%	8.9%	22.2%
Beverly Service Area		**26.7%**	**15.3%**	**39.3%**
Los Angeles County		**20.8%**	**13.2%**	**33.3%**
California		**18.1%**	**10.2%**	**33.1%**

Source: U.S. Census Bureau, American Community Survey, 2015-2019, S1701, S1702‡. https://data.census.gov/cedsci

Free and Reduced-Price Meals

The percentage of students eligible for the free and reduced-price meal program is one indicator of socioeconomic status. In area school districts, the percent of students eligible for the program ranged from 70.9% in Garvey School District to 96.6% in Mountain View School District.

Free and Reduced-Price Meals Eligibility

	Percent of Eligible Students
El Monte City School District	90.8%
El Monte Union High School District	88.2%
Garvey School District	70.9%
Los Angeles Unified School District	81.3%
Los Nietos School District	75.3%
Montebello Unified School District	78.2%
Mountain View School District	96.6%
Rosemead School District	74.8%
Valle Lindo School District	77.4%

	Percent of Eligible Students
Whittier City School District	73.4%
Whittier Union High School District (Pioneer High School)	79.5%
Los Angeles County	**68.7%**
California	**58.9%**

Source: California Department of Education, 2020-2021. DataQuest (CA Dept of Education)

Unemployment

In 2020, the unemployment rate in service area cities and Census Designated Places (CDP) ranged from 12.0% in Whittier to 18.4% in East Los Angeles. High unemployment in 2020 may be attributed, in part, to the COVID-19 pandemic.

Unemployment Rate, 2020 Annual Average

	Percent
Bell, city	13.2%
Bell Gardens, city	13.2%
Commerce, city	12.8%
East Los Angeles, CDP	18.4%
El Monte, city	13.7%
Montebello, city	13.8%
Monterey Park, city	14.9%
Pico Rivera, city	13.3%
Rosemead, city	16.2%
South El Monte, city	12.3%
Whittier, city	12.0%
Los Angeles County	**12.8%**
California	**10.1%**

Source: California Employment Development Department, Labor Market Information. 2020.
http://www.labormarketinfo.edd.ca.gov/data/labor-force-and-unemployment-for-cities-and-census-areas.html

Medical Debt

8.3% of SPA 3 adults and 9.1% of SPA 7 adults had problems paying or were unable to pay medical bills for themselves or household family members in the past 12 months. Of these adults, 35.8% in SPA 3 and 41.5% in SPA 7 reported they were unable to pay for basic necessities (food, heat, rent) due to their medical bills.

Medical Debt

	SPA 3	SPA 7	Los Angeles County	California
Ever had problems paying medical bill	8.3%	9.1%	10.2%	10.9%
Unable to pay for basic necessities due to medical bills	35.8%	41.5%	35.0%	35.0%

Source: California Health Interview Survey, 2019-2020. http://ask.chis.ucla.edu/

Community Input – Economic Insecurity

Stakeholder interviews identified the following issues, challenges and barriers related to

economic insecurity. Following are their comments summarized and edited for clarity:

- When people fear that they do not have enough money or food, when there are threats to their economic security, thefts rise. With the increased price of gas, we are seeing an increase in gas theft. Often, theft and burglaries are tied to an increase in economic insecurity. When people think they don't have enough money, they just steal it from other people.
- The majority of our residents have very limited incomes and are on Medi-Cal or Medicare. Some feel insecure economically, especially with prices right now. They are able to get meals at the YMCA and the adult day care center, so that is very beneficial to them.
- I don't see it in the community, congregate meals are more about socialization and nutrition, not economics.
- At work, inflation has challenged our staff who have to drive. They often have to drive across the community and neighborhoods and they are feeling it when they have to fill their cars with gas.
- Everything is getting more expensive and we haven't caught up yet in terms of our paychecks.
- Affordable childcare is the big concern, especially for women who want to go back to the workforce. If there isn't quality, affordable childcare, it impacts their ability to go back to work.
- Home Depot was an established business. And they pulled out of the neighborhood. And in its place a homeless encampment has sprung up. The city is talking to other businesses to bring them in. Businesses are not as busy as they were before the pandemic. It will be a while before people feel comfortable coming back. And we have fewer staff now.
- An issue is low paying jobs.
- The cost of medical insurance and deductibles is over the top.

Households

In the service area, there were 179,346 households and 187,108 housing units in 2019. From 2014 to 2019, the service area population decreased by 0.7%, housing units increased by 0.2%, and vacant units decreased by 23.6%. Owner occupied households and renter occupied households increased from 2014 to 2019.

Households and Housing Units, and Percent Change, 2014-2019

	Beverly Service Area			Los Angeles County	California
	2014	2019	Percent Change	Percent Change 2014 to 2019	Percent Change 2014 to 2019
Housing units	186,556	187,108	0.2%	2.3%	2.8%

	Beverly Service Area			Los Angeles County	California
	2014	2019	Percent Change	Percent Change 2014 to 2019	Percent Change 2014 to 2019
Households	176,397	179,346	1.6%	2.2%	3.3%
Owner-occupied	77,194	77,868	0.8%	1.0%	3.5%
Renter-occupied	99,193	101,478	2.3%	3.3%	3.3%
Vacant units	10,169	7,762	-23.6%	2.8%	-2.8%

Source: U.S. Census Bureau, American Community Survey 2010-2014, 2015-2019, DP04. https://data.census.gov/cedsci

According to the U.S. Department of Housing and Urban Development, families who pay more than 30% of their income for housing are considered “cost burdened” and may have difficulty affording other necessities including food, transportation, medical care, paying off student loans or other loans, and contributing to personal monetary savings.

In the service area, 48.4% of the population in occupied households spend 30% or more of their income on housing. This includes those living in owner-occupied housing units with a mortgage and those without a mortgage (where costs are the costs of ownership), as well as those who rent. Notably, more than half (59.7%) of renters in the service area spent more than 30% of their income on rent.

Households that Spend 30% or More of Their Income on Housing*

	Beverly Service Area	Los Angeles County	California
All occupied households	48.4%	47.3%	41.7%
Owner-occupied households with or without mortgage	34.4%	35.7%	31.4%
Renter-occupied households	59.7%	57.6%	54.8%

*Source: U.S. Census Bureau, American Community Survey, 2015-2019, DP04. *Excludes units were SMOPI and GRAPI cannot be computed. https://data.census.gov/cedsci*

In the service area, the median household income was $51,268 as compared to the county at $68,044.

Household Income

	Beverly Service Area	Los Angeles County
Median household income	$51,268	$68,044

Source: U.S. Census Bureau, American Community Survey, 2015-2019, DP03. https://data.census.gov/cedsci

Homelessness

Since 2005, the Los Angeles Homeless Services Authority (LAHSA) had conducted the annual Greater Los Angeles Homeless Count to determine how many individuals and

families are homeless on a given day. Data from the 2020 survey show the total number of homeless persons counted in SPA 3 was 4,555 and in SPA 7 was 4,586. The homeless population increased from 2018 to 2020 in both SPAs and the county. The Los Angeles County Board of Supervisors postponed the 2021 Homeless Count due to the COVID-19 pandemic.

From 2018 to 2020, the percent of sheltered homeless persons increased in SPA 3 and decreased in SPA 7. Shelter includes cars, RVs, tents, and temporary structures (e.g., makeshift shelters), in addition to official homeless shelters. In SPA 3, 79.3% of the homeless population were individual adults and 20.6% were family members. In SPA 7, 89.0% of the homeless population were individual adults and 11.0% were family members.

Los Angeles Continuum of Care Homeless Population, 2018-2020 Comparison

	SPA 3		SPA 7		Los Angeles County*	
	2018	2020	2018	2020	2018	2020
Total homeless	3,605	4,555	4,569	4,586	49,955	63,706
Sheltered	22.6%	33.5%	23.1%	20.8%	24.8%	27.7%
Unsheltered	77.4%	66.5%	76.8%	79.1%	75.2%	72.3%
Individual adults	87.2%	79.3%	81.0%	89.0%	80.0%	81.0%
Family members	12.7%	20.6%	14.7%	11.0%	16.0%	19.0%
Unaccompanied minors (<18)	0%	0%	0.0%	0.0%	0.1%	0.0%

*Source: Los Angeles Homeless Service Authority, 2018 & 2020 Greater Los Angeles Homeless Count. https://www.lahsa.org/homeless-count/ *These data represent the homeless counts from the LA County Continuum of Care, which does not include Glendale, Long Beach and Pasadena homeless counts.*

Among the homeless population, 39.0% in SPA 3 and 48.0% in SPA 7 were chronically homeless in 2020. The rates of chronic homelessness among individuals and family members increased in SPAs 3 and 7 from 2018 to 2020.

Homelessness Subpopulations

	SPA 3		SPA 7		Los Angeles County*	
	2018	2020	2018	2020	2018	2020
Chronically homeless, all	34.0%	39.0%	19.0%	48.0%	27.0%	38.0%
Chronically homeless individuals	34.0%	37.0%	19.0%	47.0%	26.0%	36.0%
Chronically homeless family members	0.2%	2.0%	1.0%	2.0%	1.0%	2.0%
Domestic violence experience	38.0%	29.0%	28.0%	35.0%	30.0%	33.0%
Persons with HIV/AIDS	1.0%	2.0%	1.0%	1.0%	1.0%	2.0%
Developmental disability	8.0%	7.0%	4.0%	5.0%	6.0%	9.0%
Physical disability	15.0%	25.0%	12.0%	25.0%	15.0%	19.0%
Serious mental illness	33%	28.0%	19.0%	23.0%	27.0%	25.0%
Substance use disorder	22%	33.0%	9.0%	36.0%	15.0%	27.0%
Veterans	6.0%	4.0%	7.0%	8.0%	7.0%	6.0%

*Source: Los Angeles Homeless Service Authority, 2018 & 2020 Greater Los Angeles Homeless Count. https://www.lahsa.org/homeless-count/ *These data represent the homeless counts from the LA County Continuum of Care, which does not include Glendale, Long Beach and Pasadena homeless counts.*

Community Input – Housing and Homelessness

Stakeholder interviews identified the following issues, challenges and barriers related to housing and homelessness. Following are their comments summarized and edited for clarity:

- We have people whose primary mission is to reach the homeless population, but our biggest challenge is dealing with people who don't want help.
- The cost of rent and the prices of homes has increased, People can't come up with the down payment and compete with so many others who want the same home.
- We have a long wait list; it is over 1,000 people. Housing is a scarcity. A lot of seniors have places to stay with their families. A lot of people with the pandemic, they weren't comfortable being in a group living situation.
- Housing in general is difficult. People have to partner up with other families to rent a room in a house.

Public Program Participation

Among adults, 14.5% in SPA 3 and 16.6% in SPA 7 avoided government benefits due to concerns about disqualification from obtaining a green card for U.S. citizenship. 20.9% of adults in SPA 3 and 16.5% in SPA 7 reported using food stamps and 6.4% in SPA 3 and 6.0% in SPA 7 are TANF/CalWORKS recipients. Among parents/guardians of eligible children, 33.9% in SPA 3 and 66.1% in SPA 7 participated in the WIC program. Among low income older and disabled adults, 11.3% in SPA 3 and 4.0% in SPA 7 received Supplemental Security Income.

Public Program Participation

	SPA 3	SPA 7	Los Angeles County	California
Avoided government benefits	14.5%	16.6%	20.6%	17.3%
Food stamp recipient (≤200% FPL)	20.9%	16.5%	24.6%	23.8%
TANF/CalWORKS recipient (≤200 FPL)	6.4%	6.0%*	8.6%	8.4%
Child ≤6 years, currently on WIC (≤200 FPL)	33.9%*	66.1%	40.3%	43.6%
Supplemental Social Security Income (SSI) (≤200% FPL)	11.3%	4.0%	10.1%	10.8%

*Source: California Health Interview Survey, 2019-2020. *Statistically unstable due to sample size. http://ask.chis.ucla.edu/*

Access to Food

The U.S. Department of Agriculture (USDA) defines food insecurity as a lack of consistent access to enough food for an active, healthy life. Among households below 300% FPL, 21.6% in SPA 3 and 25.9% in SPA 7 were food insecure. Among adults living below 200% FPL, 29.9% in SPA 3 and 32.2% in SPA 7 reported they were not able to afford food.

Food Insecurity

	SPA 3	SPA 7	Los Angeles County
Households, <300% FPL that are food insecure	21.6%	25.9%	26.8%
Not able to afford food (<200% FPL) ‡	29.9%	32.2%	39.6%

Source: 2018 Los Angeles County Health Survey; Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health. http://publichealth.lacounty.gov/ha/LACHSDataTopics2018.htm. ‡Source: California Health Interview Survey, 2019-2020. http://ask.chis.ucla.edu/

Among parents/guardians of children, ages 17 and younger, 81.5% in SPA 3 and 73.2% in SPA 7 rated community access to fresh fruits and vegetables as good or excellent.

Community Access to Fresh Produce

	SPA 3	SPA 7	Los Angeles County
Good or excellent access to fresh produce	81.5%	73.2%	78.2%

Source: 2018 Los Angeles County Health Survey; Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health. http://publichealth.lacounty.gov/ha/LACHSDataTopics2018.htm

Farmers Markets

Eligible individuals in the Women, Infants, and Children Program (WIC) and CalFresh, California's Supplemental Nutrition Assistance Program (SNAP) can use a California WIC card or Electronic Benefit Transfer card to obtain fruits and vegetables at approved farmers markets. There are four farmers markets in the service area.

Farmers Markets Accepting EBT and/or WIC

	ZIP Code	Farmers Market	Accepts EBT and/or WIC
East Los Angeles	90022	East LA Saturday Market	EBT & WIC
Montebello	90640	Beverly Hospital Certified Famers Market	Not stated
Monterey Park	91755	Monterey Park Certified Farmers Market	EBT & WIC
Rosemead	91770	Rosemead Monday Market	EBT & WIC

Source: Ecology Center https://ecologycenter.org/fmfinder. Accessed 1/17/22

Educational Attainment

Among service area adults, ages 25 and older, 37.4% have less than a high school diploma. 42.6% are high school graduates, and 20.0% have an associate, bachelor's, or graduate/professional degree.

Educational Attainment, Ages 25 and Older

	Beverly Service Area	Los Angeles County	California
Population, ages 25 and older	**411,356**	**6,886,895**	**26,471,543**
Less than 9th grade	23.5%	12.3%	9.2%
9th to 12th grade, no diploma	13.9%	8.6%	7.5%
High school graduate	26.5%	20.6%	20.5%
Some college, no degree	16.1%	19.0%	21.1%

	Beverly Service Area	Los Angeles County	California
Associate degree	5.7%	7.0%	7.8%
Bachelor's degree	10.8%	21.2%	21.2%
Graduate or professional degree	3.5%	11.3%	12.8%

Source: U.S. Census Bureau, American Community Survey, 2015-2019, DP02. https://data.census.gov/cedsci

High school graduation rates are determined by dividing the number of graduates for the school year by the number of freshmen enrolled four years earlier. The Healthy People 2030 objective for high school graduation is 90.7%. Graduation rates for Whittier Union High School District and Pioneer High School exceed the Healthy People 2030 objective for high school graduation.

High School Graduation Rates, 2019-2020

	High School Graduation Rate
El Monte Union High School District	84.2%
Los Angeles Unified School District*	85.3%
Montebello Unified School District	79.0%
Whittier Union High School District (Pioneer High School)	96.0%
Los Angeles County	**86.3%**
California	**87.7%**

*Source: California Department of Education, 2020-2021. *High schools in service area ZIP Codes only.*
http://data1.cde.ca.gov/dataquest/

Community Input – Education

Stakeholder interviews identified the following issues, challenges and barriers related to education. Following are their comments summarized and edited for clarity:

- It is an ongoing issue because people lost a year of school. Some kids thrived, but most did not.
- Kids who have had successes had their parents involved. Parents who show up at teacher conferences that is important. Then there are others who just ask are my kids staying out of trouble? That is all they ask.
- Today, people come out of college underqualified and underemployed and have to pay back student loans.

Preschool Enrollment

The percentage of service area children, ages 3 and 4, enrolled in preschool was 48.8% and ranged from 34.8% in Pico Rivera to 67.9% in Rosemead. The service area had a lower overall rate of preschool enrollment as compared to the county (54.5%) and the state (49.6%).

Enrolled in Preschool, Children, Ages 3 and 4

	ZIP Code	Children, Ages 3 and 4	Percent Enrolled
Bell/Bell Gardens	90201	3,524	49.0%
Commerce	90040	434	52.5%
East Los Angeles	90022	1,875	45.9%
East Los Angeles	90023	1,206	55.9%
East Los Angeles	90063	1,702	55.3%
El Monte	91732	1,586	39.8%
Montebello	90640	1,647	36.1%
Monterey Park	91754	431	64.0%
Monterey Park	91755	465	55.4%
Pico Rivera	90660	1,478	34.8%
Rosemead	91770	1,881	67.9%
South El Monte	91733	1,294	42.0%
Whittier	90606	847	51.1%
Beverly Service Area		**8,960**	**48.8%**
Los Angeles County		**255,273**	**54.5%**
California		**1,021,926**	**49.6%**

Source: U.S. Census Bureau, American Community Survey, 2015-2019, S1401. https://data.census.gov/cedsci

Reading to Children

Adults with children, ages 0 to 5, in their care, were asked whether their child(ren) were read to daily by a family member in a typical week. 70.2% of adults in SPA 3 and 52.7% in SPA 7, reported their child(ren) were read to every day.

Children Who Were Read to Daily by a Parent or Family Member

	SPA 3	SPA 7	Los Angeles County	California
Children read to daily	70.2%	52.7%	64.6%	63.1%

Source: California Health Interview Survey, 2019-2020. http://ask.chis.ucla.edu/

Childcare Access

Among adults, 12.9% in SPA 3 and 8.7% in SPA 7 reported not being able to find childcare for a week or longer when needed in the past 12 months. 1.2% of adults in SPA 3 and 0.8% in SPA 7 reported experiencing childcare difficulties due to the COVID-19 pandemic.

Difficulty Finding Childcare

	SPA 3	SPA 7	Los Angeles County	California
Difficulty finding childcare ≥ 1 week	12.9%	8.7%	10.7%	10.2%
Childcare difficulties due to COVID-19 pandemic‡	1.2%*	0.8%*	1.7%	1.8%

*Source: California Health Interview Survey, 2019-2020, 2020‡. *Statistically unstable due to sample size. http://ask.chis.ucla.edu/*

Transportation

In the service area, 76.1% of individuals, ages 16 and older, drove alone to work, 11.7%

carpooled, 5.3% used public transportation, 3.1% worked from home, 2.2% walked to work, and 1.5% used other means to get to work. The average service area commute time was 30.4 minutes. It should be noted these data were collected prior to the COVID-19 epidemic.

Transportation for Workers, Ages 16 and Older

	Beverly Service Area	Los Angeles County	California
Workers 16 years and older	298,518	4,811,408	18,191,555
Car, truck, or van -- drove alone	76.1%	74.0%	73.7%
Car, truck, or van -- carpooled	11.7%	9.5%	10.1%
Public transportation (excluding taxi)	5.3%	5.8%	5.1%
Walked	2.2%	2.7%	2.6%
Other means	1.5%	2.4%	2.6%
Worked from home	3.1%	5.6%	5.9%
Mean travel time to work (minutes)	30.4	31.8	29.8

Source: U.S. Census Bureau, American Community Survey, 2015-2019, DP03. https://data.census.gov/cedsci/

Community Walkability

WalkScore.com ranks over 2,800 cities in the United States (over 10,000 neighborhoods) with a walk score. The Walk Score is determined by access to amenities and pedestrian friendliness, with a scoring range of 0 to 100.[1] A higher score indicates an area is more accessible to walking while a lower score indicates a more vehicle dependent location. Walkability scores ranged from 29 (car dependent) in Commerce to 87 in Whittier 90606 (very walkable).

Walkability

	ZIP Code	Walk Score	Definition
Bell/Bell Gardens	90201	66	Somewhat Walkable
Commerce	90040	29	Car Dependent
East Los Angeles	90022	77	Very Walkable
East Los Angeles	90023	80	Very Walkable
East Los Angeles	90063	80	Very Walkable
El Monte	91732	56	Somewhat Walkable

[1] WalkScore.com has established the range of scores as follows:
0-24: Car Dependent (Almost all errands require a car)
25-49: Car Dependent (A few amenities within walking distance)
50-69: Somewhat Walkable (Some amenities within walking distance)
70-89: Very Walkable (Most errands can be accomplished on foot)
90-100: Walker's Paradise (Daily errands do not require a car)

	ZIP Code	Walk Score	Definition
Montebello	90640	66	Somewhat Walkable
Monterey Park	91754	66	Somewhat Walkable
Monterey Park	91755	62	Somewhat Walkable
Pico Rivera	90660	59	Somewhat Walkable
Rosemead	91770	71	Very Walkable
South El Monte	91733	48	Car Dependent
Whittier	90606	87	Very Walkable

Source: WalkScore.com, 2021. http://www.walkscore.com.

Parks, Playgrounds and Open Spaces

Children and teens who live near safe parks, playgrounds, and open spaces tend to be more physically active than those who do not live near those facilities.
Among children and teens, 94.8% in SPA 3 and 89.1% in SPA 7 lived within walking distance to a playground or open space.66.2% of children and teens in SPA 3 and 80.0% in SPA 7 visited a park, playground, or open space within the past month.

Open Spaces, Children and Teens, Ages One Year and Older

	SPA 3	SPA 7	Los Angeles County	California
Lived within walking distance to park, playground, or open space	94.8%*	89.1%*	92.3%*	89.2%
Visited a park/playground/open space	66.2%*	80.0%*	74.2%	81.4%

*Source: California Health Interview Survey, 2018. *Statistically unstable due to sample size. http://ask.chis.ucla.edu/*

Among parents with children, 90.5% in SPA 3 and 96.1% in SPA 7 agreed/strongly agreed parks and playgrounds closest to where they lived were safe during the day.
Among teens, 86.0% in SPA 3 and 99.4% in SPA 7 agreed/strongly agreed parks and playgrounds closest to where they lived were safe during the day.

Safe Open Spaces, Children and Teens

	SPA 3	SPA 7	Los Angeles County	California
Children, ages 1-11	90.5%*	96.1%	88.0%	89.7%
Teens, ages 12-17‡	86.0%*	99.4%*	85.2%	88.2%

*Source: California Health Interview Survey, 2019‡, 2019-2020. *Statistically unstable due to sample size. http://ask.chis.ucla.edu/*

Crime and Violence

People can be exposed to crime and violence in many ways. They may be victimized directly, witness violence or property crimes in their community, or hear about crime and violence from other residents, all of which can affect their quality of life. Safe neighborhoods are a key component of physical and mental health. Among adults, 89.5% in SPA 3 and 87.0% in SPA 7 felt safe most/all the time.

Safe Neighborhood, Adults

	SPA 3	SPA 7	Los Angeles County	California
Feels safe all the time	32.1%	32.9%	29.4%	37.0%
Feels safe most of the time	57.4%	54.1%	54.9%	51.0%
Feels safe some of the time	9.3%	12.3%	13.9%	13.9%
Feels safe none of the time	1.2%	0.7%*	1.8%	1.4%

*Source: California Health Interview Survey, 2019-2020. *Statistically unstable due to sample size. http://ask.chis.ucla.edu/*

When adults were asked about neighborhood cohesion, 78.3% in SPA 3 and 73.8% in SPA 7 agreed/strongly agreed neighbors were willing to help. 83% of adults in SPA 3 and 76% of adults in SPA 7 agreed/strongly agreed that people in their neighborhood could be trusted.

Neighborhood Cohesion, Adults

	SPA 3	SPA 7	Los Angeles County	California
People in neighborhood are willing to help	78.3%	73.8%	73.6%	78.1%
People in neighborhood can be trusted	83.0%	76.0%	76.8%	81.1%

Source: California Health Interview Survey, 2019-2020. http://ask.chis.ucla.edu/

When teens were asked about neighborhood cohesion, 79.8% in SPA 3 and 86.1% in SPA 7 agreed/strongly agreed neighbors were willing to help. 81.5% of teens in SPA 3 and 77.6% of teens in SPA 7 agreed/strongly agreed that people in their neighborhood could be trusted. 72.4% of SPA 3 teens and 80.7% of SPA 7 teens felt safe in their neighborhoods.

Neighborhood Cohesion, Teens, Ages 12-17

	SPA 3	SPA 7	Los Angeles County	California
Feels safe in neighborhood	72.4%	80.7%*	80.5%	88.5%
People in neighborhood are willing to help	79.8%*	86.1%*	84.4%	87.1%
People in neighborhood can be trusted	81.5%	77.6%*	79.3%	82.4%

*Source: California Health Interview Survey, 2019-2020. *Statistically unstable due to sample size. http://ask.chis.ucla.edu/*

Crime Statistics

Violent crimes include homicide, rape, robbery, and aggravated assault. Property crimes include burglary, larceny theft, and motor vehicle theft. Arson includes fires set to structural, mobile, or other property. From 2018 to 2020 the number of violent crimes increased in Bell Gardens, Commerce and Whittier. Property crimes increase in Bell, Commerce, and Pico Rivera. Cases of arson increased in Bell Gardens, Commerce, El

Monte, Los Angeles, Monterey Park, Rosemead and South El Monte.

Violent Crimes, Property Crimes, Arson, Number, by Jurisdiction

	Violent Crimes		Property Crimes		Arson	
	2018	**2020**	**2018**	**2020**	**2018**	**2020**
Bell	184	182	495	502	0	0
Bell Gardens	117	150	633	618	4	12
Commerce	128	136	995	1,069	7	13
El Monte	362	348	2,242	1,175	20	21
Los Angeles	30,126	28,882	101,267	85,932	1,654	2,994
Montebello	218	178	1,643	1,064	86	36
Monterey Park	124	113	1,589	1,230	2	15
Pico Rivera	228	174	1,159	1,166	5	5
Rosemead	194	189	1,274	895	5	6
South El Monte	126	118	621	597	5	9
Whittier	233	237	2,225	1,634	11	3
Los Angeles County	**58,567**	**54,600**	**237,184**	**213,377**	**2,684**	**4,271**
California	**176,866**	**173,864**	**940,998**	**841,171**	**8,523**	**11,759**

Source: California Department of Justice, Office of the Attorney General, 2020. State of California Department of Justice-OpenJustice

Intimate Partner Violence

Physical violence is defined by being hit, slapped, pushed, kicked, or hurt by an intimate partner. In SPA 3, 11.7% of adult females and 5.5% of adult males have experienced physical violence. In SPA 7, 16.9% of adult females and 7.3% of adult males have experienced physical violence.

Sexual violence is defined as experiencing unwanted sex by an intimate partner. In SPA 3, 6.8% of adult females and 1.6% of adult males experienced sexual violence. In SPA 7, 13.2% of adult females and 2.4% of adult males experienced sexual violence.

Intimate Partner Violence

	SPA 3	SPA 7	Los Angeles County
Females have experienced physical violence	11.7%	16.9%	16.0%
Males have experienced physical violence	5.5%	7.3%	11.8%
Females have experienced sexual violence	6.8%	13.2%	10.1%
Males have experienced sexual violence	1.6%*	2.4%*	3.3%

*Source: 2018 Los Angeles County Health Survey; Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health. *Statistically unstable due to sample size. http://publichealth.lacounty.gov/ha/LACHSDataTopics2018.htm*

Calls for domestic violence are categorized as with or without a weapon, and, since 2018, strangulation and suffocation were added to the classification. Weapons include

firearms, knives, other weapons, and personal weapons (hands, feet). In Los Angeles County, 78.0% of domestic violence calls included reported use of a weapon.

Domestic Violence Calls, by Jurisdiction

	Total Calls	No Weapon	Weapon Involved	Percent With Weapon	Strangulation/ Suffocation
Bell	75	30	45	60.0%	15
Bell Gardens	83	80	3	3.6%	12
Commerce	77	16	61	79.2%	0
El Monte	378	59	319	84.3%	30
Los Angeles	17,084	0	17,804	100%	1,788
Montebello	66	1	65	98.4%	0
Monterey Park	98	85	13	13.2%	2
Pico Rivera	201	74	127	63.1%	0
South El Monte	122	28	94	77.0%	0
Whittier	79	8	71	89.8%	0
Los Angeles County	**35,498**	**7,787**	**27,711**	**78.0%**	**2,541**
California	**160,646**	**88,018**	**72,628**	**45.2%**	**9,715**

Source: California Department of Justice, Office of the Attorney General, 2020. https://oag.ca.gov/crime/cjsc/stats/domestic-violence

Community Input – Community Safety

Stakeholder interviews identified the following issues, challenges and barriers related to community safety. Following are their comments summarized and edited for clarity:

- Public safety is an increasing challenge with students. There are calls we get where a student has created a disturbance and the schools call law enforcement intervention.
- We do not see human trafficking in our area.
- We have seen alarming rates of increased domestic abuse violent crimes. A lot of it is taking place inside the home and we need more resources and services to assist families in counseling, therapy anger management, and conflict resolution. It is reasonable to assume when people can't leave their homes, there is an increase in domestic related crimes.
- On the south end of town, there is more gang activity. And some of the individuals who are homeless are becoming very bold and violent. We have no security here. We don't know who is walking in and how they are going to behave.
- We have an issue with the homeless population wandering in, yelling and sleeping on the benches in the front of our building. Residents are fearful of taking a walk outside, they don't want to run into someone who is mentally unstable.
- Community areas like parks and bike trails are often overtaken by people with mental health issues. As a result, families do not go to those places anymore. Even libraries are sometimes used by persons who are homeless or with mental illness are going to access public WIFI. And they are using the bathroom for their hygiene

needs.

- Certain categories of crimes have gone up. There are more petty crime and thefts.

Air Quality

Days with Ozone Levels above Regulatory Standard

Ground-level ozone is formed from pollutants emitted from cars, power plants, and other sources. The national ambient air quality standard for ozone is 0.070 parts per million (ppm); concentrations above 0.070 ppm are considered unhealthy, especially for sensitive groups such as children, those with asthma, and the elderly. In 2019, Los Angeles County had 58 days with ground-level ozone concentrations above the U.S. standard of 0.070 parts per million, as compared to California at 11 days.

Days with Ozone Levels above Regulatory Standard

	Los Angeles County	California
Number of days	58	11

Source: California Air Resources Board, iADAM: Air Quality Data Statistics (December 2020). http://www.kidsdata.org

Annual Average Particulate Matter Concentration

Fine particulate matter (PM 2.5) is an air pollutant commonly found in diesel exhaust. PM 2.5 refers to particles with a diameter of less than 2.5 microns, or about 1/10,000 of an inch. The national annual PM 2.5 standard is 12 micrograms per cubic meter. Concentrations at or above this standard are considered potentially harmful to health, especially for sensitive groups such as young children and those with asthma, and the elderly. In 2019, the annual average PM 2.5 concentrations in Los Angeles County were measured at 11.0 micrograms per cubic meter, as compared to California at 8.1 micrograms per cubic meter.

Particulate Matter Concentration, Annual Average

	Los Angeles County	California
Micrograms per cubic meter	11.0	8.1

Source: California Air Resources Board, iADAM: Air Quality Data Statistics; U.S. Environmental Protection Agency, Particulate Matter (PM2.5) Trends (December 2020). http://www.kidsdata.org

Health Care Access

Health Insurance Coverage

Health insurance coverage is a key component to accessing health care. The Healthy People 2030 objective for health insurance coverage is 92.1%. In the service area, 87.8% of the population (all age groups), 96.1% of children, ages 0 to 18, and 82.2% of adults, ages 19 to 64 have health insurance coverage.

Health insurance coverage ranged from 83.7% in Bell/Bell Gardens to 93.7% in Monterey Park 91755. Among children, health insurance coverage ranged from 93.5% in Commerce to 98.4% in Monterey Park 91755. Among adults, ages 19 to 64, health insurance coverage ranged from 75.6% in Bell/Bell Gardens to 91.3% in Monterey Park 91755.

Health Insurance Coverage

	ZIP Code	All Ages	0 to 18 Years	19 to 64 Years
Bell/Bell Gardens	90201	83.7%	96.1%	75.6%
Commerce	90040	86.2%	93.5%	80.8%
East Los Angeles	90022	86.3%	95.3%	80.3%
East Los Angeles	90023	83.9%	94.6%	76.1%
East Los Angeles	90063	86.8%	95.3%	81.0%
El Monte	91732	85.7%	96.3%	79.3%
Montebello	90640	88.9%	96.8%	83.6%
Monterey Park	91754	93.1%	95.3%	90.3%
Monterey Park	91755	93.7%	98.4%	91.3%
Pico Rivera	90660	90.8%	97.4%	86.4%
Rosemead	91770	93.0%	98.0%	89.8%
South El Monte	91733	86.0%	95.4%	79.7%
Whittier	90606	89.6%	96.1%	85.3%
Beverly Service Area		**87.8%**	**96.1%**	**82.2%**
Los Angeles County		**90.4%**	**96.1%**	**86.6%**
California		**92.5%**	**96.7%**	**89.3%**

Source: U.S. Census Bureau, American Community Survey, 2015-2019, S2701. https://data.census.gov/cedsci

92.5% of SPA 3 residents and 90.2% of SPA 7 residents reported having health insurance, as compared to the county (91.5%) and the state (93.4%).

Current Insurance Coverage

	SPA 3	SPA 7	Los Angeles County	California
Insured	92.5%	90.2%	91.5%	93.4%
Uninsured	7.5%	9.8%	8.5%	6.6%

Source: California Health Interview Survey, 2019-2020. http://ask.chis.ucla.edu/

49.7% of SPA 3 residents and 45.5% of SPA 7 residents, were covered through employment-based insurance, and 23.1% of residents in SPA 3 and 28.7% in SPA 7 had Medi-Cal coverage.

Health Insurance, by Type

	SPA 3	SPA 7	Los Angeles County	California
Employment-based	49.7%	45.5%	47.1%	50.9%
Medi-Cal	23.1%	28.7%	24.0%	21.0%
Medicare and others	10.5%	8.3%	9.6%	11.1%
Private purchase	3.5%	2.8%	4.5%	4.7%
Medi-Cal/Medicare	3.1%	2.8%	4.0%	3.1%
Medicare only	1.6%	1.3%*	1.4%	1.5%
Other public	1.0%*	0.8%*	0.9%	1.0%

*Source: California Health Interview Survey, 2019-2020. *Statistically unstable due to sample size. http://ask.chis.ucla.edu/*

Among the total population, 49.9% in SPA 3 and 46.0% in SPA 7 reported cost as the main reason for being currently uninsured.

Main Reason for Currently Uninsured Status

	SPA 3	SPA 7	Los Angeles County	California
Cost	49.9%	46.0%	56.6%	50.7%
Change in working status or family situation	17.4%*	15.6%*	12.5%	12.7%
Employer did not offer, ineligible for insurance, or insurance dropped/ cancelled.	6.6%*	15.1%*	10.2%	10.4%
Does not need or believe in insurance	15.9%	14.9%	11.3%	10.7%
In process of learning about insurance coverage or confusion about coverage	6.9%	8.15*	7.1%	10.8%
Other	3.2%*	**	2.2%	4.8%

*Source: California Health Interview Survey, 2019-2020. *Statistically unstable due to sample size. **Suppressed due to small sample size. http://ask.chis.ucla.edu/*

5.2% of adults in SPA 3 and 4.5% of adults in SPA 7 reported their main health insurance was not accepted by a general doctor. 9.0% of adults in SPA 3 and 9.8% of adults in SPA 7 reported their main health insurance was not accepted by a medical specialist in the past 12 months.

Main Health Insurance not Accepted by Provider, Adults

	SPA 3	SPA 7	Los Angeles County	California
Main health insurance not accepted by general doctor	5.2%	4.5%	6.6%	5.3%
Main health insurance not accepted by medical specialist	9.0%	9.8%	10.7%	9.5%

Source: California Health Interview Survey, 2019-2020. http://ask.chis.ucla.edu/

Among adults, 53.4% in SPA 3 and 95.4% in SPA 7 reported finding an affordable health plan directly through an insurance company or Health Maintenance Organization (HMO) very difficult or somewhat difficult as compared to the county (82.1%) and state (80.4%).

Difficulty Finding Affordable Health Insurance Plan - Insurance Company or HMO

	SPA 3	SPA 7	Los Angeles County	California
Very difficult/somewhat difficult	53.4%	95.4%*	82.1%	80.4%
Not too difficult/not at all difficult	46.6%	4.6%*	17.9%	19.6%

*Source: California Health Interview Survey, 2019-2020. *Statistically unstable due to sample size. http://ask.chis.ucla.edu/*

Among adults, 61.6% in SPA 3 and 75.4% in SPA 7 reported finding an affordable health plan directly through Covered California very difficult or somewhat difficult.

Difficulty Finding Affordable Health Insurance Plan - Covered California

	SPA 3	SPA 7	Los Angeles County	California
Very difficult/somewhat difficult	61.6%	75.4%*	71.9%	65.6%
Not too difficult/not at all difficult	38.4%	24.6%*	28.1%	34.4%

*Source: California Health Interview Survey, 2019-2020. *Statistically unstable due to sample size. http://ask.chis.ucla.edu/*

Sources of Care

Access to a medical home and a primary care provider improves continuity of care and decreases unnecessary emergency room visits. 64.7% of residents in SPA 3 and 57.2% of residents in SPA 7 accessed care at a doctor's office, HMO or Kaiser. 19.7% of residents in SPA 3 and 27.7% in SPA 7 accessing care at a community/government clinic, or community hospital, and 14.5% of residents in SPA 3 and 14.1% in SPA 7 had no usual source of care.

Sources of Care

	SPA 3	SPA 7	Los Angeles County	California
Doctor's office/HMO/Kaiser	64.7%	57.2%	60.2%	63.9%
Community clinic/government, clinic/community hospital	19.7%	27.7%	22.2%	20.4%
ER/urgent Care	0.5%*	0.7%*	1.1%	0.9%
Other/no one place	0.6%	0.3%*	0.9%	1.2%
No usual source of care	14.5%	14.1%	15.7%	13.7%

*Source: California Health Interview Survey, 2019-2020. *Statistically unstable due to sample size. http://ask.chis.ucla.edu/*

85.5% of residents in SPA 3 and 85.9% of residents in SPA 7 had a usual source of care.

Usual Source of Care

	SPA 3	SPA 7	Los Angeles County	California
All Ages	85.5%	85.9%	84.3%	86.3%
Ages 0-17	90.0%	90.8%*	90.2%	90.7%
Ages 18-64	81.9%	83.3%	79.7%	82.5%
Ages 65 and older	94.0%	88.4%*	93.9%	94.6%

*Source: California Health Interview Survey, 2019-2020. *Statistically unstable due to sample size. http://ask.chis.ucla.edu/*

In SPA 3, 98.3% of Black/African Americans had a usual source of care. 90.8% of Whites, 87.7% of individuals of two or more races, 84.5% of Asians, and 82.5% of Latinos had a usual source of care. In SPA 7, 96.5% of Black/African Americans had a usual source of care. 93.0% of individuals of two or more races, 91.8% of Whites, 84.9% of Latinos, and 82.9% of Asians had a usual source of care.

Usual Source of Care, by Race/Ethnicity

	SPA 3	SPA 7	Los Angeles County	California
Asian	84.5%	82.9%	84.4%	85.8%
Black/African American	98.3%*	96.5%*	90.9%	90.4%
Latino	82.5%	84.9%	81.1%	82.1%
Two or More Races	87.7%	93.0%*	84.5%	88.1%
White	90.8%	91.8%	88.3%	90.1%

*Source: California Health Interview Survey, 2019-2020. *Statistically unstable due to sample size. http://ask.chis.ucla.edu/*

9.1% of adults in SPA 3 and 10.7% of adults in SPA 7 reported their doctor's office connected their family with community services, as compared to the county at 12.8% and state at 12.9%.

Connected to Community Resources

	SPA 3	SPA 7	Los Angeles County	California
Doctor's office connected family to community-based services	9.1%	10.7%	12.8%	12.9%

Source: California Health Interview Survey, 2019-2020. http://ask.chis.ucla.edu/

9.2% of adults in SPA 3 and 13.5% of adults in SPA 7 reported receiving care from their health provider through video and/or phone in the past 12 months.

Received Care by Video/Phone, Adults

	SPA 3	SPA 7	Los Angeles County	California
Received care from health provider through video/phone	9.2%	13.5%	11.7%	12.4%

Source: California Health Interview Survey, 2018. http://ask.chis.ucla.edu/

In SPA 3, 16.4% of the population visited an emergency room (ER) in the past 12

months. Children, ages 0 to 11, were the most frequent users (20.1%). In SPA 7, 15.7% of the population visited an emergency room (ER) in the past 12 months. Children were the most frequent users (19.1%).

Use of the Emergency Room

	SPA 3	SPA 7	Los Angeles County	California
Visited ER in last 12 months	16.4%	15.7%	16.7%	16.8%
Ages 0-11	20.1%	19.1%*	15.3%	13.7%
Ages 12-17	15.3%*	18.2%*	21.1%	21.4%
Ages 18-64	15.4%	13.7%	14.4%	15.5%
Ages 65 and older	17.3%	19.0%	25.1%	22.7%

*Source: California Health Interview Survey, 2019-2020. *Statistically unstable due to sample size. http://ask.chis.ucla.edu/*

Difficulty Accessing Care

Among adults, 5.7% in SPA 3 and 6.1% in SPA 7 had difficulty finding primary care. Typically, individuals find it more difficult to access specialty care than primary care. Among adults, 15.7% in SPA 3 and 13.2% in SPA 7 had difficulty finding specialty care.

Difficulty Finding Primary and Specialty Care, Adults

	SPA 3	SPA 7	Los Angeles County	California
Difficulty finding primary care	5.7%	6.1%	7.9%	7.6%
Difficulty finding specialty care	15.7%	13.2%	16.2%	14.7%

Source: California Health Interview Survey, 2019-2020. http://ask.chis.ucla.edu/

Among children, ages 0-17, 9.4% in SPA 3 and 9.9% in SPA 7 had difficulty accessing medical care in the previous 12 months.

Difficulty Accessing Care in the Past Year, Children, Ages 0-17

	SPA 3	SPA 7	Los Angeles County
Children reported to have difficulty accessing medical care	9.4%	9.9%	9.3%

Source: 2018 Los Angeles County Health Survey; Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health. http://publichealth.lacounty.gov/ha/LACHSDataTopics2018.htm

A delay of needed care can lead to an increased risk of health care complications. Among adults, 16.9% in SPA 3 and 15.2% in SPA 7 were not able to get a doctor's appointment within two days due to sickness or injury in the past 12 months.

Ability to Get Doctor's Appointment Within 2 Days in the Past 12 Months

	SPA 3	SPA 7	Los Angeles County	California
Always able	30.9%	22.6%	24.6%	28.8%
Usually able	28.1%	21.9%	28.4%	29.4%
Sometimes able	24.1%	40.2%	31.4%	28.7%
Never able	16.9%	15.2%	15.7%	13.2%

Source: California Health Interview Survey, 2019-2020. http://ask.chis.ucla.edu/.

Among adults who did not speak English "Very Well," 8.3% in SPA 3 and 5.3% in SPA 7 had difficulty or a hard time understanding their doctor.

Language Difficulty in Understanding Doctor

	SPA 3	SPA 7	Los Angeles County	California
Hard time understanding doctor	8.3%*	5.3%*	8.2%	8.2%

*Source: California Health Interview Survey, 2019-2020. *Statistically unstable due to sample size. http://ask.chis.ucla.edu/.*

Delayed or Forgone Care

13.5% of residents in SPA 3 and 9.8% of residents in SPA 7 delayed or did not get medical care within the prior 12 months. Among this population, a personal reason (39.5%) was the most frequent reason to delay or not get medical care in SPA 3. In SPA 7, cost, lack of insurance, or other insurance reason (44.1%) was the most frequent reason to delay or not get medical care. 20.6% of SPA 3 residents and 22.1% of SPA 7 residents stated COVID-19 was the reason they delayed or did not get medical care. Among the population that delayed or did not get medical care, 53.2% in SPA 3 and 57.4% in SPA 7 had to forego needed medical care. 6.0% of SPA 3 residents and 7.4% of SPA 7 residents delayed or did not get prescription medication.

Delayed Care in Past 12 Months, All Ages

	SPA 3	SPA 7	Los Angeles County	California
Delayed or did not get medical care	13.5%	9.8%	13.8%	13.8%
Cost, lack of insurance, or other insurance reasons	20.2%	44.1%	34.7%	32.7%
COVID-19	20.6%	22.1%	17.8%	21.6%
Personal reason	39.5%	19.8%	26.6%	26.8%
Healthcare system/provider issues and barriers	19.7%*	14.0%*	20.9%	18.8%
Had to forgo needed medical care	53.2%	57.4%	58.7%	59.9%
Delayed or did not get prescription meds	6.0%	7.4%	8.0%	8.1%

*Source: California Health Interview Survey, 2020. *Statistically unstable due to sample size. http://ask.chis.ucla.edu/*

Access to Primary Care Community Health Centers

Funded under section 330 of the Public Health Act, Federally Qualified Health Centers (FQHC) provide primary care services including, but not limited to, medical, dental, and mental health services to low-income, uninsured, and medically underserved populations. There are 17 FQHC and/or Look-A-Like entities located in the service

area.[2] The majority of these FQHCs operate clinic sites across the service area and beyond. However, as shown below, patients residing in service area ZIP Codes may utilize FQHC's outside of the service area.

FQHCs Serving Most Area Patients, by ZIP Code

	ZIP Code	Dominant FQHC Entity
Bell/Bell Gardens	90201	AltaMed Health Services Corporation
Commerce	90040	AltaMed Health Services Corporation
East Los Angeles	90022	AltaMed Health Services Corporation
East Los Angeles	90023	AltaMed Health Services Corporation
East Los Angeles	90063	AltaMed Health Services Corporation
El Monte	91732	AltaMed Health Services Corporation
Montebello	90640	AltaMed Health Services Corporation
Monterey Park	91754	Garfield Health Center
Monterey Park	91755	Garfield Health Center
Pico Rivera	90660	AltaMed Health Services Corporation
Rosemead	91770	Herald Christian Health Center
South El Monte	91733	AltaMed Health Services Corporation
Whittier	90606	AltaMed Health Services Corporation

Source: UDS Mapper, 2020. http://www.udsmapper.org

Even with Community Health Centers in the service area, as well as those directly outside the service area, there are many low-income residents who are not served by one of these clinic providers. In 2020, FQHCs and FQHC Look-Alikes served a total of 131,754 patients in the service area, which equates to 43.79% coverage among low-income patients and 19.60% coverage among the total population. However, 56.21% of the population, at or below 200% FPL, are not served by a Community Health Center. It should be noted that these individuals may be accessing health care services through non-FQHC providers (private, county, other) or not using health care services.

Low-Income Patients Served and Not Served by FQHCs and Look-Alikes

Low-Income Population	Patients Served by Section 330 Grantees In Service Area	Penetration of Among Low-Income Patients	Penetration of Total Population	Low-Income Not Served	
				Number	Percent
300,889	131,754	43.79%	19.60%	169,135	56.21%

Source: UDS Mapper, 2020 http://www.udsmapper.org

[2] AltaMed Health Services Corporation, Beverly Care Family Care Center, Center for Family Health and Education, Central City Community Health Center, CHAPCare, Complete Care Community Health Center, Family Health Centers of Greater Los Angeles, Garfield Health Center, Herald Christian Health Center, Los Angeles Christian Health Centers, Northeast Community Clinic, Queens Care, South Central Family Health Center, Southern California Medical Center, St. John's Well Child and Family Center, Tzu Chi Community Clinic, Via Care.

Oral Health Care Access and Utilization

Oral health is essential to overall health and wellbeing. Among children, ages 3 to 11, and those ages 2 and younger with teeth, 5.7% in SPA 3 and 8.8% in SPA 7 did not have dental insurance. Among adults, 32.3% in SPA 3 and 36.7% in SPA 7 did not have dental insurance.

Dental Insurance, Adults and Children

	SPA 3	SPA 7	Los Angeles County	California
Children without dental insurance	5.7%*	8.8%	7.5%	7.4%
Adults without dental insurance	32.3%	36.7%	34.4%	30.7%

*Source: California Health Interview Survey, 2019-2020. *Statistically unstable due to sample size. http://ask.chis.ucla.edu/*

Regular dental visits are essential for the maintenance of healthy teeth and gums. 67.6% of adults in SPA 3 and 61.0% in SPA 7 had a dentist visit less than six months and up to 1 year ago.

Dental Utilization, Adults

	SPA 3	SPA 7	Los Angeles County	California
Never been to a dentist	2.3%	2.0%	3.1%	2.6%
Been to dentist ≤ 6 months ago	48.8%	43.5%	46.0%	50.0%
Been to dentist >6 months up to 1 year ago	18.8%	17.5%	19.4%	18.4%
Been to dentist >1 year up to 2 years ago	14.4%	15.9%	14.2%	12.7%
Been to dentist >2 years up to 5 years ago	7.7%	11.6%	9.6%	8.9%
Been to dentist > 5 years ago	8.8%	9.5%	7.7%	7.3%

Source: California Health Interview Survey, 2019-2020. http://ask.chis.ucla.edu/

Among children, ages 3 to 11, and those under age 3 with teeth, 76.3% in SPA 3 had a dental visit less than six months and up to 1 year ago. 18.5% of SPA 3 children have never been to a dentist. 11.6% of families could not afford needed dental care for their child. Among children in SPA 7, 79.9% had a dental visit less than six months and up to one year ago. 16.2% of SPA 7 children have never been to a dentist. 5.8% of families could not afford needed dental care for their children.

Dental Utilization, Children, Ages 3-11

	SPA 3	SPA 7	Los Angeles County	California
Parent could not afford needed dental care for child	11.6%	5.8%*	6.5%	6.6%
Never been to the dentist	18.5%	16.2%	14.0%	14.8%
Been to dentist ≤6 months ago	64.5%	63.4%	65.6%	66.0%
Been to dentist >6 months up to 1 year ago	11.8%*	16.5%	16.6%	14.8%

	SPA 3	SPA 7	Los Angeles County	California
Been to dentist >1 year up to 2 years ago	5.2%*	2.1%*	2.9%*	3.4%
Been to dentist >2 years up to 5 years ago	**	1.9%*	1.0%*	0.8%

*Source: California Health Interview Survey, 2019-2020. *Statistically unstable due to sample size.* **Suppressed due to small sample size. http://ask.chis.ucla.edu/*

Among teens, ages 12 to 17, 97.8% in SPA 3 and 89.3% in SPA 7 had a dentist visit less than six months and up to 1 year ago.

Dental Utilization, Teens, Ages 12-17

	SPA 3	SPA 7	Los Angeles County	California
Been to dentist ≤6 months ago	79.6%*	75.2%	79.2%	75.0%
Been to dentist >6 months up to 1 year ago	18.2%*	14.1%	13.6%	16.1%
Been to dentist >1 year up to 2 years ago	**	3.8%*	3.2%	4.3%
Been to dentist >2 years up to 5 years ago	**	**	1.8%*	2.3%

*Source: California Health Interview Survey, 2019-2020. *Statistically unstable due to sample size. **Suppressed due to small sample size. http://ask.chis.ucla.edu/*

Oral Health Hygiene/Conditions

Poor oral hygiene can lead to dental cavities and gum disease, and has also been linked to heart disease, cancer, and diabetes. Poor oral health can impact the ability to chew or swallow food resulting inadequate food intake or malnutrition, as well as affect mental health and self-esteem, and possible employment. Among adults, 72.5% in SPA 3 and 69.8% in SPA 7 self-reported their teeth were in Excellent/Very Good/Good condition. 3.2% of adults in SPA 3 and 3.5% in adults of SPA 7 self-reported having no natural teeth.

Condition of Teeth, Adults

	SPA 3	SPA 7	Los Angeles County	California
Excellent	10.1%	7.1%	10.0%	11.6%
Very Good	28.1%	25.6%	27.5%	29.1%
Good	34.3%	37.1%	32.6%	31.6%
Fair	18.8%	20.3%	20.6%	18.5%
Poor	5.5%	6.4%	6.9%	6.9%
Has no natural teeth	3.2%*	3.5%*	2.3%	2.3%

*Source: California Health Interview Survey, 2019-2020. *Statistically unstable due to sample size. http://ask.chis.ucla.edu/*

Among teens, 86.4% in SPA 3 and 88.4% in SPA 7 self-reported their teeth were in Excellent/Very Good/Good condition.

Condition of Teeth, Teens

	SPA 3	SPA 7	Los Angeles County	California
Excellent	18.4%	22.9%*	14.8%	15.9%
Very Good	28.6%	29.7%	42.2%	40.5%
Good	39.4%	35.8%	27.8%	31.8%
Fair/Poor	13.6%*	11.6%*	15.8%	11.8%

*Source: California Health Interview Survey, 2019-2020. *Statistically unstable due to sample size. http://ask.chis.ucla.edu/*

Community Input – Access to Care

Stakeholder interviews identified the following issues, challenges and barriers related to access to care. Following are their comments summarized and edited for clarity:

- People are unable to get transportation to get to doctor's appointments. Or if there is an issue with their transportation, they miss their doctor appointment and care gets delayed.
- I don't know if there are health care options available for people without insurance. Is urgent care open on the weekend and late at night so people don't have to go to the ED?
- Transportation is an issue as most of our residents have several doctors. Some haven't gone to the dentist in years. And many will only go to the doctor to get their prescriptions refilled.
- Doctors are not taking sufficient time to listen to their patients. People feel their doctors aren't taking time to find out how they are really feeling, they are just pushing pills for pain.
- Having access to quality health care so families do not have to use the ED is critical.
- For persons who are undocumented, their kids qualify for Medi-Cal but they decide not to use it. They feel it will impact their ability to naturalize or become a citizen.
- Latinx, Black/African American populations have disparities with access to health care. Families struggle to reach clinics due to transportation.
- We need to inform the community on how to get health insurance.

Birth Indicators

Births

From 2014 to 2018, there were an average of 8,887 births in the service area.

Delivery Paid by Public Insurance or Self-Pay

In the service area, the rate of births paid by public insurance or self-pay was 701.5 per 1,000 live births, which is higher than the county (542.9 per 1,000 live births) and state (498.5 per 1,000 live births) rates.

Delivery Paid by Public Insurance or Self-Pay, per 1,000 Live Births

	Beverly Service Area		Los Angeles County	California
	Number	Rate	Rate	Rate
Delivery paid by public insurance or self-pay	6,234	701.5	542.9	498.5

Source: Calculated by Gary Bess Associates using California Department of Public Health Birth Profiles by ZIP Code of Residence 2014-2018 and U.S. Census Bureau American Community Survey, 5-Year Average 2014-2018, Table B01001.

Teen Birth Rate

The teen birth rate in the service area is 22.8 per 1,000 females, ages 15-19. The teen birth rate for the county and state is 17.3 per 1,000 females, ages 15-19.

Teen Birth Rate, per 1,000 Females, Ages 15 to 19

	Beverly Service Area		Los Angeles County	California
	Number	Rate	Rate	Rate
Births to teen mothers ages 15-19	524	22.8	17.3	17.3

Source: Calculated by Gary Bess Associates using California Department of Public Health Birth Profiles by ZIP Code of Residence and U.S. Census Bureau American Community Survey, 5-Year Average 2014-2018, Table B01001

Prenatal Care

Among pregnant women in the service area, 13.1% (131.1 per 1,000 live births) entered prenatal care after the first trimester. This equates to 86.9% of pregnant women started prenatal care in the first trimester.

Late Prenatal Care (After 1st Trimester) Rate, per 1,000 Live Births

	Beverly Service Area		Los Angeles County	California
	Number	Rate	Rate	Rate
Late prenatal care entry	1,165	131.1	148.2	161.7

Source: Calculated by Gary Bess Associates using California Department of Public Health Birth Profiles by ZIP Code of Residence 2014-2018 and U.S. Census Bureau American Community Survey, 5-Year Average 2014-2018, Table B01001.

Premature Birth

The rate of premature births (less than 37 full weeks of gestation) in the service area was 85.9 per 1,000 live births. This rate of premature births was lower than the county (88.5 per 1,000 live births).

Premature Birth Rate, per 1,000 Live Births

	Beverly Service Area		Los Angeles County	California
	Number	Rate	Rate	Rate
Premature birth	763	85.9	88.5	85.4

Source: Calculated by Gary Bess Associates using California Department of Public Health Birth Profiles by ZIP Code of Residence 2014-2018 and U.S. Census Bureau American Community Survey, 5-Year Average 2014-2018, Table B01001.

Low Birth Weight

Babies born at a low birth weight (<2,500g) are at higher risk for disease, disability, and possible death. The service area rate of low-birth-weight babies was 66.0 per 1,000 live births. This rate is lower than county and state rates.

Low Birth Weight (<2,500g) Rate, per 1,000 Live Births

	Beverly Service Area		Los Angeles County	California
	Number	Rate	Rate	Rate
Low birth weight	592	66.0	72.0	68.6

Source: Calculated by Gary Bess Associates using California Department of Public Health Birth Profiles by ZIP Code of Residence 2014-2018 and U.S. Census Bureau American Community Survey, 5-Year Average 2014-2018, Table B01001.

Women Who Smoked Regularly During Pregnancy

The service area rate of women who smoked during pregnancy (at least once per day for at least three months) is 2.1 per 1,000 live births. This rate is lower than the county and state.

Women Who Smoked During Pregnancy, per 1,000 Live Births

	Beverly Service Area		Los Angeles County	California
	Number	Rate	Rate	Rate
Women who smoked	18	2.1	6.2	15.8

Source: Calculated by Gary Bess Associates using California Department of Public Health Birth Profiles by ZIP Code of Residence 2014-2018 and U.S. Census Bureau American Community Survey, 5-Year Average 2014-2018, Table B01001.

Infant Mortality

For the purposes of this table, the infant mortality rate is defined as deaths to infants under 1 year of age. The infant mortality rate in Los Angeles County, from 2016 to 2018, was 4.11 deaths per 1,000 live births. This meets the Healthy People 2030 objective of 5.0 deaths per 1,000 live births.

Infant Mortality Rate, per 1,000 Live Births, Three-Year Average

	Rate
Los Angeles County	4.11
California	4.21

Source: U.S. Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Division of Vital Statistics, Linked Birth/Infant Death Records, 2016-2018, on CDC WONDER. https://wonder.cdc.gov/lbd-current.html

Breastfeeding

Data on breastfeeding are collected by hospitals on the Newborn Screening Test Form. Breastfeeding rates at Beverly Hospital indicated 89.4% of mothers engaged in any breastfeeding and 29.8% breastfeed exclusively. The hospital rates of any or exclusive breastfeeding were lower than the county and state rates.

In-Hospital Breastfeeding

	Total Births	Any Breastfeeding		Exclusive Breastfeeding	
	Number	Number	Percent	Number	Percent
Beverly Hospital	634	567	89.4%	189	29.8%
Los Angeles County	98,341	92,163	93.7%	61,455	62.5%
California	386,206	361,719	93.7%	270,189	70.0%

Source: California Department of Public Health, Breastfeeding Hospital of Occurrence, 2019
https://www.cdph.ca.gov/Programs/CFH/DMCAH/Breastfeeding/Pages/In-Hospital-Breastfeeding-Initiation-Data.aspx

Latino mothers were the most frequent ethnic group to deliver at Beverly Hospital, with 90.7% engaging in any breastfeeding and 32.7% breastfeeding exclusively.

In-Hospital Breastfeeding, Beverly Hospital, by Race/Ethnicity of Mother

	Total Births	Any Breastfeeding		Exclusive Breastfeeding	
	Number	Number	Percent	Number	Percent
Latino/Hispanic	507	460	90.7%	166	32.7%
Asian	93	80	86.0%	14	15.1%
White	15	10	66.7%	*	*
Multiple Race	4	*	*	*	*
Black/African American	4	*	*	*	*
Other	4	*	*	*	*

*Source: California Department of Public Health, Breastfeeding Hospital of Occurrence, 2019. *Numbers and percents not shown for <10 events. https://www.cdph.ca.gov/Programs/CFH/DMCAH/Breastfeeding/Pages/In-Hospital-Breastfeeding-Initiation-Data.aspx*

Community Input – Birth Indicators

Stakeholder interviews identified the following issues, challenges and barriers related to birth indicators. Following are their comments summarized and edited for clarity:

- I don't think women in our community have the same options or are even told about their options. They have emergency C-sections or go through other procedures without understanding what they are doing.

- A lot of times, for their first pregnancy, women don’t know what to expect and feel rushed into an epidural when that wasn’t the first choice and they did not feel empowered to say no to those things.
- Teen parents share that they are often talked at versus talked to. They do not have their opinions taken into account as what is best for them.

Leading Causes of Death

Life Expectancy

Life expectancy in Los Angeles County is 82.4 as compared to California at 81.7 years.

Life Expectancy, 2017-2019

	Los Angeles County	California
Life expectancy	82.4	81.7

Source: National Center for Health Statistics – Mortality Files, County Health Rankings, 2021.
https://www.countyhealthrankings.org/app/california/2021/measure/outcomes/147/datasource

Premature Mortality

In Los Angeles County, the premature mortality rate was 260 per 100,000 deaths among residents who died before the age of 75, which is considered a premature death. The total of the Years of Potential Life Lost (the difference between the age of persons who died and the age of 75, totaled) for the county is 5,000 years.

Premature Mortality, 2017-2019

	Los Angeles County	California
Premature age adjusted mortality rate	260	270
Years of Potential Life Lost (YPLL) (deaths under age 75)	5,000	5,300

Source: National Center for Health Statistics – Mortality Files, County Health Rankings, 2021.
https://www.countyhealthrankings.org/app/california/2021/measure/outcomes/127/data

Leading Causes of Death

The causes of death are reported as age-adjusted mortality rates. Age-adjusting eliminates the bias of age in the makeup of the populations that are compared. When comparing across geographic areas, age-adjusting is used to control the influence that population age distributions might have on health event rates. The five year average mortality rate for the service area was 529.0 per 100,000 persons. When looking at causes of death by number and rate in the service area population, the top five causes of death are heart disease, cancer, stroke, diabetes, and Alzheimer's disease.

Mortality Rates, Age-Adjusted, per 100,000 Persons

Causes of Death	Beverly Service Area		Los Angeles County	California
	Number	Rate	Rate	Rate
Five-Year Average	**3,513**	**529.0**	**569.8**	**614.4**
Heart Disease	957	127.5	146.9	142.7
Cancer	892	124.6	134.3	139.6
Stroke	243	32.7	33.3	36.4
Diabetes	215	29.8	23.1	21.3

Causes of Death	Beverly Service Area		Los Angeles County	California
	Number	Rate	Rate	Rate
Alzheimer's Disease	190	23.9	34.2	35.4
Pneumonia and Influenza	155	20.6	19.2	14.8
Chronic Lower Respiratory Disease	154	20.7	28.1	32.1
Unintentional Injury	139	19.7	22.6	31.8
Liver Disease	130	18.2	13.0	12.2
Kidney Disease	98	13.4	11.2	8.5
Homicide	42	6.0	5.7	5.0
Suicide	37	5.3	7.9	10.5
HIV	11	1.7	2.1	1.6

Source: Calculated by Gary Bess Associates using California Department of Public Health Master Death File 2014-2018 and U.S. Census Bureau American Community Survey, 5-Year Average 2014-2018, Table B01001, and using the 2000 U.S. standard million. California rates are from Centers for Disease Control and Prevention, National Center for Health Statistics, Underlying Cause of Death 2014-2018 on CDC WONDER Online Database. Values of 3 or less are withheld per HIPAA guidelines.

Heart Disease

In the service area, the age-adjusted mortality rate for heart disease (127.5 per 100,000 persons) was lower than the county (146.9 per 100,000 persons) and the state (142.7 per 100,000 persons) rates. The rate of ischemic heart disease deaths (a sub-category of heart disease) was 89.4 per 100,000 persons in the service area. The rate of ischemic heart disease deaths in the service area was higher than the Healthy People 2030 objective of 71.1 per 100,000 persons.

Heart Disease Mortality Rates, Age-Adjusted, per 100,000 Persons

	Beverly Service Area		Los Angeles County	California
	Number	Rate	Rate	Rate
Heart disease death rate	957	127.5	146.9	142.7
Ischemic heart disease death rate	267	89.4	106.8	88.1

Source: Calculated by Gary Bess Associates using California Department of Public Health Master Death File 2014-2018 and U.S. Census Bureau American Community Survey, 5-Year Average 2014-2018, Table B01001, and using the 2000 U.S. standard million. California rates are from Centers for Disease Control and Prevention, National Center for Health Statistics, Underlying Cause of Death 2014-2018 on CDC WONDER Online Database. Values of 3 or less are withheld per HIPAA guidelines.

Cancer

In the service area, the age-adjusted cancer mortality rate was 124.6 per 100,000 persons. This was lower than the county rate (134.3 per 100,000 persons) and the state rate (139.6 per 100,000 persons). The cancer death rate in the service area was higher than the Healthy People 2030 objective of 122.7 per 100,000 persons.

Cancer Mortality Rate, Age-Adjusted, per 100,000 Persons

	Beverly Service Area		Los Angeles County	California
	Number	Rate	Rate	Rate
Cancer death rate	892	124.6	134.3	139.6

Source: Calculated by Gary Bess Associates using California Department of Public Health Master Death File 2014-2018 and U.S. Census Bureau American Community Survey, 5-Year Average 2014-2018, Table B01001, and using the 2000 U.S. standard million. California rates are from Centers for Disease Control and Prevention, National Center for Health Statistics, Underlying Cause of Death 2014-2018 on CDC WONDER Online Database. Values of 3 or less are withheld per HIPAA guidelines.

Mortality rates for specific types of cancer are available at the county level from the National Cancer Institute. In Los Angeles County, the top five highest rates of cancer are lung and bronchus, prostate, female breast, colon and rectum, and pancreas.

Cancer Mortality Rates, Age-Adjusted, per 100,000 Persons, 2014-2018

	Los Angeles County	California
Lung and bronchus	25.5	28.1
Prostate	20.2	19.9
Breast (female)	19.6	19.4
Colon and rectum	13.2	12.5
Pancreas	10.4	10.3
Liver and intrahepatic bile duct	8.2	7.8
Ovary	7.2	6.9
Leukemias	5.9	5.9
Uterus, (Corpus & Uterus NOS)	5.4	5.0
Non-Hodgkin lymphoma	5.2	5.2
Stomach	5.1	3.9
Brain and other nervous system	4.2	4.4
Urinary Bladder	3.5	3.9
Kidney and renal pelvis	3.1	3.4
Cervix	2.6	2.2
Oral Cavity and Pharynx	2.3	2.5
Melanoma of the skin	1.4	2.1
Thyroid	0.7	0.6
Testis	0.3	0.3

Source: U.S. Cancer Statistics Working Group. U.S. Cancer Statistics Data Visualizations Tool, based on 2020 submission data (1999-2018): U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute, www.cdc.gov/cancer/dataviz

Stroke

The age-adjusted rate of death from stroke in the service area was 32.7 per 100,000 persons. The rate of stroke deaths in the service area was lower than the Healthy People 2030 objective of 33.4 per 100,000 persons.

Stroke Mortality Rates, Age-Adjusted, per 100,000 Persons

	Beverly Service Area		Los Angeles County	California
	Number	Rate	Rate	Rate
Stroke death rate	243	32.7	33.3	36.4

Source: Calculated by Gary Bess Associates using California Department of Public Health Master Death File 2014-2018 and U.S. Census Bureau American Community Survey, 5-Year Average 2014-2018, Table B01001, and using the 2000 U.S. standard million. California rates are from Centers for Disease Control and Prevention, National Center for Health Statistics, Underlying Cause of Death 2014-2018 on CDC WONDER Online Database. Values of 3 or less are withheld per HIPAA guidelines.

Diabetes

Diabetes may be underreported as a cause of death. The age-adjusted mortality rate from diabetes in the service area (29.8 per 100,000 persons) was higher the county rate (23.1 per 100,000 persons) and the state rate (21.3 per 100,000 persons).

Diabetes Mortality Rate, Age-Adjusted, per 100,000 Persons

	Beverly Service Area		Los Angeles County	California
	Number	Rate	Rate	Rate
Diabetes death rate	215	29.8	23.1	21.3

Source: Calculated by Gary Bess Associates using California Department of Public Health Master Death File 2014-2018 and U.S. Census Bureau American Community Survey, 5-Year Average 2014-2018, Table B01001, and using the 2000 U.S. standard million. California rates are from Centers for Disease Control and Prevention, National Center for Health Statistics, Underlying Cause of Death 2014-2018 on CDC WONDER Online Database. Values of 3 or less are withheld per HIPAA guidelines.

Alzheimer's Disease

According to the World Health Organization, Alzheimer's disease is the most common form of dementia and may contribute to 60% to 70% of cases.[3] In the service area, the Alzheimer's disease death rate was 23.9 per 100,000 persons. This rate was lower than the county (34.2 per 100,000 persons) and state (35.4 per 100,000 persons) rates.

Alzheimer's Disease Mortality Rate, Age-Adjusted, per 100,000 Persons

	Beverly Service Area		Los Angeles County	California
	Number	Rate	Rate	Rate
Alzheimer's disease death rate	190	23.9	34.2	35.4

Source: Calculated by Gary Bess Associates using California Department of Public Health Master Death File 2014-2018 and U.S. Census Bureau American Community Survey, 5-Year Average 2014-2018, Table B01001, and using the 2000 U.S. standard million. California rates are from Centers for Disease Control and Prevention, National Center for Health Statistics, Underlying Cause of Death 2014-2018 on CDC WONDER Online Database. Values of 3 or less are withheld per HIPAA guidelines.

Pneumonia and Influenza

In the service area, the pneumonia and influenza age-adjusted death rate was 20.6 per 100,000 persons, which was higher than the county rate (19.2 per 100,000 persons), and state rate (14.8 per 100,000 persons).

[3] *Source: World Health Organization, Dementia Fact Sheet, September 21, 2020. https://www.who.int/news-room*

Pneumonia and Influenza Mortality Rate, Age-Adjusted, per 100,000 Persons

	Beverly Service Area		Los Angeles County	California
	Number	Rate	Rate	Rate
Pneumonia/influenza death rate	155	20.6	19.2	14.8

Source: Calculated by Gary Bess Associates using California Department of Public Health Master Death File 2014-2018 and U.S. Census Bureau American Community Survey, 5-Year Average 2014-2018, Table B01001, and using the 2000 U.S. standard million. California rates are from Centers for Disease Control and Prevention, National Center for Health Statistics, Underlying Cause of Death 2014-2018 on CDC WONDER Online Database. Values of 3 or less are withheld per HIPAA guidelines.

Chronic Lower Respiratory Disease

Chronic Lower Respiratory Disease (CLRD) and Chronic Obstructive Pulmonary Disease (COPD) include emphysema and bronchitis. The age-adjusted death rate for respiratory disease in the service area was 20.7 per 100,000 persons, which was lower than county (28.1 per 100,000 persons) and state (32.1 per 100,000 persons) rates.

Chronic Lower Respiratory Disease Mortality Rate, Age-Adjusted, per 100,000 Persons

	Beverly Service Area		Los Angeles County	California
	Number	Rate	Rate	Rate
Chronic Lower Respiratory Disease death rate	154	20.7	28.1	32.1

Source: Calculated by Gary Bess Associates using California Department of Public Health Master Death File 2014-2018 and U.S. Census Bureau American Community Survey, 5-Year Average 2014-2018, Table B01001, and using the 2000 U.S. standard million. California rates are from Centers for Disease Control and Prevention, National Center for Health Statistics, Underlying Cause of Death 2014-2018 on CDC WONDER Online Database. Values of 3 or less are withheld per HIPAA guidelines.

Unintentional Injury

Major categories of unintentional injuries include motor vehicle collisions, poisonings, and falls. The age-adjusted death rate from unintentional injuries in the service area was 19.7 per 100,000 persons. In the service area, the death rate for unintentional injuries was lower than the Healthy People 2030 objective of 43.2 per 100,000 persons.

Unintentional Injury Mortality Rate, Age-Adjusted, per 100,000 Persons

	Beverly Service Area		Los Angeles County	California
	Number	Rate	Rate	Rate
Unintentional injury death rate	139	19.7	22.6	31.8

Source: Calculated by Gary Bess Associates using California Department of Public Health Master Death File 2014-2018 and U.S. Census Bureau American Community Survey, 5-Year Average 2014-2018, Table B01001, and using the 2000 U.S. standard million. California rates are from Centers for Disease Control and Prevention, National Center for Health Statistics, Underlying Cause of Death 2014-2018 on CDC WONDER Online Database. Values of 3 or less are withheld per HIPAA guidelines.

Liver Disease

Mortality from liver disease was higher in the service area (18.2 per 100,000 persons) than in the county (13.0 per 100,000 persons) and the state (12.2 per 100,000 persons). In the service area, the death rate for liver disease was above the Healthy People 2030 objective for liver disease deaths of 10.9 per 100,000 persons.

Liver Disease Mortality Rate, Age-Adjusted, per 100,000 Persons

	Beverly Service Area		Los Angeles County	California
	Number	Rate	Rate	Rate
Liver disease death rate	130	18.2	13.0	12.2

Source: Calculated by Gary Bess Associates using California Department of Public Health Master Death File 2014-2018 and U.S. Census Bureau American Community Survey, 5-Year Average 2014-2018, Table B01001, and using the 2000 U.S. standard million. California rates are from Centers for Disease Control and Prevention, National Center for Health Statistics, Underlying Cause of Death 2014-2018 on CDC WONDER Online Database. Values of 3 or less are withheld per HIPAA guidelines.

Kidney Disease

In the service area, the kidney disease death rate was 13.4 per 100,000 persons. This rate was higher than the county rate (11.2 per 100,000 persons) and the state rate (8.5 per 100,000 persons).

Kidney Disease Mortality Rate, Age-Adjusted, per 100,000 Persons

	Beverly Service Area		Los Angeles County	California
	Number	Rate	Rate	Rate
Kidney disease death rate	98	13.4	11.2	8.5

Source: Calculated by Gary Bess Associates using California Department of Public Health Master Death File 2014-2018 and U.S. Census Bureau American Community Survey, 5-Year Average 2014-2018, Table B01001, and using the 2000 U.S. standard million. California rates are from Centers for Disease Control and Prevention, National Center for Health Statistics, Underlying Cause of Death 2014-2018 on CDC WONDER Online Database. Values of 3 or less are withheld per HIPAA guidelines.

Homicide

In the service area, the age-adjusted death rate from homicides was 6.0 per 100,000 persons. This rate was higher than county (5.7 per 100,000 persons), and state (5.0 per 100,000 persons) rates. In the service area, the homicide rate was higher than the Healthy People 2030 objective of 5.5 per 100,000 persons.

Homicide Rate, Age-Adjusted, per 100,000 Persons

	Beverly Service Area		Los Angeles County	California
	Number	Rate	Rate	Rate
Homicide	42	6.0	5.7	5.0

Source: Calculated by Gary Bess Associates using California Department of Public Health Master Death File 2014-2018 and U.S. Census Bureau American Community Survey, 5-Year Average 2014-2018, Table B01001, and using the 2000 U.S. standard million. California rates are from Centers for Disease Control and Prevention, National Center for Health Statistics, Underlying Cause of Death 2014-2018 on CDC WONDER Online Database. Values of 3 or less are withheld per HIPAA guidelines.

Suicide

In the service area, the age-adjusted death rate due to suicide was 5.3 per 100,000 persons. The suicide rate for the service area was lower than the Healthy People 2030 objective of 12.8 per 100,000 persons.

Suicide Rate, Age-Adjusted, per 100,000 Persons

	Beverly Service Area		Los Angeles County	California
	Number	Rate	Rate	Rate
Suicide	37	5.3	7.9	10.5

Source: Calculated by Gary Bess Associates using California Department of Public Health Master Death File 2014-2018 and U.S. Census Bureau American Community Survey, 5-Year Average 2014-2018, Table B01001, and using the 2000 U.S. standard million. California rates are from Centers for Disease Control and Prevention, National Center for Health Statistics, Underlying Cause of Death 2014-2018 on CDC WONDER Online Database. Values of 3 or less are withheld per HIPAA guidelines.

HIV

In the service area, the death rate from HIV was 1.7 per 100,000 persons. This rate was lower than the county HIV death rate (2.1 per 100,000 persons) but higher than the state HIV death rate (1.6 per 100,000 persons).

HIV Mortality Rate, Age-Adjusted, per 100,000 Persons

	Beverly Service Area		Los Angeles County	California
	Number	Rate	Rate	Rate
HIV death rate	11	1.7	2.1	1.6

Source: Calculated by Gary Bess Associates using California Department of Public Health Master Death File 2014-2018 and U.S. Census Bureau American Community Survey, 5-Year Average 2014-2018, Table B01001, and using the 2000 U.S. standard million. California rates are from Centers for Disease Control and Prevention, National Center for Health Statistics, Underlying Cause of Death 2014-2018 on CDC WONDER Online Database. Values of 3 or less are withheld per HIPAA guidelines.

Drug-Induced Deaths

The age-adjusted death rate from drug-induced causes in Los Angeles County was 10.4 per 100,000 persons, which was lower than the state rate of 14.3 per 100,000 persons. The Healthy People 2030 objective for drug-induced deaths is 20.7 per 100,000 persons.

Drug-Induced Death Rates, Age-Adjusted, per 100,000 Persons, 2017-2019

	Rate
Los Angeles County	10.4
California	14.3

Source: California Department of Public Health, County Health Status Profiles, 2021.
https://www.cdph.ca.gov/programs/chsi/pages/county-health-status-profiles.aspx

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Acute and Chronic Disease

Hospitalization Rates by Diagnoses

At Beverly Hospital the top four primary diagnoses resulting in hospitalization were diseases of the circulatory system, diseases of the digestive system, certain infectious and parasitic diseases, pregnancy, childbirth and the puerperium.

Beverly Hospitalization Rates, by Principal Diagnoses, Top Ten Causes

	Percent
Diseases of the circulatory system	7.61%
Diseases of the digestive system	6.56%
Certain infectious and parasitic diseases	4.36%
Pregnancy, childbirth and the puerperium	4.17%
No Default CCSR	4.16%
Disease of the genitourinary system	3.96%
Certain conditions originating in the perinatal period	3.77%
Injury, poisoning and certain other consequences of external causes	3.44%
Endocrine, nutritional and metabolic diseases	2.98%
Diseases of the musculoskeletal system and connective tissue	1.98%

Source: California Department of Health Care Access and Information, Facility Summary Report Hospital Inpatient, 2020.
https://report.oshpd.ca.gov/?DID=PID&RID=Facility_Summary_Report_Hospital_Inpatient

Emergency Department Rates by Diagnoses

At Beverly Hospital, the top five primary diagnoses seen in the Emergency Department were symptoms, signs and abnormal clinical and laboratory findings, diseases of respiratory system, injuries/poisonings, diseases of the musculoskeletal system and connective tissue, and diseases of the circulatory system.

Beverly Emergency Department Rates, by Principal Diagnoses, Top Ten Causes

	Percent
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	6.12%
Diseases of the respiratory system	5.23%
Injury, poisoning and certain other consequences of external causes	5.12%
Diseases of the musculoskeletal system and connective tissue	2.37%
Diseases of the circulatory system	2.08%
Diseases of the genitourinary system	1.85%
Mental, behavioral and neurodevelopmental disorders	1.57%
Diseases of the digestive system	1.55%
Diseases of the nervous system	1.40%
Factors influencing health status and contact with health services	1.19%

Source: California Department of Health Care Access and Information, Facility Summary Report Emergency Department, 2020.
https://report.oshpd.ca.gov/?DID=PID&RID=Facility_Summary_Report_Hospital_Inpatient

COVID-19

As of January 31, 2022, there were 2,541,189 confirmed cases of COVID-19 in Los Angeles County, with a rate of 221.9 cases per 100,000 residents. This rate is higher than the statewide average of 179.9 cases per 100,000 persons. Through January 31, 2022, 28,718 residents of Los Angeles County had died due to COVID-19 complications, at a rate of 0.3 deaths per 100,000 persons, as compared to the statewide rate 0.2 per 100,000 persons.

COVID-19, Cases and Crude Death Rates, per 100,000 Persons, 1/31/2022

	Los Angeles County		California	
	Number	Rate	Number	Rate
Cases	2,541,189	221.9	7,915,768	179.9
Deaths	28,718	0.3	79,382	0.2

Source for LA County and California case and death numbers: California State Health Department, COVID-19 Dashboard, January 31, 2022. https://covid19.ca.gov/state-dashboard

In Los Angeles County, 84.8% of the Asian population, 84.3% individuals of multiple races, 73.3% of the White population, 55.5% of the Latino population, and 53.9% of the Black population are fully vaccinated for COVID-19.

Fully Vaccinated (1+ Dose) for COVID-19, by Race, 1/26/2022

	Los Angeles County Fully Vaccinated	California Fully Vaccinated
Asian	84.8%	91.2%
Multiple Race	84.3%	58.9%
White	73.3%	65.5%
Latino	55.5%	56.3%
Black	53.9%	54.7%

Source: Los Angeles Public Health Department, COVID-19 Vaccination Dashboard, Vaccination percentage, January 26, 2022. Reviewed 1/27/2022. http://publichealth.lacounty.gov/media/Coronavirus/vaccine/vaccine-dashboard.htm

In Los Angeles County, 22.4% of children, ages 5 to 11, 70.6% of teens, ages 12 to 17, 78.3% of adults, ages 18 to 49, 81.3% of adults, ages 50 to 64, and 78.6% of adults, ages 65 and older, are fully vaccinated for COVID-19.

