

In the opinion of Orrick, Herrington & Sutcliffe LLP, Bond Counsel to the Authority, based upon an analysis of existing laws, regulations, rulings and court decisions, and assuming, among other matters, the accuracy of certain representations and compliance with certain covenants, interest on the Bonds is excluded from gross income for federal income tax purposes under Section 103 of the Internal Revenue Code of 1986 and is exempt from State of California personal income taxes. In the further opinion of Bond Counsel, interest on the Bonds is not a specific preference item for purposes of the federal individual or corporate alternative minimum taxes, although Bond Counsel observes that such interest is included in adjusted current earnings when calculating corporate alternative minimum taxable income. Bond Counsel expresses no opinion regarding any other tax consequences relating to the ownership or disposition of, or the accrual or receipt of interest on, the Bonds. See “TAX MATTERS” herein.

**\$77,710,000**

**ABAG FINANCE AUTHORITY FOR NONPROFIT CORPORATIONS**

**Revenue Bonds  
(Sharp HealthCare),  
Series 2011A**



**Dated: Date of Delivery**

**Due: August 1, as set forth below**

The Series 2011A Bonds (the “Bonds”) of the ABAG Finance Authority for Nonprofit Corporations (the “Authority”) are issuable as fully registered bonds without coupons in denominations of \$5,000 and any integral multiple thereof, and, when issued, will be registered in the name of Cede & Co., as nominee of The Depository Trust Company, New York, New York (“DTC”). DTC will act as securities depository of the Bonds. Purchases will be made only in book-entry form through the DTC’s participants, and no physical delivery of the Bonds will be made to beneficial owners except as described herein. Payments of principal, interest and premium, if any, will be made to beneficial owners by DTC through its participants. So long as Cede & Co. is the registered owner, as nominee of DTC, references herein to the Bondholders or registered owners shall mean Cede & Co., as aforesaid, and shall not mean the beneficial owners of the Bonds. The principal of and premium, if any, and interest on the Bonds will be paid by U.S. Bank National Association, as bond trustee (the “Bond Trustee”) for the Bonds, to Cede & Co., as long as Cede & Co. is the registered owner, from funds on deposit under a Bond Indenture dated as of February 1, 2011 (the “Bond Indenture”), between the Authority and the Bond Trustee. Disbursement of such payments to the participants is the responsibility of DTC and disbursement of such payments to the beneficial owners is the responsibility of the participants, as more fully described herein. Interest is payable by the Bond Trustee on each February 1 and August 1 beginning August 1, 2011, to the registered owner thereof as of the applicable Record Date, as herein described, which payments shall, as long as the book-entry system described herein is in place, be made to Cede & Co. See “Appendix E” attached hereto.

The Bonds are limited obligations of the Authority, secured under the provisions of the Bond Indenture and the Loan Agreement, as described herein, and are payable from Loan Repayments made by Sharp HealthCare (the “Corporation”) under the Loan Agreement; from certain funds held under the Bond Indenture; and from payments on an Obligation (the “Series 2011A Obligation”) issued under the Master Indenture, described herein, whereunder the members of the Obligated Group (the “Obligated Group”) are obligated to make payments on the Series 2011A Obligation in amounts sufficient to pay principal of and premium, if any, and interest on the Bonds when due.

THE BONDS ARE SUBJECT TO OPTIONAL, SPECIAL AND MANDATORY REDEMPTION PRIOR TO MATURITY, AS DESCRIBED IN THIS OFFICIAL STATEMENT.

**MATURITIES, AMOUNTS, INTEREST RATES, YIELDS, PRICES AND CUSIPs**

<b>Maturity Date (August 1)</b>	<b>Principal Amount</b>	<b>Interest Rate</b>	<b>Yield</b>	<b>Price</b>	<b>CUSIP</b>
2014	\$2,985,000	3.500%	2.780%	102.368%	00037CQX1
2015	4,655,000	4.000	3.240	103.141	00037CQY9
2016	4,765,000	5.000	3.530	107.259	00037CQZ6
2017	5,065,000	5.000	3.790	106.888	00037CRA0
2018	5,345,000	5.000	4.150	105.413	00037CRB8
2019	160,000	4.375	4.440	99.543	00037CRC6
2020	245,000	4.625	4.720	99.279	00037CRD4
2022	3,435,000	5.000	5.150	98.710	00037CRE2
2023	3,990,000	5.250	5.320	99.366	00037CRF9
2024	4,400,000	5.250	5.480	97.826	00037CRH5

\$42,665,000 6.000% Term Bonds due August 1, 2030, priced at 98.587% to yield 6.125% CUSIP: 00037CRG7

THE BONDS ARE SPECIAL OBLIGATIONS OF THE AUTHORITY, PAYABLE SOLELY FROM AND SECURED BY THE PLEDGE OF REVENUES PURSUANT TO THE BOND INDENTURE. NONE OF THE AUTHORITY, THE ASSOCIATION OF BAY AREA GOVERNMENTS (“ABAG”) OR THE MEMBERS OF THE AUTHORITY OR ABAG SHALL BE DIRECTLY OR INDIRECTLY OR CONTINGENTLY OR MORALLY OBLIGATED TO USE ANY OTHER MONEYS OR ASSETS OF THE AUTHORITY, ABAG OR ANY OF THEIR MEMBERS TO PAY ALL OR ANY PORTION OF DEBT SERVICE DUE ON THE BONDS. THE BONDS AND THE OBLIGATION TO PAY PRINCIPAL THEREOF AND INTEREST THEREON AND ANY REDEMPTION PREMIUM WITH RESPECT THERETO DO NOT CONSTITUTE AN INDEBTEDNESS OR AN OBLIGATION OF THE AUTHORITY, ABAG, THE STATE OF CALIFORNIA OR ANY POLITICAL SUBDIVISION THEREOF, WITHIN THE MEANING OF ANY CONSTITUTIONAL OR STATUTORY DEBT LIMITATION, OR A CHARGE AGAINST THE GENERAL CREDIT OR TAXING POWERS OF ANY OF THEM, BUT SHALL BE PAYABLE SOLELY FROM THE REVENUES DESCRIBED HEREIN. NO OWNER OF THE BONDS SHALL HAVE THE RIGHT TO COMPEL THE EXERCISE OF THE TAXING POWER OF THE STATE OF CALIFORNIA OR ANY POLITICAL SUBDIVISION THEREOF TO PAY ANY PRINCIPAL OF, OR PREMIUM, IF ANY, OR INTEREST ON THE BONDS. NEITHER THE AUTHORITY NOR ABAG HAS ANY TAXING POWER.

There are risks associated with the purchase of the Bonds. For a discussion of certain of these risks, see the caption “Bondholders’ Risks.”

This cover page contains certain information for general reference only. It is not intended to be a summary of the security or terms of the Bonds. Investors should read the entire Official Statement to obtain information essential to the making of an informed investment decision.

The Bonds are offered when, as and if received by the Underwriter, subject to prior sale and to the approval of the validity of the Bonds and certain legal matters by Orrick, Herrington & Sutcliffe LLP, Bond Counsel to the Authority, the approval of certain matters for the Authority by its special counsel, Chapman and Cutler LLP, San Francisco, California, for the Obligated Group by Hooper, Lundy & Bookman, P.C., San Diego, California and for the Underwriter by its special counsel, SNR Denton US LLP, Chicago, Illinois. It is expected that the Bonds in book-entry form will be available for delivery to DTC in New York, New York, on or about February 10, 2011.

**Citi**

The date of this Official Statement is January 12, 2011.

The information relating to the Authority contained herein under the headings “THE AUTHORITY” and “LITIGATION—The Authority” has been furnished by the Authority. Such information is believed to be reliable but is not guaranteed as to accuracy or completeness and is not to be construed as a representation by the Authority, the Obligated Group or the Underwriter. All other information contained herein has been obtained from the Obligated Group, DTC and other sources (other than the Authority) that are believed to be reliable. Such other information is not guaranteed as to accuracy or completeness and is not to be relied upon or construed as a promise or representation by the Authority, the Obligated Group or the Underwriter. The Underwriter has provided the following sentence for inclusion in this Official Statement. The Underwriter has reviewed the information in this Official Statement in accordance with and as part of its responsibilities to investors under the federal securities laws as applied to the facts and circumstances of this transaction, but the Underwriter does not guarantee the accuracy or completeness of such information.

No dealer, broker, salesperson or other person has been authorized by the Authority, the Obligated Group or the Underwriter to give any information or to make any representations, other than those contained in this Official Statement, and, if given or made, such information or representation must not be relied upon as having been authorized by any of the foregoing. This Official Statement does not constitute an offer to sell or the solicitation of an offer to buy, nor shall there be any sale of the Bonds by any person in any jurisdiction in which it is unlawful for such person to make such offer, solicitation or sale. The information and expressions of opinion herein are subject to change without notice, and neither the delivery of this Official Statement nor any statement nor any sale made hereunder shall create under any circumstances any implication that there has been no change in the affairs of the Authority, the Obligated Group or DTC since the date hereof. This Official Statement is submitted in connection with the issuance of securities referred to herein and may not be used, in whole or in part, for any other purpose.

The CUSIP numbers included in this Official Statement are for the convenience of the holders and potential holders of the Bonds. No assurance can be given that the CUSIP numbers for the Bonds will remain the same after the date of issuance and delivery of the Bonds. CUSIP is a trademark of the American Bankers Association. The CUSIP numbers are provided by Standard and Poor’s, CUSIP Service Bureau, a division of The McGraw-Hill Companies, Inc. This number is not intended to create a database and does not serve in any way as a substitute for the CUSIP Service. The CUSIP numbers shown on the cover hereof have been assigned to the issue by an organization not affiliated with the Authority, the Underwriter or the Corporation and are included for convenience only. Neither the Authority, the Underwriter nor the Corporation is responsible for the selection of the CUSIP numbers, nor is any representation made as to their correctness on the Bonds or as indicated herein.

In connection with the offering of the Bonds, the Underwriter may over-allot or effect transactions that stabilize or maintain the market price of the Bonds at a level above that which might otherwise prevail in the open market. Such stabilizing, if commenced, may be discontinued at any time.

THE BONDS HAVE NOT BEEN REGISTERED UNDER THE SECURITIES ACT OF 1933, AS AMENDED, AND THE BOND INDENTURE AND THE MASTER INDENTURE HAVE NOT BEEN QUALIFIED UNDER THE TRUST INDENTURE ACT OF 1939, AS AMENDED, IN RELIANCE UPON EXEMPTIONS CONTAINED IN SUCH ACTS. THE REGISTRATION OR QUALIFICATION OF THE BONDS IN ACCORDANCE WITH APPLICABLE PROVISIONS OF LAWS OF THE STATES IN WHICH BONDS HAVE BEEN REGISTERED OR QUALIFIED AND THE EXEMPTION FROM REGISTRATION OR QUALIFICATION IN OTHER STATES CANNOT BE REGARDED AS A RECOMMENDATION THEREOF. NEITHER THESE STATES NOR ANY OF THEIR AGENCIES HAVE PASSED UPON THE MERITS OF THE BONDS OR THE ACCURACY OR COMPLETENESS OF THIS OFFICIAL STATEMENT. ANY REPRESENTATION TO THE CONTRARY MAY BE A CRIMINAL OFFENSE.

**CAUTIONARY STATEMENT REGARDING FORWARD-LOOKING  
STATEMENTS IN THIS OFFICIAL STATEMENT**

Certain statements included or incorporated by reference in this Official Statement constitute projections or estimates of future events, generally known as forward-looking statements. These statements are generally identifiable by the terminology used such as “plan,” “expect,” “estimate,” “budget” or other similar words. These forward-looking statements include, but are not limited to, the information under the caption “BONDHOLDERS’ RISKS” in the forepart of this Official Statement and the information in APPENDIX A to this Official Statement.

The achievement of certain results or other expectations contained in such forward-looking statements involves known and unknown risks, uncertainties and other factors which may cause actual results, performance or achievements described to be materially different from any future results, performance or achievements expressed or implied by these forward-looking statements. The Corporation does not plan to issue any updates or revisions to those forward-looking statements if or when changes in its expectations, or events, conditions or circumstances on which such statements are based occur.

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## OFFICIAL STATEMENT

**\$77,710,000**

### **ABAG FINANCE AUTHORITY FOR NONPROFIT CORPORATIONS**

**Revenue Bonds  
(Sharp HealthCare),  
Series 2011A**

## INTRODUCTORY STATEMENT

The following introductory statement is subject in all respects to the more complete information set forth in this Official Statement. All descriptions and summaries of documents referred to herein do not purport to be comprehensive or definitive and are qualified in their entirety by reference to each such document. Terms used in this Official Statement and not otherwise defined have the same meanings as in the Bond Indenture (as defined below). See APPENDIX C – “SUMMARY OF PRINCIPAL DOCUMENTS—DEFINITIONS OF CERTAIN TERMS.”

### **Purpose of the Official Statement**

This Official Statement, including the cover page, the inside cover page and the appendices hereto, is provided to furnish information in connection with the sale and delivery of \$77,710,000 aggregate principal amount of ABAG Finance Authority for Nonprofit Corporations (the “Authority”) Revenue Bonds (Sharp HealthCare), Series 2011A (the “Bonds”).

### **The Bonds**

The Bonds will be issued pursuant to and secured by a Bond Indenture dated as of February 1, 2011 (the “Bond Indenture”), between the Authority and U.S. Bank National Association, as trustee (the “Bond Trustee”). The Authority will lend the proceeds of the Bonds to Sharp HealthCare (the “Corporation”), which loan will be evidenced by a Loan Agreement, dated as of February 1, 2011 (the “Loan Agreement”), between the Authority and the Corporation, and will be secured by payments under the Series 2011A Obligation issued pursuant to the Master Indenture (each as defined below).

### **The Obligated Group and the Master Indenture**

The Corporation, Sharp Memorial Hospital (“Memorial”), Sharp Chula Vista Medical Center (“Chula Vista”) and Grossmont Hospital Corporation (“Grossmont”), each a California nonprofit public benefit corporation, are currently the only Members of the Obligated Group as such terms are used in the Master Indenture of Trust, dated as of June 1, 1988, as supplemented and amended to date (the “Original Master Indenture”), and as further supplemented by that certain Supplemental Master Indenture for Obligation No. 30 dated as of February 1, 2011 (“Supplement No. 30” and, together with the Original Master Indenture as it may be further supplemented and amended from time to time, the “Master Indenture”), among the Members of the Obligated Group and U.S. Bank National Association, as successor master trustee (the “Master Trustee”). The Members of the Obligated Group and their affiliates and operations are collectively referred to herein as the “System”. Pursuant to the Master Indenture, the Corporation is authorized to act as agent on behalf of the Members of the Obligated Group.

The System is a not-for-profit integrated regional health care delivery system based in San Diego, California. The Members of the Obligated Group own or lease and operate four acute-care hospitals and three specialty hospitals, plus a full spectrum of other facilities and services. For a description of the System, its facilities and financial performance, see APPENDIX A – “INFORMATION CONCERNING SHARP HEALTHCARE AND THE OBLIGATED GROUP.”

## **Security for the Bonds**

The Bonds are payable from payments made by the Corporation under the Loan Agreement (the “Loan Repayments”), from payments made by the Members of the Obligated Group on the Series 2011A Obligation and from certain funds held under the Bond Indenture.

In order to secure the obligation of the Corporation to make payments under the Loan Agreement, the Corporation will deliver to the Bond Trustee an Obligation (the “Series 2011A Obligation”) issued pursuant to Supplement No. 30. Pursuant to the Master Indenture, the Members of the Obligated Group agree to make payments on the Series 2011A Obligation in amounts sufficient to pay, when due, the principal of and premium, if any, and interest on the Bonds. Each Obligated Group Member is jointly and severally obligated to make payments on all Obligations issued under the Master Indenture, including the Series 2011A Obligation. The Series 2011A Obligation will entitle the Bond Trustee, as the holder thereof, to the benefit of the covenants, restrictions and other obligations imposed upon the Obligated Group under the Master Indenture. For a discussion of the enforceability of the Master Indenture and Obligations against Members of the Obligated Group, see “BONDHOLDERS’ RISKS —Security and Enforceability—Enforceability of the Master Indenture, the Loan Agreement and the Series 2011A Obligation” herein.

The obligations of the Members of the Obligated Group to pay amounts due on Obligations, including the Series 2011A Obligation, are secured by a pledge of the Gross Revenues of each Member. See “SECURITY FOR THE BONDS—The Master Indenture—Pledge of Gross Revenues” herein.

Supplement No. 30 contains certain additional covenants (the “Series 2011A Covenants”) that will be applicable while any of the Bonds are outstanding. The Series 2011A Covenants include covenants relating to debt service coverage and the withdrawal or addition of Members to the Obligated Group, as well as the ability of the Obligated Group to merge, incur indebtedness and dispose of assets. The Series 2011A Covenants may be modified, amended or waived with the prior consent of the holders of a majority in principal amount of the outstanding Bonds, but without the consent of the holders of any other Obligation issued under the Master Indenture. See APPENDIX C – “SUMMARY OF PRINCIPAL DOCUMENTS—SUPPLEMENTAL MASTER INDENTURE FOR OBLIGATION NO. 30—Modifications to Certain Covenants of the Master Indenture While Obligation No. 30 is Outstanding” for a description of the Series 2011A Covenants.

In certain circumstances, the Corporation may authorize the issuance of additional Obligations under the Master Indenture that will be equally and ratably secured under the Master Indenture with the Series 2011A Obligation.

## **Credit Provider Covenants**

The Master Indenture contains certain additional covenants and restrictions solely for the benefit of certain providers of credit enhancement (the “Credit Providers”) on the Corporation’s outstanding indebtedness (the “Credit Provider Covenants”). These Credit Provider Covenants and restrictions may be waived, modified or amended by the applicable Credit Provider(s) in their sole discretion and without notice to or consent by the bond trustee of any outstanding bonds, the Bond Trustee, the Master Trustee, the holders of outstanding bonds, including the Bonds, the holders of any Obligations or any other Person. Violation of any of such covenants may result in an Event of Default under the Master Indenture which could result in acceleration of all of the Obligations, including the Series 2011A Obligation. The Corporation may agree to provide additional covenants to certain Persons (who may not include holders of the Bonds) in the future.

## **Outstanding Indebtedness and Obligations**

Immediately following the issuance of the Bonds, approximately \$493 million in principal amount of Indebtedness will be outstanding and secured by Obligations issued under the Master Indenture (excluding Obligations issued by the Corporation in connection with interest rate hedging agreements or to providers of credit or liquidity enhancement). See Note 6 to the audited combined financial statements of the Corporation included in APPENDIX B.

In December 2010, the Authority issued tax-exempt bonds for the benefit of the Corporation in the aggregate principal amount of \$30 million (the "Series 2010A Bonds"). The Series 2010A Bonds are secured by an Obligation (the "Series 2010A Obligation") issued under the Master Indenture. The proceeds of the Series 2010A Bonds will be used to finance and/or refinance the acquisition, construction, renovation, improvement, furnishing and equipping of health facilities and ancillary facilities of certain Members of the Obligated Group and their affiliates. These improvements are part of the overall capital plan of the Obligated Group. The Series 2010A Bonds were purchased directly from the Authority by Bank of America, N.A. in a private placement.

## **Bondholders' Risks**

There are risks associated with the purchase of the Bonds. See the information under the heading "BONDHOLDERS' RISKS" in this Official Statement for a discussion of certain of these risks.

## **Miscellaneous**

The foregoing and subsequent summaries or description of provisions of the Bonds, the Bond Indenture, the Loan Agreement, the Master Indenture and the Series 2011A Obligation and all references to other documents and other materials related to issuance of the Bonds are not quoted in full and are only brief outlines of some of the provisions thereof and do not purport to summarize or describe all of the provisions thereof. Reference is made to said documents for full and complete statements of their provisions. The Appendices attached hereto are a part of this Official Statement. Following the issuance and sale of the Bonds, copies, in reasonable quantity, of the Bond Indenture, the Loan Agreement, the Master Indenture, Supplement No. 30 and the Series 2011A Obligation may be obtained upon request directed to the corporate trust office of the Bond Trustee.

## **THE AUTHORITY**

The Authority is a joint powers authority duly organized and existing under the laws of the State of California. The Authority was formed pursuant to the terms of a Joint Powers Agreement, dated as of April 1, 1990, as amended as of September 18, 1990 and June 9, 1992 (the "Joint Powers Agreement"), and the Joint Exercise of Powers Law of the State (constituting Chapter 5, commencing with Section 6500, of Division 7 of Title 1 of the California Government Code), to assist nonprofit corporations and other entities to obtain financing for projects located within the several jurisdictions of Authority members with purposes serving the public interest.

THE BONDS ARE SPECIAL OBLIGATIONS OF THE AUTHORITY, PAYABLE SOLELY FROM AND SECURED BY THE PLEDGE OF REVENUES PURSUANT TO THE BOND INDENTURE. NONE OF THE AUTHORITY, THE ASSOCIATION OF BAY AREA GOVERNMENTS ("ABAG") OR THE MEMBERS OF THE AUTHORITY OR ABAG SHALL BE DIRECTLY OR INDIRECTLY OR CONTINGENTLY OR MORALLY OBLIGATED TO USE ANY OTHER MONEYS OR ASSETS OF THE AUTHORITY, ABAG OR ANY OF THEIR MEMBERS TO PAY ALL OR ANY PORTION OF DEBT SERVICE DUE ON THE BONDS. THE BONDS AND THE OBLIGATION TO PAY PRINCIPAL THEREOF AND INTEREST THEREON AND ANY REDEMPTION PREMIUM WITH RESPECT THERETO DO NOT CONSTITUTE AN

INDEBTEDNESS OR AN OBLIGATION OF THE AUTHORITY, ABAG, THE STATE OF CALIFORNIA OR ANY POLITICAL SUBDIVISION THEREOF, WITHIN THE MEANING OF ANY CONSTITUTIONAL OR STATUTORY DEBT LIMITATION, OR A CHARGE AGAINST THE GENERAL CREDIT OR TAXING POWERS OF ANY OF THEM, BUT SHALL BE PAYABLE SOLELY FROM THE REVENUES DESCRIBED HEREIN. NO OWNER OF THE BONDS SHALL HAVE THE RIGHT TO COMPEL THE EXERCISE OF THE TAXING POWER OF THE STATE OF CALIFORNIA OR ANY POLITICAL SUBDIVISION THEREOF TO PAY ANY PRINCIPAL OF, OR PREMIUM, IF ANY, OR INTEREST ON THE BONDS. NEITHER THE AUTHORITY NOR ABAG HAS ANY TAXING POWER.

## **PLAN OF FINANCE**

The Corporation will use the proceeds of the Bonds to (i) redeem all of the outstanding principal amount of the ABAG Finance Authority for Nonprofit Corporations Revenue Bonds (San Diego Hospital Association), Series 2001A (the "Series 2001A Bonds") and (ii) prepay a portion of the outstanding principal components of the installment payments to be paid by the Corporation and Chula Vista pursuant to an Installment Sale Agreement, dated as of April 1, 1998, between the County of San Diego and the Corporation and Chula Vista in the aggregate principal amount of \$27,590,000 (the "Refunded 1998 Obligations"). The Series 2001A Bonds and the Refunded 1998 Obligations are referred to herein as the Refunded Obligations.

## **THE BONDS**

### **General**

The Bonds will mature in the years and in the principal amounts as set forth on the cover of this Official Statement. The Bonds will be issued in fully registered form and, when issued, will be registered in the name of Cede & Co., as nominee of The Depository Trust Company, New York, New York ("DTC"). DTC will act as securities depository (the "Depository") for the Bonds.

### **Description of Terms of Bonds**

The Bonds will be dated as of their date of issuance, and will bear interest at the rates set forth on the cover of this Official Statement. Interest on the Bonds is payable on August 1, 2011 and semi-annually thereafter on February 1 and August 1 of each year until maturity or redemption, to the persons whose names appear on the registration books of the Bond Trustee as the holders thereof as of the close of business on the 15th day of the January or July preceding such interest payment date (each, a "Record Date"), except with respect to interest in default, for which a special record date shall be established. The Bonds are issuable in the denominations of \$5,000 or any integral multiple thereof. Interest on the Bonds will be calculated on the basis of a 360-day year of twelve 30-day months.

So long as Cede & Co. is the registered owner of the Bonds, principal and redemption price, if any, of and interest on the Bonds are payable by wire transfer by the Bond Trustee to Cede & Co., as nominee for DTC, which, in turn, will remit such amounts to its participants for subsequent delivery to the beneficial owners. See "Book-Entry System" below. If the book-entry system for the Bonds is discontinued, payment of interest on the Bonds will be made by check mailed on each Interest Payment Date to each Holder at its address as it appears on the bond registration books, or at the written request of any Holder of \$1,000,000 or more in aggregate principal amount of Bonds, by wire transfer to an account in the United States of America upon the written request of the Holder filed with the Bond Trustee on or before the Record Date and payment of the principal and redemption price, if any, of the Bonds will be payable in lawful money of the United States of America upon presentation and surrender thereof at the Principal Corporate Trust Office of the Bond Trustee.

## Redemption Provisions

Optional Redemption. The Bonds maturing on or after August 1, 2022 are subject to redemption prior to their respective stated maturities, at the option of the Authority (which option shall be exercised as directed by the Corporation), in whole or in part (in such amounts and maturities as may be specified by the Corporation, or, if the Corporation fails to designate such maturities, in inverse order of maturity) on any date on or after August 1, 2021, at a redemption price equal to the principal amount of Bonds called for redemption, plus accrued interest to the date fixed for redemption, without premium.

Mandatory Sinking Account Redemption. The Bonds maturing on August 1, 2030 are subject to redemption prior to maturity (or payment at maturity, as the case may be) in part from sinking fund installments established pursuant to the Bond Indenture on any August 1 on or after August 1, 2025, in the amounts set forth below at the principal amount of the Bonds being redeemed or paid plus interest accrued thereon (which such accrued interest shall be paid in the normal course) to the date fixed for redemption, without premium:

<u>Year</u>	<u>Amount</u>
2025	\$6,115,000
2026	6,485,000
2027	6,875,000
2028	7,290,000
2029	7,720,000
2030*	8,180,000

\*Maturity

Special Redemption. The Bonds are subject to redemption prior to their respective stated maturities at the option of the Authority (which option shall be exercised as directed by the Corporation), in whole or in part (in such amounts and maturities as may be specified by the Corporation or, if the Corporation fails to specify such maturities, in inverse order of maturity) on any date, from certain hazard insurance or condemnation proceeds received with respect to the facilities of any Member and deposited in accordance with the Loan Agreement, at the principal amount thereof, plus accrued interest to the date fixed for redemption, without premium.

Selection of Bonds for Redemption. Whenever provision is made in the Bond Indenture for the redemption of less than all of the Bonds of any maturity or any given portion thereof, the Bond Trustee shall select the Bonds to be redeemed, from all Bonds subject to redemption or such given portion thereof not previously called for redemption, by lot in any manner which the Bond Trustee in its sole discretion shall deem appropriate and fair. Bonds or portions of Bonds to be redeemed shall result in any remaining portion of a Bond being in at least the minimum authorized denomination of \$5,000.

Notice and Effect of Redemption. Notice of redemption shall be mailed by the Bond Trustee not less than 30 days nor more than 60 days prior to the redemption date to the respective Holders of any Bonds designated for redemption at their addresses appearing on the registration books of the Bond Trustee. Failure of the Bond Trustee to mail any such notice shall not affect the sufficiency of the proceedings for the redemption of the Bonds with respect to the Holder or Holders to whom such notice was mailed. The Bonds so called for redemption shall become due and payable at the Redemption Price specified in such notice plus interest accrued thereon to the redemption date. The insufficiency of any such notice shall not affect the sufficiency of the proceedings for redemption. Interest on the Bonds so called for redemption shall cease to accrue from and after the redemption date. The Bonds so called for redemption shall cease to be entitled to any benefit or security under the Bond Indenture, and the Holders of such Bonds shall have no rights in respect thereof except to receive payment of the Redemption Price and accrued interest to the redemption date from funds held by the Bond Trustee for such payment.

Any notice of optional or special redemption given in accordance with the provisions of the Bond Indenture may be rescinded by written notice given to the Bond Trustee by the Corporation no later than five (5) Business Days prior to the date specified for redemption. The Bond Trustee shall give notice of such rescission as soon thereafter as practicable in the same manner, and to the same Persons, as notice of such redemption was given.

### **Purchase in Lieu of Redemption**

Each Holder or beneficial owner, by purchase and acceptance of any Bond, irrevocably grants to the Corporation the option to purchase such Bond at any time such Bond is subject to optional redemption. Such Bond is to be purchased at a purchase price equal to the then applicable redemption price of such Bond, plus accrued interest, if any, to the date of purchase. The Corporation may only exercise such option, after the Corporation shall have delivered a Favorable Opinion of Bond Counsel to the Bond Trustee, and shall have directed the Bond Trustee to provide notice of mandatory purchase, as and to the extent applicable, as described above under “Redemption Provisions—Notice and Effect of Redemption.” Bonds to be so purchased shall be selected by the Bond Trustee in the same manner as Bonds called for redemption pursuant to the Bond Indenture. On the date fixed for purchase of any Bond in lieu of redemption, the Corporation shall pay the purchase price of such Bond to the Bond Trustee in immediately available funds and the Bond Trustee shall pay the same to the Holders of the Bonds being purchased against delivery thereof. No purchase of any Bond in lieu of redemption shall operate to extinguish the indebtedness of the Authority evidenced by such Bond. No Holder or beneficial owner may elect to retain a Bond subject to mandatory purchase in lieu of redemption.

### **Book-Entry System**

The Bonds will be issued in book-entry form. DTC will act as securities depository for the Bonds. The Bonds will be issued as fully-registered securities registered in the name of Cede & Co. (DTC’s partnership nominee). One fully-registered Bond will be issued for each maturity of Bonds in the total aggregate principal amount due on such maturity of Bonds and will be deposited with DTC or its agent for registration. See APPENDIX E – “BOOK-ENTRY ONLY SYSTEM.”

The Corporation and the Authority cannot and do not give any assurances that DTC will distribute to DTC participants or that DTC participants or others will distribute to the beneficial owners payments of principal of and interest and premium, if any, on the Bonds or any redemption or other notices or that they will do so on a timely basis or will serve and act in the manner described in this Official Statement. Neither the Corporation nor the Authority is responsible or liable for the failure of DTC or any DTC participant or DTC indirect participant to make any payments or give any notice to a beneficial owner with respect to the Bonds or any error or delay relating thereto.

## **SECURITY FOR THE BONDS**

### **General**

In the Loan Agreement, the Corporation agrees to make the Loan Repayments to the Bond Trustee, which payments, in the aggregate, will be in amounts sufficient for the payment in full of all amounts payable with respect to the Bonds, including the total interest payable on the Bonds to the date of maturity of the Bonds or earlier redemption, the principal amount of the Bonds, any redemption premiums, and certain other fees and expenses (the “Additional Payments”), less any amounts available for such payment as provided in the Bond Indenture. The Bonds will also be payable from payments made on the Series 2011A Obligation, proceeds of the Bonds, investment earnings on proceeds of the Bonds, amounts on deposit under the Bond Indenture (except for any amounts on deposit in the Rebate Fund) and proceeds of insurance or condemnation awards, each in the manner and to the extent set forth in the Bond Indenture.

As security for its obligation to make the Loan Repayments, the Corporation, concurrently with the issuance of the Bonds, will issue the Series 2011A Obligation to the Bond Trustee pursuant to which the Corporation and the other Members of the Obligated Group agree to make payments to the Bond Trustee in amounts sufficient to pay, when due, the principal of and premium, if any, and interest on the Bonds.

## **The Master Indenture**

**Obligations.** Under the Master Indenture, the Corporation may be authorized pursuant to a related Supplemental Master Indenture to issue, for itself and on behalf of the other Members of the Obligated Group, Obligations to evidence or secure indebtedness and other obligations of the Members. All Members of the Obligated Group are jointly and severally liable with respect to the payment of each Obligation issued under the Master Indenture.

The Series 2011A Obligation will be issued by the Corporation under and pursuant to the Original Master Indenture, as supplemented by Supplement No. 30. The Corporation and the other Members of the Obligated Group are required to make payments on the Series 2011A Obligation in an amount sufficient to pay the principal of or premium, if any, and interest on the Bonds when due.

Upon the issuance of the Series 2011A Obligation and after giving effect to the transactions described in “PLAN OF FINANCE” herein, the aggregate principal amount of Obligations related to Indebtedness issued and outstanding under the Master Indenture is expected to be approximately \$493 million. See APPENDIX A – “HISTORICAL FINANCIAL INFORMATION—Capitalization” herein.

**Covenants.** The Master Indenture includes covenants that limit the Obligated Group’s ability to incur indebtedness, dispose of assets or encumber its assets. See APPENDIX C – “SUMMARY OF PRINCIPAL DOCUMENTS—Master Indenture—Particular Covenants of the Corporation and Each Member” and “—SUPPLEMENTAL MASTER INDENTURE FOR OBLIGATION NO. 30—Modifications to Certain Covenants of the Master Indenture While Obligation No. 30 is Outstanding” herein.

**Pledge of Gross Revenues.** Pursuant to the Master Indenture, the Members of the Obligated Group covenanted that all Obligations issued under the Master Indenture, including the Series 2011A Obligation, will be secured (to the extent permitted by law) by a pledge of and security interest in the Gross Revenue Fund created under the Master Indenture and the Gross Revenues of the Obligated Group. See APPENDIX C – “SUMMARY OF PRINCIPAL DOCUMENTS—Definitions of Certain Terms” and “—MASTER INDENTURE—Particular Covenants of the Corporation and Each Member—Gross Revenue Fund.” The foregoing pledge and grant of a security interest will be perfected to the extent, and only to the extent, that such security interest may be perfected under the Uniform Commercial Code of the State of California. See “BONDHOLDERS’ RISKS—Security and Enforceability—Perfection of a Security Interest in Gross Revenues” herein.

**Covenant Against Liens; Permitted Senior Indebtedness.** Pursuant to the Master Indenture, each Member of the Obligated Group agrees that it will not create, assume or suffer to exist any Lien upon the Gross Revenues or the Property of the Obligated Group, except for Permitted Encumbrances. Each Member further agrees that if a Lien that would not constitute a Permitted Encumbrance is created or assumed by a Member, it will make or cause to be made effective a provision whereby all Obligations will be secured prior to or equally and ratably with any Indebtedness secured by such Lien.

Permitted Encumbrances include Liens on Property of the Obligated Group, including Liens which may be granted to secure additional Obligations and other Indebtedness. Such Liens are not required to secure the Series 2011A Obligation, and the Series 2011A Obligation would be subordinated to such Indebtedness with respect to the Property subject to such Liens. See the definition of “Permitted

Encumbrances” in APPENDIX C – “SUMMARY OF PRINCIPAL DOCUMENTS—Definitions of Certain Terms” and “—MASTER INDENTURE—Particular Covenants of the Corporation and Each Member—Against Encumbrances.”

***Additional Covenants for the Benefit of the Holders of the Bonds.*** Supplement No. 30 contains the Series 2011A Covenants that will be applicable while any of the Bonds are outstanding. The Series 2011A Covenants include covenants relating to debt service coverage and the withdrawal or addition of Members to the Obligated Group, as well as the ability of the Obligated Group to merge, incur indebtedness and dispose of assets. The Series 2011A Covenants may be modified, amended or waived with the prior consent of the holders of a majority in principal amount of the outstanding Bonds, but without the consent of the holders of any other Obligation issued under the Master Indenture. See APPENDIX C – “SUMMARY OF PRINCIPAL DOCUMENTS—SUPPLEMENTAL MASTER INDENTURE FOR OBLIGATION NO. 30—Modifications to Certain Covenants of the Master Indenture While Obligation No. 30 is Outstanding” for a description of the Series 2011A Covenants.

### **Credit Provider Covenants**

The Master Indenture contains Credit Provider Covenants on the Corporation’s outstanding indebtedness. These Credit Provider Covenants and restrictions may be waived, modified or amended by the applicable Credit Provider(s) in their sole discretion and without notice to or consent by the bond trustee of any outstanding bonds, the Bond Trustee, the Master Trustee, the holders of outstanding bonds, including the Bonds, the holders of any Obligations or any other Person. Violation of any of such covenants may result in an Event of Default under the Master Indenture which could result in acceleration of all of the Obligations, including the Series 2011A Obligation. The Corporation may agree to provide additional covenants to certain Persons (who may not include holders of the Bonds) in the future.

### **Bonds Not General Obligations**

THE BONDS ARE SPECIAL OBLIGATIONS OF THE AUTHORITY, PAYABLE SOLELY FROM AND SECURED BY THE PLEDGE OF REVENUES PURSUANT TO THE BOND INDENTURE. NONE OF THE AUTHORITY, ABAG OR THE MEMBERS OF THE AUTHORITY OR ABAG SHALL BE DIRECTLY OR INDIRECTLY OR CONTINGENTLY OR MORALLY OBLIGATED TO USE ANY OTHER MONEYS OR ASSETS OF THE AUTHORITY, ABAG OR ANY OF THEIR MEMBERS TO PAY ALL OR ANY PORTION OF DEBT SERVICE DUE ON THE BONDS. THE BONDS AND THE OBLIGATION TO PAY PRINCIPAL THEREOF AND INTEREST THEREON AND ANY REDEMPTION PREMIUM WITH RESPECT THERETO DO NOT CONSTITUTE AN INDEBTEDNESS OR AN OBLIGATION OF THE AUTHORITY, ABAG, THE STATE OF CALIFORNIA OR ANY POLITICAL SUBDIVISION THEREOF, WITHIN THE MEANING OF ANY CONSTITUTIONAL OR STATUTORY DEBT LIMITATION, OR A CHARGE AGAINST THE GENERAL CREDIT OR TAXING POWERS OF ANY OF THEM, BUT SHALL BE PAYABLE SOLELY FROM THE REVENUES DESCRIBED HEREIN. NO OWNER OF THE BONDS SHALL HAVE THE RIGHT TO COMPEL THE EXERCISE OF THE TAXING POWER OF THE STATE OF CALIFORNIA OR ANY POLITICAL SUBDIVISION THEREOF TO PAY ANY PRINCIPAL OF, OR PREMIUM, IF ANY, OR INTEREST ON THE BONDS. NEITHER THE AUTHORITY NOR ABAG HAS ANY TAXING POWER.