COVID-19 Vaccinations, by Age, 1/26/2022

	Los Angeles County		California	
	Partially Vaccinated	Fully Vaccinated	Partially Vaccinated	Fully Vaccinated
Ages, 5-11	9.7%	22.4%	9.4%	24.1%
Ages, 12-17	8.9%	70.6%	8.3%	64.0%
Ages, 18-49	9.1%	78.3%	9.5%	76.1%
Ages, 50-64	7.5%	81.3%	8.1%	82.9%
Ages, 65+	7.2%	78.6%	8.1%	83.0%

Source: California Department of Public Health, January 26, 2022. Reviewed 1/27/2022. https://covid19.ca.gov/vaccination-progress-data/#progress-by-group

Community Input – COVID-19

Stakeholder interviews identified the following issues, challenges and barriers related to COVID-19. Following are their comments summarized and edited for clarity:

- COVID created barriers and additional exposures for employees.
- I think the small business people have been really hurt. They have had to cut back hours and they can't get workers. They feel lucky to even be able to keep their doors open.
- Initially, mask wearing was a challenge because some people would forget, others didn't believe in masking. And then others weren't comfortable being around others who weren't masked.
- There was a fear of coming outside, a lack of exercise, even taking a walk.
- The hardest issue has been staff turnover. There was a lack of childcare and parents had to stay at home and care for their children.
- Some staff felt that what they are earning wasn't worth the risk they were taking.
- People had their work hours cut or they lost their jobs all together and that added significant stress to families, especially those living in tight quarters.

Diabetes

Among adults, 11.9% in SPA 3 and 14.0% in SPA 7 reported they have been diagnosed with diabetes as compared to the county at 11.6% and state at 10.5%.

Diabetes, Adults

	SPA 3	SPA 7	Los Angeles County	California
Ever diagnosed with diabetes	11.9%	14.0%	11.6%	10.5%

Source: California Health Interview Survey, 2019-2020. http://ask.chis.ucla.edu/

In SPA 3, Latino adults had the highest rate of diabetes (13.3%), followed by Black/African American adults (12.3%), White adults (12.0%), and Asian adults (9.9%). In SPA 7, Latino adults had the highest rate of diabetes (15.0%), followed by Asian adults (12.5%), White adults (10.8%), and Black/African American adults (3.1%).

Diabetes, by Race/Ethnicity

	SPA 3	SPA 7	Los Angeles County	California
Asian	9.9%	12.5%	10.5%	10.7%
Black/African American	12.3%*	3.1%*	13.9%	14.9%
Latino	13.3%	15.0%	13.7%	12.2%
Two or more races	**	**	7.1%	8.0%
White	12.0%	10.8%	7.8%	8.4%

*Source: California Health Interview Survey, 2019-2020. *Statistically unstable due to sample size. **Suppressed due to sample size. http://ask.chis.ucla.edu/*

High Blood Pressure

A co-morbidity factor for diabetes and heart disease is hypertension (high blood pressure). Among adults, 27.0% in SPA 3 and 26.8% in SPA 7 have been diagnosed with high blood pressure. Among adults, 7.6% in SPA 3 and 7.1% in SPA 7 have been diagnosed with borderline high blood pressure.

High Blood Pressure, Adults

	SPA 3	SPA 7	Los Angeles County	California
Has/had high blood pressure	27.0%	26.8%	26.1%	25.7%
Has/had borderline high blood pressure	7.6%	7.1%	7.2%	7.5%

Source: California Health Interview Survey, 2019-2020. http://ask.chis.ucla.edu/

In SPA 3, Black/African American adults had the highest rates of high blood pressure (35.2%), followed by White adults (32.3%), Latino adults (28.2%), Asian adults (22.0%), and adults of two or more races (11.0%). In SPA 7, Black/African American adults had the highest rates of high blood pressure (36.4%), followed by White adults (32.1%), adults of two or more races (30.1%), Asian adults (28.0%), and Latino adults (26.0%).

High Blood Pressure, by Race/Ethnicity

	SPA 3	SPA 7	Los Angeles County	California
Asian	22.0%	28.0%	24.6%	21.8%
Black/African American	35.2%*	36.4%	40.3%	38.6%
Latino	28.2%	26.0%	23.8%	22.4%
Two or more races	11.0%*	30.1%*	16.7%	20.4%
White	32.3%	32.1%	27.6%	28.7%

*Source: California Health Interview Survey, 2019-2020. *Statistically unstable due to sample size. http://ask.chis.ucla.edu/*

Heart Disease

Among adults, 6.2% in SPA 3 and 3.7% in SPA 7 have been diagnosed with heart disease.

Heart Disease, Adults

	SPA 3	SPA 7	Los Angeles County	California
Has heart disease	6.2%	3.7%	6.4%	6.8%

Source: California Health Interview Survey, 2019-2020. http://ask.chis.ucla.edu/

In SPA 3, 12.1% of White adults, 5% of Latino adults and 4.7% of Asian adults have heart disease. In SPA 7, 9.9% of White adults, 4.3% of Asian adults and 2.7% of Latino adults have heart disease.

Heart Disease, by Race/Ethnicity

	SPA 3	SPA 7	Los Angeles County	California
Asian	4.7%	4.3%*	5.1%	5.3%
Black/African American	**	**	9.0%	7.1%
Latino	5.0%	2.7%	4.6%	4.3%
Two or more races	**	**	1.4%*	4.2%
White	12.1%	9.9%	10.1%	10.1%

*Source: California Health Interview Survey, 2019-2020. *Statistically unstable due to sample size. **Suppressed due to small sample size. http://ask.chis.ucla.edu/*

Asthma

Among the population, 13.3% in SPA 3 and 13.7% in SPA 7, have been diagnosed with asthma. In SPA 3, 13.6% of adults and 12.4% of children, ages 1 to 17, have been diagnosed with asthma. In SPA 7, 14.3% of adults and 11.9% of children, ages 1 to 17, have been diagnosed with asthma. Among those with diagnosed with asthma, 36.8% in SPA 3 and 30.1% in SPA 7 had an asthma episode/attack in the past 12 months. 46.1% in SPA 3 and 41.2% in SPA 7 take daily medication to control their symptoms.

Asthma, Total Population, Adults and Children

	SPA 3	SPA 7	Los Angeles County	California
Ever diagnosed with asthma, all ages	13.3%	13.7%	14.8%	15.3%
Ever diagnosed with asthma, adults	13.6%	14.3%	15.2%	16.2%
Ever diagnosed with asthma, ages 1-17	12.4%	11.9%	13.3%	12.4%
Has had an asthma episode/attack in past 12 months, all ages	36.8%	30.1%	28.7%	29.6%
Has had an asthma episode/attack in past 12 months, adults	31.7%	30.9%	25.8%	28.7%
Has had an asthma episode/attack in past 12 months, ages 1-17	57.8%*	34.5%	40.3%	33.7%
Takes daily medication to control asthma, all ages	46.1%	41.2%	44.6%	43.7%
Takes daily medication to control asthma, adults	56.8%	41.1%	46.1%	44.4%
Takes daily medication to control asthma, ages 1-17	18.7%*	36.9%*	38.5%	40.6%

*Source: California Health Interview Survey, 2019-2020. *Statistically unstable due to sample size. http://ask.chis.ucla.edu/*

In SPA 3, 29.3% of individuals of two or more races, 20.5% of Whites, 18.0% of Black/African Americans, 10.7% of Latinos, and 10.4% of Asians were diagnosed with asthma. In SPA 7, 17.6% of Black/African Americans, 15.5% of Whites, 13.9% of Latinos, and 6.5% of Asians were diagnosed with asthma.

Asthma, by Race/Ethnicity

	SPA 3	SPA 7	Los Angeles County	California
Asian	10.4%	6.5%*	10.9%	11.2%
Black/African American	18.0%*	17.6%*	22.8%	18.2%
Latino	10.7%	13.9%	13.6%	14.6%
Two or more races	29.3%*	**	25.6%	25.5%
White	20.5%	15.5%	15.6%	16.1%

*Source: California Health Interview Survey, 2019-2020. *Statistically unstable due to sample size. **Suppressed due to sample size. http://ask.chis.ucla.edu/*

Cancer

In Los Angeles County, the highest incidence rates were for female breast, prostate, lung and bronchus, colon and rectum, and uterine cancer.

Cancer Incidence Rates, Age-Adjusted, per 100,000 Persons, 2014-2018

	Los Angeles County	California
Cancer all sites	**377.3**	**402.4**
Breast (female)	117.1	121.8
Prostate	89.1	92.3
Lung and bronchus	35.7	40.3
Colon and rectum	35.5	34.8
Uterine	27.1	26.5
Non-Hodgkin lymphoma	17.5	18.3
Urinary bladder	14.4	16.4
Kidney and renal pelvis	14.2	14.9
Melanomas of the skin	13.6	23.0
Thyroid	13.3	13.1
Leukemia, all	11.8	12.3
Ovary	11.6	11.1
Pancreas	11.6	12.0
Liver and intrahepatic bile duct	9.3	9.9
Stomach	8.9	7.4
Oral Cavity and Pharynx	8.6	10.2
Cervix	7.8	7.3
Testis	6.0	6.2
Myeloma	5.8	6.0
Brain and other nervous system	5.4	5.9

Source: U.S. Cancer Statistics Working Group. U.S. Cancer Statistics Data Visualizations Tool, based on 2020 submission data (1999-2018): U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute www.cdc.gov/cancer/dataviz

Sexually Transmitted Infections

In SPA 3, the rate of chlamydia was 398 cases per 100,000 persons, the rate of gonorrhea was 132 cases per 100,000 persons, and the rate of syphilis was 27 cases per 100,000 persons in 2018. All SPA 3 rates were lower than county rates. In SPA 7, the rate of chlamydia was 533 cases per 100,000 persons, the rate of gonorrhea was 167 cases per 100,000 persons, and the rate of syphilis was 42 cases per 100,000 persons in 2018. All SPA 7 rates were lower than county rates.

Sexually Transmitted Infections Incidence Rate, per 100,000 Persons

	SPA 3		SPA 7		Los Angeles County	
	Number	Rate	Number	Rate	Number	Rate
Chlamydia	7,191	398	7,041	533	67,378	656
Gonorrhea	2,391	132	2,206	167	27,047	263
Syphilis	495	27	549	42	5,576	54

Source: Division of HIV and STD Programs, Los Angeles County Department of Public Health. 2018 Annual STD Surveillance Report. Published July 2021. Tables 2.1, 3.1, 4.1.
http://publichealth.lacounty.gov/dhsp/Reports/STD/2018_STD_Surveillance_Tables_Final.pdf

HIV

In SPA 3 and SPA 7, the number and rate of new HIV diagnoses decreased from 2018 to 2019.

New HIV Diagnoses, Number and Rate, per 100,000 Persons, Ages 13 and Older

	2018		2019	
	Number	Rate	Number	Rate
SPA 3	157	10	147	9
SPA 7	168	15	129	12
Los Angeles County	**1,709**	**20**	**1,505**	**17**

Source: Division of HIV and STD Programs, Department of Public Health, County of Los Angeles. HIV Surveillance Annual Report, 2020. Published July 30, 2021.Table 4A. 2020AnnualHIVSurveillance147ReportUpdated9-2021_fig1fig2update.pdf (lacounty.gov)

In 2020, the rate of persons living with diagnosed HIV (PLWDH) in SPA 3 was 261 per 100,000 persons, and in SPA 7 it was 343 per 100,000 persons.

Persons Living with Diagnosed HIV per 100,000 Persons, Ages 13 and Older

	Number	Rate
SPA 3	4,071	261
SPA 7	3,776	343
Los Angeles County	**52,858**	**608**

Source: Division of HIV and STD Programs, Department of Public Health, County of Los Angeles. HIV Surveillance Annual Report, 2020. Published July 30, 2021.Table 2A. 2020AnnualHIVSurveillanceReportUpdated9-2021_fig1fig2update.pdf (lacounty.gov)

Tuberculosis

In SPA 3, the Alhambra Health District and the El Monte Health District have tuberculosis rates of 5.7-11.5 per 100,000 persons. The Foothill Health District and Pomona Health District have tuberculosis rates of 2.9-5.6 per 100,000 persons.

Tuberculosis Rate, per 100,000 Population, by SPA 3 Health Districts

	Rate
Alhambra Health District	5.7-11.5
El Monte Health District	5.7-11.5
Foothill Health District	2.9-5.6
Pomona Health District	2.9-5.6

Source: Los Angeles County Department of Public Health, Tuberculosis Control Program, Tuberculosis Epidemiology Fact Sheets, 2019. http://ph.lacounty.gov/tb/docs/TB2019FactSheet_FINAL.pd

In SPA 7, the Bellflower Health District and San Antonio Health District 5.7-11.5 per 100,000 persons and the East Los Angeles Health District and Whittier Health District have tuberculosis rates of 2.9-5.6 per 100,000 persons.

Tuberculosis Rate, per 100,000 Population, by SPA 7 Health Districts

	Rate
Bellflower Health District	5.7-11.5
East Los Angeles Health District	2.9-5.6
San Antonio Health District	5.7-11.5
Whittier Health District	2.9-5.6

Source: Los Angeles County Department of Public Health, Tuberculosis Control Program, Tuberculosis Epidemiology Fact Sheets, 2019. http://ph.lacounty.gov/tb/docs/TB2019FactSheet_FINAL.pdf

Community Input – Chronic Disease

Stakeholder interviews identified the following issues, challenges and barriers related to chronic disease. Following are their comments summarized and edited for clarity:

- During the pandemic, many community members were hesitant to address non-urgent medical needs due to concerns.
- How can we encourage community members to pursue care and restart cancer prevention and early detection practices?
- Using Spanish media to get the word out is the best way to get the message through. With many Hispanic families, the news is always on or they're listening to the radio.
- We need to educate the community on what resources are available.

Health Behaviors

Health Behaviors Ranking

County Health Rankings examines healthy behaviors and ranks counties according to health behavior data. California's 58 evaluated counties are ranked from 1 (healthiest) to 58 (least healthy) based on a number of indicators that include: adult smoking, obesity, physical inactivity, excessive drinking, sexually transmitted infections, and others. A ranking of 11 puts Los Angeles County in the top quarter of California counties for health behaviors.

Health Behaviors Ranking

	County Ranking (out of 58)
Los Angeles County	11

Source: County Health Rankings, 2021. www.countyhealthrankings.org

Health Status

Among adults, 83.6% in SPA 3 and 81.5% in SPA 7 rated themselves as being in excellent, very good, or good health.

Self-Reported Health Status, Adults

	SPA 3	SPA 7	Los Angeles County	California
Excellent health status	16.3%	17.4%	18.5%	19.5%
Very good health status	32.9%	30.0%	32.3%	34.3%
Good health status	34.4%	34.1%	33.1%	31.0%
Fair health status	12.8%	15.5%	13.1%	12.6%
Poor health status	3.6%	3.1%	3.0%	2.6%

Source: California Health Interview Survey, 2019-2020. http://ask.chis.ucla.edu/

In SPA 3, adults averaged 3.7 days of poor mental and poor physical health. In SPA 7, adults averaged 4.0 days of poor mental and 3.9 days of poor physical health in the past month.

Poor Mental/Physical Health, Average Days in Past Month

	SPA 3	SPA 7	Los Angeles County
Poor mental health days	3.7	4.0	4.0
Poor physical health days	3.7	3.9	3.9

Source: 2018 Los Angeles County Health Survey; Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health. http://publichealth.lacounty.gov/ha/LACHSDataTopics2018.htm

Among children, ages 0 to 17, 96.3% in SPA 3 and 97.2% in SPA 7, were reported to be in excellent, very good, or good health.

Self-Reported Health Status, Children, Ages 0-17

	SPA 3	SPA 7	Los Angeles County	California
Excellent health status	42.2%	45.2%	49.4%	51.7%
Very good health status	31.5%	35.1%	31.5%	31.1%
Good health status	22.6%	16.9%	15.0%	14.1%
Fair/poor health status	3.6%*	2.8%*	4.1%	3.1%

*Source: California Health Interview Survey, 2019-2020. *Statistically unstable due to sample size. http://ask.chis.ucla.edu/*

Teen Sexual History

Among teens, ages 14 to 17, whose parents gave permission for the question to be asked, 77.0% in SPA 3 and 92.8% in SPA 7 reported they had never had sex.

Sexual History, Teens, Ages 14 to 17

	SPA 3	SPA 7	Los Angeles County	California
Never had sex	77.0%	92.8%*	85.6%	87.9%
Male	78.8%	92.0%*	86.6%	91.0%
Female	80.4%*	92.7%*	85.1%	84.9%

*Source: California Health Interview Survey, 2019-2020. *Statistically unstable due to sample size. http://ask.chis.ucla.edu/*

Soda/Sugar-Sweetened Beverage Consumption

Among children and adolescents, ages 2 to 17, 28.9% in SPA 3 and 27.8% in SPA 7 reported drinking one or more sodas the previous day. 49.1% of children and adolescents in SPA 3 and 63.3% in SPA 7 reported drinking one or more sweetened fruit drinks, sports, or energy drinks the previous day.

Soda/Sugary Drink Consumption

	SPA 3	SPA 7	Los Angeles County	California
Ages 2-17, drank ≥1 soda	28.9%	27.8%	24.0%	22.2%
Ages 2-17, drank ≥ sugary drink‡	49.1%	63.3%*	45.3%	39.0%

*Source: California Health Interview Survey, 2019-2020, 2018‡.*Statistically unstable due to sample size. http://ask.chis.ucla.edu/*

Adequate Fruit and Vegetable Consumption

In SPA 3, 35.6% of children, ages 2 to 11, 37.3% of teens, and 10.8% of adults ate five or more servings of fruits and vegetables in the previous day. In SPA 7, 46.2% of children, ages 2 to 11, 22.5% of teens, and 8.2% of adults ate five or more servings of fruits and vegetables in the previous day.

Five or More Servings of Fruits and Vegetables Daily

	SPA 3	SPA 7	Los Angeles County
Children, ages 2-11	35.6%	46.2%	36.8%
Teens, ages 12-17	37.3%	22.5%*	31.7%
Adults, ages 18 and older‡	10.8%	8.2%	12.1%

*Source: California Health Interview Survey, 2019-2020. *Statistically unstable due to sample size. http://ask.chis.ucla.edu/*
‡Source: 2018 Los Angeles County Health Survey; Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health. http://publichealth.lacounty.gov/ha/LACHSDataTopics2018.htm

Overweight/Obesity

In SPA 3, 17.0% of children were overweight for their age, 8.9% of teens and 34.7% of adults were overweight. In SPA 7, 20.6% of children were overweight for their age, 13.1% of teens and 30.9% of adults were overweight.

Overweight, Children, Teens, Adults

	SPA 3	SPA 7	Los Angeles County	California
Overweight for age, child	17.0%	20.6%	13.1%	13.4%
Overweight, teen	8.9%*	13.1%*	15.9%	13.7%
Overweight, adults	34.7%	30.9%	31.9%	33.2%

*Source: California Health Interview Survey, 2019-2020. *Statistically unstable due to sample size. http://ask.chis.ucla.edu/*

The Healthy People 2030 objectives for obesity are 36% of adults, ages 20 and older, and 15.5% of children and teens, ages 2 to 19. In SPA 3, 26.4% of adults and 18.7% of teens are obese. In SPA 7, 40.7% of adults and 39.5% of teens are obese.

Obesity, Adults and Teens

	SPA 3	SPA 7	Los Angeles County	California
Adults, ages 20 and older	26.4%	40.7%	30.7%	28.7%
Teens, ages 12-17	18.7%*	39.5%	20.7%	17.8%

*Source: California Health Interview Survey, 2019-2020. *Statistically unstable due to sample size. http://ask.chis.ucla.edu/*

When obesity is compared by race/ethnicity, Black/African American adults in SPA 3 had the highest percentage (51.4%), followed by Latino adults (32.8%). In SPA 7, Latino adults had the highest percentage of obesity (43.9%) followed by Black/African American adults (41.4%).

Obesity by Race/Ethnicity, Adults, Ages 20 and older

	SPA 3	SPA 7	Los Angeles County	California
Asian	10.1%	16.5%	9.5%	10.5%
Black/African American	51.4%	41.4%	43.5%	40.1%
Latino	32.8%	43.9%	39.4%	36.7%
Two or more races	28.4%*	36.8%*	25.2%	28.3%
White	27.8%	33.2%	22.1%	25.3%

*Source: California Health Interview Survey,2019-2020. *Statistically unstable due to sample size. http://ask.chis.ucla.edu/*

The physical fitness test (PFT) for students in California schools is the FitnessGram®. One of the components of the PFT is measurement of body composition (measured by skinfold measurement, BMI, or bioelectric impedance). Children who do not meet the “Healthy Fitness Zone” criteria for body composition are categorized as needing improvement (overweight) or at health risk (obese). It should be noted in academic years 2019–2020 and 2020–2021 PFTs were suspended.

- The range of 5th grade students enrolled in service area school districts that tested with a body composition at health risk was 18.3% to 42.2% as compared to Los Angeles County at 25.4%.
- The range of 7th grade students enrolled in service area school districts that tested with a body composition at health risk was 11.9% to 36.8% as compared to Los Angeles County at 23.2%.
- The range of 9th grade students enrolled in service area school districts that tested with a body composition at health risk was 14.4% to 26.5% as compared to Los Angeles County at 21.0%.

Body Composition, 'Needs Improvement' and 'Health Risk', 5th, 7th, and 9th Graders

	Fifth Grade		Seventh Grade		Ninth Grade	
	Needs Improvement	**Health Risk**	**Needs Improvement**	**Health Risk**	**Needs Improvement**	**Health Risk**
El Monte City School District	18.5%	29.3%	17.8%	29.3%	ND	ND
El Monte Union High School District	ND	ND	ND	ND	24.7%	24.3%
Garvey School District	18.7%	18.3%	18.2%	20.5%	ND	ND
Los Angeles Unified School District	20.6%	30.5%	20.5%	27.3%	21.9%	26.5%
Los Nietos School District	19.5%	42.2%	17.6%	36.8%	ND	ND
Montebello Unified School District	26.2%	21.2%	29.4%	16.7%	27.7%	17.9%
Mountain View School District	21.2%	31.4%	22.1%	33.9%	ND	ND
Rosemead School District	16.7%	19.1%	20.1%	11.9%	ND	ND
Valle Lindo School District	21.4%	27.5%	25.5%	26.8%	ND	ND
Whittier City School District	19.4%	35.7%	21.4%	28.3%	ND	ND
Whittier Union High School District (Pioneer High School)	ND	ND	ND	ND	48.7%	14.4%
Los Angeles County	**20.2%**	**25.4%**	**19.8%**	**23.2%**	**20.3%**	**21.0%**
California	**19.4%**	**21.9%**	**19.4%**	**20.6%**	**18.9%**	**18.9%**

Source: California Department of Education, Fitnessgram Physical Fitness Testing Results, 2018-2019. ND=No Data
http://data1.cde.ca.gov/dataquest/page2.asp?Level=District&submit1=Submit&Subject=FitTest

Community Input – Overweight and Obesity

Stakeholder interviews identified the following issues, challenges and barriers related to overweight and obesity. Following are their comments summarized and edited for clarity:

- During the pandemic, there were people who lost weight because they were at home and had nothing to do so they started walking every day with their neighbors. Some people have lost significant amounts of wight, which is great.

- In the south end of town, there is not much access to grocery stores, especially good quality ones. And the cost of classes can be prohibitive and some people are still afraid to be in a group of strangers in a class.
- Some seniors are very active, others hardly come out of their rooms.
- Safety in the community is a big issue. Families don't feel comfortable going out as much. For persons who are undocumented, that adds to their worries and concerns with community violence.
- More access to healthy foods is important. People often have to drive to more than one store to get groceries.
- We saw an increase in food distribution that has only gotten stronger. WE need to leverage food distribution to provide education about healthy food preparation.

Physical Activity

The U.S. Department of Health and Human Service has established physical activity guidelines for adults, and children and adolescents.[4] Physical activity guidelines for adults include 1) vigorous activity for at least 75 minutes a week, or 2) moderate activity for at least 150 minutes a week, or 3) an equivalent combination of vigorous and moderate activity. Additionally, adults should engage in muscle-strengthening activities that are moderate or high intensity and involve all major muscle groups on two or more days a week.

For children and adolescents, ages 6 to17, aerobic physical activity guidelines advise 60 minutes or more of physical activity each day. Additionally, to meet physical activity guidelines for muscle-strengthening exercises, children and adolescents must perform muscle-strengthening physical activity at least three days a week.

Among adults, 33.4% in SPA 3 and 33.8% in SPA 7 met both aerobic and muscle strengthening guidelines, as compared to the county at 35.1%. Among children and adolescents, ages 6 to 17, 12.9% in SPA 3 and 13.8% in SPA 7 met both aerobic and muscle strengthening guidelines, as compared to the county at 15.1%.

Physical Activity, Adults and Children

	SPA 3	SPA 7	Los Angeles County
No aerobic activity, adults	13.1%	9.3%	11.2%
Met aerobic guidelines, adults	63.4%	65.4%	64.4%
Met strengthening guidelines, adults	40.9%	40.1%	43.1%

[4] *Source: Physical Activity Guidelines for Americans, 2nd edition. 2018 U.S. Department of Health and Human Services. https://health.gov/sites/default/files/2019-09/Physical_Activity_Guidelines_2nd_edition.pdf*

	SPA 3	SPA 7	Los Angeles County
Met both aerobic and strengthening guidelines, adults	33.4%	33.8%	35.1%
Met aerobic guidelines, children ages 6-17	22.4%	19.9%	23.7%
Met strengthening guidelines, children ages 6-17	48.1%	48.6%	50.8%
Met both aerobic and strengthening guidelines, children ages 6-17	12.9%	13.8%	15.1%

Source: 2018 Los Angeles County Health Survey; Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health. http://publichealth.lacounty.gov/ha/LACHSDataTopics2018.htm

One of the components of the physical fitness test (PFT) is the measurement of student aerobic capacity through run and walk tests.

- The range of 5th grade students enrolled in service area school districts that met Healthy Fitness Zone aerobic capacity guidelines was 35.1% to 67.5% as compared to Los Angeles County at 57.1% and the state at 60.2%.
- The range of 7th grade students enrolled in service area school districts that met Healthy Fitness Zone aerobic capacity guidelines was 48.4% to 90.8% as compared to Los Angeles County at 57.3% and state at 61.0%.
- The range of 9th grade students enrolled in service area school districts that met Healthy Fitness Zone aerobic capacity guidelines was 36.9% to 59.2% as compared to Los Angeles County at 54.1% and state at 60.0%.

Aerobic Capacity, 5th, 7th, and 9th Graders

	Fifth Grade	Seventh Grade	Ninth Grade
	Healthy Fitness Zone	Healthy Fitness Zone	Healthy Fitness Zone
El Monte City School District	56.5%	52.3%	ND
El Monte Union High School District	ND	ND	59.2%
Garvey School District	51.7%	56.8%	ND
Los Angeles Unified School District	50.5%	48.4%	48.1%
Los Nietos School District	67.5%	64.7%	ND
Montebello Unified School District	47.0%	50.5%	44.4%
Mountain View School District	59.8%	69.8%	ND
Rosemead School District	39.9%	90.8%	ND
Valle Lindo School District	35.1%	57.0%	ND
Whittier City School District	63.9%	62.5%	ND
Whittier Union High School District (Pioneer High School)	ND	ND	36.9%
Los Angeles County	**57.1%**	**57.3%**	**54.1%**
California	**60.2%**	**61.0%**	**60.0%**

Source: California Department of Education, Fitnessgram Physical Fitness Testing Results, 2018-2019. ND=No Data
http://data1.cde.ca.gov/dataquest/page2.asp?Level=District&submit1=Submit&Subject=FitTest

Sedentary Children and Teens

Sedentary activities include time spent sitting and watching TV, playing computer games, talking with friends, or doing other sitting activities. Among children, ages 2 to 11, 20.2% in SPA 3 and 23.7% in SPA 7 spent 5 hours to more than 8 hours in sedentary activities on weekend days.

Sedentary Children, Ages 2-11

	SPA 3	SPA 7	Los Angeles County	California
<1 to <2 hours	15.8%	25.9%	21.8%	17.0%
2 to <3 hours	20.2%	24.8%	25.3%	24.3%
3 to <5 hours	43.7%	25.6%	30.4%	33.8%
5 to >8 hours	20.2%	23.7%	22.5%	25.0%

Source: California Health Interview Survey, 2019-2020. http://ask.chis.ucla.edu/

Teens spend more hours in sedentary activity on weekends as compared to children. Among teens, ages 12 to 17, 46.4% in SPA 3 and 66.6% SPA 7 spent 5 hours to more than 8 hours in sedentary activities on weekend days.

Sedentary Teens, Ages 12-17

	SPA 3	SPA 7	Los Angeles County	California
2 to <3 hours	6.4%*	4.3%*	7.8%	9.8%
3 to <5 hours	39.3%	21.3%*	29.9%	25.0%
5 to >8 hours	46.4%	66.6%	55.8%	60.2%

*Source: California Health Interview Survey, 2019-2020. *Statistically unstable due to sample size. http://ask.chis.ucla.edu/*

Social Media

On a typical day, 13.3% of adults in SPA 3 and 14.1% of adults in SPA 7 used a computer or mobile device for social media almost constantly.

Social Media, Adults

	SPA 3	SPA 7	Los Angeles County	California
Almost constantly	13.3%	14.1%	14.5%	12.1%
Many times a day	33.1%	29.3%	29.3%	29.7%
A few times a day	25.4%	29.5%	26.9%	27.4%
Less than a few times a day	28.3%	27.0%	29.3%	30.8%

Source: California Health Interview Survey, 2019-2020. http://ask.chis.ucla.edu/

On a typical day, 42.0% of teens in SPA 3 and 22.1% of teens in SPA 7 used a computer of mobile device for social media almost constantly.

Social Media, Teens, Ages 12-17

	SPA 3	SPA 7	Los Angeles County	California
Almost constantly	42.0%	22.1%	25.3%	21.3%

	SPA 3	SPA 7	Los Angeles County	California
Many times a day	28.1%	25.1%	31.1%	38.4%
A few times a day	26.6%	32.4%*	31.0%	26.3%
Less than a few times a day	3.3%*	20.4%*	12.6%	13.9%

*Source: California Health Interview Survey, 2019-2020. *Statistically unstable due to sample size. http://ask.chis.ucla.edu/*

Mental Health

Mental Health Access and Utilization

Mental health includes emotional, psychological, and social well-being. It affects how individuals think, feel, and act. It also helps determine how individuals manage stress, relate to others, and make choices. Among adults who received care for mental or emotional problems, 38.1% in SPA 3 and 31.2% in SPA 7 visited both a primary care physician and a mental health professional.

Type of Provider Giving Care for Mental and Emotional Issues in the Past Year, Adults

	SPA 3	SPA 7	Los Angeles County	California
Primary care physician only	23.8%	32.8%	25.5%	25.1%
Mental health professional only	38.1%	36.0%	38.0%	36.7%
Both	38.1%	31.2%	36.5%	38.2%

Source: California Health Interview Survey, 2019-2020. http://ask.chis.ucla.edu/

Among adults in SPA 3 and SPA 7, 14.5% self-identified the need to see a professional because of problems with mental health emotions, or nerves or use of alcohol or drugs in the past 12 months. Of these adults, 44.5% in SPA 3 and 49.3% in SPA 7 sought help from their primary care provider or other professional, (counselor, psychiatrist, or social worker, but did not receive treatment in the past 12 months.

Mental Health Access and Utilization, Adults

	SPA 3	SPA 7	Los Angeles County	California
Needed help for emotional /mental health problems or use of alcohol drugs	14.5%	14.5%	20.6%	21.2%
Sought help but did not receive treatment	44.5%	49.3%	47.8%	45.4%

Source: California Health Interview Survey, 2019-2020. http://ask.chis.ucla.edu/.

Among teens, 31.1% in SPA 3 and 28.0% in SPA 7 felt they needed help for emotional or mental health problems (feeling sad, anxious, or nervous) in the past 12 months. Of teens, 14.0% in SPA 3 and 15.9% in SPA 7 received psychological or emotional counseling in the past year.

Mental Health Access and Utilization, Teens

	SPA 3	SPA 7	Los Angeles County	California
Needed help for emotional or mental health problems	31.1%	28.0%	30.4%	31.4%
Received psychological/emotional counseling	14.0%*	15.9%*	15.2%	17.6%

*Source: California Health Interview Survey, 2019-2020. *Statistically unstable due to sample size. http://ask.chis.ucla.edu/*

5.1% of adults in SPA 3 and 4.2% of adults in SPA 7 sought on-line help (mobile apps or texting services) for mental health, emotions, nerves, or use of alcohol or drugs. 4.3% of adults in SPA 3 and 4.5% of adults in SPA 7 connected on-line with a mental health professional in the past 12 months. 2.5% of adults in SPA 3 and 4.1% of adults in SPA 7 connected online with people with similar mental health or alcohol/drug status.

Online Mental Health Utilization, Adults

	SPA 3	SPA 7	Los Angeles County	California
Sought help from an online tool for mental health or alcohol issues	5.1%*	4.2%	5.9%	6.5%
Connected with a mental health professional on-line	4.3%	4.5%	6.1%	5.9%
Connected with people on-line with similar mental health or alcohol/drug status	2.5%	4.1%	4.2%	4.4%

*Source: California Health Interview Survey, 2019-2020. *Statistically unstable due to sample size. http://ask.chis.ucla.edu/*

Among teens, 3.4% in SPA 3 and 12.0% in SPA 7 sought on-line help (mobile apps or texting services) for mental health, emotions, nerves, or use of alcohol or drugs. 8.6% of teens in SPA 3 and 9.7% of teens in SPA 7 connected on-line with a mental health professional in the past 12 months. 14.7% of teens in SPA 3 and 15.4% of teens in SPA 7 connected online with people with similar mental health or alcohol/drug status.

Online Mental Health Utilization, Teens

	SPA 3	SPA 7	Los Angeles County	California
Sought help from an online tool for mental health or alcohol issues	3.4%*	12.0%*	7.6%	7.2%
Connected with a mental health professional on-line	8.6%*	9.7%*	6.9%	6.0%
Connected with people on-line with similar mental health or alcohol/drug status	14.7%*	15.4%*	16.0%	12.8%

*Source: California Health Interview Survey, 2019-2020. *Statistically unstable due to sample size. http://ask.chis.ucla.edu/*

Mental Health Indicators - Adults

Among adults, 12.3% in SPA 3 and 14.4% in SPA 7 were at risk for major depression, as compared to the county at 13.0%. 8.7% of adults in SPA 3 and 12.0% of adults in SPA 7 were currently diagnosed with depression.

Depression, Adults

	SPA 3	SPA 7	Los Angeles County
Adults at risk of major depression	12.3%	14.4%	13.0%
Adults with current diagnosed depression	8.7%	12.0%	11.5%

Source: 2018 Los Angeles County Health Survey; Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health. http://publichealth.lacounty.gov/ha/LACHSDataTopics2018.htm

Among adults, 9.2% in SPA 3 and 8.8% in SPA 7 likely had serious psychological distress in the past year. Psychological distress for this measure was assessed through the Kessler 6 series. 6.7% of adults in SPA 3 and 4.6% of adults in SPA 7 have been on prescription medicine for an emotional/mental health issue(s) for at least two weeks in the past year.

Adults who reported moderate to severe family life, social life, household chore, or work life impairments in the past year due to emotions ranged from 16.0% to 17.0% in SPA 3 and 13.3% to 15.0% in SPA 7. These indicators were lower than the county and state rates.

Mental Health Indicators, Adults

	SPA 3	SPA 7	Los Angeles County	California
Adults who had serious psychological distress during past year	9.2%	8.8%	12.3%	12.6%
Adults on prescription medicine at least 2 weeks for emotional/mental health issue in past year	6.7%	4.6%	7.8%	10.1%
Adults reporting family life impairment during the past year	16.5%	14.8%	20.7%	20.9%
Adults reporting social life impairment during the past year	17.0%	15.0%	20.8%	21.0%
Adults reporting household chore impairment during the past year	16.2%	14.4%	20.1%	20.1%
Adults reporting work impairment during the past year	16.0%	13.3%	21.0%	20.6%

Source: California Health Interview Survey, 2019-2020. http://ask.chis.ucla.edu/

Loneliness

Utilizing the UCLA 3-Item Loneliness Scale, 20.9% of SPA 3 adults, ages 65 and older, and 17.2% of senior adults in SPA 7 were lonely some of the time.

Loneliness, Adults, Ages 65 and Older

	SPA 3	SPA 7	Los Angeles County	California
Hardly lonely	76.8%	82.1%	78.6%	76.9%
Lonely some of the time	20.9%	17.2%	19.6%	20.1%
Often lonely	2.3%*	**	1.8%	3.0%

*Source: California Health Interview Survey, 2019-2020. *Statistically unstable due to sample size. **Suppressed due to small sample size. http://ask.chis.ucla.edu/*

Mental Health Indicators - Children and Teens

Among children, ages 4 to 11, 20.7% in SPA 3 and 15.8% in SPA 7 had difficulties with emotion/concentration/behavior in the past six months. Parents of children with difficulties provided a severity rank of minor or definite/severe. Among these children, 57.9% in SPA 3 and 69.7% in SPA 7 had definite and/or severe problems.

Emotion/Concentration/Behavior Problems, Children

	SPA 3	SPA 7	Los Angeles County	California
Has had emotion or concentration or behavior problem difficulty	20.7%	15.8%	17.1%	19.2%
Minor problems	42.1%*	30.3%*	51.7%	59.6%
Definite/severe problems	57.9%	69.7%*	48.3%	40.4%

*Source: California Health Interview Survey, 2019-2020. *Statistically unstable due to sample size. http://ask.chis.ucla.edu/.*

Among students in service area school districts, responding to a recent California Healthy Kids Survey, who felt so sad or hopeless every day for two weeks or more that they stopped doing some usual activities was highest among 7th graders (36%) in the Rosemead School District. Feelings of sadness and hopelessness were highest among 9th graders (66%) and 11th graders (60%) in the El Monte Union High School District.

Chronic, Sad or Hopeless Feelings

	7th Grade	9th Grade	11th Grade
El Monte City School District	30.0%	ND	ND
El Monte Union High School District‡	ND	66.0%	60.0%
Garvey School District±	26.0%	ND	ND
Los Angeles Unified School District†	30.0%	47.0%	53.0%
Montebello Unified School District‡	27.0%	38.0%	38.0%
Mountain View School District	31.0%	ND	ND
Rosemead School District†	36.0%	ND	ND
Whittier City School District‡	32.0%	ND	ND

Source: California Department of Education, California Healthy Kids Survey, 2020-2021†, 2019-2020, 2018-2019‡, 2017-2018±. ND=No Data. https://data1.cde.ca.gov/dataquest/

Among teens, 51.1% in SPA 3 and 26.9% in SPA 7 likely had serious psychological distress during the past year. Psychological distress for this measure was assessed through the Kessler 6 series.

Serious Psychological Distress in Past Year, Teens

	SPA 3	SPA 7	Los Angeles County	California
Teens who had serious psychological distress during past year	51.1%	26.9%	35.0%	31.4%

Source: California Health Interview Survey, 2019-2020. http://ask.chis.ucla.edu/.

Bullying

Bullying by peers has been shown to affect the mental health of children and teens. Among 5th grade students enrolled in service area school districts, 45% in the El Monte City School District indicated they had been a victim of violence (hit or pushed at school in a non-playful way, mean rumors/lies spread about them, called bad names, target of mean jokes). 28% of El Monte City School District 5th graders had indicated they had

perpetrated violence by engaging in bullying at least one or more times. 28% of 5th graders in the Whittier City School District stated they had been teased about their body image.

School Bullying, 5th Graders

	Violence Victimization	Violence Perpetration	Been Teased about Body Image
El Monte City School District	45.0%	28.0%	27.0%
Montebello Unified School District‡	40.0%	24.0%	25.0%
Mountain View School District	36.0%	27.0%	27.0%
Rosemead School District†	33.0%	N/A	18.0%
Whittier City School District‡	34.0%	21.0%	28.0%

Source: California Department of Education, California Healthy Kids Survey, 2020-2021†, 2019-2020, 2018-2019‡, 2017-2018±. Tables A7.2, A7.3, A7.4. N/A=Not Asked. https://data1.cde.ca.gov/dataquest/

Among students in 7th, 9th, and 11th grades in service area school districts, 34% of 7th grade students in the Mountain View School District, 30% of 9th graders in the Garvey School District and 24% of 11th graders in the El Monte Union High School District had the highest rates of having experienced bullying.

School Bullying, 7th, 9th and 11th Graders

	7th Grade	9th Grade	11th Grade
El Monte City School District	22.0%	ND	ND
El Monte Union High School District‡	ND	24.0%	24.0%
Garvey School District±	30.0%	30.0%	ND
Los Angeles Unified School District†	16.0%	10.0%	6.0%
Montebello Unified School District‡	27.0%	26.0%	21.0%
Mountain View School District	34.0%	ND	ND
Whittier City School District‡	32.0%	ND	ND

Source: California Department of Education, California Healthy Kids Survey, 2020-2021†, 2019-20, 2018-2019‡, 2017-2018±. Table A2.1. ND=No Data. https://data1.cde.ca.gov/dataquest/

Suicide Contemplation

Among adults, 7.8% in SPA 3 and 9.2% in SPA 7 have seriously thought about committing suicide, Adults, ages 18 to 24 have the highest percentage of suicide contemplation in SPA 3 (11.2%) and SPA 7 (24.4%).

Suicide Contemplation, Adults

	SPA 3	SPA 7	Los Angeles County	California
Ever seriously considered suicide	7.8%	9.2%	11.6%	13.1%
Ages 18-24	11.2%	24.4%	20.2%	23.8%
Ages 18-64	8.8%	10.0%	13.1%	14.8%
Ages 65 and older	4.6%*	5.3%*	5.5%	6.5%

*Source: California Health Interview Survey, 2019-2020. *Statistically unstable due to sample size. http://ask.chis.ucla.edu/*

Among students in 7th, 9th, and 11th grades in service area school districts, 16% of 7th graders in the Mountain View School District and Whittier City School District had contemplated suicide. 23% of 9th graders in the LAUSD and 17% of 11th graders in the Montebello USD had contemplated suicide. 21% of students in non-traditional school programs in the El Rancho USD had contemplated suicide.

Suicide Contemplation, Teens

	7th Grade	9th Grade	11th Grade
El Monte City School District	11.0%	ND	ND
El Monte Union High School District‡	ND	14.0%	16.0%
Los Angeles Unified School District†	12.0%	23.0%	13.0%
Montebello Unified School District‡	15.0%	18.0%	17.0%
Mountain View School District	16.0%	ND	ND
Rosemead School District†	15.0%	ND	ND
Whittier City School District‡	16.0%	ND	ND

Source: California Department of Education, California Healthy Kids Survey, 2020-2021†, 2019-2020, 2018-2019‡, 2017-2018± Table A7.2 A8.4. ND=No Data. https://data1.cde.ca.gov/dataquest/

Community Input – Mental Health

Stakeholder interviews identified the following issues, challenges and barriers related to mental health. Following are their comments summarized and edited for clarity:

- We have seen an increase in mental health needs and an increase in people who need to be on hold. That can be a lengthy process because there are not enough beds in the hospitals.
- When facilities shut down, we saw persons who are homeless start to form housing complexes by our entrance.
- When we are asked to look for resources for people, we have to look outside of our community. There is nothing here in our own community. No mental health clinics that are free and no homeless shelter. I've worked here for ten years and have seen the increase in homelessness. That was not the case a few years ago. These people need more than homes, they need mental health and substance use and misuse and jobs.
- Lately, we are seeing more residents who are exhibiting pre-dementia. Some people don't know what is going on from day-to-day, others wander.
- Lack of physical activity and needing mental stimulation, those were the biggest issues because of the pandemic. People were very sad and depressed. There is a need for stimulation.
- There is still a lot of stigma around mental health and asking for help. Trauma informed care applies to a lot more private institutions than those who just work directly with families and children. Using trauma informed care in more settings as a standard could be applied in law enforcement, schools, and other sectors, not just mental health. We need more focus on prevention. We try to address problems once

they get to the point where the family is experiencing homelessness or someone is having a mental breakdown.

- The pandemic caused isolation and then created major problems.
- The pandemic has put a glaring light on the need for more mental health care.
- Mental health issues worsened with the pandemic. We are seeing more people who are homeless with mental health issues.

Substance Use and Misuse

Tobacco Use

The Healthy People 2030 objective for cigarette smoking among adults is 5.0%. 4.3% of adults in SPA 3 and 6.5% of adults in SPA 7 are current smokers. 32.8% of adults in SPA 3 and 62.2% of adults in SPA 7 reported thinking about quitting smoking in the next six months. Among adults, 2.7% in SPA 3 and 2.4% in SPA 7 are current e-cigarette smokers.

Cigarette Smoking, Adults

	SPA 3	SPA 7	Los Angeles County	California
Current cigarette smoker	4.3%	6.5%	5.9%	6.4%
Thinking about quitting in the next 6 months	32.8%	62.2%*	63.3%	64.4%
Current e-cigarette user (used in last 30 days)	2.7%	2.4%*	2.8%	3.4%
Former e-cigarette user (not used in last 30 days)	10.1%	11.5%*	12.2%	12.8%

*Source: California Health Interview Survey, 2019-2020. *Statistically unstable due to sample size. http://ask.chis.ucla.edu*

5.2% of adults in SPA 3 currently use non-cigarette tobacco products and 3.1% of adults in SPA 3 use flavored tobacco products. 4.3% of adults in SPA 7 currently use non-cigarette tobacco products and 3.4% of adults in SPA 7 use flavored tobacco products.

Tobacco Product Use, Adults

	SPA 3	SPA 7	Los Angeles County	California
Current use of non-cigarette tobacco products (past 30 days)	5.2%	4.3%	5.9%	6.4%
Current use of flavored tobacco products (past 30 days)	3.1%	3.4%	4.5%	4.9%

Source: California Health Interview Survey, 2019-2020. http://ask.chis.ucla.edu

Among students enrolled in service area public school districts, Montebello Unified School District had the highest rates of e-cigarette/vaping product use.

E-cigarette/Vaping Product Use, Teens

	7th grade	9th Grade	11th Grade
El Monte City School District	2.0%	ND	ND
El Monte Union High School District‡	ND	6.0%	7.0%
Garvey School District‡	2.0%	ND	ND
Los Angeles Unified School District†	1.0%	1.0%	3.0%

	7th grade	9th Grade	11th Grade
Montebello Unified School District‡	5.0%	9.0%	12.0%
Mountain View School District	2.0%	ND	ND
Rosemead School District†	0.0%	ND	ND
Whittier City School District‡	5.0%	ND	ND

Source: California Department of Education, California Healthy Kids Survey, 2020-2021†, 2019-2020, 2018-2019‡, 2017-2018±. Table A7.1, A10.1. ND=No Data. https://data1.cde.ca.gov/dataquest/

Alcohol Use

Binge drinking is defined as consuming a certain amount of alcohol within a set period of time. For males this is five or more drinks per occasion and for females it is four or more drinks per occasion. The Healthy People 2030 objective for binge drinking among adults ages 21 and older in the past month is 25.4%.

Among adults, ages 18 and older, 52.7% in SPA 3 and 49.7% in SPA 7 have used alcohol in the past month. 16.0% of adults in SPA 3 and 20.2% of adults in SPA 7 have engaged in binge drinking in the past month.

Alcohol Use, Adults

	SPA 3	SPA 7	Los Angeles County
Alcohol use in past month	52.7%	49.7%	53.8%
Binge drinking in past month	16.0%	20.2%	17.9%

Source: 2018 Los Angeles County Health Survey; Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health. http://publichealth.lacounty.gov/ha/LACHSDataTopics2018.htm

Among students enrolled in service area public school districts, Montebello Unified School District had the highest rates of alcohol use.

Alcohol Use, Teens

	7th grade	9th grade	11th grade
El Monte City School District	3.0%	ND	ND
El Monte Union High School District‡	ND	5.0%	10.0%
Garvey School District±	1.0%	ND	ND
Los Angeles Unified School District†	2.0%	4.0%	10.0%
Montebello Unified School District ‡	5.0%	11.0%	15.0%
Mountain View School District	4.0%	ND	ND
Rosemead School District†	3.0%	ND	ND
Whittier City School District‡	4.0%	ND	ND

Source: California Department of Education, California Healthy Kids Survey, 2020-2021†, 2019-2020, 2018-2019‡, 2017-2018±. Table A6.5, A9.1. ND=No Data. https://data1.cde.ca.gov/dataquest/

Among students enrolled in service area public school districts, Montebello Unified School District had the highest rates of binge drinking.

Binge Drinking, Teens

	7th grade	9th grade	11th grade
El Monte City School District	1.0%	ND	ND
El Monte Union High School District‡	ND	2.0%	5.0%
Garvey School District±	1.0%	ND	ND
Los Angeles Unified School District†	0.0%	0.0%	3.0%
Montebello Unified School District ‡	1.0%	5.0%	7.0%
Mountain View School District	1.0%	ND	ND
Rosemead School District†	1.0%	ND	ND
Whittier City School District‡	1.0%	ND	ND

Source: California Department of Education, California Healthy Kids Survey, 2020-2021†, 2019-2020, 2018-2019‡, 2017-2018±. Table A6.5, A9.1. ND=No Data. https://data1.cde.ca.gov/dataquest/

Marijuana Use

Among adults, 31.4% in SPA 3 and 34.0% in SPA 7 have used marijuana in the past month. 15.4% of adults in SPA 3 and 13.9% of adults in SPA 7 have used marijuana in the past year.

Marijuana Use, Adults

	SPA 3	SPA 7	Los Angeles County	California
Marijuana use in past month	31.4%	34.0%	34.8%	33.9%
Marijuana use < than 1 month to 1 year	15.4%	13.9%	18.6%	17.6%

Source: California Health Interview Survey, 2019-2020. http://ask.chis.ucla.edu

In SPA 3, 28.3% of teens ages 12 to 17 have tried marijuana. Of these teens, 27.0% used marijuana, hashish or other TCH products one or more days in the past month. In SPA 7, 19.3% of teens ages 12 to 17 have tried marijuana. Of these teens, 90.5% used marijuana, hashish or other TCH products one or more days in the past month.

Marijuana Use, Teens, Ages 12-17

	SPA 3	SPA 7	Los Angeles County	California
Has tried marijuana or hashish	28.3%*	19.3%	15.9%	14.6%
Marijuana, hashish, or TCH product use in past month	27.0%*	90.5%*	46.3%	49.5%

*Source: California Health Interview Survey, 2019-2020. *Statistically unstable due to sample size. http://ask.chis.ucla.edu*

Opioid Use

The World Health Organization states “opioid dependence develops after a period of regular use of opioids, with the time required varying according to the quantity, frequency and route of administration, as well as factors of individual vulnerability and the context in which drug use occurs. Opioid dependence is not just a heavy use of the drug but a complex health connotation that has social, psychological, and biological

determinants and consequences, including changes in the brain. It is not a weakness of character or will."[5]

The emergency department visit rate in Los Angeles County for any opioid overdose was 24.22 per 100,000 persons. The county hospitalization rate for opioid overdose was 6.37 per 100,000 persons. These rates were lower than state levels. The age-adjusted opioid death rate was 12.40 per 100,000 persons in the county as compared to the state at 13.54 per 100,000 persons. The rate of opioid prescriptions in Los Angeles County (266.13 per 1,000 persons) was lower than the state rate (333.33 per 1,000 persons).

Opioid Rates, per 100,000 Persons and 1,000 Persons

	Los Angeles County	California
ED visit rate for any opioid overdose per 100,000 persons	24.22	40.95
Hospitalization rate for any opioid overdose per 100,000 persons	6.37	10.19
Age-adjusted opioid overdose deaths per 100,000 persons	12.40	13.54
Opioid prescriptions, per 1,000 persons	266.13	333.33

Source: California Department of Justice, Controlled Substance Utilization Review and Evaluation System Data, California Department of Public Health, Substance and Addiction Prevention Branch. California Opioid Overdose Surveillance Dashboard, 2020. CA Overdose Dashboard

Pain Reliever Misuse

The misuse of prescription psychotherapeutics is defined as use in any way not directed by a doctor, including use without a prescription of one's own medications; use in greater amounts, more often, or longer than told; or use in any other way not directed by a doctor. Adults, ages 18 to 25, had the highest rate of pain reliever misuse at 5.33% in SPA 3 and at 5.49% in SPA 7.

Pain Reliever Misuse in Past Year, All Ages

	SPA 3	SPA 7	Los Angeles County	California
Ages 12 - 17	3.61%	3.52%	3.42%	3.53%
Ages 18 - 25	5.33%	5.49%	5.76%	6.17%
Ages 26 and older	2.94%	3.52%	3.43%	3.77%
Ages 18 and older	3.28%	3.83%	3.76%	4.11%

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2016, 2017, and 2018, Table 12. Published July 2020.
https://www.samhsa.gov/data/sites/default/files/reports/rpt29376/NSDUHsubstateAgeGroupTabs2018/NSDUHsubstateAgeGroupTabs2018.pdf

[5] World Health Organization (WHO). Lexicon of Alcohol and Drug Terms, 2006

Illicit Drug Use

Illicit drugs are identified as cocaine (including crack), heroin, hallucinogens, inhalants, or methamphetamine. Adults, ages 18 to 25, had the highest rate of illicit drug use at 9.53% in SPA 3 and at 6% in SPA 7.

Illicit Drug Use, in Past Month, All Ages

	SPA 3	SPA 7	Los Angeles County	California
Ages 12 - 17	**	2.25%	2.46%	2.43%
Ages 18 - 25	9.53%	6.00%	6.84%	6.73%
Ages 26 and older	5.27%	3.12%	3.54%	3.41%
Ages 18 and older	5.79%	3.58%	4.01%	3.89%

*Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2016, 2017, and 2018, Table 6. Published July 2020. **Data Suppressed.*
https://www.samhsa.gov/data/sites/default/files/reports/rpt29376/NSDUHsubstateAgeGroupTabs2018/NSDUHsubstateAgeGroupTabs2018.pdf

Community Input – Substance Use

Stakeholder interviews identified the following issues, challenges and barriers related to substance use. Following are their comments summarized and edited for clarity:

- Anytime law enforcement encounters someone under the influence, it elevates the risk of adverse contact. There are only so many places a person can go. They can either go to jail, a hospital, a substance use home or other resource facility. We try to divert them to other places, but a high percentage of them don't want any help. Even if they go to jail, they go right back to their substance use patterns and behaviors when they get out.
- A lot of people who need help don't want it, that is part of the problem. Also, it is difficult to find services that are free.
- Substance use is occurring in public places like parks and sometimes people get unruly and make it an unsafe place for kids to play. There is a lot of unreported substance use.
- Parents are struggling to get by and they are misusing alcohol.
- With our youth using marijuana and vaping, a lot of our parents don't understand the difference and what a vape pen looks like and what they are for. There are a lot of CBD products that mimic popular snacks, so they will look like gummy bears or a bag of chips. And these products contain THC and teens are getting high.
- Accidental overdose death rates during the pandemic have increased for Asians and African Americans. Fentanyl is causing accidental overdose deaths.
- We are under greater stress and people have a tendency to escape through substance use.
- Many persons experiencing homelessness are using drugs. This has grown in our community.

Preventive Practices

Childhood Immunization

For the academic year 2019-2020, in service area public school districts with kindergarten enrollment, rates of children with up-to-date immunization upon entry into kindergarten ranged from 92.7% in the Los Nietos School District to 98.6% in Montebello Unified School District.

Up-to-Date Immunization Rates of Children Entering Kindergarten, 2019-2020

	Percent
El Monte City School District	96.2%
Garvey School District	96.4%
Los Angeles Unified School District (schools in service area ZIP Codes only)	95.5%
Los Nietos School District	92.7%
Montebello Unified School District	98.6%
Mountain View School District	96.2%
Rosemead School District	97.9%
Valle Lindo School District	98.0%
Whittier City School District	97.6%
Los Angeles County	**94.5%**
California	**94.3%**

Source: California Department of Public Health, Immunization Branch,2019-2020. https://data.chhs.ca.gov/dataset/school-immunizations-in-kindergarten-by-academic-year

Human Papilloma Virus Vaccine

In SPA 3 and SPA 7, 47.1% of children, ages 11 to 17, have received at least one dose of the Human Papilloma Virus (HPV) vaccine. Among adults, ages 18 to 26, 64.3% in SPA 3 and 60.5% in SPA 7 have had an HPV vaccine.

HPV Vaccination

	SPA 3	SPA 7	Los Angeles County
Children ages 11-17	47.1%	47.1%	47.2%
Female	50.5%	56.0%	53.4%
Male	44.0%	38.3%	41.2%
Adults, ages 18-26	64.3%	60.5%	59.3%

Source: 2018 Los Angeles County Health Survey; Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health. http://publichealth.lacounty.gov/ha/LACHSDataTopics2018.htm

Influenza (Flu) Vaccine

The Healthy People 2030 objective is for 70% of the population to receive a flu shot. In SPA 3, 49.3% of adults received a flu vaccine and 45.2% of SPA 7 adults received a flu vaccine.

Flu Vaccine, All Ages

	SPA 3	SPA 7	Los Angeles County
Reported having flu vaccination in past 12 months, ages 6 months to 17 years	58.7%	63.5%	59.9%
Reported having flu vaccination in past 12 months, ages 18 and older	49.3%	45.2%	47.1%
Reported having flu vaccination in past 12 months, ages 65 and older	78.0%	75.4%	73.2%

Source: 2018 Los Angeles County Health Survey; Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health. http://publichealth.lacounty.gov/ha/LACHSDataTopics2018.htm

Pneumococcal Vaccine

Among adults, ages 65 and older, 76.5% in SPA 3 and 71.5% in SPA 7 have received a pneumonia vaccine.

Pneumococcal Vaccine, Adults, Ages 65 and Older

	SPA 3	SPA 7	Los Angeles County
Ever had a pneumonia vaccine	76.5%	71.5%	72.3%

Source: 2018 Los Angeles County Health Survey; Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health. http://publichealth.lacounty.gov/ha/LACHSDataTopics2018.htm

Mammograms

The Healthy People 2030 objective for mammograms is 77.1% of women, ages 50 to 74, to have had a mammogram in the past two years. 78.3% of women in SPA 3 and 70.4% in SPA 7 had a mammogram in the past two years.

Mammograms in Past Two Years, Women, Ages 50-74

	SPA 3	SPA 7	Los Angeles County
Mammogram in past 2 years	78.3%	70.4%	77.0%

Source: 2018 Los Angeles County Health Survey; Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health. http://publichealth.lacounty.gov/ha/LACHSDataTopics2018.htm

Pap Smears

The Healthy People 2030 objective for Pap smears is 84.3% of women, ages 21 to 65, to have been screened in the past three years. 80.9% of women in SPA 3, and 79.6% in SPA 7 had a Pap smear in the prior three years. The SPA 3 and SPA 7 Pap smear rates did not meet the Healthy People 2030 objective.

Pap Smears in Past Three Years, Women, Ages 21-65

	SPA 3	SPA 7	Los Angeles County
Pap smear within past 3 years	80.9%	79.6%	81.4%

Source: 2018 Los Angeles County Health Survey; Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health. http://publichealth.lacounty.gov/ha/LACHSDataTopics2018.htm

Colorectal Cancer Screening

The Healthy People 2030 objective for colorectal cancer screening is 74.4% for adults, ages 50 to 74, be screened based on most recent guidelines. Among adults, ages 50 to 74, 18.5% in SPA 3 and 23.1% in SPA 7 completed a blood stool test in the past 12 months and 59.5% in SPA 3 and 57.7% in SPA 7 received a sigmoidoscopy within the past five years or colonoscopy within the past 10 years. Combining data for both types of colorectal cancer screening, adults in SPA 3 (78.0%) and SPA 7 (80.8%) meet the Healthy People 2030 objective.

Colorectal Cancer Screening, Adults, Ages 50-74

	SPA 3	SPA 7	Los Angeles County
Blood stool test in past 12 months	18.5%	23.1%	20.0%
Sigmoidoscopy w/in past 5 years or Colonoscopy w/in past 10 years	59.5%	57.7%	54.6%

Source: 2018 Los Angeles County Health Survey; Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health. http://publichealth.lacounty.gov/ha/LACHSDataTopics2018.htm

Older Adult Falls

Among adults, ages 65 and older, 22.4% in SPA 3 and 26.9% in SPA 7, experienced one or more falls in the past year. 9.1% of senior adults in SPA 3 and 13.1% in SPA 7 were injured due to a fall.

Falls and Injuries from Falls, Past Year, Adults, 65 and Older

	SPA 3	SPA 7	Los Angeles County
Experienced at least 1 or more falls	22.4%	26.9%	26.5%
Injured due to a fall	9.1%	13.1%	11.1%

Source: 2018 Los Angeles County Health Survey; Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health. http://publichealth.lacounty.gov/ha/LACHSDataTopics2018.htm

Community Input – Preventive Practices

Stakeholder interviews identified the following issues, challenges and barriers related to preventive practices. Following are their comments summarized and edited for clarity:

- Because we were closed for two years, our residents did not have access to our preventive screenings, workshops and classes. We just reopened and yesterday, we had 25 people here to get their blood pressure checked.
- Doctors and nurses need to pay closer attention to their patients' wellness and wholeness. They need to be a listener. People feel rushed at their doctor appointments.
- There is a lot of misinformation and distrust with vaccines.
- People are getting information from friends that is not always accurate. For childhood vaccines, parents report they can't get an appointment for a doctor visit so

they are behind in their immunizations. Or they don't feel comfortable going to the doctor because people are sick and they don't want their kids in that environment.

- With the Human Papilloma Virus (HPV) vaccine there's a belief that there's a relationship between getting vaccinated and becoming promiscuous. Many parents believe that once kid is vaccinated then they start having sex.
- It was hard to get medical appointments for a while. And we had to help seniors get their initial COVID vaccine appointments because everything was done online.

Attachment 1: Benchmark Comparisons

Where data were available, health and social indicators in the Beverly Hospital service area were compared to Healthy People 2030 objectives. Healthy People identifies public health priorities to help individuals, organizations, and communities across the United States improve health and well-being. Healthy People 2030, the initiative's fifth iteration, builds on knowledge gained over the first four decades. The **bolded items** are indicators that did not meet established benchmarks; non-bolded items met or exceeded the objectives.

Indicators	Beverly Service Area Data	Healthy People 2030 Objectives
High school graduation rate	**79.0%-**96.0%	90.7%
Child health insurance rate	96.1%	92.1%
Adult health insurance rate	**82.2%**	92.1%
Unable to obtain medical care when needed	**16.9% (SPA 3)** **15.2% (SPA 7)**	3.3%
Ischemic heart disease deaths	**89.4**	71.1 per 100,000 persons
Stroke deaths	32.7	33.4 per 100,000 persons
Liver disease (cirrhosis) deaths	**18.2**	10.9 per 100,000 persons
Cancer deaths	**124.6**	122.7 per 100,000 persons
Unintentional injury deaths	19.7	43.2 per 100,000 persons
Suicides	5.3	12.8 per 100,000 persons
Homicides	**6.0**	5.5 per 100,000 persons
Obese adults (ages 20 and older)	26.4% (SPA 3) **40.7% (SPA 7)**	36%, ages 20 and older
Adults engaging in binge drinking (ages 18 and older)	16.0% (SPA 3) 20.2% (SPA 7)	25.4%, ages 21 and older
Cigarette smoking by adults	4.3% (SPA 3) **6.5% (SPA 7)**	5.0%
Annual adult influenza vaccination	**49.3% (SPA 3)** **45.2% (SPA 7)**	70.0%
Pap smears, ages 21-65, screened in the past 3 years	**80.9% (SPA 3)** **79.6% (SPA 7)**	84.3%
Mammograms, ages 50-74, screened in the past 2 years	78.3% (SAP 3) **70.4% (SPA 7)**	77.1%
Colorectal cancer screenings, ages 50-74, screened per guidelines	78.0% (SPA 3) 80.8% (SPA 7)	74.4%

Attachment 2: Community Stakeholder Interviewees

Community input was obtained from interviews with community stakeholders from community agencies and organizations that represent medically underserved, low-income, and/or minority populations.

Name	Title	Organization
Maria Cerdas	Center Director	Potero Community Center
Adriana G. Dugan	Member Services Specialist	Montebello Chamber of Commerce
Rosemary Gurrola	Manager	LA County Library - Montebello Library
Captain Jodi Hutak	Station Captain	Sheriff's Department, Pico Rivera
Lindsey Lastra	Senior Public Health Analyst, Service Planning Areas 7/8	LA County Department of Public Health
May Lin	Resident Service Coordinator	Beverly Towers
Lizett Olmos	Director	Pico Rivera Senior Center
Rocio Parra, LCSW, PPSC	Director of Birth to Five Programs	The Whole Child
Paul S. Parzik	Executive Director	YMCA of Metropolitans Los Angeles, Montebello-Commerce YMCA
Lauren Talbott	Community Library Manager	LA County Library - Pico Rivera Library & Rivera Library

Attachment 3: Community Stakeholder Interview Responses

Community interview participants were asked to name some of the major health issues affecting individuals in the community. Responses included:

- Getting health care evaluations and treatment for arrestees. People who come into custody and have injuries, as a result of an incident prior to arrival or injury with a later altercation, that needs to be treated at a local hospital before they are booked into jail.
- Housing and transportation.
- COVID-19.
- Mental health issues with homeless people in the area.
- Low birth weight, obesity, and homelessness is huge. Access to childcare and income equality.
- We are seeing a lot more unhoused persons coming to the library or those who are on the cusp of homelessness who are looking for assistance.
- Education is a big worry with parents, a lot of them are concerned their kids lost a year of learning because they did not thrive with distance learning.
- We are also worried about businesses that have closed and a lack of access to healthy foods. We are worried about Pico being a food desert. We are seeing some businesses leave the community and we have a lot of vacant store fronts in the city.
- A lot of gaps arise with Latinx, black/African Americans in LA County. Specifically, there are disparities with access to health care.
- The big issues are mental health and wellbeing. Families have been cloistered for much of the last two years. Under lockdowns, kids have lost ground on their academic programs. Online learning is better than nothing, but it is not good for some kids. The older kids can adapt, but the younger ones, first grade or kindergarten, that is the foundation setting time and that time is lost time.

Next, interview participants were asked what factors or conditions contribute to these health issues. Their responses included:

- Homelessness and the fact that older adults are no longer able or capable to drive because of health issues.
- COVID, and mental health and substance use.
- Aging and poor knowledge of nutrition and medication side effects, and lack of family social support. Some don’t have children, so it’s been difficult. With COVID, some people were used to going to the senior center for bingo and other social activities, and now everything has been on hold.
- Lack of resources like housing, even families who are working full-time jobs are having a hard time finding housing. We see families struggle with basic needs. For

families with young children, formula and diapers are expensive, even if you have WIC or SNAP, it is still hard to make ends meet.
- The economy, the cost of living, prices are going up but pay is not going up and people are struggling to stay employed during the pandemic.
- Environmental factors contribute if they live in communities with fewer resources. Families struggle with transportation or they have limited ability with their job hours/location to access care.
- Culturally, environmentally, socioeconomically, the have nots have suffered the greatest challenges. They have less access to health care and mental health.

Who or what groups in the community are most affected by these issues? Responses included:
- Seniors. We assist veterans, Latinos, whites.
- Older residents
- Young families, and people of color, and persons living in poverty.
- Racism. With black communities, health outcomes are often worse. We need to address systems that lead to this problem. We have inequalities in our systems.
- Small businesses that would like to provide medical insurance to their employees.

What health inequities have you observed and what solutions do you believe are needed to address those inequities? Responses included:
- Access to medical care.
- Language barriers for some people. It is not just Spanish spoken here. We have Korean, Chinese, Armenian and Vietnamese.
- Some people are still uncomfortable being in a group setting. The majority of our residents are monolingual Mandarin, Cantonese, Spanish, Korean, and Armenian.
- People need activities that are accessible and free to them.
- I've noticed families aren't able to go visit their pediatrician as quickly as they would like. There are a limited number of pediatricians in the community.
- We need more subsidized housing and more resources for those who are mentally unwell. A lot of people lack funds. We see a lot of people who are evicted from their low-income housing due to drug and alcohol use and they don't want to go into treatment.
- With the Latinx community especially, they fear getting services due to misinformation and their legal status. There are mental health concerns too for Latinx communities.

How has the COVID-19 pandemic influenced or changed the unmet needs in your community? Responses included:

- It has been significant. All of our facilities were closed and we noticed that our senior population was isolated. A lot that people were depressed.
- Many people have relocated, passed away, or are not ready to return to socializing.
- People who have jobs that don't allow them to work from home are getting exposed to COVID more than others.
- For seniors, there is fear and anxiety about contracting the virus. Transportation options are limited, especially if they have mobility issues. And the high prices and inflation is impacting everyone.
- People are weaker, their balance is off, they are frailer. Their weight is up. And children are lacking activity as well. Kids have felt the isolation just as much as the seniors.
- Pre-pandemic, homelessness was not as visible. People lost their jobs, businesses closed, and this has increased homelessness.
- There is a lack of childcare. People can't work if they can't get affordable childcare. There were little cracks in society and the pandemic broke open those cracks. And it isn't going to go back to the way it was.
- It has shone a bright light on disparities between the haves and the have nots. It is not a bad thing in and of itself. It is good we have front line workers wanting livable wages, and that there was so much aid offered, because it was urgently needed.
- There are a lot of positives that came out of the pandemic and we have learned a lot. We can adapt and we can rely on each other and support each other as well.

Attachment 4: Resources to Address Community Needs

Community stakeholders identified resources potentially available to address the identified community needs. This is not a comprehensive list of all available resources. For additional resources refer to 211 LA at www.211la.org

Need	Community Resources
Access to care	211, Alma Family Services, AltaMed, CareMore, Centro Maravilla Service Center, China Town Service Center, LA County Department of Public Health, Mexican American Opportunity Fund, Rotary Club, Senior Citizen Center of Montebello
Birth Indicators	AltaMed, CalFresh, CareMore, First 5, LA County Department of Public Health, Mexican American Opportunity Fund, The Whole Child, WIC
Chronic diseases	AltaMed, Alzheimer's Association, American Cancer Society, American Diabetes Association, American Lung Association, CareMore, China Town Service Center, LA Breathmobile Program, YMCA
COVID-19	AltaMed, Catholic Charities, China Town Service Center, LA County Department of Public Health, Senior Citizen Center of Montebello
Economic insecurity	California Lifeline, CalFresh, Catholic Charities, Centro Maravilla Service Center, County of LA Board of Supervisors, District Office of Transition Services Los Angeles Unified, Hearts of Compassion, LA Food Bank, Mexican American Opportunity Fund, Partners in Care Foundation, Potero Community Center, Salvation Army, Southeast Area Social Services Funding Authority, Whittier First Day Coalition, WIC, Whole Child, YMCA
Education	First 5, School districts and area schools
Housing/homelessness	PATH: People Assisting the Homeless, Whittier First Day Coalition
Mental health	Alma Family Services, AltaMed, Enki Health Services, Los Angeles Christian Health Centers, Salvation Army Hope Harbor Adult Rehab Center
Overweight/obesity	Montebello Senior Center, Pico Rivera Senior Center, Potero Community Center, YMCA
Preventive practices	AltaMed, CareMore, China Town Service Center, Department of Children and Family Services, LA County Department of Public Health, Senior Citizen Center of Montebello, Whole Child, YMCA
Substance use	Alma Family Services, Dare U to Care, First to Serve Inc., L.A. CADA, Salvation Army Hope Harbor Adult Rehab Center
Violence/community safety	Adult Protective Services, Office of Violence Prevention LA County, Sectors Acting for Equity, Urban Peace Institute

Attachment 5: Report of Progress

Beverly Hospital developed and approved an Implementation Strategy to address significant health needs identified in the 2019 CHNA. The hospital addressed:

- Access to health care
- Chronic diseases (including healthy eating and active living)
- Mental health
- Preventive care

To accomplish the Implementation Strategy, goals were established that indicated the expected changes in the health needs as a result of community programs and education. Strategies to address the priority health needs were identified and measures tracked. The following section outlines the health needs addressed since the completion of the 2019 CHNA.

Access to Health Care (including Preventive Care)

Insurance enrollment

In partnership with South Bay Health and Insurance Services (SBHIS) and the Los Angeles County Department of Public Health, Beverly Hospital provided enrollment assistance to patients for no cost or low-cost health insurance coverage programs. The hospital assisted 236 people with enrollment and information for Medi-Cal.

Transportation support

Beverly Hospital offered transportation to support access to care. Individuals from various hospital clinics and partnering AltaMed Clinics were eligible for transportation within a 15- mile radius of the hospital. The hospital transportation van provided 3,910 rides. The Hospital covered the cost of UberHealth rides as another travel option for individuals. 6,166 Uber rides were provided.

Cancer screenings

Beverly Hospital offered breast health screenings at low and no-cost through the Every Woman Counts program. The hospital offered diagnostic and screening mammograms, breast ultrasounds and breast biopsies. 209 screenings were provided.

Preventive screenings

The hospital presented free blood pressure and glucose screenings and health education at local community sites. Some sites included: Montebello Senior Center, Pico Rivera Senior Center, Montebello Senior Villas, and Potrero Heights Community Center. In the first quarter of 2020, 123 blood pressure and 70 glucose screenings were provided.

Community health fairs

The hospital participated in community health fairs or events as a way to connect with the community and provide health education, screenings, and or information about services. Beverly Hospital participated in the YMCA Senior Health Fair, The Shops at Montebello Think Pink Breast Cancer Walk and Go Red for Women health event, and the Montebello Senior Center Senior Health Fair.

Breastfeeding support services

Beverly Hospital is designated as a Baby-Friendly hospital. The Baby Friendly Hospital Initiative (BFHI) is a global program sponsored by the World Health Organization to encourage hospitals to promote breastfeeding as a best practice for newborn nutrition. The hospital has an ongoing training program that includes lactation consultants, nurse training, and education. Beverly hosted 9 breastfeeding education classes, which reached 19 breastfeeding moms.

Vaccines and Testing

To help increase accessibility to mobile testing sites, Beverly Hospital collaborated with Los Angeles County Supervisor Hilda L. Solis to launch an on-site COVID-19 drive through testing clinic. Over the course of 5 weeks, the clinic provided a total of 1,984 COVID-19 tests. Beverly Hospital also collaborated with the state of California to launch an on-site COVID-19 vaccine clinic. Over the course of 6 months, the clinic provided over 13,780 COVID-19 vaccines to community members. In 2020, Beverly Hospital hosted flu vaccine clinics for members of the community, ages 6 months and older.

Chronic Diseases (including Healthy Eating and Active Living)

Diabetes education programs

Accredited by the American Association of Diabetes Educators, Beverly Hospital provided education on prevention, management, and treatment of diabetes to the community. Through the Sweet Success Program, the center offered counseling to mothers who have developed gestational diabetes during their pregnancies. Diabetes Counseling was offered in English and Spanish. Additionally, monthly lectures called Diabetes Wellness Hour, which taught participants how to live a healthy lifestyle while with diabetes, were conducted.

Education and exercise classes for seniors

The 50+ Connection Program offered diverse lectures, exercise classes, and social activities to increase healthy habits and reduce isolation among seniors. Services were offered in partnership with various organizations and covered a wide range of topics, including: fall prevention, social security fundamentals, and amputation prevention. 950 seniors participated in the program.

Community CPR and first aid

CPR and First Aid classes were offered at the Hospital and health fairs, or in partnership with local organizations such as schools and community groups. In response to COVID-19, the CPR instructor changed to hosting classes with limited capacity and COVID-19 safety procedures in place. 303 people received CPR and/or first aid training.

Wound care education

The Center for Advanced Wound Healing and Hyperbaric Medicine is dedicated to preventing lower limb loss and optimizing outcomes for patients with chronic, non-healing wounds resulting from illnesses such as diabetes, pressure ulcers, and peripheral vascular disease. Education on prevention and treatment of wounds was provided.

Mental Health

Support groups

Beverly Hospital offers support groups for bereavement and for caregivers who look after someone with Alzheimer's disease or dementia. The bereavement support group is in collaboration with VITAS Healthcare. A total of 194 caregivers were served by these support groups.

Mental health services

In partnership with BHC Alhambra Hospital, Beverly Hospital covered care for patients requiring additional mental health services. Beverly covered the cost of necessary services for 110 patients.

Tele-psychiatric services

Beverly Hospital offered a Tele-Psychiatry Program for persons requiring a psychiatric consult. It allowed for timely access to care and decreased length of stay for many patients. The service was utilized 1,236 times.

NAMI Family-to-Family education

As defined by the National Alliance on Mental Illness (NAMI), NAMI Family-to-Family is a 12-session educational program for family, significant others, and friends of individuals living with mental illness. The program is designed to improve the coping and problem-solving abilities of the people closest to an individual living with a mental health condition. Beverly Hospital hosted 1 session with an overall 6 participants prior to having to postpone for the rest of the year.

11 Cal. Code Reg. Section 999.5(d)(5)(B)

A description of all charity care provided in the last five years by each health facility or facility that provides similar healthcare that is the subject of the agreement or transaction. This description shall include annual total charity care spending; inpatient, outpatient and emergency room charity care spending; a description of how the amount of charity care spending was calculated; annual charity care inpatient discharges, outpatient visits, and emergency visits; a description of the types of charity care services provided annually; and a description of the policies, procedures, and eligibility requirements for the provision of charity care

Beverly is dedicated to making healthcare services accessible to its patients and to working with those in its community who are unable to afford charges associated with the cost of their medical care. To this end, Beverly provides financial assistance for qualifying patients who receive emergency or other medically necessary care at the Beverly.

Beverly's financial assistance program helps low-income, uninsured, or underinsured patients who need help paying for all or part of their medical care. Patients are eligible for financial assistance when their family income is at or below 450% of the federal poverty guidelines, as follows: (1) patients whose income is at or below 350% of the federal poverty level receive a 100% discount; and (2) patients those whose income is between 351% and 450% of the federal poverty level pay (a) if the services are not covered, the gross amount the Medicare program would have paid if the patient was a Medicare beneficiary; or (b) if the services are covered by a third party payor, the difference between the amount paid by the third party payor and the gross amount the Medicare program would have paid if the patient was a Medicare beneficiary. In no event are patients who are eligible for financial assistance charged more than amounts generally billed for comparable care to patients with insurance.

For additional information regarding Beverly's financial assistance program, please see Beverly's financial assistance policy and financial assistance application, attached to this Section as **Exhibit 14**.

In addition, please find below the information regarding the amounts of charity care provided at Beverly in the last 5 years, which identify the costs of charity care attributed to qualifying patients at Beverly. Attached to this Section as **Exhibit 15** and **Exhibit 16** are the Community Benefit Reports for 2020 and 2021, respectively.

- Charity Care provided in 2017: $293,349
- Charity Care provided in 2018: $946,363
- Charity Care provided in 2019: $1,150,068
- Charity Care provided in 2020: $1,038,196
- Charity Care provided in 2021: $1,084,991

Attached to this Section as **Exhibit 17** are calculations illustrating the amount of charity care provided at Beverly in the last 5 years.

EXHIBIT 14

BEVERLY COMMUNITY FINANCIAL ASSISTANCE POLICY AND FINANCIAL ASSISTANCE APPLICATION

BEVERLY HOSPITAL

ADMINISTRATIVE

Effective Date: 9/24/02
Review Dates: 1/06
Revised Dates: 12/06, 2/07

Approved By:

Gary V. Kiff
President & CEO

ADMINISTRATIVE POLICY/PROCEDURE: No. 01.700.08
SUBJECT: Financial Assistance
REFERENCE: Charity Care: Policy & Procedures Accounting and Reporting Improvement Project by Clark, Koortbojian & Associates, Folsom, California **AB 774, Chan. Hospitals: Fair Pricing Policies**

I. PURPOSE:

Beverly Hospital is a non-profit organization, which provides hospital services to the community of Montebello in Southern California. Beverly Hospital is committed to meeting the health care needs of all patients in the community, including those who may be uninsured or underinsured. As part of fulfilling this commitment, Beverly Hospital provides medically necessary services, without cost or at a reduced cost, to patients who qualify in accordance with the requirements of this Financial Assistance Policy.

The Financial Assistance Policy establishes the guidelines, policies and procedures for use by hospital personnel in evaluating and determining patient qualification for financial assistance. This policy also specifies the appropriate methods for the accounting and reporting financial assistance provided to patients at Beverly Hospital.

II. SCOPE:

The Financial Assistance Policy will apply to all patients who receive services at Beverly Hospital. This policy provides guidance for all hospital decisions to provide financial assistance, full or partial aid, to individual patients. All requests for financial assistance from patients, patient families, patient financial guarantors, physicians, hospital staff, or others shall be addressed in accordance with this policy.

III. POLICY:

A. Financial Assistance Defined

1. Financial assistance, often referred to as Charity Care, is defined as any necessary[1] inpatient or outpatient hospital service provided at Beverly Hospital to a patient who is unable to pay for care. Patients unable to pay for their care must establish eligibility in accordance with requirements contained in the Beverly Hospital Financial Assistance Policy.

2. Depending upon individual patient eligibility, financial assistance may be granted on a full or partial aid basis. Financial assistance may be denied when the patient or other responsible guarantor does not meet the Beverly Hospital Financial Assistance Policy requirements.

B. Financial Assistance Reporting

1. Beverly Hospital will report the amounts of financial assistance, full or partial, provided to patients as required for charity care. Charity care reporting will be in accordance with the regulatory requirements issued by the Office of Statewide Health Planning and Development (OSHPD) as contained in the *Accounting and Reporting Manual for Hospitals*, Second Edition and any other subsequent clarification or advisement issued by OSHPD. To comply with these regulations, the hospital will maintain this policy as written documentation regarding its charity care criteria, and for individual patients, each hospital will maintain written documentation regarding all financial assistance determinations. As required by OSHPD, charity care provide to patients will be recorded on the basis of actual charges for services rendered.
2. Charity care will be reported as an element of the hospital's annual Community Benefit Report submitted to OSHPD and any other appropriate state agencies.

C. General Process and Responsibilities

1. Access to emergency medical care shall in no way be affected by whether financial assistance eligibility under this policy exists; emergency medical care will always be provided to the extent the facility can reasonably do so.

[1] Necessary services are defined as any hospital inpatient or outpatient service, or emergency care that is not entirely elective for patient comfort and/or convenience.

2. The Beverly Hospital Financial Assistance Policy relies upon the cooperation of individual applicants for accurate and timely submission of financial application information. To facilitate receipt of such information, Beverly Hospital will use a financial assistance application to collect information from patients who:

   a. Are unable to demonstrate financial coverage by a third party insurer and request financial assistance.

   b. Insured patients who indicate that they are unable to pay patient liabilities; and

   c. Any other patient who requests financial assistance.

3. The financial assistance application should be completed as soon as there is an indication the patient may be in need of financial assistance. The form may be completed prior to service, during a patient stay, or after services are completed and the patient has been discharged. Accordingly, eligibility for the Beverly Hospital Financial Assistance Program may be determined at any time the hospital has sufficient information to determine qualification.

4. Completion of a financial assistance application provides:

   a. Information necessary for the hospital to determine if the patient has income and/or assets sufficient to pay for services.

   b. Authorization for the hospital to obtain a credit report for the patient or responsible party;

   c. Documentation useful in determining eligibility for financial assistance; and

   d. An audit trail documenting the hospital's commitment to providing financial assistance.

D. Eligibility

1. Eligibility for financial assistance shall be determined solely by the patient's and/or patient guarantor's ability to pay. Eligibility for financial assistance shall not be based in any way on age, gender, sexual orientation, ethnicity, national origin, veteran status, disability or religion.

2. The patient/guarantor bears the burden of establishing eligibility for qualification under any financial assistance program. Patients/guarantors are required to provide timely, honest and complete disclosure in order to obtain financial assistance. The hospital will provide guidance and/or direct assistance to patients or their guarantors as necessary to facilitate completion of government low-income program applications when the patient may be eligible. Assistance will also be provided for completion on an application for the Beverly Hospital Financial Assistance Program.

3. Completion of the financial assistance application and submission of any or all required supplemental information might be required for establishing eligibility with the Financial Assistance Program.

4. Financial Assistance Program qualification is determined after the patient and/or patient guarantor establishes eligibility according to criteria contained in this policy. While financial assistance shall not be provided on a discriminatory or arbitrary basis, the hospital retains full discretion to establish eligibility criteria and determine when a patient has provided sufficient evidence of qualification for financial assistance.

5. Once determined, Financial Assistance Program eligibility will remain in effect for a period of six (6) months and then may be renewed by the hospital upon submission of required information by the patient. Patient financial services will develop methods for accurate tracking and verification of financial assistance program eligibility.

6. Any eligible patient account balance created by a visit that resulted in the request for Financial Assistance Program coverage and those occurring for a period of six (6) months following eligibility determination will be considered for write-off as charity care. Other pre-existing patient account balances outstanding at the time of eligibility determination by the hospital may be included as eligible for write-off at the sole discretion of hospital management.

7. Patient obligations for Medi-Cal Share of Cost (SOC) payments will not be waived under any circumstance. However, after collection of the patient share of cost portion, any other unpaid balance relating to a Medi-Cal SOC patient may be considered for charity care.

8. Factors considered when determining whether an individual is qualified for financial assistance pursuant to this policy may include, but shall not be limited to the following:

   a. No insurance coverage under any government or other third party program

   b. Household [2] income

   c. Household net worth including all assets, both liquid and non-liquid

   d. Employment status

   e. Unusual expenses

   f. Family size as defined by Federal Poverty Level (FPL) Guidelines

   g. Credit history

9. Eligibility criteria are used in making each individual case determination for coverage under the Beverly Hospital Financial Assistance Program. Financial assistance will be granted based upon each individual determination of financial need. To assure appropriate allocation of assistance, financial need may be determined based upon consideration of both income and available patient family assets.

10. Covered services include necessary inpatient and outpatient hospital care providing the services are not covered or reimbursed by MediCal/Medicaid or any other third party payer. All patients not covered by third-party insurance and those insured patients who indicate that they are unable to pay patient obligations such as co-payments and deductibles, may be considered for eligibility under the Financial Assistance Program.

[2] "Household" includes the patient, the patient's spouse, any individual to whom the patient is a dependent and any other individual legally responsible to provide for the patient's health care needs.

IV. INCOME OUALIFICATIONLEVELS

A. Full Charity

1. If the patient's household income is 350% or less of the established poverty income level, based upon current FPL Guidelines, and the patient meets all other Financial Assistance Program qualification requirements, the entire (100%) patient liability portion of the bill for services will be written off as charity care.

B. Partial Charity

1. If the patient's household income is between 351% and 450% of the established poverty income level, based upon current FPL Guidelines, and the patient meets all other Financial Assistance Program qualification requirements, the following will apply:

   a. Patient's care is not covered by a payer.

      1) If the services are not covered by any third party payer so that the patient ordinarily would be responsible for the full billed, charges, the patient's payment obligation will be the gross amount the Medicare program would have paid for the service if the patient was a Medicare beneficiary.

   b. Patient's care is covered by a payer.

      1) If the services are covered by a third party payer so that the patient is responsible for only a portion of the billed charges (i.e., a deductible or co-payment), the patient's payment obligation will be an amount that equals the difference between the amount paid by the third party payer and the gross amount the Medicare program would have paid for the service if the patient was a Medicare beneficiary. In the event the third party payer has already paid an amount greater than the gross amount the Medicare program would have paid for the service, no additional amount shall be due from the patient.

V. ASSET QUALIFICATION

A. Patient owned assets might be evaluated to determine if sufficient patient household resources exist to satisfy the hospital's bill for services rendered. Evaluation of patient assets will consider both the asset value and amounts owed against the asset to determine if potential net worth is available to satisfy the patient payment obligation.

B. Recognizing the need to protect basic household assets, each patient family unit evaluated will be allowed the following asset exemptions:

1. Primary residence
2. One vehicle per patient or two vehicles per family unit
3. Twenty-Five Thousand Dollars ($25,000) in other total assets

C. Patients who have assets beyond those specifically exempted will be expected to leverage the assets through independent financing in order to satisfy the patient account. Accordingly, patients with sufficient assets available are not qualified for the Beverly Hospital Financial Assistance Program. Patients with sufficient assets will be denied eligibility even when they meet basic income qualification requirements.

D. Notwithstanding the above, patients who qualify based on income level, but whose assets are marginally greater than the amounts specifically exempted, will be permitted to "spend-down" through liquidation of assets in order to meet Financial Assistance Pro-gram qualification levels. The specific amount of "spend-down" required will be determined on a case-by-case basis by Beverly Hospital management.

VI. SPECIAL CIRCUMSTANCES:

A. Any evaluation for financial assistance relating to patients covered by the Medicare Program must include a reasonable analysis of all patient assets net worth, income and expenses, prior to eligibility qualification for the Financial Assistance Program. Such financial assistance evaluations must be made prior to service completion by Beverly Hospital.

B. If the patient is determined to be homeless he/she will be deemed eligible for the Financial Assistance Program.

C. If the patient guarantor has recently been declared bankrupt by a federal bankruptcy court he/she will be deemed eligible for the Financial Assistance Program.

D. If the patient is deceased and there is no probate of the estate, or no estate exists, the patient will be deemed eligible for the Financial Assistance Program.

E. Patients seen in the emergency department, for whom the hospital is unable to issue a billing statement, may have the account charges written off as charity care. All such circumstances shall be identified on the patient's Financial Assistance Application as an essential part of the documentation process.

VII. OTHER ELIGIBLE CIRCUMSTANCES:

A. The Beverly Hospital deems those patients that are eligible for any or all government sponsored low-income assistance programs to be indigent. Therefore, such patients are automatically eligible for charity care under the Beverly Hospital Financial Assistance Policy and account balances are classified as charity care if the government program does not make payment for all services provided, or days during a hospital stay.

B. For example, patients who qualify for Medi-Cal, CCS, CHDP, Healthy Families, MSI, CMSP or other similar low-income government programs are included as eligible for the Beverly Hospital Financial Assistance Program.

C. Any or all non-reimbursed patient account balances are eligible for full write-off as charity care. Specifically included as charity care are charges related to denied stays, denied days of care, and non-covered services. All Treatment Authorization Request (TAR) denials and any other failure to pay for covered or non-covered services provided to Medical and/or other government low-income qualified patients are covered.

D. Patients with restricted coverage, and/or other forms of limitation shall have non-covered amounts classified as charity care when payment is not made by the low-income government program.

E. The portion of Medicare patient accounts (a) for which the patient is financially responsible (coinsurance and deductible amounts), (b) which is not covered by insurance or any other payer including Medi-Cal, and (c) which is not reimbursed by Medicare as a bad debt, may be classified as charity care if:

1. The patient is a beneficiary under Medi-Cal or another program serving the health care needs of low-income patients; or

2. The patient otherwise qualifies for financial assistance under this policy and then only to the extent of the write-off provided for under this policy.

F. Any patient who experiences a catastrophic medical event may be deemed eligible for financial assistance. The determination of a catastrophic medical event shall be based upon the amount of the patient liability at billed charges, and consideration of the individual's income and assets as reported at the time of occurrence. Management shall use reasonable discretion in making a determination based upon a catastrophic medical event. As a general guideline, any account with a patient liability for services rendered that exceeds $75,000 may be considered for eligibility as a catastrophic medical event.

G. Any account returned to the hospital from a collection agency that has determined the patient or guarantor does not have the resources to pay his or her bill, may be deemed eligible for charity care. Documentation of the patient or guarantor's inability to pay for services will be maintained in the charity care documentation file.

H. **Public Notice**

1. Beverly Hospital shall post notices informing the public of the Financial Assistance Program. Such notices shall be posted in high volume inpatient, outpatient and emergency service areas of the hospital. Notices shall also be posted in the patient financial services and collection departments. Notices will include contact information on how a patient may obtain more information on financial assistance as well as where to apply for such assistance.

2. These notices shall be posted in English and Spanish and any other languages that are representative of ten percent (10%), or more, of the patients in the hospital's service area.

3. Statements of account sent to patients as part of the routine billing process will contain information about the Beverly Hospital Financial Assistance Program.

I. **Billing and Collection Practices**

1. Patients in the process of qualifying for government or hospital low-income financial assistance programs will not be assigned to collections prior to 150 days from the date of initial billing.

2. Low-income patients, who at the sole discretion of the hospital are reasonably cooperating to settle an outstanding hospital bill, will not be sent to an outside collection agency if doing so would negatively impact the patient's credit.

J. Confidentiality

1. It is recognized that the need for financial assistance is a sensitive and deeply personal issue for recipients. Confidentiality of requests, information and funding will be maintained for all that seek or receive financial assistance. The orientation of staff and selection of personnel who will implement this policy shall be guided by these standards.

K. Good Faith Requirements

1. Beverly Hospital makes arrangements for financial assistance with hospital care for qualified patients in good faith and relies on the fact that information presented by the patient is complete and accurate.

2. Provision of financial assistance does not eliminate the right to bill, either retrospectively or at the time of service, for all services when fraudulent, inaccurate or incomplete information has been given. In addition, Beverly Hospital reserves the right to seek all remedies, including but not limited to civil and criminal damages from those who have provided false, inaccurate or incomplete information in order qualify for the Beverly Hospital Financial Assistance Program.

3. In the event that a patient qualifies for partial financial assistance under the Partial Charity component of this Policy and then fails to make payment in full on their remaining patient liability balance, then the hospital, at its sole and exclusive discretion, may use any or all-appropriate means to collect the outstanding balance.

ATTACHMENTS:

Attachment A Financial Assistance Application Instructions

Approved By: Administrative Team Meeting, 9/13/02, 11/22/06
Clinical Support MFC Committee, 11/17/05, 1/18/07
Medical Executive Committee, 1/10/06, 2/12/07
Board Audit and Finance Committee, 9/17/02, 12/11/06, 2/20/07
Board of Directors, 9/24/02, 1/24/06, 12/12/06, 2/27/07

Acknowledgement Notice of Charity Care and Discount Payment

To better service the community Beverly Hospital will accept a wide variety of payment methods and will offer resources to assist the patients in resolving an outstanding balance. Charity care represents all healthcare services that provided to patients who are financially unable to satisfy their debts resulting from a determination of the patient's liability to pay. Designation as Charity Care will only be considered after all payment sources that could be a source of payment for the patient's bill has been exhausted.

If a patient does not have health insurance coverage, the patient may be eligible for Medicare, Medi-Cal, Healthy Families, California Children's Services, or other Government program funding. The financial assistance application is available upon request.

Patient who are at or below 350% of the Federal Poverty Level and are either uninsured or insured with high medical costs are eligible to apply for Charity Care or Discount payment.

Expected discount payment for eligible patients is limited to the amount received form similar services from Medicare.

Beverly Hospital will not report adverse information to consumer credit reporting agencies or begin civil action against a patient during the first 150 days after the initial billing statement. This requirement only applies to uninsured patients and patients with high medical costs whose eligibility for partial Charity care, charity care, or discount payment is in process of being determined.

In addition, Charity Care and Discount payment does not include the doctor's bills, Pathology and Radiology services, patient would need to submit application for physician services.

Beverly Hospital will not use wage garnishments or liens on primary residents to collect unpaid bills from patients for full or partial charity care.

I acknowledge that I have received the Charity Care and hospital Discount payment notice.

Applicant Signature: _____Date: _____

Employee Signature: _____

BEVERLY HOSPITAL

ATTACHMENT A

Beverly Hospital
Financial Assistance Application
INSTRUCTIONS

1. Please complete all areas on the attached application form. If any area does not apply to you, write N/A in the space provided.
2. Attach an additional page if you need more space to answer any question.
3. You *must* provide proof of income when you submit this application. The following documents are accepted as proof of income:

   If you filed a federal income tax return you must submit a copy:

   a. Federal income tax return (Form *1040)* from the most recent year. You must include all schedules and attachments as submitted to the Internal Revenue Service;
   b. Federal W-2 Form showing wages and earnings;
   c. Two (2) most recent paycheck stubs.

   If you did not file a federal income tax return, OR if financial information has changed since your income tax return was filed, please provide the following:

   a. Two (2) most recent paycheck stubs;
   b. Two (2) most recent check stubs from any Social Security, child support, unemployment, disability, alimony or other payments;
   c. Two (2) consecutive bank statements;
   d. If you are paid only in cash, please provide a written statement explaining your income sources.

   If you have no income, please provide a letter explaining how you support your-self/ family.

4. Your application cannot be processed until all required information is provided.
5. It is important that you complete, sign and submit the financial assistance application along with all required attachments within fourteen (14) days.
6. You *must* sign and date the application. If the patient/guarantor and spouse provide information, both *must* sign the application.
7. If you have questions, please call your account representative.
8. Send your completed application to:

   Beverly Hospital
   Patient Financial Services Department
   309 West Beverly Blvd.
   Montebello, CA 90640-4308

BEVERLY HOSPITAL

Beverly Hospital
Financial Assistance Application

PATIENT/ GUARANTOR NAME		**SPOUSE NAME**	
ADDRESS		**PHONE**	
		HOME	
		WORK	
SOCIAL SECURITY NUMBER			
PATIENT/ GUARANTOR NAME		**SPOUSE NAME**	
FAMILY STATUS **List all dependents that you support**			

Name	Age	Relationship

BEVERLY HOSPITAL

EMPLOYMENT STATUS	
Patient/Guarantor Employer	**Position**
Contact Person	**Telephone**
Spouse Employer	**Position**
Contact Person	**Telephone**

INCOME		
	Patient Guarantor	**Spouse**
1. Gross Wages & Salary (before deductions)		
2. Self-Employment Income		
Other Income:		
3. Interest & Dividends		
4. Real Estate Rental & Leases		
5. Social Security		
6. Alimony		
7. Child Support		
8. Unemployment/Disability		
9. Public Assistance		
10. All Other Sources (Attach List)		
Total Income (Add Lines 1-10 Above)		

BEVERLY HOSPITAL

UNUSUAL EXPENSES	
Please provide information on any unusual expenses such as medical bills.	
Description	**Amount**

ASSETS		
Please provide an accurate estimate of value for each asset you own. Also, indicate how much you owe on any outstanding debt related to each asset listed.		
Asset	**Value**	**Amount Owed**
1. Primary Residence		
2. Other Real Estate (Attach List)		
3. Motor Vehicle (Attach List)		
4. Other Personal Property		
5. Bank Account & Investments		
6. Retirement Plan		
7. Other Assets (Attach List)		
Total Amounts (Add Lines 1 – 7 Above)		

By signing below, I/we declare that all information provided is true and correct to the best of my/our knowledge. I/we authorize Beverly Hospital to verify any information listed in this application. We expressly grant permission to contact my/our employer, banking and lending institutions, and to check my/our client credit history.

Signature of Patient/Guarantor | **Signature of Spouse**

Date | **Date**

BEVERLY HOSPITAL

Financial Assistance Programs

Beverly Hospital offers financial assistance programs to assist patients who may be uninsured. To obtain information and/or a financial assistance program application, please contact (323) 725-4347.

Programas de Asistencia Financiera

Beverly Hospital ofrece programas de asistencia financiera para asistir a pacientes que no tienen seguro medico. Para obtener informacion o una aplicacion de asistencia financiera, por favor llamar a servicios financieros al: (323) 725-4347.

BeverlyHospital

FINANCIAL ASSISTANCE APPLICATION FORM

Provided in Accordance with Cal. Health & Safety Code §127425(e)(5)

Application Date:	Date of Service:	
Patient Name:	Account Number:	
Street Address:		Phone Number:
City, State, ZIP:		Patient Date of Birth:

Please **Call 323-725-4347** *for any questions about filling out this form.*

1) Was the patient a resident of California at the time of service? Yes ◯ No ◯
2) Did the patient have medical insurance at the time of service? Yes ◯ No ◯
3) Was the patient an active Medicaid recipient at the time of service? Yes ◯ No ◯

**If you answered *yes* to questions 2 or 3, please attach a copy of your insurance or Medicaid card to this application.

INCOME:

- **All adult family members' income must be disclosed.** Income includes gross (before taxes) wages, rental income, unemployment compensation, social security benefits, public assistance, dividends and interest, etc.
- "Family" is defined as follows: (i) for persons 18 years of age and older, family means spouse, domestic partner and dependent children under 21 years of age, whether living at home or not; and (ii) for persons under 18 years of age, family means parents, caretakers, relatives, and other children under 21 years of age of the parent or caretaker relative. If the patient is a minor, the "family" is defined as the patient, the patient's natural or adoptive parents and the parent's other children (natural or adoptive) who live in the patient's home.

Family Member's Name	Age	Date of Birth	Relationship to Parent	Source of Income or Employer Name	Income for 3 months prior to date of service	Income for 12 months prior to date of service
			Self			

**Please attach additional family member information if applicable.

- **Proof of income must be supplied at the time of application (e.g., three months of pay stubs, most recent tax return (IRS Form 1040), etc.).**
- If you report $0 income, please provide a written statement of how you (or the patient) are surviving financially, including who provides food, shelter, transportation, etc. and how long you have been without income.

MONTHLY EXPENSES:		**ASSETS** This information may be used if your income is above 200% of Federal Poverty Level guidelines to determine whether you may be eligible for discounted care.	
Monthly rent/mortgage	**$**	**Checking account**	**$**
Utilities	**$**	**Savings account**	**$**
Car payment	**$**	**Business ownership**	**$**
Medical expenses	**$**	**Stocks and bonds**	**$**
Insurance premiums (life, home, car, medical)	**$**	**Real estate (excluding primary residence)**	**$**
Clothing, groceries, household goods	**$**		
Other debt/expenses (e.g., child support, loans, other)	**$**		

My signature below certifies that everything I have stated on this application is correct and subject to review under audit. I understand that if the information I provide is determined to be false, financial assistance may be denied and I may be responsible to pay for services provided.

Applicant's Signature Date

Please return completed application to:

Beverly Hospital
Attn: Patient Financial Services
309 W Beverly Blvd
Montebello, CA 90640

EXHIBIT 15

BEVERLY COMMUNITY BENEFIT REPORT (2020)

BeverlyHospital

Annual Report and Plan for **Community Benefit**

Fiscal Year 2020 (January 1, 2020 - December 31, 2020)

Contents

For submittal to:
Office of Statewide Health Planning & Development · Healthcare Information Division
Accounting and Reporting Systems Section · Sacramento, California

Mission
Beverly Hospital's mission is to provide compassionate and quality health care.

Vision
Our vision is to be a quality driven, patient centered, community-based health system focused on growth, collaboration, and innovation.

Values
- Teamwork
- Integrity
- Innovation
- Respect
- Excellence
- Service

About Beverly Hospital
Located in Montebello, Beverly Hospital is an award-winning, nationally recognized nonprofit hospital that serves Montebello, East Los Angeles, Pico Rivera, and the surrounding communities. The hospital has 202 licensed beds and provides a full range of inpatient and outpatient care. From emergency services and hospitalization to outpatient procedures, Beverly Hospital offers the latest technology for diagnostic and treatment options. A medical staff of over 375 physicians, representing a wide spectrum of specialties, is supported by experienced and dedicated employees and volunteers. As part of our team, they each strive to deliver high-tech, high-touch services, preventive education, and quality patient care.

Beverly Hospital is accredited by Det Norske Veritas (DNV) and is an ISO 9001:2015 compliant organization. We provide services driven by the health needs of the community. Having a strong presence in our community has been critical to our success for over 72 years. Over time we have not only updated the way we deliver basic health care, but by reaching beyond the walls of our hospital and working with other like-minded organizations, we seek to continuously meet the changing needs of our community.

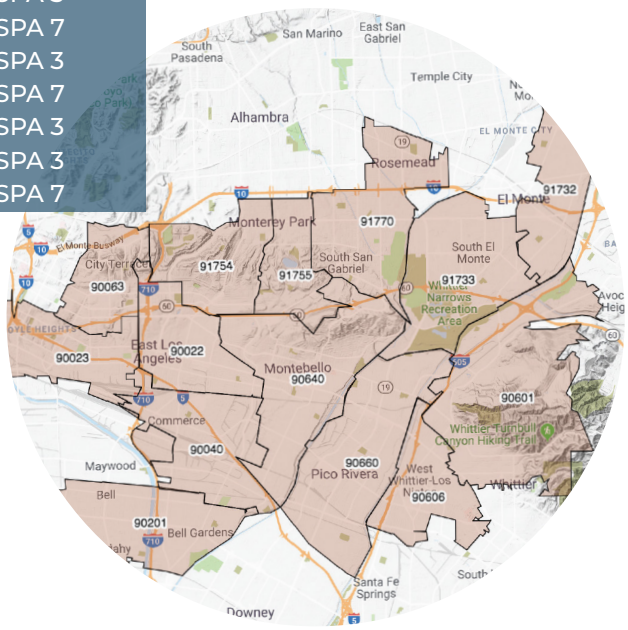
Services Offered

- Cardiac Care
- Emergency Care Center
- Hensel Maternity Center
- Intensive Care
- Medical and Surgical Services
- Pediatrics
- Radiology Diagnostic Services
- Senior Services
- Women's Pavilion and Breast Center
- Wound Care and Hyperbaric Medicine

Service Area

Beverly Hospital is located at 309 West Beverly Boulevard, Montebello, California 90640. Its service area includes 14 ZIP Codes which include 11 cities or neighborhoods. The service area covers portions of Service Planning Areas (SPAs) 3 (San Gabriel), 4 (East LA) and, 7 (South and East LA) in Los Angeles County.

CITY	ZIP CODE	SPA
Bell / Bell Gardens	90201	SPA 7
Commerce	90040	SPA 7
East Los Angeles	90022, 90023, 90063	SPA 7 & 4
El Monte	91732	SPA 3
Montebello	90640	SPA 7
Monterey Park	91754, 91755	SPA 3
Pico Rivera	90660	SPA 7
Rosemead	91770	SPA 3
South El Monte	91733	SPA 3
Whittier	90601, 90606	SPA 7



The estimated population of the service area is **711,482**[1]

24.4% 0-17 Years of Age

63.0% 18-64 Years of Age

12.6% 65+ Years of Age

Education Attainment Ages 25+

38.0%	26.0%	21.8%	21.8%
Without HS Diploma	With HS Diploma or Equivalent	Some College or Associates	Bachelor's or Higher

Languages Spoken at Home Ages 5+

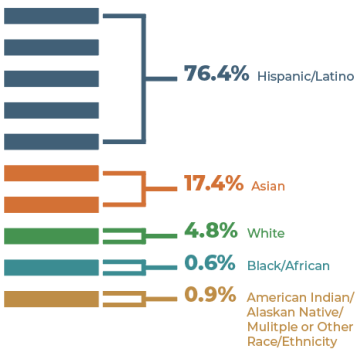
63.5%	20.3%	15.3%	0.9%
Spanish	Only English	Asian or Pacific Islander	Other

Poverty Level

$12,488	$24,858
Federal Poverty Line (FPL) Income for One Person	FPL Income for Family of Four

48.5% of Beverly Service Area are living <200% FPL

Population Ethnicities



[1] All information came from the 2013-2017 American Community Survey 5-Year Estimates. http://factfinder.census.gov

Community Health Needs Assessment

As required by state and federal law, Beverly Hospital completed a Community Health Needs Assessment (CHNA) in 2019. California Senate Bill 697 and the Patient Protection and Affordable Care Act through IRS section 501(r)(3) regulations direct nonprofit hospitals to conduct a Community Health Needs Assessment and develop an Implementation Strategy every three years. The purpose of the Community Health Needs Assessment is to identify and prioritize the significant health needs of the community served by Beverly Hospital. The health needs identified in the CHNA help to guide the hospital's community benefit activities.

Data Collection

Secondary and primary data were collected to complete the CHNA. Secondary data were collected from a variety of local, county and state sources to present community demographics, social determinants of health, health care access, birth characteristics, leading causes of death, acute and chronic disease, health behaviors, mental health, substance use and misuse, and preventive practices. The analysis of secondary data yielded a preliminary list of significant health needs, which then informed primary data collection. The following criteria were used to identify significant health needs:

1. The size of the problem (relative portion of population afflicted by the problem)
2. The seriousness of the problem (impact at individual, family, and community levels)

Primary data were obtained through four focus groups with 48 community members and interviews with 14 key community stakeholders, public health, and service providers, members of medically underserved, low-income, and minority populations in the community, and individuals or organizations serving or representing the interests of such populations. The primary data collection process was designed to validate secondary data findings, identify additional community issues, solicit information on disparities among subpopulations, ascertain community assets potentially available to address needs and discover gaps in resources.

Priority Health Needs

The stakeholder interviewees and focus group participants were asked to rank order the health needs identified in the CHNA according to highest level of importance in the community. Among the community stakeholders, access to health care violence/community safety and mental health were ranked as the top three priority needs in the service area. Beverly Hospital then undertook a process to identify the priority needs the hospital would address. Applying the following criteria, the organization was able to assess its ability to impact the prioritized health needs: organizational capacity, established relationships, ongoing investment, and acknowledged competencies and expertise. Beverly Hospital will address the following health needs through a commitment of community benefit programs and charitable resources.

- Access to health care
- Chronic diseases (including healthy eating and active living)
- Mental health
- Preventive care

The Community Health Needs Assessment can be accessed at: www.beverly.org/about-us/in-the-community/

Community Benefit Review of Progress

In FY2020, Beverly Hospital engaged in activities and programs that addressed the priority health needs identified in the 2020-2022 Implementation Strategy. In 2020, Beverly Hospital chose to address access to care, chronic diseases, mental health, overweight and obesity, and preventive practices. The review of progress provides an overview of activities that addressed these health needs. Details of these activities can be found in the Community Benefit Services Summary at: www.beverly.org

Access to Care and Preventive Practices

- Insurance enrollment
- Resource Center
- Transportation support
- Hospital-based clinics
- Cancer screenings
- Preventive screenings
- Exercise classes for seniors
- Community health fairs
- Breastfeeding support services
- Immunizations

Chronic Diseases

- Diabetes education programs
- Community CPR and first aid
- Wound care education
- Preventive health and community lectures

Mental Health

- Support groups
- NAMI Family-to-Family education
- Mental health services
- Tele-psychiatric services

Overweight and Obesity

- Nutrition education

Community Benefit Services Summary

Community benefit services promote health and healing and are focused on addressing the identified unmet health needs of the community. For a program or service to qualify as a community benefit it must: improve access to health care; enhance the health of the community; advance medical or health care knowledge; or reduce the burden of government or other nonprofit community efforts.

In FY2020 (January 1, 2020 – December 31, 2020), Beverly Hospital provided community benefit activities within its service area. A summary of these activities follows. Due to the COVID-19 global pandemic, in-person community outreach activities were put on hold beginning late March of 2020. Select programs continued through a virtual format via Zoom beginning December 2020.

Community Health Improvement Services:

Activities carried out to improve community health made available to the public which address a community need.

Dr. Jonathan Perley speaking on the advancements in prostate technology.

Community Health Education

50+ Connection Program for Seniors

Beverly Hospital's 50+ Connection Program offered diverse lectures, exercise classes, and social activities to increase healthy habits and reduce isolation among seniors. Services were offered in partnership with various organizations and covered a wide range of topics. In 2020, some topics included: fall prevention, social security fundamentals, and amputation prevention. Approximately 250 seniors participated in this program in 2020.

Breastfeeding

Beverly Hospital is designated as a Baby-Friendly hospital. The Baby Friendly Hospital Initiative (BFHI) is a global program sponsored by the World Health Organization to encourage hospitals to promote breastfeeding as a best practice for newborn nutrition. The hospital has an ongoing training program that includes lactation consultants, nurse training, and patient education. In addition to providing education and support to every new mom delivering at Beverly's Hensel Maternity center, Beverly hosted 2 breastfeeding education classes which reached 12 breastfeeding moms.

Community Health Fairs

The hospital participated in community health fairs or events as a way to connect with the community and provide health education, screenings, and or information about services. Prior to the nationwide lockdown, Beverly Hospital participated in the Shops At Montebello Go Red for Women health event where over 200 individuals were reached.

Diabetes Education Programs

Accredited by the American Association of Diabetes Educators, Beverly Hospital provided education on prevention, management, and treatment of diabetes to the community. Through the Sweet Success Program, the center offered counseling to mothers who have developed gestational diabetes during their pregnancies. Diabetes Counseling was offered in English and Spanish. Additionally, monthly lectures called Diabetes Wellness Hour, which taught participants how to live a healthy lifestyle while with diabetes, were conducted.

From left to right: Rebecca Ceballos, Diabetes Educator and RN, providing diabetes education, a member of the Rehabilitation department speaking on fall prevention, and Cindy Sanchez, RN, administering a flu vaccine. All events occurred prior to the stay at home mandate.

Maternal and Infant Health Education

A wide range of classes, which support prenatal and infant care, were offered at Beverly Hospital. Classes were offered in English and Spanish. These included: childbirth preparation, infant care, infant CPR, and infant massage. In 2020, these classes had 81 participants.

NAMI Family-to-Family Education

As defined by the National Alliance on Mental Illness (NAMI), NAMI Family-to-Family is a 12-session educational program for family, significant others, and friends of individuals living with mental illness. The program is designed to improve the coping and problem-solving abilities of the people closest to an individual living with a mental health condition. Beverly Hospital hosted 1 session with an overall 6 participants prior to having to postpone for the rest of the year.

Community CPR (Cardiopulmonary Resuscitation) and First Aid

CPR and First Aid classes were usually offered at the Hospital and health fairs, or in partnership with local organizations such as schools and community groups. In response to the COVID-19 situation, Beverly Hospital's CPR instructor changed to hosting classes with limited capacity and COVID-19 safety procedures in place. As a result, 108 people received CPR and/or first aid training.

Support Groups
Beverly Hospital offers support groups for bereavement and for caregivers who look after someone with Alzheimer's disease or Dementia. The bereavement support group is in collaboration with VITAS Healthcare. In 2020, a total of 103 were served by these support groups.

Community Based Clinical Services

Preventive Screenings
The hospital presented free blood pressure and glucose screenings and health education at local community sites. Some sites included: Montebello Senior Center, Pico Rivera Senior Center, Montebello Senior Villas, and Potrero Heights Community Center. In the first quarter of 2020, 123 blood pressure and 70 glucose screenings were provided.

Women's Breast Health Screenings
Beverly Hospital offered breast health screenings at low and no-cost through the Every Woman Counts program. The hospital offered diagnostic and screening mammograms, breast ultrasounds, breast biopsies, and others. In 2020, 136 screenings were provided.

Blood Drives
In partnership with the American Red Cross, Beverly hosts quarterly blood drives. In 2020, the hospital collected 179 pints of blood.

COVID-19 Drive Through Testing
To help increase accessibility to mobile testing sites, Beverly Hospital collaborated with Los Angeles County Supervisor Hilda L. Solis to launch an on-site COVID-19 drive through testing clinic. Over the course of 5 weeks, the clinic provided a total of 1,984 COVID-19 tests.

A Beverly Hospital employee receiving a COVID 19 swab test from a community member at the COVID 19 drive through testing clinic.

Influenza Immunizations
Beverly Hospital hosted flu vaccine clinics for members of the community, ages 6 months and older. In 2020, Beverly administered a total of 14 flu vaccines on-site.

Health Care Support Services

Insurance Enrollment
In partnership with South Bay Health and Insurance Services (SBHIS) and the Los Angeles County Department of Public Health, Beverly Hospital provided enrollment assistance to patients for no cost or low-cost health insurance coverage programs. In 2020, the hospital assisted 92 people with enrollment and information for Medi-Cal.

Mental Health Services
In partnership with BHC Alhambra Hospital, Beverly Hospital covered care for patients

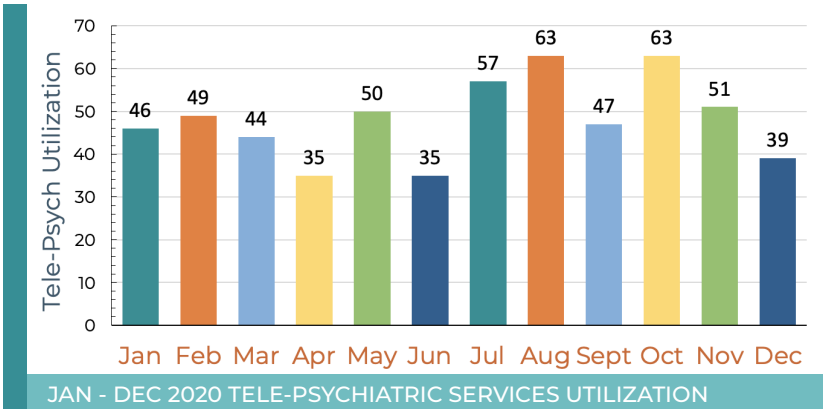
requiring additional mental health services. In 2020, Beverly covered the cost of necessary services for 93 patients.

Transportation

Beverly Hospital offered transportation to support access to care. Individuals from various hospital clinics and partnering AltaMed Clinics were eligible for transportation within a 15-mile radius of the hospital. In 2020, the hospital transportation van provided 2,015 rides. The Hospital covered the cost of UberHealth rides as another travel option for individuals. 3,008 Uber rides were provided by Beverly Hospital.

Tele-Psychiatric Services

Beverly Hospital offered a Tele-Psychiatry Program for persons requiring a psychiatric consult. It allowed for timely access to care and decreased length of stay for many patients. In 2020, the service was utilized 579 times.



JAN - DEC 2020 TELE-PSYCHIATRIC SERVICES UTILIZATION

Education for Health Professionals:

Education programs for physicians, nurses, nursing students, and other health professionals offered by the hospital throughout the fiscal year.

Nursing students had the opportunity to learn while assisting at the COVID 19 drive through testing clinic.

Health Professions Education

Throughout the year, Beverly Hospital provided continuing education opportunities for health professionals to stay up to date on new medical and safety advancements. As a result, they can better address community health and wellness needs. Examples included stroke information updates and employee safety training.

Nursing Education

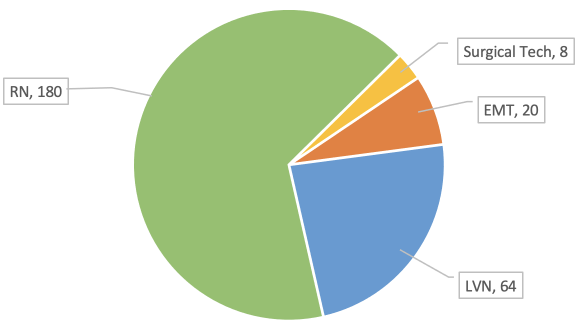
The hospital served as a site for nursing student training. In 2020, hospital staff served as preceptors for 244 nursing students. Students completed a combined 16,368 hours. RN students were from Azusa Pacific University, Glendale Career College, LA City College, Rio Hondo, or West Coast University. The hospital provided education and training to LVN students from Community Enhancement Services College and Premiere College.

Clinical Education

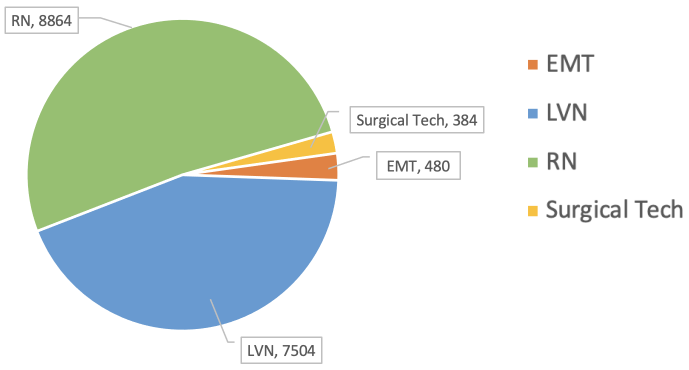
Hospital staff provided 864 hours of 1:1 instruction to 63 students from various health disciplines. Beverly hospital provided preceptors for 8 Surgical/Scrub Technician students from Premier Career College and 20 Emergency Medical Technician (EMT) students from East Los Angeles College.

JAN - DEC 2020 NUMBER OF STUDENTS AND TIME STUDENTS SPENT WITH STAFF

Number of Students



Hours Spent 1:1 With Instructors



Subsidized Health Services:

Clinical programs provided despite a financial loss.

Women's Pavilion staff member helping a patient with a screening.

Subsidized health services included hospital outpatient services and women's and children's services. These services meet identified community needs. A negative margin existed after removing financial assistance, bad debt and Medi-Cal shortfalls.

Cash and In-Kind Contributions:

Funds and in-kind services donated to community organizations or the community for a community benefit purpose.

Beverly Hospital dropping off school supply donations to Fremont Elementary.

Community Partnerships

Beverly Hospital extended support, such as services, in-kind donations, financial contributions, and donated space, to like-minded community organizations with similar community health goals. In addition, the hospital continued to host its task force meetings to address issues with homelessness and mental health. The task force met 2 times in 2020. It included members from Beverly Hospital, Montebello Fire Department, Montebello Police Department, People Assisting the Homeless (PATH), Whittier First Day, LA County MET team, Heart of Compassion Food Bank, Hospital Association of Southern California (HASC) and LA County Supervisor Hilda Solis's office.

Community Building Activities:

Activities that improve the community's health and safety by addressing the root causes of health problems, such as homelessness, poverty, and environmental concerns. Support includes offering the expertise and resources of the hospital.

Economic Development

In 2020, the hospital provided support to the Chambers of Commerce in Montebello, Pico Rivera, Rosemead, and Whittier.

LA Partnership

Beverly Hospital is a member of the Los Angeles County Community Assessment Action Partnership. The LA Partnership evolved from the Community Health Needs Assessment (CHNA) work group and met quarterly to share implementation and collaboration goals for improved county-wide public health outcomes. The group seeks to increase awareness and collaboration among hospitals to improve population health. As part of the partnership, the hospital attended quarterly meetings and participated in the Diabetes Work group.

Workforce Development

Beverly Hospital served as a training site for 20 students interested in a career in health care through the Applied Technology Center Montebello High School Pathways program.

Financial Summary of Community Benefit FY2020

Beverly Hospital community benefit funding for FY2020 (January 2020 – December 2020) is summarized in the table below. The hospital's community benefit costs are in compliance with Internal Revenue Service instructions for Form 990 Schedule H. All community benefit expenses are based on actual costs, not charges, in compliance with IRS Form 990 Schedule H instructions using a cost to charge ratio for financial assistance.

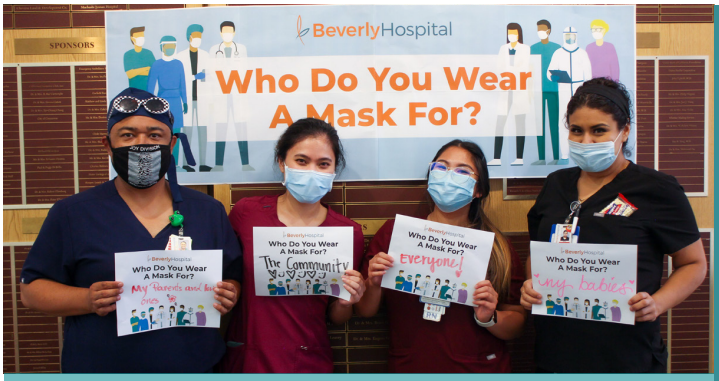
Community Benefit Categories	Net Benefit
Charity Care/Financial Assistance[1]	$1,038,196
Unpaid Costs of Medi-Cal[2]	$0
Health Professions Education	$388,454
Subsidized Health Services[3]	$4,435,427
Other for the Broader Community[4]	$295,024
Total Community Benefit Provided Excluding Unpaid Costs of Medicare	$6,157,102
Unpaid Costs of Medicare[2]	$10,223,238
Total Quantifiable Community Benefit	**$16,380,340**

[1] Charity Care includes financial assistance to eligible patients for care at reduced or no cost based upon the individual patient's financial situation.
[2] Unpaid costs of public programs include the difference between costs to provide a service and the rate at which costs are determined and are based on the overall cost to charge ratio. Includes Quality Assurance Fee and Disproportionate Share.
[3] Includes clinical programs that address an identified community need and where negative margins remain after removing financial assistance, bad debt, and Medi-Cal shortfalls.
[4] Includes non-billed activities for vulnerable populations and the broader community such as community education, screenings, and health support services. Also included are staffing, cash and in-kind donations, and community benefit operations expense.

Community Benefit Plan for FY2020-2022

As a result of the 2019 Community Health Needs Assessment process, priority health needs were identified that the hospital will focus on through its Implementation Strategy.

The Implementation Strategy spans the period 2020-2022. A strategy that outlines actions the hospital intends to take, including programs and resources it plans to commit, anticipated impacts of these actions, and planned collaboration between the hospital and other organizations for each health need the hospital plans to address are included in this implementation plan:



Hospital staff participating in the "Who Do You Wear A Mask For?" campaign to raise awareness on the importance of mask wearing.

1. Access to health care
2. Chronic diseases (including healthy eating and active living)
3. Mental health
4. Preventive care

Access to Health Care

Beverly Hospital will address access to health care by taking the following actions:

- Provide financial assistance through both free and discounted care for health care services, consistent with the hospital's financial assistance policy.
- Provide transportation support to increase access to health care services.
- Offer information and enrollment assistance in the Covered California health care exchange and other low-cost insurance programs and provide information about Medicare benefits updates.
- Pursue Federally Qualified Health Care status for hospital-based clinics to provide primary care services to underserved populations.
- Partner with Beverly Urgent Care facility in Montebello managed by AME.

Community member reviewing swab kit instructions at COVID 19 drive through testing clinic.

Chronic Diseases (including Healthy Eating and Active Living)

Beverly Hospital will address access chronic diseases by taking the following actions:

- Through the Diabetes Center, provide free diabetes education, host diabetes awareness events, including blood glucose screening and nutrition classes.
- Offer CPR classes.
- Through the Wound Care Center, provide education foot care screenings.
- Host health and wellness fairs for seniors, including screenings.
- Increase cardiac awareness through health education and screening tests to identify cardiac disease.
- Continue participation as a STEMI receiving center designation with LA County.
- Provide support groups to assist those with chronic diseases and their families.
- Provide public health education in the media and community health awareness events to encourage healthy behaviors and prevent chronic diseases.
- Continue primary stroke center designation with LA County.
- Provide educational tours of supermarkets to promote healthy food choices.
- Support local Farmers Markets.

Mental Health

Beverly Hospital will address mental health by taking the following actions:

- Offer community health education, community lectures, presentations and workshops.
- Support multisector collaborative efforts that support access to mental health services.
- Provide increased access to mental health care through the provision of tele-psych services.
- Increase community awareness of prevention efforts and availability of resources to address mental health concerns.
- Pursue Federally Qualified Health Care status for hospital-based clinics to provide mental health care services to underserved populations.
- Support community collaboration and education on mental health by hosting the Beverly Hospital Task Force on Homelessness and Mental Health.

Preventive Practices

Beverly Hospital will address access preventive practice by taking the following actions:

- Provide free health screenings.
- Provide education and resources focused on healthy living and disease prevention to be offered in English and Spanish.
- Provide education to teens on abstinence, birth control, sexually transmitted diseases and pregnancy prevention
- Offer free childhood immunizations and adult flu shots.
- Provide TB testing.
- Offer breast and cervical cancer screenings at low and no-cost for women through

the Family PACT and Every Woman Counts programs.

- Pursue Federally Qualified Health Care status for hospital-based clinics to provide primary care services to underserved populations.

Needs the Hospital Will Not Address

Taking existing hospital and community resources into consideration, Beverly Hospital will not directly address the remaining health needs identified in the CHNA including: dental care, economic insecurity, substance use and misuse, and violence/community safety. Beverly Hospital has elected to concentrate on those health needs that can most effectively be addressed, given the organization's capabilities. The hospital has insufficient resources to effectively address all the identified needs and, in some cases, the needs are currently addressed by others in the community. Beverly Hospital will continue to look for opportunities to address community needs, where we can make a meaningful contribution.

Beverly Hospital Emergency Department staff showing their appreciation of Montebello's first responders. The drive by parade featured several police and fire department vehicles as they flashed their lights to show support of and boost moral to Beverly's healthcare heroes.

Evaluation of Impact

Beverly Hospital will monitor and evaluate the programs and activities outlined above. The hospital has a system that tracks the implementation of the strategies and documents the anticipated impact. The reporting process includes the collection and documentation of tracking measures, such as the number of people reached/served and collaborative efforts to address health needs. An evaluation of the impact of the hospital's actions to address these significant health needs will be reported in the next scheduled CHNA.

Contact Information

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Administrative Director, Business Development and Marketing
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BeverlyHospital

309 West Beverly Boulevard
Montebello, California 90640
www.beverly.org | 323.726.1222

Credits

Alice Cheng, FACHE, President and Chief Executive Officer
Kenneth L. Cohen, MD, FACP, Community Outreach Medical Director
Steven Brand, Administrative Director, Business Development and Marketing
Alice Baldwin, Community Outreach Coordinator
Maianh Nguyen, Marketing Project Manager
Cindy Sanchez, RN, BSN, Community Outreach Nurse

EXHIBIT 16

BEVERLY COMMUNITY BENEFIT REPORT (2021)

BeverlyHospital

Annual Report and Plan for **Community Benefit**

Fiscal Year 2021 (January 1, 2021 - December 31, 2021)

Contents

Submitted to:
Department of Health Care Assessment and Information (HCAI)
Accounting and Reporting Systems Section
Sacramento, California

Mission

Beverly Hospital's mission is to provide compassionate and quality health care.

Vision

Our vision is to be a quality driven, patient centered, community-based health system focused on growth, collaboration, and innovation.

Values

- Teamwork
- Integrity
- Innovation
- Respect
- Excellence
- Service

About Beverly Hospital

Located in Montebello, Beverly Hospital is an award-winning, nationally recognized nonprofit hospital that serves Montebello, East Los Angeles, Pico Rivera, and the surrounding communities. The hospital has 202 licensed beds and provides a full range of inpatient and outpatient care. From emergency services and hospitalization to outpatient procedures, Beverly Hospital offers the latest technology for diagnostic and treatment options. A medical staff of over 375 physicians, representing a wide spectrum of specialties, is supported by experienced and dedicated employees and volunteers. As part of our team, they each strive to deliver high-tech, high-touch services, preventive education, and quality patient care.

Beverly Hospital is accredited by Det Norske Veritas (DNV) and is an ISO 9001:2015 compliant organization. We provide services driven by the health needs of the community. Having a strong presence in our community has been critical to our success for over 73 years. Over time we have not only updated the way we deliver basic health care, but by reaching beyond the walls of our hospital and working with other like-minded organizations, we seek to continuously meet the changing needs of our community.

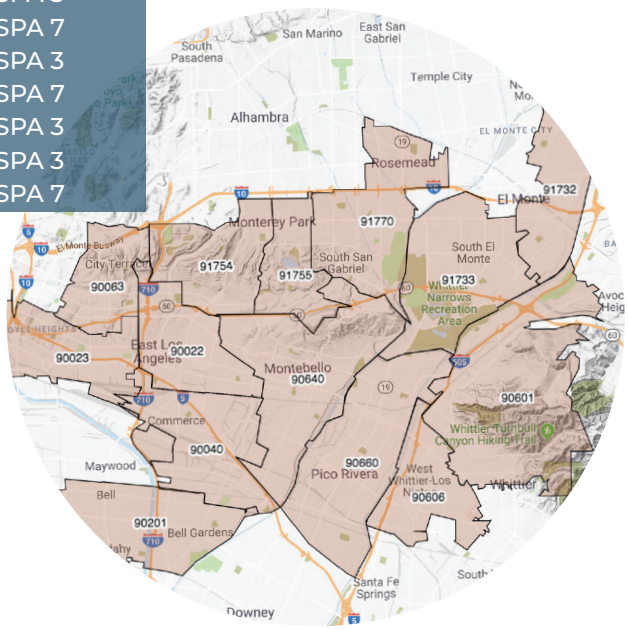
Services Offered

- Cardiac Care
- Emergency Care Center
- Hensel Maternity Center
- Intensive Care
- Medical and Surgical Services
- Pediatrics
- Radiology Diagnostic Services
- Senior Services
- Women's Pavilion and Breast Center
- Wound Care and Hyperbaric Medicine

Service Area

Beverly Hospital is located at 309 West Beverly Boulevard, Montebello, California 90640. Its service area includes 14 ZIP Codes which include 11 cities or neighborhoods. The service area covers portions of Service Planning Areas (SPAs) 3 (San Gabriel), 4 (East LA) and, 7 (South and East LA) in Los Angeles County.

CITY	ZIP CODE	SPA
Bell / Bell Gardens	90201	SPA 7
Commerce	90040	SPA 7
East Los Angeles	90022, 90023, 90063	SPA 7 & 4
El Monte	91732	SPA 3
Montebello	90640	SPA 7
Monterey Park	91754, 91755	SPA 3
Pico Rivera	90660	SPA 7
Rosemead	91770	SPA 3
South El Monte	91733	SPA 3
Whittier	90601, 90606	SPA 7



The estimated population of the service area is **711,482**[1]

24.4% 0-17 Years of Age

63.0% 18-64 Years of Age

12.6% 65+ Years of Age

Education Attainment Ages 25+

38.0%	26.0%	21.8%	21.8%
Without HS Diploma	With HS Diploma or Equivalent	Some College or Associates	Bachelor's or Higher

Languages Spoken at Home Ages 5+

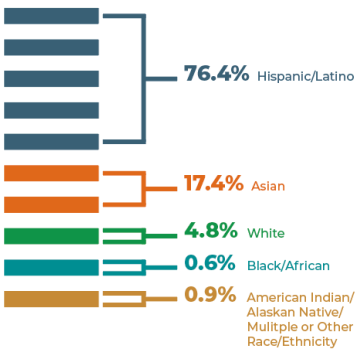
63.5%	20.3%	15.3%	0.9%
Spanish	Only English	Asian or Pacific Islander	Other

Poverty Level

$12,488	$24,858
Federal Poverty Line (FPL) Income for One Person	FPL Income for Family of Four

48.5% of Beverly Service Area are living <200% FPL

Population Ethnicities



[1] All information came from the 2013-2017 American Community Survey 5-Year Estimates. http://factfinder.census.gov

Community Health Needs Assessment

As required by state and federal law, Beverly Hospital completed a Community Health Needs Assessment (CHNA) in 2019. California Senate Bill 697 and the Patient Protection and Affordable Care Act through IRS section 501(r)(3) regulations direct nonprofit hospitals to conduct a Community Health Needs Assessment and develop an Implementation Strategy every three years. The purpose of the Community Health Needs Assessment is to identify and prioritize the significant health needs of the community served by Beverly Hospital. The health needs identified in the CHNA help to guide the hospital's community benefit activities.

Data Collection

Secondary and primary data were collected to complete the CHNA. Secondary data were collected from a variety of local, county and state sources to present community demographics, social determinants of health, health care access, birth characteristics, leading causes of death, acute and chronic disease, health behaviors, mental health, substance use and misuse, and preventive practices. The analysis of secondary data yielded a preliminary list of significant health needs, which then informed primary data collection. The following criteria were used to identify significant health needs:

1. The size of the problem (relative portion of population afflicted by the problem)
2. The seriousness of the problem (impact at individual, family, and community levels)

Primary data were obtained through four focus groups with 48 community members and interviews with 14 key community stakeholders, public health, and service providers, members of medically underserved, low-income, and minority populations in the community, and individuals or organizations serving or representing the interests of such populations. The primary data collection process was designed to validate secondary data findings, identify additional community issues, solicit information on disparities among subpopulations, ascertain community assets potentially available to address needs and discover gaps in resources.

Priority Health Needs

The stakeholder interviewees and focus group participants were asked to rank order the health needs identified in the CHNA according to highest level of importance in the community. Among the community stakeholders, access to health care violence/community safety and mental health were ranked as the top three priority needs in the service area. Beverly Hospital then undertook a process to identify the priority needs the hospital would address. Applying the following criteria, the organization was able to assess its ability to impact the prioritized health needs: organizational capacity, established relationships, ongoing investment, and acknowledged competencies and expertise. Beverly Hospital will address the following health needs through a commitment of community benefit programs and charitable resources.

- Access to health care
- Chronic diseases (including healthy eating and active living)
- Mental health
- Preventive care

The Community Health Needs Assessment can be accessed at: www.beverly.org/about-us/in-the-community/

Community Benefit Review of Progress

In FY2021, Beverly Hospital engaged in activities and programs that addressed the priority health needs identified in the 2020-2022 Implementation Strategy. In 2021, Beverly Hospital chose to address access to care, chronic diseases (including healthy eating and active living), mental health, and preventive practices. The review of progress provides an overview of activities that addressed these health needs. Details of these activities can be found in the Community Benefit Services Summary.

Access to Care and Preventive Practices

- Insurance enrollment
- Transportation support
- Cancer screenings
- Preventive screenings
- Exercise classes for seniors
- Community health fairs
- Breastfeeding support services
- Vaccines

Chronic Diseases (including healthy eating and active living)

- Diabetes education programs
- Nutrition education
- Community CPR and first aid
- Wound care education
- Preventive health and community lectures

Mental Health

- Support groups
- Mental health services
- Tele-psychiatric services

Community Benefit Services Summary

Community benefit services promote health and healing and are focused on addressing the identified unmet health needs of the community. For a program or service to qualify as a community benefit it must: improve access to health care; enhance the health of the community; advance medical or health care knowledge; or reduce the burden of government or other nonprofit community efforts.

In FY2021 (January 1, 2021 – December 31, 2021), Beverly Hospital provided community benefit activities within its service area. A summary of these activities follows. Due to the COVID-19 global pandemic, a majority of in-person community outreach activities were put on hold. Select programs continued through a virtual format via Zoom.

Community Health Improvement Services:

Activities carried out to improve community health made available to the public which address a community need.

Rehabilitation Department speaking on fall prevention.

Community Health Education

50+ Connection Program for Seniors

Beverly Hospital's 50+ Connection Program offered diverse lectures, exercise classes, and social activities to increase healthy habits and reduce isolation among seniors. Services were offered in partnership with various organizations and covered a wide range of topics. In 2021, some topics included: long-term care planning, fall prevention, nutrition management, wound care education, and Alzheimer's education. Approximately 701 seniors participated in this program in 2021.

Breastfeeding

Beverly Hospital is designated as a Baby Friendly hospital. The Baby Friendly Hospital Initiative (BFHI) is a global program sponsored by the World Health Organization to encourage hospitals to promote breastfeeding as a best practice for newborn nutrition. The hospital has an ongoing training program that includes lactation consultants, nurse training, and patient education. In addition to providing education and support to every new mom delivering at Beverly's Hensel Maternity center, Beverly hosted 7 breastfeeding education classes, which reached 13 breastfeeding moms.

Community Health Fairs

The hospital participated in community health fairs or events as a way to connect with the community and provide health education, health screenings (such as blood pressure and foot screenings), and/or information about services. We participated in the YMCA Senior Health Fair, The Shops at Montebello Think Pink Breast Cancer Walk, and Montebello Senior Center Senior Health Fair.

Rebecca Ceballos, RN, Community Outreach Nurse, providing health education to community members.

Community CPR and First Aid

In response to COVID-19, Beverly Hospital hosted CPR classes on and off site with limited capacity and COVID-19 safety procedures in place. As a result, 195 people received CPR and/or first aid training.

Diabetes Education Programs

Accredited by the American Association of Diabetes Educators, Beverly Hospital provided education on prevention, lifestyle and nutrition management, and treatment of diabetes to the community through virtual lectures.

Childbirth educator Marcela Rodriguez providing guidance to expecting mom during a breastfeeding and baby care basics class.

Maternal and Infant Health Education

A wide range of classes, which support prenatal and infant care, were offered at Beverly Hospital. Classes were offered in English and Spanish. These included: childbirth preparation, infant care, infant CPR, and infant massage. In 2021, these classes had 132 participants.

Support Groups

Beverly Hospital offered a support group for caregivers who look after a loved one with Alzheimer's disease or Dementia. In 2021, a total of 91 caregivers were served by this support group.

Community Based Clinical Services

Blood Drives

In partnership with the American Red Cross, Beverly hosted quarterly blood drives. In 2021, the hospital collected 85 pints of blood.

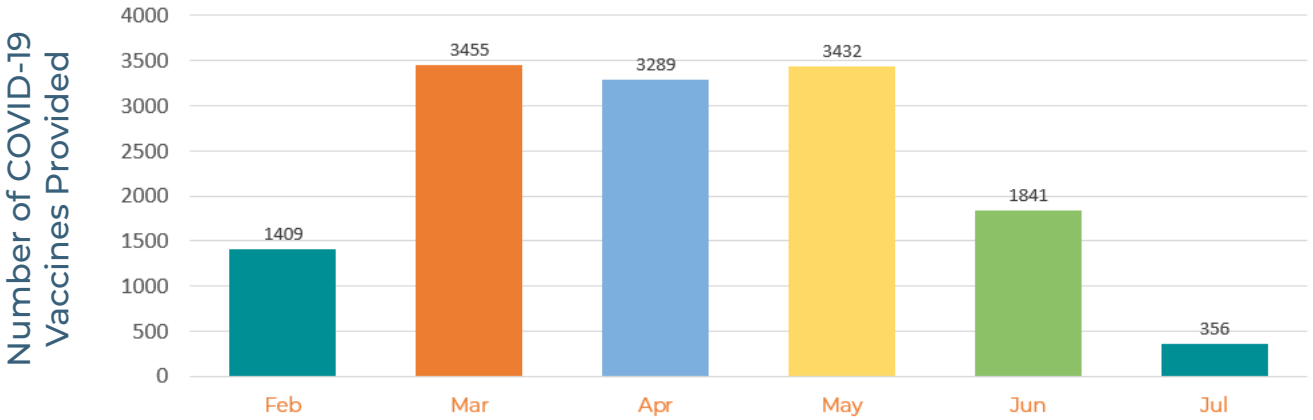
Women's Breast Health Screenings

Beverly Hospital offered breast health screenings at low and no-cost through the Every Woman Counts program. The hospital offered diagnostic and screening mammograms, breast ultrasounds, breast biopsies, and others. In 2021, 73 screenings were provided.

Community COVID-19 Vaccine Clinic

To help increase accessibility to the COVID-19 vaccine, Beverly Hospital collaborated with the state of California to launch an on-site COVID-19 vaccine clinic. Over the course of 6 months, the clinic provided over 13,780 COVID-19 vaccines to community members.

FEB - JUL 2021 NUMBER OF COVID 19 VACCINATIONS PROVIDED TO COMMUNITY



Health Care Support Services

Insurance Enrollment

In partnership with South Bay Health and Insurance Services (SBHIS) and the Los Angeles County Department of Public Health, Beverly Hospital provided enrollment assistance to patients for no cost or low-cost health insurance coverage programs. In 2021, the hospital assisted 144 people with information and enrollment for Medi-Cal.

Mental Health Services

In partnership with BHC Alhambra Hospital, Beverly Hospital covered care for patients requiring additional mental health services. In 2021, Beverly covered the cost of necessary services for 17 patients.

Transportation

Beverly Hospital offered transportation to support access to care. Individuals from various hospital clinics were eligible for transportation within a 15-mile radius of the hospital. In 2021, the hospital transportation van provided 1,895 rides. The hospital also covered the cost of UberHealth rides as another travel option for individuals. 3,158 Uber rides were provided by Beverly Hospital.

Tele-Psychiatric Services

Beverly Hospital offered a Tele-Psychiatry Program for persons requiring a psychiatric consult. It allowed for timely access to care and decreased length of stay for many patients. In 2021, the service was utilized 657 times.

Education for Health Professionals:

Education programs for physicians, nurses, nursing students, and other health professionals offered by the hospital throughout the fiscal year.

Nursing students had the opportunity to learn while assisting at the community COVID 19 vaccine clinic.

Health Professions Education

Throughout the year, Beverly Hospital provided continuing education opportunities for health professionals to stay up-to-date on new medical and safety advancements. Examples included stroke information updates and employee safety training.

Nursing Education

The hospital served as a site for nursing student training. In 2021, hospital staff served as preceptors for 572 nursing students. Students completed a combined 55,962 hours of training. RN students were from California State University, Los Angeles, Concordia University Irvine, Glendale Career College, LA City College, Los Angeles Trade-Tech Community College, Rio Hondo, and West Coast University. The hospital provided education and training to LVN students from Advanced College and Premiere College.

Clinical Education

Hospital staff provided 2,904 hours of 1:1 instruction to 46 students from various health disciplines. Beverly hospital provided preceptors for 11 Surgical Technician students from Premier Career College, 5 Paramedic students from Mt. San Antonio College, and 30 Emergency Medical Technician (EMT) students from East Los Angeles College.

Subsidized Health Services:

Clinical programs provided despite a financial loss.

Subsidized Health Services meet identified community needs. A negative margin existed after removing financial assistance, bad debt and Medi-Cal shortfalls.

Outpatient Services

The Center for Advanced Wound Healing and Hyperbaric Medicine is dedicated to preventing lower limb loss and optimizing outcomes for patients with chronic, non-healing wounds resulting from illnesses such as diabetes, pressure ulcers, and peripheral vascular disease. A multi-disciplinary team of physicians, registered nurses, hyperbaric technologists, and nutritionists work together to provide patients with the most effective treatment options to relieve pain, and promote healing.

Outpatient Surgery is a permanent outpatient service that conducts common surgical procedures that allow patients to return home on the same day.

Women's and Children's Services

The Hensel Maternity center provided obstetrical services to increase access to quality care for pregnant women and their newborn babies.

Cash and In-Kind Contributions:

Funds and in-kind services donated to community organizations or the community for a community benefit purpose.

Beverly Hospital dropping off school supply donations to Fremont Elementary.

Community Partnerships

Beverly Hospital extended support, such as services, in-kind donations, financial contributions, and donated space, to like-minded community organizations with similar community health goals. In addition, the hospital hosted task force meetings to address homelessness and mental health. The task force included members from Beverly Hospital, Montebello Fire Department, Montebello Police Department, People Assisting the Homeless (PATH), Whittier First Day, LA County MET team, Heart of Compassion Food Bank, Hospital Association of Southern California (HASC) and LA County Supervisor Hilda Solis's office.

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Community Building Activities:

Activities that improve the community's health and safety by addressing the root causes of health problems, such as homelessness, poverty, and environmental concerns. Support includes offering the expertise and resources of the hospital.

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In 2021, the hospital provided support to the Chambers of Commerce in Montebello, Pico Rivera, Rosemead, and Whittier.

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Community Benefit Categories	Net Benefit
Charity Care/Financial Assistance[1]	$1,084,991
Unpaid Costs of Medi-Cal[2]	$0
Health Professions Education	$1,452,637
Subsidized Health Services[3]	$4,380,935
Other for the Broader Community[4]	$277,607
Total Community Benefit Provided Excluding Unpaid Costs of Medicare	$7,196,170
Unpaid Costs of Medicare[2]	$9,056,161
Total Quantifiable Community Benefit	**$16,252,331**

[1] Charity Care includes financial assistance to eligible patients for care at reduced or no cost based upon the individual patient's financial situation.
[2] Unpaid costs of public programs include the difference between costs to provide a service and the rate at which costs are determined and are based on the overall cost to charge ratio. Includes Quality Assurance Fee and Disproportionate Share.
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Community Benefit Plan for FY2020-2022

As a result of the 2019 Community Health Needs Assessment process, priority health needs were identified that the hospital will focus on through its Implementation Strategy.

The Implementation Strategy spans the period 2020-2022. A strategy that outlines actions the hospital intends to take, including programs and resources it plans to commit, anticipated impacts of these actions, and planned collaboration between the hospital and other organizations for each health need the hospital plans to address are included in this implementation plan:

Families learning more about Beverly Hospital's services at a maternity tour.

1. Access to health care
2. Chronic diseases (including healthy eating and active living)
3. Mental health
4. Preventive care

Access to Health Care

Beverly Hospital will address access to health care by taking the following actions:

- Provide financial assistance through both free and discounted care for health care services, consistent with the hospital's financial assistance policy.
- Provide transportation support to increase access to health care services.
- Offer information and enrollment assistance in the Covered California health care exchange and other low-cost insurance programs and provide information about Medicare benefits updates.

Community members in line to receive the COVID 19 vaccine at Beverly Hospital's walk-in clinic day.

From left to right: Member of the community after receiving her 2nd COVID 19 vaccine, Alice Baldwin, Community Outreach Coordinator, leading a senior social activity, and Hospital staff participating in National Wear Red Day to raise awareness on heart health.

Chronic Diseases (including Healthy Eating and Active Living)

Beverly Hospital will address access chronic diseases by taking the following actions:

- Provide free diabetes education, host diabetes awareness events, including blood glucose screening and nutrition classes.
- Offer CPR classes.
- Through the Wound Care Center, provide education foot care screenings.
- Host health and wellness fairs for seniors, including screenings.
- Increase cardiac awareness through health education and screening tests to identify cardiac disease.
- Continue participation as a STEMI receiving center designation with LA County.
- Provide support groups to assist those with chronic diseases and their families.
- Provide public health education in the media and community health awareness events to encourage healthy behaviors and prevent chronic diseases.
- Continue primary stroke center designation with LA County.
- Provide educational tours of supermarkets to promote healthy food choices.
- Support local Farmers Markets.

Mental Health

Beverly Hospital will address mental health by taking the following actions:

- Offer community health education, lectures, presentations and workshops.
- Support multisector collaborative efforts that support access to mental health services.
- Provide increased access to mental health care through the provision of tele-psych services.
- Increase community awareness of prevention efforts and availability of resources to address mental health concerns.
- Support community collaboration and education on mental health by hosting the Beverly Hospital Task Force on Homelessness and Mental Health.

Preventive Practices

Beverly Hospital will address access preventive practice by taking the following actions:

- Provide free health screenings.
- Provide education and resources focused on healthy living and disease prevention to be offered in English and Spanish.
- Provide education to teens on abstinence, birth control, sexually transmitted diseases and pregnancy prevention
- Offer free childhood immunizations and adult flu shots.
- Provide TB testing.
- Offer breast and cervical cancer screenings at low and no-cost for women through the Family PACT and Every Woman Counts programs.

Needs the Hospital Will Not Address

Taking existing hospital and community resources into consideration, Beverly Hospital will not directly address the remaining health needs identified in the CHNA including: dental care, economic insecurity, substance use and misuse, and violence/community safety. Beverly Hospital has elected to concentrate on those health needs that can most effectively be addressed, given the organization's capabilities. The hospital has insufficient resources to effectively address all the identified needs and, in some cases, the needs are currently addressed by others in the community. Beverly Hospital will continue to look for opportunities to address community needs, where we can make a meaningful contribution.

Evaluation of Impact

Beverly Hospital will monitor and evaluate the programs and activities outlined above. The hospital has a system that tracks the implementation of the strategies and documents the anticipated impact. The reporting process includes the collection and documentation of tracking measures, such as the number of people reached/served and collaborative efforts to address health needs. An evaluation of the impact of the hospital's actions to address these significant health needs will be reported in the next scheduled CHNA.

Contact Information

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BeverlyHospital

309 West Beverly Boulevard
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Credits

Alice Cheng, FACHE, President and Chief Executive Officer
Kenneth L. Cohen, MD, FACP, Community Outreach Medical Director
Kathleen Curran, Director, Business Development
Alice Baldwin, Coordinator, Community Outreach
Maianh Nguyen, Project Manager, Marketing

EXHIBIT 17

BEVERLY CHARITY CARE CALCULATIONS
(2017-2021)

2017

Information for Community Benefits Plan Report
2017

Medical Care Services

Unpaid Cost of Medi-Cal Program

a)	Hospital's Total Direct & Indirect Cost / Total Patient Charges			192,024,833	total expense per Exhibit 1
				49,738,342	Capitated purchased services
				17,971,563	Hospital fee expense (per non recurring)
			Cost	124,314,928	
			Charge	426,468,680	Per Exhibit 1
			Ratio	0.29	
1)	Above Ratio * Individual Patient Charge				
2)	Above % * Medi-Cal Total Charges = Cost of Services to Patients	0.29	135,569,211	39,518,205	BAR ESS
3)	Less: Net Revenue from M-Cal			26,147,495	BAR ESS
	DSH			4,483,497	Non recurring
	Hospital Fee (net revenue and expense)			25,698,453	Non recurring
4)	Unpaid Cost of M-Cal Program (negative is a profit)			(16,811,240)	
	Unpaid Cost of M-Cal Program excluding DSH/Hospital Fee			13,370,710	

Traditional Charity Care

a)	Hospital's Total Direct & Indirect Cost / Total Patient Charge	124,314,928	426,468,680	0.29
1)	Hospital's total Direct & Indirect Cost / Total Patient Charges		BAR ESS CE	
2)	Above % * Charity Care Total Charges = Cost of Services to Patients	0.29	1,006,347	293,349
3)	Patient Payments - Above Cost of Services to Patients	-	293,349	293,349

Physician Backup Services in ECC

					MCAL HMO CM	MCAL MD	
				Charges	101,415,001	34,154,210	135,569,211
				BAR receipts			
a)	ECC Physicians on call for non-paying customers	01.7010.2000	3,288,418	FY 2017	19,361,307	6,908,833	26,270,140

American Heart cost center 8774

01.8774.0000-			12/31/16 AR	4,707,354	1,569,370	
01.8774.9999		20,854	12/31/17 AR	4,444,162	1,709,917	
			AR Change	(263,192)	140,547	

Foundation expense

	519,313	Estimated 2017 net revenue	19,098,115	7,049,380	26,147,495

Other information

	12/31/2017	**12/31/2016**	**12/31/2015**	
Women's care center total visits	5,800	6,061	5,872	Monthly stats file (Yvette) CC 7181
Family Care center total visits	738	1,431	952	Daily productivity
ECC visits	38,233	37,061	37,502	Financials
charity Care: Number of patients served	17	10	12	CE admits
Unpaid cost of Medi-Cal: Number of patients served	3,817	3,299	3,453	CM MD admits
Woundcare Visits	4,419	3,454	3,439	Financials (Data tab)
HBO Visits	2,109	1,442	1,082	Financials (Data tab)

Information for Community Benefits Plan Report
2017

Medical Care Services

Unpaid Cost of MEDICARE Program

a)	Hospital's Total Direct & Indirect Cost / Total Patient Charges			192,024,833	total expense per Exhibit 1
				49,738,342	Capitated purchased services
				17,971,563	Hospital fee expense (per non recurring)
			Cost	124,314,928	
			Charge	426,468,680	Per Exhibit 1
			Ratio	0.29	
1)	Above Ratio * Individual Patient Charge				
2)	Above % * MediCARE Total Charges = Cost of Services to Patients	0.29	188,739,741	55,017,328	BAR ESS
3)	Less: Net Revenue from Medicare			52,592,186	BAR ESS
	DSH / cost report settlement			694,628	Non recurring
4)	Unpaid Cost of MEDICARE Program (negative is a profit)			1,730,514	
	Unpaid Cost of MEDICARE Program excluding DSH/Hospital Fee			2,425,142	

Charges	MCARE HMO MH	MCARE MC	
	85,390,955	103,348,786	188,739,741
BAR receipts			
FY 2017	20,858,054	30,234,032	51,092,086
12/31/16 AR	5,274,518	2,436,519	
12/31/17 AR	6,199,073	3,012,064	
AR Change	924,555	575,545	
Estimated 2017 net revenue	21,782,609	30,809,577	52,592,186

2018

Information for Community Benefits Plan Report
2018

Medical Care Services

Unpaid Cost of Medi-Cal Program

a)	Hospital's Total Direct & Indirect Cost / Total Patient Charges			199,866,436	total expense per Exhibit 1
				48,508,925	Capitated purchased services
				15,498,411	Hospital fee expense (per non recurring)
			Cost	135,859,100	
			Charge	432,282,313	Per Exhibit 1
			Ratio	0.31	
1)	Above Ratio * Individual Patient Charge				
2)	Above % * Medi-Cal Total Charges = Cost of Services to Patients	0.31	141,427,062	44,448,160	BAR ESS
3)	Less: Net Revenue from M-Cal			26,941,477	BAR ESS
	DSH			8,385,599	Non recurring
	Hospital Fee (net revenue and expense)			26,513,342	Non recurring
4)	Unpaid Cost of M-Cal Program (negative is a profit)			(17,392,258)	
	Unpaid Cost of M-Cal Program excluding DSH/Hospital Fee			17,506,683	

Traditional Charity Care

a)	Hospital's Total Direct & Indirect Cost / Total Patient Charge	135,859,100	432,282,313	0.31	
1)	Hospital's total Direct & Indirect Cost / Total Patient Charges		Charity allowances		
2)	Above % * Charity Care Total Charges = Cost of Services to Patients	0.31	3,011,178	946,363	NOTE: use Charity allowances, not charges; because allowance come from all primary ins g
3)	Patient Payments - Above Cost of Services to Patients	-	946,363	946,363	

Physician Backup Services in ECC

						Charges	MCAL HMO CM	MCAL MD	
							110,794,060	30,633,002	141,427,062
							BAR receipts		
a)	ECC Physicians on call for non-paying customers	01.7010.2000	3,095,986	3,095,986		FY 2018	19,506,537	5,972,234	25,478,771
American Heart cost center 8774		01.8774.0000-				12/31/17 AR	4,444,162	1,709,917	
		01.8774.9999				12/31/18 AR	6,037,127	1,579,658	
						AR Change	1,592,965	(130,259)	
Foundation expense						Estimated 2018 net revenue	21,099,502	5,841,975	26,941,477

Other information

	12/31/2018	**12/31/2017**	**12/31/2016**	
Women's care center total visits	3,270	5,800	6,061	Monthly stats file (Yvette) CC 7181
Family Care center total visits	331	738	1,431	Daily productivity
ECC visits		38,233	37,061	Financials
charity Care: Number of patients served		17	10	CE admits
Unpaid cost of Medi-Cal: Number of patients served		3,817	3,299	CM MD admits

Information for Community Benefits Plan Report
2017

Medical Care Services

Unpaid Cost of MEDICARE Program

a)	Hospital's Total Direct & Indirect Cost / Total Patient Charges			192,024,833	total expense per Exhibit 1
				49,738,342	Capitated purchased services
				17,971,563	Hospital fee expense (per non recurring)
			Cost	124,314,928	
			Charge	426,468,680	Per Exhibit 1
			Ratio	0.29	
1)	Above Ratio * Individual Patient Charge				
2)	Above % * MediCARE Total Charges = Cost of Services to Patients	0.29	188,739,741	55,017,328	BAR ESS
3)	Less: Net Revenue from Medicare			52,592,186	BAR ESS
	DSH / cost report settlement			694,628	Non recurring
4)	Unpaid Cost of MEDICARE Program (negative is a profit)			1,730,514	
	Unpaid Cost of MEDICARE Program excluding DSH/Hospital Fee			2,425,142	

Charges	MCARE HMO MH	MCARE MC	
	85,390,955	103,348,786	188,739,741
BAR receipts			
FY 2017	20,858,054	30,234,032	51,092,086
12/31/16 AR	5,274,518	2,436,519	
12/31/17 AR	6,199,073	3,012,064	
AR Change	924,555	575,545	
Estimated 2017 net revenue	21,782,609	30,809,577	52,592,186

2019

Information for Community Benefits Plan Report
2019

Medical Care Services

Unpaid Cost of Medi-Cal Program

a)	Hospital's Total Direct & Indirect Cost / Total Patient Charges			194,164,866	total expense per Exhibit 1
				40,924,767	Capitated purchased services, Exhibit 1
				15,543,885	Hospital fee expense (per financials file)
			Cost	137,696,214	
			Charge	487,020,412	Per Exhibit 1
			Ratio	0.28	
1)	Above Ratio * Individual Patient Charge				
2)	Above % * Medi-Cal Total Charges = Cost of Services to Patients	0.28	160,649,702	45,420,798	BAR ESS
3)	Less: Net Revenue from M-Cal			27,256,433	BAR ESS
	DSH			8,734,920	Financials file
	Hospital Fee (net revenue and expense)			13,401,431	Financials file
4)	Unpaid Cost of M-Cal Program (negative is a profit)			(3,971,986)	
	Unpaid Cost of M-Cal Program excluding DSH/Hospital Fee			18,164,365	

Traditional Charity Care

a)	Hospital's Total Direct & Indirect Cost / Total Patient Charge	137,696,214	487,020,412	0.28	
1)	Hospital's total Direct & Indirect Cost / Total Patient Charges		Charity allowances (exhibit 1)		
2)	Above % * Charity Care Total Charges = Cost of Services to Patients	0.28	4,067,698	1,150,068	NOTE: use Charity allowances, not charges; because allowance come from all primary ins g
3)	Patient Payments - Above Cost of Services to Patients	-	1,150,068	1,150,068	

Physician Backup Services in ECC

a)	ECC Physicians on call for non-paying customers	01.7010.2000	3,110,211	3,110,211	

American Heart cost center 8774 01.8774.0000-
01.8774.9999

Foundation expense

	MCAL HMO CM	MCAL MD	
Charges	126,373,898	34,275,804	160,649,702
BAR receipts			
FY 2019	20,795,844	6,241,117	27,036,961
12/31/18 AR	6,037,127	1,579,658	
12/31/19 AR	6,445,229	1,391,028	
AR Change	408,102	(188,630)	
Estimated 2019 net revenue	21,203,946	6,052,487	27,256,433

Other information

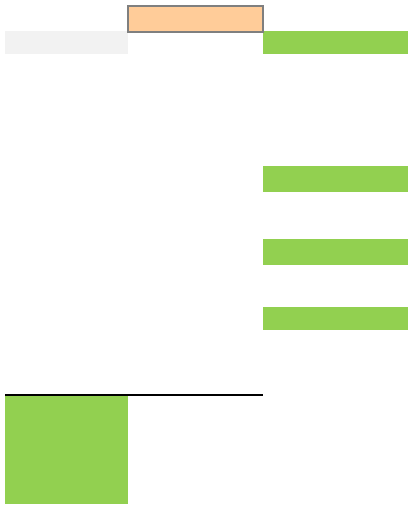
	12/31/2019	**12/31/2018**	**12/31/2017**	
Women's care center total visits	n/a	3,270	5,800	Monthly stats file (Yvette) CC 7181
Family Care center total visits	n/a	331	738	Daily productivity
ECC visits			38,233	Financials
charity Care: Number of patients served			17	CE admits
Unpaid cost of Medi-Cal: Number of patients served			3,817	CM MD admits

Information for Community Benefits Plan Report
2019

Medical Care Services

Unpaid Cost of MEDICARE Program

a)	Hospital's Total Direct & Indirect Cost / Total Patient Charges			194,164,866	total expense per Exhibit 1
				40,924,767	Capitated purchased services
				15,543,885	Hospital fee expense (per non recurring)
			Cost	137,696,214	
			Charge	487,020,412	Per Exhibit 1
			Ratio	0.28	
1)	Above Ratio * Individual Patient Charge				
2)	Above % * MediCARE Total Charges = Cost of Services to Patients	0.28	215,894,571	61,040,286	BAR ESS
3)	Less: Net Revenue from Medicare			54,895,058	BAR ESS
	DSH / cost report settlement			687,173	Non recurring
4)	Unpaid Cost of MEDICARE Program (negative is a profit)			5,458,055	
	Unpaid Cost of MEDICARE Program excluding DSH/Hospital Fee			6,145,228	



	MCARE HMO MH	MCARE MC	
Charges	108,125,969	107,768,602	215,894,571
BAR receipts			
FY 2019	25,767,114	29,025,867	54,792,981
12/31/18 AR	6,250,223	2,420,529	
12/31/19 AR	6,593,889	2,178,940	
AR Change	343,666	(241,589)	
Estimated 2019 net revenue	26,110,780	28,784,278	54,895,058

2020

Information for Community Benefits Plan Report
2020

Medical Care Services

Unpaid Cost of Medi-Cal Program

a)	Hospital's Total Direct & Indirect Cost / Total Patient Charges			183,379,246	total expense per Exhibit 1
				24,402,755	Capitated purchased services, Exhibit 1
				18,349,163	Hospital fee expense (per financials file)
			Cost	140,627,328	
			Charge	457,665,896	Per Exhibit 1
			Ratio	0.31	
1)	Above Ratio * Individual Patient Charge				
2)	Above % * Medi-Cal Total Charges = Cost of Services to Patients	0.31	156,061,182	47,953,031	BAR ESS
3)	Less: Net Revenue from M-Cal			25,677,148	BAR ESS
	DSH			13,711,036	Financials file
	Hospital Fee (net revenue and expense)			11,450,964	Financials file
4)	Unpaid Cost of M-Cal Program (negative is a profit)			(2,886,117)	
	Unpaid Cost of M-Cal Program excluding DSH/Hospital Fee			22,275,883	

Traditional Charity Care

a)	Hospital's Total Direct & Indirect Cost / Total Patient Charge	140,627,328	457,665,896	0.31	
1)	Hospital's total Direct & Indirect Cost / Total Patient Charges		Charity allowances (exhibit 1)		
2)	Above % * Charity Care Total Charges = Cost of Services to Patients	0.31	3,378,765	1,038,196	NOTE: use Charity allowances, not charges; because allowance come from all primary ins g
3)	Patient Payments - Above Cost of Services to Patients	-	1,038,196	1,038,196	

Physician Backup Services in ECC

						MCAL HMO CM	MCAL MD	
					Charges	114,254,216	41,806,966	156,061,182
					BAR receipts			
a)	ECC Physicians on call for non-paying customers	01.7010.2000	3,127,780	3,127,780	FY 2020	19,903,248	6,956,679	26,859,927
American Heart cost center 8774		01.8774.0000-			12/31/19 AR	6,445,229	1,391,028	
		01.8774.9999			12/31/20 AR	4,913,904	1,739,574	
					AR Change	(1,531,325)	348,546	
Foundation expense					Estimated 2020 net revenue	18,371,923	7,305,225	25,677,148

Other information

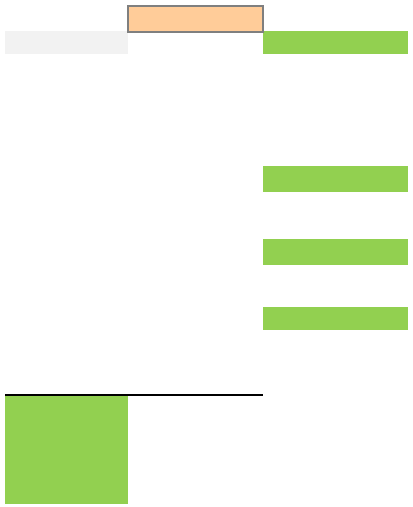
	12/31/2020	12/31/2018	12/31/2017	
Women's care center total visits	n/a	3,270	5,800	Monthly stats file (Yvette) CC 7181
Family Care center total visits	n/a	331	738	Daily productivity
ECC visits			38,233	Financials
charity Care: Number of patients served			17	CE admits
Unpaid cost of Medi-Cal: Number of patients served			3,817	CM MD admits

Information for Community Benefits Plan Report
2020

Medical Care Services

Unpaid Cost of MEDICARE Program

a) Hospital's Total Direct & Indirect Cost / Total Patient Charges			183,379,246	total expense per Exhibit 1
			24,402,755	Capitated purchased services
			18,349,163	Hospital fee expense (per non recurring)
		Cost	140,627,328	
		Charge	457,665,896	Per Exhibit 1
		Ratio	0.31	
1) Above Ratio * Individual Patient Charge				
2) Above % * MediCARE Total Charges = Cost of Services to Patients	0.31	212,498,918	65,294,695	BAR ESS
3) Less: Net Revenue from Medicare			55,267,703	BAR ESS
DSH / cost report settlement			(196,246)	Non recurring
4) Unpaid Cost of MEDICARE Program (negative is a profit)			10,223,238	
Unpaid Cost of MEDICARE Program excluding DSH/Hospital Fee			10,026,992	



	MCARE HMO MH	MCARE MC	
Charges	114,963,395	97,535,523	212,498,918
BAR receipts			
FY 2020	27,426,984	25,275,999	52,702,983
12/31/19 AR	6,593,889	2,178,940	
12/31/20 AR	8,614,018	2,723,531	
AR Change	2,020,129	544,591	
Estimated 2020 net revenue	29,447,113	25,820,590	55,267,703

2021

Information for Community Benefits Plan Report
2021

Medical Care Services

Unpaid Cost of Medi-Cal Program

a)	Hospital's Total Direct & Indirect Cost / Total Patient Charges			179,072,383	total expense per Exhibit 1
				18,570,925	Capitated purchased services, Exhibit 1
				16,450,859	Hospital fee expense (per financials file)
			Cost	144,050,599	
			Charge	502,709,645	Per Exhibit 1
			Ratio	0.29	
1)	Above Ratio * Individual Patient Charge				
2)	Above % * Medi-Cal Total Charges = Cost of Services to Patients	0.29	179,445,564	51,419,823	BAR ESS
3)	Less: Net Revenue from M-Cal			26,027,518	BAR ESS
	DSH			13,959,324	Financials file
	Hospital Fee (net revenue and expense)			14,442,645	Financials file
4)	Unpaid Cost of M-Cal Program (negative is a profit)			(3,009,664)	
	Unpaid Cost of M-Cal Program excluding DSH/Hospital Fee			25,392,305	

Traditional Charity Care

a)	Hospital's Total Direct & Indirect Cost / Total Patient Charge	144,050,599	502,709,645	0.29	
1)	Hospital's total Direct & Indirect Cost / Total Patient Charges		Charity allowances (exhibit 1)		
2)	Above % * Charity Care Total Charges = Cost of Services to Patients	0.29	3,786,416	1,084,991	NOTE: use Charity allowances, not charges; because allowance come from all primary ins g
3)	Patient Payments - Above Cost of Services to Patients	-	1,084,991	1,084,991	

Physician Backup Services in ECC

						MCAL HMO CM	MCAL MD	
					Charges	136,912,584	42,532,980	179,445,564
					BAR receipts			
a)	ECC Physicians on call for non-paying customers	01.7010.2000	3,363,730	3,363,730	FY 2021	18,613,517	7,688,057	26,301,574
American Heart cost center 8774		01.8774.0000-			12/31/20 AR	4,913,904	1,739,574	
		01.8774.9999			12/31/21 AR	5,564,641	814,781	
					AR Change	650,737	(924,793)	
Foundation expense					Estimated 2021 net revenue	19,264,254	6,763,264	26,027,518

Other information

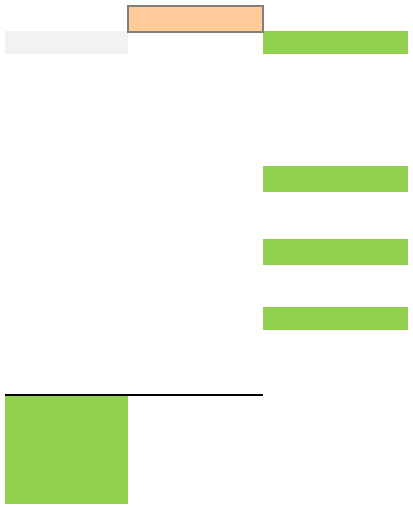
	12/31/2020	12/31/2018	12/31/2017	
Women's care center total visits	n/a	3,270	5,800	Monthly stats file (Yvette) CC 7181
Family Care center total visits	n/a	331	738	Daily productivity
ECC visits			38,233	Financials
charity Care: Number of patients served			17	CE admits
Unpaid cost of Medi-Cal: Number of patients served			3,817	CM MD admits

Information for Community Benefits Plan Report
2021

Medical Care Services

Unpaid Cost of MEDICARE Program

a) Hospital's Total Direct & Indirect Cost / Total Patient Charges			179,072,383	total expense per Exhibit 1
			18,570,925	Capitated purchased services
			16,450,859	Hospital fee expense (per non recurring)
		Cost	144,050,599	
		Charge	502,709,645	Per Exhibit 1
		Ratio	0.29	
1) Above Ratio * Individual Patient Charge				
2) Above % * MediCARE Total Charges = Cost of Services to Patients	0.29	212,498,918	60,891,206	BAR ESS
3) Less: Net Revenue from Medicare			51,817,125	BAR ESS
DSH / cost report settlement			17,920	Non recurring
4) Unpaid Cost of MEDICARE Program (negative is a profit)			9,056,161	
Unpaid Cost of MEDICARE Program excluding DSH/Hospital Fee			9,074,081	



	MCARE HMO MH	MCARE MC	
Charges	114,963,395	97,535,523	212,498,918
BAR receipts			
FY 2020	27,426,984	25,275,999	52,702,983
12/31/20 AR	8,614,018	2,723,531	
12/31/21 AR	8,737,130	1,714,561	
AR Change	123,112	(1,008,970)	
Estimated 2021 net revenue	27,550,096	24,267,029	51,817,125

11 Cal. Code Reg. Section 999.5(d)(5)(C)

A description of all services provided by each health facility or facility that provides similar healthcare that is the subject of the agreement or transaction in the past five years to Medi-Cal patients, county indigent patients, and any other class of patients. This description shall include but not be limited to the type and volume of services provided, the payors for the services provided, the demographic characteristics of and zip code data for the patients served by the health facility or facility that provides similar healthcare, and the costs and revenues for the services provided.