## DEBT SERVICE REQUIREMENTS

This table sets forth, for each year ending September 30, the amounts required in each such year for the payment of principal at maturity or by mandatory redemption for the Bonds and the payment of interest on the Bonds, together with amounts required for payment of debt service on other Obligations (excluding Obligations issued by the Corporation in connection with interest rate hedging agreements or to providers of credit or liquidity enhancement) to be outstanding after the issuance of the Bonds.

Year Ending September 30	Series 2011A Principal	Series 2011A Interest	Debt Service on other Obligations <sup>(1) (2)</sup>	Total
2011	--	\$ 2,013,944	\$ 44,060,464	\$ 46,074,407
2012	--	4,239,881	38,544,622	42,784,503
2013	--	4,239,881	31,981,027	36,220,908
2014	\$ 2,985,000	4,239,881	28,688,294	35,913,176
2015	4,655,000	4,135,406	27,126,298	35,916,704
2016	4,765,000	3,949,206	27,200,069	35,914,275
2017	5,065,000	3,710,956	27,140,615	35,916,571
2018	5,345,000	3,457,706	27,113,812	35,916,518
2019	160,000	3,190,456	32,561,056	35,911,513
2020	245,000	3,183,456	32,484,207	35,912,663
2021	--	3,172,125	41,178,739	44,350,864
2022	3,435,000	3,172,125	29,308,803	35,915,928
2023	3,990,000	3,000,375	28,921,732	35,912,107
2024	4,400,000	2,790,900	28,721,774	35,912,674
2025	6,115,000	2,559,900	27,239,437	35,914,337
2026	6,485,000	2,193,000	27,237,472	35,915,472
2027	6,875,000	1,803,900	27,236,030	35,914,930
2028	7,290,000	1,391,400	27,231,800	35,913,200
2029	7,720,000	954,000	27,238,389	35,912,389
2030	8,180,000	490,800	27,239,246	35,910,046
2031	--	--	27,237,810	27,237,810
2032	--	--	27,239,571	27,239,571
2033	--	--	27,237,178	27,237,178
2034	--	--	29,308,150	29,308,150
2035	--	--	28,931,206	28,931,206
2036	--	--	26,850,752	26,850,752
2037	--	--	26,454,375	26,454,375
2038	--	--	26,455,938	26,455,938
2039	--	--	<u>26,456,250</u>	<u>26,456,250</u>
Total	<u>\$77,710,000</u>	<u>\$57,889,300</u>	<u>\$854,625,114</u>	<u>\$990,224,414</u>

- (1) Assumes that all principal payments and mandatory sinking fund payments are due and paid on August 1 of each year.
- (2) Assumes average annual interest rates between 0.43% and 3.84%, plus certain additional annual fees, on other outstanding variable rate indebtedness. Actual rates will vary from these assumed rates.

## ESTIMATED SOURCES AND USES OF FUNDS

The following table sets forth the estimated sources and uses of funds related to the Bonds.

**Sources of Funds:**

Series 2011A Par Amount	\$77,710,000
Net Original Issue Premium	430,374
Series 2001A Debt Service Reserve Fund	7,842,737
Obligated Group Funds	<u>1,164,105</u>
 Total Sources of Funds	 <b><u>\$87,147,216</u></b>

**Uses of Funds:**

Redeem Refunded Obligations	\$85,979,469
Costs of Issuance <sup>(1)</sup>	<u>1,167,747</u>
 Total Uses of Funds	 <b><u>\$87,147,216</u></b>

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(1) Costs of issuance include legal, printing, rating agency, accounting, Bond Trustee and Authority fees, underwriter's compensation and other miscellaneous costs of issuance, which will be paid for using funds of the Obligated Group.

## **BONDHOLDERS' RISKS**

The purchase of the Bonds involves investment risks that are discussed throughout this Official Statement. Prospective purchasers of the Bonds should evaluate all of the information presented in this Official Statement. This section on Bondholders' Risks focuses primarily on the general risks associated with hospital or health system operations; whereas APPENDIX A describes the Members of the Obligated Group specifically. These should be read together.

### **General**

Except as described herein under the caption, "SECURITY FOR THE BONDS," the principal of, premium, if any, and interest on the Bonds are payable from Revenues and other amounts payable by the Corporation under the Loan Agreement and by the Obligated Group on the Series 2011A Obligation. No representation or assurance is given or can be made that revenues will be realized by the Obligated Group in amounts sufficient to pay debt service on the Bonds when due and other payments necessary to meet the obligations of the Obligated Group. The risk factors discussed below as well as those factors discussed under "SECURITY FOR THE BONDS" (including the lack of certain covenants) should be considered in evaluating the ability of the Obligated Group to make payments in amounts sufficient to provide for the payment of the principal of, premium, if any, and interest on the Bonds.

The receipt of future revenues by the System will be subject to, among other factors, federal and state policies affecting the health care industry (including changes in reimbursement rates and policies), increased competition from other health care providers, the capability of the management of the System and future economic and other conditions that are impossible to predict. The extent of the ability of the System to generate future revenues has a direct effect upon the payment of, principal of, premium, if any, and interest on the Bonds. Neither the Underwriter nor the Authority has made any independent investigation of the extent to which any such factors may have an adverse affect on the revenues of the System.

### **Utilization of Derivatives Markets**

The System utilizes interest rate hedges ("swaps") to manage its exposure to interest rate fluctuations. Swap agreements are subject to periodic "mark-to-market" valuations and may, at any time, have a negative value (which could be substantial) to the Obligated Group. Changes in the market value of such swap agreements could negatively or positively impact the Obligated Group's operating results and financial condition, and such impact could be material. Any of the Obligated Group's swap agreements may be subject to early termination upon the occurrence of certain specified events. If either the Obligated Group or the counterparty terminates such an agreement when the agreement has a negative value to the Obligated Group, the Obligated Group could be obligated to make a termination payment to the counterparty in the amount of such negative value, and such payment could be substantial and potentially materially adverse to the Obligated Group's financial condition. In the event of an early termination of a swap agreement, there can be no assurance that (i) the Obligated Group will receive any termination payment payable to it by the respective swap provider, (ii) the Obligated Group will not be obligated to or will have sufficient monies to make a termination payment payable by it to the applicable swap provider, and (iii) the Obligated Group will be able to obtain a replacement swap agreement with comparable terms. None of the System's outstanding swaps provide for the posting of collateral by any Member of the Obligated Group under any circumstances. See APPENDIX A – "HISTORICAL FINANCIAL INFORMATION—Capital Structure—Interest Rate Swaps" and the audited combined financial statements of the Corporation included in APPENDIX B hereto, including Note 6 for additional information on derivative financial instruments.

There is no guarantee that any floating amount payable by a swap provider under any swap agreement will match the amount payable by the Obligated Group to the owners of the Indebtedness to

which such swap agreement relates at all times or at any time. To the extent of a mismatch, the Obligated Group is exposed to “basis risk” in that the floating amount it receives from the swap provider pursuant to each swap agreement will not equal the variable amount it is required to pay on the Indebtedness to which such swap agreement relates.

### **Impact of Market Turmoil**

The System has significant holdings in a broad range of investments. Market fluctuations may affect the value of those investments and those fluctuations may be and historically have been at times material. The current domestic and international financial crisis has had and may continue to have negative repercussions on the national and global economies, including a scarcity of credit, lack of confidence in the financial sector, extreme volatility in the financial markets, increase in interest rates, reduced business activity, increased consumer bankruptcies and increased business failures and bankruptcies. In response, Congress, the Federal Reserve Board and other agencies of the federal government have taken various actions that are designed to enhance liquidity, improve the performance and efficiency of credit markets and generally stabilize securities markets. The market turmoil has caused challenges which may include, but not be limited to, negative investment performance, limitations on access to the credit markets, difficulty obtaining new liquidity facilities or extensions of liquidity facilities, the inability of credit or liquidity providers to meet their obligations, and the inability of remarketing agents to successfully remarket bonds.

In 2008, federally enacted legislation and regulatory and other initiatives were implemented by federal agencies and the Federal Reserve Board to attempt to stabilize the financial markets by enhancing liquidity, providing additional capital to the financial sector and improving the performance and efficiency of credit markets. On February 17, 2009, the American Recovery and Reinvestment Act of 2009 (“ARRA”) was enacted to attempt to stimulate the economy. Additional action is being considered by various federal agencies, the Federal Reserve Board and foreign governments, all of which are intended to restore the domestic and global credit markets.

The health care sector has been, and could continue to be, negatively affected by these developments. The consequences of these developments in the health care sector have generally included, and are anticipated to continue to include, realized and unrealized investment portfolio losses, reduced investment income, limitations on access to the credit markets, difficulties in extending existing or obtaining new liquidity facilities, difficulties in remarketing revenue bonds subject to tender, requiring the expenditure of internal liquidity to fund principal payments on commercial paper or tenders of revenue bonds, and increased borrowing costs. The economic recession is also increasing stresses on the State of California budget, resulting in a freeze of Medi-Cal payment rates and redesign of the Medi-Cal hospital inpatient payment system.

ARRA includes several provisions that are intended to provide financial relief to the health care sector, including \$86.6 billion in federal payments to states to fund the Medicaid program and \$24.7 billion to provide a 65% subsidy to the recently unemployed for health insurance premium costs. ARRA also includes the following: \$19 billion to establish a framework for the implementation of a nationally-based health information technology program, including incentive payments to hospitals commencing fiscal year 2011; \$10 billion for health research and construction of National Institutes of Health facilities; and \$1 billion for prevention and wellness programs. The effect of ARRA and any future regulatory actions on the Obligated Group cannot be determined at this time. See APPENDIX A of this Official Statement for specific information about the effects of these factors on the Obligated Group’s recent financial performance, financial condition and debt portfolio. In particular, reference is made to information in APPENDIX A under the caption heading, “HISTORICAL FINANCIAL INFORMATION—Management’s Discussion of Financial Performance—Historical Non-operating Performance.”

## National Health Care Reform

Health care reform has been identified as a priority by business leaders, public advocates, policy experts, political leaders and candidates for office at the federal, state and local levels. In December 2009, the United States Senate (the “Senate”) and the United States House of Representatives (the “House”) each passed their own versions of health care reform legislation. On March 21, 2010, the House passed H.R. 3590, the Patient Protection and Affordable Care Act (the “PPACA”), a Senate-approved health reform bill and a companion amendment bill (the “Reconciliation Bill”) that was approved by the House and Senate on March 25, 2010. The PPACA was signed into law by President Obama on March 23, 2010, and he signed the Reconciliation Bill into law on March 30, 2010. The PPACA and Reconciliation Bill shall be referred to herein collectively as the “Health Care Reform Act.”

Management of the Obligated Group is analyzing the Health Care Reform Act and will continue to do so to assess the effects of the legislation on current and projected operations, financial performance and financial condition. However, management cannot predict with any reasonable degree of certainty or reliability any interim or ultimate effects of the legislation.

A significant component of the Health Care Reform Act is reformation of the sources and methods by which consumers will pay for health care for themselves and their families and by which employers will procure health insurance for their employees and dependents. One of the primary drivers of the Health Care Reform Act is to provide or make available, or subsidize the premium costs of, health care insurance for some of the millions of currently uninsured (or underinsured) consumers who fall below certain income levels. Among its numerous provisions, the Health Care Reform Act includes the following reforms: (i) mandating that individual consumers obtain and certain employers provide a minimum level of health care insurance, and providing for penalties or taxes on consumers and employers that do not comply with these mandates; (ii) establishing health insurance purchasing exchanges in which individuals and small employers can purchase health care insurance; (iii) establishment of insurance reforms that expand coverage generally through such provisions as prohibitions on denials of coverage for pre-existing conditions and elimination of lifetime or annual cost caps; (iv) modifying how hospitals, physicians and other health care providers are paid; and (v) evaluating hospitals, physicians and other health care providers on a variety of quality and efficacy standards to support pay-for-performance systems. The Congressional Budget Office has projected that the Health Care Reform Act will decrease the number of uninsured Americans by approximately 30 million. Some provisions of the Health Care Reform Act took effect immediately, but others will not take effect until 2014, or even 2018.

Some of the specific provisions of the Health Care Reform Act that may affect hospitals’ operations, financial performance or financial condition are described below. This listing is not intended to be, nor should it be considered as, comprehensive. The Health Care Reform Act is complex and comprehensive, and includes a myriad of new programs and initiatives and changes to existing programs, policies, practices and laws.

- With varying effective dates, the annual Medicare market basket updates for many providers, including hospitals, will be reduced, and adjustments to payment for expected productivity gains will be implemented.
- Commencing in federal fiscal year 2014, Medicare disproportionate share hospital (“DSH”) payments will be reduced initially by 75% and reduced further thereafter to account for the national rate of consumers who do not have healthcare insurance and are provided uncompensated care. Commencing in 2014, a state’s Medicaid DSH allotment from federal funds will also be reduced.
- Expansion of Medicaid programs to a broader population with incomes up to 133% of federal poverty levels.

- Commencing in federal fiscal year 2012, Medicare payments that would otherwise be made to hospitals will be reduced by specified percentages to account for excess and “preventable” hospital readmissions.
- Commencing in federal fiscal year 2015, Medicare payments to certain hospitals for hospital-acquired conditions will be reduced by 1%. Commencing in federal fiscal year 2011, federal payments to states for Medicaid services related to hospital-acquired conditions will be prohibited.
- Effective in 2012, a value-based purchasing program will be established under the Medicare program designed to pay hospitals based on performance on quality measures.
- With varying effective dates, a mandated reduction of waste, fraud, and abuse in public programs by allowing provider enrollment screening, enhanced oversight periods for new providers and suppliers, and enrollment moratoria in areas identified as being at elevated risk of fraud in all public programs, and by requiring Medicare and Medicaid program providers and suppliers to establish compliance programs. The Health Care Reform Act requires the development of a database to capture and share healthcare provider data across federal healthcare programs and provides for increased penalties for fraud and abuse violations, and increased funding for anti-fraud activities.
- Effective for tax years commencing immediately after enactment, additional requirements for tax-exemption will be imposed upon tax-exempt hospitals, including obligations to conduct a community needs assessment every three years; adopt an implementation strategy to meet those identified needs; adopt and publicize a financial assistance policy; limit charges to patients who qualify for financial assistance to the amount generally charged to insured patients; and control the billing and collection processes. Failure to satisfy these conditions may result in the imposition of fines.
- The establishment of an Independent Payment Advisory Board to develop legislative proposals to improve the quality of care and limit cost increases. Starting in 2014, these proposals will be automatically implemented if Congress does not act to invalidate them and substitute its own recommendation.

The Health Care Reform Act also provides for the implementation of various demonstration programs and pilot projects to test, evaluate, encourage and expand new payment structures and methodologies to reduce health care expenditures while maintaining or improving quality of care, including bundled payments under Medicare and Medicaid, and comparative effectiveness research programs that compare the clinical effectiveness of medical treatments and develop recommendations concerning practice guidelines and coverage determinations. Other provisions encourage the creation of new health care delivery programs, such as accountable care organizations, or combinations of provider organizations, that voluntarily meet quality thresholds to share in the cost savings they achieve for the Medicare program. The outcomes of these projects and programs, including their effect on payments to providers and financial performance, cannot be predicted.

Because of the complexity of health reform generally, additional legislation is likely to be considered and enacted over time. The Health Care Reform Act will also require the promulgation of substantial regulations with significant effects on the health care industry. Thus, as a result of the passage of the Health Care Reform Act, the health care industry will be subjected to significant new statutory and regulatory requirements and consequently to structural and operation changes and challenges for a substantial period of time. Management of the Obligated Group will continue to assess the effect of the Health Care Reform Act and additional legislation on current and projected operations, financial performance and financial condition.

In addition, many states, including California, have enacted, or are considering enacting, measures designed to reduce their Medicaid expenditures and change private health care insurance. States have also adopted, or are considering, legislation designed to reduce coverage and program eligibility, enroll Medicaid recipients in managed care programs and/or impose additional taxes on hospitals to help finance or expand states' Medicaid systems.

This focus on health care reform may increase the likelihood of significant changes affecting the health care industry. Possible future changes in the Medicare, Medi-Cal, and other state programs, may reduce reimbursements to the Obligated Group and may also increase its operating expenses.

Legal challenges to the Health Care Reform Act have been filed by numerous states' attorneys general throughout the country, and state legislators in certain states and certain members of Congress are also contesting the validity of the Health Care Reform Act. These legal challenges are in various stages of the respective judicial or legislative process. Opponents have challenged the validity of the Health Care Reform Act based on a variety of U.S. Constitutional arguments and theories, including the appropriate scope of the federal government pursuant to the Commerce Clause, congressional taxing and spending power, and Due Process regarding individual rights. As with the provisions of the Health Care Reform Act itself, Management of the Obligated Group will continue to monitor these legal challenges and their impact, if any, on the implementation of the Health Care Reform Act. However, management cannot predict with any reasonable degree of certainty or reliability the outcome of such legal challenges.

Based upon all of the above, it is more difficult to project future performance than it has been in the past, because of the many unresolved issues in the law and the continued enactment of additional laws and promulgation of new regulations and guidelines that are expected to occur for an indefinite, but lengthy, period of time into the future. Investors should review the potential legislative and regulatory developments as they occur to assess the likelihood of reform and its effect on the health care industry generally.

### **Nonprofit Health Care Environment**

The Members of the Obligated Group are each California nonprofit public benefit corporations, exempt from federal income taxation as organizations described in Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (the "Code"). As nonprofit tax-exempt organizations, the Members of the Obligated Group are subject to federal, state and local laws, regulations, rulings and court decisions relating to their organizations and operations, including their operation for charitable purposes. At the same time, the Members of the Obligated Group each conduct large-scale complex business transactions and are major employers in their geographic areas. There can often be a tension between the rules designed to regulate a wide range of charitable organizations and the day-to-day operations of a complex healthcare business such as the System.

Recently, an increasing number of the operations or practices of healthcare providers have been challenged or questioned to determine if they are consistent with the regulatory requirements for nonprofit tax-exempt organizations. These challenges are broader than concerns about compliance with federal and state statutes and regulations, such as Medicare and Medicaid compliance, and instead in many cases are examinations of core business practices of the healthcare organizations. Areas which have come under examination have included pricing practices, billing and collection practices, charitable care, community benefit, executive compensation, exemption of property from real property taxation, and others. These challenges and questions have come from a variety of sources, including state attorneys general, the Internal Revenue Service (the "IRS"), local and state tax authorities, labor unions, Congress, state legislatures, and patients, and in a variety of forums, including hearings, audits and litigation. These challenges or examinations include the following, among others:

**Congressional Hearings.** A number of House and Senate Committees, including the House Committee on Energy and Commerce, the House Committee on Ways and Means and the Senate Finance Committee, have conducted hearings and/or investigations into issues related to nonprofit tax-exempt healthcare organizations. These hearings and investigations have included a nationwide investigation of hospital billing and collection practices, charity care and community benefit and prices charged to uninsured patients and possible reforms to the nonprofit sector. These hearings and investigations may result in new legislation. The effect on the nonprofit health care sector or the System of any such legislation, if enacted, cannot be determined at this time.

**Internal Revenue Service Examination of Compensation Practices.** In August 2004, the IRS initiated an enforcement effort to identify and halt abuses by tax-exempt organizations that pay excessive compensation and benefits to their officers and other insiders. Nearly 2,000 charities and foundations were contacted by the IRS regarding their compensation practices and procedures. No Members of the Obligated Group received the survey request for information. Management of the Obligated Group believes that its compensation practices and procedures are consistent with IRS guidelines and regulations.

**IRS Interim Report on Tax-Exempt Hospitals and Community Benefit.** In May 2006, the IRS initiated its Hospital Compliance Project to study tax-exempt hospitals and community benefit as well as to determine how these hospitals establish and report executive compensation. The IRS sent compliance questionnaires to hundreds of tax-exempt hospitals across the country, but no Member of the Obligated Group received the questionnaire. An Interim Report released by the IRS in July 2007 provided a summary of the responses received and information relating primarily to community benefit. The Final Report released by the IRS in February 2009 provided a summary of the reported community benefit and executive compensation data across various demographics, along with an analysis of patient mix and excess revenues across the various demographics.

**Form 990 and Instructions.** On June 14, 2007, the IRS released for comment a Discussion Draft of a redesigned Form 990. The Form 990 is the annual information return filed by tax-exempt organizations, including nonprofit exempt healthcare organizations. The IRS released the final 2008 Form 990 on December 20, 2007. The new Form 990 applies to tax years beginning on or after January 1, 2008.

As a result of this new Form 990, healthcare organizations now have significantly increased compliance and reporting obligations, particularly relating to community benefit, collection and billing practices and charity care. These specific reporting obligations generally are set forth in a new schedule to the return (Schedule H) and apply for tax years beginning on or after January 1, 2009.

Nonprofit healthcare organizations also became subject to additional reporting for tax-exempt bonds, the most significant of which is required for tax years beginning on or after January 1, 2009. These reporting and recordkeeping requirements go beyond what many hospitals have done historically and require substantial additional efforts on the part of hospitals with outstanding tax-exempt bonds. The recently implemented Schedule K to the Form 990 return is intended to address what the IRS believes to be significant noncompliance with recordkeeping and record retention requirements. These concerns were reinforced, in the IRS's view, by the results of a bond questionnaire distributed to select hospitals in September 2007, the results of which were released in April 2008. Schedule K also focuses on the investment of bond proceeds that could violate the arbitrage rebate requirements and the private use of bond-financed facilities.

**California Attorney General.** California nonprofit corporations, including the Members of the Obligated Group, are subject at all times to examination by the California Attorney General to ensure that the purposes of the nonprofit corporations are being carried out.

**Financial Assistance and Charity Care.** California Health and Safety Code sections 127400 through 127446 (“Section 127400”), require hospitals to maintain written policies about discounted payments for financially qualified patients and the hospital’s provision of charity care. The law requires hospitals to provide copies of such policies to patients and the Office of Statewide Health Planning and Development (“OSHPD”). California hospitals are also required to follow specific billing and collection procedures with respect to patient debt.

**Class Actions.** Hospitals and health systems have long been subject to a wide variety of litigation risks, including liability for care outcomes, employer liability, property and premises liability, and peer review litigation with physicians, among others. In recent years, consumer class action litigation has emerged as a potentially significant source of litigation liability for hospitals and health systems. These class action suits have most recently focused on hospital billing and collections practices, and they may be used for a variety of currently unanticipated causes of action. Since the subject matter of class action suits may involve uninsured risks, and since such actions often involve alleged large classes of plaintiffs, they may have material adverse consequences on hospitals and health systems in the future.

The California Supreme Court ruled that the practice of emergency room physicians “balance billing” health maintenance organization (“HMO”) patients for the difference between the physician’s charges for emergency medical services rendered to a HMO patient and the amount that a HMO patient’s insurance company paid (or offered to pay) the emergency room physician for those services is illegal. Subsequent to the California Supreme Court’s decision, several California hospitals with emergency rooms where independent emergency physician medical groups provide care have been sued (together with the emergency physicians or their medical groups) by plaintiffs who have filed class action lawsuits to recover the amounts that were “balanced billed.” While the Members of the Obligated Group themselves do not engage in the practice of “balance billing,” the independent emergency room physicians and emergency room physician medical groups that practice in the Obligated Group’s hospital emergency rooms may have “balanced billed” patients. Consequently, the Members of the Obligated Group may be sued in actions to recover balance billed amounts. Management of the System is unable to predict the outcome of any such lawsuit or whether adverse rulings or judgments would have a material adverse impact on the System.

**Action by Purchasers of Hospital Services and Consumers.** Major purchasers of hospital services also could take action to restrain hospital charges or charge increases. In California, the California Public Employees’ Retirement System, the nation’s third largest purchaser of employee health benefits, has pledged to take action to restrain the rate of growth of hospital charges and has excluded certain California hospitals from serving its covered members. As a result of increased public scrutiny, it is also possible that the pricing strategies of hospitals may be perceived negatively by consumers, and hospitals may be forced to reduce fees for their services. Decreased utilization could result, and hospitals’ revenues may be negatively impacted. In addition, consumers and groups on behalf of consumers are increasing pressure for hospitals and other health care providers to be transparent and provide information about cost and quality of services that may affect future consumer choices about where to receive health care services.

**Challenges to Real Property Tax Exemptions.** Real property tax exemptions afforded to certain nonprofit health care providers by state and local taxing authorities have been challenged on the grounds that the health care providers were not engaged in sufficient charitable activities. These challenges have been based on a variety of grounds, including allegations of aggressive billing and collection practices and excessive financial margins. Recently, the California State Board of Equalization (the “Board of Equalization”), a state regulatory agency responsible for, among other things, verifying that organizations qualify for property tax exemption in California, imposed a supplemental reporting requirement for nonprofit hospitals regarding their exemption from property taxes. In April 2009, form BOE-278-H was adopted by the Board of Equalization to collect supplemental information on the

organization and operation of nonprofit hospitals. Each of the Members of the Obligated Group timely submitted the requested information. Notification was received that Grossmont met the requirements for the property tax exemption and the other Members of the Obligated Group are currently awaiting notification. While the Members of the Obligated Group are not aware of any current challenge to the tax exemption afforded to any of their material properties, there can be no assurance that these types of challenges will not occur in the future, and no assurance can be given as to what actions the Board of Equalization or other state or local taxing authorities may take in the future with regard to such property tax exemption.

The foregoing are some examples of the challenges and examinations facing nonprofit health care organizations. They are indicative of a greater scrutiny of the billing, collection and other business practices of these organizations and may indicate an increasingly difficult operating environment for health care organizations, including the Members of the Obligated Group. The challenges and examinations, and any resulting legislation, regulations, judgments, or penalties, could have a material adverse effect on hospitals and health care providers, including the Members of the Obligated Group, and, in turn, the Corporation's ability to make payments under the Loan Agreement and Obligated Group's ability to make payments on the Series 2011A Obligation.

### **Patient Service Revenues**

**Third-Party Payment Programs.** Most of the net patient service revenues of the Obligated Group are derived from third-party payors that reimburse or pay for the services and items provided to patients covered by such third parties for such services, including the federal Medicare program, state Medicaid program and private health plans and insurers, HMOs, preferred provider organizations ("PPOs") and other managed care payors. Many of these third-party payors make payments to the Obligated Group at rates other than the direct charges of the Obligated Group, which rates may be determined on a basis other than the actual costs incurred in providing services and items to patients. Accordingly, there can be no assurance that payments made under these programs will be adequate to cover the Obligated Group's actual costs of furnishing health care services and items. In addition, the financial performance of the System could be adversely affected by the insolvency of, or other delay in receipt of payments from, third-party payors, which provide coverage for services to their patients.

**Medicare and Medicaid Programs.** Medicare and Medicaid are the commonly used names for health care reimbursement or payment programs governed by certain provisions of the federal Social Security Act. Medicare is an exclusively federal program and Medicaid is a combined federal and state program. Medicare provides certain health care benefits to beneficiaries who are 65 years of age or older, disabled or qualify for the End Stage Renal Disease Program. Medicare Part A covers inpatient services and certain other services, and Medicare Part B covers outpatient services, medical supplies and durable medical equipment. Medicaid is designed to pay providers for care given to the medically indigent and others who receive federal aid. Medicaid is funded by federal and state appropriations and is administered by state agencies. The Centers for Medicare & Medicaid Services ("CMS") administers the Medicare program and works with the states regarding the Medicaid program, as well as other health care programs.

Health care providers have been and continue to be affected significantly by changes made in the last several years in federal and state health care laws and regulations, particularly those pertaining to Medicare and Medicaid. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (the "MMA"), among other things described below, generally increased reimbursement levels. The Deficit Reduction Act of 2005 (the "DRA"), contained, among other things, a number of provisions to slow the pace of spending growth in the Medicare and Medicaid programs while increasing health care providers' focus on quality and efficient delivery of health care services. Diverse and complex statutory and regulatory mechanisms, the effect of which is to limit the amount of money paid to health care

providers under both the Medicare and Medicaid programs, have been enacted and approved in recent years, some of which are being implemented and some of which will be or may be implemented in the future. Management of the System is unable to predict what effect, if any, current and future legislative initiatives related to Medicare and Medicaid may have on operations of the System.

**Medicare.** Approximately 30.0% and 30.5% of the net patient service revenues of the Obligated Group were derived from the Medicare program for the fiscal year ended September 30, 2009 and 2010, respectively. As a consequence, any adverse development or change in Medicare reimbursement could have a material adverse effect on the financial condition and results of operations of the System. See APPENDIX A – “HISTORICAL FINANCIAL INFORMATION—Revenue Sources.”

Medicare Part A pays acute care hospitals for most inpatient services under a payment system known as the “Prospective Payment System” or “PPS.” Separate PPS payments are made for inpatient operating costs and inpatient capital-related costs.

*Inpatient Operating Costs.* Acute care hospitals such as those owned by the Obligated Group are paid a specified amount toward their operating costs based on the Diagnosis Related Group (“DRG”) to which each Medicare service is assigned, which is determined by the diagnosis and procedure and other factors for each particular inpatient stay. The amount paid for each DRG is established prospectively by CMS, an agency of the United States Department of Health and Human Services (“HHS”), based on the estimated intensity of hospital resources necessary to furnish care for each principal diagnosis and is not related directly to a hospital’s actual costs. For certain Medicare beneficiaries who have unusually costly hospital stays (“outliers”), CMS will provide additional payments above those specified for the DRG. Outlier payments cease to be available upon the exhaustion of such patient’s Medicare benefits or a determination that acute care is no longer necessary, whichever occurs first. There is no assurance that any of these payments will cover the actual costs incurred by a hospital. In addition, recent revisions to the outlier regulations, implemented in order to curb outlier payment abuse, may adversely affect hospitals’ ability to receive such subsidies. In addition to outlier payments, DRG payments are adjusted for area wage differentials. These change on a yearly basis.

DRG payments are adjusted each federal fiscal year (which begins October 1) based on the hospital “market basket” index, or the cost of providing health care services. For nearly every year since 1983, Congress has modified the increases and given substantially less than the increase in the “market basket” index. CMS has also implemented a documentation and coding adjustment to account for changes in payments under the new MS-DRG system that are not related to changes in case mix. The documentation and coding adjustments for federal fiscal years 2008 and 2009 were reductions to the base payment rate of 0.6% and 0.9%, respectively. CMS was given the authority to retrospectively determine if the documentation and coding adjustments for these years were adequate to account for changes in payments not related to changes in case mix. CMS proposed to adjust 2010 rates downward by 1.9% so that the 2008 increase in spending from documentation and coding is not carried forward. However, based on public comments, CMS decided not to make that adjustment in 2010 without knowing whether 2009 spending from documentation and coding is more or less than earlier projected. CMS did not propose any adjustment to 2010 rates to recoup excess 2008 spending, but did elect to phase in such adjustments in the 2011 IPPS Final Rule. However, the Health Care Reform Act will reduce the annual Medicare market basket updates through September 30, 2019. Beginning in fiscal year 2012, the Health Care Reform Act also provides that annual Medicare market basket updates will be subject to productivity adjustments. The reductions in market basket updates and the productivity adjustments will have a disproportionately negative effect upon those providers that are relatively more dependent upon Medicare than other providers. Additionally, the reductions in market basket updates will be effective prior to the periods during which insurance coverage and the insured consumer base will expand, which may have an interim negative effect on revenues. The combination of reductions to the market basket updates and the imposition of the productivity adjustments may, in some cases and in some years, result in reductions in

Medicare payment per discharge on a year-to-year basis. For further information regarding the Health Care Reform Act and its provisions, see “BONDHOLDERS’ RISKS – National Health Care Reform” herein.

For fiscal year 2010, the Final Inpatient IPPS Rule included an operating market basket update of 2.1%. As required by the DRA, hospitals that do not participate in the Reporting Hospital Quality Data for Annual Payment Update program will receive the market basket update less 2.0%. CMS added new quality measures that hospitals must report during calendar year 2010 in order to qualify for the full market basket update in federal fiscal year 2011. The System’s hospitals participate in the Hospital Quality Initiative.

For calendar year 2011, CMS updated acute care hospital rates by 2.35%. This update reflects a market basket increase of 2.6% for inflation reduced by 0.25%, as required by the Health Care Reform Act. In addition, CMS is applying a documentation and coding adjustment as explained above to recoup a portion of excess aggregate payments in FY 2008 and FY 2009. CMS has determined that a -5.8% adjustment is necessary to recoup all of these overpayments. The -2.9% adjustment for FY 2011 is one-half of the necessary adjustment. This reduction, coupled with other adjustments, is estimated to reduce total payments for operating expenses to IPPS hospitals in FY 2011 by 0.4% or \$440 million.

The Secretary of HHS is required to review annually the DRG categories to take into account any new procedures and reclassify DRGs and recalibrate the DRG relative weights that reflect the relative hospital resources used by hospitals with respect to discharges classified within a given DRG category. There is no assurance that the Obligated Group will be paid amounts that will reflect adequately changes in the cost of providing health care or in the cost of health care technology being made available to patients. During federal fiscal years 2007, 2008, 2009 and 2010, CMS created new DRGs and revised or deleted others in order to better recognize the severity of illness for each patient. CMS may only adjust DRG weights on a budget-neutral basis.

*Rehabilitation.* CMS reimburses inpatient rehabilitation facilities (“IRFs”) on a PPS basis. Under IRF PPS, patients are classified into case mix groups based on impairment, age, comorbidities and functional capability. IRFs are paid a predetermined amount per discharge that reflects the patient’s case mix group and is adjusted for area wage levels, low-income patients, rural areas and high-cost outliers. For federal fiscal years 2006 and 2007, CMS updated the PPS rate for rehabilitation hospitals and units by market baskets of 3.6% and 3.3%, respectively. However, CMS also applied reductions to the standard payment amount of 1.9% and 2.6% for federal fiscal years 2006 and 2007, respectively, to account for coding changes that do not reflect real changes in case mix. For federal fiscal year 2008, CMS updated the PPS rate for IRFs by the market basket of 3.2%. The Medicare, Medicaid and SCHIP Reauthorization Act of 2007 (“MMSEA”), signed into law on December 29, 2007, eliminated the market basket update as of April 2008 and continues the zero percent increase through federal fiscal year 2009.

On July 31, 2008, CMS finalized its April 21, 2008 proposed rule (the “CMS Final IRF Rule”) that recalculates the weights assigned to the case mix groups using more recent data from rehabilitation hospitals about the types of patients they are treating and the resources required. However, as required by MMSEA, the final rule sets the inflation update for the standard federal rate at zero percent for federal fiscal year 2009. Additionally, as required by the MMSEA, the CMS Final IRF Rule retains the requirement that at least 60% of a facility’s patient population have one of 13 qualifying conditions specified in Medicare regulations. At the same time, the CMS Final IRF Rule implements provisions in the MMSEA that allow facilities to continue to count patients whose principal reason for needing inpatient rehabilitation services is not one of the qualifying conditions, but whose treatment is complicated by the presence of one or more of these conditions as a secondary diagnosis.

The 2011 IRF Final Rule authorized a market basket increase of 2.5%. Reducing the market basket by 0.25% as required by the Health Care Reform Act, results in a FY 2011 update of 2.25%.

*Psychiatric Services.* On November 15, 2004, CMS published a final rule to implement the conversion of inpatient psychiatric services to PPS, as mandated by the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999. The new inpatient psychiatric facility PPS system (“IPF PPS”) applies to both freestanding psychiatric hospitals and certified psychiatric units in general acute care hospitals, and became effective for cost reporting periods beginning on or after January 1, 2005. The IPF PPS rates were phased in over a three-year period. The transition to a PPS payment methodology has not had a materially adverse impact on the Obligated Group’s finances and operations.

*Capital Costs.* Hospitals are reimbursed on a fully prospective basis for capital costs (including depreciation and interest) related to the provision of inpatient services to Medicare beneficiaries. Thus, capital costs are reimbursed exclusively on the basis of a standard federal rate (based on average national costs), subject to certain adjustments (such as for disproportionate share, indirect medical education and outlier cases) specific to the hospital. Hospitals are reimbursed at 100% of the standard federal rate for all capital costs. This applies to the standard federal rate before the application of the adjustment factors for outliers, exceptions, and budget neutrality.

There can be no assurance that the prospective payments for capital costs will be sufficient to cover the actual capital-related costs of the Obligated Group allocable to Medicare patient stays or to provide adequate flexibility in meeting the future capital needs of the Obligated Group.

*Costs of Outpatient Services.* Hospital outpatient services, including hospital operating and capital costs, are reimbursed on a PPS basis. Several Part B services are specifically excluded from this rule, including certain physician and non-physician practitioner services, ambulance, clinical diagnostic laboratory services and nonimplantable orthotics and prosthetics, physical and occupational therapy, and speech language pathology services.

Under the hospital outpatient PPS (“OPPS”), predetermined amounts are paid for designated services furnished to Medicare beneficiaries. CMS classifies outpatient services and procedures that are comparable clinically and in terms of resource use into ambulatory payment classification (“APC”) groups. Using hospital outpatient claims data from the most recent available hospital cost reports, CMS determines the median costs for the services and procedures in each APC group. Subsequently, a payment rate is established for each APC. Depending on the services provided, a hospital may be paid for more than one APC for a patient visit.

OPPS rates are adjusted annually based on the hospital inpatient market basket percentage increase. CMS authorized a 2.1% increase for calendar year 2010 as the APC market basket adjustment. In the OPPS final rule for calendar year 2011 released on November 2, 2010, CMS authorized a market basket increase of 2.35%. Hospitals that fail to report data related to eleven required quality measures will have their market basket percentage increase reduced by two percentage points, resulting in an adjustment of only 0.35% for calendar year 2011. There can be no assurance that the hospital OPPS rate, which bases payment on APC groups rather than on individual services, will be sufficient to cover the actual costs of the Obligated Group allocable to Medicare patient care.

In addition to the APC rate, there is a predetermined beneficiary coinsurance amount for each APC group. There can be no assurance that the beneficiary will pay this amount.