Beverly is a licensed general acute care hospital located in Montebello, California, which offers a full range of acute medical care and community services, ranging from general medicine to specialized programs. Attached to this Section as **Exhibit 18** is a copy of Beverly's license to operate a general acute care hospital.

A description of the medical services provided by Beverly to Medi-Cal patients, county indigent patients, and other classes of patients is set forth in the sections below. Generally, all types of medically necessary hospital services are available to these classes of patients. The description below includes data and information regarding the inpatient and outpatient services provided by Beverly to its Medi-Cal, Medicare, managed care, county indigent, and other classes of patients.

I. Type of Services Provided

1. Cardiology. Beverly's cardiology department provides state-of-the-art diagnostic, treatment, and interventional services to patients with heart-related illnesses. The Department is equipped with two Catheterization Labs with capability to perform advanced therapeutic and interventional heart procedures. It also offers free community health education, wellness classes and risk screenings.
2. Diagnostic Imaging. Beverly's Radiology/Diagnostic Imaging Center uses advanced and innovative equipment to pinpoint potential areas of concern to a patient's physician. The Radiology/Diagnostic Imaging Center's services include full-body multi-slice spiral computerized tomography (CT) scanning, digital mammography, bone densitometry, magnetic resonance imaging (MRI), nuclear medicine, ultrasound, cardiac imaging, non-invasive peripheral vascular ultrasound, angiography and interventional radiology, and full-service general diagnostic radiology. The Imaging Center is also equipped with a state-of-the-art Angiography Room with the capability to perform advanced interventional and therapeutic peripheral vascular procedures.
3. Emergency Care. Licensed for 32 beds, Beverly Hospital Emergency Care Center provides emergency care 24 hours a day, 7 days a week through its dedicated emergency medical services team. Beverly is a primary stroke center, and is 1 of only 40 hospitals in Los Angeles County qualified as an Emergency Department Approved for Pediatrics (EDAP) facility.
4. Family and Primary Care. Through its arrangements with outpatient community based clinics and hospital-based medical providers, Beverly provides primary care services ranging from preventative screens and routine examinations to vaccinations and chronic disease management.

5. Medical and Surgical. Beverly provides a full range of medical and surgical services for acute and chronic diseases including cardiac, pulmonary, renal, and diabetic disorders. Beverly's surgeons perform an array of procedures, including sports medicine, open heart, breast biopsies as well as laparoscopic, gynecologic, urologic and orthopedic surgeries, among other services.

6. Orthopedics. Beverly offers advanced diagnostics with cutting-edge, minimally invasive surgical procedures and non-surgical methods, preventive education, and physical therapy to treat a full spectrum of orthopedic conditions—ranging from strains, sprains, and fractures to complex spinal disorders and total joint replacements. Beverly's orthopedic surgeries commonly include: total joint replacements (e.g., hip, knee, shoulder), complex fracture care, arthroscopies, ACL (knee ligament) reconstruction, meniscal tear (knee cartilage) repair, Achilles tendon repair, back surgeries and carpal tunnel release.

7. Women's Health. Beverly provides women's health services through the Hensel Maternity Center, the Women's Pavilion & Breast Center, and through its arrangements with community clinics. Beverly's maternity services include private and comfortable labor-delivery-recovery (LDR) suites; couplet care for mother and baby recovery and bonding; a state-of-the-art newborn security system; antepartum testing; access to childbirth and infant care education; free transportation (within 15 miles of the hospital); and orthopedics. Beverly's Women's Pavilion & Breast Center offers state-of-the-art technology, a private facility designed for feminine comfort, and a team of specialists dedicated to making mammography convenient, reliable, and life-saving. Services include: digital mammography, breast ultrasound, ultrasound-guided breast biopsies, stereotactic breast biopsies and bone density scans. Beverly also offers a wide range of free maternity classes and a wide selection of classes and events on topics such as hormone replacement, breast self-examination, nutrition, and stress management (many offered in both English and Spanish).

8. Outpatient Lab. As a fully accredited outpatient laboratory through the College of American Pathologists (CAP), Clinical Laboratory Improvement Amendments (CLIA), and the California Department of Health Services, Beverly's outpatient laboratory offers a full-range of clinical laboratory testing for patients, which include hematology and coagulation, chemistry, serology, microbiology, blood banking, urinalysis and pathology.

9. Pediatrics. Beverly provides a full spectrum of pediatric diagnostic and inpatient treatment care from multi-disciplinary team of pediatric care experts. Beverly's pediatric services feature a 6-bed pediatric unit designed to meet the size-specific needs of children, round the clock staffing, access to a child-life specialist, and a family-centered atmosphere.

10. Wound Care and Hyperbaric Medicine. Beverly's Center for Advanced Wound Healing and Hyperbaric Medicine is a coordinated outpatient center that treats patients with chronic and non-healing wounds utilizing the latest techniques and procedures, including limb-threatening conditions, such as diabetic foot ulcers/infections and peripheral arterial disease. The Center for Advanced Wound Healing and Hyperbaric Medicine features a multi-disciplinary team dedicated to preventing lower limb loss and optimizing outcomes for patients with wounds resulting from illnesses such as diabetes, venous stasis, pressure ulcers, and peripheral vascular disease.

II. Volume of Services

Hospital Discharges by Bed Category:

	2017	2018	2019	2020	2021
Medical/Surgical Intensive	**427**	**501**	**480**	**466**	**440**
Neonatal Intensive	34	40	29	6	2
Medical/Surgical Acute	7,471	8,235	9,131	6,888	6,411
Pediatric Acute	459	486	455	137	125
Obstetrics Acute	826	653	807	649	652
Total	9,217	9,915	10,902	8,146	7,630

Emergency Services:

	2017	2018	2019	2020	2021
ER Outpatient Visits	31,208	30,825	31,846	24,602	27,323
ER Admissions	7,025	7,441	8,242	6,453	6,001
Total	38,233	38,266	40,088	31,055	33,324

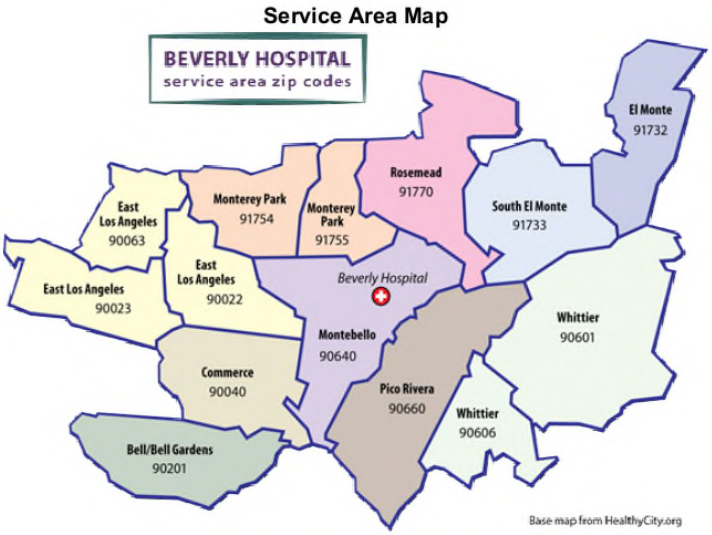
III. Payor Mix of Beverly

By Hospital Discharges:

	2017	2018	2019	2020	2021
Medicare Traditional	2,101	1,975	2,030	1,519	1,361
Medicare Managed Care	1,498	1,787	2,003	1,641	1,700
Medi-Cal Traditional	1,140	967	1,002	1,471	762
Medi-Cal Managed Care	3,526	4,174	4,535	2,413	2,795
All Other	952	1,012	1,332	1,102	1,012

IV. Demographic Characteristics

The area map below shows the zip codes for the Service Area of Beverly based on the demographics from the 2022 Community Needs Assessment. Collectively these zip codes account for about sixty-eight percent (68%) of total hospital discharges.



The communities of the Beverly's service area (the "Service Area") are identified in the table below. The overall population trends are described in the 2022 Community Needs Assessment, which is attached as **Exhibit 13** to Section 999.5(d)(5)(A) of this Notice. In comparison with Los Angeles County, the population located in the Beverly area declined from 2014 to 2019 while the population of Los Angeles County increased.

Zip Code	Community
90201	Bell/Bell Gardens
91007	Commerce
90022, 90023, 90063	East Los Angeles
90640	Montebello
91754, 91755	Monterey Park
90660	Pico Rivera
91733	South El Monte
90601, 90606	Whittier

Summary of Population, Households, and Families in Service Area:

The population of the Service Area is 672,097. From 2014 to 2019, the population decreased by 0.7%, while the populations in both Los Angeles County and California increased during the same time period.

In the Service Area, there were 179,346 households and 187,108 housing units in 2019. From 2014-2019, the number of households grew at a rate of 1.6%, housing units grew at a rate of 0.2%, and vacant units decreased by 23.6%. Owner-occupied housing increased by 0.8% and renters increased by 2.3%.

Age and Socioeconomic Description of the Service Area:

The age and ethnic breakdown of the Service Area population compared to Los Angeles County is shown below. In comparison with other areas in Los Angeles County, the Service Area population has a higher percentage of children ages 0-17, and has a lower median age of the population (36 years). The average household income in the Service Area ($51,268) is lower than the average household income in Los Angeles County ($68,044). A more detailed description of the demographic factors which describes the Service Area is provided in the 2022 Community Needs Assessment attached as **Exhibit 13** to Section 999.5(d)(5)(A) of this Notice.

Age Group Distribution Data for 2019:

Population, by ZIP Code

	ZIP Code	Total Population	Children Ages 0 – 17	Adults Ages 18-64	Adults Ages 65+	Median Age
Bell/Bell Gardens	90201	101,965	29.5%	62.3%	8.2%	29.8
Commerce	90040	12,328	23.8%	62.6%	13.5%	35.3
East Los Angeles	90022	67,014	27.0%	62.3%	10.5%	32.6
East Los Angeles	90023	46,860	28.6%	61.2%	10.2%	31.4
East Los Angeles	90063	53,980	26.9%	62.4%	10.7%	31.9
El Monte	91732	62,905	22.8%	64.8%	12.4%	36.0
Montebello	90640	62,730	22.4%	62.7%	14.9%	36.1
Monterey Park	91754	33,636	18.6%	59.7%	21.6%	43.0
Monterey Park	91755	26,083	15.6%	63.4%	21.0%	45.7
Pico Rivera	90660	63,001	22.7%	62.6%	14.7%	37.1
Rosemead	91770	62,703	19.2%	63.7%	17.1%	42.0
South El Monte	91733	45,365	24.5%	63.0%	12.5%	34.7
Whittier	90606	32,987	22.2%	64.6%	13.2%	36.8
Beverly Service Area		**672,097**	**24.2%**	**62.7%**	**13.1%**	**36.0**
Los Angeles County		**10,081,570**	**22.0%**	**64.8%**	**13.2%**	**36.5**
California		**39,283,497**	**23.0%**	**63.1%**	**14.0%**	**36.5**

Source: U.S. Census Bureau, American Community Survey, 2015-2019, B01001, DP05. https://data.census.gov/cedsci

Population, by Age

	Beverly Service Area	Los Angeles County	California
0 – 4	6.3%	6.1%	6.2%
5 – 9	6.3%	5.9%	6.3%
10 – 14	7.3%	6.2%	6.6%
15 – 17	4.4%	3.8%	3.9%
18 – 24	10.1%	9.7%	9.6%
25 – 34	15.4%	16.1%	15.2%
35 – 44	13.2%	13.8%	13.2%
45 – 54	12.8%	13.4%	13.0%
55 – 64	11.1%	11.8%	12.0%
65 – 74	7.1%	7.5%	8.1%
75 – 84	4.0%	3.9%	4.1%
85+	2.0%	1.8%	1.8%

Source: U.S. Census Bureau, American Community Survey, 2015-2019, B01001. https://data.census.gov/cedsci

Estimated Population by Ethnicity:

Race/Ethnicity

	Beverly Service Area		Los Angeles County	California
	Number	Percent	Percent	Percent
Hispanic or Latino	517,152	77.0%	48.5%	39.0%
Asian	118,173	17.6%	14.4%	14.3%
White	26,249	3.9%	26.2%	37.2%
Black or African American	4,388	0.7%	7.8%	5.5%
Two or more races/other race	3,158	0.5%	2.7%	3.2%
American Indian/Alaska Native	1,458	0.2%	0.2%	0.4%
Native Hawaiian/Pacific Islander	965	0.1%	0.2%	0.4%

Source: U.S. Census Bureau, American Community Survey, 2015-2019, DP05. https://data.census.gov/cedsci

Patient Origin and Market Share by Zip Code:

The table below provides the Beverly's hospital discharges in fiscal year 2021, grouped by the patient's home residence zip code. In addition, the table shows the total acute hospital discharges for each zip code and Beverly's market share of total discharges:

Bell/Bell Gardens	90201	207	3%
Commerce	90040	149	2%
East Los Angeles	90022	818	11%
East Los Angeles	90023	153	2%
East Los Angeles	90063	147	2%
El Monte	91732	140	2%
Montebello	90640	1792	23%
Monterey Park	91754	73	1%
Monterey Park	91755	69	1%
Pico Rivera	90660	1107	15%
Rosemead	91770	221	3%
South El Monte	91733	204	3%
Whittier	90606	140	2%
Other		2410	32%
TOTAL		7630	100%

V. Net Revenue and Costs for Beverly:

Net Revenue by Payor	2017	2018	2019	2020	2021
Total Net Patient Revenue	155,188,000	146,246,000	138,281,000	138,743,000	145,515,000
Other Operating Income	51,804,000	58,466,000	54,507,000	42,710,000	31,113,000
Total Operating Revenue	206,992,000	204,712,000	192,788,000	181,453,000	176,628,000
Total Expense	196,206,000	200,869,000	195,423,000	184,700,000	180,307,000
Net Gain (Loss) from Operations	10,786,000	3,843,000	(2,635,000)	(3,247,000)	(3,679,000)

EXHIBIT 18

BEVERLY LICENSE TO OPERATE GENERAL ACUTE CARE HOSPITAL

License: 930000389
Effective: 10/04/2022
Expires: 04/30/2023
Licensed Capacity: 202

State of California
Department of Public Health

In accordance with applicable provisions of the Health and Safety Code of California and its rules and regulations, the Department of Public Health hereby issues

this **License** *to*

Beverly Community Hospital Association

to operate and maintain the following **General Acute Care Hospital**

Beverly Hospital
309 W Beverly Blvd
Montebello, CA 90640-4308

Bed Classifications/Services/Stations

General Acute Care
18 Perinatal
15 Pediatric
13 Coronary Care
12 Intensive Care
10 Intensive Care Newborn Nursery
134 Unspecified General Acute Care

Other Approved Services

Basic Emergency Medical
Cardiac Catheterization Laboratory Services
Cardiovascular Surgery
Nuclear Medicine
Occupational Therapy
Outpatient Services at Hyperbaric Medicine Center & Wound Care, 413 Poplar Street, Montebello
Outpatient Services - Radiology at 101 East Beverly Blvd. Suite 104, Montebello
Physical Therapy
Radiation Therapy
Respiratory Care Services
Social Services

This **LICENSE** is not transferable and is granted solely upon the following conditions, limitations and comments:
10 Intensive Care Newborn Nursery beds suspended from 06/01/2022 to 06/30/2023.
Mobile MRI Unit - California Vehicle License #4NA5497

TOMÁS J. ARAGÓN, MD, DrPH
Director and State Public Health Officer

Rose McDowall, Staff Service Manager I

Refer Complaints regarding these facilities to: The California Department of Public Health, Licensing and Certification, L.A. Acute/Ancillary Unit, 3400 Aerojet Ave., Suite 323, El Monte, CA 91731, (626) 312-1135

POST IN A PROMINENT PLACE

11 Cal. Code Reg. Section 999.5(d)(5)(D)

A description of any community benefit program provided by the health facility or facility that provides similar healthcare during the past five years with an annual cost of at least $10,000 and the annual cost of each program for the past five years

Description of Program/Service	Costs	Year Offered
Charity Care/Financial Assistance	4,512,967	2017-2021
Subsidized Health Services (includes clinical programs that address an identified community need).	19,065,318	2017-2021
Other for the broader community (includes non-billed activities for vulnerable populations such as community education, screenings and health support services. Also included are staffing, cash and in-kind donations and community benefits operations expense)	2,425,882	2017-2021
Health professions education	5,248,790	2017-2021

11 Cal. Code Reg. Section 999.5(d)(5)(E)

For each health facility or facility that provides similar healthcare that is the subject of the agreement or transaction, a description of current policies and procedures on staffing for patient care areas; employee input on health quality and staffing issues; and employee wages, salaries, benefits, working conditions and employment protections. Such description shall include a list of all existing staffing plans, policy and procedure manuals, employee handbooks, collective bargaining agreements or similar employment-related documents

Staffing for Patient Care Areas

Beverly has established policies, plans, and procedures to promote adequate staffing levels for its patient care areas. Specifically, Beverly has established policies and procedures to permit its medical staff members, clinical providers, and other employees that provide patient care services, to provide care to Beverly's patients that is appropriate, individualized, and planned along a continuum of care, as set forth below.

- Plan for the Provision of Patient Care, which integrates hospital-wide disciplines and functions into a seamless network of services dedicated to safety, quality, and cost-effective patient care, treatment and services through a detailed description of each hospital unit, staffing of each hospital unit, hours of operation and internal hospital committees;
- Department scheduling and staffing policies that describe how staffing is handled, call offs, and replacement staff;
- Structures supporting patient care that provide standards for clinical area assessments and reassessments
- Medical Staff Bylaws and Rules and Regulations, which identify committee structures for Medical Staff, membership, and conduct;
- Code of Behavioral Conduct, which defines the responsibilities of Beverly employees, medical staff and allied health professionals in relation to Beverly's culture of quality and safety, and provides a mechanism to address behaviors that threaten the performance of Beverly's health care team; and
- Performance improvement plans, which describes the overall plan for improving patient safety and quality, and accountability.

Employee Input on Health Quality and Staffing Issues

The above-listed policies also permit Beverly's medical staff and other health care providers to have the opportunity to provide input on health quality and staffing issue through such mechanisms as department leadership meetings, staff meetings, Beverly Professional Practice Council, rounds, huddles, forums, and newsletters.

Employee Wages, Salaries, Benefits, Working Conditions and Employment Protections

Beverly has established a number of human resources policies and procedures that address employee wages, salaries, benefits, working conditions, and employment protections, as listed below:

- Access & Monitoring of Hospital Technology
- Alternative Work Schedule
- Annual Health Assessment
- Anti-Violence Policy Violence in the Workplace Training
- Attendance & Punctuality
- Basic Life Support Certification of Employees
- Charge Pay
- Classification Above Premium Pay
- Code of Conduct
- Compliance Program
- Confidential Information
- Continuation of Benefits
- Compensation Philosophy
- Credit Union
- Dental Insurance
- Direct Deposit
- Disciplinary Process
- Disruption of Service
- Drug and Substance Abuse Policy
- Employee Activities Committee
- Employee Classification (i.e., part-time/full-time, exempt/non-exempt)
- Employee Assistance Program
- Employee of the Month
- Employment of Relatives
- Equal Employment Opportunity
- Flexible Spending Account
- Gifts and Gratuities
- Harassment and Harassment Training
- Health Insurance
- Holiday Pay
- Immigration Rules
- Leaves of Absence
- Life Insurance
- Long Term Disability
- Meals and Rest Periods
- Modified Scheduling (Flexing)
- New Employee Orientation
- On-Call/Call Back Pay
- Overtime
- Payday
- Performance Appraisals and Performance Improvement Plan
- Seminar Approval and Expense Reimbursement
- Paid Time Off/Sick Leave Reserve

- Personal Appearance/Dress Code
- Personal use of Employer Property, Equipment, Stationery, Letterhead, Name and Logo
- Personnel Files and Release of Employee Information
- Problems, Complaints, and Grievances
- Rehire/Reinstatement
- Reporting Time Pay
- Rideshare Program
- Retirement Pan
- Salary Advances
- Salary Deductions
- Security
- Service Recognition Awards
- Shift Deferential
- Social Media – Employees Use of Personal Social Media Sites
- Social Media – Employees Participation on Authorized Social Media Sites
- Social Media – Authorized Social Media Sites
- State Disability Insurance
- Supplemental Shift Assignment Pay
- Safety and Accident Procedures
- Smoking
- Solicitation and Distribution of Literature
- Telephone Courtesy
- Wage and Salary Program
- Separation of Employment
- Timekeeping System
- Transfer, Promotion, and Demotion
- Verification of Licensure
- Vision Insurance
- Wage Garnishments, Attachments and Judgments
- Work Assignments
- Work Day
- Workers' Compensation

Beverly's employee benefits are described in Beverly's 2022 Employee Benefits Guide, attached to this Section as **Exhibit 19**.

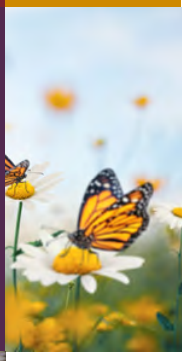
Effective January 1, 2022, a Collective Bargaining Agreement was entered into by and between Beverly and United Nurses Associations of California/Union of Health Care Professionals (UNAC/UHCP), NUHHCE, AFSCME and AFL-CIO.

EXHIBIT 19

BEVERLY EMPLOYEE BENEFITS GUIDE (2022)

Employee

BENEFITS Guide



2022

BeverlyHospital

Employee Benefits Guide 2022

General Information

Core Benefits

Other Benefits

Miscellaneous

The information in this brochure is a general outline of the benefits offered under Beverly Hospital's benefits program. Specific details and plan limitations are provided in the Summary Plan Descriptions (SPD), which is based on the official Plan Documents that may include policies, contracts and plan procedures. The SPD and Plan Documents contain all the specific provisions of the plans. In the event that the information in this brochure differs from the Plan Documents, the Plan Documents will prevail.

This brochure is considered a Summary of Material Modification.

Contact Information

Below is a listing of the telephone numbers you can call with questions about the plans available to you. You can also use the website (if available) to access information from providers for the various plans.

Benefit/Provider	Phone Number	Website/Address
Medical #H4200		
• Keenan Third Party Administrator (TPA)	866.249.0930	keenan.com/benefits P.O. Box 2744 Torrance, CA 90509
• Anthem Blue Cross – Utilization Review	800.274.7767	anthem.com/ca
• Anthem LiveHealth Online	N/A	LiveHealthOnline.com
• Blue Card Network *(Out-of-State providers)*	800.810.BLUE	bluecares.com
Prescription Drugs		
• Express Scripts – D7F	888.786.5513	express-scripts.com
Dental		
• DeltaCare® USA HMO – #01219	800.422.4234	deltadentalins.com
• Delta Dental PPO – #4849	800.765.6003	deltadentalins.com
Vision		
• Vision Service Plan (VSP) – #12047903	800.877.7195	vsp.com
Life and Disability		
• Reliance Standard – Basic Life – #GL132049 – Basic AD&D – #VAR 201816 – Voluntary Life/AD&D – #VG187953 – Voluntary LTD – #VPL303273	**Customer Service:** 800.644.1103 8:00 a.m. to 6:00 p.m. (EST) **Claims:** 800.351.7500, ext. 4149 8:00 a.m. to 6:00 p.m. (EST)	reliancestandard.com
Flexible Spending Accounts		
• Igoe	800.633.8818	www.goigoe.com
Voluntary Universal Life with LTC, Critical Illness, Accident, Short Term Disability		
• Trustmark	800.918.8877	trustmarksolutions.com
401k		
• Transamerica Retirement Solutions	800.755.5801	my.trsretire.com
MERP		
• Catilize Health	877.872.4232	Email: merp@catilizehealth.com
Employee Assistance Program (EAP)		
• Anthem Blue Cross	800.999.7222	anthemeap.com **Login**: Beverly Hospital
Pet Insurance		
• Nationwide	877.738.7874	http://benefits.petinsurance.com/beverlyhospital
Personal Choices	N/A	https://app.strivebenefits.com/BeverlyHospital **Username:** Beverly **Password:** Benefits

Overview of Your Benefits

Employees have the opportunity to make new benefit choices each year. The choices you make should reflect your needs for financial protection and security. You may enroll in the Medical/Rx, Dental and Vision plans. A Basic Group Life/AD&D Insurance Plan is offered to you at no cost. You may also elect Voluntary Benefits at a convenient payroll deduction rate.

Benefit Plan	
Medical *(Beverly Self-Funded Plans, Anthem Network)*	• Two EPO Plans *(EPO Select and EPO Plus)* • PPO Plan *(Traditional PPO)*
Prescription Drug *(Express Scripts)*	• Participating Pharmacy • **Generic:** $10 copay • **Brand:** Greater of $20 copay or 25%, up to $50 • **Non-Formulary:** Greater of $25 or 50%
Dental *(Delta Dental)*	• PPO Plan • HMO Plan
Vision *(Vision Service Plan)*	• $20 copay
Flexible Spending Accounts *(Igoe)*	• **Health Care Spending Account:** Up to $2,750 per year • **Dependent Care Spending Account:** Maximum - $5,000 per year if single or married filing a joint return; $2,500 if married and filing separately
Basic Life/AD&D *(Reliance Standard)*	• 1x earnings to a maximum of $100,000
Voluntary Universal Life with Long Term Care *(Trustmark)*	• Permanent coverage designed to last to age 100 with level premium and level benefits
Critical Illness/Cancer Insurance *(Trustmark)*	• Lump sum benefit upon the first diagnosis of a covered critical illness/cancer or condition
Accident Insurance *(Trustmark)*	• Cash benefit that helps with lost income and expenses related to accidents
Short Term Disability Insurance *(Trustmark)*	• Provides replacement income when you become disabled
Voluntary Life/AD&D *(Reliance Standard)*	
• Employee	• Increments of $10,000 to $500,000, but not to exceed 5x basic annual earnings • **Guarantee issue (New Hires only):** Under Age 70: $120,000
• Spouse	• Increments of $10,000 to $500,000, *(not tied to employee's selection)* • **Guarantee issue (New Hire only):** Under Age 60: $30,000
• Child	• **14 days up to 6 months:** $1,000 • **6 months up to Age 26:** Choice of $2,500, $5,000, $7,500, $10,000
Voluntary Long Term Disability *(Reliance Standard)*	• 60% of basic monthly earnings • **Elimination period:** 180 days
MERP *(Catilize Health)*	• Reimburses you *(the employee)* and your dependents for eligible health care expenses incurred under alternate group health coverage. Please see page 11 for more details.
Pet Insurance *(Nationwide)*	• Get cash back on eligible vet bills • Use any vet, anywhere

How to Enroll in Benefits

During Open Enrollment (October 11, 2021 - November 1, 2021) you will be able to access the Employee Self Service website through ADP to enroll in and/or to make changes to your benefit elections for the new plan year. You will be prompted through the screens to complete your enrollment online.

Enrollment: Online Benefit Election Process

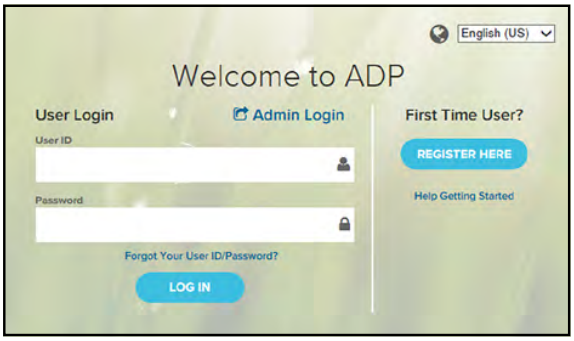
Benefit enrollment will now be an online process through the Employee Self Service website via ADP from October 11th to November 1st. In order to enroll online, you will need to have access the Employee Self Service website.

From Your Computer

1. Access the **Employee Self Service*** website via ADP.

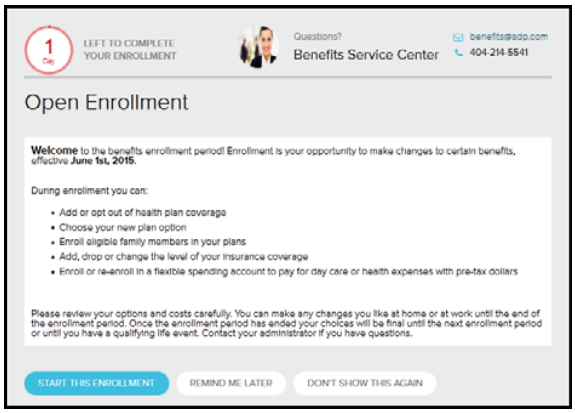
* If this is your first time logging in, or you need help getting started, click the appropriate link for instructions and assistance.

2. Click **User Login**.

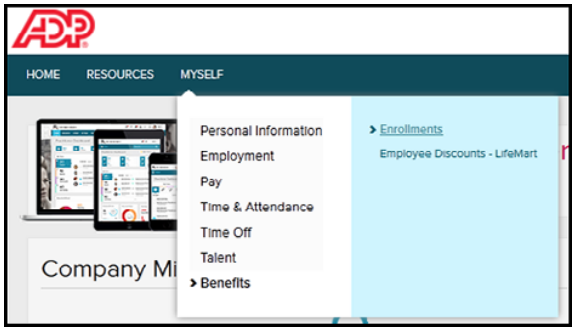


Note: Information or activity notification pages may display. Please respond as needed to continue.

3. After you log in, use the Enrollment page to review your current benefits, if applicable, and make your Open Enrollment selections.



4. To View Your Current Enrollment Details Starting Point: **Myself > Benefits > Enrollments**



   a. Click the **Plan Name** to view details of the enrollment and to edit beneficiary assignments.

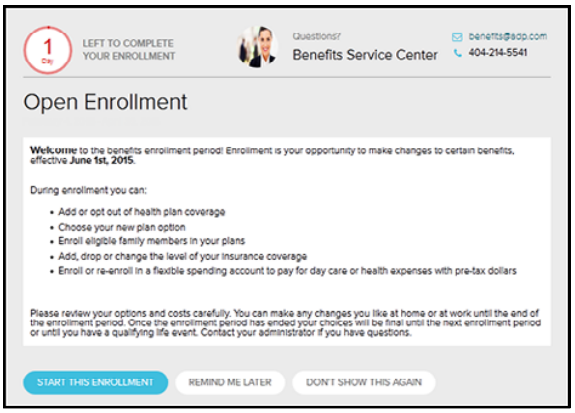
   b. On the Enrollment Details page, review enrollment information for the plan you selected.

   c. When you have completed your review, click **Done**. (You can select other plans to review as needed.)

How to Enroll in Benefits (continued)

To Make Open Enrollment Elections

Starting Point:



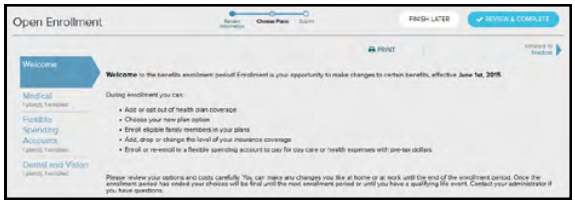
a. **Home Page > Start This Enrollment** During the Open Enrollment period you will be prompted by the Home Page upon login. To enter the Open Enrollment process, click on **Start This Enrollment**

OR

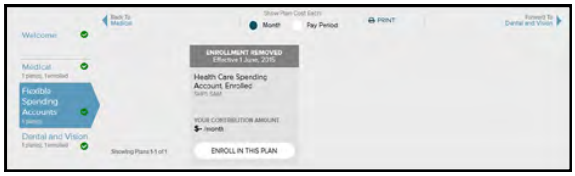
b. **Myself > Benefits > Enrollments** On the Enrollments page, click **Start** or **Resume** next to your Open Enrollment profile. (Resume is available when you are returning to complete your enrollment.)

1. Start your enrollment by selecting **Walk Me Through My Benefit Options**, **I Know What I Want to Change** or **I Do Not Want to Make Any Changes**.
2. If you select **I Know What I Want to Change**, you can select the benefit options, and then click **Continue** to go to the plans available in the selected options.

3. Select a benefit plan from the list on the left.



4. To enroll in a plan, click **Enroll in This Plan** for the appropriate benefit plan.



5. Choose a **Coverage Level** for the selected plan.
6. After reviewing all plans and making your selections, click **Review & Complete**.

7. After reviewing your benefits election selections, do one of the following:
   a. Click **Return to Choose Plan** to make changes now.
   b. Click **Finish Later** to make changes later.
   c. Click **Complete Enrollment** to finish your enrollment.

Eligibility

Eligibility for benefits is determined by employee classification, number of hours scheduled to work and a waiting period before benefits are effective.

	Eligibility for Benefits	
	Full-Time	**Part-Time**
Hours Requirement	36 hours/week or 72 hours/pay period	24 hours/week or 48 hours/pay period
Waiting Period *(benefits effective date)*	1st of the month following 30 days	
Benefits Offered	• Medical • Dental • Vision • Basic Life and AD&D *(Full-Time only)*	• Voluntary Life • Voluntary Long Term Disability • Flexible Spending Accounts • Voluntary Products

Changes to Your Coverage

Once your coverage begins, it generally remains in effect for the full plan year from January 1 through December 31. You may make changes to your coverage only during the annual Open Enrollment period, unless you experience a qualified family status change.

If you have a qualified family status change, you may add or discontinue coverage that is consistent with the qualified status change. You must do so by submitting the necessary forms to Human Resources within 31 days of the change.

Qualified family status changes include:

- Marriage, divorce, legal separation, or a change in Registered Domestic Partner status.
- Birth or adoption of a child, or change in child custody or guardianship.
- Death of your spouse, Registered Domestic Partner or dependent.
- A change in you or your spouse's or Registered Domestic Partner's employment status that affects eligibility for benefits.
- A change your spouse's or Registered Domestic Partner's employer's health care coverage.
- A change in a dependent's eligibility status due to attainment of age 26.

Medical

Medical Plan Options

We offer three Medical Plan Options: two Exclusive Provider Organization (EPO – EPO Select and EPO Plus) plans and a Traditional Preferred Provider Organization (PPO) using the Anthem Blue Cross network.

- **EPO Select Plan:** The Exclusive Provider Organization (EPO Select Plan), provides access to all providers in the Anthem Blue Cross Select PPO Network, which offers an extensive network of providers. All services, except emergency care, must be received within the Select PPO network. A Primary Care Physician (PCP) is not required. You can further reduce your costs by receiving services provided at Beverly Hospital. The EPO Select plan is the most affordable.
- **EPO Plus Plan:** This plan offers the same plan benefits as the EPO Select plan. The only difference is the network of providers and the annual out-of-pocket maximum. The EPO Plus Plan utilizes the broader Anthem Blue Cross Prudent Buyer PPO Network of providers. You can further reduce your costs by receiving services provided at Beverly Hospital.
- **Traditional PPO Plan:** The Traditional PPO plan offers the freedom of provider choice. You may receive services from any provider within the Anthem Blue Cross Prudent Buyer PPO Network. You may also utilize the provider of your choice outside the network. Your out-of-pocket costs will be lowest when utilizing the Anthem Blue Cross Prudent Buyer PPO Network providers. For services received Out-of-Network, you will be responsible for any difference between the covered expense and actual charges. You can further reduce your costs by receiving services provided at Beverly Hospital.

Health Benefits and Wellness Partnership (HBWP) Program

Beverly Hospital, in conjunction with the Hospital Association of Southern California, participates in the Health Benefits and Wellness Partnership (HBWP) Program. Arrangements have been made with three top tier academic medical centers – USC, UCLA and UCI Irvine – to provide certain specialized hospital (tertiary) services for our employees and their covered dependents. If you or your covered dependents are approved to receive services at one of these three facilities, your hospital (facility only) charges will be covered at 100% (after deductible), the same as other services provided at Beverly Hospital. You can continue to have the option to seek services from other facilities, but they will be covered at the Tier 2 or 3 network level.

In addition to the savings offered at the above facilities, any services rendered at Children's Hospital Los Angeles will provide employees and their enrolled dependents with a 5% coinsurance discount for obtaining services at CHLA.

How The Program Works

If your physician recommends specialized services not available at Beverly Hospital, contact the Keenan TPA for a Referral Verification form. This form will be forwarded to the selected academic medical center. The Referral Verification form is NOT an authorization or approval of services.

Prior Authorization and Referral Process – Required Prior to Services

Prior Authorization is required for all inpatient services. Services must be reviewed and approved by Anthem Blue Cross. Please contact Anthem Blue Cross at 800.274.7767 for Prior Authorization approval.

Medical (continued)

To keep you and your family living a healthy, happy life, Beverly Hospital is pleased to offer affordable, quality health care benefits. Our Medical benefits are designed to help maintain wellness and protect you and your family from major financial hardship in the event of illness or injury. Your costs will be lower when care is received at Beverly Hospital.

To meet the varying health care needs of our employees, we offer a variety of medical plans to choose from. Please consider cost, provider choice, convenience and coverage when selecting the option that best meets your needs.

Benefit Categories	EPO Select & Plus Plans	EPO Select Plan	EPO Plus Plan
	Beverly Hospital	Anthem Select PPO Network	Anthem Prudent Buyer PPO Network
Annual Deductible			
• Individual	$0	$250	$250
• Family	$0	$500	$500
Annual Out-of-Pocket Maximum			
• Per Individual	$500		$1,000
• Per Family *(3 or more members)*	$1,500		$3,000
• Lifetime Maximum	Unlimited		Unlimited
Hospital Services			
• Inpatient	No copay	10% after deductible	20% after deductible
• Outpatient Surgery	No copay	10% after deductible	20% after deductible
• Ambulatory Surgical Center	No copay	10% after deductible	20% after deductible
• Diagnostic X-ray/Lab	No copay	10% after deductible	20% after deductible
Physician Services			
• Primary Care Office Visits	N/A	$15 copay	$15 copay
• Specialist Office Visits	N/A	$15 copay	$15 copay
• LiveHealth Online	N/A	$10 copay	$10 copay
• Hospital Visits	N/A	No charge	No charge
Clinic Services*			
• BeverlyCare	No copay	Not covered	Not covered
Emergency Services			
• Emergency Room	No copay	$100 copay (waived if admitted)	$100 copay (waived if admitted)
• Urgent Care	N/A	$15 copay	$15 copay
• Ambulance Services	N/A	No copay	No copay
Preventive Care/Wellness Services			
• Physical Exams and Periodic Check-Ups	N/A	No copay	No copay
• Well Baby and Well Child Care	N/A	No copay	No copay
• Well Woman Exams/Mammograms	N/A	No copay	No copay
• Immunizations	N/A	No copay	No copay

* **Featured services at BeverlyCare clinic include:**

- Primary Care
- Obstetrics
- Pediatrics
- Women's Health
- Gynecology
- Specialty Care
- Annual Checkups
- Free Screenings

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Medical (continued)

Benefit Categories	EPO Select & Plus Plans	EPO Select Plan	EPO Plus Plan
	Beverly Hospital	Anthem Select PPO Network	Anthem Prudent Buyer PPO Network
General Medical Care			
• Acupuncture	N/A	$15 copay 30 visits/calendar year combined with Chiropractic	$15 copay 30 visits/calendar year combined with Chiropractic
• Chiropractic Services	N/A	$15 copay 30 visits/calendar year combined with Acupuncture	$15 copay 30 visits/calendar year combined with Acupuncture
• Diagnostic X-ray/Lab *(in office)*	N/A	No copay	No copay
• Dialysis Services	N/A	No copay - Physician 10% after deductible - Facility	No copay - Physician 20% after deductible - Facility
• Durable Medical Equipment	N/A	No copay	No copay
• Hearing Aid *(every 24 months)*	N/A	$2,000 allowance every 24 months	$2,000 allowance every 24 months
• Home Health Services *(100 visits/calendar year)*	N/A	$15 copay	$15 copay
• Hospice Care *(Inpatient)*	N/A	No copay	No copay
• Physical, Speech, Occupational Therapy	N/A	$15 copay	$15 copay
• Skilled Nursing Facility *(100 days per calendar year)*	N/A	No copay	No copay
Mental Health			
• Inpatient Hospital	N/A	10% after deductible	20% after deductible
• Inpatient Physician Visit	N/A	No charge	No charge
• Outpatient Facility	N/A	10% after deductible	20% after deductible
• Outpatient Physician Visit	N/A	$15 copay	$15 copay
Substance Abuse			
• Inpatient Hospital	N/A	10% after deductible	20% after deductible
• Inpatient Physician Visit	N/A	No charge	No charge
• Outpatient Facility	N/A	10% after deductible	20% after deductible
• Outpatient Physician Visit	N/A	$15 copay	$15 copay

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Medical (continued)

Benefit Categories	PPO Plan		
	Tier 1 Beverly Hospital	Tier 2 Anthem Prudent Buyer PPO Network	Tier 3 Out-of-Network*
Annual Deductible			
• Individual	$0	$500	$1,000
• Family	$0	$1,000	$2,000
Annual Out-of-Pocket Maximum			
• Per Individual	$2,000		Unlimited
• Per Family *(3 or more members)*	$6,000		Unlimited
• Lifetime Maximum	Unlimited		
Hospital Services			
• Inpatient	No copay	20% after deductible	50% after deductible up to $600/day
• Outpatient Surgery	No copay	20% after deductible	50% after deductible up to $350/day
• Ambulatory Surgical Center	No copay	20% after deductible	50% after deductible up to $350/day
• Diagnostic X-ray/Lab	No copay	20% after deductible	50% after deductible
Physician Services			
• Primary Care Office Visits	N/A	$20 copay	50% after deductible
• Specialist Office Visits	N/A	$30 copay	50% after deductible
• LiveHealth Online	N/A	$15 copay	N/A
• Hospital Visits	N/A	20% after deductible	50% after deductible
Clinic Services*			
• BeverlyCare	No copay	Not covered	Not covered
Emergency Services			
• Emergency Room	No copay	$100 copay +10% (waived if admitted)	
• Urgent Care	N/A	$20 copay	50% after deductible
• Ambulance Services	N/A	10% after deductible	10% after deductible
Preventive Care/Wellness Services			
• Physical Exams and Periodic Check-Ups	N/A	No copay	Not covered
• Well Baby and Well Child Care	N/A	No copay	Not covered
• Well Woman Exams/ Mammograms	N/A	No copay	Not covered
• Immunizations	N/A	No copay	Not covered

* **Featured services at BeverlyCare clinic include:**

- Primary Care
- Obstetrics
- Pediatrics
- Women's Health
- Gynecology
- Specialty Care
- Annual Checkups
- Free Screenings

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Medical (continued)

Benefit Categories	PPO Plan		
	Tier 1 Beverly Hospital	Tier 2 Anthem Prudent Buyer PPO Network	Tier 3 Out-of-Network*
General Medical Care			
• Acupuncture	N/A	$25 copay 20 visits/cal yr combined with Out-of-Network	50% after deductible 20 visits/cal yr combined with In-Network
• Chiropractic Services	N/A	$25 copay 12 visits/cal yr combined with Out-of-Network	50% after deductible 12 visits/cal yr combined with In-Network
• Diagnostic X-ray/Lab *(in office)*	N/A	20% after deductible	50% after deductible
• Dialysis Services	N/A	20% after deductible	50% after deductible up to $350/day
• Durable Medical Equipment	N/A	10% after deductible	50% after deductible
• Hearing Aid *(every 24 months)*	N/A	$2,000 allowance every 24 months	
• Home Health Services *(100 visits/calendar year)*	N/A	20% after deductible	50% after deductible
• Hospice Care *(Inpatient)*	N/A	20% after deductible	50% after deductible
• Physical, Speech, Occupational Therapy	N/A	$20 copay	50% after deductible
• Skilled Nursing Facility *(100 days per calendar year)*	N/A	20% after deductible	50% after deductible
Mental Health			
• Inpatient Hospital	N/A	20% after deductible	50% after deductible up to $600/day
• Inpatient Physician Visit	N/A	20% after deductible	50% after deductible
• Outpatient Facility	N/A	20% after deductible	50% after deductible up to $350/day
• Outpatient Physician Visit	N/A	$20 copay	50% after deductible
Substance Abuse			
• Inpatient Hospital	N/A	20% after deductible	50% after deductible up to $600/day
• Inpatient Physician Visit	N/A	20% after deductible	50% after deductible
• Outpatient Facility	N/A	20% after deductible	50% after deductible up to $350/day
• Outpatient Physician Visit	N/A	$20 copay	50% after deductible

* For Out-of-Network services, member is responsible for charges above the maximum allowable amount.

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Prescription Drugs

Prescription drug coverage is provided by Express Scripts, utilizing the National Preferred Formulary. Benefits are as follows. A higher copay applies for non-preferred pharmacies through the Express Advantage Network.

Plan Benefits	Express Scripts	
	Retail Participating Pharmacy	Mail Order
Out-of-Pocket Maximum *(Individual/Family)*	$2,500/$5,000	
Generic	$10 copay	$20 copay
Formulary Brand	Greater of $20 or 25% up to $50	Greater of $40 or 25% up to $100
Non-Formulary Brand	Greater of $25 or 50%	50% copay
Supply	34 days	90 days

Generics Preferred

If you choose a brand drug when a generic drug is available, your brand copay will be subject to an additional charge, if your doctor chooses brand the fee will not apply.

Accredo

All specialty medications must go through Accredo Pharmacy. Please call 800.922.8279 if you are on a specialty injectable medication or specialty drug.

Select Home Delivery (SHD) – Active Choice

This program allows members to decide whether to fill maintenance medication(s) via home delivery or at retail. There is no penalty for choosing retail. Members who do not communicate a home delivery or retail decision by the second fill will pay full cost at retail starting with the 3rd fill until a decision is made.

Pharmacy Vaccination Program

This program is a more convenient and less expensive way for employees to have access to vaccinations through the ESI pharmacy network. Please contact ESI customer service at 888.786.5513 to see if a vaccine is covered.

Express Advantage Network

This programs divides your current network into two types of stores – preferred and non-preferred. Members who use the preferred stores will not be impacted. Members who use the non-preferred stores, i.e., Walgreens and CVS, will have to pay an additional $15 copay.

Prior Authorization

Prior authorization is needed for certain medications. If you have questions on a particular drug, please contact Customer Service or visit express-scripts.com to perform a coverage check. Please have your doctor call Express Scripts at 800.753.2851 to go through a clinical review on your medication if it is subject to prior authorization.

Prior Authorization is a program that helps you get the prescription drugs you need ***with safety, savings, and most importantly, your good health in mind***. It helps you get the most from your healthcare dollars with ***prescription drugs that work well for you and that are covered by your pharmacy benefit***. It also helps control the rising cost of prescription drugs for everyone in your plan.

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MERP

What is MERP?

The Medical Expense Reimbursement Plan reimburses you (the employee) and your dependents for eligible health care expenses incurred under alternate group health coverage.

Who is Eligible?

This plan is voluntary and available to all benefit eligible employees and their eligible dependent child(ren) who are currently enrolled in the Beverly Hospital medical plan, as well as new hires.

MERP Benefits

- Copays, deductibles, and coinsurance are reimbursed by the MERP up to:
  - $7,350 EE Only per year
  - $14,700 Family per year
- No premium contribution is deducted from your paycheck.
- If the other coverage is more expensive, MERP will reimburse some of the difference in premium.

How Does the MERP work?

- Waive coverage for yourself and eligible dependent child(ren) under the Beverly Hospital medical plan.

If You Have Any Questions

Please Call Catilize Health
at 877.872.4232, or Email:
merp@catilizehealth.com

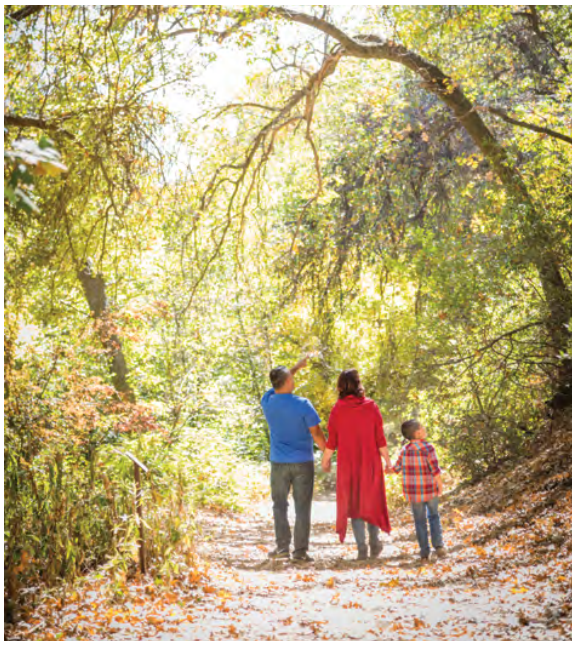
- Enroll yourself and/or dependent child(ren) into a qualified alternate plan, typically your spouse's plan.
- **Enroll in the MERP plan by contacting Catilize Health**. The MERP ID card should be presented at the time of service after the ID card for your alternate plan. The MERP ID card will give the provider information for filing claims for copays, coinsurance and deductibles.

IRS Rules

- You may be enrolled in an HRA or FSA. You **CANNOT** be reimbursed from both the MERP and your HRA or FSA.
- You are NOT eligible for the MERP if your alternate coverage is:
  - a high deductible health plan (HDHP) with active contributions to a Health Savings Account (HSA);
  - Medicare, Medicaid, Tricare (Retiree only) or an Individual Policy.

You can watch a video detailing the MERP program by visiting: https://player.vimeo.com/video/286969472

The MERP is administered by Catilize Health, who has a dedicated staff to personally handle your claims. Any paper claims can be submitted by Fax, Email or by U.S. Mail. Claim forms are available from Catilize Health. If you have questions regarding Claims Or Benefits, please call Catilize Health At 877.872.4232, Fax 877.599.3724 or Email: merp@catilizehealth.com.



Dental

Delta Dental will continue to be our Dental plan carrier. Delta Dental offers both a Preferred Provider Option (PPO) program and an HMO dental plan. You may choose to enroll in either the PPO or the HMO plan (DeltaCare®). You can access both Delta Dental PPO and DeltaCare directories at deltadentalins.com.

- **Dental PPO Plan:** There are significant advantages to utilize network providers in the PPO plan (i.e., calendar year maximum of $1,500), member is responsible for charges above the maximum allowable amount for Out-of-Network services.. Orthodontia coverage is available for adults and children to age 26.
- **DeltaCare® HMO Plan:** If you decide to participate in the DeltaCare plan, you will be required to choose a Dental provider or one will be selected for you. There are no deductibles or out-of-pocket maximums. You receive care through your selected network dentist and pay a copay based on the type of care you receive.

Plan Benefits	DeltaCare® HMO	Delta Dental PPO	
		In-Network	Out-of-Network
	Member Responsibility		
Annual Deductible *(waived for Diagnostic and Preventive Services)*			
• Individual	None	$50	$100
• Family	None	$100	$200
Annual Maximum Benefit	Unlimited	$1,500/person	$1,000/person
Diagnostic and Preventive Services			
Oral Exams, Routine Cleanings, X-Rays, Fluoride Treatment	Copays vary from $0 to $10	0% deductible waived	20% deductible waived
Basic Services			
• Fillings *(amalgam)*	Copays vary from $0 to $50	20%	40%
• Fillings *(porcelain/ceramic)*	Copays vary from $0 to $50	20%	40%
• Endodontics *(root canals)*	Copays vary from $0 to $75	20%	40%
• Oral Surgery	Copays vary from $0 to $40	20%	40%
• Periodontics *(gum treatment)*	Copays vary from $0 to $150	20%	40%
Major Services			
• Crowns, Inlays, Onlays, Cast Restorations	Copays vary from $0 to $50	50%	
• Prosthodontics *(Dentures, Bridges)*	Copays vary from $0 to $125	50%	
Orthodontics			
• Child	$1,600 copay	50%	
• Adult	$1,800 copay	50%	
• Lifetime maximum		$1,500	

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Vision

Beverly Hospital realizes that taking care of your eyes is an important part of your overall health care. Benefits are provided by Vision Service Plan (VSP).

If you use a VSP Choice network provider, the plan covers a full eye exam every 12 months with a $20 copay. Necessary materials, such as lenses (once very 24 months) and frames (every 24 months) are also covered. Your VSP benefits are now available at Costco and Walmart!

Plan Benefits	Vision Service Plan	
	In-Network	Out-of-Network
Frequency		
• Eye Exam	Once every 12 months	
• Lenses/Contacts	Once every 24 months	
• Frames	Once every 24 months	
Copay	**MEMBER RESPONSIBILITY**	**PLAN PAYS**
• Exam	$20 copay	Up to $50 allowance
• Fitting for Contacts	Up to $60 copay for contact lens exam	See "elective" contacts
Prescription Lenses	**PLAN PAYS**	**PLAN PAYS**
• Single	100% after copay	Up to $50 allowance
• Lined Bifocal	100% after copay	Up to $75 allowance
• Lined Trifocal	100% after copay	Up to $100 allowance
Frames	**PLAN PAYS**	**PLAN PAYS**
	Up to $170 retail allowance after copay	Up to $70 allowance
Contacts *(in lieu of lenses and frames)*	**PLAN PAYS**	**PLAN PAYS**
• Medically Necessary	100% after copay	Up to $210 allowance
• Elective	Up to $150 after copay	Up to $105 allowance

When you use a VSP provider, you are eligible for these added benefits:

- 20% discount on additional pairs of glasses and sunglasses, including lens options, from the same VSP doctor on the same day as your Well Vision Exam
- 20% discount on amount over frame allowance
- 15% average discount on laser vision correction surgery (LASIK and PRK) at contracted centers
- Extra $20 frame allowance for featured frame brands
- $95 frame allowance at Walmart®/Sam's Club®/Costco®
- LightCare - Use existing frame allowance for ready-made non-prescription blue-light glasses or non-prescription sunglasses (instead of prescription glasses or contacts).

For a list of VSP eye care professionals near you,
call VSP at 800.877.7195 or visit their website at vsp.com.

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Basic Life and AD&D

Reliance Standard will continue to be our Life and AD&D plan carrier. Open Enrollment is a good time to make any changes in your Beneficiary designations, if needed. This is especially true if your life circumstances have changed. If no Beneficiary designation is on file, death proceeds will be determined by legal process and not necessarily to your intended choice. Beneficiary change forms are available on the Personal Choices Website or in Human Resources.

Plan Benefits	Reliance Standard
Eligible Class	Full-Time Employees
Coverage Amount*	1x Basic Annual Earnings
Maximum Benefit	Up to $100,000
Age Reduction	50% at age 70
Accelerated Benefit Option	
Conversion	Yes
Portability	No

* If the value of any pre-tax life insurance coverage is greater than $50,000, the amount over $50,000 is added to your taxable compensation as "imputed income."

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Flexible Spending Accounts

Igoe Administrative Services

The purpose of flexible spending accounts is to save you money for certain health care and dependent care expenses by letting you pay with pre-tax dollars. It allows you to be reimbursed for certain non-covered medical expenses, such as doctor visits, copays, deductibles, prescription drugs with pre-tax dollars. It also allows you to use pre-tax dollars to pay for certain dependent care expenses, such as childcare and elder care. There are two separate accounts.

Health Care Reimbursement Account (HCRA)

The Health Care Reimbursement Account is designed specifically for medical, dental and vision care expenses you expect to incur during the plan year that are not covered or reimbursed by any health care plan. Health Care Reimbursement accounts are based on the Plan Year: January 1 through December 31.

Important Note: You may submit incurred expenses for any person who qualifies as a dependent on your income tax return. You do not have to cover that person under your medical plan.

Dependent Care Reimbursement Account

The Dependent Care Reimbursement Account allows you to pay for eligible dependent care expenses on a tax-free basis.

To be eligible, expenses must be:

- For the care of a child under age 13, or for the care of a disabled dependent of any age (an invalid parent, for example), ***and***
- Necessary to enable you and your spouse to work or attend school on a full-time basis.

Funding Your Accounts

You may participate in the Health Care Reimbursement Account, the Dependent Care Reimbursement Account, or both. When you enroll, you decide how much money to contribute to your personal accounts for the coming year. These contributions are deducted from your paycheck each pay period (26 pay periods a year) and deposited to your accounts.

You may contribute up to:

- **The Health Care Reimbursement Account:** $2,750 per year (or $105.77 per paycheck).
- **The Dependent Care Reimbursement Account:** $5,000 per year (or $192.30 per paycheck).

Health Care Flexible Spending Account Claim Submission

"Use It or Lose It"

This plan has a carryover amount of $550.00. This means that you can incur expenses between January 1, 2022 and December 31, 2022. You will have until March 31, 2023 to submit manual claims for reimbursement. Any unused balances up to $550.00 will carryover to the new plan year effective January 1, 2023 (for use seven (7) days after the March 31, 2023 run-out end date).

Dependent Care Flexible Spending Account Claim Submission

"Use It or Lose It"

This plan has a 2.5 month grace period. This means that you can incur expenses from January 1, 2022 through the end of the 2.5 month grace period of March 15, 2023. You will have until the run-out end date of March 31, 2023 to submit manual claims for reimbursement.

Flexible Spending Accounts (continued)

Benefits Card

Your Benefits Card gives you easy access to the funds in your tax-advantaged benefit accounts by swiping the card at the point of sale. Funds are automatically transferred from the benefit account directly to your service provider with no out-of-pocket cost and possibly no need to file a claim for reimbursement.

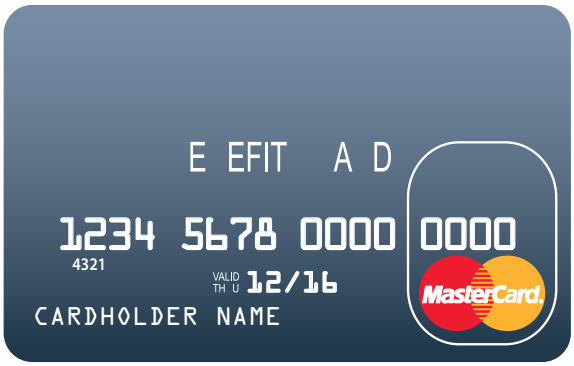
Your Benefits Card virtually eliminates:

- Out-of-pocket expenses
- Waiting for reimbursement
- Claim forms

For a list of eligible expenses, please visit www.goigoe.com.

Using Your Benefits Card is as easy as 1-2-3

1. **Check your account balance.** You can view your transaction history, current balance, claim status, and more by logging in online, calling the phone number on the back of your card or via the Igoe Mobile app.
2. **Swipe your Benefits Card.** Your first transactional swipe will activate your Benefits Card at the point-of-sale for eligible products and services. Most major retail chains utilize a system that will auto-substantiate the purchase, meaning it will approve eligible expenses without requiring submission of receipts. However, not all merchants can accommodate auto-substantiation, so keep your receipt! You may be asked to provide it later in order to fulfill the documentation requirements set forth by the IRS. The Benefits Card operates on a "good funds" model, meaning it cannot support transactions that exceed your available balance. Should your transaction exceed your available balance, your Card will be declined. You may try to run the Card for a lesser amount or pay manually and submit for reimbursement from your account. No PIN is required and transactions should be run as "credit".
3. **Keep all your receipts.** Though the need for documentation is greatly reduced when using your Benefits Card, it is a good practice to save your receipts in the instance documentation is requested by Igoe Administrative Services to satisfy claim review requirements imposed by the IRS. It's also a good idea to save your receipts in the event of an individual IRS audit.



Important IRS Rules

It is important to carefully choose how much money to place in your accounts. Because of the tax-advantaged way that both reimbursement accounts work, the IRS has established the following strict guidelines for how they may be used.

- If you contribute pre-tax dollars to a reimbursement account and then do not use all of the dollars you deposit, you will lose any remaining balance in the account at the end of the plan year, except for amounts subject to carryover and grace period. Up to $550 may be carried over for use in the following plan year.
- After you enroll, you can't change the amount in your accounts unless you have a Qualifying Event Status Change.
- You can't transfer funds from one reimbursement account to the other.
- If you use a Dependent Care Reimbursement Account, the IRS will not allow you to take a dependent care credit on your tax return for reimbursed expenses. For some people, the tax credit may be greater than the savings from a Dependent Care Reimbursement Account. If you are in doubt about which is best for you, consult a professional tax advisor.
- Flexible Spending Account plans (Section 125 and 129) are regulated under Federal Law, not California State Law; therefore, Domestic Partners are not eligible for these plans.

Employee Assistance Program

Beverly Hospital's Employee Assistance Program (EAP) is provided by Anthem Blue Cross and is available 24 hours a day, 7 days a week. No matter what's going on in your life - personal problems, planning for life events or simply managing daily life can affect your work, health and family. Our EAP is a company-sponsored benefit that is available to you and your dependents, offering confidential support, resources and information to get through life's challenges.

Here are some of the services our EAP offer — at no cost to you:

Counseling

- Up to 3 visits per issue
- Face-to-face counseling or online visits via LiveHealth Online
- Can call EAP or use the online Member Center to initiate services

Legal consultation

- 30-minute phone or in-person meeting
- Discounted fees to retain a lawyer
- Online resources, including free legal forms, seminars and a library of articles

Financial consultation

- Phone meeting with financial professionals
- Consultation available during regular business hours — no time limits or appointments needed
- Online resources, including articles, calculators and budgeting tools

ID recovery

- Identity theft risk level checked by specialists
- Help with reporting to consumer credit agencies
- Assistance filling out paperwork and negotiating with creditors

Dependent care and daily living resources

- Information available on child care, adoption, summer camps, college placement, elder care and assisted living through the EAP website
- Phone consultation with a work-life specialist
- For help with everyday needs, like pet sitting, relocation resources and more

Other anthemEAP.com resources

- Well-being articles, podcasts and monthly webinars
- Self-assessment tools for depression, anxiety, relationships, alcohol use, eating habits and more

Crisis consultation

- Toll-free number for emergencies
- Round-the-clock help available
- Critical event support online to help with planning, coping and recovery resources when tragedy strikes

On-demand digital resources

- The WellPost blog at anthemEAP.com, featuring Health & Wellness topics written by experts in the field

Need help? Give EAP a try today.

Call Anthem at 800-999-7222. Or go to anthemEAP.com and enter your company code: Beverly Hospital.

Pet Insurance

You can now provide your pets with customized health insurance just for them, through Nationwide. There are three simple ways for you to sign up for the new pet insurance voluntary benefit:

1. **Go directly to the dedicated URL:** http://benefits.petinsurance.com/beverlyhospital
2. **Visit:** http://www.PetsNationwide.com and enter their company name, Beverly Hospital
3. **Call:** 877-738-7874 and mention that they're employees of Beverly Hospital to receive preferred pricing

Plan Highlights:

- Get cash back on eligible vet bills
- Exclusive to employees, not available to the general public
- Use any vet, anywhere

	My Pet Protection
Accidents, including poisonings and allergic reactions	✔
Injuries, including cuts, sprains and broken bones	✔
Common illnesses, including ear infections, vomiting and diarrhea	✔
Serious/chronic illnesses, including cancer and diabetes	✔
Hereditary and congenital conditions	✔
Surgeries and hospitalization	✔
X-rays, MRIs and CT scans	✔
Prescription medications and therapeutic diets	✔

Note: Nationwide does not cover pre-existing conditions. However, we go above and beyond with extra features such as emergency boarding, lost pet advertising and more. Plus, both plans have a low $250 annual deductible and a generous $7,500 maximum annual benefit.

Voluntary Products

Beverly Hospital employees may take advantage of four voluntary benefit plans designed to offer you and your family additional security and peace of mind.

During this Open Enrollment period, you may apply for:

- Short Term Disability Income
- Universal Life Insurance with Long Term Care
- Critical Illness/Cancer Coverage
- Accident Insurance

All plans are optional and offered in addition to your existing benefits. You pay the full cost for these plans on an after-tax basis. They are portable, which means you can take them with you should you change jobs or retire. For cost and complete coverage details, talk to your Benefit Counselor during the Open Enrollment period.

Short Term Disability Income

This benefit is offered through Trustmark Insurance Company and replaces a percentage of your income when you are disabled and unable to work. It helps the employee pay their daily living expenses and meet their financial obligations when they are not receiving a paycheck.

Key Components

- Benefits for total disability up to 20% of salary (in addition to CA SDI) from $300 to $6,000 monthly.
- Non-occupational coverage
- Benefits for total disability resulting from pregnancy (at least 10 months after policy effective date)
- Disability is not being able to do your job at your employer (during the six month benefit duration)
- Benefit is paid to the employee
- Guaranteed Renewable to age 72

Universal Life Insurance with Long Term Care

Universal Life Insurance with Long Term Care is offered through Trustmark Insurance Company. The plan can be a valuable supplement to coverage you may already have through work or elsewhere. You may purchase coverage for yourself, your spouse, your children, and grandchildren. You are only able to insure your dependents if you elect coverage on yourself and their coverage is not greater than yours. Rates are deducted from your paycheck. A portion of your premium earns interest, and the plan provides valuable living benefits, as well as death benefits.

Plan Features

- Permanent coverage designed to last to age 100
- Premium does not increase due to age
- You can apply for coverage for yourself, your spouse, children and grandchildren. You must elect coverage on yourself to insure your dependents.
- Portable if the employee leaves the group or retires; premiums and coverage remain the same unless employee chooses to adjust them
- Accrues tax-deferred interest on the accumulated cash value at competitive rates.
- Advances the death benefit up to 75% upon diagnosis of a terminal illness.
- Premium for your coverage and your dependent children/grandchildren are waived if you are totally disabled. Spouse premium is waived only if the spouse is disabled.
- **Long Term Care Rider Includes:**
  - A Home Health and Long Term Care Rider, which pays a monthly benefit equal to 4% of your death benefit for up to 25 months for medically necessary long term, home health care, adult day care and hospice services expenses.
- Restoration of Death Benefit when paid for long-term care services.

This is a brief description of available coverage. See your Benefits Counselor for further details.

Voluntary Products (continued)

Critical Illness Insurance with Cancer

Critical Illness Insurance with Cancer is offered through Trustmark Insurance Company. The plan provides a lump-sum cash benefit, up to 100% of the policy's face value, upon the first diagnosis of a covered critical illness after the plan effective date.

Critical Illness insurance is intended to help cover some of the expenses not covered by medical insurance, such as out-of-pocket deductibles and copays, child care, travel expenses and more. Pre-existing condition limitations and exclusions may apply.

You are eligible for the plan if you are a benefits eligible full-time employee. You can enroll for coverage once each year during the annual Open Enrollment period.

Double Benefit

What happens if you experience a second covered condition? With the double benefit feature you can receive a second cash payment equal to the first. The second illness must be a different covered condition than the first and must occur at least six months later. Separation periods between diagnoses may apply.

Plan Features

Pays up to policy face amount in a cash lump sum if the insured has:

- Heart Attack
- Stroke
- Renal (kidney) Failure
- ALS (Lou Gehrig's Disease)
- Transplant of a major organ
- Occupational HIV
- Paralysis of two or more limbs
- Blindness
- Invasive Cancer (excluding some skin cancers)
- Carcinoma In Situ (Carcinoma in the stage of development when cancer cells are still within their site of origin, 25% benefit)
- Coronary Artery By-Pass Surgery (25% of benefit)

Health Screening Benefit

This built-in benefit pays the benefit of $100 per calendar year for one screening test for each insured, as defined in the rider.

Some of the many screening tests covered include:

- Pap smear (women over 18)
- Blood test for triglycerides
- Low dose mammography
- Prostate specific antigen
- Stress test on bicycle or treadmill
- Colonoscopy
- Fasting blood glucose test
- Chest X-ray

This is a brief description of available coverage. See your Benefit Counselor for further details.

Voluntary Products (continued)

Accident Insurance

Accident coverage is offered through Trustmark Insurance Company. The plan provides individuals with cash benefits that help with lost income, uncovered medical procedures, copays and many other expenses related to accidents. Accident coverage pays cash directly to the covered individual in addition to any other insurance. Payments received do not have to be used for any specific purpose. The recipient can utilize the payment for any purpose they wish.

Plan Features

- **Fully Portable:** You can keep your coverage even if you leave your employer or retire
- **Guaranteed Renewable:** Coverage can only be cancelled for nonpayment of premiums
- **Limitations:** No Underwriting or Pre-existing Condition Limitations
- **Initial Care Benefits:** Physician visit, ambulance, emergency room treatment, hospital benefits, lodging, blood, surgery, emergency dental
- **Injury Benefits:** Burn; concussion; dislocation; eye injury; fracture; herniated disc; laceration; loss of finger, toe, hand, foot, sight; tendon, ligament, rotator cuff injury; torn knee cartilage
- **Follow-up Care Benefits:** Physical therapy, appliances, prosthetic device, artificial limb, skin graft, transportation
- **Wellness Benefit:** Pays $50 for routine physical, immunizations, and health screening tests, regardless of other coverage. In addition, a maximum of two visits per person or ten visits per family, annually.

Plan forms GUL.205/IUL.205, CACI-82001, DI 902 and A-607 and applicable riders are underwritten by Trustmark Insurance Company, Lake Forest, Illinois. Underwriting conditions may vary, and determine eligibility for the offer of insurance. Benefits, availability, exclusions and limitations may vary by state and may be named differently. Pre-existing condition limitations may apply. Your policy will contain complete information. Trustmark® is a registered trademark of Trustmark Insurance Company.

Accident Benefit Payments

- **Hospital Admission Benefit:** $750
  - Provides a benefit for admission to a hospital due to a covered accident
  - Payable once per person per accident
- **Hospital Confinement Benefit:** $200 per day*
  - Provides a benefit for confinement in a hospital due to a covered accident
  - Benefit is payable for up to 365 days
- **Hospital Intensive Care Unit Benefit*:** $400 per day
  - Provides a benefit for confinement to a Hospital ICU due to a covered accident.
  - Benefit is payable for up to 15 days

* Hospital confinement and ICU benefits cannot be paid at the same time.

Example: If you or a covered family member breaks a leg, here's how accident benefits may be paid. These benefits are paid in addition to what your health insurance pays.

Event	Payment
Ambulance	$100
ER Visit	$150
Fractured Leg Benefit is dependent on the type of fracture *(open, closed, reduced, etc.)*	$800
Crutches	$100
2x Physical Therapy	$50; up to 6 visits
Follow-Up Visit	$50
Total Potential Benefit	$1,250

This is a brief description of available coverage. See your Benefit Counselor for further details.

Voluntary Products (continued)

Voluntary Life/AD&D with Reliance Standard

Reliance Standard is our Voluntary Life/AD&D and Voluntary Long Term Disability carrier. To supplement your Basic Life/AD&D coverage, you may elect to purchase Voluntary Life coverage for yourself and your dependents.

If you apply later than 31 days from the date you are first eligible to enroll – Voluntary Employee, Spouse, and Child Life Insurance can only become effective upon approval of the Medical Evidence of Insurability application.

For those currently participating in the Voluntary Life plan who do NOT wish to make any changes in coverage, no action is required. If you wish to enroll in the Voluntary Life plan for the first time or increase your coverage, during the Open Enrollment period, you will need to complete a new enrollment form and an Evidence of Insurability (EOI) application. This policy is portable, which means you can take it with you should you change jobs or retire.

Plan Benefits	Voluntary Life and AD&D Reliance Standard
Employee Benefit	An amount equal to $10,000 to $500,000 in $10,000 increments
Spouse Benefit *(to age 75)*	An amount equal to $10,000 to $500,000 in $10,000 increments (not tied to employee's selection), must enroll before age 70
Child(ren) Benefit	14 days up to 6 months: $1,000 6 months up to Age 26: Choice of $2,500, $5,000, $7,500, $10,000
Guarantee Issue Amount *(New Hires only)*	
• Employee	Under Age 70: $120,000
• Spouse	Under Age 60: $30,000
Monthly Cost	**EMPLOYEE & SPOUSE (PER $10,000)**
• 19 & under	$0.80
• 20-29	$0.90
• 30 - 34	$1.10
• 35 - 39	$1.20
• 40 - 44	$1.69
• 45 - 49	$2.66
• 50 - 54	$3.60
• 55 - 59	$5.75
• 60 - 64	$9.29
• 65 - 69	$13.59
• 70+	$26.78

Child Life Coverage Options				
Coverage Option #	**1**	**2**	**3**	**4**
14 days up to 6 months	$1,000	$1,000	$1,000	$1,000
6 months up to Age 26	$2,500	$5,000	$7,500	$10,000
Rate per month	$0.42	$0.82	$1.22	$1.62

This is a brief summary of the benefits available under the Beverly Hospital plans. In the event of a discrepancy between this summary and the Certificate of Insurance, The Certificate of Insurance will prevail. Beverly Hospital retains the right to modify or eliminate these or any other benefits at any time and for any reason.

Voluntary Products (continued)

Voluntary LTD with Reliance Standard

- **Monthly Benefit Amount:** The benefit is 60% of your Basic Monthly Earnings. The maximum monthly benefit amount is $10,000.
- **Elimination Period:** Benefits become payable after you have been disabled for a period of 180 days.
- **Benefit Reductions:** The Monthly Benefit will be reduced by other income sources such as State Disability Insurance benefits, Social Security disability benefits, Workers' Compensation benefits and income from another employer.
- **Pre-Existing Conditions Limitation:** A pre-existing condition is a sickness or injury for which you incurred charges, received medical treatment, consulted a physician, or took prescribed drugs or medicines within 3 months before you became insured. If your disability is due to a pre-existing condition and it begins within 12 months of your effective date, no benefits will be paid unless you have not incurred charges, received medical treatment, consulted a physician, or taken prescribed drugs for such condition, or any complication for six continuous months, while insured.

For those currently participating in the Voluntary Long Term Disability plan who do not wish to make any changes in coverage, no action is required. You may apply for coverage without answering any medical questions or providing Evidence of Insurability if you apply for coverage within 31 days after your initial eligibility date. If you apply more than 31 days after your initial eligibility date, your coverage will be medically underwritten, and you will be required to qualify based on information you provide regarding your medical history.

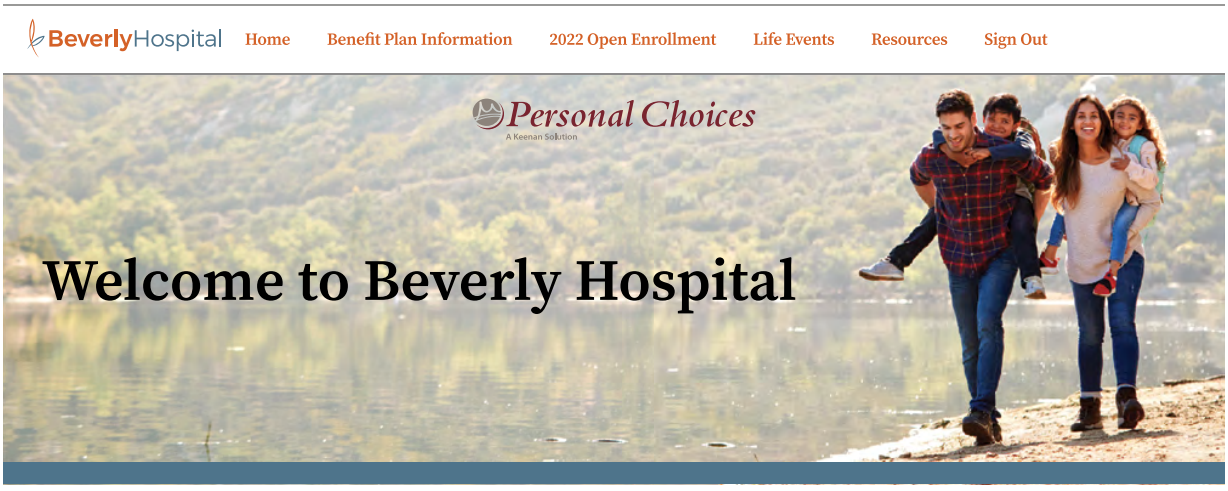
Plan Benefits	Voluntary LTD Reliance Standard
Monthly Benefit Amount	60% of your basic monthly earnings
Minimum Monthly Benefit Amount	$100
Maximum Monthly Benefit	$10,000
Elimination Period	180 days
Benefit Duration	Social Security Normal Retirement Age (SSNRA)*
Pre-Existing Limitation	3/12
Monthly Cost	Rate/$100 of Monthly Covered Benefit
• 18 - 24	$0.14
• 25 - 29	$0.21
• 30 - 34	$0.39
• 35 - 39	$0.61
• 40 - 44	$1.06
• 45 - 49	$1.39
• 50 - 54	$1.96
• 55 - 59	$2.54
• 60 - 64	$1.95
• 65 - 69	$1.33
• 70+	$0.96

* Benefits for employees that become disabled after retirement age extend for a minimum of 1 year. See Certificate with benefit schedule for details.

This is a brief summary of the benefits available under the Beverly Hospital plans. In the event of a discrepancy between this summary and the Certificate of Insurance, The Certificate of Insurance will prevail. Beverly Hospital retains the right to modify or eliminate these or any other benefits at any time and for any reason.

Employee Benefits Website

Check your Personal Choices website. Personal Choices can be accessed 24/7 from work or home PCs or smartphone and offers immediate answers to benefit questions. You can view and compare your benefit choices, link to carrier websites, download forms and analyze your benefit needs.



The following is a summary of some of the benefit information on Personal Choices:

- **Benefits:** This section lists benefit plans offered to Beverly Hospital employees, as well as a detailed description of each plan. This section can be used to compare and contrast different plans. It also contains your Summary of Benefits and Coverage (SBC), Plan Document/Summary Plan Descriptions, Evidence of Coverage (EOC) booklets and insurance forms.
- **2022 Open Enrollment:** Provides detailed plan information on new plan options.
- **Life Events:** Provides employees with information for specific life events that impact plan enrollment.
- **Resources:** Contains company forms, carrier links and information on Federal Programs including COBRA, FMLA, and HIPAA. Contact Human Resources for more specific information.

To Access Personal Choices

From Home

In your internet browser on your computer or mobile smart phone, enter https://app.strivebenefits.com/BeverlyHospital

Username: Beverly
Password: Benefits

OR

From Work

Click on the Internet Explorer icon to get the Beverly home page

Click on Personal Choices

Wellness

Beverly Hospital's employees are its greatest assets, and we take your health and well-being very seriously. That's why Beverly Hospital provides various programs to promote and support wellness among its workforce.

Tobacco-Free Incentive

Employees who indicate they are tobacco users during benefits enrollment will be assessed a $50 per month tobacco surcharge for the 2022 benefits year. As an incentive to be tobacco-free, employees who indicate during benefits enrollment that they do not use tobacco products, or who complete a tobacco cessation program (see below), will receive a waiver of the surcharge.

If you indicate during benefits enrollment that you are tobacco-free, you are verifying that you have not used tobacco products during the past 30 days, are currently tobacco-free, and will not use tobacco products during the 2022 benefits year. Tobacco products include cigarettes, electronic smoking devices, cigars, chewing or pipe tobacco, or any other tobacco products regardless of the frequency or method of use. Misrepresentation of your tobacco status may result in the imposition of the tobacco-use surcharge for the entire year, as well as disciplinary action.

Employees who are current tobacco users can become eligible for waiver of the tobacco surcharge by meeting the following tobacco cessation program requirements:

1. Complete a tobacco cessation program by June 30, 2022.
2. Submit written confirmation to your Human Resources representative after completion of the tobacco cessation program.
3. Once the above requirements are met and verified, the $50 per month tobacco surcharge will be removed from the employee cost of health care insurance effective the first pay period following the submission of verification of the completed tobacco cessation program, and the tobacco surcharge collected prior to that pay period will be rebated.

A reasonable alternative option for meeting the requirements for waiver of the tobacco use surcharge is available to any employee for whom it is unreasonably difficult to satisfy the requirement, or for whom it is medically inadvisable to attempt to satisfy the requirement.

Wellness (continued)

The following are several wellness programs offered by your Benefits Program providers:

Anthem Blue Cross

If you have a long-term health problem, Anthem's ConditionCare is a program that helps people with asthma, chronic obstructive pulmonary disease (COPD), diabetes, heart failure, coronary artery disease (CAD) and more. When you join the program, Anthem will give you the tools and resources you need to take charge of your health.

You'll also get:

- 24/7 phone access to a nurse care manager who can answer your questions and give you up-to-date information about your condition.
- A health review and follow-up calls if you need them.
- Tips on prevention and lifestyle choices to help you improve your quality of life.

Get the support you need

Call Anthem Blue Cross to sign up and use this program at no extra cost:

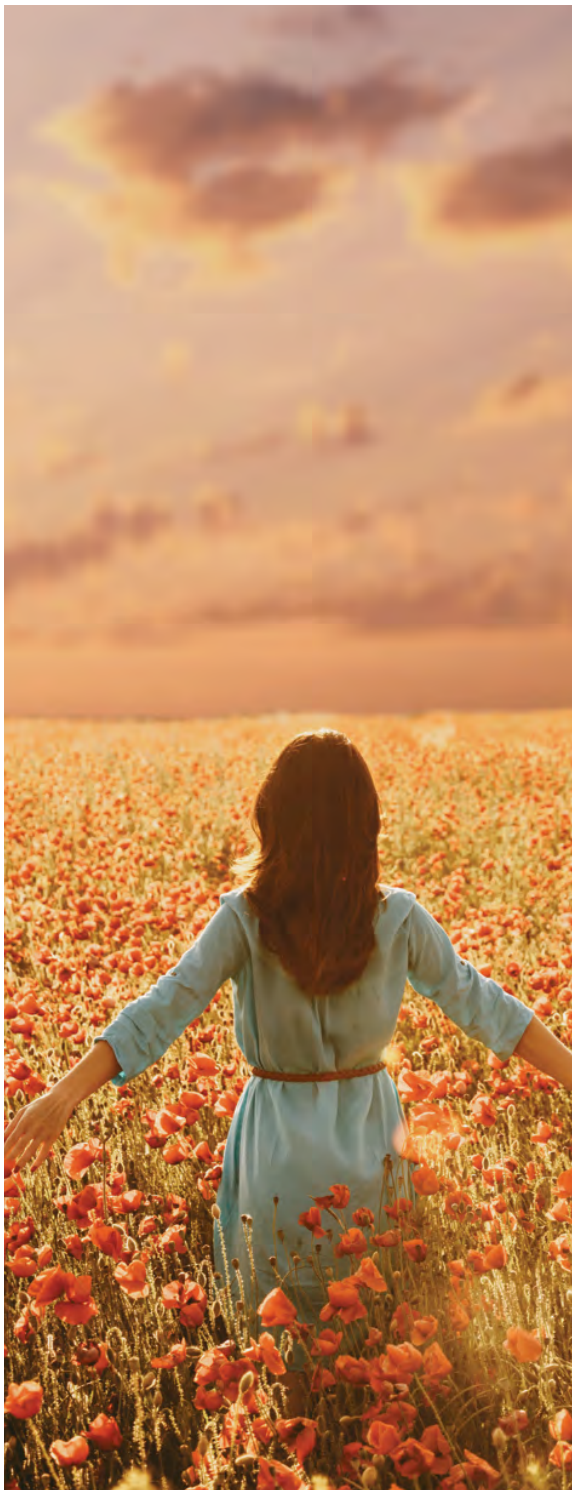
- **ConditionCare:** 800.522.5560

Delta Dental

Delta Dental is passionate about oral health and its importance to generations of families. Delta Dental provides oral health topics from amalgam fillings to x-rays as well as an online Dental health newsletter, Dental Wire. For more information, visit the Delta Dental Website at deltadentalins.com under the Oral Health section.

Vision Service Plan

VSP offers a quarterly education e-newsletter, Eye on Health. This newsletter provides timely information on eye health topics to help you keep your vision health. Subscribe to Eye on Health newsletter by visiting the VSP website at vsp.com.



Rates

Employee contributions for your medical, dental, vision and voluntary plans are taken from your paycheck each pay period, which equals 26 deductions per year. Premium deductions will be taken for Medical, Vision and Dental plans on a pre-tax basis. If you choose not to have your plan contributions pre-taxed, please contact Human Resources.

Contributions Effective January 1, 2022

Medical				
Coverage Category	**Total Premium per Month**	**Employer Cost per Month**	**Employee Cost per Month**	**Employee Cost per Pay Period**
EPO Select Plan - Full-Time				
• Employee Only	$496.57	$446.91	$49.66	$22.92
• Employee & Spouse	$1,201.76	$1,021.50	$180.26	$83.20
• Employee & Child(ren)	$1,010.59	$859.00	$151.59	$69.96
• Employee & Family	$1,702.36	$1,361.89	$340.47	$157.14
EPO Select Plan - Part-Time				
• Employee Only	$496.57	$422.09	$74.48	$34.38
• Employee & Spouse	$1,201.76	$961.41	$240.35	$110.93
• Employee & Child(ren)	$1,010.59	$808.47	$202.12	$93.29
• Employee & Family	$1,702.36	$1,276.77	$425.59	$196.43
EPO Plus Plan - Full-Time				
• Employee Only	$597.40	$537.66	$59.74	$27.57
• Employee & Spouse	$1,448.05	$1,230.84	$217.21	$100.25
• Employee & Child(ren)	$1,216.90	$1,034.36	$182.54	$84.25
• Employee & Family	$2,051.17	$1,640.94	$410.23	$189.34
EPO Plus Plan - Part-Time				
• Employee Only	$597.40	$507.79	$89.61	$41.36
• Employee & Spouse	$1,448.05	$1,158.44	$289.61	$133.67
• Employee & Child(ren)	$1,216.90	$973.52	$243.38	$112.33
• Employee & Family	$2,051.17	$1,538.38	$512.79	$236.67
PPO Plan - Full-Time				
• Employee Only	$986.53	$789.22	$197.31	$91.06
• Employee & Spouse	$2,167.72	$1,625.79	$541.93	$250.12
• Employee & Child(ren)	$1,780.93	$1,335.70	$445.23	$205.49
• Employee & Family	$3,055.60	$2,138.92	$916.68	$423.08
PPO Plan - Part-Time				
• Employee Only	$986.53	$690.57	$295.96	$136.60
• Employee & Spouse	$2,167.72	$1,409.02	$758.70	$350.17
• Employee & Child(ren)	$1,780.93	$1,157.60	$623.33	$287.69
• Employee & Family	$3,055.60	$1,833.36	$1,222.24	$564.11

Rates (continued)

Dental				
Coverage Category	**Total Premium per Month**	**Employer Cost per Month**	**Employee Cost per Month**	**Employee Cost per Pay Period**
Delta Dental PPO - Full-Time/Part-Time				
• Employee Only	$44.13	$24.00	$20.13	$9.29
• Employee & Spouse	$98.86	$48.37	$50.49	$23.31
• Employee & Child(ren)	$83.54	$46.07	$37.47	$17.29
• Employee & Family	$143.31	$75.00	$68.31	$31.53
DeltaCare® DHMO - Full-Time/Part-Time				
• Employee Only	$23.84	$17.54	$6.30	$2.91
• Employee & Spouse	$46.32	$34.08	$12.24	$5.65
• Employee & Child(ren)	$42.77	$31.48	$11.29	$5.21
• Employee & Family	$66.43	$48.86	$17.57	$8.11

Vision				
Coverage Category	**Total Premium per Month**	**Employer Cost per Month**	**Employee Cost per Month**	**Employee Cost per Pay Period**
VSP - Full-Time/Part-Time				
• Employee Only	$7.42	$1.98	$5.44	$2.51
• Employee & Spouse	$11.87	$0.56	$11.31	$5.22
• Employee & Child(ren)	$12.11	$0.57	$11.54	$5.33
• Employee & Family	$19.53	$0.86	$18.67	$8.62

Important Notices

Discrimination Is Against the Law

Beverly Hospital complies with the applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Beverly Hospital does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Beverly Hospital:

- Provides free aids and services to people with disabilities to communicate effectively with it, such as:
  - Qualified sign language interpreters
  - Written information in other formats (e.g., large print, audio, accessible electronic formats, etc.)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact George Holtz.

If you believe that Beverly Hospital has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: George Holtz, Administrative Director, Human Resources, (323) 725-4293, gholtz@beverly.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, George Holtz is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1.800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at:
http://www.hhs.gov/ocr/office/file/index.html

Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 877.746.4674.

Chinese

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 877.746.4674.

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 877.746.4674.

Filipino

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 877.746.4674.

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 877.746.4674 번으로 전화해 주십시오.

Armenian

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 877.746.4674.

Persian

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما می باشد. با 877.746.4674فراهم تماس بگیرید.

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 877.746.4674.

Japanese

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。877.746.4674まで、お電話にてご連絡ください。

Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم877.746.4674

Punjabi

ਧਿਆਨ ਦਿਓ :ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ ,ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 877.746.4674 ' ਤੇ ਕਾਲ ਕਰੋ।

Mon-Khmer Cambodian

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 877.746.4674 ។

Hmong

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 877.746.4674.

Important Notices (continued)

Hindi

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 877.746.4674 पर कॉल करें।

Thai

เรียน :ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 877.746.4674 .

Newborns' and Mothers' Health Protection Act (NMHPA)

Benefits for pregnancy hospital stay (for delivery) for a mother and her newborn generally may not be restricted to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. Also, any utilization review requirements for inpatient hospital admissions will not apply for this minimum length of stay and early discharge is only permitted if the attending health care provider, in consultation with the mother, decides an earlier discharge is appropriate.

Women's Health and Cancer Rights Act (WHCRA) Annual Notice

Your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. For more information, you should review the Summary Plan Description or call your Plan Administrator at 323.725.4295.

Networks/Claims/Appeals

The major medical plans described in this booklet have provider networks with Anthem. The listing of provider networks will be available to you automatically and free of charge. A list of network providers can be accessed immediately by using the Internet address found in the Summary of Benefits and Coverage that relates to the Plan. You have a right to appeal denials of claims, and a right to a response within a reasonable amount of time. Claims that are not submitted within a reasonable time may be denied. Please review your Summary Plan Description or contact the Plan Administrator for more details.

COBRA Continuation Coverage

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

Important Notices (continued)

The right to COBRA continuation coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "Qualifying Event." Specific Qualifying Events are listed later in this notice. After a Qualifying Event, COBRA continuation coverage must be offered to each person who is a "Qualified Beneficiary." You, your spouse, and your dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event. Under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a Qualified Beneficiary if you lose coverage under the Plan because of the following Qualifying Events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan because of the following Qualifying Events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than their gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or,
- You become divorced or legally separated from your spouse.

Your dependent children will become Qualified Beneficiaries if they lose coverage under the Plan because of the following Qualifying Events:

- The parent-employee dies;
- The parent-employee's employment ends for any reason other than their gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or,
- The child stops being eligible for coverage under the Plan as a "dependent child."

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. The employer must notify the Plan Administrator of the following Qualifying Events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or,
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other Qualifying Events (e.g., divorce or legal separation of the employee and spouse, or a dependent child's losing eligibility for coverage as a dependent child, etc.), you must notify the Plan Administrator within 60 days after the Qualifying Event occurs. You must provide this notice to your employer.

Life insurance, accidental death and dismemberment benefits, and weekly income or long-term disability benefits (if part of the employer's plan), are not eligible for continuation under COBRA.

NOTICE AND ELECTION PROCEDURES

Each type of notice or election to be provided by a covered employee or a Qualified Beneficiary under this COBRA Continuation Coverage Section must be in writing, must be signed and dated, and must be mailed or hand-delivered to the Plan Administrator, properly addressed, or as otherwise permitted by the COBRA administrator, no later than the date specified in the election form, and properly submitted to the Plan Administrator.

Important Notices (continued)

Each notice must include all of the following items: the covered employee's full name, address, phone number and Social Security Number; the full name, address, phone number and Social Security Number of each affected dependent, as well as each dependent's relationship to the covered employee; a description of the Qualifying Event or disability determination that has occurred; the date the Qualifying Event or disability determination occurred; a copy of the Social Security Administration's written disability determination, if applicable; and the name of this Plan. The Plan Administrator may establish specific forms that must be used to provide a notice or election.

ELECTION AND ELECTION PERIOD

COBRA continuation coverage may be elected during the period beginning on the date Plan coverage would otherwise terminate due to a Qualifying Event and ending on the later of the following: (1) 60 days after coverage ends due to a Qualifying Event, or (2) 60 days after the notice of the COBRA continuation coverage rights is provided to the Qualified Beneficiary.

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage rights, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver will be an election of COBRA continuation coverage. However, if a waiver is revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered to be made on the date they are sent to the employer or Plan Administrator.

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation on behalf of their dependent children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain Qualifying Events, or a second Qualifying Event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

DISABILITY EXTENSION OF THE 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. This disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. (See Notice and Election Procedures.)

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE

If your family experiences another Qualifying Event during the 18 months of COBRA continuation of coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation of coverage, for a maximum of 36 months, if the Plan is properly notified about the second Qualifying Event. This extension may be available to the spouse and any dependent children receiving COBRA continuation of coverage if the employee or former employee dies; becomes entitled to Medicare (Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second Qualifying Event would have caused the spouse or the dependent child to lose coverage under the Plan had the first Qualifying Event not occurred. (See Notice and Election Procedures.)

OTHER OPTIONS BESIDES COBRA CONTINUATION COVERAGE

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, Children's Health Insurance Program (CHIP) or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Important Notices (continued)

ENROLLMENT IN MEDICARE INSTEAD OF COBRA

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

IF YOU HAVE QUESTIONS

[For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans subject to ERISA, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Address and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

For more information about the Marketplace, visit www.healthcare.gov.

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

EFFECTIVE DATE OF COVERAGE

COBRA continuation coverage, if elected within the period allowed for such election, is effective retroactively to the date coverage would otherwise have terminated due to the Qualifying Event, and the Qualified Beneficiary will be charged for coverage in this retroactive period.

COST OF CONTINUATION COVERAGE

The cost of COBRA continuation coverage will not exceed 102% of the Plan's full cost of coverage during the same period for similarly situated non-COBRA beneficiaries to whom a Qualifying Event has not occurred. The "full cost" includes any part of the cost which is paid by the employer for non-COBRA beneficiaries.

The initial payment must be made within 45 days after the date of the COBRA election by the Qualified Beneficiary. Payment must cover the period of coverage from the date of the COBRA election retroactive to the date of loss of coverage due to the Qualifying Event (or date a COBRA waiver was revoked, if applicable). The first and subsequent payments must be submitted and made payable to the Plan Administrator or COBRA Administrator. Payments for successive periods of coverage are due on the first of each month thereafter, with a 30-day grace period allowed for payment. Where an employee organization or any other entity that provides Plan benefits on behalf of the Plan Administrator permits a billing grace period greater than the 30 days stated above, such period shall apply in lieu of the 30 days. Payment is considered to be made on the date it is sent to the Plan or Plan Administrator.

The Plan will allow the payment for COBRA continuation coverage to be made in monthly installments, but the Plan can also allow for payment at other intervals. The Plan is not obligated to send monthly premium notices.

The Plan will notify the Qualified Beneficiary, in writing, of any termination of COBRA coverage based on the criteria stated in this Section that occurs prior to the end of the Qualified Beneficiary's applicable maximum coverage period. Notice will be given within 30 days of the Plan's decision to terminate.

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods

Such notice shall include the reason that continuation coverage has terminated earlier than the end of the maximum coverage period for such Qualifying Event and the date of termination of continuation coverage.

See the Summary Plan Description or contact the Plan Administrator for more information.

Flexible Spending Accounts (FSAs) – Termination and Claims Submission Deadlines

Note: If you lose eligibility for any reason during the Plan Year, your contributions to your Health and/or Dependent Care FSAs will end as of the date your eligibility terminates. You may submit claims for reimbursement from your FSAs for expenses incurred during the Plan Year prior to your eligibility termination. You must submit claims for reimbursement from your Health and/or Dependent Care FSAs no later than 90 days after the date your eligibility terminates. Any balance remaining in your FSAs will be forfeited after claims submitted prior to this date have been processed.

Special Enrollment Rights Notice

CHANGES TO YOUR HEALTH PLAN ELECTIONS

Once you make your benefits elections, they cannot be changed until the next Open Enrollment. Open Enrollment is held once a year.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if there is a loss of other coverage. However, you must request enrollment no later than 30 days after that other coverage ends.

If you declined coverage while Medicaid or the Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and/or your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment no later than 60 days after Medicaid or CHIP coverage ends.

If you or your dependents become eligible for Medicaid or CHIP premium assistance, you may be able to enroll yourself and/or your dependents into this plan. However, you must request enrollment no later than 60 days after the determination for eligibility for such assistance.

If you have a change in family status such as a new dependent resulting from marriage, birth, adoption or placement for adoption, divorce (including legal separation and annulment), death, or Qualified Medical Child Support Order, you may be able to enroll yourself and / or your dependents. However, you must request enrollment no later than 30 days after the marriage, birth, adoption or placement for adoption or divorce (including legal separation and annulment).

For information about Special Enrollment Rights, please contact:

George Holtz
Administrative Director, Human Resources
323.725.4293
gholtz@beverly.org

Medicare Part D – Important Notice About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Beverly Hospital and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

- **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

Important Notices (continued)

- **Beverly Hospital has determined that the prescription drug coverage offered by Beverly Hospital Medical Plans are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?

If you decide to join a Medicare drug plan, your current Beverly Hospital coverage will not be affected. If you keep this coverage and elect Medicare, the Beverly Hospital coverage will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current Beverly Hospital coverage, be aware that you and your dependents will be able to get this coverage back.

WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?

You should also know that if you drop or lose your current coverage with Beverly Hospital and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without Creditable Coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (i.e., a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE

Contact the person listed below for further information. **Note:** You will get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Beverly Hospital changes. You also may request a copy of this notice at any time.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

FOR MORE INFORMATION ABOUT MEDICARE PRESCRIPTION DRUG COVERAGE

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number) for personalized help.
- Call 800.MEDICARE (800.633.4227). TTY users should call 877.486.2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 800.772.1213 (TTY 800.325.0778).

REMEMBER

Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained Creditable Coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	October 2021
Name of Entity / Sender:	Beverly Hospital
Contact:	Human Resources
Address:	309 W. Beverly Blvd. Montebello, CA 90640
Phone:	323.725.4295

Important Notices (continued)

Availability of Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices

Beverly Hospital Group Health Plan maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact Debra Whitworth at 323.725.4295.

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

This notice provides you with information about Beverly Hospital in the event you wish to apply for coverage on the Health Insurance Marketplace. All the information you need from Human Resources is listed in this notice. If you wish to have someone assist you in the application process or have questions about subsidies that you may be eligible to receive, (for California residents only) you can contact KeenanDirect at 855.653.3626 or at www.KeenanDirect.com, or (for everyone) contact the Health Insurance Marketplace directly at www.Healthcare.gov.

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget by offering "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away. Open Enrollment for health insurance coverage through Covered California will begin November 1, 2021, and is anticipated to end on January 31, 2022. Open Enrollment for other states will begin on November 1 and close on December 15 of each year. Some states have expanded the open enrollment period beyond December 15, 2021 for coverage to begin in 2022. Notably, Covered California continues its special enrollment period for coverage beginning in 2021 to December 31, 2021.

CAN I SAVE MONEY ON MY HEALTH INSURANCE PREMIUMS IN THE MARKETPLACE?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer you coverage, offers medical coverage that is not "Affordable," or does not provide "Minimum Value." If the lowest cost plan from your employer that would cover you (and not any other members of your family) is more than 9.61% (for 2022) of your household income for the year, then that coverage is not Affordable. Moreover, if the medical coverage offered covers less than 60% of the benefits costs, then the plan does not provide Minimum Value.

DOES EMPLOYER HEALTH COVERAGE AFFECT ELIGIBILITY FOR PREMIUM SAVINGS THROUGH THE MARKETPLACE?

Yes. If you have an offer of medical coverage from your employer that is both Affordable and provides Minimum Value, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's medical plan.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered medical coverage. Also, this employer contribution, as well as your employee contribution to employer-offered coverage, is often excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

PART B: EXCHANGE APPLICATION INFORMATION

In the event you wish to apply for coverage on the Exchange, all the information you need from Human Resources is listed below. If you are located in California and wish to have someone assist you in the application process or have questions about subsidies that you may be eligible to receive, you can contact KeenanDirect at 855.653.3626 or at www.KeenanDirect.com.

3. Employer name Beverly Hospital	**4. Employer Identification Number (EIN)** 95-1816005	
5. Employer address 309 W. Beverly Boulevard	**6. Employer phone number** 323.725.4295	
7. City Montebello	**8. State** CA	**9. ZIP code** 90640
10. Who can we contact about employee health coverage at this job? Human Resources		
11. Phone number (if different from above)	**12. Email address** dwhitworth@beverly.org	

Important Notices (continued)

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 877.KIDS.NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your State if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 866.444.EBSA (3272).

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2021. Contact your State for more information on eligibility.

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 855.692.5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 866.251.4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 855.MyARHIPP (855.692.7447)

CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program Website:
http://dhcs.ca.gov/hipp
Phone: 916.445.8322
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado
Colorado's Medicaid Program & Child Health Plan Plus (CHIP+)
Healthy First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 800.221.3943
TTY: Colorado relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 800.359.1991
TTY: Colorado relay 711
Health Insurance Buy-In Program (HIBI):
https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: 855.692.6442

FLORIDA – Medicaid
Website:
http://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 877.357.3268

GEORGIA – Medicaid
Website: http://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp/
Phone: 678.564.1162, ext. 2131

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 877.438.4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone: 800.457.4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members
Medicaid Phone: 800.338.8366
HIPP Website:
https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 888.346.9562

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 800.792.4884

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 855.459.6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 877.524.4718
Kentucky Medicaid Website: https://chfs.ky.gov

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 888.342.6207 (Medicaid hotline) or

Important Notices (continued)

MAINE – Medicaid
Enrollment Website:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 800.442.6003 | TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 800.977.6740 | TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa
Phone: 800.862.4840

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 800.657.3739

MISSOURI – Medicaid
Website:
https://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573.751.2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 800.694.3084

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 855.632.7633
Lincoln: 402.473.7000
Omaha: 402.595.1178

NEVADA – Medicaid
Medicaid Website: https://dhcfp.nv.gov/
Medicaid Phone: 800.992.0900

NEW HAMPSHIRE – Medicaid
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 603.271.5218
Toll-Free for the HIPP program: 800.852.3345, ext. 5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609.631.2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 800.701.0710

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 800.541.2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919.855.4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 844.854.4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 888.365.3742

OREGON – Medicaid
Websites: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 800.699.9075

PENNSYLVANIA – Medicaid
Website:
https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx
Phone: 800.692.7462

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 855.697.4347, or 401.462.0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 888.549.0820

SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov
Phone: 888.828.0059

TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 800.440.0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 877.543.7669

VERMONT – Medicaid
Website: http://www.greenmountaincare.org/
Phone: 800.250.8427

VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/en/famis-select
https://www.coverva.org/en/hipp/
Medicaid Phone: 800.432.5924
CHIP Phone: 800.432.5924

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 800.562.3022

WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/
Toll-free phone: 855.MyWVHIPP (855.699.8447)

WISCONSIN – Medicaid and CHIP
Website:
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 800.362.3002

WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 800.251.1269

To see if any other states have added a premium assistance program since July 31, 2021, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
866.444.EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877.267.2323, Menu Option 4, Ext. 61565

Title 11, Cal. Admin. Code, Section 999.5(d)(5)(F)

For each health facility or facility that provides similar healthcare that is the subject of the agreement or transaction, all existing documents setting forth any guarantees made by any entity that would be taking over operation or control of the health facility or facility that provides similar healthcare relating to employee job security and retraining, or the continuation of current staffing levels and policies, employee wages, salaries, benefits, working conditions and employment protections

Under the Affiliation, Adventist Health will become the sole corporate member or the sole controlling entity of each Beverly Entity, with each Beverly Entity retaining its assets and liabilities at the Closing.

Pursuant to the Affiliation Agreement, the Closing of the Affiliation will not negatively impact the employment status, wages, salaries, benefits, working conditions or protections of any of the employees of Beverly.

The parties have agreed, as described in the Affiliation Agreement, that Beverly's medical staff members who are in good standing may be combined with the AHWM medical staff following the Closing. The parties anticipate that such combination of the Beverly medical staff would mitigate ongoing medical staff challenges at Beverly and expand medical staff coverage.

11 Cal. Code Reg. Section 999.5(d)(5)(G)

If the agreement or transaction will have any impact on reproductive healthcare services provided by any facility that is the subject of the agreement or transaction, or any impact on the availability or accessibility of reproductive healthcare services, a description of all reproductive healthcare services provided in the last five years by each health facility or facility that provides similar healthcare that is the subject of the agreement or transaction. This description shall include the types and levels of reproductive services including, but not limited to, information about the number of pregnancy terminations and tubal ligations and a description of how this information was compiled

The Affiliation is not anticipated to have any impact on reproductive healthcare services provided by Beverly. Beverly does not restrict the provision of any reproductive healthcare services (including pregnancy terminations or tubal ligations) or subject such reproductive healthcare services to any religious or ethical directives other than any exemptions required by law.

For more information about the commitments of the parties with respect to services post-Closing, please also see the responses to Section 999.5(d)(1)(A) and Section 999.5(d)(5)(H) of this Notice.

11 Cal. Code Reg. Section 999.5(d)(5)(H)

A statement describing all effects that the proposed agreement or transaction may have on healthcare services provided by each facility proposed to be transferred including, but not limited to, any changes in the types or levels of medical services that may be provided at the health facility or facility that provides similar healthcare and a statement of how the proposed transaction may affect the availability and accessibility of healthcare in the affected communities

The Affiliation provides for Adventist Health to become the sole member or sole controlling entity of Beverly, and it is not intended or anticipated to have any adverse impact on the availability or accessibility of healthcare services to the affected community. In fact, the proposed transaction is expected to have a positive effect on the delivery of healthcare services to the communities serviced by Beverly because without the Affiliation, Beverly, as a failing firm within the meaning of the federal antitrust rules, may be forced to shut down its operations and cease providing all healthcare services. Thus, the Affiliation will permit Beverly to maintain community access to essential healthcare service.

The Affiliation will result in Beverly's integration within a large regional health system that has a similar objective of ensuring high quality healthcare services are delivered to underserved populations, which will preserve Beverly's ability to deliver critical healthcare services in the community. Moreover, the parties intend for the Affiliation to strengthen Beverly by giving Beverly access to the resources of the Adventist Health system, thus allowing patients to benefit from an increase in care coordination.

Following the Closing of the Affiliation, Beverly and Adventist Health intend to maximize operational efficiencies arising from the parties' ability to provide services at either of the Beverly and AHWM campuses, which are located in the same service area. AHWM currently operates at capacity in certain service lines and is often unable to serve all patients presenting at the facility, in comparison with Beverly, which generally has excess capacity. The Affiliation will enable healthcare services to be located at either of the Adventist Health member hospitals in the community (i.e., Beverly and AHWM) in order to permit all patients of these facilities to have appropriate access to healthcare services in the communities served by these facilities. In furtherance of such, Adventist Health intends to effectuate a corporate restructuring of Beverly so that it is operated under a single hospital license with AHWM.

Following the Closing, in the event that Adventist Health elects to cease operating Beverly as a general acute care hospital, the Affiliation Agreement requires that Adventist Health will utilize the Beverly's net assets (calculated in accordance with the terms of the Affiliation Agreement) to support health care in the local community.

11 Cal. Code Reg. Section 999.5(d)(5)(I)

A description and copy of all current contracts between the applicant and the city in which the applicant is located and current contracts between the applicant and the county in which the applicant is located for each health facility or facility that provides similar healthcare that are the subject of the agreement or transaction

The Beverly Entities do not hold any contracts with the City or County of Los Angeles.

11 Cal. Code Reg. Section 999.5(d)(5)(J)

A description of compliance with 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), for each health facility or facility that provides similar healthcare that is the subject of the agreement or transaction, including the certified Structural Performance Category of every building affected by the agreement or transaction and a copy of every final determination letter received from the Office of Statewide Health Planning and Development for every building affected by the agreement or transaction

The following attachments provide documentation of Beverly's compliance with the Alfred E. Alquist Hospital Facilities Seismic Safety Act of 1983, as amended by the California Hospital Facilities Seismic Safety Act:[1]

1. Map of the Structural Performance Category ("SPC") ratings by the California Department of Health Care Access and Information ("HCAI") for Beverly's Facility No. 11441, dated October 4, 2022, attached as **Exhibit 20**.

2. Summary of HCAI SPC Ratings for Beverly's facility, attached as **Exhibit 21**.

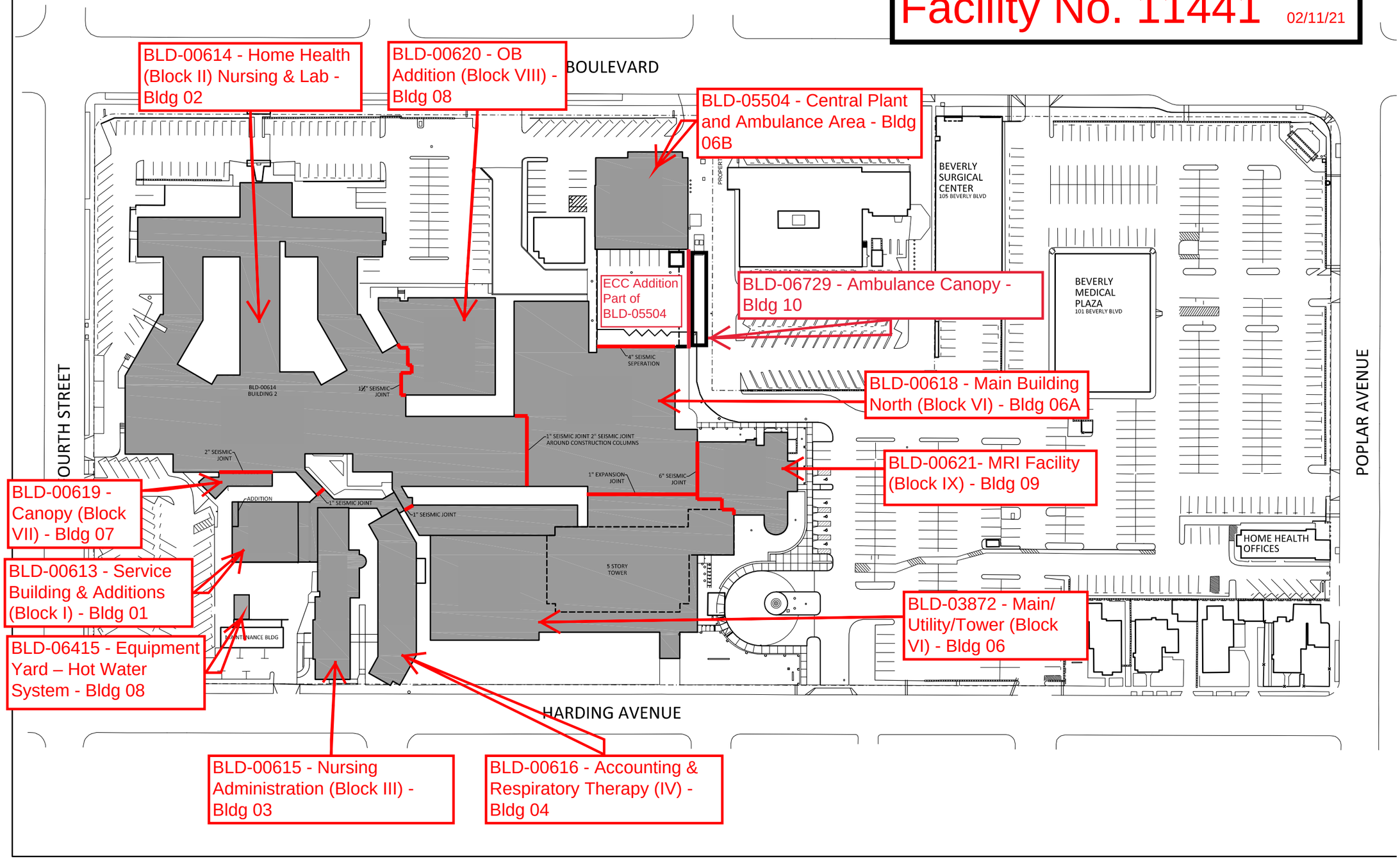
[1] Data and map obtained from https://hcai.ca.gov/.

EXHIBIT 20

MAP OF SPC RATINGS BY CALIFORNIA DEPARTMENT OF HCAI FOR BEVERLY FACILITY NO. 11441 (OCTOBER 4, 2022)

Beverly Hospital
Facility No. 11441

02/11/21



11441 Beverly Hospital

Bldg Num & Classification	Bldg Name	RACs Date	
BLD 00613, OSHPD 1	Service Building & Additions (Block I)	1/1/2030	
BLD 00614, OSHPD 1	Home Health (Block II) Nursing & Lab	1/1/2030	
BLD 00615, OSHPD 1	Nursing Administration (Block III)	1/1/2030	
BLD 00616, OSHPD 1	Accounting & Respiratory Therapy (IV)	1/1/2030	
BLD 00618, OSHPD 1	Main Building North (Block VI)	1/1/2030	
BLD 00619, OSHPD 1	Canopy (Block VII)		
BLD 00620, OSHPD 1	OB Addition (Block VIII)		
BLD 00621, OSHPD 1	MRI Facility (Block IX)		
BLD 03872, OSHPD 1	Main/Utility/ Tower (Block VI)	1/1/2030	
BLD 05504, OSHPD 1	Central Plant and Ambulance Area		
BLD 06415, OSHPD 1	Equipment Yard – Hot Water System		
BLD 06729, OSHPD 1	Ambulance Canopy		NPC 4

SPC, Measure Names
- 2, No Measure Value
- 4, No Measure Value
- 5, No Measure Value
- N/A, No Measure Value

11441 Beverly Hospital

Bldg Num	Bldg Name	Classification & Status	RACs Date	CO/CF Received	NPC Extension Date	Building Code	Year Built	Stories	Height in Feet	Hazus Score	Instrumented	Construction Type	Sprinklered	
BLD 00613	Service Building & Additions (Block I)	OSHPD 1, In Service	1/1/2030	Yes	1/1/2030	1949 Uniform Building Code (UBC)	1952	1	10	2010 HAZUS SCORE = 0.20	No			SPC: 2 NPC: 2
BLD 00614	Home Health (Block II) Nursing & Lab	OSHPD 1, In Service	1/1/2030		1/1/2030	1949 Uniform Building Code (UBC)	1952	1	13	2007 HAZUS SCORE = 1.10 2010 HAZUS SCORE = 0.90	No			SPC: 2 NPC: 2
BLD 00615	Nursing Administration (Block III)	OSHPD 1, In Service	1/1/2030		1/1/2030	1955 Uniform Building Code (UBC)	1958	1	16.5	2010 HAZUS SCORE = 0.10	No			SPC: 2 NPC: 2
BLD 00616	Accounting & Respiratory Therapy (IV)	OSHPD 1, In Service	1/1/2030		1/1/2030	1955 Uniform Building Code (UBC)	1957	1	16.5	2010 HAZUS SCORE = 0.10	No			SPC: 2 NPC: 2
BLD 00618	Main Building North (Block VI)	OSHPD 1, In Service	1/1/2030		1/1/2030	1967 Uniform Building Code (UBC)	1972	1	15	2010 HAZUS SCORE = 0.90	No			SPC: 2 NPC: 2
BLD 00619	Canopy (Block VII)	OSHPD 1, In Service			1/1/2030	1976 California Building Code (CBC)	1979	1	Unknown		No			SPC: 4 NPC: 2
BLD 00620	OB Addition (Block VIII)	OSHPD 1, In Service			1/1/2030	1982 California Building Code (CBC)	1989	1	15		No			SPC: 4 NPC: 2
BLD 00621	MRI Facility (Block IX)	OSHPD 1, In Service			1/1/2030	1992 California Building Code (CBC)	1998	1	Unknown		No			SPC: 5 NPC: 2
BLD 03872	Main/Utility/Tower (Block VI)	OSHPD 1, In Service	1/1/2030	Yes	1/1/2030	1967 Uniform Building Code (UBC)	1972	5	69.67	2007 HAZUS SCORE = 15.5 2010 HAZUS SCORE = 1	No			SPC: 2 NPC: 2
BLD 05504	Central Plant and Ambulance Area	OSHPD 1, In Service				1967 Uniform Building Code (UBC)	1972	UNKNOWN	Unknown		No			SPC: 5 NPC: 4
BLD 06415	Equipment Yard – Hot Water System	OSHPD 1, Equipment Yard			1/1/2030	1949 Uniform Building Code (UBC)	1952	UNKNOWN	Unknown		No			SPC: N/A NPC: 2
BLD 06729	Ambulance Canopy	OSHPD 1, In Service				2013 California Building Code (CBC)	2019	1	14.98		No			SPC: 5 NPC: 4

SPC, Measure Names
2, No Measure Value
4, No Measure Value
5, No Measure Value
N/A, No Measure Value

EXHIBIT 21

SUMMARY OF HCAI SPC RATINGS FOR BEVERLY FACILITY NO. 11441

11441 Beverly Hospital

Bldg Num	Bldg Name	Classification & Status	RACs Date	CO/CF Received	NPC Extension Date	Building Code	Year Built	Stories	Height in Feet	Hazus Score	Instrumented	Construction Type	Sprinklered	
BLD 00613	Service Building & Additions (Block I)	OSHPD 1, In Service	1/1/2030	Yes	1/1/2030	1949 Uniform Building Code (UBC)	1952	1	10	2010 HAZUS SCORE = 0.20	No			SPC: 2 NPC: 2
BLD 00614	Home Health (Block II) Nursing & Lab	OSHPD 1, In Service	1/1/2030		1/1/2030	1949 Uniform Building Code (UBC)	1952	1	13	2007 HAZUS SCORE = 1.10 2010 HAZUS SCORE = 0.90	No			SPC: 2 NPC: 2
BLD 00615	Nursing Administration (Block III)	OSHPD 1, In Service	1/1/2030		1/1/2030	1955 Uniform Building Code (UBC)	1958	1	16.5	2010 HAZUS SCORE = 0.10	No			SPC: 2 NPC: 2
BLD 00616	Accounting & Respiratory Therapy (IV)	OSHPD 1, In Service	1/1/2030		1/1/2030	1955 Uniform Building Code (UBC)	1957	1	16.5	2010 HAZUS SCORE = 0.10	No			SPC: 2 NPC: 2
BLD 00618	Main Building North (Block VI)	OSHPD 1, In Service	1/1/2030		1/1/2030	1967 Uniform Building Code (UBC)	1972	1	15	2010 HAZUS SCORE = 0.90	No			SPC: 2 NPC: 2
BLD 00619	Canopy (Block VII)	OSHPD 1, In Service			1/1/2030	1976 California Building Code (CBC)	1979	1	Unknown		No			SPC: 4 NPC: 2
BLD 00620	OB Addition (Block VIII)	OSHPD 1, In Service			1/1/2030	1982 California Building Code (CBC)	1989	1	15		No			SPC: 4 NPC: 2
BLD 00621	MRI Facility (Block IX)	OSHPD 1, In Service			1/1/2030	1992 California Building Code (CBC)	1998	1	Unknown		No			SPC: 5 NPC: 2
BLD 03872	Main/Utility/Tower (Block VI)	OSHPD 1, In Service	1/1/2030	Yes	1/1/2030	1967 Uniform Building Code (UBC)	1972	5	69.67	2007 HAZUS SCORE = 15.5 2010 HAZUS SCORE = 1	No			SPC: 2 NPC: 2
BLD 05504	Central Plant and Ambulance Area	OSHPD 1, In Service				1967 Uniform Building Code (UBC)	1972	UNKNOWN	Unknown		No			SPC: 5 NPC: 4
BLD 06415	Equipment Yard – Hot Water System	OSHPD 1, Equipment Yard			1/1/2030	1949 Uniform Building Code (UBC)	1952	UNKNOWN	Unknown		No			SPC: N/A NPC: 2
BLD 06729	Ambulance Canopy	OSHPD 1, In Service				2013 California Building Code (CBC)	2019	1	14.98		No			SPC: 5 NPC: 4

SPC, Measure Names
2, No Measure Value
4, No Measure Value
5, No Measure Value
N/A, No Measure Value

11 Cal. Code Reg. Section 999.5(d)(5)(K)

A description of each measure proposed by the applicant to mitigate or eliminate any potential adverse effect on the availability or accessibility of healthcare services to the affected community that may result from the agreement or transaction

As described in the response to Section 999.5(d)(5)(H) of this Notice, the Affiliation is not anticipated to have any adverse effect on the availability or accessibility of healthcare services in the community. Under the Affiliation Agreement, Adventist Health has made important commitments to the continuation of Beverly's healthcare operations and preservation of Beverly's assets for the benefit of its community. As such, the parties anticipate that the Affiliation will benefit the community by improving the efficiency and quality of healthcare services in the area by strengthening the long-term viability of Beverly, and enhancing access to crucial healthcare services for the communities served by Beverly.

As described in Section 999.5(d)(1)(A) of this Notice, following the Closing, Beverly and Adventist Health further intend to maximize operational efficiencies arising from the parties' ability to provide services at either of the Beverly and AHWM campuses, and Adventist Health intends to effectuate a corporate restructuring of Beverly so that it is operated under a single hospital license with AHWM. The flexibilities resulting from the integration of Beverly into Adventist Health's health system will enable healthcare services to be located at either of the member hospitals (i.e., Beverly and AHWM) in order to permit all patients of such facilities to have appropriate access to healthcare services in the community and that each facility has sufficient medical staff coverage and support for all inpatient care services, particularly to account for the fact that AHWM currently operates at capacity in certain service lines and typically turns away approximately ten patients per day due to capacity limits, in comparison with Beverly, which generally has excess capacity.

11 Cal. Code Reg. Section 999.5(d)(5)(L)

A list of the primary languages spoken at the health facility or facility that provides similar healthcare and the threshold languages for Medi-Cal beneficiaries, as determined by the State Department of Healthcare Services for the county in which the health facility or facility that provides similar healthcare is located

The languages spoken at Beverly either as a primary language or through Beverly's telephone translation service include the following: Acehnese, Acholi, Afghani, Afrikaans, Akan, Akateco, Albanian, Amharic, Anuak, Arabic, Armenian, Ashanti, Assyrian, Azeri, Bahasa (Malaysian), Bambara, Bashkir, Basque, Bassa, Belarusian, Bengali, Bosnian, Bulgarian, Burmese, Cambodian, Cape Verde Creole, Carolinian, Catalan, Cebuano, Chaldean, Chamorro , Chao-Chow, Cherokee, Chin, Chin (Falam), Chin (Hakha), Chin (Lai), Chin (Mizo), Chin (Tedim), Chin (Zo, Zomi), Chin (Zophei), Chinese Cantonese, Chinese Mandarin, Choujo, Chuukese, Cotocoli (Tem), Croatian, Czech, Danish, Dari, Dinka, Dioula, Dutch, Edo, Egnlish, Estonian, Ewe, Farsi, Finnish, Flemish, Foochow (Fuzhou), French, French Canadian, French Creole, Fukienese, Fulani, Fulde, Fuzhou, Ga, Garre, Georgian, German, Greek, Guarani, Gujarati, Hainanese, Haitian Creole, Hakka (Chinese), Harar, Hassaniya, Hausa, Hebrew, Hindi, Hmong, Hokkien, Hungarian, Icelandic, Igbo, Ilocano, Ilonggo, Indonesian, Italian, Japanese, Jarai, Jiangsu, K'iche', Kanjobal, Kannada, Karen, Karenni (Kayah), Kazakh, K'iche (Quiche), Kikongo, Kikuyu, Kinyamulenge, Kinyarwanda, Kirundi, Kissi, Kituba, Kizigua (Kizigula) , Korean, Kosraean, Krahn, Krio, Kunama, Kurdish, Kyrgyz, Lao, Latvian, Lautu, Lingala, Lithuanian, Lorma, Luganda, Luo, Macedonian, Malay, Malayalam, Mam, Mandinka, Mara, Marathi, Marshallese, Masalit, Matu, Mbay, Mende, Mien, Mina, Mixteco, Moldovan, Mongolian, Montenegrin, More, Mushunguli, Navajo, Nepali, Norwegian, Nuer, Oromifa, Pashto, Patois (Jamaican), Pidgin (Cameroonian), Pidgin (Nigerian), Polish Ponapean/Pohnpeian, Portuguese (Brazilian), Portuguese (European), Portuguese Creole, Pulaar, Punjabi, Q'anjob'al, Rohingya, Romanian, Russian, Samoan, Sango, Senthang, Serbian Shanghainese, Shona, Sichuan, Sicilian, Sinhalese, Siyin, Slovak, Slovene, Somali, Soninke, Sousou, Spanish, Swahili, Swedish, Sylheti, Tagalog (Filipino), Taiwanese, Tajik, Tamil, Telugu, Temne, Teochew, Thai, Tibetan, Tigrinya, Toisanese, Tongan, Tosk, Turkish, Twi, Ukrainian, Urdu, Uzbek, Vietnamese, Visayan, Wolof, Xhosa, Yiddish, Yoruba, Yup'ik, Zapotec, Zomi, Zophei, Zyphe, Zulu.

The threshold languages for Medi-Cal beneficiaries, as determined by the California Department of Healthcare Services for Los Angeles County include the following 11 languages: Arabic, Armenian, Cambodian, Chinese, English, Farsi, Korean, Russian, Spanish, Tagalog, and Vietnamese.

Title 11, California Code of Regulations, § 999.5(d)(6)

POSSIBLE EFFECT ON COMPETITION

11 Cal. Code Reg. Section 999.5(d)(6)(A)

For any agreement or transaction for which a Premerger Notification and Report Form is required to be submitted to the Federal Trade Commission under the Hart-Scott-Rodino Antitrust Improvements Act of 1976, a brief analysis of the possible effect of any proposed merger or acquisition of each healthcare facility or facility that provides similar healthcare that is the subject of the agreement or transaction on competition and market share in any relevant product or geographic market

A Premerger Notification and Report pursuant to the Hart-Scott-Rodino Antitrust Improvements Act of 1976 is not required for the Affiliation, and accordingly, was not submitted by the parties.

11 Cal. Code Reg., Section 999.5(d)(6)(B)

The applicant shall provide the Premerger Notification and Report Form and any attachments thereto as filed with the Federal Trade Commission pursuant to the Hart-Scott-Rodino Antitrust Improvements Act of 1976 and 16 C.F.R. Parts 801-803.

A Premerger Notification and Report pursuant to the Hart-Scott-Rodino Antitrust Improvements Act of 1976 is not required for the Affiliation, and accordingly, was not submitted by the parties.

Title 11, California Code of Regulations, § 999.5(d)(7)

OTHER PUBLIC INTEREST FACTORS

11 Cal. Code Reg. Section 999.5(d)(7)

"Other Public Interest Factors": Any other information the applicant believes the Attorney General should consider in deciding whether the proposed agreement or transaction is in the public interest

Without this Affiliation, the assets of Beverly, as a financially distressed entity, would no longer be available to provide important healthcare services in the community. Beverly is a failing firm as defined by the United States Department of Justice and Federal Trade Commission in their Horizontal Merger Guidelines: (1) it is unable to meet its financial obligations in the near future; (2) it would not be able to reorganize successfully; and (3) it has made unsuccessful good-faith efforts to elicit reasonable alternative offers that would keep its assets in the market. Beverly emphasizes, however, that, even if it were not a failing firm, Adventist Health's proposed acquisition of Beverly would not pose any dangers to competition. There exists ample competition in the area in which both parties are situated. Strong competitors include specialty/academic hospitals; other mission-driven systems and for-profit systems.

Beverly believes that the Affiliation with Adventist Health will serve to uphold its over 70-year legacy and enhance the facility's ability to continue to provide critical healthcare services to its community. Adventist Health's commitment and dedication to delivering quality healthcare services has historically empowered communities through collaborative programs, community investments, and employee engagement. Further, the parties believe the Affiliation with Adventist Health will result in collaboration and sharing of resources throughout the Adventist Health system, which will ultimately allow Beverly to secure locally-accessible health services for vulnerable populations and preserve Beverly's services, which represent a crucial community asset.

In addition, Adventist Health's mission, which is focused on transforming the health experience of its communities by improving physical, mental and spiritual health, enhancing interactions, and making care more accessible and affordable, is aligned with Beverly's primary objective of delivering quality healthcare services to populations in need. Thus, affiliating with Adventist Health, another nonprofit institution with similar values to that of Beverly, will benefit the public interest by ensuring that community assets are preserved for residents served by Beverly and Adventist Health, and provide shared clinical expertise that benefits Beverly's clinical staff.

Title 11, California Code of Regulations, § 999.5(d)(8)

RESOLUTIONS OF THE BOARD AND STATEMENT OF BOARD CHAIR

11 Cal. Code Reg. Section 999.5(d)(8)

The written notice of any proposed agreement or transaction set forth in section 999.5(a)(1) shall include a resolution of the board of directors of the applicant authorizing the filing of the written notice and a statement by the chair of the board that the contents of the written notice are true, accurate and complete

Please refer to the Beverly Board's meeting minutes authorizing the filing of the application, attached to Section 999.5(d)(1)(C) as **Exhibit 7**.

Attached to this Section as **Exhibit 22** is the statement of the Beverly Chairman of the Board that the contents herein are true, accurate, and complete.

EXHIBIT 22

STATEMENT OF BEVERLY BOARD CHAIRMAN

BeverlyHospital

November 8, 2022

Office of Attorney General
Healthcare Rights and Access, California Department of Justice
1300 I Street, 12th Floor
Sacramento, California 95814
Attention: Neli N. Palma, Supervising Deputy Attorney General

Re: **Beverly Community Hospital Association and Montebello Community Health System, Inc. Proposed Affiliation Agreement with Adventist Health System/West**

Dear Ms. Palma,

This letter will confirm that I am informed and believe that the contents of the written notice from Beverly Community Hospital Association d/b/a Beverly Hospital, a California nonprofit public benefit corporation and Montebello Community Health Services, Inc., a California nonprofit public benefit corporation, to the Attorney General of the State of California under Section 5920 of the California Corporations Code (to which this letter is attached as required by California Code of Regulations, Title 11, Section 999.5(d)(8)) are true, accurate, and complete.

Sincerely,

By: [redacted]
Name: Lyla Eddington, Ed.D., RN
Title: Chairman of the Board of Directors
Beverly Community Hospital Association and Montebello Community Health System, Inc.

Title 11, California Code of Regulations, § 999.5(d)(9)

TRANSFEREE INFORMATION

11 Cal. Code Reg. Section 999.5(d)(9)

The written notice of any proposed agreement or transaction set forth in Section 999.5(a)(1) shall include a list of the officers and directors of the transferee, the most recent audited financial statements for the transferee, the transferee's governance documents, such as the articles of incorporation and bylaws, and a description of the transferee's policies, procedures, and eligibility requirements for the provision of charity care

Adventist Health Officers

- John Freedman, Chair of the Board
- Bradford Newton, Vice Chair
- Kerry Heinrich, Chief Executive Officer
- Todd Hofheins, Chief Operating Officer, Assistant Secretary
- John Beaman, Chief Financial Officer
- Meredith Jobe, Secretary

Adventist Health Directors

- David Banks
- Robert Cherry
- Andrew Davis
- Joy Fehr
- John Freedman
- Kerry Heinrich
- Larry Innocent
- Bradford Newton
- Lucy Ocampo
- Richard Reiner
- Velino Salazar
- Marc Woodson
- Jack Wagner

Audited Financial Statements of Adventist Health

Attached to this Section as **Exhibit 23** include: the income statement of Adventist Health for the years ended December 31, 2020 and December 31, 2021, and the consolidated audited financial statements of Adventist Health for years ended December 31, 2020 and December 31, 2021.

Governance Documents of Adventist Health

Attached to this Section as **Exhibit 24** are the Articles of Incorporation of Adventist Health.

Attached to this Section as **Exhibit 25** are the Bylaws of Adventist Health.

Charity Care

Attached to this Section as **Exhibit 26** is the charity care policy of Adventist Health, which provides for the policies, procedures, and eligibility requirements for Adventist Health and the Adventist Health Facilities. After the Closing, Beverly will implement the Adventist Health Charity Care Policy.

EXHIBIT 23

INCOME STATEMENT OF ADVENTIST HEALTH; CONSOLIDATED AUDITED FINANCIAL STATEMENTS FOR ADVENTIST HEALTH (YEARS ENDING DECEMBER 31, 2020 AND 2021)

MUNICIPAL SECONDARY MARKET DISCLOSURE
INFORMATION COVER SHEET

This cover sheet should be sent with all submissions made to the Municipal Securities Rulemaking Board and Nationally Recognized Municipal Securities Information Repositories (NRMSIRS) pursuant to Securities and Exchange Commission rule 15c2-12 or any analogous state statute.

Issuers' and/or Other Obligated Person's Names: California Health Facilities Financing Authority, California Adventist Health System/West (CHFFA)
California Statewide Communities Development Authority Adventist Health System/West (CSCDA)
Multnomah County Hospital Facilities Authority
Roseville Finance Authority

CUSIP Numbers:

CSCDA AHS/W 2007A
13080SYC2

CHFFA AHS/W 2009 Series B
13033LBC0

CHFFA AHS/W 2011A
13032UUX4

AHS/W Taxable 2013
007944AC5

CHFFA AHS/W 2013 Series A
13033LR58 13033LS24
13033LR66 13033LS32
13033LR74 13033LS40
13033LR82 13033LS65
13033LS73 13033LS57
13033LR90

CSCDA AHS/W 2015 Series A
13080SHY3 13080SJG0
13080SHZ0 13080SJH8
13080SJA3 13080SJJ4
13080SJB1 13080SJK1
13080SJC9 13080SJN5
13080SJD7 13080SJL9
13080SJE5 13080SJP0
13080SJF2 13080SJM7

CHFFA AHS/W 2016 Series A
13032UFV5 13032UGE2
13032UFW3 13032UGF9
13032UFX1 13032UGG7
13032UFY9 13032UGH5
13032UGD4 13032UFZ6

CHFFA 2016A – cont.
13032UGA0 13032UGJ1
13032UGB8 13032UGK8
13032UGC6 13032UGL6

Roseville Finance Authority
2017 Series B
77781PDG9 77781PDP9
77781PDH7 77781PDQ7
77781PDJ3 77781PDR5
77781PDK0 77781PDS3
77781PDL8 77781PDT1
77781PDM6 77781PDU8
77781PDX2 77781PDV6
77781PDN4 77781PDW4

CSCDA AHS/W 2018 Series A
13080SVR2 13080SWB6
13080SVS0 13080SWC4
13080SVT8 13080SWD2
13080SVU5 13080SWE0
13080SVV3 13080SWF7
13080SVW1 13080SWG5
13080SVX9 13080SWH3
13080SVY7 13080SWJ9
130808VZ4 13080SWK6
13080SWA8

AHS/W Taxable 2019
007944AE1 007944AG6
007944AF8

Multnomah County, OR 2019
62551PCX3

Description of Material Event Notice/Financial Information (Check One):

1. _____ Principal and interest payment delinquencies
2. _____ Non-payment related defaults
3. _____ Unscheduled draws on debt service reserves reflecting financial difficulties
4. _____ Unscheduled draws on credit enhancements reflecting financial difficulties
5. _____ Substitution of credit or liquidity providers, or their failure to perform
6. _____ Adverse tax opinions or events affecting the tax-exempt status of the security
7. _____ Modifications to rights of security holders
8. _____ Bond calls
9. _____ Defeasances
10. _____ Release, substitution or sale of property securing repayment of the securities
11. _____ Rating changes
12. _____ Failure to provide annual financial information as required
13. _____ Other material event notice
14. X Financial information (**not** to be filed with the MSRB): Please check all appropriate boxes

CAFR [1]: a. X includes Annual Financial Information __ does not include Annual Information
b. Audited? **Yes** X **No** __

Operating Data

Period Covered: 12 months ended December 31, 2021

I hereby represent that I am authorized by the Obligated Person to distribute this information publicly:

Signature: _____

Name: John Beaman Title: CFO
Employer: Adventist Health System/West
Address: ONE Adventist Health Way
City, State, and Zip Code: Roseville, CA 95661
Voice Telephone Number: 916.406.1372

Adventist Health System/West
Annual Report: December 31, 2021
Per Continuing Disclosure Certificates:

CSCDA 2007 Series A
CHFFA 2009 Series B
CHFFA 2013 Series A
Adventist Health System/West Taxable Bonds 2013
CSCDA 2015 Series A
CHFFA 2016 Series A
Roseville Finance Authority 2017 Series B
CSCDA 2018 Series A
Multnomah County, OR 2019 Series A
Adventist Health System/West Taxable Bonds 2019

Certificate Reference	**Requirement**	**Location**
Section 3(b)(2)*	Long-term debt disclosure	Tab "Financial Ratios"
Section 3(b)(3)*	Statement regarding accounts receivable liens	Tab "Financial Ratios"
Section 4(a)	Audited combined financial statement	Tab "AH 2021 Audited Financials"
Section 4(b)(1)	Summary Listing of Hospitals	Tab "Operating/Utilization Statistics"
(2)	Combined Summary of Revenues & Expenses **Note that 10.5% of Revenues are from entities outside of the Obligated Group**	Tab "AH 2021 Audited Financials"
(3)	Combined Balance Sheet **Note that 5.1% of Assets are from entities outside of the Obligated Group**	Tab "AH 2021 Audited Financials"
(4)	Debt Service Coverage and Capitalization	Tab "Financial Ratios"
(5)	Payor Mix – Obligated Group	Tab "Operating/Utilization Statistics"
(6)	Utilization Statistics – Obligated Group	Tab "Operating/Utilization Statistics"
(7)	Operating Statistics – Obligated Group	Tab "Operating/Utilization Statistics"
Section 4(c)	Combining financial statements	Tab "AH 2021 Audited Financials"

*Does not apply for CSCDA 2007A, CSCDA 2015A, CHFFA 2016A and Multnomah 2019A

Consolidated Financial Statements and Supplementary Information

Adventist Health System/West

Years Ended December 31, 2021 and 2020 with Report of Independent Auditors

Audited Consolidated Financial Statements
and Supplementary Information

Adventist Health System/West

Years Ended December 31, 2021 and 2020

Audited Consolidated Financial Statements

Supplementary Information

Ernst & Young LLP
Suite 900
400 Capitol Mall
Sacramento, CA 95814

Tel: +1 916 218 1900
ey.com

Report of Independent Auditors

The Board of Directors
Adventist Health System/West

Opinion

We have audited the consolidated financial statements of Adventist Health System/West (Adventist Health), which comprise the consolidated balance sheets as of December 31, 2021 and 2020, and the related consolidated statements of operations and changes in net assets and cash flows for the years then ended, and the related notes (collectively referred to as the "financial statements").

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of Adventist Health at December 31, 2021 and 2020, and the results of its operations, changes in its net assets and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

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

Responsibilities of Management for the Financial Statements

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

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

Building a better working world

Auditor's Responsibilities for the Audit of the Financial Statements

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

In performing an audit in accordance with GAAS, we:

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

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

Ernst & Young LLP

March 18, 2022

Adventist Health

Consolidated Balance Sheets
(In millions of dollars)

	December 31	
	2021	**2020**
Assets		
Cash and cash equivalents	**$ 304**	$ 261
Short-term investments	**157**	176
Patient accounts receivable	**689**	612
Receivables from third-party payors	**379**	501
Other current assets	**227**	243
Total current assets	**1,756**	1,793
Noncurrent investments	**2,291**	2,236
Other assets	**432**	413
Property and equipment, net	**2,185**	2,302
Total assets	**$ 6,664**	$ 6,744
Liabilities and net assets		
Accounts payable	**$ 370**	$ 265
Accrued compensation and related payables	**325**	306
Liabilities to third-party payors	**209**	232
Other current liabilities	**242**	140
Short-term financing	**30**	60
Current maturities of long-term debt	**36**	20
Total current liabilities	**1,212**	1,023
Long-term debt, net of current maturities	**2,000**	2,036
Other noncurrent liabilities	**323**	570
Total liabilities	**3,535**	3,629
Net assets without donor restrictions:		
Controlling	**3,044**	3,040
Noncontrolling	**15**	14
Net assets with donor restrictions	**70**	61
Total net assets	**3,129**	3,115
Total liabilities and net assets	**$ 6,664**	$ 6,744

See notes to consolidated financial statements.

Adventist Health

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

	Year Ended December 31	
	2021	**2020**
Revenues and support		
Patient service revenue	**$ 4,660**	$ 4,097
Premium revenue	**189**	185
Other revenue	**348**	477
Net assets released from restrictions for operations	**18**	15
Total revenues and support	**5,215**	4,774
Expenses		
Employee compensation	**2,308**	2,246
Professional fees	**782**	587
Supplies	**785**	641
Purchased services and other	**1,231**	1,105
Interest	**65**	68
Depreciation and amortization	**193**	201
Total expenses	**5,364**	4,848
Loss from operations	**(149)**	(74)
Nonoperating income		
Investment income	**163**	178
Loss on acquisition and divestitures	**–**	(1)
Other nonoperating (loss) gain	**(5)**	6
Total nonoperating income	**158**	183
Excess of revenues over expenses	**9**	109
(Excess) deficit of revenues over expenses from noncontrolling interests	**(1)**	2
Excess of revenues over expenses from controlling interests	**8**	111

See notes to consolidated financial statements.

Adventist Health

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

	Year Ended December 31 2021	2020
Net assets without donor restrictions		
Controlling		
Excess of revenues over expenses from controlling interests	**$ 8**	$ 111
Net change in unrealized gains and losses on other-than-trading securities	**(10)**	7
Donated property and equipment	**–**	1
Net assets released from restrictions for capital additions	**5**	7
Other	**1**	–
Increase in net assets without donor restrictions – controlling	**4**	126
Noncontrolling		
Excess (deficit) of revenues over expenses from noncontrolling interests	**1**	(2)
Increase (decrease) in net assets without donor restrictions – noncontrolling	**1**	(2)
Net assets with donor restrictions		
Restricted gifts and grants	**32**	24
Net assets released from restrictions	**(23)**	(22)
Other donor-restricted activity	**–**	1
Increase in net assets with donor restrictions	**9**	3
Increase in net assets	**14**	127
Net assets, beginning of year	**3,115**	2,988
Net assets, end of year	**$ 3,129**	$ 3,115

See notes to consolidated financial statements.

Adventist Health

Consolidated Statements of Cash Flows
(In millions of dollars)

	Year Ended December 31	
	2021	**2020**
Operating activities		
Increase in net assets	**$ 14**	$ 127
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Depreciation and amortization	**193**	201
Gain on early extinguishment of debt	**–**	(4)
Amortization of bond issuance costs and discount/premium	**(7)**	(7)
Noncash operating lease expense	**38**	37
Loss on note receivable	**1**	1
Net loss on investments	**(71)**	(27)
Net gain on sale of property and equipment	**19**	–
Net changes in operating assets and liabilities:		
Patient accounts receivable	**(77)**	(14)
Other assets	**3**	(38)
Net payables to third-party payors and other liabilities	**32**	289
Net cash provided by operating activities	**145**	565
Investing activities		
Purchases of property and equipment	**(136)**	(167)
Proceeds from sale of property and equipment	**13**	–
Proceeds of insurance for property and equipment	**29**	–
Purchase of investments	**(2,520)**	(1,060)
Proceeds from sale of investments	**2,555**	487
Net cash used in investing activities	**(59)**	(740)
Financing activities		
Proceeds from issuance of short-term financing	**–**	60
Payments on short-term financing	**(30)**	–
Proceeds from lines of credit	**–**	200
Payments on lines of credit	**–**	(200)
Payments on long-term debt	**(13)**	(106)
Net cash used in financing activities	**(43)**	(46)
Increase (decrease) in cash and cash equivalents	**43**	(221)
Cash and cash equivalents, beginning of year	**261**	482
Cash and cash equivalents, end of year	**$ 304**	$ 261

See notes to consolidated financial statements.

Adventist Health

Notes to Consolidated Financial Statements
(In millions of dollars)

Note A – Summary of Significant Accounting Policies

Reporting Entity and Principles of Consolidation: Adventist Health System/West (Adventist Health) is a California not-for-profit religious corporation that controls and operates hospitals and other healthcare facilities, and wellness promoting operations in the western United States and beyond (collectively, the "System"). Many of the hospitals now controlled and operated by Adventist Health were formerly operated by various conferences of the Seventh-day Adventist Church (the "Church"). The obligations and liabilities of Adventist Health and its hospitals and other healthcare facilities are neither obligations nor liabilities of the Church or any of its other affiliated organizations. Adventist Health maintains close ties to our heritage through connection to our Sponsor, the Church. Church leaders serve on the Adventist Health Membership and the Board of Directors (the "Board") but the Church does not control or have ownership in the System.

The consolidated financial statements include the accounts of the following entities:

Adventist Health System/West dba Adventist Health – Roseville, California
San Joaquin Community Hospital dba Adventist Health Bakersfield – Bakersfield, California
Castle Medical Center dba Adventist Health Castle – Kailua, Hawaii
Adventist Health Clearlake Hospital, Inc., dba Adventist Health Clear Lake – Clearlake, California
Adventist Health Delano – Delano, California
Feather River Hospital dba Adventist Health Feather River – Paradise, California
Glendale Adventist Medical Center dba Adventist Health Glendale – Glendale, California
Hanford Community Hospital dba Adventist Health Hanford, Adventist Health Selma – Hanford, California
Willits Hospital, Inc., dba Adventist Health Howard Memorial – Willits, California
Lodi Memorial Hospital Association, Inc., dba Adventist Health Lodi Memorial – Lodi, California
Adventist Health Mendocino Coast – Fort Bragg, California
Adventist Health Plan, Inc – Roseville, California
Adventist Health Physicians Network – Roseville, California
Portland Adventist Medical Center dba Adventist Health Portland – Portland, Oregon
Reedley Community Hospital dba Adventist Health Reedley – Reedley, California
Rideout Memorial Hospital dba Adventist Health and Rideout – Marysville, California
Simi Valley Hospital and Health Care Services dba Adventist Health Simi Valley – Simi Valley, California
Sonora Community Hospital dba Adventist Health Sonora – Sonora, California
St. Helena Hospital dba Adventist Health St. Helena, Adventist Health Vallejo – St. Helena, California
Adventist Health Medical Center Tehachapi dba Adventist Health Tehachapi Valley – Tehachapi, California
Northwest Medical Foundation of Tillamook dba Adventist Health Tillamook – Tillamook, Oregon
Adventist Health Tulare – Tulare, California
Ukiah Adventist Hospital dba Adventist Health Ukiah Valley – Ukiah, California
White Memorial Medical Center dba Adventist Health White Memorial – Los Angeles, California
Western Health Resources dba Adventist Health Home Care Services – Roseville, California

The Board of Adventist Health or Stone Point Health serves as the legal board for each individual hospital corporation. Adventist Health management serves as the legal board of the non-hospital corporations. All material intercompany transactions have been eliminated in consolidation.

Note A – Summary of Significant Accounting Policies (continued)

Basis of Accounting: The financial statements are prepared in conformity with United States generally accepted accounting principles (U.S. GAAP).

Cash and Cash Equivalents: Cash and cash equivalents consist primarily of unrestricted readily marketable securities with original maturities not in excess of three months when purchased and net deposits in demand accounts. Cash deposits are federally insured in limited amounts.

Marketable Securities: Marketable securities, stated at fair value, consist primarily of U.S. government treasury, U.S. agency securities, corporate notes, exchange-traded funds, open-end mutual funds comprised of fixed-income securities and domestic and international equities, and alternative investments comprised of commingled funds and hedge funds. Investment income or loss (including realized gains and losses on investments and unrealized gains and losses on trading investments) is included in the excess of revenues over expenses unless the income or loss is restricted by donor or law. Interest and dividends are included in other revenue. Securities with remaining maturity dates of one year or less as of the consolidated balance sheet date are classified as current.

Investments and Assets Whose Use is Limited: Certain System investments are limited as to use through Board resolution, provisions of contractual arrangements with third parties, terms of indentures, self-insurance trust arrangements, or donors who restrict the use of specific assets. Assets that are expected to be expended within one year are classified as current, including board-designated assets that are available and periodically borrowed for working capital needs.

Split-interest Agreements: The System is the trustee and beneficiary of various split-interest agreements. The carrying amounts of the System's split-interest assets are included with investments held by trustee and donor-restricted investments and include marketable securities and real estate. Trust assets are carried at fair value. Assets under split-interest agreements were $8 at December 31, 2021 and 2020. Trust obligations are reported in other noncurrent liabilities at their discounted estimated present value using actuarially determined life expectancy tables. Discount rates range between approximately 2% and 9%. Liabilities under split-interest agreements were $2 and $3 at December 31, 2021 and 2020, respectively.

Goodwill: The System records goodwill as the excess of purchase price and related costs over the fair value of net assets acquired. These amounts are evaluated for impairment annually or when there is an indicator of impairment. If it is determined that goodwill is impaired, the carrying value is reduced. The System had goodwill of $75 and $65 at December 31, 2021 and 2020, respectively, which is included in other long-term assets with additions of $10 and $43 in 2021 and 2020, respectively.

Note A – Summary of Significant Accounting Policies (continued)

Property and Equipment: Property and equipment are reported on the basis of cost, except for donated items, which are recorded as an increase in net assets without donor restrictions based on fair market value at the date of the donation. During the period of construction, the System capitalizes expenditures and interest costs, net of earnings on invested bond proceeds that materially increase values, change capacities, and extend useful lives. Accrued obligations for property and equipment are $8 as of December 31, 2021 and 2020, respectively.

Management periodically evaluates the carrying amounts of long-lived assets for possible impairment. The System estimates that it will recover the carrying value of long-lived assets from the estimated future undiscounted cash flows; however, considering the regulatory environment, competition, and other factors affecting the industry, there is at least a reasonable possibility this estimate might change in the near term. The effect of any change could be material.

Depreciation is computed using the straight-line method over the expected useful lives of the assets, which range from 3 to 40 years. Amortization of equipment is included in depreciation expense.

Short Term Financing: In December 2020, the System initiated a taxable commercial paper program supported by self-liquidity for general corporate purposes. Under the program, the System is registered to issue up to $150. At December 31, 2021, $30 of commercial paper was outstanding with a maturity date of January 3, 2022 and is included in short-term financing on the consolidated balance sheet. On January 3, 2022, the System paid down the outstanding balance.

Debt Issuance Costs: Debt issuance costs are reported as a reduction of long-term debt and are deferred and amortized over the life of the financings using the effective-interest method.

Bond Discounts/Premiums: Bonds payable are included in long-term debt, net of unamortized original issue discounts or premiums. Such discounts or premiums are amortized using the effective interest method based on outstanding principal over the life of the bonds.

Other Noncurrent Liabilities: Other noncurrent liabilities are comprised primarily of accruals for workers' compensation claims, professional and general liability claims, deferred revenue, lease liabilities, and long-term charitable gift annuity obligations.

Net Assets: All resources not restricted by donors are included in net assets without donor restrictions. Resources restricted by donors for specific operating purposes, or for a period of time greater than one year, are reported as net assets with donor restrictions. When the restrictions have been met, the net assets with donor restrictions are reclassified to net assets without donor restrictions. Resources restricted by donors for additions to property and equipment are initially reported as net assets with donor restrictions and are transferred to net assets without donor restrictions when expended. Investment income is classified as net assets without donor restrictions or net assets with donor restrictions based on the intent of the donor. Gifts of future interests are reported as net assets with donor restrictions. Gifts, grants, and bequests not restricted by donors are reported as other revenue.

Note A – Summary of Significant Accounting Policies (continued)

Charity Care: The System provides care without charge or at amounts less than its established rates to patients who meet certain criteria under its charity care policy. In assessing a patient's ability to pay, the System uses federal poverty income levels and evaluates the relationship between the charges and the patient's income. The System did not change its charity care policy during 2021. The estimated cost of charity care was $19 and $26 in 2021 and 2020, respectively. The costs were determined using cost-to-charge ratios.

Premium Revenue: The System has agreements with various Health Maintenance Organizations (HMOs) to provide medical services to subscribing participants. Under these agreements, the System receives monthly capitation payments based on the number of each HMO's covered participants, regardless of the services actually performed by the System.

Other Revenue: Other revenue is comprised primarily of contributions received related to the Public Health and Social Services Emergency Fund and other programs (collectively "Provider Relief Funds"), rental income, retail pharmacy, interest and dividend income, and other miscellaneous income.

Income Tax: The principal operations of the System are exempt from taxation pursuant to Internal Revenue Code Section 501(c)(3) and related state provisions. The System recognizes tax benefits from any uncertain tax positions only if it is more-likely-than-not the tax position will be sustained, based solely on its technical merits, with the taxing authority having full knowledge of all relevant information. The System records a liability for unrecognized tax benefits from uncertain tax positions as discrete tax adjustments in the first interim period the more-likely-than-not threshold is not met. The System recognizes deferred tax assets and liabilities for temporary differences between the financial reporting basis and the tax basis of its assets and liabilities, along with net operating loss and tax credit carryovers only for tax positions that meet the more-likely-than-not recognition criteria. At December 31, 2021 and 2020, no such assets or liabilities were recorded.