The OPPS final rule for calendar year 2011 also implemented several provisions of the Health Care Reform Act which may impact the reimbursement and operations of hospitals across the country. Some of the specific reforms addressed in the 2011 OPPS final rule that have the potential to impact hospitals are: (i) reduction of the hospital outpatient department fee schedule increase factor by a

productivity adjustment and an additional adjustment for payments to hospital outpatient departments beginning in various years from 2010 through 2019; (ii) application of similar productivity adjustments for payment for ambulatory surgical center (“ASC”) services; (iii) new provisions relating to the prohibition against referrals to a hospital by a physician who has an ownership or investment interest in the hospital; (iv) adjustments to the area wage adjustment factor for outpatient department services; and (v) changes related to payment for GME and IME.

*Physician Payments.* Certain physician services are reimbursed on the basis of a national fee schedule called the “resource based-relative value scale” (“RB-RVS”). The RB-RVS fee schedule establishes payment amounts for all physician services, including services of provider-based physicians, and is subject to annual updates. In the RB-RVS system, payments for physician services are determined by the resource costs needed to provide them. The cost of providing each service is divided into three components: physician work, practice expense and professional liability insurance, each of which is resource-based. These factors are translated into relative value units (“RVU”) and payments are calculated by multiplying the combined RVUs of a service by a conversion factor (a monetary amount that is determined by CMS). Payments are also adjusted for geographical differences in resource costs. The Sustainable Growth Rate (“SGR”), which is a limit on the growth of Medicare payments for physician services, is linked to changes in the U.S. Gross Domestic Product over a ten-year period. SGR targets are compared to actual expenditures in order to determine subsequent physician fee schedule updates. Use of the SGR in determining physician fee schedule updates has been widely criticized as an unworkable formula, and in the absence of continuing Congressional intervention the use thereof will result in a considerable decrease to Medicare physician payments.

The 2011 Medicare Physician Fee Schedule Final Rule (the “2011 MPFS”) was published on November 2, 2010. In the absence of further action by Congress, the conversion factor used to calculate payment amounts to physicians under the 2011 RB-RVS fee schedule would have been reduced by 25.5% effective January 1, 2011. On December 15, 2010, President Obama signed into law the Medicare and Medicaid Extenders Act of 2010, which prevents the scheduled 25.5% reduction and extends the current physician fee schedule payment rates through December 31, 2011.

Although most of the provisions included in the 2011 MPFS directly affect payments provided under the physician fee schedule, the rule also addresses a number of policies that are not directly related to that payment system. The 2011 MPFS also addresses and implements a number of provisions of the Health Care Reform Act, each of which may impact the reimbursement levels of hospitals, such as: (i) elimination of deductible and coinsurance for most preventive services; (ii) coverage of annual wellness visit providing a personalized prevention plan; (iii) incentive payments to primary care practitioners for primary care services; (iv) incentive payments for major surgical procedures in health professional shortage areas; (v) an update to the Medicare Economic Index (MEI); (vi) revisions to the practice expense geographic adjustment; (vii) permitting Physician Assistants to order post-hospital extended care services; (viii) payment for bone density tests; (ix) increased payments for Certified Nurse-Midwife services; (x) extension of Medicare reasonable cost payments for certain clinical diagnostic laboratory tests furnished to hospital patients in certain rural areas; (xi) amendment to the physician self-referral disclosure requirement related to certain imaging services; (xii) expansion of the Medicare durable medical equipment competitive bidding program; (xiii) identification of misvalued codes under the MPFS; (xiv) adoption of a multiple procedure payment reduction policy for therapy services; (xv) modification of equipment utilization factor and modification of multiple procedure payment policy for advanced imaging services; (xvi) adjustments to the payment schedule for power-driven wheelchairs; and (xvii) reduction of the maximum period for submission of Medicare claims to no more than 12 months.

*Skilled Nursing Care.* Medicare Part A reimburses on a PPS basis for certain post-acute inpatient skilled nursing and rehabilitation care for up to 100 days during the same spell of illness. Medicare Part A reimburses for certain post-hospital inpatient skilled nursing and rehabilitation care for up to 100

days during the same spell of illness. For skilled nursing facilities (“SNFs”), the federal government has implemented a PPS for Medicare reimbursement, which utilizes prospective, case-mix adjusted per diem rates applicable to all covered SNF services. Reimbursement under PPS also incorporates adjustments to account for facility case-mix using the Resource Utilization Groups (“RUGs”) system. Effective January 1, 2006, nine new RUGs were added to a refined RUGs classification system, for a total of 53, and additional payments for certain existing RUGs were eliminated. CMS expanded the number of RUGs to achieve budget neutrality, but the expansion has resulted in increased Medicare expenditures. The SNF PPS payments are adjusted annually based on the skilled nursing facility “market basket” index, or the cost of providing SNF services. On August 11, 2009, CMS published its final rules related to nursing home payment rates and implemented a 2.2% market basket increase for federal fiscal year 2010. CMS expected the market basket increase to yield an increase of \$690 million in increased Medicare payments. The 2011 final rule for nursing home payment rates was published on July 22, 2010 and included a 1.7% increase to the SNF market basket, which represents the 2.3% increase factor combined with the negative 0.6% forecast error adjustment for FY 2009. Estimated payments to SNFs are expected to increase by \$542 million compared with those in FY 2010.

*Home Health Care.* CMS pays home health agencies for 60-day episodes of care based on PPS and reimburses agencies at higher rates for beneficiaries with greater needs. The system uses national payment rates that vary with the level of care required by each beneficiary, adjusted to reflect area wage differences. Additional payments may be made to the 60-day case-mix adjusted episode payments for beneficiaries who incur unusually large costs. Total national outlier payments for home health services annually will be no more than five percent of estimated total payments under home health PPS. CMS provided for a 2.2% market basket update for calendar year 2010. As required by the DRA, agencies that do not submit data to CMS relating to ten quality indicators will have their market basket update percentage reduced by two percent. The Health Care Reform Act mandated reduction in the home health market basket update by 1.0% in 2011, 2012 and 2013, and beginning in 2015, required that the home health market basket annual update be subject to a productivity adjustment. The 2011 final rule for home health agencies, published November 2, 2010, stated that the market basket increase for 2011 was calculated as 2.1% based on third quarter forecasts, but due to the requirements of the Health Care Reform Act, must be reduced to 1.1%.

*Provider-Based Standards.* CMS made significant changes to the provider-based regulation included in the final OPPTS rulemaking for federal fiscal year 2003. Generally, CMS eliminated a few requirements for on-site provider-based facilities and clarified some of the provisions of the prior provider-based rules. CMS clarified that prior approval of provider-based status by CMS is not required for an entity to bill as provider-based. Rather, a provider may provide an optional attestation of its status as a provider-based entity. Although such attestation is not required to bill as a provider-based entity, it may provide some overpayment protection in the event that CMS subsequently makes a determination that an entity is not provider-based, assuming accurate representation by the provider to CMS. Any reclassification by CMS may adversely affect the entity’s reimbursement under the Medicare program. Based on current regulations, the Obligated Group believes all of its current facilities that bill for services as provider-based entities qualify as “provider-based” entities under the current regulations.

*Medicare Advantage.* Medicare beneficiaries may obtain Medicare coverage through a managed care Medicare Advantage plan (formerly known as a “Medicare+Choice” plan). A Medicare Advantage plan may be offered by a coordinated care plan (such as an HMO or PPO), a provider sponsored organization (“PSO”) (a network operated by health care providers rather than an insurance company), a private fee-for-service plan, or a combination of a medical savings account (“MSA”) and contributions to a Medicare Advantage plan. Each Medicare Advantage plan, except an MSA plan, is required to provide benefits approved by the Secretary of HHS. A Medicare Advantage plan will receive a monthly capitated payment from HHS for each Medicare beneficiary who has elected coverage under the plan. Health care providers such as the Obligated Group must contract with Medicare Advantage plans to treat Medicare

Advantage enrollees at agreed upon rates or may form a PSO to contract directly with HHS as a Medicare Advantage plan. Covered inpatient and emergency services rendered to a Medicare Advantage beneficiary by a hospital that is an out-of-plan provider (i.e., that has not entered into a contract with a Medicare Advantage plan) will be paid at Medicare fee-for-service payment rates as payment in full.

The MMA made several substantive changes to Medicare Advantage in addition to renaming the program. These changes are designed to improve Medicare Advantage by providing increased payments to providers and by offering more health plan choices, including expanded rural coverage through the inclusion of regional plans, beginning in 2006. Increased payments to Medicare Advantage providers were effective as of March 2004. There can be no assurance, however, that rates negotiated for the treatment of Medicare Advantage enrollees will be sufficient to cover the cost of providing services to such patients of the Obligated Group.

The Health Care Reform Act provides that from October 1, 2010 through September 30, 2019, payments under the Medicare Advantage programs will be reduced, which may result in increased premiums or out-of-pocket costs to Medicare beneficiaries enrolled in Medicare Advantage plans. These beneficiaries may terminate their participation in such Medicare Advantage plans and opt for the traditional Medicare fee-for-service program. The reduction in payments to Medicare Advantage plans may also lead to decreased payments to providers by managed care companies operating Medicare Advantage plans. All or any of these outcomes will have a disproportionately negative effect upon those providers with relatively high dependence upon Medicare managed care revenues. For further information regarding the Health Care Reform Act and its provisions, see “BONDHOLDERS’ RISKS – National Health Care Reform” herein.

*Medicare Audits.* The Obligated Group receives payments for various services provided to Medicare patients based upon charges or other reimbursement methodologies that are then reconciled annually based upon the preparation and submission of annual cost reports. Estimates for the annual cost reports are reflected as amounts due to/from third-party payors and represent several years of open cost reports due to time delays in the fiscal intermediary’s audits and the basic complexity of billing and reimbursement regulations. These estimates are adjusted periodically based upon correspondence received from the fiscal intermediary. Medicare regulations also provide for withholding Medicare payment in certain circumstances if it is determined that an overpayment of Medicare funds has been made. In addition, under certain circumstances, payments may be determined to have been made as a consequence of improper claims subject to the federal False Claims Act (the “Federal False Claims Act”) or other federal statutes, subjecting the Obligated Group to civil or criminal sanctions. Management of the System is not aware of any situation whereby a material Medicare payment is being withheld from the System.

The System, like other hospital systems throughout the country, are subject from time to time to audits and other investigations relating to various aspects of their operations. Medicare participating hospitals are subject to audits and retroactive audit adjustments with respect to reimbursement claimed under the Medicare program. Medicare regulations also provide for withholding Medicare payment in certain circumstances. Although management of the System does not anticipate or have reason to believe that a substantial withholding or audit adjustment will be made with respect to the System, there can be no assurance that, if such withholdings or audit adjustments were to be assessed, they would not have a material adverse effect on the financial position of the System. Management of the System does not believe that any other type of audit or investigation would result in a liability that would have a material adverse effect on the business, operations, or financial condition of the System.

*RAC Audits.* In accordance with the MMA and the Tax Relief and Health Care Act of 2006 (the “2006 Tax Act”), CMS has designated the use of recovery audit contractors (“RAC”) to search for improper Medicare payments in Arizona, Florida, California, Massachusetts, New York and South

Carolina. While originally part of a demonstration program that was set to expire in 2008, the provisions of the 2006 Tax Act make the RAC program permanent and require CMS to expand the program to all 50 states by no later than 2010. CMS released a report in July 2008 stating that more than \$693 million had been deposited in the Medicare Trust Funds between 2005 and March 2008 as part of the RAC program. Government officials have expressed concern that current payment integrity efforts are insufficient to identify and seek recovery of Medicare overpayments that are estimated currently to be in excess of \$20 billion per year. The audit contractors have scrutinized provider payments made during a current federal fiscal year and the four previous federal fiscal years. The System has had several RAC audits conducted for payment years between 2003 and 2007, none of which resulted in a material adjustment to the System's Medicare payments for such periods. RAC automated reviews of claims began in 2009 and medical necessity complex reviews have begun in 2010. Management cannot anticipate the amount or volume of future Medicare claims that will be reviewed by the recovery audit contractors or what the results of any such audits may be.

**Medicaid Program.** Medicaid is a program of medical assistance, funded jointly by the federal government and the states, for certain needy individuals and their dependants. Under Medicaid, the federal government provides limited funding to states that have medical assistance programs that meet federal standards. Fiscal considerations of both federal and state governments in establishing their budgets will directly affect the funds available to the providers for payment of services rendered to Medicaid beneficiaries. For example, the DRA included Medicaid cuts of approximately \$4.8 billion over a five-year period.

For the fiscal years ended September 30, 2009 and 2010, the Obligated Group received approximately 7.8% and 8.3%, respectively, of net patient service revenues from Medi-Cal, California's Medicaid program. See APPENDIX A – "HISTORICAL FINANCIAL INFORMATION—Revenue Sources."

*California Medi-Cal.* Medi-Cal is the California Medicaid program. The State of California selectively contracts with general acute care hospitals to provide inpatient services to Medi-Cal patients. The State is obligated to make contractual payments only to the extent the legislature appropriates adequate funding. Except in areas of the State that have been excluded from contracting, a general acute care hospital generally will not qualify for payment for non-emergency acute inpatient services rendered to a Medi-Cal beneficiary unless it is a contracting hospital. Typically, either party may terminate such contracts on 120 days' notice and the State may terminate without notice under certain circumstances. No assurances can be made that hospitals will be awarded Medi-Cal contracts or that any such contracts will reimburse hospitals for the cost of delivering services.

*Disproportionate Share Payments.* Under Medicare PPS and the California Medi-Cal programs, hospitals that serve a disproportionate share of low-income patients may receive an additional disproportionate share hospital adjustment ("DSH"). A hospital may be classified as a DSH hospital based upon any of several circumstances related to the number of beds, the hospital's location, and its disproportionate patient percentage. The DSH adjustment is calculated under one of several methods, depending upon the basis for the hospital's classification as a DSH hospital. For the fiscal year ended September 30, 2010, the Obligated Group received State DSH payments totaling approximately \$0.3 million for two of the Obligated Group's hospitals, and federal DSH payments totaling approximately \$37.0 million for three of the Obligated Group's hospitals. In addition, the Obligated Group has just been notified that Chula Vista is eligible for state Medi-Cal DSH payments for the fiscal year ending September 30, 2010. The Obligated Group does not know the amount of such state DSH payments. Under healthcare reform, with the expected decrease in the uninsured population, federal DSH payments will be reduced by 75% commencing in federal fiscal year 2014 and state Medicaid DSH payments are anticipated to be reduced quarterly starting in 2014. From 2014 to 2020, the estimated total

loss of Medicaid DSH funds to states will be \$18.1 billion. There also can be no assurance that payments for disproportionate share will not be further decreased or eliminated in the future.

The federal DSH adjustment for the Obligated Group's hospitals is calculated under a method based in part on the ratio of Supplemental Security Income ("SSI") days to total patient days. CMS changed methodologies and published its calculation of the SSI ratios for fiscal 2007 in the Federal Register on June 24, 2009 ("2007 SSI Ratios"). The 2007 SSI Ratios for the Obligated Group's hospitals receiving DSH payments were lower than prior years, which would result in reduced DSH payments to the Obligated Group's hospitals for fiscal year 2007. Until SSI ratios are published for subsequent years, CMS and the Obligated Group use the most recently published SSI ratios to estimate reimbursement. As a result, reductions in DSH payments were estimated and reserved by the Obligated Group for fiscal years 2008, 2009 and 2010. On July 31, 2009, CMS issued a Joint Signature Memorandum, which required all fiscal intermediaries to stop issuing final settlements for cost reports that use the 2007 SSI data until further notice. As a result, the fiscal intermediary has not requested reimbursement of the potential overpayments for fiscal years 2007 and 2008, estimated to total \$5.4 million and \$5.9 million, respectively, for the Obligated Group's hospitals and reserved for in the Obligated Group's financial statements. The interim reimbursement rates paid to the Obligated Group's hospitals for fiscal years 2009 and 2010 were updated to reflect the decreased reimbursement associated with the DSH reduction. The Obligated Group intends to appeal the 2007 DSH adjustment. The resolution of such an appeal is likely to take several years and there is no assurance that the Obligated Group will prevail.

For further information regarding the Health Care Reform Act and its provisions, see "BONDHOLDERS' RISKS – National Health Care Reform" herein.

*California Hospital Provider Fee.* On October 11, 2009, Governor Schwarzenegger signed into law Assembly Bill 1383, the Medi-Cal Hospital Provider Rates Stabilization Act and the Quality Assurance Fee Act, as amended by Assembly Bill 1683 (the "Provider Fee Law"). The Provider Fee Law imposes a one-time quality assurance fee on California's general acute care hospitals, except for designated public hospitals and certain other exempt hospitals. The amount of the quality assurance fee owed by each California hospital varies, based upon each hospital's managed care, fee-for-service and Medi-Cal total patient days, as derived from hospital census data for 2007 and applied to the period from April 1, 2009 through December 31, 2010. The fee proceeds are to be used to earn federal matching funds for Medi-Cal, including increases in Medi-Cal payments to hospitals, supplemental payments to Medi-Cal managed care plans, health care coverage for children and certain costs of administering the quality assurance fee program. Under the program, some California hospitals will receive more money in increased Medi-Cal reimbursement than the quality assurance fees paid, while other California hospitals will receive less money in Medi-Cal payments than the fees paid. Based upon the methodology for calculating fees and supplemental Medi-Cal payments, the Members of the Obligated Group, collectively, anticipate that they will be net "beneficiaries," who receive more funds than the fees that they pay and not net "contributors," of the fee program.

The quality assurance fee will be payable in installments during the last three months of 2010, and supplemental Medi-Cal payments will be distributed to hospitals also in installments between October 2010 and February 2011. The Provider Fee Law also directs the State legislature to enact subsequent legislation to extend the collection of quality assurance fees after December 31, 2010. An extension would be subject to federal approval to enable Medi-Cal to obtain federal matching funds for periods subsequent to December 31, 2010. There can be no predictions as to whether the State legislature will take action to extend the fee beyond December 31, 2010.

*California State Budget.* Many states, including California, face severe financial challenges, including erosion of general fund tax revenues, falling real estate values, slower economic growth and higher unemployment, which may continue or worsen over the coming years. Shortfalls between State revenues and spending demands, along with balanced budget requirements, have in the past and may in

the future result in cutbacks to government health care programs. Failure by the California legislature to approve budgets prior to the start of a new fiscal year can also result in a temporary hold on or delay of Medi-Cal reimbursement. See APPENDIX A – “HISTORICAL FINANCIAL INFORMATION—Revenue Sources.”

California’s budget for the 2008–2009 fiscal year included a 10% reduction in payments to health care providers under Medi-Cal until March 1, 2009, at which point smaller reductions took effect. The enacted legislation also requires Medi-Cal beneficiaries to verify their eligibility every six months, rather than each year, as previously required, in order to achieve savings by reducing the number of enrollees in the Medi-Cal program. Such changes to reimbursement rates and program enrollment might negatively affect the Obligated Group in a number of ways, including, but not limited to, reduced revenue and an increase in uninsured and underinsured patients.

In late 2008 and early 2009, the California legislature and Governor of California took action to close an estimated \$42 billion shortfall. On May 19, 2009, the voters of California rejected several ballot initiatives which, in the aggregate, were expected to increase State tax revenues by approximately \$6 billion, thereby reducing the projected budget deficit for the 2009-2010 fiscal year to approximately \$15.5 billion.

The final fiscal year 2010-2011 budget, signed by the Governor of California on October 8, 2010, includes a Medi-Cal rate freeze for hospitals that is expected to save the State general fund \$84.5 million. The fiscal year 2010-2011 budget closes a deficit of approximately \$19 billion through a combination of expenditure reductions, receipt of federal funds and other solutions.

The final budget for fiscal year 2010-2011 includes a provision to freeze inpatient Medi-Cal rates to those that were in effect on January 1, 2010, or July 1, 2010, whichever is less. The rates will be frozen until the Medicaid Management Information System converts to claims processing based on a new DRG payment method, also mandated by state legislation impacting the budget. SB 853 requires the California Legislature to design a new Medi-Cal hospital inpatient payment system based on DRGs by June 30, 2014. The new payment system is expected to ensure, among other things, higher payments to hospitals for patients with more serious conditions. The new payment methodology will be used for patients in all general acute-care hospitals, including Medicare Critical Access Hospitals. However, it excludes designated public, psychiatric and rehabilitation (including alcohol and drug) hospitals.

Management of the System is analyzing the financial impact of the recently passed California budget on the System.

Additional State financial constraints may result from litigation regarding the prison healthcare system. In April 2001 (and by an amended complaint filed in August 2001), a class-action lawsuit, now known as *Plata v. Schwarzenegger*, was filed in federal court contending that the State was in violation of the Eighth Amendment of the United States Constitution, the federal Americans with Disabilities Act, and section 504 of the federal Rehabilitation Act, as a result of providing inadequate medical care to prison inmates. In August 2008, the receiver (the “Receiver”) appointed by the *Plata* court to oversee the State’s prison healthcare system filed a motion asking the court to hold the Governor and State Controller in contempt of court for failing to fund prison healthcare capital projects and requested the district court judge to order the State to pay contracts totaling \$8 billion to fund such projects. The district court judge granted the motion and ordered the State to transfer an initial \$250 million payment to the Receiver by December 2008. A trial in front of a federal three-judge court began on November 18, 2008. On August 4, 2009, the three judges found that overcrowding is the primary cause of unconstitutional conditions in California’s prisons, such as the system’s inability to provide competent and timely health care for prisoners. The judges also found compelling evidence that reducing the prison population is the only way

to address the problems. The judges issued a 184-page order for the State to develop a plan to reduce the prison population by up to 40,000, to 137.5% of the system's design capacity within two years.

On September 18, 2009, the State filed a population reduction plan. The three-judge court rejected that plan because it failed to make the necessary reductions. On November 12, 2009, the State submitted a revised plan.

On January 12, 2010, a federal three-judge court issued an order that would require California to reduce its prison overcrowding to 137.5% of design capacity, in accord with the revised plan submitted by the state on November 12, 2009 (currently the prisons house more than 160,000 prisoners, which is nearly twice as many as the facilities are designed to hold). However, the federal three-judge court stayed the population reduction order, meaning that it will not take effect until the U.S. Supreme Court decides the appeal that the State has filed in the case. The U.S. Supreme Court heard oral arguments on November 30, 2010. At this point, the financial impact to the State of California's budget upon resolution of this case is unclear.

The financial challenges facing the State and their interaction with health care reform may negatively affect hospitals in a number of ways, including, but not limited to, a greater number of indigent, uninsured or underinsured patients who are unable to pay for their care or access to primary care facilities and a greater number of individuals who qualify for Medicaid and/or reductions in Medicaid and Medi-Cal reimbursement rates. The Obligated Group cannot predict what actions will be taken in the current and future years by the State legislature and the Governor to address the State's financial problems and in response to health care reform. The State's actions will likely depend on national and State economic conditions and other factors that are uncertain at this time. See "Impact of Market Turmoil" and "National Health Care Reform" above.

### **Commercial Insurance and Other Third-Party Plans**

Many commercial insurance plans, including group plans, reimburse their customers or make direct payments to the System for charges at rates established by agreement. Generally, these plans pay per diem rates plus ancillary service charges, which are subject to various limitations and deductibles depending on the plan. To the extent allowed by law, patients carrying such coverage are responsible to the hospital for any deficiency between the commercial insurance proceeds and total billed charges.

**Managed Care and Integrated Delivery Systems.** Many hospitals and health systems, including the System, are pursuing strategies with physicians in order to offer an integrated package of health care services, including physician hospital services, to patients, health care insurers, and managed care providers. These integration strategies take many forms, several of which are discussed below. Further, many of these integration strategies are capital intensive and may create certain business and legal liabilities for the System. These types of alliances are generally designed to respond to trends in the delivery of medicine to better integrate hospital and physician care, to increase physician availability to the community and/or to enhance the managed care capability of the affiliated hospitals and physicians. However, these goals may not be achieved, and an unsuccessful alliance may be costly and counterproductive to all of the above-stated goals.

Integrated delivery systems carry with them the potential for legal or regulatory risks in varying degrees. The ability of hospitals or health systems to conduct integrated physician operations may be altered or eliminated in the future by legal or regulatory interpretation or changes, or by health care fraud enforcement. In addition, participating physicians may seek their independence for a variety of reasons, thus putting the hospital or health system's investment at risk, and potentially reducing its managed care leverage and/or overall utilization. Growth of integrated delivery systems may be resisted by local communities and physician groups.

The Members of the Obligated Group have entered into contractual arrangements with PPOs, HMOs, and other similar managed care organizations (“MCOs”), pursuant to which they agree to provide or arrange to provide certain health care services for these organizations’ eligible enrollees. Revenues received under such contracts are expected to be sufficient to cover the variable cost of the services provided. There can, however, be no assurance that revenues received under such contracts will be sufficient to cover all costs of services provided. Failure of the revenues received under such contracts to cover all costs of services provided may have a material adverse effect on the operations or financial condition of the System.

Medicare law states that MCO and provider contracts may include a physician incentive plan only if (1) no specific payment is made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual enrollee; and (2) the stop-loss protection, enrollee survey and disclosure requirements of this section are met. If an MCO and provider enter into an agreement that does not meet these requirements, the IRS may apply intermediate sanctions or HHS, through the Office of Inspector General (“OIG”), may apply CMP.

MCOs in general reimburse participating providers on the basis of capitation for services rendered to enrollees. A capitated payment does not fluctuate with the frequency of patient visits. Rather, an MCO typically negotiates with the provider a flat fee per patient regardless of the extent of covered medical services required by that patient. Therefore, there is a risk that the provider may need to furnish the enrollee with additional services whose cost will not be covered by the capitated rate paid by the MCO. See “Capitated Payments” below for more information.

**Health Plans and Managed Care.** Most private health insurance coverage is provided by various types of “managed care” plans, including HMOs and PPOs, that generally use discounts and other economic incentives to reduce or limit the cost and utilization of health care services. Medicare and Medicaid also purchase hospital care using managed care options. Payments to hospitals from managed care plans typically are lower than those received from traditional indemnity or commercial insurers.

In California, managed care plans have replaced indemnity insurance as the prime source of non-governmental payment for hospital services, and hospitals must be capable of attracting and maintaining managed care business, often on a regional basis. Regional coverage and aggressive pricing may be required. However, it is also essential that contracting hospitals be able to provide the contracted services without significant operating losses, which may require multiple forms of cost containment.

For the fiscal years ended September 30, 2009 and 2010, managed care payments (excluding capitated contracts) constituted approximately 38.4% and 38.0%, respectively, of net patient service revenues of the Obligated Group. See APPENDIX A – “HISTORICAL FINANCIAL INFORMATION—Revenue Sources.”

Many HMOs and PPOs currently pay providers on a negotiated fee-for-service basis or, for institutional care, on a fixed rate per day of care, which, in each case, usually is discounted from the usual and customary charges for the care provided. As a result, the discounts offered to HMOs and PPOs may result in payment to a provider that is less than its actual cost. Additionally, the volume of patients directed to a provider may vary significantly from projections, and/or changes in the utilization may be dramatic and unexpected, thus jeopardizing the provider’s ability to manage this component of revenue and cost.

Some HMOs employ a “capitation” payment method under which hospitals are paid a predetermined periodic rate for each enrollee in the HMO who is “assigned” or otherwise directed to receive care at a particular hospital. The hospital may assume financial risk for the cost and scope of institutional care given. If payment is insufficient to meet the hospital’s actual costs of care, or if utilization by such enrollees materially exceeds projections, the financial condition of the hospital could

erode rapidly and significantly. For the fiscal year ended September 30, 2009 and 2010, capitated managed care contracts constituted approximately 22.9% and 22.4%, respectively, of net patient service revenue of the Obligated Group. See APPENDIX A – “HISTORICAL FINANCIAL INFORMATION—Revenue Sources.”

Often, HMO contracts are enforceable for a stated term, regardless of hospital losses and may require hospitals to care for enrollees for a certain time period, regardless of whether the HMO is able to pay the hospital. Hospitals from time to time have disputes with managed care payors concerning payment and contract interpretation issues.

Failure to maintain contracts could have the effect of reducing the System’s market share and net patient services revenues. Conversely, participation may result in lower net income if participating hospitals are unable to adequately contain their costs. Thus, managed care poses one of the most significant business risks (and opportunities) the hospitals face.

Physician Contracting and Relations. The System has contracted with physician organizations (“POs”) (e.g., independent physician associations) to arrange for the provision of physician and ancillary services. Because POs are separate legal entities with their own goals, obligations to shareholders, financial status and personnel, there are risks involved in contracting with the POs. See APPENDIX A for more information regarding the System’s PO relationships.

The success of the System will be partially dependent upon its ability to attract physicians to join the POs and to attract POs to participate in its network, and upon the physicians’ abilities to perform their obligations and deliver high-quality patient care in a cost-effective manner. There can be no assurance that the POs will be able to attract and retain the requisite number of physicians, or that such physicians will deliver high-quality health care services. Without impaneling a sufficient number of providers and requisite specialties, the System could fail to be competitive, could fail to keep or attract payor contracts, or could be prohibited from operating until its panel provided adequate access to patients. Such occurrences could have a material adverse effect on the business or operations of the System.

State Laws. States are increasingly regulating the delivery of health care services. Much of this increased regulation has centered around the managed care industry. State legislatures have cited their right and obligation to regulate and oversee health care insurance and have enacted sweeping measures that aim to protect consumers and, in some cases, providers. For example, a number of states have enacted laws mandating a minimum of 48-hour hospital stays for women after delivery; laws prohibiting “gag clauses” (contract provisions that prohibit providers from discussing various issues with their patients); laws defining “emergencies,” which provide that a health care plan may not deny coverage for an emergency room visit if a layperson would perceive the situation as an emergency; and laws requiring direct access to obstetrician-gynecologists without the requirement of a referral from a primary care physician.

Due to this increased state oversight, the System could be subject to a variety of state health care laws and regulations, affecting both MCOs and health care providers. In addition, the System could be subject to state laws and regulations prohibiting, restricting, or otherwise governing PPOs, third-party administrators, physician-hospital organizations, independent practice associations or other intermediaries; fee-splitting; the “corporate practice of medicine”; selective contracting (“any willing provider” laws and “freedom of choice” laws); coinsurance and deductible amounts; insurance agency and brokerage; quality assurance, utilization review, and credentialing activities; provider and patient grievances; mandated benefits; rate increases; and many other areas.

## **Regulation of the Health Care Industry**

**General.** The health care industry is highly dependent on a number of factors that may limit the ability of the Corporation to meet its obligations under the Loan Agreement and the Obligated Group and any future Member of the Obligated Group to meet their respective obligations under the Master Indenture and the Series 2011A Obligation. Among other things, participants in the health care industry (such as the System) are subject to significant regulatory requirements of federal, state and local governmental agencies and independent professional organizations and accrediting bodies, technological advances and changes in treatment modes, various competitive factors and changes in third-party reimbursement programs. Discussed below are certain of these factors that could have a significant effect on the future operations and financial condition of the System.

**Balanced Budget Act of 1997.** As described below, the Balanced Budget Act of 1997 (the “BBA”) contains a number of provisions that may affect the System in addition to those previously referenced. The System has taken operational steps to address the impact of the BBA.

Conviction of health care-related crimes can result in either mandatory or permissive exclusion from participation in federal and certain state health care programs for various periods of time depending on the nature of such crimes. Under the BBA, those convicted of three health care-related crimes for which mandatory exclusion is the penalty will be permanently excluded from participation. Those convicted of two health care-related crimes for which mandatory exclusion is the penalty will be excluded for a minimum of ten years. The Secretary of HHS will be able to deny entry into Medicare or Medicaid or deny renewal to any provider or supplier convicted of any felony that the Secretary deems to be “inconsistent with the best interests” of the program’s beneficiaries.

**Federal Privacy Laws.** The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) added two prohibited practices, the commission of which may lead to CMP: (1) the practice or pattern of presenting a claim for an item or service on a reimbursement code that the person knows or should know will result in greater payment than appropriate, i.e., upcoding, and (2) engaging in a practice of submitting claims for payment for medically unnecessary services. Violation of such prohibited practices could amount to CMP of up to \$10,000 for each item or service involved. Management of the System believes that its operations comply with HIPAA.

HIPAA also includes administrative simplification provisions intended to facilitate the processing of health care payments by encouraging the electronic exchange of information and the use of standardized formats for health care information. Congress recognized, however, that standardization of information formats and greater use of electronic technology presents additional privacy and security risks due to the increased likelihood that databases of personally identifiable health care information will be created and the ease with which vast amounts of such data can be transmitted. Therefore, HIPAA requires the establishment of distinct privacy and security protections for individually identifiable health information.

HHS promulgated privacy regulations under HIPAA that protect patient medical records and other personal health information maintained by health care providers, hospitals, health plans, health insurers, and health care clearinghouses (the “Privacy Regulations”). Compliance with the Privacy Regulations was required as of April 14, 2003. Management of the System believes that its operations and information systems comply with the Privacy Regulations.

Security regulations have also been promulgated under HIPAA. These security regulations were issued in final form on February 20, 2003, with a compliance date of April 21, 2005 (the “Security Regulations”). Additionally, HHS promulgated regulations to standardize the electronic transfer of information pursuant to certain enumerated transactions (the “Code Set Transactions”), with a compliance

deadline of October 16, 2003. Management of the System believes that all of their health care facilities are in substantial compliance with the Security Regulations and the Code Set Transactions.

Violations of HIPAA could result in CMP of up to \$25,000 per type of violation in each calendar year and criminal penalties of up to \$250,000 per violation.

On February 17, 2009, President Obama signed into law the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), which is part of ARRA. The HITECH Act significantly changes the landscape of federal privacy and security law with regard to individually identifiable health information. The HITECH Act (i) extended the reach of HIPAA and the Security Regulations, (ii) imposed a breach notification requirement on HIPAA covered entities, (iii) limited certain uses and disclosures of individually identifiable health information, (iv) increased individuals' rights with respect to individually identifiable health information and (v) increased enforcement of, and penalties for, violations of privacy and security of individually identifiable health information. Many of the HITECH Act's provisions became effective on February 17, 2010, but other provisions require implementing regulations or may become effective at some point in 2011 or thereafter. Management of the System does not expect that the prohibited practices provisions of the HITECH Act will affect the System in a material respect.

Any violation of the HITECH Act is subject to HIPAA civil and criminal penalties. Additionally, the HITECH Act also creates a tiered approach to CMP for violations of HIPAA and the HITECH Act that became effective immediately upon President Obama signing the HITECH Act into law on February 17, 2009. The new tiered approach under the HITECH Act provides for CMP of up to \$1.5 million for violations during a calendar year.

**State Privacy Laws.** Two State privacy laws, A.B. 211 and S.B. 541, became effective on January 1, 2009. The laws create new obligations for health care providers and facilities in the State to protect against unlawful or unauthorized access to patient medical information. Unauthorized access includes the inappropriate review or viewing of patient medical information without a direct need for diagnosis, treatment, or other lawful use as permitted under State law. A new State agency, the Office of Health Information Integrity, has been established to enforce A.B. 211 and impose fines that can range from \$1,000 up to a maximum of \$250,000 per violation.

S.B. 541 applies to clinics, health facilities, home health agencies, or hospice and requires those facilities to prevent unlawful or unauthorized access to, and use or disclosure of, patient's medical information. S.B. 541 also requires those facilities to report any unlawful or unauthorized access to patient medical information to the California Department of Public Health ("CDPH") within five days after such unlawful or unauthorized access has been detected and empowers the CDPH to levy fines that range from \$25,000 up to a maximum of \$250,000 per violation. The Obligated Group has educated its employees about the laws and has implemented policies and procedures on compliance with the reporting requirements.

**Federal "Fraud and Abuse" Laws and Regulations.** The Federal Medicare/Medicaid Anti-Fraud and Abuse Amendments to the Social Security Act (the "Anti-Kickback Law") make it a felony offense to knowingly and willfully offer, pay, solicit, or receive remuneration in order to induce business for which reimbursement is provided under the Medicare or Medicaid programs. In addition to criminal penalties, including fines of up to \$25,000 and five years' imprisonment, violations of the Anti-Kickback Law can lead to CMP and exclusion from Medicare, Medicaid and certain other state and federal health care programs. The scope of prohibited payments in the Anti-Kickback Law is broad and includes economic arrangements involving hospitals, physicians and other health care providers, including joint ventures, space and equipment rentals, purchases of physician practices and management and personal services contracts. HHS has published regulations which describe certain "safe harbor" arrangements that

will not be deemed to constitute violations of the Anti-Kickback Law. The safe harbors described in the regulations are narrow and do not cover a wide range of economic relationships which many hospitals, physicians and other health care providers consider to be legitimate business arrangements not prohibited by the statute. Because the regulations describe safe harbors and do not purport to describe comprehensively all lawful or unlawful economic arrangements or other relationships between health care providers and referral sources, hospitals and other health care providers having these arrangements or relationships may be required to alter them in order to ensure compliance with the Anti-Kickback Law.

The BBA provides for CMP in the case of violations of the Anti-Kickback Law in which a person contracts with an excluded provider for the provision of health care items or services where the person knows or should know that the provider has been excluded from participation in a federal health care program. Violations will result in damages three times the remuneration involved as well as a penalty of \$50,000 per violation.

Management of the System has and is taking steps it believes are reasonable to ensure that its contracts with physicians and other referral sources are in material compliance with the Anti-Kickback Law. However, in light of the narrowness of the safe harbor regulations and the scarcity of case law interpreting the Anti-Kickback Law, there can be no assurances that the System will not be found to have violated the Anti-Kickback Law, and if so, whether any sanction imposed would have a material adverse effect on the operations of the System.

**The Federal False Claims Act.** The Federal False Claims Act provides that an individual may bring a civil action for a violation of the Act on behalf of the government alleging that the defendant has defrauded the federal government. These actions are referred to as *qui tam actions* or whistleblower suits. If the federal government intervenes and proceeds with an action brought by an individual, then he/she could receive as much as 25% of any money recovered. Even if the federal government does not intervene and proceed with an action, the employee could still proceed and receive a portion of any money recovered.