The System currently files Form 990 (informational return of organizations exempt from income taxes) and Form 990-T (business income tax return for an exempt organization) in the U.S. federal jurisdiction and the state of California. The System is not subject to income tax examinations prior to 2018 in major tax jurisdictions.

Loss from Operations: The System's consolidated statements of operations and changes in net assets include an intermediate measure of operations, labeled "Loss from operations." Items that are considered nonoperating are excluded from loss from operations and include investment income and losses, gains and losses on acquisitions and divestitures, and gains and losses on debt refinancing.

Excess of Revenues Over Expenses: The consolidated statements of operations and changes in net assets include excess of revenues over expenses as a performance indicator. Changes in net assets without donor restrictions that are excluded from excess of revenues over expenses include unrealized gains and losses on investments in other-than-trading debt securities, contributions of long-lived assets, use of net assets with donor restricted funds for capital additions, and losses from discontinued operations.

Note A – Summary of Significant Accounting Policies (continued)

Use of Estimates: The preparation of consolidated financial statements in conformity with U.S. GAAP requires management to make estimates and assumptions that affect the reported amounts in the consolidated financial statements and the accompanying notes. Actual results could differ from these estimates.

Note B – Fair Value of Financial Instruments

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

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

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

Level 3: Pricing inputs are generally unobservable for the assets and include situations where there is little, if any, market activity for the investment. The System had no Level 3 investments at December 31, 2021 or 2020.

(In millions of dollars)

Note B – Fair Value of Financial Instruments (continued)

The following represents assets measured at fair value or at net asset value (NAV) as a practical expedient on a recurring basis at December 31, 2021:

	Quoted Prices in Active Markets for Identical Instruments (Level 1)	Significant Observable Inputs (Level 2)	Totals
Cash and cash equivalents	**$ 304**	**$ –**	**$ 304**
Money market funds	**38**	**–**	**38**
Fixed income:			
U.S. government treasury obligations	**50**	**–**	**50**
U.S. corporation and agency debentures	**–**	**47**	**47**
U.S. agency mortgage-backed securities	**–**	**6**	**6**
U.S. corporate debt securities	**–**	**429**	**429**
Municipal bonds	**–**	**8**	**8**
Mutual funds	**217**	**164**	**381**
Equities:			
Equities	**9**	**–**	**9**
Mutual funds	**929**	**–**	**929**
Total financial assets stated at fair value	**$ 1,547**	**$ 654**	**2,201**
Commercial real estate			**23**
Investments measured at NAV			**528**
Other investments			**86**
Total cash and investments			**$ 2,838**

Money market funds of $38 at December 31, 2021 includes funds held in the investment portfolio for self-insurance programs. The money market funds are used for both buying investments and self-insurance program claims. The amounts are internally separated into a separate account; however, such funds are not restricted and can be used for any purpose.

(In millions of dollars)

Note B – Fair Value of Financial Instruments (continued)

The following represents assets measured at fair value or at NAV as a practical expedient on a recurring basis at December 31, 2020:

	Quoted Prices in Active Markets for Identical Instruments (Level 1)	Significant Observable Inputs (Level 2)	Totals
Cash and cash equivalents	$ 261	$ –	$ 261
Money market funds	71	–	71
Fixed income:			
U.S. government treasury obligations	143	–	143
U.S. corporation and agency debentures	–	51	51
U.S. agency mortgage-backed securities	–	4	4
U.S. corporate debt securities	–	227	227
Municipal bonds	–	24	24
Mutual funds	679	200	879
Equities:			
Equities	6	–	6
Mutual funds	717	–	717
Total financial assets stated at fair value	$ 1,877	$ 506	2,383
Commercial real estate			26
Investments measured at NAV			264
Other investments			79
Total cash and investments			$ 2,752

Money market funds of $71 at December 31, 2020 includes funds held in the investment portfolio for self-insurance programs. The money market funds are used for both buying investments and self-insurance program claims. The amounts are internally separated into a separate account; however, such funds are not restricted and can be used for any purpose.

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

(In millions of dollars)

Note B – Fair Value of Financial Instruments (continued)

As of December 31, 2021 and 2020, the Level 2 instruments listed in the fair value hierarchy tables above use the following valuation techniques and inputs:

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

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

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

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

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

	December 31, 2021			
	NAV	**Unfunded Commitments**	**Redemption Frequency (if currently Eligible)**	**Redemption Notice Period (if currently Eligible)**
Commingled funds – equity securities	**$ 107**	**$ –**	Weekly/Monthly	4-30 days
Hedge funds	**313**	**10**	Weekly/Monthly/ Quarterly	30-65 days
Private equity funds	**108**	**100**	None	None
Total	**$ 528**	**$ 110**		

(In millions of dollars)

Note B – Fair Value of Financial Instruments (continued)

	December 31, 2020			
	NAV	Unfunded Commitments	Redemption Frequency (if currently Eligible)	Redemption Notice Period (if currently Eligible)
Commingled funds – equity securities	$ 96	$ –	Weekly/Monthly	4-30 days
Hedge funds	139	23	Monthly/Quarterly	45-60 days
Private equity funds	29	36	None	None
Total	$ 264	$ 59		

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

Hedge funds: This class includes investments in hedge funds that expand the universe of potential investment approaches available by employing a variety of strategies and techniques within and across various asset classes. The primary objective for these funds is to balance returns while limiting volatility by allocating capital to external portfolio managers selected for expertise in one or more investment strategies, which may include, but are not limited to, equity long/short, event driven, relative value, and directional. The following summarizes the redemption criteria for the hedge fund portfolio as of December 31, 2021:

% of Hedge Funds	Redemption Criteria	Notice Period
31%	Redeemable weekly	30 days
26%	Redeemable monthly	45-65 days
38%	Redeemable quarterly	45-65 days
5%	Up to 12.5% redeemable quarterly on non-consecutive quarters	60 days

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

(In millions of dollars)

Note C – Patient Accounts Receivable

The System's primary concentration of credit risk is patient accounts receivable, which consists of amounts owed by various governmental agencies, insurance companies, and self-pay patients. The System manages its receivables by regularly reviewing its patient accounts and contracts and by providing an appropriate allowance for contractual reimbursement, policy discounts, charity, and price concessions. These allowances are estimated based upon an evaluation of governmental reimbursements, negotiated contracts, and historical payments.

The following is a summary of significant concentrations of net patient accounts receivable:

	December 31	
	2021	**2020**
Medicare	**31%**	33%
Medicaid	**20**	19
Other third-party payors	**47**	46
Self-pay	**2**	2
	100%	100%

(In millions of dollars)

Note D – Investments and Assets Whose Use is Limited

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

	December 31	
	2021	**2020**
Total unrestricted investments	**$ 2,352**	$ 2,232
Assets designated by the Board, primarily for property and equipment	**24**	13
Investments held by trustees for:		
Self-insurance programs	**55**	150
Charitable annuities and other	**2**	3
Total investments held by trustees	**57**	153
Donor-restricted investments for:		
Charitable trusts and life estate tenancies	**6**	5
Other purposes	**9**	9
Total donor-restricted investments	**15**	14
Total investments	**2,448**	2,412
Less short-term investments	**157**	176
Total noncurrent investments	**$ 2,291**	$ 2,236

Total investments and assets whose use is limited above excludes other investments of $86 and $79 at December 31, 2021 and 2020, respectively which includes retirement plan assets, joint ventures, and partnerships and are included in other assets.

Liquidity Management: As part of its liquidity management, the System's strategy is to structure its financial assets to be available to satisfy general operating expenses, current liabilities, and other obligations as they come due. The System invests cash in excess of daily requirements in short-term investments and has a committed syndicated line of credit and a commercial paper program to help manage unanticipated liquidity needs. Additionally, other unrestricted noncurrent investments of $2,253 at December 31, 2021 may be utilized if necessary.

(In millions of dollars)

Note D – Investments and Assets Whose Use is Limited (continued)

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

	December 31 2021
Cash and cash equivalents	$ 304
Short-term investments	157
Patient accounts receivable	689
Receivables from third-party payors	379
Other current assets	63
	$ 1,592

Note E – Investment Income

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

	Year Ended December 31	
	2021	**2020**
Realized gains, net	**$ 87**	$ 37
Unrealized gains, net	**76**	141
	163	178
Interest and dividend income	**48**	38
	$ 211	$ 216

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

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

(In millions of dollars)

Note F – Property and Equipment

The following is a summary of property and equipment:

	December 31	
	2021	**2020**
Land	**$ 178**	$ 179
Land improvements	**92**	101
Buildings and improvements	**3,009**	3,016
Equipment	**1,328**	1,307
	4,607	4,603
Less accumulated depreciation	**(2,492)**	(2,402)
	2,115	2,201
Construction-in-progress	**70**	101
	$ 2,185	$ 2,302

The System has commitments to complete certain construction projects approximating $56 (unaudited) at December 31, 2021.

The System is in the process of developing internal use software for clinical and financial operations. Depreciation expense for the software placed in service totaled $19 for the years ended 2021 and 2020. Amounts capitalized are included in property and equipment as follows:

	December 31	
	2021	**2020**
Equipment	**$ 281**	$ 278
Less accumulated depreciation	**(198)**	(179)
	83	99
Construction-in-progress	**4**	3
	$ 87	$ 102

Note G – Long-Term Debt

A master note under the master bond indenture provides security for substantially all long-term debt. Under the terms of the master bond indenture, substantially all System consolidated entities are jointly and severally obligated for the payments to be made under the master note. In addition, security is provided by bank letters of credit aggregating to $47 at December 31, 2021. Bonds are not secured by any property of the System.

The System has a syndicate line of credit to meet temporary capital requirements and to provide flexibility in meeting the System's capital needs of $350. There were no draws outstanding under this line of credit at December 31, 2021 and 2020.

The System is obligated under variable-rate demand instruments, which are subject to certain market risks. The letters of credit, which the System intends to renew on a long-term basis, expire between 2024 and 2025, with the arrangements converting any unpaid amounts to term loans due within three years after conversion. The term loans would bear interest based on prime or the London Interbank Offered Rate.

Certain financing agreements impose limitations on the issuance of new debt by the System and require it to maintain specified financial ratios. The System was in compliance with its debt covenants at December 31, 2021.

Interest paid, net of amounts capitalized, totaled $66 and $64 in 2021 and 2020, respectively. Interest capitalized totaled $2 and $2 in 2021 and 2020, respectively.

In February 2020, the System defeased in full $14 of bonds issued in 2012 through the City of Delano for Adventist Health Delano. The bonds were defeased with assets placed in an irrevocable trust and derecognized at the date of refunding. The extinguishment and defeasance of this bond issue resulted in a loss on refinancing of $1.

In September 2020, the System redeemed $60 of bonds. The redemption of these bonds resulted in a gain on refinancing of $4.

No significant financing transactions were undertaken in 2021.

(In millions of dollars)

Note G – Long-Term Debt (continued)

The following is a summary of long-term debt:

	December 31	
	2021	**2020**
Non-taxable debt:		
Long-term bonds payable, with fixed rates currently ranging from 3.00% to 5.00%, payable in installments through 2048	**$ 1,049**	$ 1,058
Long-term bonds payable, with rates that vary with market conditions, payable in installments through 2038	**47**	47
Taxable debt:		
Long-term bonds payable, with fixed rates currently ranging from 2.43% to 3.63%, payable in installments through 2049	**802**	802
Long-term notes payable, with fixed rates currently ranging from 3.00% to 6.50%, payable in installments through 2045	**76**	80
Net unamortized debt issuance costs and original issue premiums and discounts	**62**	69
	2,036	2,056
Less current maturities	**(36)**	(20)
	$ 2,000	$ 2,036

(In millions of dollars)

Note G – Long-Term Debt (continued)

Scheduled maturities of long-term debt are as follows as of December 31, 2021:

	Long-Term Debt
2022	$ 30
2023	81
2024	184
2025	31
2026	31
Thereafter	1,617
	$ 1,974

Note H – Leases

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

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

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

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

The System uses the incremental borrowing rate based on the information available at the lease commencement date to determine the present value of lease payments.

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

(In millions of dollars)

Note H – Leases (continued)

		December 31	
	Classification	**2021**	**2020**
Right-of-use Assets			
Operating	Other assets	**$ 186**	$ 186
Finance	Other assets	**7**	–
		$ 193	$ 186
Current Lease liabilities			
Operating	Other current liabilities	**$ 30**	$ 28
Finance	Other current liabilities	**2**	–
Noncurrent Lease liabilities			
Operating	Other noncurrent liabilities	**162**	162
Finance	Other noncurrent liabilities	**5**	–
Total lease liabilities		**$ 199**	$ 190

		December 31	
	Classification	**2021**	**2020**
Operating lease expense			
Operating lease cost	Purchased services and other	**$ 38**	$ 36
Finance lease cost:			
Amortization of leased assets	Depreciation and amortization	**$ 1**	$ –
Interest on lease liabilities	Interest	**$ –**	$ –

Cash paid for amounts not included in the measurement of lease liabilities	December 31 **2021**	**2020**
Operating cash outflows for operating leases	**$ 38**	$ 37

Right-of-use assets obtained in exchange for lease obligations	December 31 **2021**	**2020**
Operating	**$ 39**	$ 46
Finance	**$ 7**	$ –

(In millions of dollars)

Note H – Leases (continued)

Operating lease payments include payments relating to options to extend lease terms that are reasonably certain of being exercised. Excluded are any legally binding lease payments for signed leases not yet commenced, which are immaterial for the System. Minimum lease payments for operating and finance leases with initial terms in excess of one year are as follows for the period ended December 31, 2021:

Maturity of Lease Liabilities	**Operating Leases**	**Finance Leases**
2022	**$ 35**	**$ 2**
2023	**30**	**2**
2024	**26**	**1**
2025	**22**	**1**
2026	**17**	**1**
Thereafter	**104**	**–**
Total lease payments	**234**	**7**
Less imputed interest	**(42)**	**–**
	$ 192	**$ 7**

Lease Term and Discount Rate	**December 31 2021**
Weighted average operating remaining lease term (years)	10.25
Weighted average finance remaining lease term (years)	4.50
Weighted average operating lease discount rate	3.47%
Weighted average finance lease discount rate	2.42%

(In millions of dollars)

Note I –Net Assets with Donor Restrictions

The System receives donations from generous individuals and organizations that support certain programs and services. Donations included in net assets with donor restrictions were maintained for the following purposes:

	December 31	
	2021	**2020**
Subject to expenditure for specified purpose:		
Capital projects and medical equipment	**$ 27**	$ 23
Research and education	**27**	25
	54	48
Subject to passage of time	**4**	3
Investment in perpetuity – endowment	**12**	10
	$ 70	$ 61

The Board has designated certain net assets without donor restrictions funds to be used in the future for specific projects. Board-designated funds included in net assets without donor restrictions are held for the following purposes:

	December 31	
	2021	**2020**
Capital	**$ 15**	$ –
Subject to expenditures for patient care, education, and other	**4**	6
Board designated – endowments	**5**	7
	$ 24	$ 13

Note J – Patient Service Revenue and Premium Revenue

Patient service revenue is reported at the amount the System expects to be paid for providing patient care. These amounts are due from patients and third-party payors (including health insurers and government programs) and include variable consideration for retroactive revenue adjustments due to the settlement of audits, reviews, and investigations. Generally, the System bills the patients and third-party payors soon after the services are performed.

Patient service revenue is recognized as performance obligations are satisfied based on the nature of the services provided by the System. Revenue for performance obligations that are satisfied over time is recognized based on actual charges incurred in relation to total expected or actual charges. The System believes that this method provides a faithful depiction of the transfer of services over the term of the performance obligation based on the inputs needed to satisfy the obligation. Generally, performance obligations satisfied over time relate to patients receiving inpatient services. The System measures the performance obligation for inpatient services from admission into the hospital to the point when it is no longer required to provide services to that patient, which is generally at the time of discharge. The System measures the performance obligations for outpatient services

Note J – Patient Service Revenue and Premium Revenue (continued)

over a period of less than one day when goods or services are provided and the System does not believe it is required to provide additional goods or services to the patient.

Because all its performance obligations relate to contracts with a duration of less than one year, the System has elected to apply the optional exemption provided in ASC 606. Under this exemption, the System is not required to disclose the aggregate amount of the transaction price allocated to performance obligations that are unsatisfied or partially unsatisfied at the end of the reporting period. Since the unsatisfied or partially unsatisfied performance obligations referred to above are primarily related to inpatient services at the end of the reporting period, the performance obligations for these contracts are generally completed within days or weeks of the end of the reporting period.

The System determines the transaction price based on standard charges for goods and services provided, reduced by contractual adjustments provided to third-party payors, discounts provided to uninsured patients in accordance with the System's policy, and other implicit price concessions provided to uninsured patients. The System determines its estimates of contractual adjustments and discounts based on contractual agreements, its discount policies, and its historical settlement experience. The System determines its estimate of implicit price concessions for uninsured patients based on its historical collection experience with this class of patients.

Agreements with third-party payors typically provide for payments at amounts less than established charges. A summary of the payment arrangements with major third-party payors follows:

- **Medicare:** Certain services are paid at prospectively determined rates based on clinical, diagnostic, and other factors. Certain services are paid based on cost-reimbursement methodologies (subject to certain limits) with final settlement determined after Medicare Administrative Contractors have audited annual cost reports submitted by the System. Physician services are paid based upon established fee schedules based on services provided.

- **Medicaid:** Reimbursements for Medicaid services are generally paid at prospectively determined rates per discharge, per occasion of service, or per covered member. Supplemental funding is generally provided by the various states in which the System operates for Medicaid Disproportionate Share and hospital fee programs.

- **Other:** Payment agreements with certain commercial insurance carriers, HMOs, and preferred provider organizations provide for payment using prospectively determined rates per discharge, discounts from established charges, and prospectively determined daily rates.

Note J – Patient Service Revenue and Premium Revenue (continued)

The healthcare industry is subject to laws and regulations concerning government programs, including Medicare and Medicaid, which are complex and subject to varying interpretation. Compliance with such laws and regulations may also be subject to future government review and interpretation as well as significant regulatory action, including fines, penalties, and potential exclusion from the related programs. While the System operates a compliance program, which reviews its compliance with these laws and regulations, there can be no assurance that regulatory authorities will not challenge the System's compliance with these laws and regulations, and it is not possible to determine the impact (if any) such claims or penalties would have upon the System. In addition, the contracts the System has with commercial payors also provide for retroactive audit and review of claims.

Settlements with third-party payors for retroactive adjustments due to audits, reviews, or investigations are considered variable consideration and are included in the determination of the estimated transaction price for providing patient care. These settlements are estimated based on the terms of the payment agreement with the payor, correspondence from the payor, and the System's historical settlement activity, including an assessment to ensure that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustment is subsequently resolved. Estimated settlements are adjusted in future periods as adjustments become known (that is, new information becomes available), or as years are settled or are no longer subject to such audits, reviews, and investigations. Subsequent revisions compared favorably to original estimates by $29 and $7 for the years ended December 31, 2021 and 2020, respectively.

Consistent with the System's mission, care is provided to patients regardless of their ability to pay. Therefore, the System has determined it has provided implicit price concessions to uninsured patients and patients with other uninsured balances (for example, copays and deductibles). For uninsured patients, the System applies a policy discount from standard charges to determine amounts billed to those patients. The implicit price concessions included in estimating the transaction price represent the difference between amounts billed to patients and the amounts the System expects to collect based on its collection history with that class of patients.

Subsequent changes to the estimate of the transaction price are generally recorded as adjustments to patient service revenue in the period of the change. Subsequent changes that are determined to be the result of an adverse change in the patient's ability to pay are recorded as bad debt expense. Bad debt expense for the years ended December 31, 2021 and 2020 was not significant.

(In millions of dollars)

Note J – Patient Service Revenue and Premium Revenue (continued)

The composition of net patient service revenues by payor is as follows:

	Year Ended December 31	
	2021	**2020**
Medicare	**$ 1,649**	$ 1,520
Medicaid	**1,428**	1,292
Other payors	**1,583**	1,285
	$ 4,660	$ 4,097

The composition of patient service revenues by area of operation and business type is as follows:

	Year Ended December 31, 2021					
	Pacific Northwest	**Northern California**	**Central California**	**Southern California**	**Other**	**Total**
Inpatient	**$ 261**	**$ 728**	**$ 1,098**	**$ 851**	**$ (21)**	**$ 2,917**
Outpatient and other	**209**	**226**	**275**	**158**	**54**	**922**
Emergency	**60**	**89**	**205**	**83**	**–**	**437**
Physician services	**75**	**96**	**182**	**11**	**106**	**470**
Eliminations	**(11)**	**(18)**	**(26)**	**(15)**	**(16)**	**(86)**
Grand total	**$ 594**	**$ 1,121**	**$ 1,734**	**$ 1,088**	**$ 123**	**$ 4,660**

	Year Ended December 31, 2020					
	Pacific Northwest	**Northern California**	**Central California**	**Southern California**	**Other**	**Total**
Inpatient	$ 248	$ 579	$ 877	$ 772	$ (5)	$ 2,471
Outpatient and other	179	214	344	134	61	932
Emergency	54	24	184	69	–	331
Physician services	66	127	168	11	75	447
Eliminations	(14)	(23)	(23)	(11)	(13)	(84)
Grand total	$ 533	$ 921	$ 1,550	$ 975	$ 118	$ 4,097

(In millions of dollars)

Note J – Patient Service Revenue and Premium Revenue (continued)

Premium revenues: The System has entered into payment agreements with certain HMOs to provide medical services to subscribing participants. Under these agreements, the System receives monthly capitation payments based on the number of each HMO's covered participants regardless of the services actually provided by the System. The transaction price may be adjusted for stop loss recoveries, ceded premiums, and risk adjustment factors. Performance obligations are satisfied over the passage of time by standing ready to provide services.

The composition of premium revenues based on area of operation and payor class is as follows:

	Year Ended December 31, 2021					
	Pacific Northwest	**Northern California**	**Central California**	**Southern California**	**Other**	**Total**
Medicaid managed care	**$ 6**	**$ 79**	**$ 1**	**$ 52**	**$ 40**	**$ 178**
Other managed care	**1**	**–**	**–**	**(6)**	**16**	**11**
	$ 7	**$ 79**	**$ 1**	**$ 46**	**$ 56**	**$ 189**

	Year Ended December 31, 2020					
	Pacific Northwest	**Northern California**	**Central California**	**Southern California**	**Other**	**Total**
Medicaid managed care	$ 21	$ 85	$ 11	$ 41	$ 3	$ 161
Other managed care	2	–	–	–	22	24
	$ 23	$ 85	$ 11	$ 41	$ 25	$ 185

The composition of premium revenues based on type of service and area of operation is as follows:

	Year Ended December 31, 2021					
	Pacific Northwest	**Northern California**	**Central California**	**Southern California**	**Other**	**Total**
Institutional services	**$ –**	**$ 37**	**$ (1)**	**$ 46**	**$ 36**	**$ 118**
Professional services	**7**	**42**	**1**	**–**	**21**	**71**
	$ 7	**$ 79**	**$ –**	**$ 46**	**$ 57**	**$ 189**

	Year Ended December 31, 2020					
	Pacific Northwest	**Northern California**	**Central California**	**Southern California**	**Other**	**Total**
Institutional services	$ 17	$ 74	$ 9	$ 41	$ –	$ 141
Professional services	6	11	2	–	25	44
	$ 23	$ 85	$ 11	$ 41	$ 25	$ 185

(In millions of dollars)

Note J – Patient Service Revenue and Premium Revenue (continued)

The System recorded variable consideration from state programs for serving a disproportionate share of Medicaid and low-income patients in the amount of $66 and $49 in 2021 and 2020, respectively, including final settlements on prior years.

The State of California enacted legislation for a hospital fee program to fund certain Medi-Cal program coverage expansions. The program charges hospitals a quality assurance fee that is used to obtain federal matching funds for Medi-Cal with the proceeds redistributed as supplemental payments to California hospitals that treat Medi-Cal patients. There was one hospital fee program active in 2020: a 30-month program covering the period from July 1, 2019 to December 31, 2021, which was submitted to CMS for approval on September 30, 2019, and was approved on February 26, 2020. Accordingly, all related supplemental payments have been recognized as variable consideration and related quality assurance fees recognized as expense as of December 31, 2021.

Federal and state payments received from these programs are included in patient service revenue, and fees paid or payable to the state and California Health Foundation and Trust (CHFT) are included in purchased services and other expenses, as follows:

	Year Ended December 31	
	2021	**2020**
Patient service revenue	**$ 486**	$ 432
Purchased services:		
Quality assurance fees	**186**	167
CHFT payments	**4**	3
Total purchased services and other expenses	**190**	170
Income from operations	**$ 296**	$ 262

Accrued net receivables related to the hospital fee programs are included in receivables from third-party payors, and amount to $419 and $422 as of December 31, 2021 and 2020, respectively.

Note K – COVID-19

On March 11, 2020, the World Health Organization declared the novel coronavirus disease (COVID-19) a pandemic. Following this, the Centers for Disease Control and Prevention declared a national public health emergency, followed by state emergency declarations, and the Centers for Medicare & Medicaid Services (CMS) issued guidance regarding elective procedures. Several national restrictions were put in place and the governors in the states in which the System has operations issued shelter-in-place orders and executive orders postponing nonessential or elective surgeries. Several unavoidable factors are impacting both revenue and expense as the result of necessary actions by the System as well as local, state, and federal governments to mitigate the spread and effect of the virus.

In response to COVID-19, the Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act") was enacted on March 27, 2020 and the American Rescue Plan ("ARP") was enacted on March 11, 2021. The CARES Act and the ARP authorize funding to hospitals and other healthcare providers through Provider Relief Funds. Grant payments from the Provider Relief Fund are intended to reimburse healthcare providers for lost revenue and increased expenses due to the pandemic. The System received approximately $288 through December 31, 2020 and an additional $174 through December 31, 2021. The consolidated statements of operations and changes in net assets recognized contributions in other revenue in the amount of $105 and $288 for the years ended 2021 and 2020, respectively.

On March 28, 2020, CMS expanded the existing Accelerated and Advance Payments Program to a broader group of Medicare Part A providers and Part B suppliers. At the end of April 2020, the System received approximately $358 of Medicare advance payments as part of the CMS Accelerated and Advance Payments Program. Originally, CMS announced that it would begin to offset the payments by future Medicare reimbursements up to 210 days after disbursement, depending on whether a facility is an acute or non-acute facility. On October 1, 2020, a continuing resolution was signed, which included an extension to delay repayments to one year from receipt of these accelerated and advance disbursements. The repayment terms specify that for the first 11 months after repayment begins, repayment will occur through an automatic recoupment of 25% of Medicare payments otherwise owed to the provider. At the end of the eleven-month period, recoupment will increase to 50% for six months. At the end of the six months (29 months from the receipt of the initial accelerated payment), Medicare will issue a letter for full repayment of any remaining balance, as applicable. In other current liabilities, the System has recorded $180 and $160 for the years ended 2021 and 2020, respectively. In other noncurrent liabilities the system has recorded $0 and $198 for the years ended 2021 and 2020, respectively.

The CARES Act also allows for deferred payment of the employer portion of certain payroll taxes between March 27, 2020 and December 31, 2020, with half due December 31, 2021 and the remaining half due December 31, 2022. As of December 31, 2020, the System had deferred payroll tax payments of approximately $37.5 and $75 for years ended 2021 and 2020, respectively, with $37.5 included in accrued compensation and related payables for years ended 2021 and 2020. Included in other noncurrent liabilities in the consolidated balance sheet is $0 and $37.5 for years ended 2021 and 2020, respectively.

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

(In millions of dollars)

Note L – Functional Classification of Expenses

The System groups like expenses into financial statement lines and classifies programmatic expenses by business line. Expenses that are attributable to one or more programs or supporting functions are allocated based on operating expenses, square footage, and other criteria.

The following is a functional classification of the System's expenses:

	Year Ended December 31, 2021		
	Program Services	**General and Administrative**	**Total**
Employee compensation	**$ 1,837**	**$ 471**	**$ 2,308**
Professional fees	**689**	**93**	**782**
Supplies	**777**	**8**	**785**
Purchased services and other	**1,013**	**218**	**1,231**
Interest	**65**	**–**	**65**
Depreciation and amortization	**182**	**11**	**193**
Total expenses	**$ 4,563**	**$ 801**	**$ 5,364**

	Year Ended December 31, 2020		
	Program Services	**General and Administrative**	**Total**
Employee compensation	$ 1,835	$ 411	$ 2,246
Professional fees	496	91	587
Supplies	631	10	641
Purchased services and other	895	210	1,105
Interest	68	–	68
Depreciation and amortization	191	10	201
Total expenses	$ 4,116	$ 732	$ 4,848

Note M – Retirement Plan

Most of the System's operating entities participate in a single defined contribution plan (the "Plan"). The Plan is exempt from the Employee Retirement Income Security Act of 1974. The Plan provides, among other things, that the employer will contribute 3% of wages plus additional amounts for employees earning more than the Social Security wage base capped by the IRS compensation limit for the Plan year. Additionally, the Plan provides that the employer will match 50% of the employee's contributions up to 4% of the contributing employee's wages. Substantially all full-time employees who are at least 18 years of age are eligible for coverage in the Plan. The cost to the System for the Plan is included in employee compensation in the amount of $74 and $64 for the years ended December 31, 2021 and 2020, respectively.

Note N – Self-Insurance Liability Programs

The System has established a separate self-insurance program (the "System Program") that covers the System's entities for professional and general liability claims up to $9 per occurrence and $25 in the aggregate for the years ended December 31, 2021 and 2020. The System contracts with Adhealth, Limited (Adhealth), a Bermuda company, to provide excess coverage for professional and general liability claims that exceed the System Program limits. Adhealth provided excess coverage with aggregate and per claim limits of $125 for professional and general liability claims for the years ended December 31, 2021 and 2020, which brought total coverage per claim and aggregate limits to $134 for the years ended December 31, 2021 and 2020. Adhealth has purchased reinsurance through commercial insurers for 100% of the excess limits of coverage.

Claim liabilities (reserves) for future losses and related loss adjustment expenses for professional liability claims have been determined by an actuary at the present value of future claim payments using a 2% discount rate for program years 2021 and 2020. Such claim reserves are based on the best data available to the System; however, these estimates are subject to a significant degree of inherent variability. Accordingly, there is at least a reasonable possibility that a material change to the estimated reserves will occur in the near term. The System Program's accrued liability for professional and general liability claims is included in the consolidated balance sheets in the amount of $115 and $119 at December 31, 2021 and 2020, respectively.

The System has a 50% ownership position in Adhealth at December 31, 2021 and 2020, and accounts for its investment using the equity method of accounting. The cost of acquiring commercial insurance by Adhealth is reflected as an expense in the consolidated statements of operations and changes in net assets.

The System maintains a self-insured workers' compensation plan to pay for the cost of workers' compensation claims. The System has entered into an excess insurance agreement with an insurance company to limit its losses on claims. The cost of workers' compensation claims is accrued using actuarially determined estimates that are based on historical factors. Such claim reserves are based on the best data available to the System; however, these estimates are subject to a significant degree of inherent variability. Accordingly, there is at least a reasonable possibility that a material change to the estimated reserves will occur in the near term.

Workers' compensation claim liabilities have been determined by an actuary at the present value of future claim payments using a 2% discount rate for program years 2021 and 2020. The System's accrued liability for workers' compensation claims is recorded in the consolidated balance sheets in the amount of $78 and $80 at December 31, 2021 and 2020, respectively.

(In millions of dollars)

Note O – Commitments and Contingencies

Certain member organizations are involved in litigation and investigations arising in the ordinary course of business. In addition, certain member organizations in the ordinary course of business identified matters that they have reported to CMS, CMS contractors, or Medicaid/Medi-Cal contractors. Such disclosures typically involve simple repayment of affected claims; however, federal and state contractors may refer these matters to the Department of Health and Human Services' Office of Inspector General to investigate whether certain member organizations have submitted false claims to the Medicare and Medicaid programs or have violated other laws. Submission of false claims or violation of other laws can result in substantial civil and/or criminal penalties and fines, including treble damages and/or possible debarment from future participation in such programs. The System is committed to cooperating in such investigations as they arise. Although management does not believe these matters will have a material adverse effect on the System's consolidated financial position, there can be no assurance that this will be the case.

Note P – Acquisitions

On March 10, 2020, the System finalized the purchase of Blue Zones, LLC and Thrive Production, Inc. for $78 in initial consideration. These companies focus on supporting a number of activities, including charitable and education activities, designed to help people live longer and better through community transformation programs that lower healthcare costs, improve productivity, and boost national recognition as great places to live, work, and play. The purchase resulted in $42 of goodwill and $30 of other identifiable intangible assets primarily related to trade name and customer relationships.

The following unaudited pro forma consolidated operating results for the year ended December 31, 2020. The pro forma consolidated operating results do not necessarily represent the System's consolidated operating results had the acquisitions occurred on the date assumed, nor are these results necessarily indicative of the System's future consolidated operating results.

	December 31 2020
Pro forma revenues and support	**$ 4,775**
Pro forma excess of revenues over expense	**109**
Pro forma increase in net assets without donor restrictions	**126**
Pro forma increase (decrease) in donor-restricted net assets	**3**

In July 2020, the System commenced a long-term lease with Mendocino Coast Health Care District to become the sole operator of Mendocino Coast District Hospital, located in Fort Bragg, California. The lease agreement specifies that the hospital remain an acute care in-patient hospital, maintain at least 25 beds (the current number), and continue to provide emergency room services. It is expected that, as a result of the affiliation, more resources will be available to recruit and retain staff as well as bolster departments that currently have unmet needs such as new equipment and upgrading existing facilities. A new community board was formed with members appointed by Adventist Health consisting of 15 members, including two members from Adventist Health, two members from the Mendocino Coast Health District Board, the hospital's Chief of Staff, and ten representatives from the local community.

Note Q – Camp Fire Impact

In November 2018, the System's Adventist Health Feather River (AHFR) facilities in Paradise, California, and neighboring communities incurred extensive damage as a result of the Camp Fire; most of the AHFR properties, including the 100-bed acute care hospital, remain closed.

At the time of the Camp Fire, the System maintained an insurance policy with an insurance company providing for total per occurrence aggregate coverage of $1,000 subject to a one hundred twenty-five thousand dollars per-occurrence deductible with other limitations. The System also filed a claim against Pacific Gas and Electric (PG&E), which has accepted responsibility for the Camp Fire and filed for bankruptcy protection in January 2019.

When all property insurance coverage and PG&E claims applicable to the above-mentioned Camp Fire damaged and destroyed buildings and assets are considered, the System believes it is entitled to the recovery of substantially all Camp Fire related expenses and reconstruction costs. In addition, pursuant to the business interruption policy, the System believes it is entitled to substantially all lost income at the impacted properties resulting from the Camp Fire. However, there can be no assurance that the System will ultimately collect substantially all of the Camp Fire related expenses and reconstruction costs and the lost income resulting from the related interruption of business at the impacted properties.

As of December 31, 2021, the System received additional Camp Fire related insurance payments of $68. $30 of this payment has been applied to a casualty loss receivable and $29 was applied against the net book value of the impaired assets at December 31, 2021. This resulted in a gain of $9 recorded in other revenue.

Note R – Subsequent Events

The System has evaluated subsequent events and disclosed all material events through March 18, 2022, the date the accompanying consolidated financial statements were issued.

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Report of Independent Auditors on Supplementary Information

The Board of Directors
Adventist Health System/West

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The accompanying consolidating financial statement schedules for Adventist Health System/West is presented for purposes of additional analysis and is not a required part of the financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated, in all material respects, in relation to the financial statements as a whole.

Ernst & Young LLP

March 18, 2022

Adventist Health
Consolidating Balance Sheets
(In millions of dollars)
December 31, 2021

	Consolidated Balances	Adjustments and Eliminations	Adventist Health System Office	Adventist Health Bakersfield	Adventist Health Castle	Adventist Health Clear Lake	Adventist Health Delano	Adventist Health Feather River	Adventist Health Glendale	Adventist Health Hanford	Adventist Health Howard Memorial	Adventist Health Lodi Memorial
Assets												
Cash and cash equivalents	$ 304	$ (2,089)	$ 15	$ 100	$ 112	$ 31	$ 120	$ 79	$ 41	$ 434	$ 69	$ 45
Short-term investments	157	–	154	–	–	–	–	–	1	–	–	–
Patient accounts receivable	689	(13)	–	65	22	32	9	1	78	51	12	41
Receivables from third-party payors	379	(7)	–	48	1	13	26	4	14	75	4	29
Other current assets	227	(444)	447	36	12	4	2	5	15	10	2	15
Total current assets	1,756	(2,553)	616	249	147	80	157	89	149	570	87	130
Noncurrent investments	2,291	(9)	2,261	–	17	–	–	3	3	–	–	–
Other assets	432	8	159	10	20	5	–	–	33	24	10	7
Property and equipment, net	2,185	–	292	133	121	36	48	10	172	165	45	125
Total assets	$ 6,664	$ (2,554)	$ 3,328	$ 392	$ 305	$ 121	$ 205	$ 102	$ 357	$ 759	$ 142	$ 262
Liabilities and net assets												
Accounts payable	$ 370	$ –	$ 124	$ 24	$ 9	$ 5	$ 5	$ 1	$ 22	$ 18	$ 5	$ 20
Accrued compensation and related payables	325	(13)	175	14	7	5	5	–	18	11	3	8
Liabilities to third-party payors	209	(7)	8	4	9	2	7	–	26	21	10	13
Other current liabilities	242	(447)	222	38	16	31	5	1	32	28	6	25
Short-term financing	30	(99)	33	–	–	–	–	–	–	–	–	–
Current maturities of long-term debt	36	–	10	3	1	1	–	–	5	3	1	4
Total current liabilities	1,212	(566)	572	83	42	44	22	2	103	81	25	70
Long-term debt, net of current maturities	2,000	–	369	94	73	65	15	18	179	234	28	135
Other noncurrent liabilities	323	(1,988)	2,124	7	4	4	–	–	24	4	9	5
Total liabilities	3,535	(2,554)	3,065	184	119	113	37	20	306	319	62	210
Net assets (deficit) without donor restrictions:												
Controlling	3,044	–	261	206	181	7	168	80	42	439	79	48
Noncontrolling	15	–	–	–	–	–	–	–	–	–	–	–
Net assets with donor restrictions	70	–	2	2	5	1	–	2	9	1	1	4
Total net assets	3,129	–	263	208	186	8	168	82	51	440	80	52
Total liabilities and net assets	$ 6,664	$ (2,554)	$ 3,328	$ 392	$ 305	$ 121	$ 205	$ 102	$ 357	$ 759	$ 142	$ 262

See accompanying auditors' report on supplementary information.

Adventist Health Mendocino Coast	Adventist Health Physicians Network	Adventist Health Plan	Adventist Health Portland	Adventist Health Reedley	Adventist Health and Rideout	Adventist Health Simi Valley	Adventist Health Sonora	Adventist Health St. Helena	Adventist Health Tehachapi Valley	Adventist Health Tillamook	Adventist Health Tulare	Adventist Health Ukiah Valley	Adventist Health White Memorial	Western Health Resources
$ –	$ 8	$ 6	$ 160	$ 170	$ 46	$ –	$ 214	$ –	$ 19	$ 62	$ –	$ 126	$ 536	$ –
–	–	–	–	–	–	–	–	–	–	–	–	–	2	–
9	12	–	48	26	78	32	36	31	9	14	15	21	50	10
2	–	2	2	8	25	6	26	7	–	–	15	20	59	–
13	19	–	7	2	15	5	9	15	2	2	2	9	20	3
24	39	8	217	206	164	43	285	53	30	78	32	176	667	13
–	–	–	–	–	–	–	–	16	–	–	–	–	–	–
8	–	–	32	42	12	15	12	10	1	3	8	10	1	2
1	–	–	114	42	336	115	82	98	42	10	7	73	117	1
$ 33	$ 39	$ 8	$ 363	$ 290	$ 512	$ 173	$ 379	$ 177	$ 73	$ 91	$ 47	$ 259	$ 785	$ 16
$ 3	$ 3	$ 1	$ 12	$ 6	$ 32	$ 7	$ 11	$ 14	$ 4	$ 4	$ 7	$ 9	$ 21	$ 3
2	2	–	10	5	19	7	8	8	1	3	2	6	16	3
–	–	2	13	3	33	9	15	14	3	7	–	7	10	–
10	19	3	38	49	26	14	17	21	4	6	6	25	39	8
17	–	–	–	–	–	4	–	16	–	–	44	–	–	15
–	–	–	–	–	2	2	2	1	–	–	–	1	–	–
32	24	6	73	63	112	43	53	74	12	20	59	48	86	29
–	–	–	92	53	166	103	84	60	60	6	41	53	71	1
6	1	–	29	30	14	7	10	8	1	2	4	8	9	1
38	25	6	194	146	292	153	147	142	73	28	104	109	166	31
(7)	14	2	164	144	205	19	231	10	(2)	63	(57)	149	613	(15)
–	–	–	–	–	15	–	–	–	–	–	–	–	–	–
2	–	–	5	–	–	1	1	25	2	–	–	1	6	–
(5)	14	2	169	144	220	20	232	35	–	63	(57)	150	619	(15)
$ 33	$ 39	$ 8	$ 363	$ 290	$ 512	$ 173	$ 379	$ 177	$ 73	$ 91	$ 47	$ 259	$ 785	$ 16

Adventist Health
Consolidating Statements of Operations and Changes in Net Assets
(In millions of dollars)
Year Ended December 31, 2021

	Consolidated Balances	Adjustments and Eliminations	Adventist Health System Office	Adventist Health Bakersfield	Adventist Health Castle	Adventist Health Clear Lake	Adventist Health Delano	Adventist Health Feather River	Adventist Health Glendale	Adventist Health Hanford	Adventist Health Howard Memorial	Adventist Health Lodi Memorial
Revenues and support												
Patient service revenue	$ 4,660	$ (85)	$ (21)	$ 478	$ 179	$ 143	$ 98	$ (8)	$ 495	$ 375	$ 85	$ 261
Premium revenue	189	(22)	–	–	2	7	–	–	–	21	3	–
Other revenue	348	(741)	787	19	20	11	5	10	23	22	5	11
Net assets released from restrictions for operations	18	–	–	1	–	3	–	–	2	2	1	–
Total revenues and support	5,215	(848)	766	498	201	164	103	2	520	420	94	272
Expenses												
Employee compensation	2,308	(111)	430	159	89	67	37	–	212	126	34	94
Professional fees	782	–	73	63	7	32	17	–	54	43	10	38
Supplies	785	–	(6)	90	36	13	13	–	88	51	12	38
Purchased services and other	1,231	(737)	348	173	56	42	28	2	191	116	24	85
Interest	65	(5)	18	3	2	2	–	–	6	7	1	4
Depreciation and amortization	193	–	33	11	7	4	6	1	17	13	4	11
Total expenses	5,364	(853)	896	499	197	160	101	3	568	356	85	270
(Loss) gain income from operations	(149)	5	(130)	(1)	4	4	2	(1)	(48)	64	9	2
Nonoperating income												
Investment income	163	(5)	70	4	9	2	5	2	3	16	2	2
Other nonoperating losses	(5)	–	(5)	–	–	–	–	–	–	–	–	–
Total nonoperating income	158	(5)	65	4	9	2	5	2	3	16	2	2
Excess (deficit) of revenues over expenses	9	–	(65)	3	13	6	7	1	(45)	80	11	4
Less: excess of revenues over expenses from noncontrolling interests	(1)	–	–	–	–	–	–	–	(1)	–	–	–
Excess (deficit) of revenues over expense from controlling interests	8	–	(65)	3	13	6	7	1	(46)	80	11	4

See accompanying auditors' report on supplementary information.

Adventist Health Mendocino Coast	Adventist Health Physicians Network	Adventist Health Plan	Adventist Health Portland	Adventist Health Reedley	Adventist Health and Rideout	Adventist Health Simi Valley	Adventist Health Sonora	Adventist Health St. Helena	Adventist Health Tehachapi Valley	Adventist Health Tillamook	Adventist Health Tulare	Adventist Health Ukiah Valley	Adventist Health White Memorial	Western Health Resources
$ 56	$ 107	$ –	$ 331	$ 175	$ 468	$ 196	$ 286	$ 225	$ 52	$ 96	$ 34	$ 170	$ 412	$ 52
–	21	36	5	2	–	–	–	29	–	–	–	40	45	–
2	14	–	17	28	7	6	27	23	7	2	1	24	17	1
–	–	–	–	–	1	–	1	2	–	1	–	1	3	–
58	142	36	353	205	476	202	314	279	59	99	35	235	477	53
28	51	–	168	69	198	80	102	88	21	42	28	68	185	43
14	96	–	24	37	78	18	39	30	8	11	12	34	42	2
9	15	–	48	13	83	31	53	62	6	11	9	35	73	2
10	(20)	36	98	49	164	67	67	99	13	26	28	69	187	10
1	–	–	3	1	5	3	3	2	2	–	3	2	2	–
–	–	–	11	3	21	9	7	8	2	1	2	6	16	–
62	142	36	352	172	549	208	271	289	52	91	82	214	505	57
(4)	–	–	1	33	(73)	(6)	43	(10)	7	8	(47)	21	(28)	(4)
–	–	–	6	4	4	–	8	3	1	2	–	4	21	–
–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
–	–	–	6	4	4	–	8	3	1	2	–	4	21	–
(4)	–	–	7	37	(69)	(6)	51	(7)	8	10	(47)	25	(7)	(4)
–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
(4)	–	–	7	37	(69)	(6)	51	(7)	8	10	(47)	25	(7)	(4)

Adventist Health
Consolidating Statements of Operations and Changes in Net Assets (continued)
(In millions of dollars)
Year Ended December 31, 2021

	Consolidated Balances	Adjustments and Eliminations	Adventist Health System Office	Adventist Health Bakersfield	Adventist Health Castle	Adventist Health Clear Lake	Adventist Health Delano	Adventist Health Feather River	Adventist Health Glendale	Adventist Health Hanford	Adventist Health Howard Memorial	Adventist Health Lodi Memorial
Net assets without donor restrictions												
Controlling												
Excess (deficit) of revenues over expenses from controlling interests	$ 8	$ –	$ (65)	$ 3	$ 13	$ 6	$ 7	$ 1	$ (46)	$ 80	$ 11	$ 4
Net change in unrealized (losses) on other-than-trading securities	(10)	–	(10)	–	–	–	–	–	–	–	–	–
Net assets released from restrictions for capital additions	5	–	–	–	1		–	–	–	–	–	–
Transfers from (to) related parties	–	–	537	(52)	(20)	(28)	–	2	(59)	(50)	(6)	(27)
Other	1	–	1	–	–	–	–	–	–	–	–	–
Increase (decrease) in net assets without donor restrictions – controlling	4	–	463	(49)	(6)	(22)	7	3	(105)	30	5	(23)
Noncontrolling												
Excess of revenues over expenses from noncontrolling interests	1	–	–	–	–	–	–	–	1	–	–	–
Increase in net assets without donor restrictions – noncontrolling	1	–	–	–	–	–	–	–	1	–	–	–
Net assets with donor restrictions												
Restricted gifts and grants	32	–	1	1	3	3	–	–	4	2	1	1
Net assets released from restrictions	(23)	–	–	(1)	(1)	(3)	–	–	(2)	(2)	(1)	–
Increase (decrease) in net assets with donor restrictions	9	–	1	–	2	–	–	–	2	–	–	1
Increase (decrease) in net assets	14	–	464	(49)	(4)	(22)	7	3	(102)	30	5	(22)
Net assets, beginning of year	3,115	–	(201)	257	190	30	161	79	153	410	75	74
Net assets, end of year	$ 3,129	$ –	$ 263	$ 208	$ 186	$ 8	$ 168	$ 82	$ 51	$ 440	$ 80	$ 52

See accompanying auditors' report on supplementary information.

Adventist Health Mendocino Coast	Adventist Health Physicians Network	Adventist Health Plan	Adventist Health Portland	Adventist Health Reedley	Adventist Health and Rideout	Adventist Health Simi Valley	Adventist Health Sonora	Adventist Health St. Helena	Adventist Health Tehachapi Valley	Adventist Health Tillamook	Adventist Health Tulare	Adventist Health Ukiah Valley	Adventist Health White Memorial	Western Health Resources
$ (4)	$ –	$ –	$ 7	$ 37	$ (69)	$ (6)	$ 51	$ (7)	$ 8	$ 10	$ (47)	$ 25	$ (7)	$ (4)
–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
–	–	–	–	1	–	–	–	2	–	–	–	–	1	–
(2)	13	–	(43)	(32)	(46)	(18)	(35)	(30)	(5)	(13)	–	(20)	(59)	(7)
–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
(6)	13	–	(36)	6	(115)	(24)	16	(35)	3	(3)	(47)	5	(65)	(11)
–	–	–	–	–	–	–	–	–	–	–	–	–	–`	–
–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
2	–	–	–	–	1	–	–	8	–	1	–	1	3	–
–	–	–	–	(1)	(1)	–	(1)	(4)	–	(1)	–	(1)	(4)	–
2	–	–	–	(1)	–	–	(1)	4	–	–	–	–	(1)	–
(4)	13	–	(36)	5	(115)	(24)	15	(31)	3	(3)	(47)	5	(66)	(11)
(1)	1	2	205	139	335	44	217	66	(3)	66	(10)	145	685	(4)
$ (5)	$ 14	$ 2	$ 169	$ 144	$ 220	$ 20	$ 232	$ 35	$ –	$ 63	$ (57)	$ 150	$ 619	$ (15)

Section 4(b)(4)

Debt Service Coverage	**2021**
Excess of Revenues over Expenses from Continuing Operations	$ 8
Net unrealized gains and losses on investments	(76)
Loss on acquisition	-
Depreciation, amortization, interest expense and non-cash charges	258
Income available for debt service	190
Maximum annual debt service	112
Debt service coverage ratio	1.70

Capitalization	**2021**
Long-term Debt (including current maturities)	$ 2,036
Unrestricted Net Assets	3,059
Total Capitalization	5,095
Total Long-term Debt as a Percentage of Total Capitalization	40.0%

Adventist Health System/West
Municipal Secondary Market Disclosure
December 31, 2021
(In millions of dollars)

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

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

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

On December 31, 2021, the long-term debt of the Members of the Obligated Group (including current maturities) totaled $2,030. Of that amount, $47 was variable interest rate debt, with the remaining $1,983 being fixed interest rate debt.

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

During the year ended December 31, 2021 no Member of the Obligated Group has granted a Lien on accounts receivable nor sold any accounts receivable as permitted under the Master Indenture.

Section 4(b)(1). Below is a listing of the System's hospital facilities, grouped by state, and sorted within each state alphabetically.

Summary Listing of the System's Hospitals

Obligated Group Hospital Name	Location	Number of Licensed Beds at December 31, 2021	2021 Total Revenue (in millions)
Adventist Health Bakersfield	Bakersfield, CA	254	$498
Adventist Health Delano	Delano, CA	156	103
Adventist Health Hanford	Hanford, CA	235	420
Adventist Health Feather River	Paradise, CA	-	2
Adventist Health Glendale	Glendale, CA	515	520
Adventist Health Howard Memorial[(1)]	Willits, CA	25	94
Adventist Health Lodi Memorial	Lodi, CA	194	272
Adventist Health Reedley	Reedley, CA	49	205
Adventist Health and Rideout	Marysville, CA	366	476
Adventist Health Simi Valley	Simi Valley, CA	144	202
Adventist Health Sonora	Sonora, CA	152	314
Adventist Health St Helena	Deer Park, CA	212	279
Adventist Health Ukiah Valley	Ukiah, CA	68	235
Adventist Health White Memorial	Los Angeles, CA	353	477
Adventist Health Castle	Kailua, HI	160	201
Adventist Health Portland	Portland, OR	302	353
Adventist Health Tillamook[(1)]	Tillamook, OR	25	99
Non-Obligated Group Hospital Name			
Adventist Health Clear Lake[(1)]	Clearlake, CA	25	164
Adventist Health Mendocino Coast[(1)]	Fort Bragg, CA	25	58
Adventist Health Tehachapi Valley[(1)]	Tehachapi, CA	25	59
Adventist Health Tulare	Tulare, CA	108	35

[(1)] Critical Access Hospital.

Source: The Corporation.

Adventist Health System/West
Obligated Group Operating Statistics

Section 4(b)(5)

	Payor Mix		
	2019	2020	2021
Medicare	44.7%	44.4%	43.9%
Medicaid	30.5%	30.3%	30.4%
HMO/PPO	19.7%	20.7%	21.2%
Commercial	2.8%	2.4%	2.5%
Self-Pay and Other	2.4%	2.2%	1.9%

Section 4(b)(6)

	Patient Days (Including Sub-Acute)		
Hospital	2019	2020	2021
Adventist Health Hanford	42,428	49,201	52,475
Adventist Health Portland	31,831	28,492	30,810
Adventist Health Reedley	4,318	6,016	7,703
Adventist Health Castle	28,231	25,561	25,679
Adventist Health Feather River	-	-	-
Adventist Health Glendale	95,227	90,374	91,885
Adventist Health Howard Memorial	7,409	7,389	8,067
Adventist Health Lodi Memorial	30,204	27,152	30,723
Adventist Heatlh and Rideout	55,490	55,226	112,867
Adventist Health St Helena	44,538	32,299	39,124
Adventist Health Bakersfield	60,860	60,037	70,154
Adventist Health Delano	-	24,913	25,737
Adventist Health Sonora	39,072	35,794	34,809
Adventist Health Simi Valley	29,414	29,128	34,047
Tillamook Regional Medical Center	4,373	3,780	4,160
Adventist Health Ukiah Valley	12,534	12,719	13,797
Adventist Health White Memorial	88,418	81,513	79,272
	574,347	569,594	661,309

	Average Length of Stay		
Hospital	2019	2020	2021
Adventist Health Hanford	3.82	4.56	4.90
Adventist Health Portland	3.43	3.69	4.13
Adventist Health Reedley	2.42	3.46	4.36
Adventist Health Castle	3.95	3.92	4.04
Adventist Health Feather River	-	-	-
Adventist Health Glendale	4.76	5.42	5.44
Adventist Health Howard Memorial	4.17	4.20	4.33
Adventist Health Lodi Memorial	3.65	3.91	4.45
Adventist Health and Rideout	4.92	4.98	8.97
Adventist Health St Helena	6.74	7.33	7.13
Adventist Health Bakersfield	3.60	4.07	4.46
Adventist Health Delano	-	12.76	12.03
Adventist Health Sonora	7.55	7.50	7.14
Adventist Health Simi Valley	3.90	4.41	4.57
Tillamook Regional Medical Center	3.20	3.17	3.86
Adventist Health Ukiah Valley	3.47	3.55	3.95
Adventist Health White Memorial	4.47	4.56	4.56
	4.36	4.81	5.41

Adventist Health System/West
Obligated Group Operating Statistics

Section 4(b)(6)

Hospital	Discharges (Including Sub-Acute) 2019	2020	2021
Adventist Health Hanford	11,097	10,784	10,709
Adventist Health Portland	9,272	7,722	7,465
Adventist Health Reedley	1,785	1,738	1,768
Adventist Health Castle	7,142	6,513	6,350
Adventist Health Feather River	-	-	-
Adventist Health Glendale	20,003	16,687	16,884
Adventist Health Howard Memorial	1,775	1,761	1,865
Adventist Health Lodi Memorial	8,284	6,945	6,898
Adventist Health and Rideout	11,270	11,087	12,578
Adventist Health St Helena	6,611	4,409	5,484
Adventist Health Bakersfield	16,902	14,766	15,743
Adventist Health Delano	-	1,952	2,139
Adventist Health Sonora	5,173	4,775	4,872
Adventist Health Simi Valley	7,533	6,606	7,447
Tillamook Regional Medical Center	1,366	1,192	1,078
Adventist Health Ukiah Valley	3,608	3,585	3,496
Adventist Health White Memorial	19,785	17,869	17,385
	131,606	118,391	122,161

Section 4(b)(7)

	Other Key Volume Indicators 2019	2020	2021
Number of Licensed Beds	3,049	3,210	3,210
Discharges	131,606	118,391	122,161
Patient Days	574,347	569,594	661,309
Occupancy - Licensed Beds	51.6%	48.6%	56.4%
Average Length of Stay	4.36	4.81	5.41
Outpatient Revenues as % of Gross Pt. Revenues	46.1%	43.5%	44.8%

Management Discussion and Analysis of Financial Condition and Results of Operations

Year End: December 31, 2021

AdventistHealth

Adventist Health Overview

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

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

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

Strategy and Mission

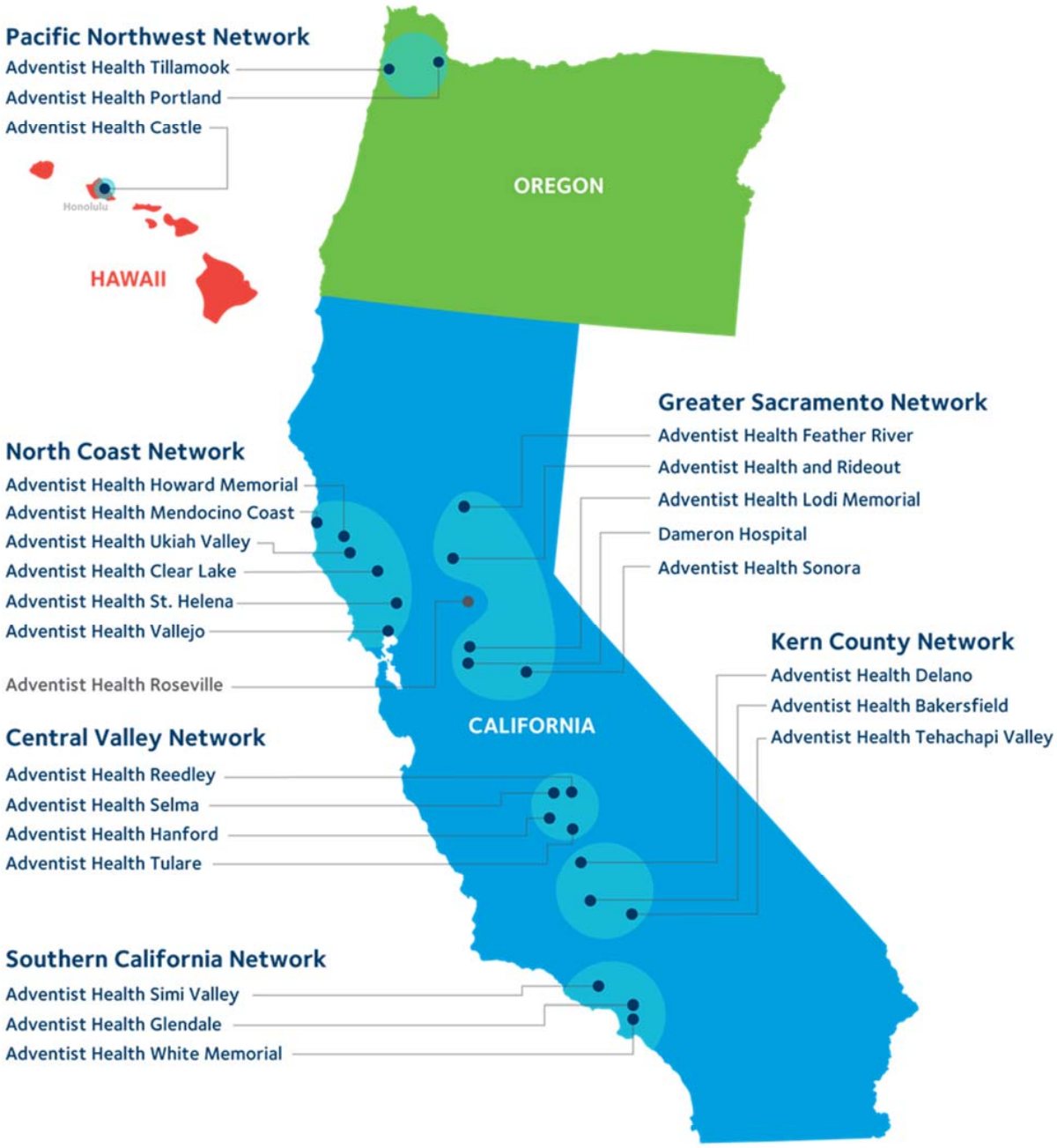
The 2030 Strategy:

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

Embedded within the Adventist Health strategy are several key themes:

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

Adventist Health Overview (Continued)



AdventistHealth

Organization Structure

Operating Structure Updates:

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

Kerry Heinrich became the organization's new president and CEO in January 2022. Kerry brings extensive executive experience and expertise to this role, having led Loma Linda University Medical Center, Children's Hospital, Medical Center - Murrieta, East Campus, Surgical Hospital and Behavioral Medicine Center. Named one of Becker's Hospital Review's "Nonprofit Hospital and Health System CEOs to Know" in 2016 and 2017, Kerry has more than 30 years of experience in healthcare legal counsel and leadership. He earned his bachelor's degree in history and a minor in business with an emphasis in finance and management from Walla Walla University in Washington, followed by his juris doctor (JD) degree from the University of Oregon's School of Law.

Affiliation and Other Activities

Dameron Hospital

In December 2019, Adventist Health entered into an 18-month agreement to manage Dameron Hospital in Stockton, California. This agreement was subsequently extended to March 31, 2027. Extending the service area of Adventist Health Lodi Memorial in neighboring Lodi, California, Dameron Hospital adds more than 200 inpatient beds to Adventist Health's footprint and ensures ongoing access to a population of more than 310,000. At the conclusion of the management services agreement, the corporation will have the option to pursue a membership transfer.

Adventist Health Mendocino Coast

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

Adventist Health Feather River - Camp Fire

In November 2018, the System's Adventist Health Feather River (AHFR) facilities in Paradise, California and neighboring communities incurred extensive damage as a result of the most destructive wildfire in California history. The fire destroyed the majority of homes and businesses throughout the community. Most of the AHFR properties, including the 100-bed acute care hospital, remain temporarily closed and non-operational as the System completes damage assessments. As of December 31, 2021, the timelines of Adventist Health's fixed acute care services in Paradise was yet to be determined.

Adventist Health St. Helena - Glass Fire

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

COVID-19 Update

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

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

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

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

- Opened a virtual hospital, Adventist Health Hospital@Home, in collaboration with Medically Home and Huron, to create capacity for COVID-19 patients by caring for patients with the coronavirus and other specified diagnoses in their homes through medical command centers and rapid response teams
- Reconfigured facilities to maximize patient service capacity during COVID-19 surge periods and to allow for social distancing, screening and taking other safety measures
- Temporarily closed unused services or minimized services at medical office buildings to meet the critical need to conserve PPE, and limit exposure to COVID-19 for both team members and patients
- Launched web pages, a chatbot and patient email responses to answer community members' questions and direct them to appropriate services
- Used System marketing and communication campaigns to remind community members not to neglect emergency care, informed the community as services resumed, shared enhanced safety measures to reduce patients' fears and promoted COVID-19 vaccination
- Adjusted supplemental and contract workforce, flexed staffing, furloughed positions and announced temporary or permanent staff reductions
- The System administered 349,852 COVID-19 vaccine doses at 30 locations as of December 31, 2021

In response to COVID-19, the Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act"), was enacted on March 27, 2020 and the American Rescue Plan was enacted on March 11, 2021. These Acts authorize funding to hospitals and other healthcare providers through the Public Health and Social Services Emergency Fund (Provider Relief Fund) and other mechanisms. Grant payments from these Acts are intended to reimburse healthcare providers for lost revenue and increased expenses due to the pandemic and to fund treatment and mitigation of the impacts of COVID-19. As of December 31, 2021, the System has received approximately $462 million of provider relief funds from various provisions in these Acts, of which $105 million and $288 million have been recognized in 2021 and 2020, respectively, as contributions in other revenue in the consolidated statement of operations and changes in net assets.

On March 28, 2020, CMS expanded the existing Accelerated and Advance Payments Program to a broader group of Medicare Part A providers and Part B suppliers. At the end of April 2020, the System received approximately $358 million of Medicare advance payments as part of the CMS Accelerated and Advance Payments Program. Originally, CMS announced that it would begin to offset the payments by future Medicare reimbursements up to 210 days after disbursement, depending on whether a facility was an acute or non-acute facility. On October 1, 2020, a continuing resolution was signed, which included an extension to delay repayments to one year from receipt of these accelerated and advance disbursements. Repayment terms specify that for the first 11 months after repayment begins, repayment will occur through an automatic recoupment of 25% of Medicare payments otherwise owed to the provider. At the end of the 11-month period, recoupment will increase to 50% for six months. At the end of the six months (29 months from the receipt of the initial accelerated payment), Medicare will issue a letter for full repayment of any remaining balance, as applicable. The System has recorded $180 million in other current liabilities in the consolidated balance sheet as of December 31, 2021.

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

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

Ratings and Outlook Updates

In September 2021, Fitch Ratings downgraded its long-term rating from 'A+' to 'A' while maintaining a Stable outlook and S&P Global Ratings affirmed its 'A' long-term rating and revised the outlook from Stable to Negative on Adventist Health's bonds. The Fitch rating reflects Adventist Health's historically solid operating income levels, which have more recently, through a series of one-time events and the lingering deleterious impact from the novel coronavirus, resulted in lower than anticipated operating EBIDA margins. Strength of the credit is still conferred through Adventist's position as the leading acute care provider in multiple growing markets, a gradually improving balance sheet, and accretive affiliation and expansion activity. The S&P outlook revision reflects a multiyear trend of negative operating performance that has pressured the financial profile. Precluding a downgrade is Adventist Health's historical operating strength prior to fiscal 2019, indicating a solid run rate can be achieved, as well as the System's largescale improvement plan being implemented during the outlook period. In addition, Adventist Health's balance sheet continues to improve.

Key Operating Metrics: Volume Trends

During the twelve months ended December 31, 2021, the System's inpatient discharges increased by 4.3%. Combined inpatient and observation stays increased by 4.6% from the same period in the previous year. On a same store basis that excludes Adventist Health Mendocino Coast, inpatient discharges increased by 4.1% primarily driven by impacts of COVID-19.

Total inpatient surgeries increased by 2.7% and outpatient surgeries increased by 15.6% from the same period in the previous year. On a same store basis, inpatient surgeries increased by 2.6% and outpatient surgeries increased by 14.7% from the same period in the previous year.

UTILIZATION STATISTICS

Twelve Months Ended December 31,	2021	2020
Discharges	128,128	122,794
Patient days	688,221	588,519
Observation stays	19,480	18,618
Outpatient procedures	3,977,724	3,554,932
Emergency department visits	682,364	638,246
Inpatient surgeries	22,539	21,953
Outpatient surgeries	51,327	44,384
Capitated lives	224,912	217,768
Average length of stay (in days)	5.4	4.8
Outpatient revenues as % of gross patient revenue	46.3%	45.0%

Key Operating Metrics: Total Operating Revenue and Income from Operations

Total operating revenue increased 9.2% for the twelve months ended December 31, 2021 as compared to the previous year. On a same store basis, total operating revenue increased 8.7% for the twelve months ended December 31, 2021 as compared to the previous year. The increase in operating revenue was the result of recognizing $105 million of CARES Act and American Rescue Plan funds and stronger inpatient volume (measured in patient days) and inpatient acuity (measured in Case Mix Index) compared to the prior year, offset by aged A/R write-off at recently acquired hospital. 2020 Q2 volumes were weak due to patient hesitancy and restrictions imposed at the beginning of the pandemic. Approximately $288 million CARES Act Provider Relief Funds were recognized as of December 31, 2020.

Total operating expenses increased 11.5% for the twelve months ended December 31, 2021 as compared to the previous year. On a same store basis, total operating expenses increased 10.9% for the twelve months ended December 31, 2021 as compared to the previous year. Salaries and benefits expenses increased 2.8% for the twelve months ended December 31, 2021 as compared to the previous year. This increase was primarily due to challenges from retaining and recruiting staff during the peak of the COVID-19 pandemic. It was compounded by increases in contract labor which are reported as Professional Fees and were 33.2% above the previous year.

Supplies increased by 22.5% from the previous year due to increase in per unit pricing and utilization of PPE and other supplies related to COVID-19.

Purchased services and other increased by 11.4% from the previous year due to the consolidation of Adventist Health Plan, which was previously unconsolidated, an increase in revenue cycle costs and purchased services under capitated contracts and an outsourcing of certain costs that were previously performed internally.

On both an all-inclusive and same-store basis, income (loss) from operations as a percent of total operating revenue was (2.9%) and (1.6%) for the twelve months ended December 31, 2021 and December 31, 2020, respectively.

Lost revenue and expenses attributed to the COVID-19 pandemic exceeded relief funds by $161 million in the year ended December 31, 2020 and by $153 million in the year ended December 31, 2021. The System is pursuing additional opportunities to fund these losses, most notably FEMA. The amount and timing of further relief payments is uncertain.

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

TOTAL OPERATING REVENUE AND INCOME FROM OPERATIONS

Twelve Months Ended December 31,	2021	2020
Total operating revenue	$5,215	$4,774
Total EBIDA expenses	$5,106	$4,579
EBIDA	$109	$195
EBIDA as a percentage of total operating revenue	2.1%	4.1%
Depreciation and interest expense	$258	$269
Loss from operations	($149)	($74)
Loss from operations as a percentage of total operating revenue	(2.9%)	(1.6%)

Key Operating Metrics: Total Nonoperating Income

Investment income decreased by 8.4% for the twelve months ended December 31, 2021 as compared to the previous year. Management maintains a long-term asset allocation strategy.

NONOPERATING INCOME

Twelve Months Ended December 31,	2021	2020
Investment income	$163	$178
Other nonoperating gains (losses)	($5)	$6
Nonoperating income before gain on acquisition and divestitures	$158	$184
Gain (Loss) on acquisition and divestitures	$0	($1)
Nonoperating income	$158	$183

Balance Sheet Ratios

Cash and unrestricted investments increased by $174 for the twelve months ended December 31, 2021. Days cash on hand decreased to 189.2 on December 31, 2021 from 197.4 at December 31, 2020. Long-term debt to capitalization decreased to 39.5% on December 31, 2021 from 40.0% at December 31, 2020. Adventist Health is able to maintain lower-than-median cash to debt and long-term debt to capitalization ratios as the system has no pension liability and operates under a defined contribution plan.

BALANCE SHEET RATIOS

Period Ended	Dec 31, 2021	Dec 31, 2020
Total cash and unrestricted investments	$2,680	$2,506
Days cash on hand	189.2	197.4
Cash to debt	134%	123%
Long-term debt to capitalization	39.5%	40.0%
Debt service coverage (Obligated Group)	2.0	2.1
Capital expenditures as a percentage of depreciation expense	70.5%	83.1%

Adventist Health Hospitals

OBLIGATED GROUP MEMBERS

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

NON-MEMBER ENTITIES

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

Entities in italics are consolidated with their respective parent entities

EXHIBIT 24

ARTICLES OF INCORPORATION OF ADVENTIST HEALTH

A0573828

FILED
In the office of the Secretary of State
of the State of California

DEC 5 2001

BILL JONES, Secretary of State

98 07 46

CERTIFICATE OF AMENDMENT OF

ARTICLES OF INCORPORATION

OF

ADVENTIST HEALTH SYSTEM/WEST

Thomas J. Mostert and Robert G. Carmen certify:

1. That we are the Chairman of the Board and the Secretary, respectively, of Adventist Health System/West, a California nonprofit religious corporation.

2. That Article VI of the Articles of Incorporation of Adventist Health System/West shall be amended to read as hereinafter set forth:

VI

A. The property of this corporation is irrevocably dedicated to religious purposes, and 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. Upon winding up and dissolution of this corporation, after paying or adequately providing for the debts and obligations of the corporation, the remaining assets shall be distributed to the Pacific Union Conference of Seventh-day Adventists and the North Pacific Union Conference of Seventh-day Adventists, nonprofit religious associations organized and operated exclusively for religious purposes that have established their tax-exempt status under Internal Revenue Code Section 501 (c)(3) or to one of them if the other is unable for any reason to be the recipient of said assets. In the event both Pacific Union Conference of Seventh-day Adventists and North Pacific Union Conference of Seventh-day Adventists are unable for any reason to be the recipient of said assets, remaining assets shall be distributed to the General Conference corporation of Seventh-day Adventists, a

corporation organized and operated under the laws of the district of Columbia exclusively for religious purposes that has established its tax-exempt status under internal Revenue code Section 501 (c)(3), or to any equally qualified successor organization. In the event that the General Conference organization or any qualified successor organization is unable for any reason to be the recipient of said assets, the remaining assets shall be distributed to a corporation selected by a court of competent jurisdiction over the distribution of said assets which is organized and operated exclusively for religious, charitable, scientific, and/or hospital purposes, which meets the requirements for exemption provided by section 214 of the Revenue and Taxation Code, which has established its tax exempt status under section 501 (c)(3) of the Internal Revenue Code, and which has purposes as similar as possible to the purposes of Adventist Health System/West.

3. That the foregoing amendments have been approved by the Board of Directors.

4. That the foregoing amendments were approved by the required vote of the members.

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: 9/17/2001

[redacted]

Thomas J. Mostert, Chairman of the Board

[redacted]

Robert G. Carmen, Secretary

I hereby certify that the foregoing transcript of 2 page(s) is a full, true and correct copy of the original record in the custody of the California Secretary of State's office.

JAN 11 2021

Date: FSS

ALEX PADILLA, Secretary of State

A363168

FILED
In the office of the Secretary of State
of the State of California

DEC 12 1988

MARCH FONG EU, Secretary of State

980746

CERTIFICATE OF AMENDMENT OF

ARTICLES OF INCORPORATION

OF

ADVENTIST HEALTH SYSTEM/WEST

Thomas J. Mostert and Donald R. Ammon certify:

1. That we are the Chairman of the Board and the Secretary, respectively, of Adventist Health System/West, a California nonprofit religious corporation.

2. That Articles II, V and VI of the Articles of Incorporation of Adventist Health System/West shall be amended to read as hereinafter set forth:

II

> This corporation is a 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 this 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 through the following activities:

A. To establish, manage and maintain acute care hospitals.

B. To establish, manage and maintain a Health Maintenance Organization (HMO) or similar organizations, utilizing health delivery systems designed and coordinated to maximize benefits to the communities served.

C. 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.

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

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

V

The authorized number and qualification of members of the corporation and the rights and privileges or members shall be as set forth in the bylaws; provided, however, that all of the members shall be members in good standing of the Seventh-day Adventist Church.

VI

A. The property of this corporation is irrevocably dedicated to religious purposes, and 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. Upon winding up and dissolution of this corporation, after paying or adequately providing for the debts and obligations of the corporation, the remaining assets shall be distributed to the Pacific Union Conference of Seventh-day Adventists and the North Pacific Union

Conference of Seventh-day Adventists, nonprofit religious associations organized and operated exclusively for religious purposes that have established their tax-exempt status under Internal Revenue Code Section 501(c)(3). In the event Pacific Union Conference of Seventh-day Adventists and North Pacific Union Conference of Seventh-day Adventists are unable for any reason to be the recipient of said assets, remaining assets shall be distributed to the General Conference Corporation of Seventh-day Adventists, a corporation organized and operated under the laws of the District of Columbia exclusively for religious purposes that has established its tax-exempt status under Internal Revenue Code Section 501(c)(3).

3. That the foregoing amendments have been approved by the Board of Directors.

4. That the foregoing amendments were approved by the required vote of the members.

[redacted]

Thomas J. Mostert, Chairman of the Board

[redacted]

Donald R. Ammon, Secretary

DECLARATION

Each of the undersigned declares under penalty of perjury that the statements contained in the foregoing Certificate of Amendment of Articles of Incorporation are true of his own knowledge and that this declaration was

executed on 29th November, 1988, at Roseville, California.

[redacted]

Thomas J. Mostert, Chairman of the Board

[redacted]

Donald R. Ammon, Secretary

AHSW65/12

I hereby certify that the foregoing transcript of 4 page(s) is a full, true and correct copy of the original record in the custody of the California Secretary of State's office.

JAN 11 2021

Date: FSK

ALEX PADILLA, Secretary of State

ADVENTIST HEALTH SYSTEM/WEST

A323257

980746

FILED
In the office of the Secretary of State
of the State of California

OCT 17 1986

MARCH FONG EU, Secretary of State

CERTIFICATE OF AMENDMENT OF
ARTICLES OF INCORPORATION OF
ADVENTIST HEALTH SYSTEM-WEST

The undersigned hereby certify that:

1. They are the President and the Secretary, respectively, of Adventist Health System-West, a California nonprofit public benefit corporation.

2. Article I of the Articles of Incorporation of this corporation is amended in its entirety to read as follows:

I

The name of this corporation shall be Adventist Health System/West.

3. The foregoing amendment of the Articles of Incorporation was duly approved by the Board of Directors of this corporation.

4. The foregoing amendment of the Articles of Incorporation was duly approved by the required vote of the voting members of the corporation.

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

Dated: 9/24/86

[redacted]

Frank F. Dupper, President

[redacted]

Naomi Parson, Secretary

ahsw5/08

I hereby certify that the foregoing transcript of 2 page(s) is a full, true and correct copy of the original record in the custody of the California Secretary of State's office.

JAN 11 2021

Date: FSK

ALEX PADILLA, Secretary of State

980746

RE
FILED
In the office of the Secretary of State
of the State of California
APR 17 1980
MARCH FONG EU, Secretary of State
By [signature]
Deputy

ARTICLES OF INCORPORATION

OF

ADVENTIST HEALTH SYSTEM-WEST

I

The name of this corporation is "Adventist Health System-West".

II

This corporation is a 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 this corporation are to further the medical ministry of the Seventh-day Adventist Church and to promote the wholeness of man physically, mentally and spiritually in the following ways:

A. To act on behalf of the Seventh-day Adventist Church to establish, manage and maintain acute care hospitals.

B. To promote and carry on scientific research related to the care of the sick and injured insofar as, in the opinion of the board of directors, such research can be carried on in, or in connection with, the hospital.

C. To establish, manage and maintain a Health Maintenance Organization (HMO), utilizing health delivery systems designed and coordinated to maximize benefits to the communities served.

D. 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.

E. To promote and carry [illegible] cientific research related to the care of the sick [illegible] jured, with particular reference to the philosop[illegible] d practice of the Seventh-day Adventist Church.

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

III

The name and address of this State of the corporation's initial agent for service of process is:

Frank F. Dupper
1545 North Verdugo Road
Glendale, California 91209.

IV

A. The number of directors shall be fixed by the bylaws of this corporation, and the number of directors may be changed from time to time by amendment of the bylaws adopted by the vote or written assent of the members of the corporation entitled to exercise a majority of the voting power, or the vote of a majority of a quorum of members called pursuant to the bylaws; provided, however, that all of the directors shall be members in good standing of the Seventh-day Adventist Church.

B. The bylaws shall provide for tenure, selection, removal and resignation of directors.

V

The authorized number and qualification of members of the corporation and the rights and privileges or members shall be as set forth in the bylaws; provided, however, that all of the membership shall be composed of members from specific Seventh-day Adventist institutions, constituencies, boards or executive committees of organizations that are listed in the Seventh-day Adventist Yearbook, published by the General Conference of Seventh-day Adventists.

VI

A. The property of this corporation is irrevocably dedicated to religious purposes, and 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. This corporation is a totally owned subordinate corporate agency operating subject to and in harmony with the policies, guidelines and procedures required by the Pacific Union Conference of Seventh-day Adventists and the North Pacific Union Conference of Seventh-day Adventists, nonprofit religious associations directly responsible for the management of the affairs of the Seventh-day Adventist Church in the western United States. Upon winding up and dissolution of this corporation, after paying or adequately providing for the debts and obligations of the corporation, the remaining assets shall be distributed to the Pacific Union Conference of Seventh-day Adventists and the North Pacific Union Conference of Seventh-day Adventists, nonprofit religious associations organized and operated exclusively for religious and/or charitable purpose that have established their tax-exempt status under Internal Revenue Code Section 501(c)(3). In the event Pacific Union Conference of Seventh-day Adventists and North Pacific Union

Conference of Seventh-day Adventists are unable for any reason to be the recipient of said assets, remaining assets shall be distributed to the General Conference Corporation of Seventh-day Adventists, a religious corporation organized under the laws of the District of Columbia that has established its tax-exempt status under Internal Revenue Code Section 501(c)(3).

VII

A. This corporation is organized exclusively for religious purposes within the meaning of Internal Revenue Code Section 501(c)(3). Notwithstanding any other provisions 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 Section 501(c)(3) of the Internal Revenue Code of 1954 (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 Internal Revenue Code of 1954 (or the corresponding provision of any future United States Internal Revenue law).

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

Dated: March 1, 1966

[redacted]

Warren L. Johns, Incorporator

I declare that I am the person who executed the above articles of incorporation, and such instrument is my act and deed.

[redacted]

Warren L. Johns

I hereby certify that the foregoing transcript of 5 page(s) is a full, true and correct copy of the original record in the custody of the California Secretary of State's office.

JAN 11 2021

Date: FSM

ALEX PADILLA, Secretary of State

EXHIBIT 25

BYLAWS OF ADVENTIST HEALTH

Bylaws
of
Adventist Health System/West
(the "Corporation")

Article 1
Principal Office and Purpose

1.1 Office. The principal office for the transaction of the operations of the Corporation shall be fixed from time to time by the Corporation's board of directors (the "**Board**"). The Corporation shall operate in that portion of the United States served by the Pacific Union Conference of Seventh-day Adventists ("**Pacific Union**") and the North Pacific Union Conference of Seventh-day Adventists ("**North Pacific Union**"), as well as any other location approved by the Board.