The government may use the Federal False Claims Act to prosecute Medicare and other government program fraud in areas such as coding errors, billing for services not provided and submitting false cost reports. When a defendant is determined by a court of law liable under the Federal False Claims Act, the defendant may be required to pay three times the actual damages sustained by the government, plus CMP of between \$5,500 and \$11,000 for each separate false claim. Liability under the Federal False Claims Act often arises when an entity “knowingly” submits a false claim for reimbursement to the federal government. “Knowingly” is defined to include reckless disregard.

**Restrictions on Referrals.** Current federal law (known as the “Stark” law provisions) prohibits providers of “designated health services” from billing Medicare or Medicaid when the patient is referred by a physician, or an immediate family member, with a financial relationship with the provider, with limited exceptions. “Designated health services” include the following: clinical laboratory services; physical therapy services; occupational therapy services; radiology services, including magnetic resonance imaging, computerized axial tomography scans, and ultrasound services; radiation therapy services and supplies; durable medical equipment and services; parenteral and enteral nutrients, equipment and supplies; prosthetics, orthotics, and prosthetic devices and supplies; home health services; outpatient prescription drugs; and inpatient and outpatient hospital services. The sanctions under the Stark law include denial and refund of payments, CMP of up to \$15,000 per prohibited service provided and exclusions from the Medicare and Medicaid programs. The statute also provides for a penalty of up to \$100,000 for a circumvention scheme.

Like the Anti-Kickback Law, and as highlighted below, there are exceptions to the self-referral prohibitions for many of the customary financial arrangement between physicians and providers,

including employment contracts, leases and recruitment agreements. Unlike the safe harbors under the Anti-Kickback Law with which compliance is voluntary, an arrangement must comply with every requirement of a Stark law exception or the arrangement is in violation of the Stark law.

On January 4, 2002, Phase I of a final regulation interpreting Stark law provisions as they relate to designated health services became effective. Phase I covers the general prohibition on certain referrals, the general exemption to both the ownership and compensation arrangement prohibition, and related definitions.

On March 26, 2004, CMS published the Phase II Interim Final Stark II regulations, with an effective date of July 26, 2004. The Phase II regulations cover those parts of the Stark law that were not covered by Phase I, namely the ownership and investment exceptions to the general prohibition, the compensation arrangement exceptions to the general prohibition and the Stark law's reporting provisions. Phase II also includes additional regulatory exceptions, definitions and CMS's response to public comments regarding the Phase I regulations.

On September 5, 2007, CMS published the Phase III Final Stark II regulations, with an effective date of December 4, 2007. The Phase III regulations finalize and respond to public comments regarding the Phase II regulations, as well as providing revisions to the definitions of compensation arrangements and other regulatory modifications.

CMS continues to revise, supplement and update the Stark law. On July 31, 2008, CMS published final changes to the regulations that further restrict the types of arrangements that facilities and physicians may enter, including additional restrictions on certain leases, percentage compensation arrangements, and agreements under which a hospital purchases services under arrangements. In the 2011 OPFS final rule that was published on November 2, 2010, CMS incorporated changes mandated by the Health Care Reform Act into regulation. Section 6001 of PPACA narrowed access to the "rural provider" and "whole hospital" exceptions to the physician self-referral law by prohibiting their use by new physician-owned hospitals, and limiting the ability of existing physician-owned hospitals to expand their capacity. Under section 6001, physician-owned hospitals that were converted from ASCs on or after March 23, 2010 cannot qualify for the revised rural provider and whole hospital exceptions. Additional provisions in section 6001 were aimed at preventing conflicts of interest, ensuring that all ownership and investment interests are bona fide, and promoting patient safety.

Portions of the 2011 MPFS also implement changes from the Health Care Reform Act related to self-referral disclosures. PPACA amended the in-office ancillary services exception to the physician self-referral law as applied to magnetic resonance imaging, computed tomography, and positron emission tomography, to require a physician to disclose to a patient in writing at the time of the referral that the patient may obtain these services from another supplier. CMS now requires, according to the final rule, that the referring physician provide the patient with a list of five alternative suppliers within a 25-mile radius of the physician's office location at the time of the referral who provide the imaging services ordered.

Non-Obligated Affiliate Compliance. The Corporation, other Members of the Obligated Group and certain Non-Obligated Affiliates (as defined in APPENDIX A) have an active compliance program to identify situations which raise potential issues with respect to compliance with the Stark law. These issues may include missing signatures on agreements, operating under agreements after expiration and other technical issues. Recently the Corporation identified that such a situation may have occurred at a Non-Obligated Affiliate. The initial results of the investigation show no inappropriate costs to any governmental entity as a result of a technical compliance issue. The Corporation is continuing its investigation and expects to self-disclose this issue to CMS pursuant to the authority granted to CMS to accept such self-disclosures under the Health Care Reform Act if its investigation determines self

disclosure is warranted. If a self disclosure to CMS is made there can be no assurance as to the response of CMS, however, management of the System does not anticipate that the results of such a self-disclosure will materially adversely affect the Obligated Group's operations or financial condition or that of any Non-Obligated Affiliate.

Management of the System believes that the System is currently in material compliance with the Stark law provisions. However, in light of the scarcity of case law interpreting the Stark law provisions and the breadth and complexity of these provisions, there can be no assurances that the System will not be found to have violated the Stark law provisions, and if so, whether any sanction imposed would have a material adverse effect on the operations of the System or the financial condition of the System.

**State "Fraud" and "False Claims" Laws.** Hospital providers in California also are subject to a variety of State laws related to false claims (similar to the Federal False Claims Act or that are generally applicable false claims laws), anti-kickback (similar to the federal Anti-Kickback Law or that are generally applicable anti-kickback or fraud laws), and physician referral (similar to Stark). These prohibitions, while similar in public policy and scope to the federal laws, have not in all instances been vigorously enforced to date. Management of the System believes the System is currently in material compliance with these State laws. However, in the future their enforcement could have a material adverse impact on the operations or financial condition of the System.

**Compliance/Investigations.** Medicare requires that extensive financial information be reported on a periodic basis and in a specific format or content. These requirements are numerous, technical and complex and may not be fully understood or implemented by billing or reporting personnel. With respect to certain types of required information, the Federal False Claims Act and the Social Security Act may be violated by mere recklessness in the submission of information to the government even without any intent to defraud. New billing systems, new medical procedures and procedures for which there are no clear guidance from CMS may all result in liability. The penalties for violation include criminal or civil liability and may include, for serious or repeated violations, exclusion from participation in the Medicare program.

The OIG conducts national investigations of Medicare billings for certain services. The focus of these investigations varies annually according to the OIG Workplan. While the Obligated Group makes every effort to be in compliance with Medicare billing requirements, there can be no assurance that the Obligated Group will not be subject to an investigation.

Both federal and state government agencies have increased their investigative and enforcement initiatives. Such initiatives relate to a wide-range of health care operations including billing practices, arrangements between providers and physicians, outliers and cost reports.

**Patient Transfers.** In response to concerns regarding inappropriate hospital transfers of emergency patients based on the patient's inability to pay for the services provided, Congress has enacted the Emergency Medical Treatment and Active Labor Act ("EMTALA"). Among other things, EMTALA imposes certain requirements that must be met before transferring a patient to another facility or refusing to accept a patient, including conducting a medical screening examination of all patients that present on hospital property and request examination and treatment for an emergency medical condition, or have a request made on his or her behalf. While failure to comply with EMTALA can result in exclusion from the Medicare and/or Medicaid programs as well as imposition of civil and criminal penalties, noncompliance with the requirements of EMTALA, specifically the treatment of uninsured patients, could also affect the financial condition of the System.

**Accreditation.** The System and its operations are subject to regulation and certification by various federal, state and local government agencies and by certain nongovernmental agencies such as The Joint Commission. No assurance can be given as to the effect on future operations of the System of

existing laws, regulations and standards for certification or accreditation or of any future changes in such laws, regulations and standards.

**Environmental Laws and Regulations.** Health care providers are subject to a wide variety of federal, state and local environmental and occupational health and safety laws and regulations that address, among other things, hospital operations, facilities and properties owned or operated by hospitals. Among the type of regulatory requirements faced by hospitals are (i) air and water quality control requirements, (ii) waste management requirements, (iii) specific regulatory requirements regarding asbestos, polychlorinated biphenyls and radioactive substances, (iv) requirements for providing notice to employees and members of the public about hazardous materials handled by or located at the hospital, (v) requirements for training employees in the proper handling and management of hazardous materials and wastes, and (vi) other requirements.

In their role as the owner and operator of properties or facilities, the Members of the Obligated Group, may be subject to liability for investigating and remedying any hazardous substances that may have migrated off their property. Typical hospital operations include, but are not limited to, in various combinations, the handling, use, storage, transportation, disposal and discharge of hazardous, infectious, toxic, radioactive, flammable and other hazardous materials, wastes, pollutants or contaminants. As such, hospital operations are particularly susceptible to the practical, financial and legal risks associated with compliance with such laws and regulations. Such risks may (i) result in damage to individuals, property or the environment, (ii) interrupt operations and increase their cost, (iii) result in legal liability, damages, injunctions or fines and (iv) result in investigations, administrative proceedings, penalties or other governmental agency actions. There is no assurance that the Obligated Group will not encounter such risks in the future, and such risks may result in material adverse consequences to the operations or financial condition of the System.

At the present time, management of the System is not aware of any pending or threatened claim, investigation or enforcement action regarding such environmental issues which, if determined adversely to the System, would have a material adverse effect on the System's operations or financial condition.

### **Corporate Compliance Program**

The Corporation has developed and implemented a compliance program for itself and its affiliates that includes a compliance plan to assist all employees in understanding and adhering to the legal and ethical standards that govern the provision of patient care (the "Compliance Plan"). The Compliance Plan has been designed to (i) comply with the standards set forth in the Federal Sentencing Guidelines for Organizational Defendants and (ii) help assure that the System acts in accordance with its mission, values and known legal duties. Amendments to the Federal Sentencing Guidelines, effective November 1, 2004, recommend an effective compliance and ethics program with knowledgeable and reasonable oversight by the governing authority of an organization.

### **Antitrust**

Enforcement of the antitrust laws against health care providers is becoming more common, and antitrust liability may arise in a wide variety of circumstances, including medical staff privilege disputes, third-party contracting, physician relations, and joint venture, merger, affiliation and acquisition activities. In some respects, the application of federal and state antitrust laws to health care is still evolving, and enforcement activity by federal and state agencies appears to be increasing. At various times, health care providers may be subject to an investigation by a governmental agency charged with the enforcement of antitrust laws, or may be subject to administrative or judicial action by a federal or state agency or a private party. Violators of the antitrust laws could be subject to criminal and civil enforcement by federal and state agencies, as well as by private litigants.

The ability to consummate mergers, acquisitions or affiliations may also be impaired by the antitrust laws, potentially limiting the ability of health care providers to fulfill their strategic plans. Liability in any of these or other antitrust areas of liability may be substantial, depending on the facts and circumstances of each case.

### **Issues Related to the Health Care Market of the System**

**Affiliation, Merger, Acquisition and Divestiture.** Significant numbers of affiliations, mergers, acquisitions and divestitures have occurred in the health care industry. As part of its ongoing planning process, the System considers potential affiliations and acquisition of operations or properties that may become affiliated with or become part of the System in the future. As a result, it is possible that the organizations and assets that currently comprise the Obligated Group may change from time to time. See APPENDIX C – “SUMMARY OF PRINCIPAL DOCUMENTS—MASTER INDENTURE—Particular Covenants of the Corporation and Each Member—Consolidation, Merger, Sale or Conveyance” hereto.

**Possible Increased Competition.** The System could face increased competition in the future from other hospitals, from skilled nursing facilities and from other forms of health care delivery that offer health care services to the populations which the System currently serves. This could include the construction of new or the renovation of existing hospitals and skilled nursing facilities, HMO facilities, ambulatory surgery centers, freestanding emergency facilities, private laboratory and radiological services, skilled and specialized nursing facilities, home care, intermediate nursing home care, preventive care and drug and alcohol abuse programs.

In addition, competition could result from forms of health care delivery that are able to offer lower priced services to the population served by the System. These services could be substituted for some of the revenue-generating services currently offered by the System. The services that could serve as substitutes for hospital services include skilled and specialized nursing facilities, diagnostics, home care, intermediate nursing home care, preventive care, and drug and alcohol abuse programs. Competition may also come from specialty hospitals or organizations, particularly those facilities providing specialized services in areas with high visibility and strong margins, such as cardiac services and surgical services, and having specialty physicians as investors.

Specialty hospital developments that attract away an important segment of an existing hospital’s admitting specialists and/or services that generate a significant source of revenue may be particularly damaging. For example, some large hospitals may have significant dependence on heart surgery programs, as revenue streams from those programs may cover significant fixed overhead costs. If a significant component of such a hospital’s heart surgeons develop their own specialty heart hospital (alone or in conjunction with a growing number of specialty hospital operators and promoters), taking with them their patient base, the hospital could experience a rapid and dramatic decline in net revenues that is not proportionate to the number of patient admissions or patient days lost. It is also possible that the competing specialty hospital, as a for-profit venture, would not accept indigent patients or other payors and government programs, leaving low-pay patient populations in the full-service hospital. In certain cases, such an event could be materially adverse to the hospital. A variety of proposals have been advanced recently to permanently prohibit such investments. Nonetheless, specialty hospitals continue to represent a significant competitive challenge for full-service hospitals.

Likewise, freestanding ambulatory surgery centers may attract away significant commercial outpatient services traditionally performed at hospitals. Commercial outpatient services, currently among the most profitable for hospitals, may be lost to competitors who can provide these services in an alternative, less costly setting. Full-service hospitals rely upon the revenues generated from commercial outpatient services to fund other less profitable services, and the decline of such business may result in the significant reduction of profitable income. Competing ambulatory surgery centers, more likely a for-

profit business, may not accept indigent patients or low paying programs and would leave these populations to receive services in the hospital setting. Consequently, hospitals are vulnerable to competition from ambulatory surgery centers.

## **Tax-Exempt Status and Other Tax Matters**

**Maintenance of the Tax-Exempt Status of the Members of the Obligated Group.** The tax-exempt status of the Bonds presently depends upon maintenance by the Members of the Obligated Group of their respective status as organizations described in Section 501(c)(3) of the Code. The maintenance of such status is contingent on compliance with general rules promulgated in the Code and related regulations regarding the organization and operation of tax-exempt entities, including their operation for charitable and other permissible purposes and their avoidance of transactions that may cause their earnings or assets to inure to the benefit of private individuals. As these general principles were developed primarily for public charities that do not conduct large-scale technical operations and business activities, they often do not adequately address the myriad of operations and transactions entered into by a modern health care organization. Although traditional activities of health care providers, such as medical office building leases, have been the subject of interpretations by the IRS in the form of Private Letter Rulings, many activities or categories of activities have not been fully addressed in any official opinion, interpretation or policy of the IRS.

The Members of the Obligated Group participate in a variety of transactions with physicians either directly or indirectly. Management believes that the transactions to which the Members of the Obligated Group are a party are consistent with the requirements of the Code as to tax-exempt status, but, as noted above, there is uncertainty as to the state of the law.

The IRS has periodically conducted audit and other enforcement activity regarding tax-exempt health care organizations. The IRS conducts special audits of large tax-exempt health care organizations with at least \$500 million in assets or \$1 billion in gross receipts. Such audits are conducted by teams of revenue agents, often take years to complete and require the expenditure of significant staff time by both the IRS and taxpayers. These audits examine a wide range of possible issues, including tax-exempt bond financing of partnerships and joint ventures, retirement plans and employee benefits, employment taxes, political contributions and other matters.

If the IRS were to find that any Members of the Obligated Group participated in activities in violation of certain regulations or rulings, the tax-exempt status of such entity could be in jeopardy. Although the IRS has not frequently revoked the Code Section 501(c)(3) tax-exempt status of nonprofit health care corporations, it could do so in the future. Loss of tax-exempt status by the Members of the Obligated Group potentially could result in loss of tax exemption of the Bonds and of other tax-exempt debt of the Members of the Obligated Group and defaults in covenants regarding the Bonds and other related tax-exempt debt and obligations likely would be triggered. Loss of tax-exempt status also could result in substantial tax liabilities on income of the Members of the Obligated Group. For these reasons, loss of tax-exempt status of the Members of the Obligated Group could have a material adverse effect on the financial condition of the Obligated Group.

In some cases, the IRS has imposed substantial monetary penalties on tax-exempt hospitals in lieu of revoking their tax-exempt status. In those cases, the IRS and exempt hospitals entered into settlement agreements requiring the hospital to make substantial payments to the IRS. Given the size of operations of the Obligated Group, the wide range of complex transactions its Members enter into, and potential exemption risks, the Obligated Group could be at risk for incurring monetary and other liabilities imposed by the IRS.

In addition, the IRS may impose penalty excise taxes on certain “excess benefit transactions” involving Code Section 501(c)(3) organizations and “disqualified persons.” An excess benefit transaction is one in which a disqualified person or entity receives more than fair market value from the exempt

organization or pays the exempt organization less than fair market value for property or services, or shares the net revenues of the tax-exempt entity. A disqualified person is a person (or an entity) who is in a position to exercise substantial influence over the affairs of the exempt organization during the five years preceding an excess benefit transaction. The statute imposes excise taxes on the disqualified person and any “organization manager” who knowingly participates in an excess benefit transaction. These rules do not penalize the exempt organization itself, so there would be no direct impact on the Members of the Obligated Group or the tax status of the Bonds if an excess benefit transaction were subject to IRS enforcement, pursuant to these “intermediate sanctions” rules.

**State Tax Exemption.** It is possible that legislation may be proposed to strengthen the role of the California Franchise Tax Board and the California Attorney General in supervising nonprofit health systems. It is likely that the loss by the Members of the Obligated Group of federal tax exemption would also trigger a challenge to their state tax-exemption. Depending on the circumstances, such event could be material and adverse.

**Maintenance of Tax-Exempt Status of Interest on the Bonds.** The Code imposes a number of requirements that must be satisfied for interest on state and local obligations, such as the Bonds, to be excludable from gross income for federal income tax purposes. These requirements include limitations on the use of bond proceeds, limitations on the investment earnings of bond proceeds prior to expenditure, a requirement that certain investment earnings on bond proceeds be paid periodically to the United States Treasury, and a requirement that the Authority file an information report with the IRS. The Corporation has covenanted in the Loan Agreement that it will comply with such requirements. Future failure by the Corporation to comply with the requirements stated in the Code and related regulations, rulings and policies may result in the treatment of interest on the Bonds as taxable, retroactively to the date of issuance. The Authority has covenanted in the Bond Indenture that it will not take any action or refrain from taking any action that would cause interest on the Bonds to be included in gross income for federal income tax purposes.

The Corporation believes that the Bonds properly comply with the tax laws. In addition, Bond Counsel will render an opinion with respect to the tax-exempt status of the Bonds, as described under the caption “TAX MATTERS.” No ruling with respect to the Bonds has been or will be sought by the IRS, however, and opinions of counsel are not binding on the IRS or the courts. There can be no assurance that an IRS examination of the Bonds will not adversely affect the Bonds or the market value of the Bonds. See “TAX MATTERS” herein.

**Limitations on Contractual and Other Arrangements Imposed by the Internal Revenue Code.** As tax-exempt organizations, the Members of the Obligated Group are limited with respect to their use of practice income guarantees, reduced rent on medical office space, low interest loans, joint venture programs and other means of recruiting and retaining physicians. Uncertainty in this area has been reduced somewhat by the issuance by the IRS of guidelines on permissible physician recruitment practices. The IRS scrutinizes a broad variety of contractual relationships commonly entered into by hospitals and has issued a detailed audit guide suggesting that field agents scrutinize numerous activities of the hospitals in an effort to determine whether any action should be taken with respect to limitations on or revocation of their tax-exempt status or assessment of additional tax. Any suspension, limitation, or revocation of one or more Member’s tax-exempt status or assessment of significant tax liability would have a materially adverse effect on the Obligated Group and might lead to loss of tax exemption of interest on the Bonds.

## **Other Risk Factors**

**Earthquakes.** Many hospitals in California are in close proximity to active earthquake faults. A significant earthquake in California could destroy or disable the hospital facilities of the Members of the Obligated Group.

The Alfred E. Alquist Hospital Facilities Seismic Safety Act of 1983 establishes, under the jurisdiction of the Office of Statewide Health Planning and Development (the “Office” or “OSHPD”), a program of seismic safety building standards for certain hospitals constructed on and after March 7, 1973. Existing law authorizes the Office to assess an application fee for the review of facilities’ design and construction, and requires that full and complete plans be submitted to the Office for review and approval. Existing law requires that, after January 1, 2008, any general acute care hospital building that is determined to have a potential risk of collapse or pose risk of significant loss of life be used only for non-acute care hospital purposes, except that the Office may grant a 5-year extension under prescribed circumstances. Existing law also allows the Office to grant an additional 2-year extension to the January 2008 deadline in specified circumstances. The law has been amended several times, most recently on October 11, 2009 by the passage of Senate Bill 499. The most recent amendment would also permit a hospital to receive the additional two-year deadline extension if alternative prescribed conditions are met.

First, the compliance deadline can be extended to January 1, 2013 if a hospital shows that capacity lost in the closure of a facility cannot be provided by another facility in the area or if a hospital agrees that, on or before January 1, 2013, designated services will be provided by moving into an existing conforming building, relocating to a newly built building or continuing in the building as retrofitted to comply with the standards.

The second type of extension allows the 2013 deadline to be extended for up to two years to January 1, 2015, in limited cases. To qualify for the extension, such hospital must have (i) begun construction when the extension is requested; (ii) submitted construction plans that were deemed ready for review to OSHPD at least four years prior to the applicable deadline for the building; (iii) obtained a building permit for construction at least two years prior to the applicable deadline for the building; (iv) submitted to state officials a timetable for construction at least two years prior to the applicable deadline for the building; and (v) made reasonable progress in meeting this timetable. The Obligated Group will assess the need for and the benefit of this second extension over time if circumstances warrant.

The third type of extension allows an acute care hospital that has obtained a compliance extension to 2013 to extend its compliance deadline to 2030. This extension is meant for hospitals that cannot afford to retrofit existing facilities by 2013, and gives them an opportunity to forego retrofitting and instead construct replacement facilities by 2030. To qualify for this extension, the hospital must (i) certify that it lacks financial capacity to comply with applicable seismic safety standards by 2013 using statutory criteria; (ii) show that it serves otherwise underserved communities; (iii) submit its facility master plan to OSHPD before January 1, 2010; (iv) comply with statutory construction planning timeline; and (v) document its progress on the project. The Obligated Group will assess the need for and the benefit of this third extension over time if circumstances warrant. See APPENDIX A – “ORGANIZATIONAL STRUCTURE—Capital Planning and Seismic Upgrade Activities” for further information regarding the Obligated Group’s seismic upgrades.

**Risks Related to Variable Rate Indebtedness.** Upon the issuance of the Series 2011A Obligation and after giving effect to the transactions described in “PLAN OF FINANCE” herein, Obligations outstanding under the Master Indenture in the principal amount of \$115.4 million will be subject to variable interest rate exposure, which amount does not include variable rate bonds which are subject to Financial Product Agreements. Such interest rates vary from time to time and may be converted to fixed interest rates. This protection against rising interest rates is limited, however, because

the Obligated Group would be required to continue to pay interest at the applicable variable rate until it is permitted to either convert the obligation to a fixed rate pursuant to the terms of the applicable transaction documents or terminate any related swap agreement. Credit market turmoil in the auction rate markets and downgrades of the credit ratings of various bond insurers and liquidity facility providers triggered suddenly high interest costs to many healthcare organizations.

**Markets for the Bonds.** Subject to prevailing market conditions, the Underwriter intends, but is not obligated, to make a market for the Bonds.

**Bond Ratings.** There is no assurance that the ratings assigned to the Bonds at the time of issuance will not be lowered or withdrawn at any time, the effect of which could adversely affect the market price for, and marketability of, the Bonds. See “RATINGS” herein.

**Labor Matters.** Not-for-profit health care providers and their employees are under the jurisdiction of the National Labor Relations Board (“NLRB”). As of September 30, 2010, the Obligated Group had approximately 10,972 full-time equivalent employees, 2,981 of whom are represented by unions. Such unionized employees are represented by Sharp Professional Nurses Network, United Nurses of California, National Union of Hospital and Health Care Employees, American Federation of State, County and Municipal Employees, AFL-CIO (“UNAC”). While management of the Obligated Group believes that its overall employee relations are good, and that a direct relationship between the Members of the Obligated Group and its employees is more beneficial for both the Members of the Obligated Group and the employees than a union relationship, unionization continues for the Obligated Group. See APPENDIX A – “ORGANIZATIONAL STRUCTURE—Employees” for further information regarding the System’s collective bargaining agreement with UNAC.

**Cost and Availability of Insurance.** In the past few years, the insurance market for casualty and professional liability insurance has tightened significantly with respect to both cost and availability of coverage, resulting in escalating fees and premiums and in some cases a lack of adequate coverage. See APPENDIX A – “ORGANIZATIONAL STRUCTURE—Insurance” hereto for additional information regarding insurance coverage of the System.

**Nursing, Technician and Specialty Physician Shortage.** In recent years, the healthcare industry, including the Obligated Group, has experienced a shortage of nurses, technicians, physicians in certain specialties and other related staff, which has resulted in increased costs and lost revenues due to the need to hire agency nursing personnel at higher rates, to increased compensation levels, and to the inability to use otherwise available beds as a result of staffing shortages. Competition for physicians and employees, coupled with increased recruiting and retention costs will increase hospital operating costs, possibly significantly. The Obligated Group has incurred increased employment costs at certain of its facilities. This ongoing shortage will continue to adversely affect the Obligated Group’s operations. See APPENDIX A – “ORGANIZATIONAL STRUCTURE—Nurse Staffing” for more information on the nursing shortage and Obligated Group initiatives in response to the shortage.

California imposes mandatory nurse staffing ratios for all hospital patient care areas. The impact on California hospitals varies by facility, but the required staffing, in aggregate, is more costly than prior staffing patterns.

**Other Future Risks.** In the future, the following factors, among others, may adversely affect the operations of health care providers, including the Members of the Obligated Group, or the market value of the Bonds, to an extent that cannot be determined at this time.

- (a) Adoption of legislation that would establish a national or statewide single-payor health program or that would establish national, statewide or otherwise regulated rates applicable to hospitals and other health care providers.

- (b) Reduced demand for the services of the Obligated Group that might result from decreases in population or loss of market share to competitors.
- (c) Bankruptcy of an indemnity/commercial insurer, managed care plan or other payor.
- (d) Efforts by insurers and governmental agencies to limit the cost of hospital services, to reduce the number of beds and to reduce the utilization of hospital facilities by such means as preventive medicine, improved occupational health and safety and outpatient care, or comparable regulations or attempts by third-party payors to control or restrict the operations of certain health care facilities.
- (e) Cost and availability of any insurance, such as professional liability, fire, automobile and general comprehensive liability coverages, which health care facilities of a similar size and type generally carry.
- (f) The occurrence of a natural or man-made disaster, a pandemic or an epidemic, or terrorist actions, that could damage the Obligated Group's facilities, interrupt utility service to the facilities, result in an abnormally high demand for health care services or otherwise impair the Obligated Group's operations and the generation of revenues from the facilities.
- (g) Limitations on the availability of, and increased compensation necessary to secure and retain, nursing, technical and other professional personnel.

### **Security and Enforceability**

**Certain Matters Relating to Security for the Bonds.** See "SECURITY FOR THE BONDS" for a discussion of certain factors including the absence of certain covenants in the Master Indenture. The facilities of the Obligated Group are not pledged as security for the Bonds. The Obligated Group's health care facilities are not comprised of general purpose buildings and generally would not be suitable for industrial or commercial use and consequently, it could be difficult to find a buyer or lessee for such health care facilities. If it were necessary to proceed against such facilities, whether pursuant to a judgment, if any, against the Obligated Group or otherwise, upon any default which results in the acceleration of the Bonds, an amount may not be realized sufficient to pay in full the Obligations, including the Series 2011A Obligation, from the sale or lease of such facilities.

Certain amendments to the Bond Indenture may be made without the consent of any Holders of the outstanding Bonds and certain other amendments to the Bond Indenture may be made with the consent of the Holders of not less than a majority of the principal amount of the outstanding Bonds. Certain amendments to the Master Indenture may be made with the consent of the Holders of not less than a majority of the principal amount of Obligations Outstanding under the Master Indenture. Such amendments may adversely affect the security of the Bondholders. With respect to amendments to the Master Indenture, the Holders of the requisite percentage of Outstanding Obligations may be composed wholly or partially of the Holders of additional Obligations. Such amendments may adversely affect the security of the Bondholders. See APPENDIX C – "SUMMARY OF PRINCIPAL DOCUMENTS."

**Perfection of a Security Interest in Gross Revenues.** Each Member of the Obligated Group has granted a security interest in all of the Gross Revenues of the Obligated Group and has agreed to perfect the grant of a security interest in the Gross Revenues to the extent, and only to the extent, that such security interest may be perfected under the Uniform Commercial Code of the State of California. The effectiveness of the security interest in the Gross Revenues may be limited by a number of factors, including (i) the absence of an express provision permitting assignment of receivables due any Member of the Obligated Group under the Medicare and Medi-Cal programs or under capitated risk contracts, and

present or future prohibitions against assignment contained in any federal statutes or regulations; (ii) certain judicial decisions that cast doubt upon the right of the Master Trustee, in the event of the bankruptcy of any Member of the Obligated Group, to collect and retain accounts receivable from Medicare, Medi-Cal, general assistance and other governmental programs; (iii) statutory liens; (iv) rights arising in favor of the United States of America, the State of California or any agency thereof; (v) constructive trusts, equitable or other rights impressed or conferred by a federal or state court in the exercise of its equitable jurisdiction; (vi) federal bankruptcy laws which may affect the priority of claims against the assets of the Obligated Group and the enforceability of the Bond Indenture or the security interest in the Gross Revenues which are earned by any Member of the Obligated Group within 90 days preceding and after any effectual institution of bankruptcy proceedings by or against such Member; (vii) rights of third parties in the Obligated Group's revenues converted to cash and not in the possession of the Bond Trustee or the Master Trustee; and (viii) claims that might gain priority if appropriate financing or continuation statements are not filed in accordance with the California Uniform Commercial Code as from time to time in effect.

**Enforceability of the Master Indenture, the Loan Agreement and the Series 2011A Obligation.** The state of the insolvency, fraudulent conveyance and bankruptcy laws relating to the enforceability of guaranties or obligations issued by one corporation in favor of the creditors of another or the obligations of an Obligated Group Member to make debt service payments on behalf of an Obligated Group Member is unsettled, and the ability to enforce the Master Indenture and the Obligations against any Obligated Group Member that would be rendered insolvent thereby could be subject to challenge. In particular, such obligations may be voidable under the Federal Bankruptcy Code or applicable state fraudulent conveyance laws if the obligation is incurred without "fair" and/or "fairly equivalent" consideration to the obligor and if the incurrence of the obligation thereby renders the Obligated Group Member insolvent. The standards for determining the fairness of consideration and the manner of determining insolvency are not clear and may vary under the Federal Bankruptcy Code, state fraudulent conveyance statutes and applicable cases.

The joint and several obligation described herein of each Member of the Obligated Group to pay debt service on the Series 2011A Obligation may not be enforceable under any of the following circumstances:

- (i) to the extent payments on the Series 2011A Obligation are requested to be made from assets of a Member which are donor-restricted or which are subject to a direct, express or charitable trust that does not permit the use of such assets for such payments;
- (ii) if the purpose of the debt created and evidenced by the Series 2011A Obligation is not consistent with the charitable purposes of the Member from which such payment is requested or required, or if the debt was incurred or issued for the benefit of an entity other than a nonprofit corporation that is exempt from federal income taxes under Sections 501(a) and 501(c)(3) of the Code and is not a "private foundation" as defined in Section 509(a) of the Code;
- (iii) to the extent payments on the Series 2011A Obligation would result in the cessation or discontinuation of any material portion of the health care or related services previously provided by such Member; or
- (iv) if and to the extent payments are requested to be made pursuant to any loan violating applicable usury laws.

These limitations on the enforceability of the joint and several obligations of the Members of the Obligated Group on the Series 2011A Obligation also apply to their obligations on all Obligations. If the obligation of a particular Member of the Obligated Group to make payment on an Obligation is not

enforceable and payment is not made on such Obligation when due in full, then Events of Default will arise under the Master Indenture.

In addition, common law authority and authority under state statutes exists for the ability of courts in such states to terminate the existence of a nonprofit corporation or undertake supervision of its affairs on various grounds, including a finding that such corporation has insufficient assets to carry out its stated charitable purposes. Such court action may arise on the court's own motion or pursuant to a petition of the attorney general of such states or such other persons who have interests different from those of the general public, pursuant to the common law and statutory power to enforce charitable trusts and to see to the application of their funds to their intended charitable uses.

The legal right and practical ability of the Bond Trustee to enforce its rights and remedies against the Corporation under the Loan Agreement and related documents and of the Master Trustee to enforce its rights and remedies against the Members of the Obligated Group under the Series 2011A Obligation may be limited by laws relating to bankruptcy, insolvency, reorganization, fraudulent conveyance or moratorium and by other similar laws affecting creditors' rights. In addition, the Bond Trustee's and the Master Trustee's ability to enforce such terms will depend upon the exercise of various remedies specified by such documents which may in many instances require judicial actions that are often subject to discretion and delay or that otherwise may not be readily available or may be limited.

The various legal opinions delivered concurrently with the issuance of the Bonds are qualified as to the enforceability of the various legal instruments by limitations imposed by state and federal laws, rulings, policy and decisions affecting remedies and by bankruptcy, reorganization or other laws of general application affecting the enforcement of creditors' rights or the enforceability of certain remedies or document provisions.

For a further description of the provisions of the Bond Indenture, the Loan Agreement and the Master Indenture, including covenants that secure the Bonds, events of default, acceleration and remedies under the Master Indenture, see APPENDIX C – "SUMMARY OF PRINCIPAL DOCUMENTS."

**Bankruptcy.** In the event of bankruptcy of an Obligated Group Member, the rights and remedies of the Bondholders are subject to various provisions of the federal Bankruptcy Code. If an Obligated Group Member were to file a petition in bankruptcy, payments made by that Obligated Group Member during the 90 day (or perhaps one-year) period immediately preceding the filing of such petition may be avoidable as preferential transfers to the extent such payments allow the recipients thereof to receive more than they would have received in the event of such Obligated Group Member's liquidation. Security interests and other liens granted to the Bond Trustee or the Master Trustee and perfected during such preference period also may be avoided as preferential transfers to the extent such security interest or other lien secures obligations that arose prior to the date of such perfection. Such a bankruptcy filing would operate as an automatic stay of the commencement or continuation of any judicial or other proceeding against the Obligated Group Member and its property and as an automatic stay of any act or proceeding to enforce a lien upon or to otherwise exercise control over its property, as well as various other actions to enforce, maintain or enhance the rights of the Bond Trustee and the Master Trustee. If the bankruptcy court so ordered, the property of the Obligated Group Member, including accounts receivable and proceeds thereof, could be used for the financial rehabilitation of such Obligated Group Member despite any security interest of the Bond Trustee therein. The rights of the Bond Trustee and the Master Trustee to enforce their respective security interests and other liens could be delayed during the pendency of the rehabilitation proceeding.

Such Obligated Group Member could file a plan for the adjustment of its debts in any such proceeding, which plan could include provisions modifying or altering the rights of creditors generally or any class of them, secured or unsecured. The plan, when confirmed by a court, binds all creditors who

had notice or knowledge of the plan and, with certain exceptions, discharges all claims against the debtor to the extent provided for in the plan. No plan may be confirmed unless certain conditions are met, among which are conditions that the plan be feasible and that it will have been accepted by each class of claims impaired thereunder. Each class of claims has accepted the plan if at least two-thirds in dollar amount and more than one-half in number of the class cast votes in its favor. Even if the plan is not so accepted, it may be confirmed if the court finds that the plan is fair and equitable with respect to each class of non-accepting creditors impaired thereunder and does not discriminate unfairly.

In addition, the obligations of the Corporation under the Loan Agreement and of the Members of the Obligated Group any future Members under the Master Indenture are not secured by a lien on or security interest in any assets or revenues of the Members, other than the pledge of Gross Revenues. In the event of a bankruptcy of the Members of the Obligated Group or any future Members, Bondholders would be considered unsecured creditors on a parity with all unsecured creditors of the Members of the Obligated Group. The Bondholders would have a subordinate interest to any creditor of the Members of the Obligated Group that holds a security interest in the Obligated Group Member's property.

In the event of bankruptcy of any Member, there is no assurance that certain covenants, including tax covenants, contained in the Loan Agreement and certain other documents would survive. Accordingly, a bankruptcy trustee could take action that would adversely affect the exclusion of interest on the Bonds from gross income of the Bondholders for federal income tax purposes.

## **TAX MATTERS**

In the opinion of Orrick, Herrington & Sutcliffe LLP, Bond Counsel to the Authority ("Bond Counsel"), based upon an analysis of existing laws, regulations, rulings and court decisions, and assuming, among other matters, the accuracy of certain representations and compliance with certain covenants, interest on the Bonds is excluded from gross income for federal income tax purposes under Section 103 of the Code and is exempt from State of California personal income taxes. Bond Counsel is of the further opinion that interest on the Bonds is not a specific preference item for purposes of the federal individual or corporate alternative minimum taxes, although Bond Counsel observes that such interest is included in adjusted current earnings when calculating corporate alternative minimum taxable income. Bond Counsel expresses no opinion regarding any other tax consequences relating to the ownership or disposition of, or the accrual or receipt of interest on, the Bonds. A complete copy of the proposed form of opinion of Bond Counsel is set forth in APPENDIX D hereto.