1.2 Purpose. The Corporation is a nonprofit religious corporation ("**Religious Corporation**") 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 that is consistent with the philosophy, teachings, and practices of the Seventh-day Adventist Church (the "**Church**").

Article 2
Membership

2.1 Members. There shall be a single class of members of the Corporation who shall exercise the powers of members of a Religious Corporation as set forth in the Nonprofit Code and as provided in these bylaws and the articles of incorporation of the Corporation.

2.2 Number and Qualifications. Each member shall be more than 21 years of age; shall have an interest in health care matters; shall support the philosophy, teachings, and practices of the Church; and shall be a member in regular standing in the Church in either the Pacific Union or North Pacific Union. The membership shall be composed of the following:

(a) The president, treasurer, and one other representative from both the office of the Pacific Union and the office of the North Pacific Union.

(b) One representative from each of the local conferences of the Church in which are located facilities affiliated with the Corporation.Four representatives, with one selected from each of the colleges or universities affiliated with the Church and located in the Pacific Union or North Pacific Union.

(c) Four representatives, with one selected from each of the colleges and universities affiliated with the Church and located in the Pacific Union or North Pacific Union.

(d) The CEO and three additional representatives of the management of the Corporation.

(e) Three representatives selected from among the presidents of hospital corporations affiliated with the Corporation.

(f) Three representatives selected from among physician members of the medical staffs of hospital corporations affiliated with the Corporation.

(g) Up to 16 lay representatives who do not belong to any of the categories of persons set forth in (a) through (e) above, but who otherwise meet the qualifications for membership set forth in these bylaws.

2.3 Election and Term of Office. The term of office for each member shall be five years or until that member's successor is elected. Successors for members whose terms of office are expiring shall be elected at the regular meeting of the members in the year such terms expire. A member may be elected to successive terms. The Nominating Committee (see Section 2.14) shall recommend member candidates.

2.4 Resignation, Removal, Vacancies. Any member may resign by giving written notice to the chair or to the CEO. The resignation shall be effective when the notice is given unless it specifies a later time for the resignation to become effective. A member may be removed from office by a majority vote of the members. The members shall fill vacancies in the membership by a majority vote of the members then still serving, even though less than a quorum, or by the vote of the sole remaining member. Successor members so elected shall serve until the completion of the term.

2.5 Regular Meetings. The regular meeting of the membership of the Corporation shall be held annually at the time and place determined by the Board. Meetings will be held on a triennial cycle, with meetings every three years held in person and electronic membership meetings held between these triennial in-person meetings, as provided in Section 2.9.

2.6 Special Meetings. Special meetings of the membership shall be held at such time and place (either in person or electronically), and pursuant to such notice, as may be fixed by the Board.

2.7 Meeting Notices. Written notice of meetings (regular or special) shall be by first-class mail, express delivery service (e.g., FedEx or UPS), or electronic transmission by the Corporation (as defined in Section 9.3) sent not more than 90 days nor less than 10 days (20 days if by mail) immediately preceding the time fixed for said meeting. The general purposes for which a special meeting is called shall be specified in the notice.

2.8 Waiver of Notice or Consent. The meeting of the members of the Corporation, however called and noticed, shall be as valid as a meeting held after a proper call and notice if a quorum is present and if, either before or after the meeting, each of the voting members not present signs a written waiver of notice, or a consent to holding the meeting, or an approval of the minutes of the meeting. All waivers, consents, or approvals shall be filed with the corporate records and be made a part of the minutes of the meeting. A member's attendance at a meeting shall also constitute a waiver of notice of that meeting unless the member objects at the beginning of the meeting to the transaction of any matter because the meeting was not lawfully called or convened. Also, attendance at a meeting is not a waiver of any right to object to the consideration of matters required to be included in the notice of the meeting but not so included, if that objection is expressly made at the meeting.

2.9 Meeting Location; Electronic Meetings. Beginning in 2017, triennial meetings of the members shall be held at the principal office of the Corporation or at any place designated by the Board. The Board may authorize members who are not present in person to participate by electronic transmission or by electronic video communication. If authorized by the Board in its sole discretion, and subject to the requirements of consent in the Nonprofit Code and guidelines and procedures the Board may adopt, members not physically present in person at a meeting of members may, by electronic transmission or by electronic video screen communication, participate in a meeting of members, be deemed present in person, and vote at a meeting of members whether that meeting is held (i) at a designated physical location or (ii) at a physical location, together with electronic transmission or by electronic video screen communication, subject to the requirements of this Section. Unless the Board elects otherwise, regular meetings of the members between triennial meetings will be conducted using electronic transmission or by electronic video screen communication. Where membership meetings are held by electronic transmission or by electronic video screen communication, the (a) Corporation must implement reasonable measures to provide all members a reasonable opportunity to participate in the meeting and to vote on matters submitted to the members, including an opportunity to read or hear the proceedings of the meeting substantially concurrently with those proceedings, and (b) if any member votes or takes other action at the meeting by means of electronic transmission to the Corporation or electronic video screen communication, a record of that vote or action is maintained by the Corporation.

2.10 Quorum. A quorum of any meeting of the members shall be 50 percent of the voting members. Except as otherwise required by law, the articles of incorporation, or these bylaws, the members present at a duly called or held 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.

2.11 Order of Business. The order of business at a membership meeting shall be determined by the Board or the members.

2.12 Voting; Written Ballots. At all membership meetings, all questions shall be determined by a majority vote, except as provided in Section 9.2. Each member of the Corporation shall be entitled to one vote. No member may vote or act by proxy. Except for the election of directors, any action that members may take at a membership meeting may also be taken by written ballot without a meeting, as follows:

(a) The Corporation shall distribute one written ballot and any related material to each member entitled to vote on the matter either by mail or by electronic transmission by the Corporation. Responses may be returned by mail or by electronic transmission to the Corporation.

(b) All solicitations of votes by written ballot shall specify the time by which the ballot must be received in order to be counted.

(c) Each ballot so distributed shall (1) set forth the proposed action; (2) give the members an opportunity to specify approval or disapproval of each proposal; and (3) provide a reasonable time in which to return the ballot to the Corporation.

2.13 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.

2.14 Nominating Committee. There shall be a nominating committee of the membership (the "**Nominating Committee**") consisting of the individuals serving on the Governance Committee (described in Section 4.2, below), together with three individuals selected by the Board from the member categories described in Subsections 2.2(a), (b), (c), (f), and (g), who shall serve for a term of one year. The Nominating Committee shall meet prior to any meeting of the membership at which directors or members are to be elected, and the Nominating Committee will recommend eligible candidates to the full membership for election to the Board or membership. The report of the Nominating Committee shall include the attendance records of current directors and members who are being nominated for election. The membership may also name one or more alternates to serve on the Nominating Committee in the event of the inability of a committee member to continue serving on the committee.

2.15 Bylaws Committee. There shall be a bylaws committee of the membership (the "**Bylaws Committee**") consisting of the individuals serving on the Governance Committee (described in Section 4.2, below), together with three individuals selected by the Board from the member categories described in Subsections 2.2(a), (b), (c), (f), and (g), who shall serve for a term of one year. The Bylaws Committee shall meet prior to any meeting of the membership and review the Corporation's bylaws and articles of incorporation. This committee will forward any recommended amendments to these documents to the membership for its consideration. Amendments will not be effective unless adopted by the membership.

Article 3
Board of Directors

3.1 Number and Qualification. The Board shall be composed of no more than 15 members. Each member shall be more than 21 years of age, shall have an interest in health care matters, and shall support the goals and objectives of the Church in its health care work and be a member in regular standing in the Church. The Board shall be composed of the following:

(a) The president of the Pacific Union and the president of the North Pacific Union.

(b) Two presidents selected from among the local conferences of the Church in which are located health care institutions affiliated with the Corporation.

(c) The CEO of the Corporation.

(d) Two professional health care providers who are practicing or serving in health care leadership.

(e) Eight lay representatives with business backgrounds and perspectives who do not belong to any of the categories of persons set forth in Subsections 3.1(a) to (c) above.

3.2 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.

3.3 Powers of the Board. The Board shall control and generally manage the operations of the Corporation and exercise all of the powers, rights, and privileges permitted to be exercised by directors of 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.

3.4 Nomination, Election, and Term of Office. The Nominating Committee (see Section 2.14) shall present the names and qualifications of its nominees for the Board to the members. The members shall consider all nominees and may elect a nominee to serve on the Board pursuant to a majority vote of the membership. The directors described in Subsections 3.1(a), (c), and (d) are ex officio directors, with vote, and are not elected. The term of office of each elected director shall be three years, beginning immediately following the membership meeting at which that person is elected, and ending following the close of the third annual membership meeting following such election or until that director's successor is elected. Successors for directors whose terms of office are expiring shall be elected at the regular meeting of the members in the year such terms expire. A director may be reelected to consecutive terms of office. Directors may be elected to terms of less than three years in order to stagger the terms of directors so that the terms of approximately one-third of the directors expire each year.

3.5 Vacancies. The Board shall have the power to fill vacancies among the directors between meetings of the membership of the Corporation by a majority vote of the directors then in office even though less than a quorum or by the sole remaining director. Successor directors so elected shall serve until the end of the next regularly scheduled meeting of the members.

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 CEO 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. The Board shall hold regular meetings at least four times each year at such times 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 CEO 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 15 days, but not more than 45 days, before the time of the holding of the meeting; and (b) for special meetings, at least four days before the time of the meeting, if notice is sent by mail, and at least 48 hours before the time of the meeting, if notice is delivered personally, telephonically, or by electronic transmission. 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 and 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 of the 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 CEO. 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 be removed from office by a majority vote of the members.

3.11 Compensation. Ordinarily, directors and committee members serve as volunteers to advance the Corporation's mission. The Board may, however, elect to compensate directors and committee members for their services and reimburse them for their expenses. Any compensation must be just and reasonable and it must be set forth in a resolution adopted by the Board.

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, understands, 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. In addition to the Governance Committee described in Section 4.2, the Board may appoint standing or special Board committees, consisting of at least two or more directors, to serve at the pleasure of the Board. Committees may also include one or more nondirectors as members. Each committee shall have any of the powers and authority of the Board provided in the Board resolution forming that committee, and memorialized in the Board's charter for that committee, except that no committee may do the following:

(a) Take any final action on matters that, under the Nonprofit Code or these bylaws, also require approval of the Board;

(b) Fill vacancies on the Board or on any committee of the Board;

(c) Fix compensation of directors or committee members for serving on the Board or any committee;

(d) Amend or repeal these bylaws or adopt new bylaws;

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

(f) Appoint committees of the Board or committee members.

A Board committee chair must be 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. The Board chair or vice chair shall preside over the Governance Committee.

4.2 Governance Committee. Without limiting the foregoing, the Board shall appoint a standing governance committee of the Board (the "**Governance Committee**") comprised solely of directors.

4.3 Advisory Committees. The Board may establish one or more advisory committees, consisting of directors, nondirectors, or both. 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.

4.4 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.

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 chief executive officer (who may also be referred to as CEO), a secretary, and a chief financial officer (who may also be referred to as treasurer). The Corporation may also have, at the discretion of the Board, a president (who may also be referred to as chief operating officer), one or more assistant secretaries and one or more assistant chief financial officers. Any person may hold more than one office, except that none of the chair, the CEO, or the president may serve concurrently as the secretary or chief financial officer. 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; Removal; Resignation. The Board shall elect all officers of the Corporation, each of whom shall serve at the pleasure of the Board, subject to the rights of any officer under an employment contract. A person shall serve as chair or vice chair only so long as that person satisfies the requirements of Sections 5.4 or 5.5, below. Any officer may resign at any time by giving written notice to the Board. The resignation shall take effect on the date the notice is received or at any later time specified in the notice.

5.3 Vacancies. A vacancy in any office because of death, resignation, removal, disqualification, or otherwise, shall be filled by the Board.

5.4 Chair of the Board. The chair of the Board shall be one of the individuals described in Section 3.1(a) of these bylaws, who shall preside at the meetings of the membership, the Board, and the executive committee, if any executive committee is appointed. The chair shall also exercise and perform such other powers and duties as the Board may assign from time to time.

5.5 Vice Chair of the Board. The vice chair of the Board shall be the individual described in Section 3.1(a) of these bylaws who is not elected chair. In the absence or request of the chair, the vice chair shall preside at the meetings of the membership, the Board, and the executive committee, if an executive committee is appointed. The vice chair shall also exercise and perform such other powers and duties as the Board may assign from time to time.

5.6 CEO. The CEO shall be an experienced health care executive and shall exercise all of the rights and privileges and perform all of the duties usually pertaining to the office of a CEO of a health care system, and shall perform additional duties as directed by the Board. The CEO shall act as the duly authorized representative of the Board in all matters in which the Board has not formerly designated some other person to act. The authorities and duties of the CEO shall include the responsibility for:

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

(b) Development and submission to the Board for approval of a plan of organization of the personnel and others concerned with the operation of the Corporation and its affiliated institutions;

(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 and its affiliated institutions;

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

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

(g) Presentation to the Board or to its authorized committees of periodic reports reflecting the professional services and financial activities of the Corporation and its affiliated institutions and preparation and submission of such special reports as may be required by the Board;

(h) Attendance at all meetings of the Board and committees thereof and serving as chair of the Board in the absence of both the chair and vice chair;

(i) Serving as the liaison officer and channel of communication for all official communications between the Board or any of its committees and its affiliated institutions;

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

(l) Together with the management team, operating the Corporation in an ethical manner, implementing an effective compliance program, and reporting regularly (directly and together with other corporate officers) to the Board on compliance matters; and

(m) Performance of other duties that may be necessary in the best interests of the Corporation and its affiliated institutions.

5.7 President. During the unavailability or incapacity of the CEO, the president (if appointed by the Board) will act in the place and stead of the CEO. The president shall have such other powers and duties as the Board or the bylaws may require.

5.8 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.

5.9 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 CEO and the president (if appointed by the Board), the chief financial officer will act in the place and stead of the CEO.

5.10 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.

5.11 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 one of whom shall perform the duties of the chief financial officer in the absence of the chief financial officer.

Article 6
Affiliated Institutions

6.1 Affiliation Authority. The Corporation may enter into an association with any hospital or health institution having objectives similar to those outlined in these bylaws, provided that the best interest of the Corporation and that of the affiliated institution will be served. An affiliated hospital shall function in harmony with the management guidelines established by the Corporation.

6.2 Reimbursement for Services. The Corporation may enter into contracts with an affiliated or unaffiliated institution on a fee basis.

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 CEO under this Section, prior to such advance being paid to the CEO. 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 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); 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 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. The CEO, president (if any), treasurer, or secretary may execute, and the Board may authorize specific other persons or officers to execute, all contracts, transactions, or arrangements, and other documents related to such transactions or arrangements. These officers 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 word "California."

Article 9
General Provisions

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

9.2 Amendment of Bylaws. These bylaws may be amended or repealed by the vote of two-thirds of the members present at any regular meeting or special meeting of the membership or by two-thirds of the members voting by written ballot, as provided in Section 2.12.

9.3 Electronic Transmission.

(a) "**Electronic transmission by the Corporation**" means a communication (1) delivered by (A) electronic mail when directed to the 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; and (2) that creates a record that is capable of retention, retrieval, and review, and that may thereafter be rendered into clearly legible tangible form.

(b) "**Electronic transmission to the Corporation**" means a communication (1) delivered by (A) electronic mail when directed to the 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.

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

9.4 Emergency Powers.

(a) Emergency. The emergency bylaw provisions of this section are adopted in accordance with Corporations Code §9151(g). Notwithstanding anything to the contrary herein, this section applies solely during an Emergency, which is the limited period of time during which a quorum cannot be readily convened for action as a result of the following events or circumstances until the event or circumstance has subsided or ended and a quorum can be readily convened in accordance with the quorum and notice requirements in Sections 3.2 and 3.8 of these bylaws:

(1) A natural catastrophe, including, but not limited to, a hurricane, tornado, storm, high water, wind-driven water, tidal wave, tsunami, earthquake, volcanic eruption, landslide, mudslide, snowstorm, or drought, or regardless of cause, any fire, flood, or explosion;

(2) An attack on this state or nation by an enemy of the United States of America, or on receipt by this state of a warning from the federal government indicating that an enemy attack is probable or imminent;

(3) An act of terrorism or other man-made disaster that results in extraordinary levels of casualties or damage or disruption severely affecting the infrastructure, environment, economy, government function, or population, including, but not limited to, mass evacuations; or

(4) A state of emergency proclaimed by the governor of the state in which one or more Directors are resident, or by the President of the United States.

(b) Emergency Actions. During an emergency, the Board may

(1) Modify lines of succession to accommodate the incapacity of any director, officer, employee, or agent resulting from the emergency;

(2) Relocate the principal office or authorize the officers to do so;

(3) Give notice to a director or directors in any practicable manner under the circumstances, including, but not limited to, by publication and radio, when notice of a meeting of the Board cannot be given to that director or directors in the manner prescribed by Section 3.8 of these bylaws; and

(4) Deem that one or more officers present at a Board meeting is a director, in order of rank and within the same rank in order of seniority, as necessary to achieve a quorum.

(c) Membership Vote. During an emergency the Board may not take any action that requires the vote of the members or otherwise is not in the Corporation's ordinary course of business, unless the required vote of the members was obtained before the emergency. Any actions taken in good faith during an emergency under this section may not be used to impose liability on a director, officer, employee, or agent.

Certificate of Secretary

Adventist Health System/West

I, Meredith Jobe, certify that I am the duly elected and acting secretary of Adventist Health System/West, a California nonprofit religious corporation ("Adventist Health"); that the foregoing bylaws, consisting of 14 pages, are a true and correct copy of the bylaws of Adventist Health as duly adopted by the vote of more than two-thirds of the membership at a meeting held on October 18, 2022; and that these bylaws have not been amended or modified since that date.

Date: 10/27/2022

[redacted]

Meredith Jobe, Secretary

EXHIBIT 26

CHARITY CARE POLICY OF ADVENTIST HEALTH

Financial Assistance Policy

Disclaimer

Approvals

- Committee Approval: Nonclinical Policy Review Team - Revenue Cycle approved on 7/18/2022
- Signature: John A Beaman, Chief Finance Officer signed on 7/18/2022, 1:21:26 PM

Revision Insight

Document ID:	11927
Revision Number:	10
Owner:	Kevin Longo, Chief Compliance Officer
Revision Official Date:	7/18/2022

Revision Note:
New Revision. Only one small correction and removal of the billing and collection portion of this policy. No other changes.

Separating the Billing and Collection Policy to be separate and distinct from the FAP.

Link appropriate documents and legislation.

☒ Systemwide Standard Policy
☐ Systemwide Model Policy

Standard Policy No. 11927
Approval Pathway: Nonclinical
Department: Revenue Cycle

STANDARD POLICY: FINANCIAL ASSISTANCE POLICY

POLICY SUMMARY/INTENT:

Adventist Health facilities are built on a team of dedicated health care professionals - physicians, nurses, technicians, management, trustees, volunteers, and many other devoted health care workers. Together, these individuals serve to protect the health of their communities. Their ability to serve requires a special relationship built on trust and compassion. Through mutual trust and goodwill, Adventist Health and patients will be able to meet their responsibilities. This policy is designed to strengthen that relationship and make sure patients receive services regardless of their ability to pay.

This policy describes Adventist Health's Financial Assistance (both Charity Care and Discounted Care) policy. Adventist Health does not discriminate, and is fair in reviewing and assessing eligibility for Financial Assistance for community members who may be in need of financial help. Adventist Health provides financial assistance to patients and families when they are unable to pay, all or part, of their medical bill. This policy describes how Adventist Health reviews a patient's financial resources to determine if financial assistance can be provided.

The intent of this policy is to comply with applicable federal, state and local laws and regulations.

DEFINITIONS

1. **Allowable Medical Expenses** - All family members' medical expenses that are eligible for federal income tax deduction, even if the expenses are more than the medical expense deduction allowed by the IRS. Paid and unpaid bills may be included
2. **Amount Generally Billed (AGB)** - The amounts generally billed for emergency or other medically necessary care to individuals who have insurance covering such care. This is usually described as a percent of Gross Charges. The AGB percentages for each hospital facility are updated annually.
3. **Application Period** – The period during which Adventist Health must accept and process an application for financial assistance under its Financial Assistance Policy submitted by an individual in order to have made reasonable efforts to determine whether the individual is eligible for financial assistance under the policy. The Application Period begins on the date the care is provided and ends on the latter of the 240th day after the date that the first post-discharge billing statement for the care is provided or at least 30 days after Adventist Health provides the individual with a written notice that sets a deadline after which ECAs may be initiated.
4. **Billed Charges** - Charges for items and services provided by Adventist Health as published in the Charge Description Master (CDM) and available at www.adventisthealth.org website under Patient Resources, Healthcare Costs and Charges page.
5. **Charge Description Master** - A list of items and services, along with their individual prices and codes, used to bill for services.
6. **Charity Care** - Free or Discounted Care provided when the patient is not expected to pay a bill or is expected to pay only a small amount of the patient's payment obligation for items and services provided by Adventist Health. Charity Care is based on financial need.
7. **Discounted Care** - A deduction from the payment obligations for items and services that is given for cash, prompt, or advanced payment, or to certain categories of patients, e.g., self-pay patient or uninsured patient. A discount is usually described as a percentage of Gross Charges.
8. **Extraordinary Collection Action (ECA)** - ECAs are legal or judicial actions taken to receive payment from a patient for care covered under the hospital facility's Financial Assistance Policy. Selling a patient's debt to another company for collection purposes without adequate protections in place is also an ECA. Other examples include garnishing a patient's wages and adverse credit reporting.
9. **Emergency Medical Care** - Refers to Emergency Services and Care, as defined in the Adventist Health Emergency Medical Treatment and Labor Act policy (EMTALA) #AD-06-019-S.
10. **Essential Living Expenses (ELE)** - The following expenses are considered Essential Living Expenses: rent or house payment and maintenance, food, household supplies, laundry and cleaning, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child or spousal support, transportation and auto expenses, including insurance, gas, repairs and installment payments, and other extraordinary expenses.
11. **Family Members** –
    a. Family Members, of persons **18 years or older**, include a spouse, domestic partner, as defined by the state where the facility is licensed, and dependent children under 26 years, whether living at home or not.
    b. Family Members of **persons under 18 years** include parents, caretaker relatives, and other children of the parent or caretaker relative who are less than 26 years of age of the parent or caretaker relative.
12. **FAP** – The Adventist Health Financial Assistance Policy.
13. **Federal Income Tax Return** - The Internal Revenue Service (IRS) form/s used to report taxable income. The IRS form must be a copy of the signed and dated forms sent to the IRS.
14. **Federal Poverty Level (FPL)** - The poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services under it's statutory authority.
15. **Financial Assistance** - The reductions in payment obligation afforded to Adventist Health patients if such patients qualify for assistance under this policy.

16. **High Medical Costs** - Defined as any of the following

    a. Annual Out-of-Pocket expenses, billed to an individual by Adventist Health, , that exceeds the lesser of ten percent (10%) of the patient's current family or family income in the prior 12 months.

    b. Annual Out-of-Pocket expenses that are more than ten percent (10%) of the patient's family income, if the patient provides documentation of their medical expenses paid by the patient, or the patient's family, in the prior 12 months.

17. **Household Income** - Cumulative income of all Family Members who live in the same household as the patient, or at the home address the patient uses on income tax returns, or on other government documents. This includes the following:

    1. Gross wages, salaries, tips, etc.

    2. Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income

    3. Interest, dividends, royalties, income from rental properties, estates and trusts, alimony, child support, assistance from outside the household, and other miscellaneous sources

18. **Limited English Proficiency (LEP) Group** - A group of people whose first language is not English. The size of the group is the lesser of either 1,000 individuals, or five percent (5%) of the community served by the facility, or the non-English speaking 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 that may be affected, or encountered, by the facility.

19. **Medically Necessary** - A service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to either (a) protect life, to prevent significant illness or significant disability, (b) to alleviate severe pain, or (c) to prevent, diagnose or treat an illness, injury, condition or disease, the symptoms of an illness, injury, condition or disease, and (d) meets accepted standards of medicine.

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

21. **Patient Financial Services (PFS)** - The Adventist Health department responsible for billing, collecting, and processing payments.

22. **Payment Plan** - A series of payments, made over a period of time, to pay the patient's payment obligation for items and services provided by Adventist Health. Monthly payments cannot be more than ten percent (10%) of a patient's monthly family income, excluding deductions for Essential Living Expense.

23. **Plain Language** - Writing designed to ensure the reader understands quickly, easily, and completely as possible. Plain language strives to be easy to read, understand and use.

24. **Presumptive Financial Assistance** - When Adventist Health staff may assume a patient will qualify for 100% Financial Assistance based on information given to them, e.g., homelessness, etc.

25. **Qualifying Patient** - Patient who meets the financial qualifications for Financial Assistance as defined in Section C below.

26. **Reasonable Payment Plan** - A payment plan is a reasonable payment plan if the monthly payments are not more than 10 percent of a patient's family income for a month, excluding deductions for essential living expenses (as defined above).

27. **Self-Pay Liability** - Any balance due by the person who is responsible for payment. This could be a patient, or the patient's guarantor (not a third-party payer).

28. **Third-Party Coverage** - A policy of insurance or other prepaid coverage purchased for protection against certain events, such as health, automobile and general liability insurance, etc.

29. **Uninsured Patient** - Patients who do not have insurance to cover the services received.

30. **Underinsured Patient** - A patient who does not have enough insurance or prepaid coverage to cover the services received.

POLICY: COMPLIANCE – KEY ELEMENTS

Adventist Health is committed to providing Financial Assistance to patients who seek Emergency Medical Care, or Medically Necessary Care, but have limited, or no means, to pay for that care. Financial Assistance is comprised of both Charity Care (free care) and/or Discounted Care. Adventist Health will provide, without discrimination, Emergency Medical Care, or Medically Necessary Care as defined in this policy, to persons regardless of their ability to pay, their eligibility under this policy, or their eligibility for government assistance.

Accordingly, this written policy:

1. includes eligibility criteria for Financial Assistance – Charity Care (free) and Discounted Care (reduction in the patient's payment obligation);

2. describes the basis for how Adventist Health calculates the amount charged to patients who qualify for Financial Assistance under this policy;

3. describes how patients apply for Financial Assistance;

4. describes how the Adventist Health hospital or other Adventist Health facility will publicize this policy in the community it serves; and

5. describes how the Adventist Health hospital or other Adventist Health facility limits the amount billed to patients who qualify for Financial Assistance

6. includes a list of physician and other providers who provide ermergency or other medically necessary care in the hospital facility that specifies which providers are covered by the FAP and which are not.

Charity Care and Discounted Care are not substitutes for personal responsibility. Patients are expected to work with the facility when seeking Financial Assistance. Persons must help pay for the cost of their care based on their ability to pay. Persons with financial means to purchase health insurance will be encouraged to do so since this helps improve their access to health care services.

A. **COMMITMENT TO PROVIDE EMERGENCY MEDICAL CARE:**

1. Adventist Health provides, without discrimination, care for emergency medical conditions to individuals regardless of whether they are eligible for assistance under this policy. Adventist Health will not engage in actions that discourage individuals from seeking emergency medical care, such as by demanding that emergency department patients pay before receiving treatment for emergency medical conditions or by permitting debt collection activities that interfere with the provision, without discrimination, of emergency medical care. Emergency medical services, including emergency transfers, pursuant to EMTALA, are provided to all Adventist Health patients in a non-discriminatory manner, pursuant to each Adventist Health hospital's EMTALA policy (see AH Model Policy AD-06-109-S "EMTALA – Compliance with EMTALA").

    a. **Qualifying Care Under This Policy includes:**

        i. Emergency Medical Care, or other Medically Necessary Care, provided at Adventist Health owned and operated facilities listed in Appendix B

        ii. Emergency department physician services that the Adventist Health facility bills for on the physicians' behalf.

        iii. Note: Emergency room physicians, who provide emergency medical services in an Adventist Health general acute care facility are excluded from this policy unless listed as a "Covered Provider" in the documentation from Appendix D. California requires these physicians to have their own financial assistance policies. Patients who receive a bill from an Emergency Room physician, and are uninsured, underinsured, or have High Medical Costs, should contact that physician's office and ask about their Financial Assistance policy.

        iv. An emergency physician who provides emergency medical services at an Adventist Health hospital in California is required by law to provide discounts to uninsured patients or patients with high medical costs who are at or below 400 percent of the federal poverty level.

        v. A California rural hospital may establish eligibility levels for finanical assistance and charity care at less than 400 percent of the federal poverty level as appropriate to maintain their financial an operational integrity.

    b. **Communication of Financial Assistance**

        i. Adventist Health gives patient's information about Financial Assistance in different ways, including, but not limited to:

            I. Placing notices in Emergency Rooms, Admitting and Registration Offices, Patient Financial Services Departments, other public places and other outpatient settings, including observation units;

            II. Placing information in the Adventist Health Conditions of Registration Form;

            III. Printing information in Adventist Health Post-Discharge Billing Statement. This includes information about how patients can obtain more information about financial assistance along with the internet link for the Financial Assistance Policy;

            IV. Posting a "plain language summary" of the Financial Assistance Policy on all Adventist Health websites;

            V. Prominently displaying information on Adventist Health facility websites, with a link to the Financial Assistance Policy itself;

            VI. Placing, in a "plain language" brochure, mailings, and at other community locations.

            VII. For patients of Adventist Health's California hospitals;

                A. Providing the patient with written notice about the Financial Assistance Policy when the patient receives services. If, however, the patient is unconcious and not able to receive written notice at that time, then the notice will be provided when the patient is discharged.

                B. If the patient is not admitted, the written notice is provided when the patient leaves the facility or is mailed to the patient within 72 hours of the facility providing services to the patient.

                C. The notice includes the internet address of the Health Consumer alliance (https://healthconsumer.org) and shall explain that there are organizations that will help the patient understand the billing and payment process, as well as information regarding Covered California and Medi-Cal presumptive eligibility (if the California hospital particpates in the presumptive eligibility program).

                D. The notice shall also include the internet address for the Adventist Health Hospital's shoppable services (as per 45 CFR 180.60)

        ii. Notices and information are provided to patients in their primary language, when the patient is identified as being within a Limited English Proficiency (LEP) group. In addition to the above, Adventist Health personnel may us their discretion to give individual notice of financial assistance to patients who appear to be at risk of not being able to pay their bill. Referral of patients for financial assistance may be made by any member of the medical, or facility, staff. A request for financial assistance may also be made by the patient, his or her guardian, or family member. Requests are subject to applicable privacy laws.

            I. The written notices will contain information about availability of the hosptial's discount payment and charity care policies. This includes information about eligibility, as well as contact information for a hospital employee or office from which the person may obtain further information about these policies

        iii. Individuals can get information about the Financial Assistance Policy, a copy of our Plain Language Summary, and an application in different languages, free of charge, by:

            I. Going to the registration area

            II. Speaking with an Adventist Health facility financial counselor

            III. Going to the website for Adventist Health: https://www.adventisthealth.org/patient-resources/financial-assistance/

            IV. Calling us at 1-844-827-5047 (or local hospital – See appendix B of this policy)

            V. Writing to: Adventist Health, ATTN: Financial Assistance, P.O. Box 677000, Paradise, CA 95967

VI. Patients may get a paper copy of this Financial Assistance Policy upon request by contacting any of the five contacts listed above

c. **Eligibility Criteria for Financial Assistance**

i. Patients who are uninsured, or underinsured with High Medical Costs, and are unable to pay for their care are eligible for financial assistance if they qualify under the Financial Assistance Policy. Decisions on whether a patient will be granted financial assistance are based on a patient's financial need. Race, color, national origin, citizenship, religion, creed, gender, sexual preference, gender identity and expression, age, or disability are not considered.

ii. For patients on Medicaid (called "Medi-Cal" in California) the patient's Share of Cost (SOC) amounts are not eligible for financial assistance. The SOC amounts are set by the State. States require patients to pay the SOC as a condition of receiving Medicaid/Medi-Cal covered services.

iii. A patient may qualify for Financial Assistance under this policy, if they meet one of the following criteria:

I. Income: Household Income is at, or below, 400% of the FPL.

II. Expenses: Patients who do not meet the income criteria, may be eligible for financial assistance based on essential living expenses and resources. The following two (2) qualifications must both apply:

A. Essential Living Expenses: Exceed fifty percent (50%) of the Household Income; and

B. Resources: The patient's excess medical expenses (the amount that Allowable Medical Expenses are greater than 50% of annual Household Income) must be greater than available Qualifying Assets.

d. **Financial Assistance Levels:** Basis for Calculating Amounts Charged to Patients

i. There is a limit to the amount an individual who is eligible for Financial Assistance may be charged. That individual may not be charged more than the Amount Generally Billed (AGB) for emergency or other medically necessary care. Adventist Health does not bill or expect payment of gross charges from individuals who qualify for financial assistance under this policy. Appendix C describes the specific AGB methodology used for each Adventist Health hospital facility.

ii. Charity Care and Discounted Care: Discounts are based on Household Income. Documentation of Household income include recent pay stubs, income tax returns, and other documents.

iii. The discount amount is based on the percentages in the following tables:

I. Emergency and Medically Necessary Care for Uninsured and Insured Patients

Uninsured Patients		
Household Income	**Patient Responsibility**	**Oregon All Locations Amounts Charged**
200% or less of the Federal Poverty Level	Zero	Zero
> 200% to 300% of the Federal Poverty Level	50% of the Amount Generally Billed	25% of the Amount Generally Billed
> 300% to 350% of the Federal Poverty Level	75% of the Amount Generally Billed	50% of the Amount Generally Billed
> 350% to 400% of the Federal Poverty Level	75% of the Amount Generally Billed	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	Not covered under the Financial Assistance Policy, refer to the Uninsured Discount Policy

Patients with Commercial Insurance or Non-Contracted Managed Care Plans and High Medical Costs		
Household Income	**Amounts Charged**	**Oregon All Locations Amounts Charged**
400% or less of the Federal Poverty Level	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, the patient obligation is zero.	Any patient liability after amounts paid by the patient's insurer failed to pay AGB shall follow the FPL groupings and minimum % discounts from AGB applied as outlined in the table above for uninsured patients.
>400% of the Federal Poverty Level	Not covered under the Financial Assistance Policy, the patient is responsible for their cost sharing obligation amount.	Not covered under the Financial Assistance Policy, the patient is responsible for their Self-Pay Liability amount.

II. Non-Emergency and non-Medically Necessary Care for Uninsured and Insured Patients:

Uninsured Patients

Household Income	Amounts Charged
200% or less of the Federal Poverty Level	Zero
>200% to 400% of the Federal Poverty Level	50% 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 Plan and High Medical Costs	
Household Income	**Patient Liability**
400% or less of the Federal Poverty Level	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 obligation 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.

e. **How Patients Apply for Financial Assistance:**

i. To be considered for Financial Assistance under this policy, a patient or guarantor must:

I. Work with Adventist Health to find other sources of payment, or coverage, from public and/or private payment programs;

II. Submit a true, accurate, and complete confidential → Financial Assistance Application within the Application Period;

III. Provide a copy of patient's or guarantor's most recent pay stub (or certify that he or she is currently unemployed);

IV. Provide a copy of patient's or guarantor's most recent Federal Income Tax Return (including all schedules)

ii. The patient or guarantor is responsible for meeting the conditions of coverage of their insurance or health plan, if they have third-party insurance or health plan. Failure to do so, may result in a denial of financial assistance.

iii. Human dignity, and stewardship, are considered in the application process for deciding financial need and granting financial assistance.

iv. Adventist Health shall not use any information given by a patient regarding monetary assets, pay stubs or income tax returns, in connection with his or her application, for any collection activities of Adventist Health. Information provided by the patient about their household income will only be used to evaluate whether the patient qualifies for financial assistance under this policy.

f. **Eligibility for Other Government Programs**

i. The facility will make reasonable efforts to help the patient find insurance options including:

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

II. Medicare; or

III. The Medicaid program, the Children's Services program, or other state-funded programs designed to provide health coverage. If a patient applied or has a pending application for another health coverage program at the same time that the patient applies for a facility financial assistance program, neither application will stop eligibility for the other program.

g. **Presumptive Financial Assistance Eligibility**

i. Presumptive Financial Assistance takes place when Adventist Health staff may assume a patient will qualify for financial assistance based on information received by the facility, i.e., homelessness, etc.

I. A staff or management member of the Patient Financial Services Department will complete an internal Financial Assistance Application for a patient, to include:

A. The reason the patient, or patient's guarantor, cannot apply on his/her own behalf; and

B. The patient's documented medical or socio-economic reasons that stop the patient, or patient's guarantor, from completing the application.

II. Adventist Health staff may also assign patient accounts to be evaluated for eligibility for Charity Care or Dicsounted Care, if they think the patient may be in need of financial help paying the bill. This may occur if:

A. The patient's medical record that documents they are homeless;

B. It is verified that the patient expired with no known estate or spouse;

C. The patient is currently in jail or prison;

D. The patient qualifies for a public benefit program including Social Security, Unemployment Insurance Benefits, Medicaid, County Indigent Health, AFDC, Food Stamps, WIC, etc.;

E. The patient meets another public benefit program's requirement that are similar to Adventist Health's Financial Assistance program;

F. Adventist Health tried to get a payment from the patient, and is not able to do so;

G. The patient has not completed a Financial Assistance Application;

H. The patient does not respond to requests for documentation;

I. Any other information required by the Financial Assistance Application

ii. If the patient does not or cannot respond to the application process, then the patient's account will be screened using the presumptive eligibility information outlined above to make an individual assessment of financial need. The above information helps Adventist Health make an informed decision on the financial need of a patient by using the best estimates available if the patient does not or cannot provide the requested information.

I. Adventist Health facilities use a third-party to conduct electronic reviews of patient information to assess financial need. These reviews use a healthcare industry-recognized model that is based on public record databases. This predictive model uses public record data to calculate a socio-economic and financial capacity score. It includes estimates of income,(and for California, assets and liquidity). The electronic technology compares each patient using standards that are analogous to the standards in the formal application process.

II. Electronic technology will be used after all other eligibility, and payment sources, have been tried before a patient account is considered bad debt and turned over to a collection agency. This ensures Adventist Health facilities screen all patients for Financial Assistance before taking any collection actions.

III. The electronic eligibility review data that supports the financial need to qualify at 200% FPL, or less, will only be applied to past patient balances.

iii. Patient accounts granted presumptive eligibility will be reclassified under the Financial Assistance policy, Adventist Health will not:

I. send them to collection agencies, debt buyers, or other assignees that is not a subsidiary or affiliate of Adventist Health;

II. subject them to further collection actions;

III. notify them of their qualification; or

IV. include them in the facility's bad debt expense

h. **Eligibility Period**

i. The Financial Assistance adjustment will be applied to all eligible patient account balances, including those received before the application approval date.

ii. The financial assistance approval is good for180 days after the approval is granted.

iii. For bills received after 180 days from when the financial assistance is approved, a separate Financial Assistance Application will need to be filled out if the patient is seeking financial assistance to pay those bills

i. **Appeal Regarding Application of This Policy**

i. Patients may submit a written a request for reconsideration to the Finance Officer (FO) of the Adventist Health Facility at which they received services when:

I. they believe their Financial Assistance Application was not approved according to this policy; or

II. they disagree with the way the policy was applied to their case

ii. The FO will be the final level of appeal.

iii. Appeal must be submitted within 90 days of the date of the decision letter.

j. **Agreements with other Parties** - If Adventist Health sells or refers and individual's debt related ot care to another party, Adventist Health will enter into a legally binding written agreement with the party that is reasonably desinged to ensure that no ECAs are taken to obtain payment for the care until reasonable efforts have been made to determine whether the individual is FAP-eligible for the care. At a minimum such an agreement must provide the following:

i. if the individual submits a FAP application after the referral or sale of the debt but before the end of the application period, the party will suspend ECAs to obtain payment for the care as described in Paragraph A(j)(iii)(1) of the Financial Assitance Policy

ii. if the individual submits a FAP application after the referral or sale of the debt but before the end of the application period and is determined to be FAP-eligible for the care, the party will do the following in a timely manner:

I. Adhere to procedures specified in the agreement that ensure that the individual does not pay, and has not obligation to pay, the party and the Adventist Health facility together more than the individual is required to pay for the care as a FAP-eligible individual

II. if applicable and if the party (rather than the hospital facility) has the authority to do so, take all reasonably available mesures to reverse any ECA (other than the sale of a debt or a lien that a hospital facility is entitled to assert under state law on the proceeds of a judgment, settlement, or compromise owed to an individual (or his or her representative) as a result of personal injuries for which the hospital facility provided care) taken against the individual as described in Paragraph A(j)(iii)(III)(C) of the Financial Assistance Policy

iii. if the individual submits a FAP application after the referral or sale of the debt but before the end of the application period, the party will suspend ECAs to obtain payment for the care as described in Paragraph A(j)(iii)(1) of the Financial Assistance Policy.

iv. The party shall be required to comply with Adventist Health's definition and application of a reasonable payment plan, as that

term is defined in the Financial Assistance Policy

v. If the party refers or sells the debt to yet another party during the Application Period, the party will obtain a written agreement from that other party including all of the other elements described in this Paragraph k.

k. **Documentation**

i. Confidential Financial Assistance Application

l. **List of Covered Providers**

i. The list of Covered and Non-covered Providers who deliver Emergency Medical Care, and other Medically Necessary Care will be updated at least quarterly.

ii. See Appendix D of the Policy for a link to the lists of Covered and Non-covered Providers

iii. See Appendix B of the Policy for the physical address where to get a free copy of the Covered and Non-covered Providers list.

iv. Section B of the Policy describes how this list will be made available.

m. **Authorized Body**

i. Adventist Health Finance Cabinet will review any subsequent changes to this policy and recommend approval to the Adventist Health Board of Directors.

APPENDIX A

2022 FEDERAL POVERTY LEVELs (FPL)

Persons in Family	48 Contiguous States and the District of Columbia	Alaska	Hawaii
1	$13,590	$16,990	$15,630
2	$18,310	$22,890	$21,060
3	$23,030	$28,790	$26,490
4	$27,750	$34,690	$31,920
5	$32,470	$40,590	$37,350
6	$37,190	$46,490	$42,780
7	$41,910	$52,390	$48,210
8	$46,630	$58,290	$53,640
For each additional person, add	$4,720	$5,900	$5,640

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

APPENDIX B

Covered Facility List

List of Adventist Health facilities covered under this policy:

Doing Business As (DBA)	Address	Phone Number
Adventist Health Bakersfield	2615 Chester Avenue Bakersfield, CA 93301	661-395-3000
Adventist Health Castle	640 Ulukahiki Street Kailua, HI 96374	808-263-5500
Adventist Health Clear Lake	15630 18th Avenue Clearlake, CA 95422	707-994-6486
Adventist Health Delano	1401 Garces Highway Delano, CA 93215	661-725-4800
Adventist Health Feather River	5125 Skyway Road Paradise, CA 95969	530-872-2000

Adventist Health Glendale	1509 Wilson Terrace Glendale, CA 91206e	818-409-8000
Adventist Health Hanford	115 Mall Drive Hanford, CA 93230	559-582-9000
Adventist Health Howard Memorial	1 Marcela Drive Willits, CA 95490	707-459-6801
Adventist Health Lodi Memorial	975 S. Fairmont Avenue Lodi, CA 95240	209-334-3411
Adventist Health Mendocino Coast	700 River Drive Fort Bragg, CA 95437	707-961-1234
Adventist Health Physicians Network or Adventist Health Medical Foundation Clinics	Please use contact address for the nearest AH facility	Please use phone listed for nearest AH Facility
Adventist Health Portland	10123 S. E. Market Street Portland, OR 97216	503-257-2500
Adventist Health Reedley	372 W. Cypress Avenue Reedley, CA 93654	559-638-8155
Adventist Health Rideout	726 4th Street Marysville, CA 95901	530-749-4300
Adventist Health Selma	1141 Rose Avenue Selma, CA 93662	559-891-1000
Adventist Health Simi Valley	2975 North Sycamore Drive Simi Valley, CA 93065	805-955-6000
Adventist Health Sonora	1000 Greenley Road Sonora, CA 95370	209-536-5000
Adventist Health St. Helena	10 Woodland Road St. Helena, CA 94574	707-963-3611
Adventist Health Tehachapi Valley	1100 Magellan Drive Tehachapi, CA 93561	661-823-3000
Adventist Health Tillamook	1000 Third Street Tillamook, OR 97141	503-842-4444
Adventist Health Tulare	869 N. Cherry Street Tulare, CA 93274	559-688-0821
Adventist Health Ukiah Valley	275 Hospital Drive Ukiah, CA 95482	707-462-3111
Adventist Health Vallejo	525 Oregon Street Vallejo, CA 94590	707-648-2200

Adventist Health White Memorial	1720 East Cesar E. Chavez Ave. Los Angeles, CA 90033	323-268-5000
Adventist Health Home Care	Please Call for the Information	844-827-5047

APPENDIX C

Amount Generally Billed (AGB) for facilities in California:

AGB Table #1:

The method used to calculate the AGB is the Look-Back Method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a 12-month period (as defined by Treasury Regulations under section 501(r) of the Internal Revenue Code of 1986, as amended). A single average percentage of gross charges, or multiple percentages for separate categories of care or separate items or services may apply, as set forth in the chart below. The AGB rate will be updated annually on January 1st of each year and implemented within 120 days of any AGB rate change.

Facility Abbreviation	Facility	Service	Effective	AGB
AHBD	Adventist Health Bakersfield	All services	5/1/2022	19%
AHCL	Adventist Health Clear Lake	All services	5/1/2022	42%
AHDL	Adventist Health Delano	All services	5/1/2022	34%
AHGL	Adventist Health Glendale	All services	5/1/2022	16%
AHHF	Adventist Health Hanford	All services	5/1/2022	18%
AHHM	Adventist Health Howard Memorial	All services	5/1/2022	32%
AHLM	Adventist Health Lodi Memorial	All services	5/1/2022	16%
AHMC	Adventist Health Mendocino Coast	All services	5/1/2022	51%
AHRD	Adventist Health Reedley	All services except Rural Health Clinics – See Appendix D	5/1/2022	18%
AHRO	Adventist Health and Rideout	All services	5/1/2022	28%
AHSV	Adventist Health Simi Valley	All services	5/1/2022	21%
AHSR	Adventist Health Sonora	All services	5/1/2022	17%
AHSH	Adventist Health St. Helena	All services	5/1/2022	17%
AHTV	Adventist Health Tehachapi Valley	All services	5/1/2022	38%
AHTR	Adventist Health Tulare	All Services	5/1/2022	18%
AHUV	Adventist Health Ukiah Valley	All services	5/1/2022	27%
AHWM	Adventist Health White Memorial	All services	5/1/2022	12%
AHPN	Adventist Health Physician Network	All Services	5/1/2022	45%

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

AGB Table #2

The method used to calculate the AGB is the Look-Back Method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a 12-month period (as defined by Treasury Regulations under section 501(r) of the Internal Revenue Code of 1986, as amended). A single average percentage of gross charges, or multiple percentages for separate categories of care or separate items or services may apply, as set forth in the chart below. The AGB rate will be updated annually on January 1st of each year and implemented within 120 days of any AGB rate change.

Facility Abbreviation	Facility	Service	Effective	AGB
AHCS	Adventist Health Castle	All services except Physician Clinics - See Below Table 3	5/1/2022	42%
AHPL	Adventist Health Portland	All Services	5/1/2022	32%
AHTM	Adventist Health Tillamook	All Services	5/1/2022	56%

AGB Table #3

The method used to calculate the AGB is the Look-Back Method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a 12-month period (as defined by Treasury Regulations under section 501(r) of the Internal Revenue Code of 1986, as amended). A single average percentage of gross charges, or multiple percentages for separate categories of care or separate items or services may apply, as set forth in the chart below. The AGB rate will be updated annually on January 1st of each year and implemented within 120 days of any AGB rate change.

Facility Abbreviation	Facility	Service	Effective	AGB
AHHC	Adventist Health Home Care	All Services	5/1/2022	75%

APPENDIX D

Sliding Scale – Adventist Health Reedley – Rural Health Clinics

A completed Sliding Scale attestation must be submitted, and any qualification is valid for 90 days from the date of qualification.

Adventist Health Reedley – RHC Visit			
Nominal Amounts	**$30.00**	**$45.00**	**$60.00**
Family Size	50% of nominal amount	75% of nominal amount	100% of nominal amount
	100% of the 2022 FPL	150% of the 2022 FPL	200% of the 2022 FPL
1	$13,590	$20,385	$27,180
2	$18,310	$27,465	$36,620
3	$21,960	$34,545	$46,060
4	$27,750	$41,625	$55,500
5	$32,470	$48,705	$64,940
6	$37,190	$55,785	$74,380
7	$40,120	$62,865	$83,820
8	$46,630	$69,945	$93,260
Additional Person	$4,720	$7,080	$9,440

APPENDIX E

Covered and Noncovered Provider's List

The list of Covered and Noncovered Providers who provide Emergency Medical Care or other Medically Necessary Care, in each Adventist Health hospital facility, is maintained in the supplemental document called, PFS-112 Financial Assistance Covered and Noncovered Physicians List". This list is updated quarterly and is published on the Adventist Health website at the links in the following table.

Patients may get a free hard copy of the "PFS-112 Financial Assistance Covered and Noncovered Physicians List" at the facility addresses listed in Appendix B, above.

Below are the links to the lists of Covered and Non-Covered Providers included in this supplemental document:

Facility Abbreviation	Facility

Adventist Health Bakersfield	https://www.adventisthealth.org/documents/financial-assistance/financial-assistance-providers/AHBD-501R-FAP-Providers.pdf
Adventist Health Castle	https://www.adventisthealth.org/documents/financial-assistance/financial-assistance-providers/AHCS-501R-FAP-Providers.pdf
Adventist Health Clear Lake	https://www.adventisthealth.org/documents/financial-assistance/financial-assistance-providers/AHCL-501R-FAP-Providers.pdf
Adventist Health Delano	https://www.adventisthealth.org/documents/financial-assistance/financial-assistance-providers/AHDL-501R-FAP-Providers.pdf
Adventist Health Glendale	https://www.adventisthealth.org/documents/financial-assistance/financial-assistance-providers/AHGL-501R-FAP-Providers.pdf
Adventist Health Hanford	https://www.adventisthealth.org/documents/financial-assistance/financial-assistance-providers/AHHF-501R-FAP-Providers.pdf
Adventist Health Howard Memorial	https://www.adventisthealth.org/documents/financial-assistance/financial-assistance-providers/AHHM-501R-FAP-Providers.pdf
Adventist Health Lodi Memorial	https://www.adventisthealth.org/documents/financial-assistance/financial-assistance-providers/AHLM-501R-FAP-Providers.pdf
Adventist Health Mendocino Coast	https://www.adventisthealth.org/documents/financial-assistance/financial-assistance-providers/AHUV-501R-FAP-Providers.pdf
Adventist Health Physician Network	To be determined
Adventist Health Portland	https://www.adventisthealth.org/documents/financial-assistance/financial-assistance-providers/AHPD-501R-FAP-Providers.pdf
Adventist Health and Rideout	https://www.adventisthealth.org/documents/financial-assistance/financial-assistance-providers/AHRO-501R-FAP-Providers.pdf
Adventist Health Simi Valley	https://www.adventisthealth.org/documents/financial-assistance/financial-assistance-providers/AHSV-501R-FAP-Providers.pdf
Adventist Health Sonora	https://www.adventisthealth.org/documents/financial-assistance/financial-assistance-providers/AHSR-501R-FAP-Providers.pdf
Adventist Health Tehachapi Valley	https://www.adventisthealth.org/documents/financial-assistance/financial-assistance-providers/AHTV-501R-FAP-Providers.pdf
Adventist Health Tillamook	https://www.adventisthealth.org/documents/financial-assistance/financial-assistance-providers/AHTM-501R-FAP-Providers.pdf
Adventist Health Ukiah Valley	https://www.adventisthealth.org/documents/financial-assistance/financial-assistance-providers/AHUV-501R-FAP-Providers.pdf
Adventist Health Home Care Services	To be determined
Adventist Health White Memorial	https://www.adventisthealth.org/documents/financial-assistance/financial-assistance-providers/AHWM-501R-FAP-Providers.pdf

MANUAL(S):

ATTACHMENTS:
(REFERENCED BY THIS DOCUMENT)

www.ftc.gov
http://www.aspe.hhs.gov/poverty/
www.ftc.gov
www.adventisthealth.org
Financial Assistance Policy - Facility Application Letter (English)
EMTALA - Compliance With EMTALA
Charity Care/Financial Assistance Application Form - Confidential (English)
Charity Discount Application - ENG
Charity Discount Application - SPN
CA Health and Safety Code Sec. 127405 (a)(1)(B), as amended by AB 1020 (2021)
ORS 442.612(7)
IRS Section 501(r)
CA Health & Safety Code Sec. 127410 (b) by AB 532

OTHER DOCUMENTS:
(WHICH REFERENCE THIS DOCUMENT)

Self Pay Billing and Collection Policy

FEDERAL REGULATIONS:

Other

https://www.irs.gov/charities-non-profits/charitable-organizations/requirements-for-501c3-hospitals-under-the-affordable-care-act-section-501r

ACCREDITATION:	
CALIFORNIA:	**https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB1020; https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB532**
HAWAII:	**No specific state requirements noted. Corporate policy applies as written.**
OREGON:	**https://olis.leg.state.or.us/liz/2018R1/Downloads/MeasureDocument/HB4020, https://olis.leg.state.or.us/liz/2019R1/Downloads/MeasureDocument/HB3076**
WASHINGTON:	**No specific state requirements noted. Corporate policy applies as written.**
REFERENCES:	**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)) 3/1/2017 DISTRIBUTION: PFS Directors, CFOs**
ADVENTIST HEALTH SYSTEM/WEST POLICY OWNER:	**Kevin K Longo - Chief Compliance Officer**
ENTITY POLICY OWNER:	**Not applicable**
COLLABORATION:	**Adam M Cain - Manager, E-Learning Alyssa M Joyner - Director, Privacy Amy K Miller - Director, Revenue Cycle Compliance Cheryl A Brooksher - Director, Business Intelligence Claudia G Kanne - Regional Director, Compliance Colleen A Fiore - Sr. Application Analyst Jacalyn Liebowitz - System Chief Nursing Officer Jessica M Hoops - Legal Support Assistant Joan S Dillon - Program Manager, Nonclinical Policies & Procedures Jodi L Oldes - Regulatory Specialist Kathy J Leppanen - Program Manager, Regulatory Lori Esquivel - Director, Patient Access Mona A Snyder - Director, Revenue Cycle-Home Care CBO Sarah M Janosz - Program Manager, Polices and Procedures Serena L Avila - Administrative Coordinator Shelly J Williams - Financial Analyst**
APPROVED BY:	
ADVENTIST HEALTH SYSTEM/WEST:	**(06/22/2022) Nonclinical Policy Review Team - Revenue Cycle**
ADVENTIST HEALTH SYSTEM/WEST INDIVIDUAL:	**(07/18/2022 01:21PM PST) John A Beaman, Chief Finance Officer**
ENTITY:	**Not applicable**
ENTITY INDIVIDUAL:	**Not applicable**
REVIEW DATE:	
REVISION DATE:	**05/02/2019, 05/10/2019, 04/20/2020, 04/22/2020, 04/24/2020, 10/14/2020, 05/03/2021, 06/06/2021, 01/05/2022, 05/02/2022, 07/18/2022**
NEXT REVIEW DATE:	**07/17/2024**
APPROVAL PATHWAY:	**Nonclinical**

Title 11, California Code of Regulations, § 999.5(d)(10)

PUBLIC COMMUNICATIONS

11 Cal. Code Reg. Section 999.5(d)(10)

The written notice of any proposed agreement or transaction set forth in Section 999.5(a)(1) shall include a description of the applicant's efforts to inform local governmental entities, professional staff and employees of the health facility or facility that provides similar healthcare and the general public of the proposed transaction. This description shall include any comments or reaction to this effort

The parties have made efforts to inform local governmental entities, professional staff, employees, donors, volunteers, and the community as to the proposed Affiliation through a variety of communication strategies. Responses to the proposed Affiliation have been positive and supportive, and the feedback was and continues to be in favor of the Affiliation, and reflects approval of Beverly's selection of Adventist Health as the entity with which Beverly is affiliating. Copies of the announcements regarding the Affiliation are attached to this Section as **Exhibit 27**, as listed below:

- Interoffice memoranda circulated via email to Beverly's Medical Staff, employees, and the Foundation's Board of Trustees on October 15, 2022.

EXHIBIT 27

ANNOUNCEMENTS REGARDING TRANSACTION

BeverlyHospital

INTEROFFICE MEMORANDUM

DATE: October 15, 2022

TO: Beverly Hospital Medical Staff

FROM: Alice Cheng
President and CEO

[redacted]

CC: Beverly Hospital Board of Directors

SUBJECT: Letter of Intent - Beverly Hospital and Adventist Health

We are pleased to announce that Beverly Hospital has executed a 'Letter of Intent' with Adventist Health for Beverly Hospital to become part of the Adventist Health system of hospitals in California. Beverly and Adventist expect to file an application for approval by the Office of the Attorney General very soon.

This process will take approximately 6 – 12 months for the merger to be approved by the California Attorney General. We will keep you advised on the progress and any major changes.

Please be advised that there will be a Medical Staff Forum during the MEC Meeting on Friday, October 21st. A meeting invitation will be sent via email/fax on Monday, October 17, 2022.

We look forward to carrying on the mission of Beverly Hospital and Adventist Health in service of the communities that rely on us each day for healthcare.

BeverlyHospital

INTEROFFICE MEMORANDUM

DATE: October 15, 2022

TO: Beverly Hospital Employees

FROM: Alice Cheng
President and CEO [redacted]

CC: Beverly Hospital Board of Directors

SUBJECT: Letter of Intent - Beverly Hospital and Adventist Health

We are pleased to announce that Beverly Hospital has executed a 'Letter of Intent' with Adventist Health for Beverly Hospital to become part of the Adventist Health system of hospitals in California. Beverly and Adventist expect to file an application for approval by the Office of the Attorney General very soon.

This process will take approximately 6 – 12 months for the merger to be approved by the California Attorney General. We will keep you advised on the progress and any major changes.

Please be advised that there will be three employee meetings Monday, October 17th, in the Tower Basement Center at 7:45 a.m., 11:00 a.m. and 6:00 p.m.

We look forward to carrying on the mission of Beverly Hospital and Adventist Health in service of the communities that rely on us each day for healthcare.

BeverlyHospital

INTEROFFICE MEMORANDUM

DATE: October 15, 2022

TO: Beverly Hospital Foundation Board of Trustees
Beverly Hospital Guild

FROM: Alice Cheng
President and CEO [redacted]

CC: Beverly Hospital Board of Directors

SUBJECT: Letter of Intent - Beverly Hospital and Adventist Health

We are pleased to announce that Beverly Hospital has executed a 'Letter of Intent' with Adventist Health for Beverly Hospital to become part of the Adventist Health system of hospitals in California. Beverly and Adventist expect to file an application for approval by the Office of the Attorney General very soon.

This process will take approximately 6 – 12 months for the merger to be approved by the California Attorney General. We will keep you advised on the progress and any major changes.

We look forward to carrying on the mission of Beverly Hospital and Adventist Health in service of the communities that rely on us each day for healthcare.

Title 11, California Code of Regulations, § 999.5(d)(11)

ADDITIONAL ATTACHMENTS

11 Cal. Code Reg. Section 999.5(d)(11)(A)

Any board minutes or other documents relating or referring to consideration by the board of directors of the applicant and any related entity, or any committee thereof of the agreement or transaction or of any other possible transaction involving any of the health facilities or facilities that provide similar healthcare that are the subject of agreement or transaction

Attached to this Section as **Exhibit 28** is the Letter of Intent, approved by the Beverly Board and entered into by the parties on June 15, 2022.

In addition, the Beverly Board meeting minutes will be submitted to the Attorney General under separate cover as confidential documents in accordance with 11 Cal. Code Reg. § 999.5(c)(3). Any attachments referenced in the below-listed materials have either been submitted separately as confidential documentation pursuant to 11 Cal. Code Reg. § 999.5(c)(3), or are documents that are protected from production by the attorney-client privilege. Such documents will be redacted copies that exclude any information and discussions by the Beverly Board that are not related to the Affiliation. The primary purpose for such redactions is to prevent the public disclosure of Beverly's internal deliberations and discussions unrelated to the Affiliation, including sensitive financial information, confidential business planning discussions and reports, staffing and employment-related matters, and other internal organizational matters not pertinent to the Affiliation.

The below-listed materials serve as supporting documentation for the Beverly Board's deliberative process described in the response to Section 999.5(d)(1)(C). To the extent that the Beverly Board had other discussions, such discussions were not documented in writing.

1. Minutes for the Board Executive Session of Beverly and Montebello on March 26, 2019 wherein the Beverly Board discussed the potential affiliations and partnerships with health systems in the context of Beverly's financial sustainability as an independent hospital;

2. Minutes for the Board Executive Session of Beverly and Montebello on April 23, 2019 wherein the Beverly Board discussed preliminary discussions between Beverly's Chief Executive Officer and potential affiliation partners and viability of such discussions to proceed;

3. Minutes for the Board Executive Session of Beverly and Montebello on May 28, 2019 wherein the Beverly Board discussed preliminary discussions between Beverly's Chief Executive Officer and potential affiliation partners and viability of such discussions to proceed;

4. Minutes for the Board Executive Session of Beverly and Montebello on June 25, 2019 wherein the Beverly Board discussed preliminary discussions between Beverly's Chief Executive Officer and potential affiliation partners and viability of such discussions to proceed;

5. Beverly Hospital Strategic Plan for 2021-2023 presented September 2020;

6. Agenda for Board Strategic Plan Working Group Meeting of Beverly and Montebello (the "Working Group") on February 23, 2021;

7. Agenda for the Working Group on February 18, 2021;

8. Minutes for the Working Group on October 13, 2021 wherein the Working Group discussed potential affiliation partners and viability of continued discussions with potential affiliation partners to proceed;

9. Minutes for the Working Group on November 17, 2021 wherein the Working Group discussed potential affiliation partners and viability of continued discussions with potential affiliation partners to proceed;

10. Minutes for the Working Group on November 23, 2021 wherein the Working Group discussed potential affiliation partners and viability of continuing discussions with potential affiliation partners;

11. Minutes for the Working Group on November 30, 2021 wherein the Working Group discussed potential affiliation partners, viability of continuing discussions with potential affiliation partners, and issues regarding executing confidentiality agreements with potential affiliation partners;

12. Minutes for the Working Group on December 7, 2021 wherein the Working Group discussed potential affiliation partners, viability of continuing discussions with potential affiliation partners, and issues regarding executing confidentiality agreements with potential affiliation partners;

13. Minutes for the Board Executive Session of Beverly and Montebello on December 14, 2021, discussing potential affiliation partners and executing letter of intent with potential affiliation partner;

14. Minutes for the Working Group on February 15, 2022 wherein the Working Group discussed ongoing issues and actions regarding potential affiliation;

15. Minutes for the Working Group on March 1, 2022 wherein the Working Group discussed ongoing issues and actions regarding potential affiliation;

16. Minutes for the Working Group on March 17, 2022 wherein the Working Group discussed ongoing issues and actions regarding potential affiliation;

17. Minutes for the Working Group on April 12, 2022 wherein the Working Group discussed ongoing issues and actions regarding potential affiliation; and alternative potential affiliation partners;

18. Minutes for the Working Group on April 19, 2022 wherein the Working Group discussed potential affiliation partners, viability of continuing discussions with potential affiliation partners, and issues regarding executing letter of intent with potential affiliation partner;

19. Minutes for the Working Group on May 4, 2022 wherein the Working Group discussed potential affiliation partners, viability of continuing discussions with potential affiliation partners, and issues regarding executing letter of intent with potential affiliation partner;

20. Minutes for the Working Group on May 19, 2022 wherein the Working Group discussed potential affiliation partners, viability of continuing discussions with potential affiliation partners, and issues regarding executing letter of intent with potential affiliation partner;

21. Minutes for the Working Group on June 7, 2022 wherein the Working Group discussed potential affiliation partners, viability of continuing discussions with potential affiliation partners, and issues regarding executing letter of intent with potential affiliation partner;

22. Minutes for the Working Group on June 21, 2022 wherein the Working Group discussed potential affiliation partners, viability of continuing discussion with potential affiliation partner, and executing letter of intent with potential affiliation partner;

23. Minutes for the Working Group on July 5, 2022 wherein the Working Group discussed ongoing issues and actions regarding potential affiliation;

24. Minutes for the Working Group on July 19, 2022 wherein the Working Group discussed ongoing issues and actions regarding potential affiliation;

25. Minutes for the Working Group on August 9, 2022 wherein the Working Group discussed ongoing issues and actions regarding potential affiliation;

26. Minutes for the Working Group on August 16, 2022 wherein the Working Group discussed ongoing issues and actions regarding potential affiliation;

27. Minutes for the Working Group on August 30, 2022 wherein the Working Group discussed ongoing issues and actions regarding potential affiliation;

28. Minutes for the Working Group on September 13, 2022 wherein the Working Group discussed ongoing issues and actions regarding potential affiliation;

29. Minutes for the Working Group on September 20, 2022 wherein the Working Group discussed ongoing issues and actions regarding potential affiliation;

30. Minutes for the Working Group on September 27, 2022 wherein the Board discussed the Affiliation and approved the material terms of the Affiliation Agreement;

31. Minutes for the Working Group on October 4, 2022 wherein the Working Group discussed ongoing issues and actions regarding potential affiliation;

32. Minutes for the Working Group on October 18, 2022 wherein the Working Group discussed ongoing issues and actions regarding potential affiliation;

33. Minutes for the Board Executive Session of Beverly and Montebello on October 25, 2022 wherein the Board discussed the Affiliation and approved revisions to the Affiliation Agreement; and

34. Minutes for the Working Group on November 1, 2022 wherein the Working Group discussed ongoing issues and actions regarding potential affiliation.

EXHIBIT 28

LETTER OF INTENT BETWEEN BEVERLY AND ADVENTIST HEALTH (JUNE 15, 2022)

Execution Version

June 15, 2022

Adventist Health System/West
ONE Adventist Health Way
Roseville, CA 95661
Attention: Andrew Jahn, President

Re: Letter of Intent

Dear Mr. Heinrich:

As we have discussed, Beverly Community Hospital Association dba Beverly Hospital, a California nonprofit public benefit corporation ("Beverly") and Adventist Health System/West, a California nonprofit religious corporation dba Adventist Health ("Adventist Health"), mutually desire to jointly collaborate to enter into a proposed transaction effectuated through an affiliation between Adventist Health or a designated affiliate of Adventist Health and Beverly (the "Transaction"). This letter of intent (this "Letter") sets forth the mutual understanding of Beverly and Adventist Health with respect to the Transaction and is effective upon the date of full execution by both parties (the "Effective Date").

1. Structure and Timeline of Negotiations. The parties agree to negotiate diligently and to proceed with a good faith negotiation of the Transaction and definitive agreements necessary to implement the Transaction. A non-binding term sheet setting forth certain fundamental terms of the Transaction is attached as **Exhibit A** to this Letter (the "Term Sheet") and is incorporated herein by this reference. The parties acknowledge and agree that the terms described in the Term Sheet may be subject to change based upon due diligence and other factors. Any obligation to consummate the Transaction will be subject in all respects to the negotiation, execution and delivery of one or more definitive agreements (collectively, the "Definitive Agreements"), and the satisfaction of the terms and conditions contained in the Definitive Agreements. The parties acknowledge and agree that any binding commitment to proceed with the Transaction will arise only if one or more Definitive Agreements with respect thereto are approved by the parties, and such Definitive Agreements are executed and delivered by the parties. The parties intend to begin preparation and negotiation of the Definitive Agreements as soon as reasonably practicable after execution of this Letter, and that each of Beverly and Adventist Health shall appoint representatives to serve on a negotiating committee. Such negotiating committee will meet on a regular schedule to negotiate the Definitive Agreements.

2. Exclusivity. From and after the Effective Date until the earlier to occur of (a) the execution of the Definitive Agreements, (b) immediately after Adventist Health provides written notice to Beverly of its desire and intention to terminate discussions regarding the Transactions, or (c) the later of (i) sixty (60) days after the Effective Date or (ii) immediately after Beverly provides written notice to Adventist Health of its desire and intention to terminate discussions regarding the Transactions (in any such case, the "Exclusivity Period"), Beverly shall not, and shall cause its respective affiliates, members, officers, directors, employees, investment bankers, brokers or agents ("Representatives") to not, without the prior written consent of Adventist Health:

a. offer for sale, purchase, lease or any other transaction any of its assets or any portion of its equity interest in or control of its affiliated businesses in which the party owns less than 100% beneficial interest ("Affiliated Businesses"), whether by merger, consolidation, tender

[redacted]

offer, substitution of corporate member or otherwise, other than in the ordinary course consistent with past practice;

b. solicit, encourage, negotiate or take any other action to facilitate offers to sell any material portion of its assets, business, equity or any portion of its equity interest in any Affiliated Businesses, whether by merger, consolidation, tender offer, substitution of corporate member or otherwise;

c. hold any discussions with any party (other than the other party hereto) involving such offers, solicitations, or transactions as described above; or

d. enter into any agreement with any party (other than the other party hereto) with respect to an affiliation relationship that involves any form of transfer of any part of Beverly's assets, equity or business.

3. Confidentiality and Public Communication. The parties have entered into that certain Mutual Nondisclosure Agreement ("NDA") dated as of July 16, 2021 and effective until December 31, 2022. Without the prior written consent of both parties, neither party will (and each party will direct its Representatives to ensure that they will not), disclose to any third-party not involved in representing either such party and bound by an obligation of confidentiality that discussions or negotiations are taking place concerning a possible Transaction or any terms, conditions or other facts with respect to any such possible transaction, including the status thereof, including the information contained in this Letter, and all information related to this Letter, that is not otherwise known to the public, it being understood that the terms of this Letter shall be subject to the terms of the NDA. The timing and content of any announcements, press releases or any public statements concerning the proposed transaction shall be determined by mutual written agreement of Beverly and Adventist Health, unless, with respect to a party, in the judgment of such party upon advice of counsel, disclosure is otherwise required by applicable law, provided that such party shall use commercially reasonable efforts consistent with such applicable law to consult with and notify the other in advance, with respect to any such disclosure and statement thereof.

4. Due Diligence. The proposed Transaction is contingent upon Adventist Health's completion of a due diligence review of Beverly and its operations. During the course of the diligence review, documentation will be requested, as deemed to be necessary by Adventist Health. Beverly agrees to reasonably cooperate with Adventist Health's due diligence investigation and to provide Adventist Health and its Representatives with prompt and reasonable access to key employees, books, records, contracts and other information reasonably requested by Adventist Health as pertaining to the Transaction. The results of the due diligence review must be satisfactory to Adventist Health, as determined in its sole discretion.

5. Documentation. The Definitive Agreements will be entered into by the parties with respect to the proposed transaction and will include representations and warranties, events of default, conditions, covenants, indemnifications, remedies, and other provisions usual and customary for a transaction of the type agreed to by the parties. The initial draft of the Definitive Agreements will be prepared by Adventist Health. Notwithstanding any provision to the contrary contained herein, the Definitive Agreements, at such time as they are fully executed by the parties thereto, will supersede this Letter and, thereafter, this Letter will be of no further force or effect. No party will have any obligation to execute the Definitive Agreements unless and until the terms thereof are acceptable to that party, as determined in that party's sole discretion.

6. Expenses. Each party will bear its own legal, accounting, and other fees and expenses related to the preparation of this Letter and in connection with the Transaction, unless otherwise mutually agreed in writing by the parties.

7. Nonbinding Effect. Although this Letter does express the current intentions of the parties, as provided herein, the parties acknowledge and agree that, except as provided in the next sentence of this Section 7, this Letter will not create any binding legal commitments between them and any such binding legal commitments will come into place only upon execution and delivery of the Definitive Agreements setting forth the full scope, rights and responsibilities of the parties. Notwithstanding the foregoing, the parties agree upon the execution of this Letter to be bound by the provisions of this Letter concerning Section 2 (Exclusivity/No-Shop), Section 3 (Confidentiality and Public Communication), Section 6 (Expenses), Section 8 (Assignment), Section 9 (Miscellaneous) and Section 10 (Injunctive Relief).

8. Assignment. No party to this Letter may assign its rights or responsibilities without the prior written approval of the other party.

9. Miscellaneous. This Letter will be governed by and construed in accordance with the laws of the State of California. The language used in this Letter will be deemed to be the language chosen by the parties to express their mutual agreement, and this Letter will not be deemed to have been prepared by any single party hereto. This Letter contains the entire agreement of the parties concerning the matters addressed herein. No modification of this Letter or any of its terms and conditions will be binding upon any party hereto, unless approved in writing by the party to be bound thereby. Each party represents and warrants that is has the corporate power and authority to enter into this Letter and that the execution of this Letter shall not result in the material breach of termination of any provision of any contract, agreement or other instrument to which such party is bound. This Letter may be executed in counterparts and by electronic means.

10. Injunctive Relief. The parties acknowledge and agree that in the event of the violation of Section 2 or Section 3 of this Letter, the non-breaching party could not be fully or adequately compensated in damages and that, in addition to any other relief to which such party may become entitled, such party shall be entitled to temporary and permanent injunctive and other equitable relief without the necessity of posting a bond.

11. Consents. It is the parties' expectation that the parties shall cooperate with each other and use commercially reasonable efforts to complete due diligence and definitive documentation as promptly as reasonably practical, and then to provide appropriate notices to, and seek and obtain all necessary consents and approvals from any boards of directors, shareholders, vendors, lenders, trustees, bondholders, landlords, governmental authorities, and other third parties that may be required as a precondition to execute the Definitive Agreements.

12. Closing Conditions. The implementation of the Transaction (the "Closing") shall be conditioned upon, but not limited to, the following:

a. The execution of Definitive Agreements;

b. The completion of a successful due diligence review, with no findings deemed unacceptable to either Adventist Health or Beverly;

[redacted]

c. Third party approvals or non-objection as required, including, but not limited to, by the Office of the California Attorney General, California State Board of Pharmacy, California Department of Public Health and the Federal Trade Commission (as applicable);

d. Final approval by the applicable boards of directors/shareholders;

e. Neither Beverly nor Adventist Health otherwise experiencing a material adverse change prior to the Closing; and

f. Any other conditions specified in the Definitive Agreements.

* * * *

Please acknowledge your consent to the foregoing terms by signing this Letter below and returning it to the undersigned. Once fully executed, this Letter, subject to the terms and conditions set forth above, will remain in effect until the earlier to occur of (a) the execution of the Definitive Agreements, or (b) one party provides written notice of termination to the other party; and this Letter shall thereafter expire and be null and void and of no further force and effect, except for the provisions of Sections 3, 6, 7, 8, 9 and 10 hereof, each of which shall survive the expiration of this Letter.

Sincerely,

BEVERLY COMMUNITY HOSPITAL ASSOCIATION
dba BEVERLY HOSPITAL

By: [redacted]

Name: Alice Cheng

Title: President and CEO

Date: 6-23-22

Address: 309 W. Beverly Blvd., Montebello, CA 90640

ACKNOWLEDGED AND AGREED TO:

ADVENTIST HEALTH SYSTEM/WEST

By: [redacted]

Name: Kerry Heinrich

Title: CEO

Date: 6/15/2022

Address: ONE Adventist Health Way, Roseville, CA 95661

EXHIBIT A – Term Sheet

Although the parties intend and expect to proceed with a good faith negotiation of the Transaction based on the following terms and conditions, the following terms and conditions are not intended to create enforceable rights in favor of either party with respect to the Transaction. The obligations of the parties to consummate the Transaction shall be subject in all respects to the negotiation, execution and delivery of the Definitive Agreements, which would be prepared in a manner consistent with the requirements of applicable laws.

A. Vision	A regionally-integrated healthcare delivery system with aligned interests among community constituents, patients, providers, and payors
B. Growth and Alignment	a. **Clinical Program Integration**: Cardiology (Surgical and Rehabilitation); Neurology (medical, interventional, and surgical), pediatric/NICU b. **Physician Alignment and Network Development**: FQHC network expansion, PCP network development, and specialty providers coverage c. **Teaching Programs**: Family/Internal Medicine and OB/GYN d. **Payor Relations**: Medi-Cal/QAF strategy, Medicare Advantage, employer-based payors
C. Services/Operations	a. **Quality Program**: VBP and other quality mandates collaboration b. **Revenue Cycle Management**: Denials management, group purchase/inventory management c. **IT System**: Ambulatory/clinic data integration, clinical analytic capability, virtual/digital health platform, and enhanced cyber security

D. Capital Commitment	a. **Routine Capital**: budgeted in accordance with Adventist Health system budgeting policies and procedures which allows for 70% of the hospital's EBITDA being committed to Beverly's routine capital b. **Strategic Capital**: budgeted in accordance with Adventist Health system budgeting policies and procedures c. **Seismic Capital**: Beverly Hospital, with the oversight of Adventist Health, shall comply with all applicable California regulatory requirements for seismic, as and when required, subject to Beverly Hospital's ability to maintain its fiscal sustainability based on its balance sheet as a stand-alone enterprise. d. **IT Upgrade**: Upgrade Meditech and or conversion to an EHR platform of Adventist's discretion
E. Governance	a. **Board Composition**: upon Closing, Adventist Health shall appoint a new Board of Directors for Beverly ("Governing Board"). The existing Beverly Board of Directors shall convert to a "Community Board" that will have delegated authority from the Governing Board for oversight with respect to credentialing, quality, safety, and input with respect to strategic planning, as well as other delegated authority at the discretion of the Governing Board b. **Beverly Hospital Foundation**: shall continue its sole purpose of benefiting Beverly, and Beverly shall continue to be the sole corporate member of Beverly Hospital Foundation
F. Special Consideration: Aligned Future Uses Pre-Transaction Dialogue *(enhanced revenue sources)*	**Montebello Community Health Services**: Adventist Health shall become the sole corporate member of MCHS
G. Executive Team Retention	Adventist Health may, in its sole discretion, retain members of the executive team at Beverly, including but not limited to the CEO, COO/CNO, and other Senior Executive Members

H. Transaction Structure; CA Attorney General Conditions	Adventist Health will become the sole corporate member of Beverly Adventist Health will consider acceptance of those conditions and commitments required by the California Attorney General, and will retain the right to terminate the Definitive Agreements if such conditions and commitments are unacceptable
I. Branding	**Adventist Health Beverly** - retain the dba name

11 Cal. Code Reg. Section 999.5(d)(11)(B)

Copies of all documents relating or referring to the reasons why any potential transferee was excluded from further consideration as a potential transferee for any of the health facilities or facilities that provide similar healthcare that are the subject of the agreement or transaction

Beverly did not exclude any potential transferee from consideration. Rather, Beverly evaluated and considered all potential options in light of its financial condition, including its entrance into an affiliation with any organization that expressed an interest in an affiliation with Beverly. Adventist Health presented as the only option that would allow Beverly to continue to operate as a healthcare facility in its community. Accordingly, Beverly's consideration and selection of an organization with which to affiliate was based on whether an organization proceeded with discussions with Beverly for an affiliation that would enable Beverly to continue to provide healthcare services to its community into the future. Please see our response to Section 999.5(d)(1)(C) and Section 999.5(d)(11)(A) of this Notice for further details on this process.

11 Cal. Code Reg. Section 999.5(d)(11)(C)

Copies of all Requests for Proposal sent to any potential transferee, and all responses received thereto

Due to the lack of interested parties, Beverly did not send Requests for Proposal to any potential transferee. Instead, Beverly engaged directly with all interested, potential transferees. Please see the response to Section 999.5(d)(1)(C) and the supporting materials included in the response to Section 999.5(d)(11)(A) and Section 999.5(d)(11)(E) of this Notice.

11 Cal. Code Reg. Section 999.5(d)(11)(D)

All documents reflecting the deliberative process used by the applicant and any related entity in selecting the transferee as the entity to participate in the proposed agreement or transaction

For information about Beverly Board's deliberation process and ultimate selection of Adventist Health as the organization with which Beverly would affiliate, please see the responses and documents attached to Section 999.5(d)(1)(C) and Section 999.5(d)(11)(A) of this Notice.

11 Cal. Code Reg. Section 999.5(d)(11)(E)

Copies of each Proposal received by the applicant from any potential transferee suggesting the terms of a potential transfer of applicant's health facilities or facilities that provide similar healthcare, and any analysis of each such Proposal

As previously noted, due to the lack of interested parties, Beverly did not send Requests for Proposal to any potential transferee. Instead, Beverly engaged directly with all interested, potential transferees. The proposals received by Beverly in connection with its Affiliation with Adventist Health include: (1) the Letter of Intent (attached as **Exhibit 28** to Section 999.5(d)(11)(A)); and (2) the Affiliation Agreement (attached as **Exhibit 1** to Section 999.5(d)(1)(B)).

For additional information regarding the Beverly Board's evaluation of potential transactions and selection of Adventist Health as the best option for Beverly's continued viability, please see the responses to Sections 999.5(d)(1)(C) and 999.5(d)(11)(A) of this Notice.