To the extent the issue price of any maturity of the Bonds is less than the amount to be paid at maturity of such Bonds (excluding amounts stated to be interest and payable at least annually over the term of such Bonds), the difference constitutes "original issue discount," the accrual of which, to the extent properly allocable to each beneficial owner thereof, is treated as interest on the Bonds which is excluded from gross income for federal income tax purposes and State of California personal income taxes. For this purpose, the issue price of a particular maturity of the Bonds is the first price at which a substantial amount of such maturity of the Bonds is sold to the public (excluding bond houses, brokers, or similar persons or organizations acting in the capacity of underwriters, placement agents or wholesalers). The original issue discount with respect to any maturity of the Bonds accrues daily over the term to maturity of such Bonds on the basis of a constant interest rate compounded semiannually (with straight-line interpolations between compounding dates). The accruing original issue discount is added to the adjusted basis of such Bonds to determine taxable gain or loss upon disposition (including sale, redemption, or payment on maturity) of such Bonds. Beneficial owners of the Bonds should consult their own tax advisors with respect to the tax consequences of ownership of Bonds with original issue discount, including the treatment of beneficial owners who do not purchase such Bonds in the original offering to the public at the first price at which a substantial amount of such Bonds is sold to the public.

Bonds purchased, whether at original issuance or otherwise, for an amount higher than their principal amount payable at maturity (or, in some cases, at their earlier call date) (“Premium Bonds”) will be treated as having amortizable bond premium. No deduction is allowable for the amortizable bond premium in the case of bonds, like the Premium Bonds, the interest on which is excluded from gross income for federal income tax purposes. However, the amount of tax-exempt interest received, and a beneficial owner’s basis in a Premium Bond, will be reduced by the amount of amortizable bond premium properly allocable to such beneficial owner. Beneficial owners of Premium Bonds should consult their own tax advisors with respect to the proper treatment of amortizable bond premium in their particular circumstances.

The Code imposes various restrictions, conditions and requirements relating to the exclusion from gross income for federal income tax purposes of interest on obligations such as the Bonds. The Authority and the Members of the Obligated Group have made certain representations and have covenanted to comply with certain restrictions, conditions and requirements designed to ensure that interest on the Bonds will not be included in federal gross income. Inaccuracy of these representations or failure to comply with these covenants may result in interest on the Bonds being included in gross income for federal income tax purposes, possibly from the date of original issuance of the Bonds. The opinion of Bond Counsel assumes the accuracy of these representations and compliance with these covenants. Bond Counsel has not undertaken to determine (or to inform any person) whether any actions taken (or not taken) or events occurring (or not occurring), or any other matters coming to Bond Counsel’s attention after the date of issuance of the Bonds may adversely affect the value of, or the tax status of interest on, the Bonds. Accordingly, the opinion of Bond Counsel is not intended to, and may not, be relied upon in connection with any such actions, events or matters.

In addition, Bond Counsel has relied, among other things, on the opinion of Hooper, Lundy & Bookman, P.C., special counsel to the Members of the Obligated Group, regarding the current qualification of the Members of the Obligated Group as organizations described in Section 501(c)(3) of the Code. Such opinion is subject to a number of qualifications and limitations. Bond Counsel has also relied upon representations of the Corporation concerning the Members’ of the Obligated Group “unrelated trade or business” activities as defined in Section 513(a) of the Code. Neither Bond Counsel nor special counsel to the Members of the Obligated Group has given any opinion or assurance concerning Section 513(a) of the Code and neither Bond Counsel nor special counsel to the Members of the Obligated Group can give or has given any opinion or assurance about the future activities of the Members of the Obligated Group, or about the effect of future changes in the Code, the applicable regulations, the interpretation thereof or the resulting changes in enforcement thereof by the IRS. Failure of the Members of the Obligated Group to be organized and operated in accordance with the IRS’s requirements for the maintenance of their status as organizations described in Section 501(c)(3) of the Code, or to operate the facilities refinanced by the Bonds in a manner that is substantially related to the Members’ of the Obligated Group charitable purpose under Section 513(a) of the Code, may result in interest payable with respect to the Bonds being included in federal gross income, possibly from the date of the original issuance of the Bonds.

Although Bond Counsel is of the opinion that interest on the Bonds is excluded from gross income for federal income tax purposes and is exempt from State of California personal income taxes, the ownership or disposition of, or the accrual or receipt of interest on, the Bonds may otherwise affect a beneficial owner’s federal, state or local tax liability. The nature and extent of these other tax consequences depends upon the particular tax status of the beneficial owner or the beneficial owner’s other items of income or deduction. Bond Counsel expresses no opinion regarding any such other tax consequences.

Future legislative proposals, if enacted into law, clarification of the Code or court decisions may cause interest on the Bonds to be subject, directly or indirectly, to federal income taxation or to be subject

to or exempted from state income taxation, or otherwise prevent beneficial owners from realizing the full current benefit of the tax status of such interest. The introduction or enactment of any such future legislative proposals, clarification of the Code or court decisions may also affect the market price for, or marketability of, the Bonds. Prospective purchasers of the Bonds should consult their own tax advisors regarding any pending or proposed federal or state tax legislation, regulations or litigation, as to which Bond Counsel expresses no opinion.

The opinion of Bond Counsel is based on current legal authority, covers certain matters not directly addressed by such authorities, and represents Bond Counsel's judgment as to the proper treatment of the Bonds for federal income tax purposes. It is not binding on the IRS or the courts. Furthermore, Bond Counsel cannot give and has not given any opinion or assurance about the future activities of the Authority or the Members of the Obligated Group, or about the effect of future changes in the Code, the applicable regulations, the interpretation thereof or the enforcement thereof by the IRS. The Authority and the Members of the Obligated Group have covenanted, however, to comply with the requirements of the Code.

Bond Counsel's engagement with respect to the Bonds ends with the issuance of the Bonds, and, unless separately engaged, Bond Counsel is not obligated to defend the Authority, the Corporation or the beneficial owners regarding the tax-exempt status of the Bonds in the event of an audit examination by the IRS. Under current procedures, parties other than the Authority, the Corporation and their appointed counsel, including the beneficial owners, would have little, if any, right to participate in, the audit examination process. Moreover, because achieving judicial review in connection with an audit examination of tax-exempt bonds is difficult, obtaining an independent review of IRS positions with which the Authority or the Corporation legitimately disagrees, may not be practicable. Any action of the IRS, including but not limited to selection of the Bonds for audit, or the course or result of such audit, or an audit of bonds presenting similar tax issues may affect the market price for, or the marketability of, the Bonds, and may cause the Authority, the Corporation or the beneficial owners to incur significant expense.

## **CONTINUING DISCLOSURE**

### **General**

The Corporation, acting on behalf of itself and the other Members of the Obligated Group, has covenanted for the benefit of Holders and Beneficial Owners of the Bonds to provide certain financial information and operating data relating to the Corporation for each of the Corporation's fiscal years in accordance with the requirements of Rule 15c2-12, as amended (the "Rule"), promulgated by the Securities and Exchange Commission pursuant to the Securities Exchange Act of 1934, as amended. The covenants of the Obligated Group are in an agreement (the "Master Continuing Disclosure Agreement") with U.S. National Bank Association as successor Dissemination Agent (the "Dissemination Agent"), dated as of April 1, 1998, as amended. The Corporation will execute a Continuing Disclosure Certificate (together with the Master Continuing Disclosure Agreement, the "Continuing Disclosure Agreement") concurrently with the issuance of the Bonds, designating the Master Continuing Disclosure Agreement as the Obligated Group's written undertaking under the Rule, to provide or cause to be provided to the Dissemination Agent, for dissemination (i) certain financial information and operating data relating to the Corporation by not later than five months following the end of the Corporation's fiscal year (which fiscal year currently ends on September 30) (the "Annual Report"), commencing with the report for the fiscal year ending September 30, 2011, (ii) to provide certain unaudited financial information relating to the Corporation by not later than 60 days after the end of each of the first three fiscal quarters of the Corporation, commencing with the fiscal quarter ending March 31, 2011, and (iii) to provide notices of the occurrence of certain listed events (described below). Effective December 1, 2010, certain amendments to the Rule (including new provisions effective on such date) relating to the disclosure of

such listed events apply to continuing disclosure for the Bonds. “Beneficial Owners” means, under this caption only, any person which (i) has the power, directly or indirectly, to vote or consent with respect to, or to dispose of directly or indirectly, to vote or consent with respect to, or to dispose of ownership of the Bonds (including persons holding Bonds through nominees, depositories or other intermediaries), or (ii) is treated as the owner of any Bonds for federal income tax purposes.

The Annual Report and notices of certain listed events will be filed by or on behalf of the Obligated Group with the Municipal Securities Rulemaking Board (“MSRB”), in an electronic format as prescribed by the MSRB. The MSRB has designated its Electronic Municipal Market Access system (“EMMA”), found at <http://emma.msrb.org>, as the sole repository for such disclosure filings. These covenants have been made in order to assist the Underwriter and registered brokers, dealers and municipal securities dealers in complying with the requirements of the Rule. In addition, the Corporation has agreed to cause to be filed with the MSRB copies of the Obligated Group’s unaudited quarterly financial information containing a statement of revenues and expenses and a balance sheet prepared by management for each of the first three fiscal quarters of each year within 60 days of the end of each such fiscal quarter. All such information will also be available electronically at no cost from Digital Assurance Certification LLC (“DAC”). There is no assurance that the Corporation will continue to make information available from DAC for the life of the Bonds. The Corporation has never failed to comply in all material respects with any previous undertaking with regard to the Rule to provide financial information and data, operating data or notices of certain listed events.

#### **Notice of Certain Events**

The Corporation covenants to provide, or cause to be provided, notice of the occurrence of any of the following events with respect to the Bonds, within ten business days of the occurrence of such event and in accordance with the Rule:

- (1) Principal and interest payment delinquencies;
- (2) Nonpayment related defaults, if material;
- (3) Unscheduled draws on debt service reserves reflecting financial difficulties;
- (4) Unscheduled draws on credit enhancements reflecting financing difficulties;
- (5) Substitution of credit or Credit Facility or Liquidity Facility providers, or their failure to perform;
- (6) Adverse tax opinions or events adversely affecting the tax-exempt status of the Bonds or any other outstanding bonds issued on behalf of the Obligated Group and subject to the continuing disclosure requirements under the Rule;
- (7) Modifications to rights of bondholders, if material;
- (8) Bond calls, if material;
- (9) Defeasances;
- (10) Release, substitution, or sale of property securing repayment of the securities, if material;
- (11) Rating changes;
- (12) Tender offers;

(13) Bankruptcy, insolvency, receivership or similar event of the obligated person;

(14) Consummation of a merger, consolidation, or acquisition involving an obligated person or the sale of all or substantially all of the assets of the obligated person, other than in the ordinary course of business, the entry into a definitive agreement to undertake such an action or the termination of a definitive agreement relating to any such actions, other than pursuant to its terms, if material; and

(15) Appointment of a successor or additional trustee or the change of name of a trustee, if material.

### **Annual Report**

The Annual Report will contain or incorporate by reference at least the following items:

(a) The audited financial statements of the Corporation for the fiscal year immediately preceding the due date of the Annual Report; provided, however, that if such audited financial statements are not available by the deadline for filing the Annual Report, they shall be provided as soon as practicable after they have been approved by the governing body of the Corporation, and unaudited financial statements shall be included in the Annual Report. The financial statements shall be audited and prepared pursuant to accounting and reporting policies conforming in all material respects to U.S. Generally Accepted Accounting Principles (“GAAP”) or accompanied by a quantified explanation of material deviations from GAAP, if possible, or a full explanation of the accounting principles used.

(b) An update of the material financial information and material operating data of the same general nature as that contained in APPENDIX A under the captions “HEALTH CARE OPERATIONS OF THE OBLIGATED GROUP—Utilization,” “HISTORICAL FINANCIAL INFORMATION—Revenue Sources (table only), —Liquidity (historic only), —Debt Service Coverage Ratio (historic only) and —Capitalization (historic only).”

Any or all of the items listed above may be included by specific reference to other documents which previously have been provided to each of the repositories described above or filed with the SEC. If the document included by reference is a final official statement, it must be available from the MSRB. The Corporation shall clearly identify each such other document as included by reference.

### **Failure to Comply**

In the event of a failure of the Corporation to comply with any provision of the Continuing Disclosure Agreement, any Bondholder or Beneficial Owner may seek specific performance by court order to cause the Corporation to comply with the obligations under the Continuing Disclosure Agreement. A failure to comply with the Continuing Disclosure Agreement shall not be deemed an Event of Default under the Master Indenture or the Bond Indenture. The sole remedy under the Continuing Disclosure Agreement in the event of any failure of the Corporation to comply with the Continuing Disclosure Agreement shall be an action to compel performance, and no person or entity shall be entitled to recover monetary damage thereunder under any circumstances.

### **Amendment of the Continuing Disclosure Agreement**

The provisions of the Continuing Disclosure Agreement, including but not limited to the provisions relating to the accounting principles pursuant to which the financial statements are prepared, may be amended as deemed appropriate by the Corporation; but any such amendment must be adopted procedurally and substantively in a manner consistent with the Rule, including any interpretation thereof made from time to time by the SEC. Such interpretations currently include the requirements that (i) the amendment may only be made in connection with a change in circumstances that arises from a change in

legal requirements, change in law, or change in the identity, nature or status of any Obligated Person or the type of activities conducted thereby, (ii) the undertaking, as amended, would have complied with the requirements of the Rule at the time of the primary offering of the Bonds, after taking into account any amendments or interpretations of the Rule, as well as any change in circumstances, and (iii) the amendment does not materially impair the interests of Bondholders, as determined by parties unaffiliated with the Corporation (such as independent legal counsel). The foregoing interpretations may be changed in the future.

Because the Bonds are limited obligations of the Authority, payable solely from amounts received from the Corporation or other Members of the Obligated Group, financial or operating data concerning the Authority is not material to an evaluation of the offering or to any decision to purchase, hold or sell the Bonds. Accordingly, the Authority will not provide any such information. The Corporation, acting on behalf of itself and the other Members of the Obligated Group, has undertaken all responsibilities for continuing disclosure to Holders of the Bonds as described above, and the Authority shall have no liability to the Holders or any other person with respect to the Rule.

### **APPROVAL OF LEGALITY**

The validity of the Bonds and certain other legal matters are subject to the approving opinion of Orrick, Herrington & Sutcliffe LLP, Bond Counsel to the Authority. A complete copy of the proposed form of Bond Counsel opinion is contained in APPENDIX D hereto. Bond Counsel undertakes no responsibility for the accuracy, completeness or fairness of this Official Statement. Certain other legal matters will be passed upon for the Authority by its special counsel, Chapman and Cutler LLP, San Francisco, California, for the Obligated Group by its special counsel Hooper, Lundy & Bookman, P.C., San Diego, California and for the Underwriter by its special counsel, SNR Denton US LLP, Chicago, Illinois, which also undertakes no responsibility for the accuracy, completeness or fairness of this Official Statement.

### **INDEPENDENT AUDITORS**

The combined financial statements of the Corporation as of September 30, 2010 and 2009 and for the years then ended, included in APPENDIX B, have been audited by Ernst & Young LLP, independent auditors, as stated in their report included in APPENDIX B.

### **FINANCIAL ADVISOR**

Ponder & Co. has served as financial advisor (the “Financial Advisor”) to the Corporation for purposes of assisting with the development and implementation of a bond structure in connection with the Bonds. Ponder & Co. is not obligated to undertake, and has not undertaken, an independent verification or to assume responsibility for the accuracy, completeness, or fairness of the information contained in this Official Statement. Ponder & Co. is an independent advisory firm and is not engaged in the business of underwriting or distributing municipal securities or other public securities.

### **LITIGATION**

#### **The Members of the Obligated Group**

There is no controversy or litigation of any nature now pending against the Members of the Obligated Group or, to the knowledge of its respective officers, threatened, seeking to restrain or enjoin the issuance, sale, execution or delivery of the Bonds, or in any way contesting or affecting the validity of the Bonds, any proceedings of the Members of the Obligated Group taken concerning the issuance or sale thereof, the pledge or application of any moneys or security provided for the payment of the Bonds.

As with most health care providers, the Members of the Obligated Group are subject to certain legal actions that, in whole or in part, are not or may not be covered by insurance because of the type of action or amount or types of damages requested (e.g., punitive damages), because of a reservation of rights by an insurance carrier, or because the action has not proceeded to a stage that permits full evaluation. There are certain legal actions currently pending against the Members of the Obligated Group known to management of the Members of the Obligated Group and for which insurance coverage is uncertain for the above reasons. Except as described herein, Management of the Members of the Obligated Group does not anticipate that any such suits will ultimately result in punitive damage awards or judgments in excess of applicable insurance limits, or if such awards or judgments were to be entered, that they would have a material adverse impact on the financial condition of the Members of the Obligated Group. The Members of the Obligated Group have been served with a lawsuit seeking class action status on behalf of nurses employed by Members of the Obligated Group alleging wage and hour law violations. The Members of the Obligated Group believe they comply with applicable wage and hour laws, and intend to vigorously defend the lawsuit. Nonetheless, if the matter is certified as a class action and there is an adverse decision to the Members of the Obligated Group, such an adverse decision could have a material adverse effect on the financial condition of the Obligated Group.

Additionally, the Members of the Obligated Group have been served with a lawsuit seeking class action status on behalf of uninsured patients who received care at the Obligated Group's hospital facilities. The lawsuit alleges that the Obligated Group members deceptively and unfairly charged uninsured patients fees for medical services that substantially exceeded the fees Obligated Group members accepted from patients covered by Medicare or private insurance. The lawsuit seeks a number of remedies including the disgorgement of the allegedly excessive fees and punitive damages. The Members of the Obligated Group believe they comply with applicable laws and are vigorously defending the lawsuit. Nonetheless, if the matter is certified as a class action and there is an adverse decision to the Members of the Obligated Group, such an adverse decision could have a material adverse effect on the financial condition of the Obligated Group.

Other than as described above, there is no litigation of any nature now pending against the Members of the Obligated Group or, to the knowledge of its officers, threatened, which, if successful, would materially adversely affect the operations or financial condition of the Members of the Obligated Group.

### **The Authority**

To the knowledge of the officers of the Authority, there is no litigation of any nature now pending or threatened against the Authority, restraining or enjoining the issuance, sale, execution or delivery of the Bonds, or in any way contesting or affecting the validity of the Bonds, any proceedings of the Authority taken concerning the issuance or sale thereof, the pledge or application of any moneys or security provided for the payment of the Bonds, or the existence or powers of the Authority relating to the issuance of the Bonds.

### **RATINGS**

S&P and Moody's have assigned ratings on the Bonds of "A" and "A2", respectively. The Obligated Group has furnished to S&P and Moody's certain information and materials concerning the Bonds and itself. No application was made to any other rating agency for the purpose of obtaining additional ratings on the Bonds. Any explanation of the significance of such ratings may only be obtained from the rating agency furnishing the same. Generally, rating agencies base their ratings on such information and materials and on investigations, studies and assumptions made by the rating agencies themselves. There is no assurance that the ratings mentioned above will remain in effect for any given period of time or that they might not be lowered or withdrawn entirely by the rating agencies, if in their

judgment circumstances so warrant. Any such downward change in or withdrawal of the ratings might have an adverse effect on the market price or marketability of the Bonds.

## **UNDERWRITING**

The Bonds are being purchased by Citigroup Global Markets Inc. (the “Underwriter”). Pursuant to the Purchase Contract for the Bonds, the Underwriter has agreed to purchase the Bonds at a purchase price of \$78,140,373.55, including net original issue premium of \$430,373.55. The Obligated Group will pay the Underwriter a fee of \$682,104.75 for its services in immediately available funds on the date of Closing. The Purchase Contract for the Bonds provides that the Underwriter will purchase all of the Bonds, if any are purchased, and contains the agreements of the Obligated Group to indemnify the Underwriter and the Authority against certain liabilities. The Underwriter is utilizing a selling group to assist in the initial sale of the Bonds and will share with selling group members a portion of the underwriting compensation with respect to the Bonds.

Citigroup Inc., parent company of Citigroup Global Markets Inc., an underwriter of the Bonds, has entered into a retail brokerage joint venture with Morgan Stanley Smith Barney LLC. As part of the joint venture, Citigroup Global Markets Inc. will distribute municipal securities to retail investors through the financial advisor network of a new broker-dealer, Morgan Stanley Smith Barney LLC. This distribution arrangement became effective on June 1, 2009. As part of this arrangement, Citigroup Global Markets Inc. will compensate Morgan Stanley Smith Barney LLC for its selling efforts with respect to the Bonds.

## **MISCELLANEOUS**

The foregoing and subsequent summaries or descriptions of provisions of the Bonds, the Bond Indenture, the Loan Agreement, the Master Indenture, Supplement No. 30 and the Series 2011A Obligation and all references to other materials not purporting to be quoted in full are only brief outlines of some of the provisions thereof and do not purport to summarize or describe all of the provisions thereof, and reference is made to said documents for full and complete statements of their provisions. The Appendices attached hereto are a part of this Official Statement. Following the issuance and sale of the Bonds, copies, in reasonable quantity, of the Bond Indenture, the Loan Agreement, the Master Indenture, Supplement No. 30 and the Series 2011A Obligation may be obtained upon request directed to the corporate trust office of the Bond Trustee.

It is anticipated that CUSIP identification numbers will be printed on the Bonds, but neither the failure to print such numbers on any Bonds nor any error in the printing of such numbers shall constitute cause for a failure or refusal by the purchaser thereof to accept delivery of and pay for any Bonds.

The information contained in this Official Statement has been compiled or prepared from information obtained from the Members of the Obligated Group and official and other sources deemed to be reliable and, while not guaranteed as to completeness or accuracy, is believed to be correct as of the date of this Official Statement. The Authority furnished only the information contained under the headings “THE AUTHORITY” and “LITIGATION—The Authority” and, except for such information, makes no representation as to the adequacy, completeness or accuracy of this Official Statement or the information contained herein. Any statements involving matters of opinion, whether or not expressly so stated, are intended as such and not as representations of fact.

This Official Statement has been delivered by the Authority and approved by the Corporation as agent of the Obligated Group. The Bond Trustee has not participated in the preparation of this Official Statement. This Official Statement is not to be construed as a contract or agreement among any of the Authority, the Corporation and the purchasers or Holders of the Bonds.

ABAG FINANCE AUTHORITY FOR  
NONPROFIT CORPORATIONS

By: /s/ Herbert Pike  
Chief Financial Officer

Approved:

SHARP HEALTHCARE, on behalf of  
the Obligated Group

By: /s/ Alison Fleury \_\_\_\_\_  
Senior Vice President Business Development

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**APPENDIX A**

**INFORMATION CONCERNING  
SHARP HEALTHCARE  
AND THE OBLIGATED GROUP**

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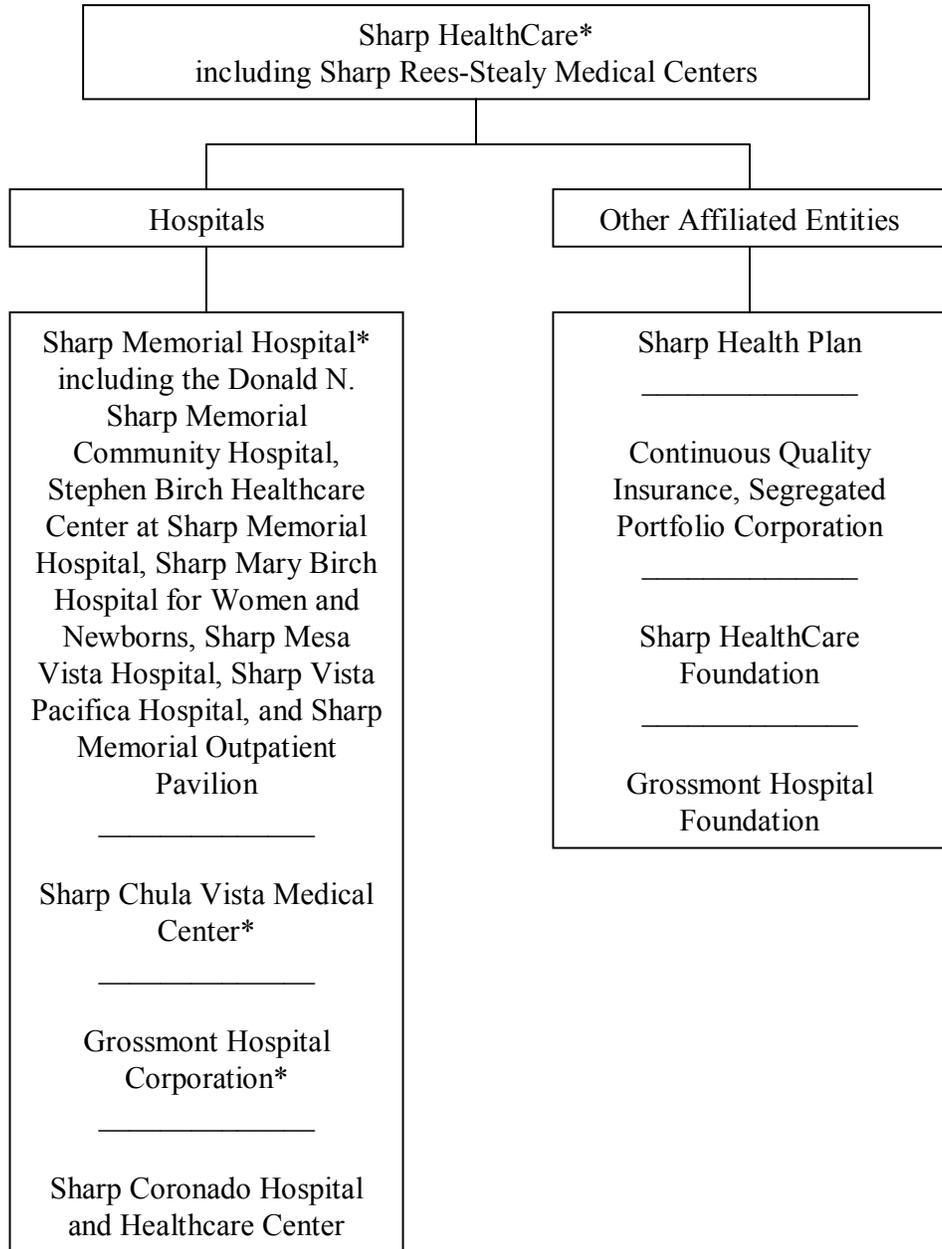
*The information contained in this Appendix A has been prepared by  
Sharp HealthCare.*

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\* Member of the Obligated Group

## APPENDIX A

### OVERVIEW OF THE SHARP HEALTHCARE SYSTEM

#### General

Sharp HealthCare (the “Corporation”) is a California nonprofit public benefit corporation with its corporate offices in San Diego, California. The Corporation is the sole member or sole shareholder of the affiliated entities discussed below, which together constitute a regional integrated health care delivery system known as Sharp HealthCare (“Sharp HealthCare”). The Corporation and its affiliated entities currently own or lease and operate a variety of facilities and programs throughout San Diego County (the “County”), which is home to a population of approximately 3.1 million<sup>1</sup>. Sharp HealthCare is comprised of:

- Four acute care hospitals
- Three specialty hospitals
- Twenty-one outpatient clinics operated in conjunction with one of its two affiliated medical groups
- Five urgent care centers
- Three skilled nursing facilities
- Two inpatient acute rehabilitation programs
- Home health, hospice, and home infusion programs
- Numerous outpatient facilities and programs
- A nonprofit health maintenance organization

As of September 30, 2010, Sharp HealthCare was licensed for 2,060 beds, had approximately 2,600 physicians on medical staffs and in affiliated medical groups, employed more than 14,800 people, and reported approximately \$1.9 billion in assets.

The Corporation’s affiliated entities include Sharp Memorial Hospital (“Sharp Memorial”), Sharp Chula Vista Medical Center (“Sharp Chula Vista”), Grossmont Hospital Corporation (“Sharp Grossmont”), Sharp Health Plan (“Sharp Health Plan”), Sharp Coronado Hospital and Healthcare Center (“Sharp Coronado”), Continuous Quality Insurance, Segregated Portfolio Corporation (“Continuous Quality Insurance”), Sharp HealthCare Foundation (“Sharp Foundation”), and Grossmont Hospital Foundation (“Grossmont Foundation”). The Corporation is the sole member of the aforementioned affiliated entities with the exception of Grossmont Foundation, whose sole member is Sharp Grossmont, and Continuous Quality Insurance, where the Corporation is the sole shareholder. The Corporation operates the Sharp Rees-Stealy Medical Centers (“Sharp Rees-Stealy”) as a division of the Corporation. Sharp Memorial includes the Donald N. Sharp Memorial Community Hospital (“Memorial Hospital”), Stephen Birch Healthcare Center at Sharp Memorial Hospital (“Stephen Birch Center”), Sharp Mary Birch Hospital for Women and Newborns (“Sharp Mary Birch”), Sharp Mesa Vista Hospital (“Sharp Mesa Vista”), Sharp Vista Pacifica Hospital (“Sharp Vista Pacifica”), and Sharp Memorial Outpatient Pavilion (“Sharp Outpatient Pavilion”). The Obligated Group (as defined

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<sup>1</sup> Source: Thomson-Reuters Market Expert; Claritas, Inc.; US Census Bureau.

herein) is comprised of the Corporation, Sharp Memorial, Sharp Chula Vista, and Sharp Grossmont. The other affiliated entities have no repayment obligation with respect to the Series 2011A Bonds (the “Bonds”).

### **Awards and Honors**

In 2007, Sharp HealthCare was named a Malcolm Baldrige National Quality Award recipient, the nation’s highest Presidential honor for quality and organizational performance excellence. The Baldrige award is presented to businesses — manufacturing and service, small and large — and to education, health care, and nonprofit organizations judged to be outstanding in seven areas, including leadership; strategic planning; customer and market focus; measurement, analysis, and knowledge management; human resource focus; process management; and results. Since the award’s inception in 1987, Sharp HealthCare is the only health care provider in California and one of only eleven health care organizations nationally to receive the award.

Sharp HealthCare has been named the top integrated health care network in California and the 6<sup>th</sup> in the nation in an annual survey conducted by SDI Health, a leading health care data analyst. This is the 12<sup>th</sup> consecutive year that Sharp HealthCare has placed among the top in the State of California (the “State”) in this national survey, which was announced by *Modern Healthcare* magazine in February 2010. The SDI Health ranking is based on Sharp HealthCare’s achievements in the areas of hospital utilization, financial stability, services and access, outpatient utilization, technology integration, contractual capabilities, physician participation, and overall system integration. Additionally, *InformationWeek* magazine selected Sharp HealthCare as one of the nation’s 500 most innovative users of information technology for its 2010 “InformationWeek 500” list. In 2009, Sharp HealthCare was named to the *Hospitals & Health Networks* 100 “Most Wired” list for the eleventh consecutive year since the award’s inception in 1999.

Sharp HealthCare was ranked fifth in the large-sized company category of *California's Best Places to Work program* for 2008. This best workplace program, exclusively for California employers, was sponsored by Employers Group, a human resources advisor serving California employers. *Modern Healthcare* magazine ranked Sharp HealthCare 47<sup>th</sup> in its national ranking of the “100 Best Places to Work” in 2008. This awards and honors program recognizes workplaces in the health care industry that enable employees to perform at their optimum level to provide patients and customers with the best possible care and services. Also in 2008, Sharp HealthCare won a crystal Workplace Excellence Award from the San Diego Society for Human Resource Management. The Workplace Excellence Award recognizes small and large companies from various industries that implement cutting-edge human resource practices that lead to employee satisfaction and company performance.

The American Nurses Credentialing Center (“ANCC”) awarded Sharp Grossmont and Sharp Memorial with the prestigious Magnet designation for their excellence in nursing practices and quality patient care in 2006 and 2008, respectively. In 2010, Sharp Memorial and Sharp Grossmont Cancer Centers were designated as Breast Health Centers – two of only eight hospitals in California to receive the three-year designation – by the National Accreditation Program for Breast Centers. Also in 2010, readers of *The San Diego Union-Tribune* recognized

Sharp Grossmont Hospital and Sharp Memorial Hospital as San Diego's number one and number three "Best Hospitals," respectively, in the newspaper's "Best of San Diego" Readers' Poll.

In 2010, the American Heart Association/American Stroke Association's Get With The Guidelines Program honored Sharp Memorial with a Gold award for coronary artery disease care; Sharp Grossmont with a Gold award for the treatment of coronary artery disease and heart failure, and a Silver Plus award for stroke care; Sharp Chula Vista with a Silver award for the treatment of heart failure; and Sharp Coronado with a Silver award for stroke care. These recognitions were announced in the July 14, 2010, edition of *U.S. News & World Report*. Also in 2010, Sharp Memorial's Trauma Center was ranked among the best in the nation by the American College of Surgeons' Trauma Quality Improvement Program ("TQIP"), an outcomes-based benchmarking program to improve patient care. Of the 25 trauma centers that participated in TQIP, Sharp Memorial was the only community hospital invited to participate and ranked in the top 20 percent in the categories of mortality, complication rates, and length of stay.

In 2009, Sharp Coronado and Sharp Mary Birch received Best Place to Practice awards from Press Ganey, a leading national health care consulting group that partners with more than 10,000 hospitals across the country. In 2007, Sharp Coronado was one of just five hospitals nationwide to receive the Planetree Patient-Centered Hospital Designation. It was also the only hospital in California to have met the stringent criteria developed by Planetree, a nonprofit organization committed to improving medical care from the patient's perspective. In 2010, Sharp Coronado was the first hospital in the country to achieve re-designation by Planetree.

In 2009, Sharp Rees-Stealy Medical Group, Inc. ("SRSMG"), an independently owned professional medical corporation affiliated with Sharp HealthCare and providing the professional medical services at Sharp Rees-Stealy, was named California's top-performing physician group by two different health plans. Anthem Blue Cross and Aetna recognized SRSMG for its leading performance among participating medical groups across the State in clinical quality, patient satisfaction, and information technology. CIGNA and PacifiCare have also recognized SRSMG as one of the top-performing groups in California. SRSMG and Sharp Community Medical Group, Inc. ("SCMG"), a multi-specialty medical group operating as an Independent Practice Association ("IPA") and affiliated with Sharp HealthCare, were awarded Elite Status, the highest possible designation for quality care given by the California Association of Physician Groups, as part of its 2009 Standards of Excellence program.

The California Office of the Patient Advocate awarded SRSMG the highest rating of four stars in both quality and service in their 2009 annual report card released in spring 2010. SRSMG was the only group in the County to receive four stars in both measures. Also in 2010, SRSMG was named the American Medical Group Association's prestigious Acclaim Award honoree. This was the third time the group has received the Acclaim Award, which honors organizations that embrace the Institute of Medicine's ("IOM") Aims for Improvement for an ideal health care system and have demonstrated dramatic, measurable progress in moving their organization toward the IOM's six aims to achieve health care delivery that is safe, effective, patient-centered, timely, efficient, and equitable.

## **Obligated Group**

A substantial portion of the Corporation's debt is secured under a Master Indenture of Trust, dated as of June 1, 1988, as supplemented and amended to date (the "Master Indenture"), which is summarized in part in Appendix C to this Official Statement. Pursuant to the Master Indenture, the Corporation, Sharp Memorial, Sharp Chula Vista, and Sharp Grossmont (collectively, the "Obligated Group" and each individually a "Member" or an "Obligated Group Member") have agreed to be jointly and severally liable for debt secured by obligations issued under the Master Indenture (each an "Obligation"). See "INTRODUCTORY STATEMENT – Outstanding Indebtedness and Obligations" in the front part of this Official Statement for more information on the Obligated Group's outstanding debt.

The Obligated Group Members are all California nonprofit public benefit corporations domiciled in the County. The Obligated Group Members accounted for 92.8% of Sharp HealthCare's total revenues, 96.6% of income from operations, and 96.6% of its net assets, as of and for the fiscal year ended September 30, 2010. See "HEALTH CARE OPERATIONS OF THE OBLIGATED GROUP" and "HISTORICAL FINANCIAL INFORMATION" herein.

The affiliated entities of the Corporation that are not Obligated Group Members (collectively, "Non-Obligated Affiliates") include Sharp Coronado, Sharp Health Plan, Sharp Foundation, and Grossmont Foundation, all of which are California nonprofit public benefit corporations, and Continuous Quality Insurance, an off-shore captive insurance company. Measured in terms of annual revenues, the largest of the Corporation's Non-Obligated Affiliates is Sharp Health Plan, which accounted for 8.7% of Sharp HealthCare's total revenues for the year ended September 30, 2010. See "NON-OBLIGATED AFFILIATES" herein.

*The Members of the Obligated Group are the only entities that are obligated to make payments on the Obligations issued under the Master Indenture, including the Series 2011A Obligation, and, therefore, with respect to the Bonds.*

## **Mission, Goals, and Vision**

Sharp HealthCare's mission is "to improve the health of those it serves with a commitment to excellence in all that it does." Sharp HealthCare's goal is "to offer quality care and services that set community standards, exceed patients' expectations, and are provided in a caring, convenient, cost-effective, and accessible manner." Sharp HealthCare's vision is "to transform the health care experience through a culture of caring, quality, service, innovation, and excellence and be recognized as the best place to work, the best place to practice medicine, and the best place to receive care."

Sharp HealthCare's programs and services support its mission by providing a full continuum of integrated care. This continuum includes prevention and wellness programs, an array of outpatient and clinical programs, primary through quaternary acute inpatient care, acute inpatient and outpatient rehabilitation, acute inpatient and outpatient behavioral health programs, and home health, hospice, home infusion, and skilled nursing care. See "HEALTH CARE OPERATIONS OF THE OBLIGATED GROUP" and "NON-OBLIGATED AFFILIATES" herein for details.

## Historical Perspective

The Corporation (formerly known as San Diego Hospital Association) was formed in 1946 to raise funds for hospital facilities in the San Diego area. In 1949, the P.L. Gildred family donated 12.5 acres of land in the Kearny Mesa area of San Diego to the Corporation as a proposed hospital site. The following year, Thomas E. Sharp, a rancher and radio communications pioneer, gave \$500,000 to the Corporation in memory of his son, United States Army Air Corps Lt. Donald N. Sharp, a World War II pilot who perished at the age of 22 while saving his crew. Ground was broken in 1953 for Memorial Hospital, which opened in 1955 as a nonprofit, non-sectarian, charitable institution providing general hospital care for the people of San Diego. Memorial Hospital was dedicated at the Sharp family's request to all the servicemen who sacrificed their lives in World War II.

In 1960, the "Stork Club," a \$1.5 million maternity wing, opened at Memorial Hospital and eventually evolved into Sharp Mary Birch, offering gynecological and obstetric/perinatal services. In 1962, a long-term care unit was dedicated at Memorial Hospital, one of the first of its kind in California. The unit has subsequently grown into the Sharp Rehabilitation Center, the only regionally accredited comprehensive rehabilitation center serving San Diego and specializing in care for patients with spinal cord, stroke, and brain injuries. In 1967, the Corporation received more than \$1 million from Thomas E. Sharp's estate. The Corporation then began a program to develop Memorial Hospital into a comprehensive medical center. This program led to medical and technological innovations and further campus investments through the 1970s. Since 1982, Memorial Hospital has been operated by Sharp Memorial.

In the early 1980s, the Corporation's management reevaluated the role of the traditional, freestanding acute care hospital in the health care marketplace and embarked on a strategy to develop a vertically integrated network of health care facilities and providers throughout the County. Since that time, Sharp HealthCare has developed an extensive network of physicians, hospitals, clinics, and other facilities and programs located throughout the County. In addition to creating a network that integrates facilities and providers, Sharp HealthCare has included the payor and financing mechanism into its network through Sharp Health Plan, a nonprofit health maintenance organization ("HMO") created in 1992, which is licensed pursuant to California's Knox-Keene Health Care Service Act of 1975 ("Knox-Keene").

In September 2001, Sharp HealthCare launched an initiative to enhance the organization's culture. The initiative involves the way the organization interacts with and serves its patients and their families, its physicians, and its employees. This initiative is called *The Sharp Experience* and it embraces many aspects of the organization and the organization's determination to achieve a high level of employee, patient, and physician engagement and satisfaction. *The Sharp Experience* centers on six pillars of performance: Quality, Service, People, Finance, Growth, and Community. The organization's efforts to achieve excellence in these areas are the basis for striving to attain its stated vision to be "the best place to work, the best place to practice medicine, and the best place to receive care."

## RECENTLY COMPLETED AND CURRENT PROJECTS

Listed below are brief summaries of recently completed and current projects affecting Sharp HealthCare's operations, as well as certain projects Sharp HealthCare currently is undertaking as part of its overall strategic plan. For a detailed review of the results of day-to-day operations, see "HISTORICAL FINANCIAL INFORMATION – Management's Discussion of Financial Performance" herein.

- In 2004, Sharp Grossmont completed construction of a new \$62.2 million five-story Emergency and Critical Care Center designed to meet the needs of the growing East County. The new tower, funded by philanthropic donations and cash reserves, includes expanded emergency services on the first floor of the facility. The emergency department consists of 43 beds separated into three areas designed specifically for minor, acute, and critical care services. The second floor of the facility houses 24 critical care beds. In 2004, the remaining three floors were shelled for future expansion. Such expansion was completed in September 2009, as discussed below.
- In 2006, Grossmont Healthcare District (formerly Grossmont Hospital District) (the "District") received approval from voters to issue \$247 million of general obligation bonds ("GO Bonds") for the purpose of financing the expansion, improvement, and renovation of facilities on the Sharp Grossmont campus, including the completion of the three shelled floors in the Emergency and Critical Care Center. The District leases the acute care facilities of Grossmont Hospital to Sharp Grossmont pursuant to a thirty-year lease (see "HEALTH CARE OPERATIONS OF THE OBLIGATED GROUP – Sharp Grossmont" herein). Current law provides that the Lease may be renegotiated or extended for up to an additional 30-year term upon approval of a majority of the voters of the District. Sharp Grossmont has no principal or interest payment obligations on the GO Bonds. Substantially all building construction and renovation costs will be funded through the GO Bonds. Sharp HealthCare's Five-Year Operating, Cash, and Capital Plan ("Five-Year Plan") includes \$24.2 million to equip and furnish the new and renovated spaces funded through the proceeds of the GO Bonds. The first phase was completed in September 2009 and provided an additional 90 licensed acute care beds for Sharp Grossmont, consisting of a new 24-bed medical intensive care unit and two 33-bed telemetry units in the three previously shelled floors of the Emergency and Critical Care Center. One of the new telemetry units was used to accept patients from one of Sharp Grossmont's existing towers (the "East Tower"), to allow for infrastructure improvement and remodel of the East Tower, which is currently in process and also funded by the GO Bonds. Additionally, GO Bond proceeds will fund the construction of a Diagnostic and Treatment Center, which is expected to be operational in 2014 and will provide up to eight new multipurpose procedural rooms with the flexibility to support a wide range of specialties, including general surgery, minimally invasive surgery, image guided surgery, catheterization procedures, and endovascular interventional procedures, as well as a new clinical laboratory and pharmacy. Concurrently, planning is underway for the expansion

of the central utility plant. GO Bonds in the amount of \$85.5 million were issued in July 2007 and together with proceeds from the future issuance of GO Bonds, up to the approved \$247 million, will be used to fund the above mentioned infrastructure improvements and facility renovations.

- In November 2004, Sharp Rees-Stealy selected the Allscripts Healthcare Solutions' ambulatory electronic health record ("EHR") information system, at the time called TouchWorks, but recently rebranded as Allscripts Enterprise. The Allscripts Enterprise system applications include charge capture, document scanning, electronic chart documentation, automated testing results, online dictation, electronic prescribing, and computerized physician order entry ("CPOE"). The system is implemented at all Sharp Rees-Stealy physician office and urgent care locations and utilized by nursing, support staff, and physicians. Devices have been installed in all exam rooms, which allow care providers to access a patient's medical information, as well as complete ordering, prescribing, documenting, and charging tasks during a patient's visit. The final phase of the implementation, including CPOE and electronic chart documentation, was completed in 2010, and an upgrade to the latest technology is in process with expected completion by the end of 2011. The total cost of the EHR system was approximately \$16.8 million, which was funded through cash reserves.
- In August 2006, the Corporation entered into a contract with Cerner Corporation ("Cerner") to implement the Cerner Millennium electronic medical record ("EMR") information system in Sharp HealthCare hospitals. The EMR system allows physicians to electronically enter their physician orders for patient treatment and is expected to provide significant benefits to Sharp HealthCare, including reduced adverse drug events, reduced hospitalization costs, increased patient and employee satisfaction, and increased quality of care. The Memorial Hospital implementation was completed in January 2008, followed by the Stephen Birch Center in January 2009, Sharp Mary Birch in November 2009, Sharp Mesa Vista in June 2010, and Sharp Grossmont in October 2010. The remaining Sharp HealthCare hospitals are expected to implement the Cerner Millennium products by September 30, 2011. The total cost of the EMR system is expected to be \$28.2 million, which has been and is being funded through cash reserves. Sharp HealthCare's Cerner EMR and Allscripts EHR will interoperate in a variety of ways. Certain data, such as laboratory and radiology results, will be retained in both systems and caregivers can toggle between systems to view the same patient's hospital and medical group records. Additionally, a health information exchange will be implemented to transmit key information, such as problems, medications, immunizations, allergies, and other data, between systems in a standard format.
- The Centers for Medicare & Medicaid Services ("CMS") has developed incentive programs to provide a financial reward for the meaningful use of qualified, certified electronic health records to achieve health and efficiency goals. Stage 1 sets the baseline for electronic data capture and information sharing and will be implemented in 2011 and 2012. The stage 1 provisions

include 25 meaningful use objectives, of which 20 must be completed to qualify for an incentive payment. Stages 2 and 3 of the electronic health records incentive program are expected to be implemented in 2013 and 2015, respectively. With implementation of Sharp HealthCare's EHR and EMR systems, management believes the organization is well positioned to receive incentive payments beginning in fiscal 2011.

- In April 2008, the Corporation began leasing 41,800 square feet for Sharp Rees-Stealy in a new two-story medical office building in inland North County to provide a stronger presence in this growing community. The new facility includes family practice, internal medicine, pediatrics, allergy, laboratory, radiology, and obstetrics/gynecology services, as well as a variety of other specialty services. Equipment and tenant improvements for the facility totaled \$3.6 million, which were funded through cash reserves.
- In 2008, construction of a new medical office building and parking structure on the Sharp Grossmont campus was completed in April and September, respectively. Sharp Grossmont leases approximately 17,000 square feet in the medical office building for outpatient imaging and more than half of the 750-space parking structure is utilized for Sharp Grossmont campus parking needs. The parking structure, equipment, and tenant improvements totaled \$12.2 million, which were funded through cash reserves.
- In March 2003, 50 years after philanthropic support launched Memorial Hospital, Sharp Foundation introduced a fundraising campaign to raise \$50 million from the San Diego community to support Sharp HealthCare's strategic initiatives. As part of Sharp HealthCare's vision to transform health care in San Diego, the campaign supported capital improvements for emergency and critical care centers, outpatient services, new hospital towers, and medical and information technologies. As of September 30, 2008, Sharp Foundation completed the campaign with a total of \$60.5 million raised, including a \$10 million donation from the Stephen and Mary Birch Foundation, the largest single gift in Sharp HealthCare's history, to support and name the Stephen Birch Center.
- In June 2008, construction of a new 1,000-space parking structure on the Sharp Memorial campus was completed to provide additional parking in preparation for the opening of the Stephen Birch Center in January 2009. The parking structure cost totaled \$13.9 million, which was funded through cash reserves.
- In January 2009, the Stephen Birch Center opened on the Sharp Memorial campus. The new patient tower was designed as a seven-story, 315,000 square foot structure, with 334 private inpatient beds, 10 operating suites, 37 emergency bays, 10 emergency observation beds, a new entry lobby, and a family care pavilion on each patient care floor. The total cost of the project was approximately \$200 million, which was funded by previously issued bonds,

philanthropic donations, and cash reserves. The Stephen Birch Center opened with 302 inpatient beds and eight operating suites and was designed with future inpatient bed and surgical suite expansion capabilities of 32 beds and two suites, respectively. The inpatient bed expansion was approved by the Corporation's Board of Directors ("Board") in January 2010. The \$10.6 million project is being funded through previously issued bonds and cash reserves, and completion is expected by the end of January 2011.

- In October 2009, the Corporation's Board approved expansion of the Sharp Chula Vista emergency department. The project will increase licensed emergency room treatment beds from 20 to 40 and create a four-bed observation unit. The estimated cost of the project is \$12.2 million, which also includes the purchase of a 16-slice computed tomography ("CT") scanner, furnishings, and other clinical and information technology equipment to support the expanded space. The project will be funded through previously issued bonds and cash reserves. The project is expected to be completed by November 2011.
- In February 2010, the Corporation's Board approved construction of a medical office building and radiation treatment center on the Sharp Chula Vista campus. Approximately 15,220 square feet of the 45,543 square foot building will be leased by Sharp Chula Vista to relocate its radiation treatment center from the hospital to this new and expanded space. The remaining 30,323 square feet will provide office space for physicians on Sharp Chula Vista's medical staff. The medical office building will be designed, built, owned, and managed by a third party and is expected to be completed by January 2012. The total estimated cost of the project is \$15.2 million, which includes tenant improvements, clinical equipment, information systems, and furnishings, and is being funded through previously issued bonds and cash reserves.
- In April 2010, the Corporation's Board approved construction of a medical office building and parking structure to replace the existing Sharp Rees-Stealy downtown medical office site. The three-story, 66,365 square foot medical office building will be constructed on land currently owned by the Corporation. The estimated project cost is \$38.1 million and is being funded through philanthropy, sale of excess land, cash reserves, and other sources. The medical office building and parking structure are expected to be completed by June 2012.
- In May 2010, the Corporation's Board approved the conversion of 27 semi-private rooms into 54 private rooms at Sharp Mary Birch. The project will also include remodeling the lobby and refurbishing the nurse stations and corridors. The estimated cost of the project is \$7.2 million and is being funded through previously issued bonds and cash reserves. The project is expected to be completed in December 2011.
- In May 2010, the Corporation's Board approved the expansion of Sharp Mary Birch to add 37 new beds to the hospital, including 23 neonatal intensive care unit beds and 14 women's acute care unit beds. The estimated cost of the

project is \$30.4 million and is being funded through previously issued bonds and cash reserves. The project is expected to be completed in May 2012.

- In May 2010, the Corporation's Board approved the renovation of the sixth and seventh floors of the Memorial Hospital south tower, which was built in 1955. The renovation converted all semi-private patient rooms to private rooms, with upgraded interior finishes to coordinate with the Stephen Birch Center and minor space modifications to make the units more efficient workplaces. The 38 renovated inpatient acute beds will be utilized for overflow from the Stephen Birch Center, as well as to provide the ability to meet future inpatient and outpatient capacity needs for the community. The project was completed in October 2010 for a total cost of \$1.5 million, which was funded through previously issued bonds and cash reserves.
- In July 2010, the Corporation's Board approved \$2.1 million for the design and permitting phase of the Memorial Hospital south tower and center tower seismic retrofit to allow the buildings to be used for acute care services until 2030 in accordance with California seismic regulations. At a fraction of the cost of new construction, such retrofitting allows Sharp Memorial to keep the acute care beds in the towers licensed until 2030, ensuring space for inpatient growth without construction of a new building. It also keeps ancillary services housed in the south and center towers intact and adjacent to the inpatient beds. Following Office of Statewide Health Planning and Development ("OSHPD") approval and permitting for the retrofit design, Board approval for the construction phase of the seismic retrofit work will be requested. The Five-Year Plan includes total project costs of \$20.0 million, to be funded through previously issued bonds and cash reserves, with completion planned by the end of 2013.

## **ACQUISITION AND DISPOSITION ACTIVITIES**

The Corporation continually evaluates various business opportunities as part of the Corporation's overall strategy of providing quality health care services in an effective manner. Such opportunities range from the addition of or affiliation with existing health-related entities to the divestiture of enterprises that it currently owns and operates. Such transactions could involve changes to the composition of the Obligated Group (defined herein) but would be subject to the terms of the Master Indenture.

In 1992, Sharp HealthCare entered into an affiliation agreement with Sharp Mission Park Medical Group, Inc. ("SMPMG"), an independent professional medical corporation. As part of the affiliation, Sharp HealthCare acquired SMPMG's equipment and facilities and began operating the Sharp Mission Park Medical Centers ("Sharp Mission Park"), located in the North Coastal area of the County, with SMPMG providing the professional medical services at Sharp Mission Park pursuant to a services agreement that was scheduled to expire in 2013. Sharp Mission Park was included as a division within the Corporation. In April 2008, the Corporation's Board approved the sale of Sharp Mission Park to Scripps Health ("Scripps"). The transaction was completed on August 1, 2008, the services agreement between Sharp

HealthCare and SMPMG was terminated, and Sharp Mission Park assets and employees were transferred to Scripps.

Sharp Memorial previously included a 76-bed skilled nursing facility located approximately six miles from the Sharp Memorial campus, operating as the Sharp Cabrillo Skilled Nursing Center (“Sharp Cabrillo”). Sharp HealthCare discontinued operations and closed the facility when its seven-year facility lease expired on April 3, 2009. The operation of Sharp Cabrillo had resulted in financial losses in the last several years due to a variety of factors, including the age and maintenance of the ten-story building, high utility costs, low reimbursements associated with skilled nursing facility services, increasing medical supply costs, and the facility’s lease expense. Sharp Memorial patients requiring skilled nursing care are able to access services through other Sharp HealthCare or community skilled nursing facilities.

## ORGANIZATIONAL STRUCTURE

### Corporate Governance

**Board of Directors.** The Corporation is governed by a 25-member Board, including three *ex officio* members. *Ex officio* members of the Board serve by virtue of their positions within the Corporation or with certain of its affiliated corporations. All Board members have the right to vote on matters considered by the Board, subject to the Corporation’s conflict of interest policy. Regular meetings of the Board are held monthly.

In addition to the *ex officio* members, one director from each of the following affiliated entities is designated (each such director a “Designated Director” and collectively “Designated Directors”) by their respective boards: Sharp Memorial, Sharp Chula Vista, Sharp Grossmont, and Sharp Coronado. Additionally, a physician member each is appointed by SRSMG and SCMG. The remaining members are elected by the Board for three, three-year terms from a slate of nominees presented. Up to one-third of the members of the Board may be physicians. At present a total of seven members of the Board are physicians.

Current Board members, their occupations, and the expiration dates of their respective terms are set forth in the table below. The terms of all elected members expire on May 31 of the year indicated. Except as denoted by an asterisk in the table, all current members are eligible to serve at least one additional three-year term. *Ex officio* members and Designated Directors are not subject to the three-year term limit. There currently are two vacancies on the Board.

NAME/TITLE	OCCUPATION	TERM EXPIRATION
Deirdre Alpert, Chair*	Retired Legislator, Community Leader	2013
Anette Asher	CEO Information Technology Firm	<i>Ex-officio</i>
James B. Smith III, Vice Chair	Business Consultant	2013
Timothy Considine, Treasurer	Consultant, Certified Public Accounting Firm	2013
Yvonne W. Larsen, Secretary *	Community Leader	2012
Henry M. Killmar, Past Chair	Retired Banker	<i>Ex-officio</i>
Michael W. Murphy, President	President and Chief Executive Officer, Sharp HealthCare	<i>Ex Officio</i>
Donald C. Balfour, M.D.	Physician	<i>Designated Director</i>
James S. Brown	Retired Banker	<i>Designated Director</i>
VAdm. Walter J. Davis, Jr., USN (ret)	Retired United States Navy Admiral	2012

NAME/TITLE	OCCUPATION	TERM EXPIRATION
Margaret Elizondo, M.D.	Physician	2012
Sergio Flores, M.D.	Physician	Designated Director
Peter Hanson, M.D.	Physician	Designated Director
Francisco Hernandez, M.D.	Physician	Designated Director
Robert Kelly	President, Philanthropic Foundation	2012
L. Daniel Malcolm	Attorney, Commercial Real Estate Services	Designated Director
Richard Mejia, Jr.	Retired Certified Public Accountant	2013
Lori Moore, R.N.	Real Estate Investment	2012
Michael A. Morton	Chairman, Restaurant Chain	2012
Regina Petty	Attorney, Law Firm Partner	2012
Kenneth Roth, M.D.*	Physician	2012
Geoffrey M. Stiles, M.D.	Physician	2012
Gordon L. Witter, Jr.	Retired Airline Captain and Banker	2013

**Executive Committee.** The Executive Committee of the Board meets on an ad hoc basis and consists of the six officers of the Board and, unless one of the officers is a physician, an additional physician member of the Board. The Executive Committee has the power to transact all business of the Corporation between Board meetings (subject to specific limitations imposed by the Board, the Corporation’s bylaws, and California law). The Executive Committee (excluding physician members) also serves as the Personnel Committee of the Board.

**Audit and Compliance Committee.** The Audit and Compliance Committee of the Board meets bi-monthly and consists of a minimum of five Board members. The Audit and Compliance Committee reviews and approves the annual financial reports prepared by the Corporation’s external auditors, approves the Corporation’s annual internal audit and compliance plans, and monitors the internal audit and compliance functions of the Corporation to assure adequate reviews and audits of Sharp HealthCare’s internal controls.

**Finance Committee.** The Finance Committee of the Board meets monthly and consists of a minimum of five Board members and one Sharp Grossmont board member designated by the District. At least one member of the Finance Committee is required to be a physician member of the Board. The Finance Committee reviews the combined financial statements of the Corporation and provides recommendations to the Board regarding significant financial transactions.

**Other Committees.** Other committees of the Board include a Governance/Nominating and Bylaws Committee, a Future Directions Committee, an Advocacy Committee, a Quality Committee, a Marketing and Advertising Committee, a Construction Committee, a Litigation Committee, an Information Technology Committee, and a Personnel Committee.

### **Affiliated Entities Governance**

The Corporation’s Board elects the members of the governing bodies (other than Designated Directors or those serving *ex officio*) of certain affiliated corporations, including the Obligated Group Members, and generally may replace such members at its sole discretion. Each governing body is responsible for overseeing day-to-day operations of its respective facilities and coordinating its strategic initiatives, budget preparation, and capital expenditures with the

Corporation. In aggregate, approximately 150 members serve on the boards of directors of Sharp HealthCare affiliated entities.

## **Management**

Each Member's governing body delegates the day-to-day management of such Member to an executive management team. The Corporation provides various centralized management services to its affiliated entities including information technology, finance, strategic planning, marketing, business development, facility management, public affairs, legal, risk management, human resources, patient financial services, clinical effectiveness, managed care contracting, supply chain management, nurse call center, and other services. Michael W. Murphy serves as President and Chief Executive Officer of the Corporation and utilizes a senior executive team to manage day-to-day activities and to generate strategic opportunities for the Corporation and its affiliated entities. Following are the members of Sharp HealthCare's executive team:

***Michael W. Murphy (53), President and Chief Executive Officer.*** Mr. Murphy's career in health care spans nearly 30 years. He began his career with Sharp HealthCare in 1991 as Chief Financial Officer of Sharp Grossmont. He later assumed Sharp HealthCare's system-wide role for managing financial services as Vice President of Financial Accounting and Reporting, then rose to the position of Senior Vice President of Business Development and Legal Affairs. In 1996, he was appointed to his current position. Before joining the Sharp HealthCare organization, Mr. Murphy was a partner at Deloitte & Touche, an international public accounting and consulting firm, specializing in health care. Mr. Murphy is past Chair of the board of directors of the Greater San Diego Regional Chamber of Commerce, member of the Anthem Blue Cross Hospital Relations Committee, member of the Health Management Academy, member of the San Diego Rotary Club, member of the Executive Partners Group of Community Health Improvement Partners ("CHIP"), which works to improve health care in San Diego, and an adjunct professor in the graduate School of Public Health at San Diego State University ("SDSU"). Mr. Murphy received his Bachelor of Science Degree in Business and Accounting from California State University at Long Beach in 1979. Mr. Murphy is a Certified Public Accountant.

***Melissa Hayden Cook (48), Sharp Health Plan President and Chief Executive Officer.*** Ms. Hayden Cook has more than 25 years experience in the health care industry. She previously worked for Sharp HealthCare from 1994 to 2000 as Senior Vice President of Marketing, during which time she served on the Sharp Health Plan Board of Directors for three years, and rejoined Sharp HealthCare in 2005 in her current role. Prior to joining Sharp HealthCare, Ms. Hayden Cook held key management positions with HealthNet and Cigna, where she was responsible for managed care strategy, sales and management, revenue growth, product development, and broker development. Ms. Hayden Cook has a Bachelor's Degree in Business Administration from the University of San Diego ("USD"). In 1996 she received the YWCA Tribute to Women in Industry ("TWIN") Award, and was Chair of the March of Dimes WalkAmerica in 1998 and 1999. In 2000 she was named "Top 40 under Forty" by *San Diego Metropolitan* magazine. At the local level, Ms. Hayden Cook is a member of the board of Health Sciences High and Middle College ("HSHMC"), a charter school focused on developing the health care leaders of tomorrow. She serves on the board of 211 San Diego, a non-profit organization offering community, health, and disaster referral services in the area, and is also a board member of the

San Diego North Chamber of Commerce. At the State level, Ms. Hayden Cook sits on the board of the California Association of Health Plans (“CAHP”), and is a member of the CAHP Foundation board. In addition, at the national level, Ms. Hayden Cook serves on the board of the Health Plan Alliance (“HPA”), an association of nonprofit health plans.

***Alison Fleury (48), Senior Vice President, Business Development.*** Ms. Fleury has more than 25 years of experience in the health care industry. She joined Sharp HealthCare in 1991 and has held several system-wide financial leadership positions, including Vice President of Finance. Ms. Fleury was promoted to her current position in 1997. She is responsible for Sharp HealthCare’s strategic planning and financing and capital structure initiatives, as well as the purchase and sale of health-related businesses and the formation of partnership arrangements involving physicians and other health care organizations. Prior to joining Sharp HealthCare, she was a manager and firm-designated health care specialist at Deloitte & Touche. Ms. Fleury received her Bachelor of Science Degree in Business Administration from SDSU in 1985, graduating Summa Cum Laude, and was named the 1985 Outstanding Accounting Graduate by the SDSU College of Business. She received the YWCA TWIN Award in 2000 and was named one of San Diego’s “Top 40 Under Forty” by *San Diego Metropolitan* magazine in 2001. Ms. Fleury serves on the board of directors, finance committee, and executive committee of the YWCA of San Diego County and the Board of Directors of Sharp Health Plan. Ms. Fleury is a Certified Public Accountant and a Sharp HealthCare-certified Six Sigma Green Belt and Change Agent.

***Daniel Gross (55), Executive Vice President, Hospital Operations.*** Mr. Gross has been involved in the health care field for more than 30 years and has been associated with Sharp HealthCare since 1979. He began his career with Sharp HealthCare as a clinical nurse in the surgical intensive care unit at Memorial Hospital, and progressively advanced from this position to a variety of key leadership roles in both patient and non-patient areas of hospital management, including serving as Sharp Memorial’s Chief Executive Officer for 12 years. Mr. Gross was promoted to his current position in 2006 and oversees the operations of Sharp HealthCare’s acute care and specialty hospitals, government relations, and clinical effectiveness. Mr. Gross is past chair of the board of directors of the California Hospital Association (“CHA”), chair-elect of the board of directors of the Healthcare Association of San Diego and Imperial Counties (“HASDIC”), a member of the board of directors of the American Heart Association, San Diego Chapter, a member of the American Hospital Association (“AHA”) Regional Policy Board 9, a member of the Trauma Center Association of America, a member of the board of directors of Lumetra Healthcare Solutions, a member of San Diego Gas & Electric Community Advisory Council, a member of the adjunct faculty at SDSU and USD, and serves as Community Program Director for the University of California, San Diego (“UCSD”). In 1998, he received the Sigma Theta-Tau Gamma Gamma Chapter Administrative Leadership Award and in 1999 he received the SDSU Alumnus of Distinction Award for the College of Health and Human Services and the USD Author E. Hughes Career Achievement Award. Mr. Gross received the HASDIC Health Care Leadership Award in 1998 and 2007. Mr. Gross received his Bachelor of Science Degree in Nursing from Wichita State University in 1979, his Master’s Degree in Nursing Systems Administration, Business, and Leadership from SDSU in 1988, and his Doctorate in Nursing Science from USD in 1997. Mr. Gross also is the recipient of the California Health Foundation and Trust 2010 Walker-Sullivan Health Care Fellowship.

***Marcia Hall (61), Sharp Coronado Chief Executive Officer.*** Ms. Hall has more than 35 years of experience in the health care industry. She began her career with Sharp HealthCare in 1987 as the Director of Pharmacy for Sharp Cabrillo Hospital. Ms. Hall subsequently was promoted to Associate Administrator of the facility in 1989 and to Vice President of Clinical Services and Quality Systems for Sharp Memorial and Sharp Cabrillo Hospital in 1991. In 1995, she was promoted to her current position. Ms. Hall led Sharp Coronado to an affiliation with Planetree in 2002. The hospital was honored in 2007 as one of only five hospitals nationwide to be selected as a Planetree Designated Patient Centered Care Hospital and the first hospital in the country to achieve re-designation by Planetree in 2010. She received the YWCA TWIN Award in 1998. Ms. Hall received her Bachelor of Science Degree in Pharmacy from Oregon State University in 1971 and is a Registered Pharmacist.

***Mary Henrikson (56), Sharp Mary Birch Chief Executive Officer.*** Ms. Henrikson has more than 30 years of health care experience. She began her career at Sharp HealthCare in 2000 as Sharp Mary Birch Chief Operating Officer and was promoted to her current position in 2006. Prior to joining Sharp HealthCare, she was the Director of Prentice Women's Hospital of Northwestern Hospital in Chicago. Ms. Henrikson is a member of the executive committee for the Council of Women's and Infants Specialty Hospitals, the board of directors for the National Perinatal Information Center, and the Miracle Babies Foundation. Ms. Henrikson received her Bachelor of Science Degree in Nursing from Montana State University and a Master's of Science Degree from the University of Washington. In 1981, she received her nurse practitioner certificate from Harbor-University of California, Los Angeles ("UCLA") Medical Center. Ms. Henrikson received the YWCA TWIN Award in 2009 and is a Registered Nurse.

***John Jenrette, M.D. (56), SCMG Chief Executive and Medical Officer.*** Dr. Jenrette has been with SCMG since 1993. During this time he has served as Medical Director for Quality, Health Services Management, and beginning in 1999, as Chief Medical Officer. He began his role as Chief Executive and Medical Officer in August 2007. In addition to his responsibilities as Chief Executive and Medical Officer, Dr. Jenrette is a board member and chairman elect of the California Association of Physician Groups and also serves on their executive committee. Prior to joining SCMG, Dr. Jenrette served as Residency Program Director for the Sharp HealthCare Family Practice Residency and has been in academic medicine since 1987. As faculty to Northeastern Ohio University's College of Medicine, Dr. Jenrette created and ran a leadership and management fellowship for faculty of residency training programs while also directing the Family Medicine Residency Program in Northwestern Ohio. Dr. Jenrette received his Bachelor of Science Degree in Science and completed his medical education at Ohio State University. He is board certified in Family Medicine and Geriatrics and practiced in these specialties for over 15 years before joining SCMG.

***John ("Rick") LeMoine, M.D. (63), Chief Medical Information Officer.*** Dr. LeMoine, who joined Sharp HealthCare in 1982 and assumed his current role in 2003, is responsible for providing medical direction and physician input for clinical effectiveness and information systems department initiatives. A graduate of Dalhousie Medical School in Nova Scotia, Canada, Dr. LeMoine completed his Fellowship program in Pulmonary and Critical Medicine at the UCSD Medical Center. Dr. LeMoine has served on the faculty of medicine at both Dalhousie Medical School and UCSD. In addition, he has held leadership roles as Executive Director for Insured Programs and Clinical Rationalization for the Government of Nova Scotia.

Dr. LeMoine is the chair of the Center for Hospital Medical Executives of CHA and a member of the board of trustees of CHA.

***Kathi Lencioni (57), Sharp Mesa Vista and Sharp Vista Pacifica Chief Executive Officer.*** Ms. Lencioni joined Sharp HealthCare in 2002 as Vice President of Clinical Services and Operations at Sharp Grossmont and was selected for her current position in 2006. Prior to joining Sharp HealthCare, she served as the Vice President of Ambulatory and Clinical Services at Sarasota Memorial HealthCare System in Florida. Ms. Lencioni has over 25 years of health care industry experience. Ms. Lencioni is a Fellow with the American College of Healthcare Executives and serves on the Regents Advisory Council for San Diego/Imperial County. She serves on the board of trustees for the National Association of Psychiatric Health Systems, CHA's Center for Behavioral Health, and the San Diego Organization for Healthcare Leaders. Ms. Lencioni received her Bachelor of Science Degree in Medical Technology from Illinois State University and her Master's Degree in Public Health in Health Organization Management from the University of South Florida.

***Carlisle ("Ky") C. Lewis, III (54), Senior Vice President and General Counsel.*** Mr. Lewis joined Sharp HealthCare in 1991 as Legal Counsel. Currently, Mr. Lewis serves as General Counsel for all Sharp HealthCare entities on a wide variety of matters. Additionally, he has management responsibilities for the human resources, facilities management, and risk management functions for Sharp HealthCare. Prior to joining Sharp HealthCare, Mr. Lewis was Vice President and Counsel for Great American Bank, a large financial institution based in San Diego. Mr. Lewis received his Bachelor of Arts Degree from the University of Puget Sound in 1978 and his Juris Doctorate from USD in 1985. He has been an active member of the California State Bar since 1986. Mr. Lewis is a past president of the California Society for Health Care Attorneys.

***William S. Littlejohn (52), Senior Vice President and Sharp Foundation Chief Executive Officer.*** Mr. Littlejohn joined Sharp HealthCare in 2002 and has more than two decades of health care philanthropy experience. During his tenure, Sharp HealthCare has generated more than \$125 million in philanthropy, including the recently concluded \$60.5 million campaign for Sharp HealthCare, the largest philanthropic effort in Sharp HealthCare's history. Prior to joining Sharp HealthCare, Mr. Littlejohn worked for 10 years with The Greenwood Company, a professional fundraising firm, where he supervised and directed more than 40 fundraising projects for health care institutions throughout the United States. Mr. Littlejohn is a 1980 graduate of the University of Virginia with a Bachelor of Arts Degree in Economics. He is the secretary and treasurer of the Association for Healthcare Philanthropy and is a charter advisor to The Advisory Board Company's Philanthropy Leadership Council. He serves on several boards and committees for nonprofit institutions in San Diego and has spoken and written extensively on all aspects of fundraising.

***Todd Miller (45), Senior Vice President, Marketing and Communications.*** Mr. Miller has more than 20 years of marketing experience and has been with Sharp HealthCare since 2003. He is responsible for Sharp HealthCare's brand strategy, advertising, internal and external corporate communications, public relations, special events, multicultural services, web strategy, consumer information services, and consumer research. In addition, he and his team are champions of *The Sharp Experience*, an initiative focused on the organization's culture, with the

goal of becoming the best place to work, practice medicine, and receive care. Prior to joining Sharp HealthCare, Mr. Miller held leadership positions at advertising agencies on the East and West coasts including Matthews/Evans/Albertazzi in San Diego, Deutsch in New York City, and Loeffler/Ketchum/Mountjoy in Charlotte. Mr. Miller received his Bachelor of Arts Degree in Journalism in 1987 from the University of North Carolina at Chapel Hill.

***Donna Mills (66), Sharp Rees-Stealy Chief Executive Officer.*** Ms. Mills' career in health care spans more than 30 years. She began her career at Sharp HealthCare with Mission Park Medical Clinics in 1986, which was a part of Sharp HealthCare from 1992 to 2008. Since 1998, Ms. Mills has served as the Chief Executive Officer for Sharp Rees-Stealy and Sharp Mission Park. Prior to joining Sharp HealthCare, she held the position of Director of Programs with UCSD. Ms. Mills is an American College of Medical Practice executive, a Medical Group Management Association Fellowship candidate, and has been honored as one of the "Women Who Mean Business" in health care by the *San Diego Business Journal*. In 1997, she received the YWCA TWIN Award. Ms. Mills has served on the YWCA of San Diego board of directors and previously was the presiding officer for the Greater San Diego and Desert Cities chapter of the Crohn's and Colitis Foundation of America. Ms. Mills received her Bachelor of Science Degree in Business Administration in 1982 and her Master's Degree in Business Administration in 1984 from National University, San Diego.

***Nancy Pratt (53), Senior Vice President, Clinical Effectiveness.*** Ms. Pratt has worked in the health care field for over 25 years. She is responsible for quality, patient safety, service lines, research, and clinical decision support. Prior to joining Sharp HealthCare in 2002, Ms. Pratt was Vice President of Clinical Data Services for MEDai, Inc., a national computer information services company that assists health care providers in the measurement of quality. She has worked in the clinical effectiveness field for nearly 15 years and is a noted national speaker. Ms. Pratt has prior experience as a Manager in Cardiovascular Care and Trauma. Additionally, she has more than 20 years experience as a critical care nurse in a variety of settings including positions at Sharp HealthCare from 1983 to 1986. Ms. Pratt has a Bachelor's Degree in Nursing from the State University of New York, a Master's Degree in Nursing Administration from SDSU, and is an American Society of Quality certified Six Sigma Black Belt. She served as a member of the 2006, 2007, and 2008 Board of Examiners for the Malcolm Baldrige National Quality Award and led the initiative resulting in Sharp HealthCare's recognition as a recipient of the 2007 Malcolm Baldrige National Quality Award. She received the YWCA TWIN Award in 2008. Ms. Pratt is a Registered Nurse.

***Ann Pumpian (55), Senior Vice President and Chief Financial Officer.*** Ms. Pumpian has more than 30 years of experience in the health care field, specializing in accounting and health care financial management. She joined Sharp HealthCare in 1984 as Government and Contracts Manager and has been in her current role since 1993. She is responsible for strategic financial planning, management service organization programs, capitation management, patient financial services, supply chain management, third-party insurance contracting, government reimbursement, budgeting, payroll, accounts payable, accounting, treasury, and cash management functions. Prior to joining Sharp HealthCare, she was employed as a health care specialist in audit and consulting for Ernst & Whinney, an international public accounting and consulting firm. Ms. Pumpian serves on the Health Management Academy Committee for Chief Financial Officers, CHA Chief Financial Officer Committee, and is a member of the State of

California Department of Managed Care Financial Solvency Standards Board. She is a past recipient of the YWCA TWIN Award and the Healthcare Financial Management Association's service award. Ms. Pumpian received her Bachelor of Science Degree in 1977 and her Master of Science Degrees in Health Care Finance and Business Administration in 1981 from the University of Wisconsin, Madison. Ms. Pumpian is a Certified Public Accountant.

***Tim Smith (53), Memorial Hospital Chief Executive Officer.*** Mr. Smith joined Sharp HealthCare in 2007 and has more than 25 years of health care industry experience. Prior to joining Sharp HealthCare, he served as interim Chief Operating Officer at University of California Irvine Medical Center for two years and as Chief Executive Officer for two Tenet Healthcare Hospitals in California for 11 years, Fountain Valley Regional Hospital and Garden Grove Hospital. Mr. Smith is a fellow of the American College of Healthcare Executives, serves on the Lifesharing Executive Advisory Board, and is a current board member of the San Diego Blood Bank. He is a past corporate cabinet chair of the American Heart Association Orange County Chapter and a former chairman of the board for the Hospital Association of Southern California. Mr. Smith earned a Bachelor of Arts Degree in Business Economics from the University of California, Santa Barbara, in 1979 and a Master of Public Health Degree in Health Services Management from UCLA.

***William Spooner (65), Senior Vice President and Chief Information Officer.*** Mr. Spooner has worked in the health care field for more than 30 years and has been associated with Sharp HealthCare since 1981. In addition to holding responsibility for information technology strategy, he oversees Sharp HealthCare's system-wide clinical, financial, and administrative computer systems. Mr. Spooner has led the team directing the strategic planning and implementation of integrated information systems and the EHR and EMR initiatives for the Sharp HealthCare enterprise, resulting in Sharp HealthCare being named to the *Hospitals & Health Networks* 100 "Most Wired" list from 1999 to 2009. He is a member of the Healthcare Information Services Executive Association, College of Healthcare Information Management Executives ("CHIME"), and Healthcare Information and Management Systems Society ("HIMSS"). He received the 2009 John E. Gall Jr. CIO of the Year award, presented each year by CHIME and HIMSS. Mr. Spooner served as a CHIME Board member from 2004 to 2007, including as chair in 2006. He also has served on CHIME's Advocacy Leadership Team since its inception in 2004, providing education and promoting measures to facilitate the adoption of electronic health records. He serves on the CHA Health Informatics and Technology Committee, the Cal eConnect Technology Work Group, the California Health Care Foundation e-Prescribing Advisory Group, and numerous other working groups concerned with implementation of the Health Information Technology for Economic and Clinical Health Act component of the American Recovery and Reinvestment Act of 2009. Mr. Spooner received his Bachelor of Science Degree in Business Administration from California State University, Chico in 1976.