11 Cal. Code Reg. Section 999.5(d)(11)(F)

The applicant's prior two annual audited financial statements, the applicant's most current unaudited financial statement, business projection data and current capital asset valuation data

Attached to this Section are the following documents:

- **Exhibit 29**, a copy of Beverly's audited consolidated financial statements for the years ending December 31, 2020 and December 31, 2021.

- **Exhibit 30**, a copy of Beverly's unaudited financial statements for months ending August 31, 2022.

- **Exhibit 31**, a copy of Beverly's business projections for 2023.

Beverly does not have any current asset valuation data.

EXHIBIT 29

BEVERLY'S AUDITED CONSOLIDATED FINANCIAL STATEMENTS (YEARS ENDING DECEMBER 31 2020 AND 2021)

REPORT OF INDEPENDENT AUDITORS AND
CONSOLIDATED FINANCIAL STATEMENTS
WITH SUPPLEMENTARY INFORMATION

BEVERLY COMMUNITY HOSPITAL ASSOCIATION

December 31, 2021 and 2020

MOSSADAMS

Table of Contents

MOSSADAMS

Report of Independent Auditors

The Board of Directors
Beverly Community Hospital Association

Report on the Audit of the Financial Statements

Opinion

We have audited the consolidated financial statements of Beverly Community Hospital Association (the "Hospital"), which comprise the consolidated balance sheets as of December 31, 2021 and 2020, and the related consolidated statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

In our opinion, the accompanying consolidated financial statements present fairly, in all material respects, the financial position of Beverly Community Hospital Association as of December 31, 2021 and 2020, and the results of their operations and their cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

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

Responsibilities of Management for the Financial Statements

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

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

Auditor's Responsibilities for the Audit of the Financial Statements

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

In performing an audit in accordance with GAAS, we:

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

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

Supplementary Information

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The consolidating schedules listed in the foregoing table of contents are presented for purposes of additional analysis and are not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Moss Adams LLP

Los Angeles, California
April 29, 2022

Beverly Community Hospital Association
Consolidated Balance Sheets

ASSETS

	December 31, 2021	December 31, 2020
CURRENT ASSETS		
Cash and cash equivalents	$ 44,317,000	$ 43,371,000
Patient accounts receivable	19,469,000	21,371,000
Due from third-party payors, current	19,243,000	21,530,000
Inventories of drugs and supplies	3,244,000	3,548,000
Prepaid expenses and other assets	3,481,000	3,086,000
Total current assets	89,754,000	92,906,000
DUE FROM THIRD-PARTY PAYORS, less current portion	12,415,000	12,822,000
ASSETS LIMITED AS TO USE	3,542,000	3,033,000
PROPERTY AND EQUIPMENT, net	99,077,000	99,795,000
OTHER ASSETS	8,246,000	7,938,000
	$ 213,034,000	$ 216,494,000

LIABILITIES AND NET ASSETS

CURRENT LIABILITIES		
Accounts payable	$ 11,315,000	$ 8,850,000
Accrued expenses and other liabilities	8,651,000	9,147,000
Medical claims liabilities	4,562,000	5,101,000
Shared risk liability	8,011,000	2,810,000
Current portion of accrued self-insurance claims reserves	2,070,000	2,547,000
Current portion of Medicare advance payment	10,925,000	4,795,000
Current maturities of long-term debt	1,418,000	1,354,000
Current maturities of lease obligations	2,808,000	2,922,000
Total current liabilities	49,760,000	37,526,000
OTHER LONG-TERM LIABILITIES	-	1,176,000
ACCRUED SELF-INSURANCE CLAIMS RESERVES, less current portion	5,168,000	5,038,000
MEDICARE ADVANCE PAYMENT, less current portion	-	10,178,000
REVOLVING LOAN	10,000,000	10,000,000
LONG-TERM DEBT, net	58,199,000	59,677,000
LEASE OBLIGATIONS, less current maturities	5,546,000	5,019,000
Total liabilities	128,673,000	128,614,000
NET ASSETS		
Without donor restrictions	82,647,000	86,326,000
With donor restrictions	1,714,000	1,554,000
Total net assets	84,361,000	87,880,000
	$ 213,034,000	$ 216,494,000

See accompanying notes.

Beverly Community Hospital Association
Consolidated Statements of Operations

	Years Ended December 31,	
	2021	2020
UNRESTRICTED REVENUES, GAINS, AND OTHER SUPPORT		
Net patient service revenue	$ 145,515,000	$ 138,743,000
Premium revenue	24,204,000	27,248,000
In-kind contributions	3,019,000	-
Grant revenue – Provider Relief Funds	798,000	12,396,000
Other operating revenue	2,902,000	2,616,000
Net assets released from restrictions	190,000	450,000
Total unrestricted revenues, gains, and other support	176,628,000	181,453,000
EXPENSES		
Salaries and employee benefits	73,285,000	71,426,000
Supplies	22,474,000	21,838,000
Capitated medical services	18,571,000	24,403,000
Quality assurance fee	16,451,000	18,349,000
Other purchased services	14,736,000	15,565,000
Professional fees	12,711,000	10,230,000
Depreciation and amortization	9,764,000	9,454,000
Interest	3,073,000	3,086,000
Utilities	2,599,000	2,375,000
Rentals	2,406,000	3,912,000
Insurance	2,186,000	2,426,000
Other	2,051,000	1,636,000
Total expenses	180,307,000	184,700,000
Deficiency of revenues over expenses	$ (3,679,000)	$ (3,247,000)

See accompanying notes.

Beverly Community Hospital Association
Consolidated Statements of Changes in Net Assets

	Years Ended December 31,	
	2021	2020
NET ASSETS WITHOUT DONOR RESTRICTIONS		
Deficiency of revenues over expenses	$ (3,679,000)	$ (3,247,000)
Decrease in net assets without donor restriction	(3,679,000)	(3,247,000)
NET ASSETS WITH DONOR RESTRICTIONS		
Contributions	350,000	576,000
Net assets released from restrictions used for operations	(190,000)	(450,000)
Increase in net assets with donor restrictions	160,000	126,000
Decrease in net assets	(3,519,000)	(3,121,000)
NET ASSETS, beginning of year	87,880,000	91,001,000
NET ASSETS, end of year	$ 84,361,000	$ 87,880,000

See accompanying notes.

Beverly Community Hospital Association
Consolidated Statements of Cash Flows

	Years Ended December 31,	
	2021	2020
CASH FLOWS FROM OPERATING ACTIVITIES		
Decrease in net assets	$ (3,519,000)	$ (3,121,000)
Adjustments to reconcile decrease in net assets to net cash provided by (used in) operating activities		
Depreciation and amortization	9,764,000	9,454,000
Amortization of premiums and debt issuance costs	(58,000)	32,000
In-kind contributions	(3,019,000)	-
Changes in operating assets and liabilities		
Patient accounts receivable	1,902,000	766,000
Due from third-party payors	2,694,000	3,440,000
Inventories, prepaid expenses, and other assets	(399,000)	(415,000)
Accounts payable, accrued expenses, and other liabilities	793,000	(3,559,000)
Medical claims liabilities	(539,000)	(1,082,000)
Shared risk liability	5,201,000	(164,000)
Accrued self-insurance claims reserves	(347,000)	31,000
Medicare advance payment	(4,048,000)	14,973,000
Net cash provided by operating activities	8,425,000	20,355,000
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchases of assets limited as to use, net	(509,000)	(128,000)
Purchases of property and equipment	(2,823,000)	(2,125,000)
Net cash used in investing activities	(3,332,000)	(2,253,000)
CASH FLOWS FROM FINANCING ACTIVITIES		
Borrowings under revolving loan	35,000,000	17,500,000
Payments on revolving loan	(35,000,000)	(17,500,000)
Principal payments of long-term debt	(1,356,000)	(953,000)
Principal payments of finance lease obligations	(2,791,000)	(2,149,000)
Net cash used in financing activities	(4,147,000)	(3,102,000)
NET INCREASE IN CASH AND CASH EQUIVALENTS	946,000	15,000,000
CASH AND CASH EQUIVALENTS, beginning of year	43,371,000	28,371,000
CASH AND CASH EQUIVALENTS, end of year	$ 44,317,000	$ 43,371,000

See accompanying notes.

	Years Ended December 31,	
	2021	2020
SUPPLEMENTAL DISCLOSURE OF CASH FLOW INFORMATION		
Cash paid for interest, net of capitalized interest	$ 3,123,000	$ 3,032,000

Note 1 – Nature of Business

Organization – Beverly Community Hospital Association (the "Hospital") operates a 202-bed acute care hospital in Montebello, California. The Hospital is the sole corporate member of Beverly Hospital Foundation (the "Foundation") and is affiliated with Montebello Community Health Services ("MCHS") through a common board of directors.

MCHS was established for the exclusive benefit of the Hospital, which may include performing activities for, or providing services to, the Hospital and organizations affiliated with the Hospital. MCHS operates a medical office building, a health center, and certain rental properties.

The Foundation is organized to engage in the solicitation, receipt, and administration of funds for the benefit of the Hospital.

Note 2 – Summary of Significant Accounting Policies

Basis of consolidation – The consolidated financial statements include the accounts of the Hospital, MCHS, and the Foundation (collectively the "Corporation"). All intercompany transactions have been eliminated in consolidation.

Basis of presentation – The accompanying consolidated financial statements have been prepared on the accrual basis of accounting in accordance with accounting principles generally accepted in the United States (U.S. GAAP).

Use of estimates – The preparation of consolidated financial statements in accordance with U.S. GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from these estimates.

Cash and cash equivalents – Cash and cash equivalents include investments in highly liquid debt instruments with a maturity of three months or less, excluding those amounts that are limited for use by board designation or other arrangements under trust agreements or with third-party payors. Money market funds are included in cash and cash equivalents in the amount of $25,317,000 and $31,559,000 as of December 31, 2021 and 2020, respectively.

Patient accounts receivable – The Hospital carries its accounts receivable at billed amounts less uncollectible amounts. The Hospital does not accrue interest on its receivables. On a periodic basis, the Hospital evaluates its patient accounts receivable and establishes implicit and explicit price concessions based on contractual arrangements, history of past write-offs, collections, and current credit conditions. The Hospital's policy for writing off receivables as uncollectible varies based on the payor arrangements and management's estimate of the customer's ability to pay.

Inventories – Inventories are recorded at cost using the first-in, first-out method, which is not in excess of net realizable value.

Note 2 – Summary of Significant Accounting Policies (continued)

Assets limited as to use – Assets limited as to use include investments pledged to collateralize the outstanding letters of credit for workers' compensation self-insurance policies (see Note 5) and investments restricted by donors.

Investments in equity securities with readily determinable fair values and all investments in debt securities are measured at fair value in the consolidated balance sheets. Fair value is established based on quoted prices from recognized securities exchanges. Management determines the appropriate classification of all marketable securities at the date of purchase and reevaluates such designations at each balance sheet date. The Corporation determined that all debt investments held as of December 31, 2021 and 2020, are designated as held-to-maturity. Accordingly, unrealized gains or losses on investments are included in the consolidated statements of operations.

Income or loss on investments included in net assets with donor restriction, including realized and unrealized gains and losses on investments, interest, and dividends, is reported in the consolidated statements of operations unless the income or loss is restricted by donor or law.

Fair value of financial instruments – The Corporation's consolidated balance sheets include the following financial instruments: cash and cash equivalents, assets limited as to use, patient accounts receivable, accounts payable, accrued expenses and other liabilities, long-term debt, and lease obligations. The Corporation considers the carrying amounts of current assets and liabilities in the consolidated balance sheets to approximate the fair value of these financial instruments because of the relatively short period of time between origination of the instruments and their expected realization or payment. All investments are carried at fair value. The fair value of the Corporation's long-term debt is based on current market rates for debt of the same risk and maturity (see Note 9).

Property and equipment – Property and equipment are stated at cost. Major renewals are charged to the property and equipment accounts while replacements, maintenance, and repairs, which do not improve or extend the respective lives of the assets, are expensed currently. Depreciation is provided over the estimated useful life of each class of depreciable asset, ranging from three to forty years, and is computed using the straight-line method. Interest cost incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets. Total interest incurred amounted to $3,133,000 and $3,136,000 for the years ended December 31, 2021 and 2020, respectively. Total interest capitalized amounted to $60,000 and $50,000 as of December 31, 2021 and 2020, respectively. Total interest expense amounted to $3,073,000 and $3,086,000 for the years ended December 31, 2021 and 2020, respectively.

Equipment under finance lease obligations is amortized in the manner consistent with the policy for owned assets or over the lease term, whichever is shorter.

Note 2 – Summary of Significant Accounting Policies (continued)

The Hospital accounts for the costs incurred to obtain software for internal use in accordance with Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC), *Intangibles-Goodwill and Other – Internal-Use Software (Topic 350-40)*. Costs incurred in obtaining computer software for internal use, which include costs of configuration, installation, and testing, are capitalized by the Hospital. Costs incurred during the preliminary project along with post-implementation stages of internal use computer software are expensed as incurred. Capitalized development costs are amortized over a period of ten years. The capitalization and ongoing assessment of recoverability of computer software costs require considerable judgment with respect to certain external factors, including, but not limited to, technological and economic feasibility and estimated economic life.

Gifts of long-lived assets such as land, buildings, or equipment are reported as unrestricted support and are included in the consolidated statements of operations unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted support. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

Leases – Leases with durations greater than 12 months are recognized on the consolidated balance sheets through recognition of a liability for the discounted present value of future fixed lease payments and a corresponding right-of-use (ROU) asset. The ROU asset recorded at commencement of the lease represents the right to use the underlying asset over the lease term in exchange for the lease payments. Leases with an initial term of 12 months or less that do not have an option to purchase the underlying asset that is deemed reasonably certain to be exercised are not recorded on the consolidated balance sheets; rather, rent expense for these leases is recognized on a straight-line basis over the lease term or when incurred if a month-to-month lease. When readily determinable, the Corporation uses the interest rate implicit in a lease to determine the present value of future lease payments. For leases where the implicit rate is not readily determinable, the Corporation's incremental borrowing rate is utilized. The Corporation calculates its incremental borrowing rate on a quarterly basis using a financial model that estimates the rate of interest the Corporation would have to pay to borrow an amount equal to the total lease payments on a collateralized basis over a term similar to the lease. The Corporation's lease agreements do not contain any material residual value guarantees or material restrictive covenants.

The Corporation uses the package of practical expedients provided in FASB ASC, *Leases (Topic 842),* whereby an entity need not reassess expired contracts for lease identification or classification as a finance or operating lease, or for the reassessment of initial direct costs. Certain of the Corporation's lease agreements have lease and non-lease components, which, for most leases, the Corporation accounts for separately when the actual lease and non-lease components are determinable. For equipment leases with immaterial non-lease components incorporated into the fixed rent payment, the Corporation accounts for the lease and non-lease components as a single lease component in determining the lease payment. Additionally, for certain individually insignificant equipment leases such as copiers, the Corporation applies a portfolio approach to effectively record the operating lease liability and ROU asset.

Note 2 – Summary of Significant Accounting Policies (continued)

Equipment under finance and operating lease obligations is amortized in the manner consistent with the policy for owned assets or over the lease term, whichever is appropriate based on the type of lease.

The Corporation leases property and equipment under finance and operating leases. For leases with terms greater than 12 months, the Corporation records the related ROU assets and ROU obligations at the present value of lease payments over the term.

Generally, the Corporation uses estimated incremental borrowing rates to discount the lease payments based on information available at lease commencement, as most of the leases do not provide a readily determinable implicit interest rate.

Unamortized debt issuance costs – Debt issuance costs are amortized using the effective interest method over the life of the bonds. Amortization of debt issuance cost is included in interest expense. Accumulated amortization on the debt issuance costs was approximately $360,000 and $302,000 as of December 31, 2021 and 2020, respectively. Unamortized costs are presented net of long-term debt on the accompanying consolidated balance sheets.

Estimated self-insurance costs – The provision for estimated self-insurance costs for medical malpractice, workers' compensation, and employee health insurance claims includes estimates of the ultimate costs for both reported claims and claims incurred but not reported. The Hospital estimates claims liabilities without consideration of insurance recoveries in accordance with FASB ASC, *Health Care Entities – Contingencies (Topic 954-450),* and records insurance recoveries separately within other assets on the consolidated balance sheets.

Net assets classification – Based on the existence or absence of donor-imposed restrictions, the Hospital classifies net assets into two categories: without donor restrictions and with donor restrictions.

Without donor restrictions – Net assets that are not subject to donor-imposed restrictions and may be expended for any purpose in performing the primary objectives of the Hospital. These net assets may be used at the discretion of the Corporation's management and Board of Directors.

With donor restrictions – Net assets subject to stipulations imposed by donors and grantors. Some donor-imposed restrictions are temporary in nature, such as those that will be met by the passage of time or other events specified by the donor. Other donor-imposed restrictions are perpetual in nature, where the donor stipulates that resources be maintained in perpetuity. Donor-imposed restrictions are released when a restriction expires; that is, when the stipulated time has elapsed, when the stipulated purpose for which the resource was restricted has been fulfilled, or both.

Expiration of donor-imposed restrictions – Net assets are released from restrictions by incurring expenses satisfying the restricted purposes and by occurrence of events specified by the donors, including the passage of time. Donor restrictions on long-lived assets or cash to construct or acquire long-lived assets are considered to have expired when the assets are placed in service or expenditures exceed the amount of the gift.

Note 2 – Summary of Significant Accounting Policies (continued)

Patient service revenue – Patient service revenue is reported at the amount that reflects the consideration to which the Hospital expects to be entitled in exchange for providing patient care. These amounts are due from patients, third-party payors (including health insurers and government programs), and others and include variable consideration for retroactive revenue adjustments due to settlement of audits, reviews, and investigations. Generally, the Hospital bills the patients and third-party payors several days after the services are performed or the patient is discharged from the facility. Revenue is recognized as performance obligations are satisfied.

Performance obligations are determined based on the nature of the services provided by the Hospital. Revenue for performance obligations satisfied over time is recognized pro rata based on actual charges incurred in relation to total expected (or actual) charges. The Hospital believes that this method provides a reasonable depiction of the transfer of services over the term of the performance obligation based on the services provided to satisfy the obligation. Generally, performance obligations satisfied over time relate to patients in the hospital receiving inpatient acute care services. The Hospital measures the performance obligation from admission into the Hospital, or the commencement of an outpatient service, to the point when it is no longer required to provide services to that patient, which is generally at the time of discharge or completion of the outpatient services. Revenue for performance obligations satisfied at a point in time is generally recognized when services are provided, and the Hospital does not believe it is required to provide additional services to the patient.

Because all of its performance obligations relate to contracts with a duration of less than one year, the Hospital has elected to apply the optional exemption provided in FASB ASC, *Revenue from Contracts with Customers – Disclosure (Topic 606-10-50)*; therefore, is not required to disclose the aggregate amount of the transaction price allocated to performance obligations that are unsatisfied or partially unsatisfied at the end of the reporting period. The unsatisfied or partially unsatisfied performance obligations referred to previously are primarily related to inpatient acute care services at the end of the reporting period. The performance obligations for these contracts are generally completed when the patients are discharged, which generally occurs within days or weeks of the end of the reporting period.

The Hospital determines the transaction price based on standard charges for goods and services provided, reduced by contractual adjustments provided to third-party payors, discounts provided to uninsured patients in accordance with the Hospital's policy, and/or implicit price concessions provided to uninsured patients. The Hospital determines its estimates of explicit price concessions based on contractual agreements, its discount policies, and historical experience. The Hospital determines its estimate of implicit price concessions based on historical collection experience with this class of patients.

Agreements with third-party payors provide for payments at amounts less than established charges. A summary of the payment arrangements with major third-party payors follows:

Medicare – Certain inpatient acute care services are paid at prospectively determined rates per discharge based on clinical, diagnostic, or other factors. Certain services are paid based on a cost reimbursement methodology subject to certain limits. Physical services are paid based upon established fee schedules. Outpatient services are paid using prospectively determined rates.

Note 2 – Summary of Significant Accounting Policies (continued)

Medicaid – Reimbursements for Medicaid services are generally paid at prospectively determined rates per discharge, per occasion of services, or per covered member.

Other – Payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations provide for payment using prospectively determined rates per discharge, discounts from established charges, and prospectively determined daily rates.

Laws and regulations concerning government programs, including Medicare and Medicaid, are complex and subject to varying interpretation. As a result of investigations by governmental agencies, various health care organizations have received requests for information and notices regarding alleged noncompliance with those laws and regulations, which, in some instances, have resulted in organizations entering into significant settlement agreements. Compliance with such laws and regulations may also be subject to future government review and interpretation as well as significant regulatory action, including fines, penalties, and potential exclusion from the related programs. There can be no assurance that regulatory authorities will not challenge the Hospital's compliance with these laws and regulations, and it is not possible to determine the impact, if any, such claims or penalties would have upon the Hospital. In addition, the contracts the Hospital has with commercial payors also provide for retroactive audit and review of claims.

Settlements with third-party payors for retroactive adjustments due to audits, reviews, or investigations are considered variable consideration and are included in the determination of the estimated transaction price for providing patient care in the period the related services are provided or when results of audits and appeals can reasonably be determined or finalized. These settlements are estimated based on the terms of the payment agreement with the payor, correspondence from the payor, and the Hospital's historical settlement activity, including an assessment to ensure that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustment is subsequently resolved. Estimated settlements are adjusted in future periods as adjustments become known; that is, new information becomes available or as years are settled or are no longer subject to such audits and reviews. Adjustments arising from a change in the transaction price were not significant for the years ended December 31, 2021 or 2020.

Generally, patients who are covered by third-party payors are responsible for related deductibles and coinsurance, which vary in amount. The Hospital also provides services to uninsured patients and offers those uninsured patients a discount, either by policy or law, from standard charges. The Hospital estimates the transaction price for patients with deductibles and coinsurance and from those who are uninsured based on historical experience and current market conditions. The initial estimate of the transaction price is determined by reducing the standard charge by any explicit and implicit price concessions. Subsequent changes to the estimate of the transaction price are generally recorded as adjustments to patient service revenue in the period of the change. For the years ended December 31, 2021 and 2020, revenue reductions of approximately $1,628,000 and $731,000, respectively, were recognized due to changes in its estimates of implicit price concessions for performance obligations satisfied in prior years. Subsequent changes that are determined to be the result of an adverse change in the patient's ability to pay are recorded as bad debt expense. Bad debt expense for the years ended December 31, 2021 and 2020, was not significant.

Note 2 – Summary of Significant Accounting Policies (continued)

Consistent with the Hospital's mission, care is provided to patients regardless of their ability to pay. Therefore, the Hospital has determined it has provided implicit price concessions to uninsured patients and patients with other uninsured balances (for example, copays and deductibles). The implicit price concessions included in estimating the transaction price represent the difference between amounts billed to patients and the amounts the Hospital expects to collect based on its collection history with those patients.

Patients who meet the Corporation's criteria for charity care are provided care without charge or at amounts less than established rates. Such amounts determined to quality as charity care are not reported as revenue.

Net patient service revenue by major payor source is as follows:

	Years Ended December 31,			
	2021		2020	
Medicare	$ 26,120,000	18%	$ 24,581,000	18%
Medicare managed care	35,994,000	25%	27,342,000	20%
Medi-Cal	5,607,000	4%	7,161,000	5%
Medi-Cal managed care	16,671,000	11%	17,820,000	13%
Medi-Cal hospital fee and DSH	44,853,000	31%	43,511,000	31%
Other third party and commercial	13,979,000	10%	16,369,000	12%
Self pay	2,291,000	1%	1,959,000	1%
	$ 145,515,000	100%	$ 138,743,000	100%

The administrative procedures related to the cost reimbursement programs in effect generally preclude final determination of amounts due to the Hospital until cost reports are audited or otherwise reviewed and settled upon with the applicable administrative agencies. Normal estimation differences between final settlements and amounts accrued in previous years are reported as adjustments of the current year's net patient service revenue. In the opinion of management, adequate provision has been made for adjustments, if any, that might result from subsequent review. During the years ended December 31, 2021 and 2020, the Hospital updated anticipated final settlement amounts on previously filed Medicare and Medi-Cal cost reports and supplemental payment programs. The effect of these changes in estimates to net patient service revenue for the years ended December 31, 2021 and 2020, was an increase of $1,711,000 and $217,000, respectively.

To ensure accurate payments to providers, the Tax Relief and Healthcare Act of 2006 mandated the Centers for Medicare & Medicaid Services (CMS) to implement a Recovery Audit Contractor (RAC) program on a permanent and nationwide basis no later than 2010. The program uses RAC to search for potentially improper Medicare payments that may have been made to health care providers that were not detected through existing CMS program integrity efforts, which have occurred at least one year ago but not longer than three years ago. RAC assessment against the Hospital began during 2012. During the years ended December 31, 2021 and 2020, settlements repaid to CMS were immaterial.

Note 2 – Summary of Significant Accounting Policies (continued)

The Hospital is reimbursed for services provided to patients under certain programs administered by governmental agencies. Revenues from the Medicare and Medi-Cal programs including Hospital Fee (see Note 4) and Disproportionate Share Hospital (DSH) program (see Note 4) accounted for approximately 22% and 9%, respectively, for the year ended December 31, 2021, and 21% and 10%, respectively, for the year ended December 31, 2020, of the Hospital's net patient service revenue. Laws and regulations governing the Medicare and Medi-Cal programs are complex and subject to interpretation. The Hospital believes that it is in compliance with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing. While no such regulatory inquiries have been made, compliance with such laws and regulations can be subject to future government review and interpretation, as well as significant regulatory action, including fines, penalties, and exclusion from the Medicare and Medi-Cal programs.

Premium revenue and capitated medical services – The Hospital has agreements with various Health Maintenance Organizations (HMOs) to provide medical services to subscribing participants. Under these agreements, the Hospital receives monthly capitation payments based on the number of each HMO's participants, regardless of services actually performed by the Hospital. Revenue from monthly premiums is recognized in the month in which the Hospital is required to provide services. The amounts are included as premium revenue in the accompanying consolidated statements of operations. Liabilities for services provided to enrollees by service providers outside the Hospital are accrued in the month the services are rendered to enrollees based in part on estimates, including an accrual for services incurred but not reported to the Hospital. The Hospital retains an independent actuary to perform an annual review of the actuarial projections. Amounts for claims payment incurred related to prior years vary from previously estimated liabilities as the claims ultimately are settled. Liabilities of $4,562,000 and $5,101,000 as of December 31, 2021 and 2020, respectively, have been accrued in the accompanying consolidated balance sheets. In management's opinion, these accruals are adequate to cover ultimate claims expenses under the program. Normal estimation differences between the estimates and amounts finally paid to service providers are reflected in claims expense in the current period. These differences resulted in a decrease of $1,800,000 and increase of $1,919,000 in capitated medical services expense during the years ended December 31, 2021 and 2020, respectively.

Certain HMO contracts contain risk-sharing programs whereby the Hospital participates in the surplus and deficit of the risk-sharing program. The Hospital's partner physician groups also share in the proceeds of risk-sharing programs. Estimated settlements are accrued based upon the performance of the risk-sharing contracts in the period the Hospital was obligated to provide the services to the enrollees and adjusted in the future periods as final settlements are determined.

Grant revenue – The Hospital receives grants from various federal, state, and local agencies. Revenues from grants are recognized when all eligibility requirements are met.

In-kind contributions – Contributions of donated services are recognized if the services received: (a) create or enhance long-lived assets; or (b) require specialized skills, are provided by individuals possessing those skills, and would typically need to be purchased if not provided by donation.

Note 2 – Summary of Significant Accounting Policies (continued)

Excess of revenues over expenses – The consolidated statements of operations include excess of revenues over expenses. Changes in unrestricted net assets without donor restriction, which are excluded from excess of revenues over expenses, consistent with industry practice, include unrealized gains and losses on investments other than trading securities, permanent transfers of assets to and from subsidiaries for other than goods and services, and contributions of long-lived assets, including assets acquired using contributions which by donor restriction were to be used for the purpose of acquiring such assets.

Charity care – The Hospital provides care to patients who lack financial resources and are deemed to be medically indigent based on criteria established under the Hospital's charity care policy. This care is provided without charge or at amounts less than its established rates. Because the Hospital does not pursue collection of amounts determined to qualify as charity care, such amounts are not reported as revenue. The Hospital maintains records to identify and monitor the level of charity care provided. These records include the amount of direct and indirect costs for services and supplies furnished under its charity care policy. The direct and indirect costs related to this care totaled approximately $1,211,000 and $1,174,000 for the years ended December 31, 2021 and 2020, respectively. Direct and indirect costs for providing charity care are estimated by calculating a ratio of cost to gross charges and then multiplying that ratio by the gross uncompensated charges associated with providing care to charity patients. In addition, the Hospital provides services to other medically indigent patients under the state Medicaid programs. The state program pays amounts less than the cost of the services provided to the recipients.

Income taxes – The Hospital, MCHS, and the Foundation are not-for-profit entities organized under the laws of the state of California. All have been determined to be exempt from income taxes under Section 501(c)(3) of the Internal Revenue Code and Section 23701(d) of the state of California Revenue and Taxation Code by the Internal Revenue Service and Franchise Tax Board, respectively. The Hospital is recognized as a public charity under sections 509(a)(1) and 170(b)(1)(A)(iii) of the Internal Revenue Code.

The Corporation recognizes the tax expense or provision from uncertain tax positions only if it is more-likely-than-not that the tax positions will be sustained on examination by the tax authorities, based on the technical merits of the position. The tax benefit is measured based on the largest benefit that has a greater than 50% likelihood of being realized upon ultimate settlement.

Concentrations of credit risk – Financial instruments which potentially subject the Corporation to concentrations of credit risk consist primarily of cash, patient accounts receivable, and assets limited as to use.

Cash deposits are maintained in financial institutions that may exceed the amounts insured by the United States government. Nonperformance by these institutions could expose the Corporation to losses for amounts in excess of the insured balances. The Corporation monitors the financial condition of these institutions on an ongoing basis and does not believe significant risks exist at this time.

Note 2 – Summary of Significant Accounting Policies (continued)

Significant concentrations of net patient accounts receivable are as follows:

	December 31,	
	2021	2020
Medicare	9%	13%
Medicare managed care	45%	40%
Medi-Cal	4%	8%
Medi-Cal managed care	29%	23%
Other third party and commercial	8%	14%
Self pay	5%	2%
	100%	100%

The investment portfolio of assets limited as to use is managed by an outside investment firm within the guidelines established by the Board of Directors which, as a matter of policy, limit the amounts which may be invested in any one issuer.

Long-lived asset impairment – The Corporation reviews long-lived assets for impairment when events or changes in business conditions indicate that their carrying value may not be recoverable. The Corporation considers assets to be impaired and writes these down to fair value if expected associated cash flows are less than the carrying amounts. Fair value is the present value of the associated cash flows. The Corporation has determined that no long-lived assets are impaired as of December 31, 2021 and 2020.

Going concern – In connection with the preparation of the consolidated financial statements for the year ended December 31, 2021, the Corporation conducted an evaluation as to whether there were conditions and events, considered in the aggregate, which raised substantial doubt as to the Corporation's ability to continue as a going concern within one year after the date of the consolidated financial statements were available for issuance. Management determined that there were no conditions or events that raised substantial doubt about the Corporation's ability to continue as a going concern.

Legal proceedings – The Corporation is a defendant in certain legal actions arising from the normal conduct of business. Management believes that the ultimate resolution of these proceedings will not have a material adverse effect upon the Corporation's consolidated financial position but could be material to consolidated results of operations and cash flows of a particular future year, if resolved unfavorably.

During the year ended December 31, 2014, the Corporation made a disclosure to the Centers for Medicare and Medicaid Services under the Self-Referral Disclosure Protocol. This disclosure concerns Medicare referrals made to the Corporation by physicians who have financial arrangements with the Corporation that may have been prohibited. An estimate of the range of loss in this matter cannot currently be made with the available information.

Note 2 – Summary of Significant Accounting Policies (continued)

Subsequent events – Subsequent events are events or transactions that occur after the consolidated balance sheet date but before the consolidated financial statements were issued. The Corporation recognizes in the consolidated financial statements the effects of all subsequent events that provide additional evidence about conditions that existed at the date of the consolidated balance sheet, including the estimates inherent in the process of preparing the consolidated financial statements. The Corporation's consolidated financial statements do not recognize subsequent events that provide evidence about conditions that did not exist at the date of the consolidated balance sheets but arose after the consolidated balance sheet date and before the consolidated financial statements were issued.

Management has evaluated events that have occurred subsequent to April 29, 2022, the date on which the consolidated financial statements were issued.

Note 3 – Liquidity and Availability

The Hospital has financials assets available within one year of the consolidated balance sheet date of December 31, 2021, to meet cash needs for general expenditure as follows:

Financial assets as of December 31, 2021	
Cash and cash equivalents	$ 44,317,000
Patient accounts receivable	19,469,000
Due from third-party payors, current	19,243,000
Financial assets available to meet cash needs for general expenditures within one year	$ 83,029,000

The Hospital has $83,029,000 of financial assets available within one year of the statement of financial position date to meet cash needs for general expenditure. None of the financial assets are subject to donor or other contractual restrictions that make them unavailable for general expenditure within one year of the balance sheet date. The Corporation has a policy to structure its financial assets to be available as its general expenditures, liabilities, and other obligations come due.

Note 4 – Supplemental Payments

SB1100 (previously SB855) – During the years ended December 2021 and 2020, the Hospital was eligible to participate in the DSH program, which entitles the Hospital to supplemental payment adjustments from the California Department of Health Care Services (DHCS). Included in due from third-party payors in the accompanying consolidated balance sheets are receivable from DHCS of $607,000 as of December 31, 2021, and deferred revenue of $443,000 as of December 31, 2020. The Hospital recognized approximately $12,519,000 and $11,321,000 within net patient service revenue for the years ended December 31, 2021 and 2020, respectively, in the accompanying consolidated statements of operations.

Note 4 – Supplemental Payments (continued)

SB1100 (previously SB1255) – The Hospital met the eligibility criteria for funds available from the state of California's Emergency Services and Supplemental Payment Fund as of December 31, 2021 and 2020. Included in due from third-party payors in the accompanying consolidated balance sheets are deferred revenue from DHCS of $13,000 and $25,000 as of December 31, 2021 and 2020, respectively. The Hospital recognized approximately $1,440,000 and $2,390,000 within net patient service revenue for the years ended December 31, 2021 and 2020, respectively, in the accompanying consolidated statements of operations.

Hospital fee program – The California Hospital Fee Program (the "Program") is comprised of multiple laws enacted by the state of California. The most recent laws cover the periods from January 1, 2017 through June 30, 2019 (the "QAF V Program"), and July 1, 2019 through December 31, 2021 (the "QAF VI Program"). The Program requires a Quality Assurance Fee ("QA Fee") to be paid by certain hospitals to a state fund established to accumulate the assessed QA Fees in order to receive matching federal funds. QA Fees and corresponding matching federal funds are then paid to participating hospitals in two supplemental payment methodologies: a fee-for-service methodology and a managed care plan methodology. The Hospital recognizes Program-related revenue and expense ratably over the Program period. In relation to the Program, the Hospital has consistently recognized revenues and expenses based on reasonable estimates of what will ultimately be realized, considering among other things adjustments associated with regulatory reviews, audits, investigations, and other proceedings. Under the original legislation, uncertainty of the Program's approval resulted in deferral of revenue and expense recognition until reasonable approval of the Program had been made by CMS. Since the inception of the Program in 2010, CMS has continued to approve funding, and no portion of the applications by the state to CMS for matching has been rejected or overturned.

CMS approved the tax waiver for the fee-for-service and managed care plan methodologies for the QAF V Program as of December 14, 2017. From the inception of the QAF V Program on January 1, 2017 through December 31, 2021, the Hospital recognized $82,658,000 in net patient service revenues and $36,839,000 in QA fee expenses with a net benefit of $45,819,000. The Hospital has recorded the entirety of the revenues and expenses of the QAF V Program as of December 31, 2021.

CMS approved the tax waiver for the fee-for-service and managed care plan methodologies for the QAF VI Program. From the inception of the QAF VI Program on July 1, 2019 through December 31, 2021, the Hospital recognized $78,457,000 in net patient service revenues and $40,907,000 in QA fee expenses with a net benefit of $37,550,000.

As of December 31, 2021 and 2020, a net receivable for the Program of $28,458,000 and $31,358,000, respectively, is included within due from third-party payors on the accompanying consolidated balance sheets. The net amount includes a receivable for the Program that totaled approximately $43,654,000 and $44,894,000 for the years ended December 31, 2021 and 2020, respectively, offset by accrued fees for the Program that totaled approximately $15,196,000 and $13,536,000 for the years ended December 31, 2021 and 2020, respectively. The Hospital recognized expenses of approximately $16,451,000 and $18,349,000 and revenues of approximately $30,894,000 and $29,800,000 during the years ended December 31, 2021 and 2020, respectively. The Program revenue is included as a component of net patient service revenue in the accompanying consolidated statements of operations.

Note 5 – Self-Insurance

The Hospital self-insures against professional and general liability claims, workers' compensation claims, and certain employee group health and dental benefits. The Hospital purchases claims-made malpractice insurance coverage from a closely held insurance company, of which the Hospital is a 3% shareholder. Commercial insurance has been purchased for losses in excess of the closely held insurance company's coverage limits. The investment in the insurance company of $298,000 is included in other assets and is accounted for under the cost method. If the Hospital decides to cancel or not renew its policy with this insurance company, the Hospital must offer its shares for redemption and the insurance company must purchase the shares at the lower of either the original purchase price paid or the fair market value at the date of sale.

The Hospital's malpractice liability risks vary by accident year, as follows:

Coverage Period	Self-Insured Risks
October 1, 2003 to September 30, 2007	$25,000 per occurrence
October 1, 2007 to December 31, 2021	$50,000 per occurrence

Accruals for uninsured malpractice claims and claims incurred but not reported are actuarially estimated based upon the Hospital's claims experience and are discounted at a 2.25% rate. Liabilities of $2,553,000 and $2,418,000 as of December 31, 2021 and 2020, respectively, have been accrued in the accompanying consolidated balance sheets, included in accrued self-insurance claims reserves. In management's opinion, these accruals are adequate to cover ultimate claims expenses.

The Hospital's workers' compensation risks vary by accident year, as follows:

Coverage Period	Self-Insured Risks
March 1, 2004 to December 31, 2021	$250,000 per occurrence / $2,180,000 in aggregate

Accruals for the self-insured periods for workers' compensation claims and claims incurred but not reported are actuarially estimated based on the Hospital's claims experience and are discounted at a 2.25% rate. Liabilities of $3,861,000 and $4,207,000 as of December 31, 2021 and 2020, respectively, have been accrued in the accompanying consolidated balance sheets, included in accrued self-insurance claims reserves. In management's opinion, these accruals are adequate to cover ultimate claims expenses. As of December 31, 2021 and 2020, the Corporation had standby letters of credit of $1,828,000 and $1,479,000, respectively, available with a bank to collateralize payment of workers' compensation claims.

On January 1, 2017, the Hospital became self-insured against claims for employee group health benefits. The Hospital is self-insured for up to a retention of $250,000 per covered person. Liabilities of $824,000 and $960,000 as of December 31, 2021 and 2020, respectively, have been accrued in the accompanying consolidated balance sheets (included in accrued self-insurance claims reserves).

Note 5 – Self-Insurance (continued)

Total accrued workers' compensation, professional liability, and group health claims reserves and related insurance receivables as of December 31 were as follows:

	2021	
	Assets	Liabilities
	Insurance Receivable	Claims Liabilities
Current portion	$ 607,000	$ 2,070,000
Long-term portion	3,148,000	5,168,000
Total	$ 3,755,000	$ 7,238,000

	2020	
	Assets	Liabilities
	Insurance Receivable	Claims Liabilities
Current portion	$ 898,000	$ 2,547,000
Long-term portion	3,014,000	5,038,000
Total	$ 3,912,000	$ 7,585,000

Note 6 – Assets Limited as to Use

A summary of the limitations as to the use of assets, stated at fair value, consisted of the following as of December 31:

	2021	2020
Pledged deposit held by bank to collateralize outstanding letters of credit	$ 1,828,000	$ 1,479,000
Assets with donor restrictions	1,714,000	1,554,000
	$ 3,542,000	$ 3,033,000

Note 7 – Fair Value Measurement

The Corporation measures and reports the fair value of its financial assets and liabilities in accordance with FASB ASC, *Fair Value Measurements and Disclosures (Topic 820).* Topic 820 defines fair value as the price that would be received to sell an asset or transfer a liability in an orderly transaction between market participants at the measurement date. Topic 820 also establishes a fair value hierarchy which requires an entity to maximize the use of observable inputs and minimize the use of unobservable inputs when measuring fair value. Three levels of inputs that may be used to measure fair value are established.

Level 1 – Quoted prices in active markets for identical assets or liabilities.

Level 2 – Observable inputs other than Level 1 prices, such as quoted prices for similar assets or liabilities; quoted prices in markets that are not active; or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities.

Level 3 – Unobservable inputs that are supported by little or no market activity and that are significant to the fair value of the assets or liabilities.

In determining fair value, the Corporation utilizes valuation techniques that maximize the use of observable inputs and minimize the use of unobservable inputs to the extent possible as well as considers counterparty credit risk in its assessment of fair value.

The following is a description of the valuation methodologies used for instruments measured at fair value.

Certificates of deposit – Valued based on original cost, plus accrued interest which approximates fair value.

Equity securities – Fair value of equity securities has been determined by the Corporation from observable market quotations.

Corporate bonds – Valued using pricing models maximizing the use of observable inputs for similar securities, which includes basing value on yields currently available on comparable securities of issuers with similar credit ratings.

Alternative investments – The alternative investments consist of six funds which are invested in commodities, real estate, and reinsurance. These investments are in mutual fund format and hedge fund strategies.

- Mutual funds – valued at Net Asset Value (NAV) of shares held at year end using prices quoted by relevant pricing agents and are classified within Level 1 of the valuation hierarchy for fair value measurements.

- Hedge funds – valued at NAV using prices quoted by relevant fund managers and are excluded from the valuation hierarchy for fair value measurements.

Note 7 – Fair Value Measurement (continued)

The following tables present the fair value measurements of assets recognized in the accompanying consolidated balance sheets measured at fair value on a recurring basis and the level within the Topic 820 fair value hierarchy in which the fair value measurements fall as of December 31:

	2021		
	Fair Value	Level 1	Level 2
ASSETS			
Assets limited as to use			
Certificates of deposit	$ 1,828,000	$ -	$ 1,828,000
Corporate bonds	432,000	-	432,000
Equity securities	1,140,000	1,140,000	-
	3,400,000	$ 1,140,000	$ 2,260,000
Alternative investments measured using NAV as practical expedient			
Hedge funds	142,000		
	$ 3,542,000		

	2020		
	Fair Value	Level 1	Level 2
ASSETS			
Assets limited as to use			
Certificates of deposit	$ 1,479,000	$ -	$ 1,479,000
Corporate bonds	415,000	-	415,000
Equity securities	987,000	987,000	-
Mutual funds	99,000	99,000	-
	2,980,000	$ 1,086,000	$ 1,894,000
Alternative investments measured using NAV as practical expedient			
Hedge funds	53,000		
	$ 3,033,000		

Note 8 – Property and Equipment

Property and equipment were comprised of the following as of December 31:

	2021	2020
Depreciable assets		
Buildings and land improvements	$ 157,725,000	$ 153,440,000
Equipment	45,530,000	41,931,000
Computer software	15,652,000	15,329,000
	218,907,000	210,700,000
Less: accumulated depreciation and amortization	(129,068,000)	(120,981,000)
	89,839,000	89,719,000
Non-depreciable assets		
Land	8,279,000	8,279,000
Construction-in-progress (cost to complete at December 31, 2021, is approximately $1,875,000)	959,000	1,797,000
	9,238,000	10,076,000
	$ 99,077,000	$ 99,795,000

For the years ended December 31, 2021 and 2020, depreciation and amortization expense amounted to $9,764,000 and $9,454,000, respectively. Of this amount, depreciation and amortization expense from financing leases for the years ended December 31, 2021 and 2020, amounted to $2,350,000 and $2,245,000, respectively. Capitalized cost of equipment under financing lease obligations as of December 31, 2021 and 2020, totaled $21,312,000 and $17,234,000, respectively. Related accumulated amortization on equipment under financing lease obligations as of December 31, 2021 and 2020, totaled $12,153,000 and $9,804,000, respectively.

Note 9 – Revolving Loan and Long-Term Debt

Revolving loan – On August 1, 2019, the Hospital entered into a revolving loan agreement that allows for draws and repayments with a maximum draw of $10,000,000 and a maturity date of January 3, 2024, which classifies the balance as long-term at December 31, 2021. The interest rate is the greater of 1.75% or Prime minus 2%. The amount outstanding as of December 31, 2021 and 2020, was $10,000,000. The interest rate was 1.75% at December 31, 2021.

Note 9 – Revolving Loan and Long-Term Debt (continued)

Long-term debt – On December 2, 2015, the Corporation issued California Statewide Communities Development Authority Revenue Bonds Series 2015 ("2015 Bonds") at the par amount of $39,725,000 with stated fixed interest rates of 4% for maturity dates between 2019 and 2025 and 5% for maturity dates between 2026 and 2045. The 2015 Bonds sold at a premium of $2,043,000, which is being amortized over the life of the bonds using the effective interest rate method. The effective interest rates range between 2.14% and 4.46%. The 2015 Bonds are secured by certain assets of the Corporation. Interest is payable in arrears semi-annually on February 1 and August 1 of each year. As of December 31, 2021 and 2020, the estimated fair value of the 2015 Bonds, based on Level 2 inputs, was $39,465,000 and $37,797,000, respectively.

On May 9, 2017, the Corporation issued California Statewide Communities Development Authority Revenue Bonds Series 2017 ("2017 Bonds") at the par amount of $19,840,000 with stated fixed interest rates ranging from 3% to 5% with maturity dates between 2021 and 2048. The 2017 Bonds sold at a premium of $1,158,000, which is being amortized over the life of the bonds using the effective interest rate method. The effective interest rates range between 2.66% and 4.14%. The 2018 Bonds are secured by certain assets of the Corporation. Interest is payable in arrears semi-annually on May 1 and November 1 of each year. As of December 31, 2021 and 2020, the estimated fair value of the Bonds, based on Level 2 inputs, were $20,983,000 and $19,164,000, respectively.

The 2015 Bonds and the 2017 Bonds require the Corporation to maintain compliance with certain financial and non-financial covenants including the maintenance of day's cash on hand and debt service coverage. As defined in the master indenture agreement, the Corporation agrees to manage its business such that day's cash on hand calculated as of the end of each fiscal year will not be less than 60 days on hand for such fiscal year (the "Consultant Level"). If at the end of any fiscal year day's cash on hand is less than the Consultant Level, the Corporation covenants to retain promptly an Independent Consultant to make recommendations to increase day's cash on hand for the following fiscal year. If the Corporation retains and substantially complies with the recommendations of the independent consultant, the Corporation will be deemed to have complied with the day's cash on hand covenant, provided that day's cash on hand for any fiscal year is not less than 40 days' cash on hand (the "Minimum Level"). Failure to have day's cash on hand as of the end of any fiscal year in amount at least Minimum Level for such fiscal year is an event of default under the master indenture agreement. As of December 31, 2021, the Corporation was above the required Consultant Level for both day's cash on hand and debt service coverage.

On August 13, 2020, the Corporation entered into a loan agreement in the amount of $1,834,000 with an unrelated party to finance the purchase of patient monitors, bearing interest at 6.07% per annum. As of December 31, 2021 and 2020, the equipment loan payable was $1,348,000 and $1,666,000, respectively, and is included in long-term debt in the consolidated balance sheets. With the exception of the first installment payment of $100,000, the Corporation shall pay monthly installments of $34,000, inclusive of principal and interest, through September 1, 2025.

Note 9 – Revolving Loan and Long-Term Debt (continued)

The balance of long-term debt consists of the following as of December 31:

	2021	2020
2015 CSCDA Revenue Bonds	$ 37,365,000	$ 38,185,000
2017 CSCDA Revenue Bonds	19,625,000	19,840,000
Equipment Loan Payable	1,348,000	1,669,000
Total	58,338,000	59,694,000
Add: unamortized premium and less debt issuance costs	1,279,000	1,337,000
Less: current portion	(1,418,000)	(1,354,000)
Long-term debt, net of current portion	$ 58,199,000	$ 59,677,000

Future maturities of long-term debt are as follows:

Years Ending December 31,	
2022	$ 1,418,000
2023	1,485,000
2024	1,552,000
2025	1,488,000
2026	1,270,000
Thereafter	51,125,000
	$ 58,338,000

Note 10 – Net Assets with Donor Restrictions

Net assets with donor restrictions are available for the purpose of nursing education and for the purchase of equipment.

As of December 31, 2021 and 2020, net assets were released from donor restrictions by satisfying the restricted purpose of nursing education, construction, and equipment in the amount of $190,000 and $450,000, respectively.

As of December 31, 2021 and 2020, approximately $1,137,000 of the net assets with donor restrictions are to be held in perpetuity, the income from which is expendable to support unrestricted purposes (see Note 11).

Note 11 – Endowment

Interpretation of relevant law – The Board of Directors has interpreted the California Prudent Management of Institutional Funds Act (CPMIFA) as requiring the preservation of the fair value of the original gift as of the date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. As a result of this interpretation, the Foundation has classified as permanently restricted net assets (1) the original value of gifts donated to the permanent endowment, (2) the original value of subsequent gifts to the permanent endowment, and (3) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. Donor-restricted endowment income and accumulated gains are classified as net assets with donor restrictions until those amounts are appropriated for expenditure by the Foundation in a manner consistent with the standard of prudence prescribed by CPMIFA.

In accordance with CPMIFA, the Foundation considers the following factors in making a determination to appropriate or accumulate endowment funds:

- The duration and preservation of the fund
- The purpose of the Foundation's donor-restricted endowment fund
- General economic conditions
- The possible effect of inflation and deflation
- The expected total return from income and the appreciation of investments
- Other Foundation resources
- The investment policies of the Foundation

Return objectives and risk parameters – The Foundation has adopted investment and spending policies for endowment assets that attempt to provide a predictable stream of funding to programs supported by its endowment while seeking to maintain the purchasing power of the endowment assets. Endowment assets include those assets of donor-restricted funds that the Foundation must hold in perpetuity or for a donor-specified period(s). Under this policy, as approved by the Board of Directors, the endowment assets are invested in a manner that is intended to produce results that exceed inflation and a custom benchmark composed of a benchmark for each asset class, while assuming a low level of investment risk.

Strategies employed for achieving objectives – To satisfy its long-term rate-of-return objectives, the Foundation relies on a total return strategy in which investment returns are achieved through both capital appreciation, realized and unrealized, and current yield, interest and dividends. The Foundation targets a diversified asset allocation that places a greater emphasis on equity-based investments to achieve its long-term return objectives within prudent risk constraints.

Spending policy and how investment objectives relate to spending policy – The Foundation has a policy of spending all investment earnings each year, as recommended by the Board of Directors, and under no circumstances should any fund's market value fall below its corpus value or as specified by donor instructions. In establishing this policy, the Foundation considered the long-term expected return on its endowment.

Note 11 – Endowment (continued)

Endowment funds with deficits – Endowment funds with deficits are fair value of assets associated with individual donor-restricted endowment funds that fall below the value of the initial and subsequent donor gift amounts. When donor endowment deficits exist, they are classified as a reduction of net assets without donor restriction. There were no funds with deficits at December 31, 2021 and 2020. Per the terms of the agreement, these funds are to be invested with the income to be used as follows:

Catherine P. and George R. Hensel endowment fund – Per the terms of the agreement, these funds are to be invested and all income generated will be unrestricted and used to further the charitable health care purposes of the Hospital.

Changes in endowment net assets are as follows:

Balance at December 31, 2019	$	1,000,000
Investment income		24,000
Additions		137,000
Net realized and unrealized investment gains		330,000
Appropriation of endowment assets for expenditure		(354,000)
Balance at December 31, 2020		1,137,000
Investment income		29,000
Additions		-
Net realized and unrealized investment gains		141,000
Appropriation of endowment assets for expenditure		(170,000)
Balance at December 31, 2021	$	1,137,000

Note 12 – Seismic Regulation

The California Hospital Facilities Safety Act (SB 1953) specifies certain requirements that must be met at various dates in order to increase the probability that hospitals could maintain uninterrupted operations following major earthquakes. By January 1, 2013, all general acute care buildings must be life safe. In June 2012, the California Legislative passed Senate Bill 90 (SB 90). SB 90 provides for further extension of the January 1, 2013 deadline for achieving compliance for up to seventeen years. The Hospital has filed applications for SB 90 extensions. By January 1, 2030, all general acute care inpatient buildings must be operational after an earthquake. Management believes that the Hospital will be in compliance with the requirements of SB 1953.

Note 12 – Seismic Regulation (continued)

These upgrades may include asbestos abatement, which is an asset retirement obligation (ARO). ASC 410-20-25 requires an entity to recognize a liability for the fair value of conditional asset retirement obligations if the fair value of the liability can be reasonably estimated. The fair value of a liability for conditional ARO must be recognized when incurred, generally upon acquisition, construction, or development and/or through the normal operation of the asset. The Corporation is currently evaluating its renovation and replacement need for the Hospital to comply with California's seismic safety standards. Because the Corporation's plans for renovation are not complete and the date and amounts for which the ARO could be settled are unknown, the Corporation concluded that it could not reasonably estimate the fair value of a liability, and no liability has been recorded. However, the Corporation may record a liability in a future period in which the fair value can be reasonably estimated.

Note 13 – Leases

The following table presents the Corporation's lease-related assets and liabilities as of December 31:

Component of Lease Balance	Consolidated Balance Sheets Classification	2021	2020
Assets			
Operating leases	Property and equipment, net	$ 590,000	$ 827,000
Finance leases	Property and equipment, net	9,159,000	7,430,000
Total lease assets		$ 9,749,000	$ 8,257,000
Current liabilities			
Operating leases	Current maturities lease obligations	$ 370,000	$ 498,000
Finance leases	Current maturities lease obligations	2,438,000	2,424,000
		2,808,000	2,922,000
Non current liabilities			
Operating leases	Lease obligations, less current maturities	417,000	594,000
Finance leases	Lease obligations, less current maturities	5,129,000	4,425,000
		5,546,000	5,019,000
Total lease liabilities		$ 8,354,000	$ 7,941,000

Note 13 – Leases (continued)

The following table presents certain information related to lease expense for finance and operating leases for the year ended December 31:

Component of Lease Expense	Consolidated Statements of Operations Classification	2021	2020
Finance lease expense			
Amortization of leased assets	Depreciation and amortization	$ 2,350,000	$ 2,245,000
Interest on leased assets	Interest expense	361,000	258,000
Total finance lease expense		2,711,000	2,503,000
Operating lease expense	Rentals expense	1,520,000	2,796,000
Variable and short-term lease expense	Rentals expense	886,000	1,116,000
Total rental expense		2,406,000	3,912,000
Total lease expense		$ 5,117,000	$ 6,415,000

As of December 31, 2021, future minimum lease payments under non-cancelable operating leases (with an initial or remaining lease term in excess of one year) and future minimum finance lease payments are as follows:

	Finance Leases	Operating Leases	Total
Years Ending December 31,			
2022	$ 2,676,000	$ 383,000	$ 3,059,000
2023	1,930,000	239,000	2,169,000
2024	1,771,000	215,000	1,986,000
2025	1,154,000	-	1,154,000
2026	525,000	-	525,000
Thereafter	98,000	-	98,000
Total minimum lease payments	8,154,000	837,000	8,991,000
Less: imputed interest	587,000	50,000	637,000
Total lease obligations	7,567,000	787,000	8,354,000
Less: current obligations under leases	2,438,000	370,000	2,808,000
Long-term lease obligations	$ 5,129,000	$ 417,000	$ 5,546,000
Weighted-average remaining lease term (in years)	3.61	2.52	
Weighted-average discount rate	4.02%	3.50%	

Note 13 – Leases (continued)

During the years ended December 31, 2021 and 2020, the Hospital had the following cash and noncash activities associated with the leases:

	2021	2020
Cash paid for amounts included in the measurement of lease liabilties		
Operating cash flows from operating leases	$ 1,520,000	$ 2,796,000
Operating cash flows from finance leases	361,000	258,000
Financing cash flows from finance leases	2,791,000	2,149,000
ROU assets obtained in exchange for new operating lease liabilties	-	-
ROU assets obtained in exchange for new finance lease liabilties	3,508,000	2,537,000

Note 14 – Retirement Plans

The Corporation has a Defined Contribution Retirement Plan that meets the requirements of Section 401(a) of the Internal Revenue Code. Contributions to the plan were made solely by the Corporation based on a specified percentage of the participants' annual compensation. The Corporation notified its employees in October 2006 that the defined contribution retirement plan would be frozen as of December 31, 2006. On December 11, 2006, the Corporation adopted a Matching Savings Plan, effective on April 1, 2007. This plan is intended to meet the requirements of Section 403(b) of the Internal Revenue Code. The Corporation may match 100% of the first 3% of an employee's base salary. The Corporation began matching 25% of the first 3% of employee's base salary at January 1, 2017. Eligible employees can begin salary deferrals immediately upon becoming an employee and begin receiving any matching contribution after a period of 12 consecutive months during which an employee has at least 1,000 hours of qualifying service. Contribution expense for the plan for the years ended December 31, 2021 and 2020, was approximately $335,000 and $289,000, respectively, and is included in salaries and employee benefits on the consolidated statements of operations.

Note 15 – Expenses

Expenses by function and nature consist of the following for the year ended December 31, 2021:

	Healthcare Services	Management and General	Total
Salaries and employee benefits	$ 60,451,000	$ 12,834,000	$ 73,285,000
Supplies	22,265,000	209,000	22,474,000
Capitated medical services	17,154,000	1,417,000	18,571,000
Quality assurance fee	16,451,000	-	16,451,000
Other purchased services	9,068,000	5,668,000	14,736,000
Professional fees	11,256,000	1,455,000	12,711,000
Depreciation and amortization	2,525,000	7,239,000	9,764,000
Interest	-	3,073,000	3,073,000
Utilities	-	2,599,000	2,599,000
Rentals	2,007,000	399,000	2,406,000
Insurance	246,000	1,940,000	2,186,000
Other	313,000	1,738,000	2,051,000
Total operating expenses	$ 141,736,000	$ 38,571,000	$ 180,307,000

Expenses by function and nature consist of the following for the year ended December 31, 2020:

	Healthcare Services	Management and General	Total
Salaries and benefits	$ 57,102,000	$ 14,324,000	$ 71,426,000
Supplies	21,694,000	144,000	21,838,000
Capitated medical services	22,705,000	1,698,000	24,403,000
Quality assurance fee	18,349,000	-	18,349,000
Other purchased services	10,302,000	5,263,000	15,565,000
Professional fees	8,600,000	1,630,000	10,230,000
Depreciation and amortization	2,285,000	7,169,000	9,454,000
Interest	-	3,086,000	3,086,000
Utilities	-	2,375,000	2,375,000
Rentals	2,819,000	1,093,000	3,912,000
Insurance	154,000	2,272,000	2,426,000
Other	333,000	1,303,000	1,636,000
Total operating expenses	$ 144,343,000	$ 40,357,000	$ 184,700,000

Note 16 – Union Contract

The Hospital has a contract with the United Nurses Associations of California/Union of Health Care Professionals; National Union of Hospital and Health Care Employees; American Federation of State, County and Municipal Employees; and American Federation of Labor and Congress of Industrial Organizations to represent all regular full-time, part-time, and per diem non-management registered nurses employed at the Hospital as their union representative. Negotiations for a contract between management and the bargaining unit were completed and ratified by both the union and the Board of Directors of the Hospital in February 2022. The union contract expires on April 30, 2025.

Note 17 – COVID-19 Pandemic Impact

During 2020, the World Health Organization declared the novel coronavirus (COVID-19) outbreak a public health emergency. The COVID-19 outbreak in the United States resulted in a temporary suspension of non-urgent elective surgeries at various times during 2020 due to government mandate.

During 2021 and 2020, the Corporation received a payment of approximately $798,000 and $12,396,000, respectively, through the Coronavirus Aid, Relief, and Economic Security Act (“CARES Act”) Provider Relief Fund (PRF). The United States Senate passed the CARES Act in March 2020 and it included a relief fund for hospitals and other health care providers on the front lines of the coronavirus response. This funding is used to support health care-related expenses or lost revenue attributable to COVID-19 and to ensure uninsured Americans can get testing and treatment for COVID-19. The Corporation was required to sign attestations agreeing to the terms and conditions prior to receiving the funds. Documentation is required to ensure that these funds are to be used for health care-related expenses or lost revenue attributable to COVID-19, limitations of out-of-pocket payments from certain patients, and the acceptance of several other reporting and compliance requirements. The U.S. Department of Health and Human Services (HHS) and the Office of the Inspector General will monitor and audit the compliance requirements. HHS may issue more specific guidance in the future on how the funding is used, which may result in modification to management's estimates in the future. Based on the current guidance, the Corporation has recognized approximately $798,000 and $12,396,000 of the grant revenue received in the consolidated statements of operations during the years ended December 31, 2021 and 2020, respectively.

In April 2020, the Corporation received an advance payment for future services to be provided to Medicare patients of approximately $14,973,000 through the Accelerated and Advance Payment Program. CMS expanded their current Accelerated and Advance Payment Program to increase cash flow to providers of services and suppliers impacted by the COVID-19 pandemic. There is no repayment requirement for the first 12 months of receipt. From months 13 through 23, Medicare will automatically recoup 25% of the Medicare payments. From months 24 through 29, Medicare will automatically recoup 50% of the Medicare payments. If the loan has not been fully paid off after the 29th month, Medicare will issue a demand letter to request payment for the remaining balance and will need to be paid 30 days from the date of the letter. Recouped amounts totaled $4,048,000 for the year ending December 31, 2021. The Corporation recorded approximately $10,925,000 as current and $0 as long-term liability in the consolidated balance sheets as of December 31, 2021, and approximately $4,795,000 as current and $10,178,000 as long-term liability in the consolidated balance sheets as of December 31, 2020.

Note 17 – COVID-19 Pandemic Impact (continued)

During February 2021, the Corporation received assistance from the U.S. Army Corps of Engineers to expand patient care during patient surges in response to the COVID-19 pandemic. Construction commenced in February 2021 and was completed in March 2021. The costs associated with the construction are paid for by California Governor's Office of Emergency Services. The maintenance, operation, and any potential deconstruction costs are the responsibility of the Corporation. Management determined that the estimated fair value of the assistance received was approximately $3,019,000 and recorded the amount as in-kind contributions on the consolidated statement of operation for the year ended December 31, 2021.

Supplementary Information

Beverly Community Hospital Association
Consolidating Balance Sheet
December 31, 2021

ASSETS

	Hospital	MCHS	Foundation	Eliminations	Consolidated
CURRENT ASSETS					
Cash and cash equivalents	$ 41,737,000	$ 2,070,000	$ 510,000	$ -	$ 44,317,000
Patient accounts receivable	19,469,000	-	-	-	19,469,000
Due from third-party payors, current	19,243,000	-	-	-	19,243,000
Due from affiliates	3,362,000	3,647,000	34,000	(7,043,000)	-
Inventories of drugs and supplies	3,244,000	-	-	-	3,244,000
Prepaid expenses and other assets	2,198,000	208,000	1,075,000	-	3,481,000
Total current assets	89,253,000	5,925,000	1,619,000	(7,043,000)	89,754,000
DUE FROM THIRD-PARTY PAYORS, less current portion	12,415,000	-	-	-	12,415,000
ASSETS LIMITED AS TO USE	1,828,000	-	1,714,000	-	3,542,000
PROPERTY AND EQUIPMENT, net	90,830,000	8,247,000	-	-	99,077,000
BENEFICIAL INTEREST IN FOUNDATION	3,333,000	-	-	(3,333,000)	-
OTHER ASSETS	8,246,000	-	-	-	8,246,000
	$ 205,905,000	$ 14,172,000	$ 3,333,000	$ (10,376,000)	$ 213,034,000

See report of independent auditors.

LIABILITIES AND NET ASSETS

	Hospital	MCHS	Foundation	Eliminations	Consolidated
CURRENT LIABILITIES					
Accounts payable	$ 11,315,000	$ -	$ -	$ -	$ 11,315,000
Accrued expenses and other liabilities	8,475,000	176,000	-	-	8,651,000
Medical claims liabilities	4,562,000	-	-	-	4,562,000
Shared risk liability	8,011,000	-	-	-	8,011,000
Due to affiliates	3,696,000	3,347,000	-	(7,043,000)	-
Current portion of accrued self-insurance claims reserves	2,070,000	-	-	-	2,070,000
Medicare advance payment	10,925,000	-	-	-	10,925,000
Current maturities of long-term debt	1,418,000	-	-	-	1,418,000
Current maturities of lease obligations	2,808,000	-	-	-	2,808,000
Total current liabilities	53,280,000	3,523,000	-	(7,043,000)	49,760,000
ACCRUED SELF-INSURANCE CLAIMS RESERVES, less current portion	5,168,000	-	-	-	5,168,000
REVOLVING LOAN	10,000,000	-	-	-	10,000,000
LONG-TERM DEBT, net	58,199,000	-	-	-	58,199,000
LEASE OBLIGATIONS, less current maturities	5,546,000	-	-	-	5,546,000
Total liabilities	132,193,000	3,523,000	-	(7,043,000)	128,673,000
NET ASSETS					
Without donor restrictions	73,712,000	10,649,000	1,619,000	(3,333,000)	82,647,000
With donor restrictions	-	-	1,714,000	-	1,714,000
Total net assets	73,712,000	10,649,000	3,333,000	(3,333,000)	84,361,000
	$ 205,905,000	$ 14,172,000	$ 3,333,000	$ (10,376,000)	$ 213,034,000

Beverly Community Hospital Association
Consolidating Balance Sheet (Continued)
December 31, 2020

ASSETS

	Hospital	MCHS	Foundation	Eliminations	Consolidated
CURRENT ASSETS					
Cash and cash equivalents	$ 40,752,000	$ 1,781,000	$ 838,000	$ -	$ 43,371,000
Patient accounts receivable	21,371,000	-	-	-	21,371,000
Due from third-party payors, current	21,530,000	-	-	-	21,530,000
Due from affiliates	3,782,000	3,833,000	-	(7,615,000)	-
Inventories of drugs and supplies	3,548,000	-	-	-	3,548,000
Prepaid expenses and other assets	2,641,000	166,000	279,000	-	3,086,000
Total current assets	93,624,000	5,780,000	1,117,000	(7,615,000)	92,906,000
DUE FROM THIRD-PARTY PAYORS, less current portion	12,822,000	-	-	-	12,822,000
ASSETS LIMITED AS TO USE	1,479,000	-	1,554,000	-	3,033,000
PROPERTY AND EQUIPMENT, net	91,710,000	8,085,000	-	-	99,795,000
BENEFICIAL INTEREST IN FOUNDATION	2,767,000	-	-	(2,767,000)	-
OTHER ASSETS	7,488,000	-	450,000	-	7,938,000
	$ 209,890,000	$ 13,865,000	$ 3,121,000	$ (10,382,000)	$ 216,494,000

See report of independent auditors.

LIABILITIES AND NET ASSETS

	Hospital	MCHS	Foundation	Eliminations	Consolidated
CURRENT LIABILITIES					
Accounts payable	$ 8,850,000	$ -	$ -	$ -	$ 8,850,000
Accrued expenses and other liabilities	9,038,000	109,000	-	-	9,147,000
Medical claims liabilities	5,101,000	-	-	-	5,101,000
Shared risk liability	2,810,000	-	-	-	2,810,000
Due to affiliates	3,833,000	3,428,000	354,000	(7,615,000)	-
Current portion of accrued self-insurance claims reserves	2,547,000	-	-	-	2,547,000
Current portion of Medicare advance payment	4,795,000	-	-	-	4,795,000
Current maturities of long-term debt	1,354,000	-	-	-	1,354,000
Current maturities of lease obligations	2,922,000	-	-	-	2,922,000
Total current liabilities	41,250,000	3,537,000	354,000	(7,615,000)	37,526,000
OTHER LONG-TERM LIABILITIES	1,176,000	-	-	-	1,176,000
ACCRUED SELF-INSURANCE CLAIMS RESERVES, less current portion	5,038,000	-	-	-	5,038,000
MEDICARE ADVANCE PAYMENT, less current portion	10,178,000	-	-	-	10,178,000
REVOLVING LOAN	10,000,000	-	-	-	10,000,000
LONG-TERM DEBT, net	59,677,000	-	-	-	59,677,000
LEASE OBLIGATIONS, less current maturities	5,019,000	-	-	-	5,019,000
Total liabilities	132,338,000	3,537,000	354,000	(7,615,000)	128,614,000
NET ASSETS					
Without donor restrictions	77,552,000	10,328,000	1,213,000	(2,767,000)	86,326,000
With donor restrictions	-	-	1,554,000	-	1,554,000
Total net assets	77,552,000	10,328,000	2,767,000	(2,767,000)	87,880,000
	$ 209,890,000	$ 13,865,000	$ 3,121,000	$ (10,382,000)	$ 216,494,000

See report of independent auditors.

Beverly Community Hospital Association
Consolidating Statement of Operations
Year Ended December 31, 2021

	Hospital	MCHS	Foundation	Eliminations	Consolidated
UNRESTRICTED REVENUES, GAINS, AND OTHER SUPPORT					
Net patient service revenue	$ 145,515,000	$ -	$ -	$ -	$ 145,515,000
Premium revenue	24,204,000	-	-	-	24,204,000
Beneficial interest in Foundation	566,000	-	-	(566,000)	-
In-kind contributions	3,019,000	-	-	-	3,019,000
Grant revenue - Provider Relief Funds	798,000	-	-	-	798,000
Other operating revenue	1,131,000	1,657,000	641,000	(527,000)	2,902,000
Net assets released from restrictions	-	-	190,000	-	190,000
Total unrestricted revenues, gains, and other support	175,233,000	1,657,000	831,000	(1,093,000)	176,628,000
EXPENSES					
Salaries and employee benefits	73,101,000	-	184,000	-	73,285,000
Supplies	22,459,000	15,000	-	-	22,474,000
Capitated medical services	18,571,000	-	-	-	18,571,000
Quality assurance fee	16,451,000	-	-	-	16,451,000
Other purchased services	14,386,000	323,000	27,000	-	14,736,000
Professional fees	12,693,000	18,000	-	-	12,711,000
Depreciation and amortization	9,561,000	203,000	-	-	9,764,000
Interest	3,073,000	-	-	-	3,073,000
Utilities	2,328,000	271,000	-	-	2,599,000
Rentals	2,620,000	123,000	-	(337,000)	2,406,000
Insurance	1,950,000	236,000	-	-	2,186,000
Other	1,880,000	147,000	24,000	-	2,051,000
Program support	-	-	190,000	(190,000)	-
Total expenses	179,073,000	1,336,000	425,000	(527,000)	180,307,000
(Deficiency) excess of revenues over expenses	(3,840,000)	321,000	406,000	(566,000)	(3,679,000)
NET ASSETS WITHOUT DONOR RESTRICTIONS, beginning of year	77,552,000	10,328,000	1,213,000	(2,767,000)	86,326,000
NET ASSETS WITHOUT DONOR RESTRICTIONS, end of year	$ 73,712,000	$ 10,649,000	$ 1,619,000	$ (3,333,000)	$ 82,647,000

See report of independent auditors.

Beverly Community Hospital Association
Consolidating Statement of Operations
Year Ended December 31, 2020

	Hospital	MCHS	Foundation	Eliminations	Consolidated
UNRESTRICTED REVENUES, GAINS, AND OTHER SUPPORT					
Net patient service revenue	$ 138,743,000	$ -	$ -	$ -	$ 138,743,000
Premium revenue	27,248,000	-	-	-	27,248,000
Beneficial interest in Foundation	58,000	-	-	(58,000)	-
Grant revenue – Provider Relief Funds	12,396,000	-	-	-	12,396,000
Other operating revenue	1,577,000	1,551,000	398,000	(910,000)	2,616,000
Net assets released from restrictions	-	-	450,000	-	450,000
Total unrestricted revenues, gains, and other support	180,022,000	1,551,000	848,000	(968,000)	181,453,000
EXPENSES					
Salaries and employee benefits	71,247,000	-	179,000	-	71,426,000
Supplies	21,832,000	6,000	-	-	21,838,000
Capitated medical services	24,403,000	-	-	-	24,403,000
Quality assurance fee	18,349,000	-	-	-	18,349,000
Other purchased services	15,119,000	409,000	37,000	-	15,565,000
Professional fees	10,209,000	21,000	-	-	10,230,000
Depreciation and amortization	9,259,000	195,000	-	-	9,454,000
Interest	3,086,000	-	-	-	3,086,000
Utilities	2,150,000	225,000	-	-	2,375,000
Rentals	4,011,000	112,000	-	(211,000)	3,912,000
Insurance	2,183,000	243,000	-	-	2,426,000
Other	1,531,000	104,000	1,000	-	1,636,000
Program support	-	-	700,000	(700,000)	-
Total expenses	183,379,000	1,315,000	917,000	(911,000)	184,700,000
(Deficiency) excess of revenues over expenses	(3,357,000)	236,000	(69,000)	(57,000)	(3,247,000)
NET ASSETS WITHOUT DONOR RESTRICTIONS, beginning of year	80,909,000	10,092,000	1,282,000	(2,710,000)	89,573,000
NET ASSETS WITHOUT DONOR RESTRICTIONS, end of year	$ 77,552,000	$ 10,328,000	$ 1,213,000	$ (2,767,000)	$ 86,326,000

See report of independent auditors.

EXHIBIT 30

BEVERLY'S UNAUDITED FINANCIAL STATEMENTS (MONTHS ENDING AUGUST 31, 2022)

Beverly Community Hospital Association

Consolidating Balance Sheet

31-Aug-22

	Hospital	MCHS	Foundation	Eliminations	Consolidated
Assets					
Current assets:					
Cash and cash equivalents	21,614,686	631,878	710,772	-	22,957,336
Patient accounts receivable, net	18,730,927		-	-	18,730,927
Due from third-party payors	31,196,244		-	-	31,196,244
Due from affiliates	3,410,029	5,019,617	-	(8,429,646)	-
Inventories of drugs and supplies	3,074,632		-	-	3,074,632
Prepaid expenses and other assets	2,437,915	259,149	-	-	2,697,064
Total current assets	80,464,433	5,910,644	710,772	(8,429,646)	78,656,203
Other assets:					
Assets limited as to use	2,129,208	-	1,417,519	-	3,546,727
Property and equipment, net	89,351,733	8,416,588	-	-	97,768,321
Beneficial interest in Foundation	2,636,608	-	-	(2,636,608)	-
Other assets	8,874,586	3	601,272	-	9,475,861
Total assets	183,456,568	14,327,236	2,729,563	(11,066,254)	189,447,112
Liabilities and net assets					
Current liabilities:					
Accounts payable	14,623,599			(6,288)	14,617,311
Accrued expenses and other liabilities	7,577,574	194,139	-	-	7,771,712
Medical claims liabilities	6,185,852				6,185,852
Shared risk liability	3,306,926				3,306,926
Due to affiliates	5,019,572	3,310,832	92,955	(8,423,359)	-
Current portion of accrued self-insurance claims reserves	2,280,975	-	-	-	2,280,975
Current portion of medicare advance payment	5,164,507				5,164,507
Revolving lines of credit	-	-			-
Current maturities of long-term debt	1,688,445	-	-	-	1,688,445
Current maturities of lease obligations	2,402,825	-			2,402,825
Total current liabilities	48,250,274	3,504,971	92,955	(8,429,647)	43,418,553
Other long term liabilities	-				-
medicare advance payment, less current portion	-				-
Long-term debt, less current maturities	56,823,778	-	-	-	56,823,778
Revolving Loan	9,500,000				9,500,000
lease obligations, less current maturities	7,268,772	-	-	-	7,268,772
Accrued self-insurance claims less current portion	5,493,774	-	-	-	5,493,774
Net assets:					
Unrestricted	56,119,970	10,822,265	1,219,090	(2,636,607)	65,524,718
Temporarily restricted	-	-	280,318	-	280,318
Permanently restricted	-	-	1,137,200	-	1,137,200
Total net assets	56,119,970	10,822,265	2,636,608	(2,636,607)	66,942,236
Total liabilities and net assets	183,456,568	14,327,236	2,729,563	(11,066,254)	189,447,113

Beverly Community Hospital Association

Consolidating Statement of Operations

8 months ending
31-Aug-22

	Hospital	MCHS	Foundation	Eliminations	Consolidated
Unrestricted revenues, gains and other suppor:					
Net patient service revenue	$ 107,859,418	$ –	$ –	$ –	$ 107,859,418
Provision for bad debts	(15,687,893)	–	–	–	(15,687,893)
Net patient service revenue less provision for bad debts	92,171,525	–	–	–	92,171,525
Premium revenue	16,620,995	–	–	-	16,620,995
Beneficial interest in Foundation	(696,450)	–	–	696,450	–
Other operating revenue	717,734	1,069,517	(262,023)	(650,533)	874,695
Net assets released from restrictions	–	–	427,476		427,476
Total unrestricted revenues, gains and other suppor	108,813,804	1,069,517	165,453	45,917	110,094,691
Expenses:					
Salaries and employee benefits	49,932,032	(4,790)	115,837	-	50,043,079
Professional fees	14,635,540	15,875	–	-	14,651,415
Supplies and other	13,815,653	5,048	1,837	-	13,822,538
Capitated medical services	14,124,749		–	-	14,124,749
Other purchased services	9,685,609	228,091	26,655	-	9,940,355
Utilities	1,486,065	220,301	–	-	1,706,366
Insurance	1,312,970	173,236	–	-	1,486,206
Rentals	1,007,787	80,104	–	(223,057)	864,834
Depreciation and amortization	6,679,164	138,735	–	-	6,817,899
Interest	2,151,186	–	–	–	2,151,186
Program support	–	–	427,476	(427,476)	–
Quality assurance fee	10,128,256	–	–	–	10,128,256
Other	1,446,786	27,279	(7,708)	–	1,466,357
Total expenses	126,405,797	883,880	564,096	(650,533)	127,203,241
Excess of (expenses over revenues) revenues over expenses	(17,591,993)	185,636	(398,643)	696,450	(17,108,550)
Transfers from (to) affiliates, net	–	–	–	–	–
Increase (decrease) in unrestricted net assets	(17,591,993)	185,636	(398,643)	696,450	(17,108,550)
Unrestricted net assets (deficit) at December 31, 2021	73,711,963	10,636,629	1,617,733	(3,333,057)	82,633,268
Unrestricted net assets (deficit) at August 31, 2022	$ 56,119,970	$ 10,822,265	$ 1,219,090	$ (2,636,607)	$ 65,524,718

EXHIBIT 31

BEVERLY'S BUSINESS PROJECTIONS (2023)

Beverly Community Hospital Association
Income and Expense Statement
Forecast Year 2023

	2023 Forecast
Adult Occupancy %	40.0%
Adult Patient Days	32,664
Inpatient Revenue	$320,400,404
Outpatient Revenue	$227,001,458
Gross Patient Revenue	$547,401,862
	79.9%
Contractual Allowances	$412,237,252
Provision for Bad Debts	$25,179,068
	$437,416,320
Total Net Patient Revenue FFS	$109,985,541
Other Revenue	
Medi-Cal DSH	$6,233,357
Hospital Fee Revenue	$31,716,404
Hospital Fee Expense	$16,566,342
Net	$21,383,419
Capitation Revenue	
Premium Revenue	$18,698,619
Purchased Services	$15,890,340
Net Capitation Revenue	$2,808,279
Other Revenue	
Total Other Revenue	$577,062
Total Operating Revenue	$134,754,301
Operating Expense	
Salaries	$61,130,728
Employment Benefits	$16,763,234
Registry	$13,322,984
Gross Salaries & Wages	$91,216,946
Supplies	$22,795,827
Prof Fees - Physicians	$6,259,998
Prof Fees - Legal, Audit, Consulting	$3,027,604
Purchased Services	$14,825,430
Bldg & Equip Rent/Leases	$1,662,850
Utilities -Elec, Gas, Water, Phone	$2,685,461
Insurance Expense	$2,166,401
Travel & Outside Training	$4,019
Other Expenses	$1,248,944
Total Operating Expense	$145,893,479
EBIDA	($11,139,178)
Depreciation	$10,519,682
Interest Expense	$3,710,794
Total Non Operating Expense	$14,230,476
Net Income or (Loss)	($25,369,653)

11 Cal. Code Reg. Section 999.5(d)(11)(G)

Any requests for opinions to the Internal Revenue Service for rulings attendant to this transaction and any Internal Revenue Service responses thereto

The Beverly Entities have not submitted any requests to the Internal Revenue Service for rulings related to the Affiliation.

11 Cal. Code Reg. Section 999.5(d)(11)(H)

Pro forma post-transaction balance sheet for the surviving or successor nonprofit corporation

The proposed transaction does not involve any sale, transfer or other disposition of any of the assets of either Beverly Entity, but rather only involves an Affiliation between the Beverly Entities and Adventist Health under which Adventist Health will become the sole member or sole controlling entity of each Beverly Entity. All cash, cash equivalents, and investments held by the Beverly Entities will continue to be held by the Beverly Entities for uses that benefit the local area as of the Closing of the Affiliation. Therefore, there is no anticipated change to the pro forma balance sheets of the Beverly Entities as a result of the Affiliation.