***Michele Tarbet (58), Sharp Grossmont Chief Executive Officer.*** Ms. Tarbet joined Sharp HealthCare in 1995 as Chief Administrative Officer of Sharp Grossmont and advanced to her current position in 1996. She has more than 35 years of progressive health care management experience, including both nursing management and hospital operations in both the for-profit and nonprofit sectors. Prior to joining Sharp HealthCare, Ms. Tarbet held several Chief Nursing Officer and Chief Operating Officer positions in the Los Angeles area, including Woodruff Community Hospital in Long Beach and Memorial Hospital of Gardena. Ms. Tarbet serves on

the boards of directors for the La Mesa Parks Foundation, East County Boys and Girls Club, and Salvation Army Ray and Joan Kroc Corporation Community Center Advisory Council. She is a member of the La Mesa Rotary Club. In addition, she serves on the board of managers of the University of Virginia Alumni Association. Ms. Tarbet was recognized as a San Diego Community Health Hero by the Council of Community Clinics in 2007, received the YWCA TWIN Award in 1999, and the East County Chamber of Commerce's Women in Leadership Award in 2004. She received her Bachelor of Science Degree in Nursing from the University of Virginia in 1974 and her Master of Science Degree from the University of La Verne in 1985. Ms. Tarbet is a Registered Nurse.

***Pablo Velez (48), Sharp Chula Vista Chief Executive Officer.*** Dr. Velez has been a member of the Sharp Chula Vista team since 1996. He has held numerous leadership positions within the organization, including Director of Critical Care Services, responsible for the leadership and operations of the intensive care, post-anesthesia care, and intermediate care units, and Vice President of Patient Care Services, a position he held for nine years prior to his appointment as Chief Executive Officer in 2010. Dr. Velez began his health care career nearly 25 years ago as a nurse manager at the Boston VA Medical Center and served at several hospitals in progressive leadership positions in the Boston area before moving to San Diego. He earned his Bachelor's Degree in Nursing from the University of Puerto Rico, and also holds a dual Master's Degree in Critical Care and Nursing Administration from the University of Massachusetts Boston, as well as a Doctorate Degree in Nursing Philosophy from USD. The current president of the Association of California Nurse Leaders San Diego Chapter, he also serves as an adjunct faculty member at SDSU. Dr. Velez is a Registered Nurse.

**Medical Staff**

Each Member of the Obligated Group (other than the Corporation) has the responsibility for appointments to its medical staff. The Corporation assists these organizations and certain other Non-Obligated Affiliates in credentialing, continuing education programs, and other medical staff activities. The table below provides a summary of each Obligated Group Member's medical staff, with data presented as of September 30, 2010.

	<b><u>Sharp Memorial</u></b>	<b><u>Sharp Chula Vista</u></b>	<b><u>Sharp Grossmont</u></b>
Total Providers	1,148	455	689
% Board Certified	90.9%	86.2%	85.1%
Average Age	50.8	50.9	49.8

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Source: Corporation records.

**Medical Groups**

Sharp HealthCare has two affiliated medical groups, which are key elements in Sharp HealthCare's integrated delivery system. Listed below are brief descriptions of each affiliated medical group as of September 30, 2010.

**SRSMG.** Initially founded as the Rees-Stealy Medical Group, Inc. in 1923, SRSMG is San Diego's oldest multi-specialty medical group and is nationally known for superior clinical practices and leading-edge research. SRSMG is composed of 122 primary care physicians who are supported by 234 specialists and sub-specialists representing virtually every medical specialty. SRSMG contracts with the Corporation to provide outpatient health care services within the Sharp Rees-Stealy facilities. The contract between the Corporation and SRSMG expires in 2030 and can be extended by mutual agreement.

**SCMG.** SCMG is an association of private practice primary care physicians and specialists in the County operating as an IPA. SCMG was formed in 1989 and today is San Diego's largest IPA. SCMG is composed of over 205 primary care physicians and 787 specialists. SCMG leases space within the Corporation's administrative offices and contracts with the Corporation for administrative services including management, contracting, claims processing, utilization management, payroll, human resources, marketing, internal audit, compliance, credentialing, and information services.

## **Employees**

As of September 30, 2010, Sharp HealthCare employed approximately 14,800 people, which calculates to be 10,974 full-time equivalent employees, approximately 10,336 of whom were full-time equivalent employees of the Obligated Group. All Sharp HealthCare employees are provided compensation and benefits believed by management to be competitive with those offered by other health care providers in the County.

Effective June 30, 2010, Sharp Professional Nurses Network (SPNN), United Nurses Associations of California, National Union of Hospital and Health Care Employees, American Federation of State, County and Municipal Employees, AFL-CIO ("UNAC") extended the collective bargaining agreement with Sharp HealthCare that has been in effect since February 1997. As extended, Sharp HealthCare's current collective bargaining agreement with UNAC expires September 30, 2011. The union represents approximately 4,000 registered nurses employed by Sharp HealthCare in the hospital and outpatient facilities. The current agreement provides guaranteed wage changes on each October 1 of the contract period. The yearly wage changes include general wage increases and flat rate per diem wage increases. The contract includes a "no-strike" clause during the term of the collective bargaining agreement. The compensation and benefit provisions mandated by the agreement are generally consistent with those offered to non-unionized employees of Sharp HealthCare.

## **Nurse Staffing**

The County has experienced nursing shortages consistent with the nursing shortages across the nation. The key factors influencing the shortage include population growth, an older population, an aging nursing population, and an inability for the education system to keep up with the demand for nursing education. While the current economic recession has caused many nurses to return to the workforce thus easing the nursing shortage in the County, a stronger economy or other influences could cause the shortage to return. Retention of nurses is a top priority for Sharp HealthCare and turnover rates are considerably lower than state and national averages. Competitive salary and benefit packages, professional development opportunities, a

positive working environment, and nurse mentoring programs are a focus of employee retention. Sharp HealthCare has a dedicated nurse recruiting program, maintains an emphasis on support systems for new graduates, and offers economic incentive programs for hard-to-fill nursing positions.

To address future nursing shortages in the County, Sharp HealthCare collaborates with local colleges and universities to expand the supply of nurses. Since 2000, Sharp HealthCare has been one of six local hospitals providing financial support to the Nurses Now program at SDSU. The faculty-expanding partnership increased enrollment opportunities for 300 additional nursing students and supported overall efforts of the County's largest registered nursing school. In 2008, Sharp HealthCare donated \$1.0 million to SDSU in support of a patient-care simulation lab to aide students in their clinical practice. Additionally, Sharp HealthCare, along with Kaiser Permanente and several skilled-nursing facilities, is a partner in the San Diego Community College Health Care Career Ladder Grant. The program provides support for employees to advance up the nursing career ladder. Sharp HealthCare also partnered with the University of Oklahoma ("OU") to offer a nine-month Bachelor of Science in Nursing ("BSN") program for existing registered nurses and a 14-month accelerated BSN program for individuals with a bachelor's degree in a non-nursing area. Various other community collaborations exist with high schools, community college nursing programs, and the development of HSHMC, which was created through a collaboration of Sharp HealthCare, area community colleges, and several SDSU professors.

In 2004, the State implemented regulations mandating specific nurse staffing ratios for all acute patient care areas. The proposed ratios were the first-ever attempt by any state in the nation to establish a predetermined ratio of nurses to patients in various services of acute care hospitals. California hospitals were initially required to comply with the staffing ratios by January 1, 2004. The ratios were updated in January 2005 to require one nurse for every five patients on medical surgical units. The last phase of the legislation was effective January 1, 2008, and required telemetry units to maintain one nurse for every four patients. The mandated ratios must be maintained at all times, even when licensed staff take meal and other breaks, and daily tracking of the actual staffing is required to be documented. Measures taken by Sharp HealthCare include staffing based on the acuity of each patient's condition, innovative recruitment and retention efforts, and the use of nurse registries and traveling nurses. Sharp HealthCare currently provides what management believes is adequate nurse staffing to meet the needs of its patients.

## **Insurance**

The Corporation currently maintains comprehensive general liability and professional liability insurance coverage for the Corporation, Sharp Memorial, Sharp Chula Vista, and Sharp Grossmont, including comprehensive general liability and professional liability through a policy issued by Continuous Quality Insurance, an affiliated entity of the Corporation. The Continuous Quality Insurance policy provides coverage with a per occurrence limit of \$3.0 million and an aggregate limit of \$13.5 million. Excess insurance through a commercial carrier provides limits to \$40.0 million. Coverage for workers' compensation, property, network risk, and corporate liability is provided through the commercial insurance market.

## Community Benefit

Enacted in September 1994, State Senate Bill 697 requires nonprofit hospitals to file a report annually with OSHPD on activities undertaken to address community needs, within their mission and financial capacity. In addition, nonprofit hospitals are, to the extent possible, to assign and report the economic value of community benefits provided. Sharp HealthCare's Community Benefits Plan and Report is prepared in accordance with the requirements of Senate Bill 697 and represents the community benefit activities for all Sharp HealthCare nonprofit entities, summarized in the following four categories:

- **Medical Care Services** include uncompensated care for patients who are unable to pay for services and the unreimbursed costs of public programs such as Medi-Cal (Medicaid), Medicare, San Diego County Indigent Medical Services, Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA), and the regionally managed health care program for active duty and retired members of the uniformed services, their families, and survivors (TRICARE). Also included are unreimbursed costs of workers' compensation programs and financial support for onsite workers to process Medi-Cal eligibility forms.
- **Other Services for Vulnerable Populations** include transportation for patients to and from medical appointments; financial and other support to community clinics to assist in providing health services and improving access to health services; funds to assist patients who cannot afford to pay with transportation, medication, and other needs (Project HELP); contribution of staff time and other in-kind support for Project CARE (Community Action to Reach the Elderly), a community program that places computerized telephone calls to seniors and disabled individuals to ensure they are safe in their homes; contribution of time to Habitat for Humanity, Stand Down for Homeless Veterans, and the San Diego Food Bank; financial and other support to the Sharp HealthCare Humanitarian Service Program; and other assistance for the needy.
- **Other Services for the Broader Community** include health education and information, participation in community health fairs and events addressing the unique needs of the community, providing flu vaccinations, and health screenings. Sharp HealthCare collaborated with local schools to promote interest in health care careers and provided the use of Sharp HealthCare facilities by community groups at no charge. Additionally, executive leadership and staff actively participated in numerous community organizations, committees, and coalitions to improve the health of the community.
- **Health Research, Education, and Training Programs** include education and training programs for medical, nursing, and other health care professionals. To increase the pool of nursing graduates, Sharp HealthCare and other area health care providers continued sponsorship of health-related programs, classes, and professors at SDSU (Nurses Now Partnership) and UCSD. Sharp HealthCare also partnered with Southwestern College, SDSU, and OU to provide clinical

experience in the County for students enrolled in the OU Online Accelerated Second Degree Bachelor of Science in Nursing Program. Additionally, Sharp HealthCare continued its five-year agreement with SDSU for financial support of the Sharp HealthCare Human Patient Simulation Center, to provide specialized education to nursing students. Additionally, Sharp HealthCare continued its collaboration with Rady Children’s Hospital – San Diego (“Rady Children’s”) and Scripps in support of the National Partnership for Smoke-Free Families, a program designed to help pregnant smokers quit to improve their health and protect the health of their unborn babies.

In its fiscal year ended September 30, 2009, Sharp HealthCare provided \$342.5 million in community benefit programs and services that were unreimbursed. The following table summarizes the estimated net cost to Sharp HealthCare of providing programs and services for the poor and for the broader community in fiscal year 2009:

<b><u>Economic Value of Community Benefits</u></b>	<b><u>Estimated Fiscal 2009 Unreimbursed Costs (in millions)</u></b>
Medical Care Services	\$334.5
Other Services for Vulnerable Populations	2.3
Other Services for the Broader Community	3.0
Health Research, Education, and Training Programs	<u>2.7</u>
<b>Total Community Benefits</b>	<b><u>\$342.5</u></b>

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Source: Sharp HealthCare’s Fiscal Year 2009 Community Benefits Plan and Report.

### **Strategic Plan**

In 1999, Sharp HealthCare initiated a strategic planning effort to refocus Sharp HealthCare’s direction, ensure its success as a stand-alone integrated health care delivery system, and enhance its position as San Diego’s health care leader. Sharp HealthCare leaders engaged in numerous best-practice site visits to transform the organization from a good health care system to a great one. This good-to-great focus became the cornerstone of Sharp HealthCare’s strategic planning process.

Sharp HealthCare’s strategic plan is focused on each of its six pillars – Quality, Service, People, Finance, Growth, and Community – and the following goals have been established for each:

- **Quality.** Demonstrate and improve clinical excellence and patient safety to set community standards and exceed patient expectations.
- **Service.** Create exceptional experiences at every touch point for customers, physicians, and partners by demonstrating service excellence.

- **People.** Create a workforce culture that attracts, retains, and promotes the best and brightest people, who are committed to Sharp HealthCare’s mission, vision, and values.
- **Finance.** Achieve financial results to assure Sharp HealthCare’s ability to provide quality health care services, new technology, and investment in the organization.
- **Growth.** Achieve consistent net revenue growth to enhance market dominance, sustain infrastructure improvements, and support innovative development.
- **Community.** Be an exemplary community citizen.

The strategic planning process involves “top-down” direction-setting and identification of system goals, as well as “bottom-up” planning founded on environmental analyses and the identification of issues and opportunities for each affiliated entity. This process incorporates strategic, financial, technology, human resource, philanthropic, marketing, facility, and quality planning to ensure Sharp HealthCare’s strength and viability and enhance its market position. Departments, entities, and the Corporation prepare integrated plans, including a five-year (long-term) horizon and an annual (short-term) focus. Measurable objectives are established for each of Sharp HealthCare’s six pillars for each year of the long-term planning horizon. Annual targets are defined and published in system and entity report cards, which are measured and analyzed monthly. The capital and operating impact of each affiliated entity’s strategies and action plans is forecasted in the Five-Year Plan.

As a component of Sharp HealthCare’s strategic planning process, enterprise risk management methods are utilized to identify and manage organizational risks and seize opportunities related to the achievement of objectives. Due to the uncertainties surrounding health care reform, it was identified by management as the key enterprise risk for the organization. Management and the Board evaluated Sharp HealthCare’s strategic plan and identified strategies to favorably position Sharp HealthCare in light of the anticipated changes related to health care reform, including an enhanced care-continuum and service line focus, continued improvement in care management-focused data solutions, and enhanced and innovative care delivery models. As an integrated health care delivery system, with a current reimbursement structure that accepts capitated payments from payors, a full continuum of health care services, a health plan, and affiliated physicians, Sharp HealthCare management believes the organization is well positioned for health care reform.

### **Capital Planning and Seismic Upgrade Activities**

Sharp HealthCare’s capital plan reflects the strategic initiatives of Sharp HealthCare and is part of an ongoing strategic and community need planning process. Management assesses near-term and long-term capital requirements for each entity including both growth opportunities and replacement needs. Management also assesses strategic opportunities beyond the existing facilities for growth and to improve access to care in the communities Sharp HealthCare serves.

The State issued seismic safety standards, which call for more stringent structural building standards to be in place for buildings providing acute care services, with an initial compliance date of January 1, 2008. Three of Sharp HealthCare's four hospital campus sites have now satisfied seismic regulations until 2030. Those sites are Sharp Grossmont, Sharp Chula Vista, and Sharp Coronado. The fourth campus site is Sharp Memorial. Two buildings on this site still require seismic upgrades. Those seismic upgrades must be completed by January 1, 2015.

OSHPD was directed to review the previously established seismic performance categories for acute care hospital buildings using a software program, HAZUS, developed by the Federal Emergency Management Agency ("FEMA"). This evaluation takes into account the earthquake hazard in specific locations and also vulnerabilities of different building structure types in order to predict stability of a building after an earthquake. Sharp HealthCare has evaluated its hospital buildings under HAZUS and current estimates included in the Five-Year Plan are that the remediation costs to meet the seismic standards applicable by 2015 will be approximately \$21.0 million over the next five years for Sharp Memorial, although actual costs may vary. Construction plans are in progress for Sharp Memorial and management expects to meet the seismic requirements for these buildings by the compliance date.

In the event Sharp HealthCare facilities do not meet required seismic standards by a regulatory required date, Sharp HealthCare may be precluded by OSHPD from using such facilities to care for patients, which could materially adversely affect Sharp HealthCare's operations.

Sharp HealthCare's capital plan is approximately \$596.1 million, including seismic upgrade costs, for fiscal years 2011 through 2015. It contemplates that certain seismic issues will be addressed by a combination of retrofit, replacement, or withdrawal from use. Before any individual project is commenced or significant capital costs are incurred, it is evaluated internally to determine financial feasibility. For capital projects contemplated in the Five-Year Plan, Sharp HealthCare's management expects that the sources of funding will be cash from operations, investment earnings, philanthropic donations, and previously issued bond proceeds. To the extent that available funds are not sufficient to pay for projected capital and seismic improvement expenditures through 2015, capital projects will be postponed or reduced in scope.

## **MARKET CHARACTERISTICS AND COMPETITION**

### **General**

Sharp HealthCare defines its primary market area to include substantial portions of the County. As can be seen from the map on page A-28, through its subsidiaries and affiliated entities, the Corporation provides a variety of inpatient and outpatient services at sites located throughout the County. The penetration of specific geographic areas within the County by each of the Sharp HealthCare hospitals varies due to a variety of factors including the range of programs and services offered, each facility's location, and the locations and services of competing acute care providers.

## Market Characteristics

Estimates indicate the County's population increased by approximately 2.9% between 2007 and 2010, and relative to 2007 will increase by 8.6% to more than 3.2 million by 2015.

### San Diego County Population

	2007 ( <u>Estimated</u> )	2010 ( <u>Estimated</u> )	2015 ( <u>Projected</u> )
Total Population	3,021,510	3,108,884	3,280,882
% Change from 2007	--	2.9%	8.6%

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Source: Thomson Reuters Market Expert; Claritas, Inc.; US Census Bureau.

According to Claritas, Inc., current estimates for 2010 indicate the median household income in the County is \$64,142, which is 2.2% higher than the median for the State as a whole and 18.3% greater than the nation's median household income.

## Market Share and Competition

As of December 31, 2009, there were 20 general acute care hospitals operating in the County, including those operated by Sharp HealthCare. The table on page A-30 compares the consolidated market share of the Corporation's affiliated hospitals with that of competing locally-based hospitals and health care systems with facilities in the County for the year ended December 31, 2009. Reported data include all inpatient types, except for Normal Newborns.

**General.** The Obligated Group Members compete with other area hospitals located both within and outside of their respective service areas for patients residing within their service area and in the County as a whole. The table on page A-29 presents information about acute care hospitals located within the County for the year ended December 31, 2009.



## SAN DIEGO COUNTY MAP

Sharp has approximately 2,600 affiliated physicians on medical staffs and in medical groups. They provide quality medical services in a variety of settings, ranging from primary care in private offices or clinics to outpatient surgery and inpatient care at Sharp hospitals.

### HOSPITALS

- 1 Sharp Chula Vista Medical Center
- 2 Sharp Coronado Hospital
- 3 Sharp Grossmont Hospital
- 4 Sharp Mary Birch Hospital for Women & Newborns
- 5 Sharp Memorial Hospital
- 6 Sharp Mesa Vista Hospital
- 7 Sharp Vista Pacifica Hospital

### SKILLED NURSING LOCATIONS

- ▲ Birch Patrick Convalescent Center
- ▲ Villa Coronado Skilled Nursing Facility
- Sharp Grossmont Hospital Transitional Care Unit

### MEDICAL OFFICE LOCATIONS

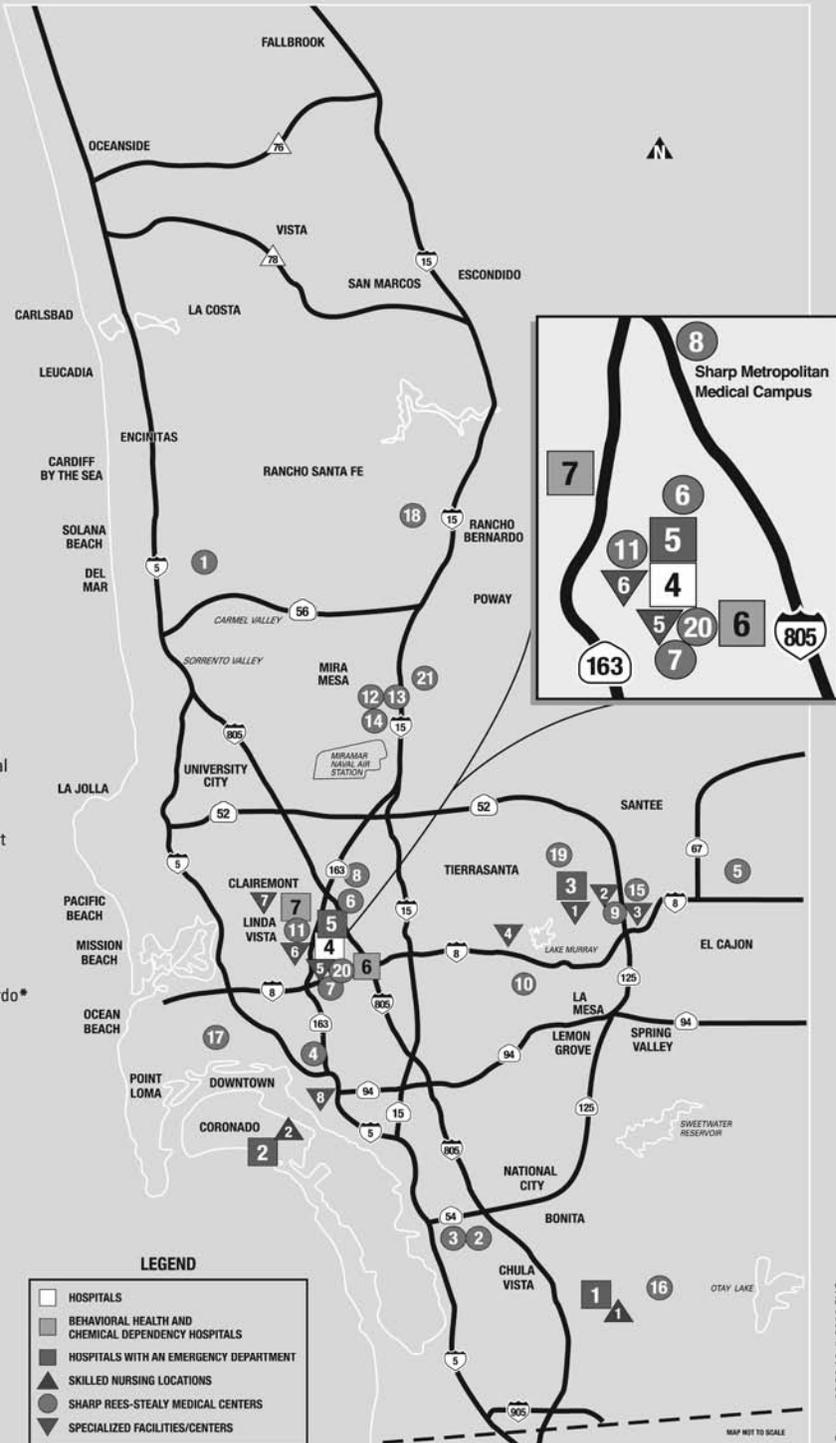
\* Urgent Care services available

- 1 Sharp Rees-Stealy Medical Center • Carmel Valley/ Del Mar
- 2 Sharp Rees-Stealy Medical Center • Chula Vista\*
- 3 Sharp Rees-Stealy Medical Center • Chula Vista Physical Therapy
- 4 Sharp Rees-Stealy Medical Center • Downtown San Diego\*
- 5 Sharp Rees-Stealy Medical Center • El Cajon
- 6 Sharp Rees-Stealy Medical Center • Frost Street
- 7 Sharp Rees-Stealy Medical Center • Genesee
- 8 Sharp Rees-Stealy Medical Center • Kearny Villa
- 9 Sharp Rees-Stealy Medical Center • La Mesa\*
- 10 Sharp Rees-Stealy Medical Center • La Mesa West
- 11 Sharp Rees-Stealy Medical Center • Sharp Memorial Outpatient Pavilion
- 12 Sharp Rees-Stealy Medical Center • Mira Mesa\*
- 13 Sharp Rees-Stealy Medical Center • Mira Mesa East
- 14 Sharp Rees-Stealy Medical Center • Mira Mesa Rehabilitation Services
- 15 Sharp Rees-Stealy Medical Center • Mt. Helix
- 16 Sharp Rees-Stealy Medical Center • Otay Ranch
- 17 Sharp Rees-Stealy Medical Center • Point Loma
- 18 Sharp Rees-Stealy Medical Center • Rancho Bernardo\*
- 19 Sharp Rees-Stealy Medical Center • San Carlos
- 20 Sharp Rees-Stealy Medical Center • San Diego
- 21 Sharp Rees-Stealy Medical Center • Scripps Ranch

### SPECIALIZED FACILITIES/CENTERS

- ▼ Sharp Grossmont David and Donna Long Center for Cancer Treatment
- ▼ Sharp Grossmont Hospital Rehabilitation Center
- ▼ Sharp HospiceCare LakeView Home
- ▼ Sharp HospiceCare ParkView Home
- ▼ Sharp Memorial Hospital Rehabilitation Center
- ▼ Sharp Memorial Outpatient Pavilion
- ▼ Sharp Memorial Senior Health Center – Clairemont
- ▼ Sharp Memorial Senior Health Center – Downtown

For more information, call 1-800-82-SHARP (1-800-827-4277) or visit [www.sharp.com](http://www.sharp.com).



County/09.30.10 © 2010 SHC

## San Diego County Hospitals Market Share Information <sup>(1)</sup>

Year Ended December 31, 2009

	Discharges	Inpatient Market Share	Patient Days	Average Length of Stay (days)	Available Beds (avg.)	Occupancy Rate <sup>(2), (3)</sup>
<b>Sharp HealthCare</b>						
Sharp Chula Vista Medical Center	14,841	5.3%	89,839	6.1	343	81.5%
Sharp Coronado Hospital and Healthcare Center	2,673	0.9%	34,753	13.0	175	81.3%
Sharp Grossmont Hospital	26,173	9.3%	111,980	4.3	438	73.8%
Sharp Mary Birch Hospital for Women & Newborns <sup>(4)</sup>	11,590	4.1%	49,297	4.3	169	86.8%
Sharp Memorial Hospital	16,731	5.9%	84,952	5.1	516	48.1%
Sharp Mesa Vista Hospital	4,883	1.7%	36,037	7.4	149	73.4%
Sharp Vista Pacifica	185	0.1%	3,089	16.7	14	63.7%
Sharp Cabrillo Skilled Nursing Center <sup>(5)</sup>	120	0.0%	6,324	52.7	19	97.2%
<b>Total Sharp HealthCare</b>	<b>77,196</b>	<b>27.4%</b>	<b>416,271</b>	<b>5.4</b>	<b>1,823</b>	<b>70.1%</b>
<b>Scripps Health</b>						
Scripps Green Hospital	10,151	3.6%	33,931	3.3	173	63.9%
Scripps Memorial Hospital - Encinitas	9,668	3.4%	41,113	4.3	137	87.9%
Scripps Memorial Hospital - La Jolla	16,073	5.7%	66,101	4.1	331	67.9%
Scripps Mercy Hospital (both campuses)	28,608	10.2%	128,596	4.5	561	69.1%
<b>Total Scripps Health</b>	<b>64,500</b>	<b>22.9%</b>	<b>269,741</b>	<b>4.2</b>	<b>1,201</b>	<b>70.2%</b>
<b>Palomar Pomerado Health</b>						
Palomar Medical Center	19,849	7.0%	99,011	5.0	422	73.8%
Pomerado Hospital	6,880	2.4%	65,275	9.5	236	81.6%
<b>Total Palomar Pomerado Health</b>	<b>26,729</b>	<b>9.5%</b>	<b>164,286</b>	<b>6.1</b>	<b>658</b>	<b>76.6%</b>
<b>UCSD Health System</b>						
UCSD Medical Center (both campuses)	21,018	7.5%	113,211	5.4	533	69.2%
<b>Total UCSD Health System</b>	<b>21,018</b>	<b>7.5%</b>	<b>113,211</b>	<b>5.4</b>	<b>533</b>	<b>69.2%</b>
<b>All Other Hospitals</b>						
Alvarado Hospital	8,378	3.0%	38,802	4.6	296	41.0%
Alvarado Parkway Institute B.H.S.	1,883	0.7%	17,718	9.4	66	87.1%
Aurora San Diego	2,267	0.8%	16,821	7.4	80	82.2%
Fallbrook Hospital District	2,324	0.8%	21,575	9.3	146	62.7%
Kaiser Fnd Hosp - San Diego	28,848	10.2%	114,704	4.0	392	82.8%
Kindred Hospital - San Diego	449	0.2%	14,339	31.9	66	65.5%
Paradise Valley Hospital	9,464	3.4%	45,695	4.8	301	44.6%
Promise Hospital of San Diego	1,549	0.5%	25,097	16.2	100	81.1%
Rady Children's Hospital - San Diego	12,283	4.4%	70,998	5.8	318	60.0%
San Diego County Psychiatric Hospital	1,183	0.4%	64,336	54.4	419	51.5%
San Diego Hospice and Palliative Care - Acute Care Ctr	906	0.3%	7,733	8.5	24	96.8%
Tri-City Medical Center	16,647	5.9%	71,035	4.3	397	51.2%
Vibra Hospital of San Diego	695	0.2%	18,099	26.0	105	52.4%
out-migration of County residents to non-County hospitals	5,467	1.9%	35,024	6.4	--	--
<b>Total, All Other Hospitals</b>	<b>92,343</b>	<b>32.8%</b>	<b>561,976</b>	<b>6.1</b>	<b>--</b>	<b>--</b>
<b>TOTAL, SAN DIEGO COUNTY RESIDENTS</b>	<b>281,786</b>	<b>100.0%</b>	<b>1,525,485</b>	<b>5.4</b>	<b>6,924</b>	<b>66.4%</b>

- (1) Figures for Discharges, Market Share, and Patient Days are limited to County residents. Non-County residents discharged from these hospitals are not included in the totals. All patient types are included, except for Normal Newborns.
- (2) Occupancy Rate is based upon available beds. The calculation uses each hospital's total patient days, excluding Nursery discharges (includes in-migrating patients).
- (3) Sharp Memorial Hospital (SMH) opened a new patient tower, the Stephen Birch Healthcare Center, on January 14, 2009. While portions of the original SMH remain in use, the majority of inpatient services have transitioned to the new tower. To facilitate a gradual transition of services, equipment, and patients into the new tower, SMH continued to maintain the combined total of all beds in its old and new towers on its license for much of 2009. As such, SMH also reported a higher number of Available Beds, which contributed to a low Occupancy Rate. The transition was largely completed by mid-year, and for the last five months of 2009, SMH reported 358 Available Beds. If 358 beds are used, SMH's Occupancy Rate would be 69.7%, Sharp HealthCare's overall rate would be 76.7%, and the overall San Diego County rate would be 68.0%.
- (4) Effective November 1, 2009, Sharp Mary Birch Hospital for Women & Newborns (SMBHWN) consolidated its license into that of Sharp Memorial Hospital, and patient discharges and days for both hospitals are reported under SMH. For purposes of this summary, a combination of internal and public data were used to enable separate listings for these hospitals.
- (5) In April 2009, Sharp HealthCare discontinued operations and closed Sharp Cabrillo.

Sources: 2009 Office of Statewide Health Planning and Development Annual Hospital Discharge Data and Hospital Quarterly Financial Data Files.

**Market Share Trends.** The service area market share is based upon the number of inpatient discharges of County residents from hospitals located in California. Excluded from this analysis are non-County residents discharged from hospitals located in the County. The table below presents market share of County residents and Sharp HealthCare’s historical competitive position relative to other providers in the service area.

<b>Hospital/Health System <sup>(1)</sup></b>	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Sharp HealthCare	26.3%	26.7%	27.1%	27.1%	27.4%
Scripps Health	22.3%	22.4%	22.4%	22.4%	22.9%
Kaiser San Diego	9.8%	9.4%	9.8%	10.0%	10.2%
Palomar Pomerado Health	10.3%	10.5%	10.4%	10.1%	9.5%
UCSD Health System	6.9%	7.1%	7.2%	7.3%	7.5%
Tri-City Medical Center	6.7%	6.7%	6.5%	6.1%	5.9%
Rady Children's Hospital - San Diego	4.3%	4.3%	4.2%	4.5%	4.4%
Paradise Valley Hospital	4.4%	4.1%	3.7%	3.6%	3.4%
Alvarado Hospital	2.9%	2.8%	2.8%	2.9%	3.0%
Fallbrook Hospital District	0.8%	0.8%	0.8%	0.8%	0.8%
Aurora San Diego	0.8%	0.8%	0.8%	0.8%	0.8%
Alvarado Parkway Institute B.H.S.	0.7%	0.7%	0.7%	0.7%	0.7%
Promise Hospital of San Diego	1.0%	0.7%	0.5%	0.6%	0.5%
San Diego County Psychiatric Hospital	0.3%	0.3%	0.3%	0.4%	0.4%
San Diego Hospice and Palliative Care	0.3%	0.3%	0.3%	0.3%	0.3%
Vibra Hospital of San Diego	0.3%	0.3%	0.3%	0.3%	0.2%
Kindred Hospital - San Diego	0.1%	0.1%	0.1%	0.1%	0.2%
out-migration to non-County hospitals	1.9%	2.0%	2.0%	2.0%	1.9%

<sup>(1)</sup> Market Share figures are based on all inpatient discharges of County residents from any California Hospital. All patient types are included, except for Normal Newborns

Source: 2005 - 2009 Office of Statewide Health Planning and Development Annual Hospital Discharge Data.

## **HEALTH CARE OPERATIONS OF THE OBLIGATED GROUP**

This section provides an overview of the acute care services and programs offered by each of the Members of the Obligated Group. The section below entitled “Non-Obligated Affiliates” discusses other major subsidiaries and affiliated entities of the Corporation.

### **Utilization**

The table on A-31 presents selected utilization statistics for the Obligated Group by entity and in total for the three most recent fiscal years.

	Year Ended September 30,		
	2008	2009	2010
<b>SHARP MEMORIAL</b>			
Licensed Beds	855	977	977
Maintained Beds <sup>(1)</sup>	741	709	696
Patient Days <sup>(2)</sup>	205,820	198,254	191,987
Discharges <sup>(2)</sup>	34,184	35,159	35,109
Average Length of Stay <sup>(2)</sup>	6.02	5.64	5.47
Occupancy <sup>(3)</sup>	75.9%	76.6%	75.6%
Outpatient Registrations	257,204	290,951	276,514
Births	8,666	8,568	8,565
Emergency Room Visits	47,137	52,173	57,605
<b>SHARP CHULA VISTA</b>			
Licensed Beds	343	343	343
Maintained Beds <sup>(1)</sup>	343	343	343
Patient Days <sup>(2)</sup>	101,026	101,413	102,367
Discharges <sup>(2)</sup>	15,464	15,107	15,353
Average Length of Stay <sup>(2)</sup>	6.53	6.71	6.67
Occupancy <sup>(3)</sup>	80.5%	81.0%	81.8%
Outpatient Registrations	85,566	89,269	85,606
Births	3,582	3,530	3,220
Emergency Room Visits	47,935	50,545	50,959
<b>SHARP GROSSMONT</b>			
Licensed Beds	446	536	536
Maintained Beds <sup>(1)</sup>	434	437	511
Patient Days <sup>(2)</sup>	116,637	117,257	121,354
Discharges <sup>(2)</sup>	26,226	26,646	28,695
Average Length of Stay <sup>(2)</sup>	4.45	4.40	4.23
Occupancy <sup>(3)</sup>	73.4%	73.5%	63.8%
Outpatient Registrations	193,866	195,367	191,324
Births	3,766	3,589	3,593
Emergency Room Visits	81,307	84,749	87,106
<b>SHARP REES-STEALY</b>			
Average Enrollment	142,105	141,353	139,167
Visits	1,045,918	1,076,118	1,108,678
Physician Offices	20	21	21
Urgent Care Facilities	5	5	5
Primary Care Physicians	111	116	122
Specialist Physicians	210	225	234
<b>TOTAL – OBLIGATED GROUP</b>			
Licensed Beds	1,644	1,856	1,856
Maintained Beds <sup>(1)</sup>	1,518	1,489	1,550
Patient Days <sup>(2)</sup>	423,483	416,924	415,708
Discharges <sup>(2)</sup>	75,874	76,912	79,157
Average Length of Stay <sup>(2)</sup>	5.58	5.42	5.25
Occupancy <sup>(3)</sup>	76.2%	76.7%	73.5%
Outpatient Registrations	536,636	575,587	553,444
Births	16,014	15,687	15,378
Emergency Room Visits	176,379	187,467	195,670

(1) Maintained beds represent the weighted average for the fiscal year.

(2) Patient days include acute care, skilled nursing, psychiatric, and rehabilitation.

(3) Occupancy is calculated on maintained beds.

Source: Sharp HealthCare Administrative Statistical Reports and Financial Ratio Analysis Reports.

## Sharp Memorial

**General.** The collective Sharp HealthCare facilities operated by Sharp Memorial include the 643-bed<sup>1</sup> quaternary care Memorial Hospital and Stephen Birch Center, the 169-bed women's hospital Sharp Mary Birch, the 149-bed psychiatric facility Sharp Mesa Vista, the 16-bed chemical dependency recovery hospital Sharp Vista Pacifica, and the approximately 122,500 square foot Sharp Outpatient Pavilion. Sharp Memorial is the largest non-university, quaternary care hospital campus in the County. It provides a comprehensive range of primary, secondary, and specialized quaternary medical/surgical care to a diverse geographic distribution of patients residing in the City of San Diego and surrounding communities in the County. Memorial Hospital is a County-designated trauma center.

**Programs and Services.** Sharp Memorial provides a broad range of programs and services to patients in its service area and is a Magnet hospital as designated by ANCC. Listed below are descriptions of selected major programs and services provided at Sharp Memorial facilities.

- **Cancer Treatment.** Memorial Hospital is one of three Sharp HealthCare hospitals to achieve the American College of Surgeons Commission on Cancer (“ACoSoc”) Accreditation for cancer surgery and care in an inpatient setting. Memorial Hospital also has the ability to provide chemotherapy, radiation therapy, and surgery.
- **Cardiac Care.** In 1957, the first cardiac catheterization in San Diego was performed at Memorial Hospital, followed by the County's first open-heart surgery a year later. Since that time, the Cardiac Center at Memorial Hospital, with four cardiac catheterization laboratories, has treated patients with heart conditions such as congestive heart failure, heart attacks, hypertension, angina/chest pain, and other cardiac diseases. Every year Sharp HealthCare physicians and staff perform more than 7,000 cardiac catheterizations and 1,200 open-heart surgeries. Memorial Hospital has the largest vascular center in the County and the fifth largest in the State, providing the full spectrum of care including multimodality intervention, electrophysiology, noninvasive diagnosis, acute care, cardiac rehabilitation, and prevention and education. Memorial Hospital has the largest mechanical assist device program on the West Coast. Memorial Hospital is established as a County-designated STEMI center, providing streamlined and optimized treatment for heart attack patients.
- **Transplant Services.** The cardiac program was expanded in 1985 with the successful implementation of a heart transplant program, the first in San Diego. Since its inception, this program's success rate at 12 months post-transplant has been significantly higher than the national average. In 1987, Memorial Hospital was the first hospital on the West Coast to use the mechanical Jarvik-7 heart for patients awaiting a transplant. Memorial Hospital has become nationally known for its mechanical assist device program and is one of two centers on the west

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<sup>1</sup> Represents licensed beds, of which 368 beds are maintained and available for use.

coast that participates in national research for this procedure. Memorial Hospital is the only heart transplant program in the County. In addition to heart transplant, Memorial Hospital has certification to perform kidney and kidney-pancreas transplants, as well as bone marrow transplants through a joint program with UCSD.

- *Trauma Services.* Memorial Hospital is part of the San Diego Regional Trauma Program, comprised of five County adult centers and one pediatric center, and is certified by the San Diego County Emergency Medical System and the American College of Surgeons. Currently, approximately 1,600 adult trauma patients are evaluated and treated annually at Memorial Hospital.
- *Women's Health.* In order to provide for the continued growth of perinatal services, the six-story Sharp Mary Birch opened in October 1992 as a division of Sharp Memorial. Sharp Mary Birch is the largest and most extensive freestanding center for women's health in Southern California, offering a variety of alternatives for the birthing experience including conventional delivery, labor/delivery/recovery, and Cesarean delivery. The Level III, 61-bed NICU at Sharp Mary Birch provides care for premature and seriously ill infants, including special ventilatory management to infants with severe respiratory distress syndrome. Aside from obstetrical care, Sharp Mary Birch offers a full range of inpatient and outpatient medical and surgical gynecological services, including robotic gynecologic surgery and oncology, as well as plastic surgery, extensive health education, and prevention and support services.
- *Chemical Dependency Treatment.* The 16-bed freestanding Alcohol and Drug Treatment Center at Sharp Vista Pacifica is the only medically supervised chemical dependency recovery hospital in the County and offers one of the most comprehensive recovery programs in Southern California. A variety of recovery options are offered including medically monitored detoxification and rehabilitation, a 30-day residential program, day and partial hospitalization, evening outpatient sessions, and an aftercare program that extends recovery into a lifelong process.
- *Behavioral Health.* With 149 beds, Sharp Mesa Vista is the largest psychiatric hospital in the County and has been a provider of psychiatric and substance abuse recovery services for the past 40 years. The hospital provides behavioral health care services to all persons in the County in need of emergency psychiatric acute care. Sharp Mesa Vista provides a full continuum of behavioral health services, including inpatient, outpatient, and partial hospital programs, with specialized services designed for children, adolescents, adults, and seniors experiencing anxiety, bi-polar disorder, depression, eating disorders, and other conditions.
- *Rehabilitative Services.* The 40-bed Rehabilitation Center at Memorial Hospital was dedicated in 1962 and was the first comprehensive rehabilitation center south of Los Angeles. Today, Memorial Hospital's Rehabilitation Center

includes the County's largest brain and spinal injury treatment program. The Rehabilitation Center addresses the unique needs of individuals affected by catastrophic injury or debilitating illness by focusing on their abilities, not disabilities, and preparing them to live as independently as possible.

- *Outpatient Services.* The Sharp Outpatient Pavilion, which opened on the Sharp Memorial campus in April 2003, is a comprehensive, multidisciplinary outpatient facility providing access for patients to services including diagnostic imaging, surgical and endoscopy services, cancer treatment, a women's outpatient imaging center, ophthalmology and vision laser centers, a wellness center, and a variety of other specialty services. The facility houses 12 surgery suites, 24 chemotherapy treatment areas, radiation therapy, 16-slice CT body scanning, digital mammography, and computerized radiology, including a picture archival and communication system ("PACS"), which provides the infrastructure for a film-less radiology system. Additionally, positron emission tomography CT ("PETCT") services and magnetic resonance imaging ("MRI") services are provided on the Sharp Memorial campus, with the MRI services conducted through a joint venture between Sharp HealthCare, Rady Children's, and physician radiologists.
- *Home Health Services.* Sharp Home Care provides an extensive array of medical, nursing, rehabilitation, social, and educational services. Sharp Home Care is a licensed and Medicare-certified home health agency serving the County as an operating division of Sharp Memorial. Its services include specialty nursing care, comprehensive rehabilitative care, support services, diabetes instruction, and senior behavioral health services.

## **Sharp Chula Vista**

*General.* Sharp Chula Vista operates a 243-bed acute care hospital, including a 41-bed intensive care unit, and the adjacent 100-bed Birch-Patrick Skilled Nursing Facility, which provides short- and long-term care for individuals requiring daily living assistance, respite care, and post-surgical rehabilitation. The hospital was founded in 1944 as Chula Vista Community Hospital to operate a nursing home and became licensed to operate an acute care hospital the following year. The hospital was moved to its present location in 1975. In 1989, the Corporation became affiliated with the Chula Vista Community Hospital (then known as the Community Hospital of Chula Vista), which was subsequently renamed Sharp Chula Vista Medical Center. Sharp Chula Vista has the largest inpatient market share in the South Bay area of the County.

*Programs and Services.* Sharp Chula Vista operates in the South Bay region of the County and offers a full complement of programs and services, including emergency services, intensive care, medical/surgical inpatient care, surgery, cancer treatment, cardiac services, obstetrics, NICU, orthopedics, a bloodless surgery and medicine program, and a broad range of outpatient services. A heliport allows immediate access for patients critically in need of treatment. Sharp Chula Vista also provides a variety of community education programs on topics such as diabetes, cardio pulmonary resuscitation, nutrition, smoking cessation, first aid,

and stress management. Listed below are descriptions of selected major programs and services provided at Sharp Chula Vista.

- *Cancer Treatment.* Sharp Chula Vista is the only hospital in the South Bay region of the County with certification from the Commission on Cancer as a Community Hospital Cancer Program to provide cancer surgery and inpatient care. The cancer treatment program offers a full range of cancer services, including surgery, oncology, infusion therapy, nuclear medicine, and radiation therapy.
- *Cardiac Care.* Sharp Chula Vista cardiac services include open-heart surgery, cardiac catheterization, angioplasty, coronary stents, vascular surgery, and rehabilitation, as well as mechanical assist devices for the support of the heart and lungs. Sharp Chula Vista was the first hospital in the South Bay region to provide endoscopic vein harvesting, a minimally invasive procedure that assists with bypass surgery, and has two state-of-the-art cardiac catheterization laboratories. Sharp Chula Vista is established as a County-designated STEMI center, providing streamlined and optimized treatment for heart attack patients.
- *Women's Health.* Sharp Chula Vista's 19-bed obstetrics unit provides a full range of labor and delivery services. Care for premature and ill infants is provided in the nine-bed, Level II NICU.
- *Outpatient Services.* A full complement of outpatient programs and services are offered at Sharp Chula Vista. In December 2001, Sharp Chula Vista opened an approximately 24,000 square foot Outpatient Surgery and Diagnostic Imaging Center. The Outpatient Surgery Center is operated by Sharp Chula Vista and provides surgical, endoscopy, and special procedures. The Diagnostic Imaging Center, operated through a joint venture between Sharp Chula Vista and physician radiologists, provides MRI, CT, PETCT, ultrasound, mammography, general radiography, fluoroscopy, and bone densitometry services, and includes a PACS. The enhancement of outpatient services was designed to assist Sharp Chula Vista in meeting the growing and diverse needs of the communities it serves, where population growth is estimated to exceed 5.9% in its primary service area over the next five years<sup>1</sup>.

## **Sharp Grossmont**

*General.* Sharp Grossmont was formed by the Corporation in 1991 and operates and leases a 536-bed acute care facility ("Grossmont Hospital") located in the East County region, which includes the 48-bed Sharp Grossmont Women's Health Center and a 30-bed skilled nursing unit. Sharp Grossmont is a Magnet hospital as designated by ANCC.

*Hospital Lease.* Grossmont Hospital is owned by the District, which leases Grossmont Hospital to Sharp Grossmont pursuant to a thirty-year lease, as amended as of January 3, 2007

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<sup>1</sup> Source: Thompson-Reuters Market Expert; Claritas, Inc.; US Census Bureau.

(the “Lease”), that commenced on May 29, 1991 and expires on May 29, 2021. Current law provides that the Lease may be renegotiated or extended for up to an additional 30-year term upon approval of a majority of the voters of the District. The District, Sharp Grossmont, and the Corporation each have passed resolutions acknowledging their intent to extend the term of the Lease.

Pursuant to the terms of the Lease, Sharp Grossmont is obligated to make lease payments equal to the payments due on the long-term, tax-exempt debt assumed by Sharp Grossmont from the District (the “District Debt”). In 1992, with the issuance of the California Health Facilities Financing Authority Insured Hospital Revenue Refunding Bonds (San Diego Hospital Association), Series 1992A Bonds, which were subsequently refunded, Sharp Grossmont became a Member of the Obligated Group and the District Debt was refunded and defeased. The refunding and defeasance of the District Debt was considered to be a prepayment of rent under the Lease, and, in accordance with the terms of the Lease, the annual rent now paid by Sharp Grossmont to the District is \$1. Sharp Grossmont is not obligated to make payments of principal or interest on the GO Bonds issued or to be issued by the District to fund renovations and expansion of Grossmont Hospital. See “RECENTLY COMPLETED AND CURRENT PROJECTS”.

Upon the occurrence of certain events of default under the Lease, the District may pursue a variety of remedies including the termination of the Lease. At termination or expiration of the Lease, the revenues derived by Sharp Grossmont from Grossmont Hospital will cease to be available to make payments with respect to the Obligations issued under the Master Indenture, including the Series 2011A Obligation. Furthermore, the long-term debt allocated to Sharp Grossmont will become the responsibility of the District. As of September 30, 2010, Sharp Grossmont constituted 22.8% of the Obligated Group’s total assets, 32.3% of the Obligated Group’s net assets, and 19.1% of the Obligated Group’s cash, cash equivalents, short-term investments, and total assets limited as to use. Sharp Grossmont has 9.9% of the Obligated Group’s long-term debt. For the year ended September 30, 2010, Sharp Grossmont generated 24.0% of the Obligated Group’s total net revenues and 7.2% of its excess of revenues over expenses.

***Programs and Services.*** Sharp Grossmont provides a comprehensive range of primary, secondary, and specialized medical/surgical care and has the largest inpatient market share in the East County region of the County. Services provided at Sharp Grossmont include emergency, women’s services, psychiatry, cardiology, cancer treatment, robotic surgery, physical rehabilitation, hyperbaric oxygen therapy, behavioral health, and a full spectrum of outpatient services. Sharp Grossmont operates one of the busiest emergency departments in the County, where each year approximately 86,260 people receive treatment<sup>1</sup>. It also offers a variety of specialty services that include skilled nursing, home infusion, and hospice services. In 2009, Sharp Grossmont completed construction of the three shelled floors in the Emergency and Critical Care Center, which provided an additional 90 licensed acute care beds. Listed below are descriptions of selected major programs and services provided at Sharp Grossmont.

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<sup>1</sup> Source: OSHPD Emergency Department Encounters by Facility Report, Calendar Year 2009.

- *Cancer Treatment.* When Sharp Grossmont’s David and Donna Long Center for Cancer Treatment (“Long Cancer Center”) opened in July 1993, it was the first comprehensive outpatient center for cancer screening, diagnosis, treatment, and educational resources in San Diego County. Today, the Long Cancer Center is accredited by ACoSCoC as a comprehensive cancer center, providing cancer surgery, inpatient care, radiation therapy, chemotherapy, and hematology.
- *Cardiac Care.* The cardiac program at Sharp Grossmont offers minimally invasive, noninvasive, and surgical procedures designed to treat a number of heart conditions. Services include open-heart surgery, cardiac catheterization, angioplasty, coronary stents, vascular surgery, and cardiac rehabilitation, as well as mechanical assist devices for the support of the heart and lungs. Sharp Grossmont is established as a County-designated STEMI center, providing streamlined and optimized treatment for heart attack patients.
- *Women’s Health.* The 48-bed women’s center specializes in gynecology, obstetrics, and neonatology, and includes a 24-bed Level II NICU.
- *Hospice Services.* Sharp HospiceCare provides comprehensive end-of-life care and compassionate support for people with a life-limiting illness that have decided, with the support of their physician and family members, to forego further curative treatment in favor of comfort measures. Sharp HospiceCare is a licensed and Medicare-certified hospice agency serving the County as an operating division of Sharp Grossmont.
- *Pediatrics.* In 2008, Sharp Grossmont entered into an agreement with Rady Children’s to lease 11 pediatric beds to Rady Children’s to operate within Grossmont Hospital. Under the three-year agreement, Rady Children’s licensed the 11 beds as part of their hospital license and is responsible for billing for services and providing physician and nurse staffing for the unit. Sharp Grossmont provides the pediatric space, ancillary services, and support services. The agreement expires May 11, 2011.
- *Outpatient Services.* A full complement of outpatient programs and services are offered at Sharp Grossmont, including surgical, cardiac, interventional radiology, vascular, endoscopy services, radiation oncology, laboratory, physical therapy, wound care, hyperbaric oxygen therapy, and a sleep center, as well as imaging services, including general diagnostic radiography, MRI, CT, PETCT, ultrasound, fluoroscopy, and nuclear medicine. In 2008, Sharp Grossmont began leasing 17,000 square feet in a newly constructed medical office building on the Sharp Grossmont campus to provide fully digital outpatient diagnostic imaging services. In 2006, Sharp Grossmont entered into a joint venture arrangement with physician radiologists to provide imaging services at two off-campus locations, including general radiography, ultrasound, open air MRI, CT, and digital mammography.

## Corporation

The Corporation provides the centralized administrative and management functions of Sharp HealthCare and also provides health care services through the Sharp Rees-Stealy operating division.

### *Sharp Rees-Stealy*

**General.** The Corporation contracts with SRSMG to provide outpatient health care services. These services are provided through 21 multi-specialty medical clinics throughout the County, which are owned or leased by the Corporation and managed by the Corporation. Outpatient visits totaled approximately 1.1 million for the year ended September 30, 2010. See “HISTORICAL FINANCIAL INFORMATION – Revenue Sources – Physician Network and Managed Care”. See also “BONDHOLDERS’ RISKS – Tax-Exempt Status and Other Tax Matters” in this Official Statement. In 2010, the Corporation and SRSMG extended the term of their contract to December 31, 2030.

**Programs and Services.** The Corporation operates the multi-specialty medical clinics and five urgent care centers throughout the County doing business as Sharp Rees-Stealy. Services include primary care, specialty care, urgent care, laboratory, radiology, physical therapy, and pharmacy services. In addition, the occupational health program provides a full range of services including injury and illness treatment, rehabilitation, physical examinations, and other programs designed to evaluate, treat, and prevent work-related injuries. SRSMG is accredited by the Accreditation Association for Ambulatory Health Care (“AAAHC”), an industry benchmark for measuring quality. In March 2009, SRSMG was surveyed by AAAHC and earned the highest rating of “substantial compliance,” receiving a three-year accreditation.

## Accreditations, Licenses, and Memberships

The Joint Commission surveyed Memorial Hospital in May 2009 and Sharp Chula Vista and Sharp Grossmont in March 2009. Each hospital received full accreditation along with The Joint Commission’s Gold Seal of Approval and a three-year accreditation. During 2008, Sharp Vista Pacifica, Sharp Mary Birch, and Sharp Mesa Vista were surveyed by The Joint Commission in March, June, and July, respectively. Each of these hospitals received full accreditation along with The Joint Commission’s Gold Seal of Approval and a three-year accreditation.

Sharp Memorial, Sharp Mesa Vista, Sharp Vista Pacifica, Sharp Chula Vista, and Sharp Grossmont are each licensed to conduct and provide health care services by the State of California Department of Public Health Licensing and Certification Program, and have each been approved as eligible health care providers by Medicare, Medi-Cal, Blue Cross, and various commercial insurance programs. In addition, each of these hospitals maintains memberships in HASDIC, CHA, and AHA.

## NON-OBLIGATED AFFILIATES

With the exception of Grossmont Foundation, the Corporation is the sole member or sole shareholder of each of the Non-Obligated Affiliates listed below. None of the following entities is a Member of the Obligated Group. As discussed under “HISTORICAL FINANCIAL INFORMATION – Management’s Discussion of Financial Performance” herein, Members of the Obligated Group have significant organizational and financial relationships with each of the entities listed below. **None of the following entities is obligated with respect to the Series 2011A Obligation and therefore they are not obligated with respect to the Bonds.**

- *Sharp Health Plan* is a California nonprofit public benefit corporation formed by the Corporation in September 1992. Sharp Health Plan received its Knox-Keene license in September 1992 from the California Department of Corporations. Such license, now under the jurisdiction of the California Department of Managed Health Care, enables Sharp Health Plan to offer managed care products through an HMO. Sharp Health Plan enhances Sharp HealthCare’s ability to provide affordable and available health care coverage to its employees and the communities it serves. As of September 30, 2010, Sharp Health Plan had more than 48,800 commercial enrollees, including more than 21,600 employees of Sharp HealthCare and their dependents. Sharp Health Plan provides services to its enrollees through a number of providers, including SRSMG and SCMG. Sharp Health Plan also contracts with Sharp Memorial, Sharp Chula Vista, Sharp Grossmont, and Sharp Coronado for inpatient and certain other institutional services.
- *Sharp Coronado* (formerly known as The Coronado Hospital) became affiliated with the Corporation in July 1994. Sharp Coronado operates a 204-bed hospital consisting of 59 acute care beds and a 145-bed sub-acute and skilled nursing facility. The hospital facilities are owned by the Coronado Hospital Foundation (“Coronado Foundation”), which leases them to Sharp Coronado pursuant to a 30-year lease that commenced July 1, 1994 and that expires June 30, 2024. Services offered by Sharp Coronado include emergency care, general acute inpatient care, intensive care, ambulatory surgery, diagnostic imaging, physical and occupational therapy, sub-acute, and skilled nursing care to meet the needs of the populations of Coronado and Imperial Beach, where Sharp Coronado has the largest inpatient market share. Sharp Coronado operates one of the largest sub-acute units in California and it performs more total joint replacement surgeries than any other hospital in San Diego County.

Sharp Coronado is a member of the Planetree network and is one of just ten hospitals nationwide distinguished with the Planetree Patient-Centered Hospital Designation. It is also the only hospital in California to have met the stringent criteria developed by Planetree, a nonprofit organization committed to patient-centered care through humanizing, personalizing, and demystifying the hospital experience. The Coronado Foundation has a matching grant with the City of Coronado to provide \$17.0 million to Sharp Coronado for facility upgrades and renovations. The Joint Commission surveyed Sharp Coronado in April 2009 and awarded the hospital its Gold Seal of Approval and a three-year

accreditation. Sharp Coronado is licensed to conduct and provide health care services by the State Department of Public Health Licensing and Certification Program, and is an eligible health care provider under Medicare, Medi-Cal, Blue Cross, and various commercial insurance programs.

- *Continuous Quality Insurance* is an offshore captive insurance company of the Corporation domiciled in Grand Cayman. It provides various professional and commercial general liability insurance services to the Corporation, as well as certain affiliated entities of the Corporation.
- *Sharp Foundation* is a California nonprofit public benefit corporation formed in October 1979 and exists solely for the purpose of raising funds for Sharp HealthCare. The use of these funds is for capital expenditures, program support, and endowment. Unrestricted gifts are expended at the discretion of Sharp Foundation's Board of Directors (within guidelines established by the Corporation).
- *Grossmont Foundation* is a California nonprofit public benefit corporation formed in 1985 and exists solely for the purpose of raising funds for Grossmont Hospital. The use of these funds is for capital expenditures, program support, and endowment. Unrestricted gifts are expended at the discretion of Grossmont Foundation's Board of Governors.

## HISTORICAL FINANCIAL INFORMATION

Financial and statistical information relating solely to the Obligated Group is included in this Section. The Obligated Group Members accounted for 92.8% of Sharp HealthCare's total revenues, 96.6% of income from operations, and 96.6% of its net assets, as of and for the fiscal year ended September 30, 2010. The Non-Obligated Affiliates included in the Sharp HealthCare audited combined financial statements have no obligation to make any payments on the Bonds or the Series 2011A Obligation or any other Obligations outstanding under the Master Indenture.

### Summary of Revenues and Expenses

The following Summary Statements of Revenues and Expenses of the Obligated Group for the years ended September 30, 2008, 2009, and 2010 have been derived from unaudited Other Financial Information to Sharp HealthCare's Audited Combined Financial Statements for the years then ended. The following summary should be read in conjunction with the Audited Combined Financial Statements for the years ended September 30, 2009 and 2010, related notes, and unaudited Other Financial Information that appear in Appendix B. The Audited Combined Financial Statements include information concerning the Obligated Group Members and Non-Obligated Affiliates. For purposes of the remainder of this section, the years ended September 30, 2008, 2009, and 2010 are referred to as Fiscal 2008, Fiscal 2009, and Fiscal 2010, respectively.

**Summary Statements of Revenues and Expenses of the Obligated Group  
(in thousands)**

	Year Ended September 30,		
	2008	2009	2010
Revenues:			
Net Patient Service <sup>(1)</sup>	\$1,178,335	\$1,259,610	\$1,370,024
Premium	558,927	592,096	617,392
Other	65,503	64,674	71,184
Total Revenues	<u>1,802,765</u>	<u>1,916,380</u>	<u>2,058,600</u>
Expenses:			
Operating Expenses	1,652,924	1,768,059	1,859,605
Depreciation/Amortization	68,532	75,335	77,320
Interest Expense	12,550	22,036	24,597
Total Expenses	<u>1,734,006</u>	<u>1,865,430</u>	<u>1,961,522</u>
Income from Operations	68,759	50,950	97,078
Other Income (Loss) <sup>(2)</sup>	(8,955)	16,024	29,648
Income from Continuing Operations	59,804	66,974	126,726
Gain on Discontinued Operations	7,262	1,480	132
Excess of Revenues Over Expenses	<u>\$ 67,066</u>	<u>\$ 68,454</u>	<u>\$ 126,858</u>

<sup>(1)</sup> Fiscal 2009 reflects the impact of the estimated reduction of the DSH payments discussed in “BONDHOLDERS’ RISKS – Patient Service Revenues – Medicaid Program” in this Official Statement.

<sup>(2)</sup> Other Income (Loss) includes investment income, unrealized gain (loss) on investments, mark-to-market on interest rate swaps, and foundation activity.

Source: Derived from the Other Financial Information to the Audited Combined Financial Statements for the years ended September 30, 2008, 2009, and 2010. Fiscal 2010 is included in Appendix B.

## Revenue Sources

Payments on behalf of certain patients are made to the Obligated Group by the federal government under the Medicare program, by the State and the federal government under the Medicaid program, known as Medi-Cal in California, by commercial insurance carriers, and by other third-party payors, including HMOs and preferred provider organizations (“PPOs”). Sharp HealthCare conducts centralized contracting and contract management for third party payor contracts and Medi-Cal inpatient hospital services.

**Governmental Payors.** For a discussion of government payment programs, refer to the subsections “Medicare,” “Medicaid Program,” and “California Medi-Cal” in the section “BONDHOLDERS’ RISKS” in this Official Statement.

**Physician Network and Managed Care.** The Members of the Obligated Group have numerous contracts with HMOs, PPOs, and other managed care providers. Some of these providers also contract with Non-Obligated Affiliates of the Corporation, as well as SCMG. The Members and the medical groups are paid under the managed care contracts pursuant to a variety of mechanisms, including: discounted fee-for-service, negotiated case-rate-per-procedure, negotiated fixed-rate-per-day-of-care, and capitation. For Fiscal 2010, revenue from capitated contracts represented 33.0% of total net patient revenues, with 48.0% of Sharp HealthCare’s capitated revenue generated through contracts with United Healthcare, covering both commercial and senior enrollees. See “BONDHOLDERS’ RISKS – Health Plans and Managed Care” in this Official Statement.

***Disproportionate Share Payments.*** Certain Sharp HealthCare hospitals qualify for and have received additional funding as “disproportionate share hospitals” due to their relative proportions of low-income patients. The amounts received by the Obligated Group from the State disproportionate share hospital program for Fiscals 2008, 2009, 2010 were \$4.5 million, \$0.3 million, and \$0.3 million, respectively. These amounts are included in net patient revenue and represent payments made to Sharp Mary Birch and Sharp Chula Vista in Fiscal 2008, Fiscal 2009, and Fiscal 2010. The amounts received by the Obligated Group from the federal disproportionate share hospital program for Fiscals 2008, 2009, and 2010 were \$25.2 million, \$27.9 million, and \$37.0 million, respectively. These amounts are included in net patient revenue and represent payments made to Sharp Memorial, Sharp Chula Vista, and Sharp Grossmont in all three fiscal years, and Sharp Mary Birch for Fiscals 2008 and 2009. During Fiscal 2010, Sharp Memorial and Sharp Mary Birch were successfully merged under one license and as a result, Sharp Mary Birch no longer receives separate disproportionate share payments, but is combined with Sharp Memorial. The disproportionate share hospital programs are generally thought to be vulnerable to being eliminated or substantially reduced, and therefore there is no certainty that these payments will be continued in the future. See “BONDHOLDERS’ RISKS – Patient Service Revenues – Medicaid Program” in this Official Statement.

The following table presents a comparison of net revenues by payor source on a combined basis for the Obligated Group. The composition of revenues for each Member varies from these overall averages based on the characteristics of their specific service area and the programs and services provided at each site.

	Year Ended September 30,		
	2008	2009	2010
Medicare Fee-for-Service and HMO	19.6%	19.2%	19.9%
Capitated Medicare	11.5	10.8	10.6
Medi-Cal Fee-for-Service and HMO	7.6	7.8	8.3
Commercial Contracts – Capitated	22.4	22.9	22.4
Commercial Contracts – Fee-for-Service <sup>(1)</sup>	37.5	38.4	38.0
County Medical Services <sup>(2)</sup>	0.6	0.5	0.6
All Other <sup>(3)</sup>	0.8	0.4	0.2
	<u>100.0%</u>	<u>100.0%</u>	<u>100.0%</u>

<sup>(1)</sup> Commercial contracts are negotiated on a per diem, per discharge, or percent discount basis.

<sup>(2)</sup> Sponsored by the County for medically indigent adults.

<sup>(3)</sup> Includes indemnity, private pay, bad debt, and charity care.

Source: Corporation records.

## Summary Balance Sheets

The following Summary Balance Sheets of the Obligated Group as of September 30, 2008, 2009, and 2010 have been derived from unaudited Other Financial Information to Sharp HealthCare's Audited Combined Financial Statements for the years then ended. The following summary should be read in conjunction with the Audited Combined Financial Statements for the years ended September 30, 2009 and 2010, related notes, and unaudited Other Financial Information that appear in Appendix B.

### Summary Balance Sheets of the Obligated Group (in thousands)

	As of September 30,		
	2008	2009	2010
<b>ASSETS</b>			
Current Assets:			
Cash, Cash Equivalents and Short-term Investments	\$ 196,347	\$ 191,150	\$ 175,846
Accounts Receivable – Net	155,289	169,262	164,810
Other Current Assets	68,709	72,734	73,097
Total Current Assets	420,345	433,146	413,753
Assets Limited as to Use – Net	231,355	384,310	545,096
Property, Plant and Equipment – Net	701,832	772,944	776,474
Other Assets	79,980	83,199	82,643
Total Assets	<u>\$1,433,512</u>	<u>\$1,673,599</u>	<u>\$1,817,966</u>
<b>LIABILITIES AND NET ASSETS</b>			
Current Liabilities:			
Current Portion of Long-term Debt	\$ 19,980	\$ 19,454	\$ 18,479
Other Current Liabilities	199,557	232,651	249,180
Total Current Liabilities	219,537	252,105	267,659
Long-term Liabilities	87,168	131,088	131,053
Long-term Debt – Net	409,777	508,817	489,780
Total Net Assets	717,030	781,589	929,474
Total Liabilities and Net Assets	<u>\$1,433,512</u>	<u>\$1,673,599</u>	<u>\$1,817,966</u>

Source: Derived from the Other Financial Information to the Audited Combined Financial Statements as of September 30, 2008, 2009, and 2010. Fiscal 2010 is included in Appendix B.

## Liquidity

The following table sets forth the days cash on hand of the Obligated Group as of September 30, 2008, 2009, and 2010.

	As of and for the Year Ended September 30,		
	(\$ in thousands)		
	2008	2009	2010
Cash, Cash Equivalents, and Short-term Investments	\$ 196,347	\$ 191,150	\$ 175,846
Add: Assets Limited as to Use, Designated for Property	220,206	321,333	493,322
Total Cash and Unrestricted Investments (A)	\$ 416,553	\$ 512,483	\$ 669,168
Total Expenses	\$1,734,006	\$1,865,430	\$1,961,522
Less: Depreciation and Amortization	68,532	75,335	77,320
Adjusted Annual Expenses	1,665,474	1,790,095	1,884,202
÷ Calendar Days	366	365	365
Daily Operating Expenses (B)	\$ 4,551	\$ 4,904	\$ 5,162
Days Cash on Hand (A/B)	91.5	104.5	129.6

Source: Derived from the Other Financial Information to the Audited Combined Financial Statements and Corporation records for the years ended September 30, 2008, 2009, and 2010. Fiscal 2010 is included in Appendix B.

## Debt Service Coverage Ratio

The following table sets forth income available for debt service of the Obligated Group for each of the three most recent fiscal years and the coverage of maximum annual debt service pertaining to Obligations issued under the Master Indenture (other than the guarantees secured by Obligations issued thereunder) and other indebtedness for each of these periods. The pro forma column provides for an adjustment to the Fiscal 2010 amounts to give effect to the issuance of the Bonds and the Series 2010A Bonds as if such issuance had occurred as of September 30, 2010. See "INTRODUCTORY STATEMENT – Outstanding Indebtedness and Obligations" in the front part of this Official Statement for more information on the Series 2010A Bonds. Pro forma maximum annual debt service is the highest requirement from fiscal 2011 forward, as adjusted for the bond issuance, and reflects the extension of the life of the Bonds as a result of the refinancing.

	Year Ended September 30,			
	(\$ in thousands)			
	2008	2009	2010	
			Historic	Pro Forma
Excess of Revenues Over Expenses	\$ 67,066	\$ 68,454	\$ 126,858	\$ 126,858
Unrealized (Gains)/Losses on Investments	18,424	(6,452)	(20,597)	(20,597)
Mark-to-Market on Interest Rate Swaps	5,451	(461)	311	311
Discontinued Operations	(7,262)	(1,480)	(132)	(132)
Depreciation/Amortization	68,532	75,335	77,320	77,320
Interest Expense	12,550	22,036	24,597	24,597
Income Available for Debt Service	\$164,761	\$157,432	\$ 208,357	\$ 208,357
Maximum Annual Debt Service Requirements	\$ 47,227	\$ 52,358	\$ 52,050	\$ 47,692
Coverage Ratio	3.49x	3.01x	4.00x	4.39x

Source: Derived from the Other Financial Information to the Audited Combined Financial Statements and Corporation records for the years ended September 30, 2008, 2009, and 2010. Fiscal 2010 is included in Appendix B. Pro Forma provided by the Corporation.

## Capitalization

The following table sets forth the capitalization of the Obligated Group for each of the three most recent fiscal years, including capitalized leases and other indebtedness. The pro forma column provides for an adjustment to the Fiscal 2010 amounts to give effect to the issuance of the Bonds and the Series 2010A Bonds as if such issuances had occurred as of September 30, 2010.

	Year Ended September 30,				
	(\$ in thousands)				
	2008	2009	2010		
		Historic	Pro Forma		
Series 1988A Bonds	\$ 14,400	\$ 13,400	\$ 12,300	\$ 12,300	
1998 Certificates of Participation	90,045	86,700	82,408	54,818	
Series 2001A Bonds	63,880	60,100	56,086	-	
Series 2003A and B Bonds	89,725	-	-	-	
Series 2003C Bonds	27,820	27,145	26,449	26,449	
Series 2007A and B Bonds	99,880	-	-	-	
Series 2009A Bonds	-	57,065	54,010	54,010	
Series 2009B Bonds	-	137,291	137,386	137,386	
Series 2009C and D Bonds	-	99,880	99,880	99,880	
Series 2010A Bonds	-	-	-	30,000	
Series 2011A Bonds	-	-	-	77,710	
Other Long-term Debt	44,007	46,690	39,740	39,740	
Total Long-term Debt	429,757	528,271	508,259	532,293	
Add: Short-term Debt <sup>(1)</sup>	-	-	27	27	
Total Debt (A)	429,757	528,271	508,286	532,320	
Unrestricted Net Assets	669,208	727,746	873,282	873,282	
Total Capitalization (B)	\$1,098,965	\$1,256,017	\$1,381,568	\$1,405,602	
Debt-to-Capitalization Ratio (A/B)	39.1%	42.1%	36.8%	37.9%	

<sup>(1)</sup> Short-term Debt is included in Accounts Payable and Other Accrued Liabilities in the Other Financial Information to the Audited Combined Financial Statements for the year ended September 30, 2010.

Source: Corporation records.

## Management's Discussion of Financial Performance

The Obligated Group's financial results for its three most recently completed fiscal years reflect profitability from operations. These operating results were obtained through a combination of factors, including specific management initiatives, certain organizational changes, and a continued emphasis on pursuing operating efficiencies at all levels of the organization.

The balance of this section discusses each of these general premises in greater detail and describes certain financial relationships between Members of the Obligated Group and Non-Obligated Affiliates.

**Historical Operating Performance.** As depicted in the table on page A-41, the Obligated Group generated income from operations in Fiscal 2008, Fiscal 2009, and Fiscal 2010. The operating results of the Obligated Group demonstrate strong operating performance each year.

Patient activity increased for the Members of the Obligated Group from Fiscal 2008 to Fiscal 2010. As depicted in the table on page A-31, total discharges increased 1.4% in Fiscal

2009 and 2.9% in Fiscal 2010. Outpatient registrations increased 7.3% in Fiscal 2009 and decreased 3.8% in Fiscal 2010, due primarily to reductions in elective procedures resulting from economic conditions. In comparison, total revenues increased by 6.3% in Fiscal 2009 and 7.4% in Fiscal 2010. The increase in total revenues can be attributed to increased patient activity and successful contracting strategies by management, as further discussed below.

Operating expenses (other than interest, depreciation and amortization) increased 7.0% in Fiscal 2009 and 5.2% in Fiscal 2010. The cost increases in Fiscal 2009 and Fiscal 2010 reflect the increased patient activity, offset by savings generated by a decrease in the average length of stay of 2.9% and 3.1% in Fiscal 2009 and Fiscal 2010, respectively. The cost of maintaining a competitive compensation and benefits program for employees, along with growth in the number of employees to provide care to patients, resulted in increased salary and employee benefit expenses of 9.0% and 6.8% in Fiscals 2009 and 2010, respectively. For Fiscal 2010, salary and employee benefit costs represent 49.3% of total revenues, a decrease from 49.6% in Fiscal 2009. The Obligated Group's interest expense for Fiscal 2010 increased by 11.6% from Fiscal 2009 due to the impact of a full year of interest on the Series 2009B Bonds, the cumulative effect of a change in amortization for costs of issuance, and reduced capitalized interest as large capital projects, including the Stephen Birch Center, were completed in mid-Fiscal 2009, partially offset by write-off of costs of issuance of the Series 2003A&B Bonds and Series 2007 SWEEP Bonds due to refinance transactions in Fiscal 2009. Favorable maximum rate formulas on all auction rate securities, an optimal capital structure of fixed and variable rate debt, and the positive hedging effects from the Corporation's interest rate swaps (as discussed herein) helped offset the increased interest expense.

The Obligated Group's results for Fiscal 2010 indicate a continuation of profitability from operations. Total net patient service revenues for this period were 8.8% higher than those experienced in Fiscal 2009. For the same periods, operating expenses (other than interest, depreciation and amortization) increased by 5.2% and resulted in income from operations of \$97.1 million in Fiscal 2010, an increase of \$46.1 million, or 90.5%, compared to Fiscal 2009.

Among the factors contributing to the strong financial results in Fiscal 2010 were increased patient volumes, realization of the continuing impact of favorable payor contract negotiations, decreased usage of outside registry which utilize a significantly higher rate of pay, returns on investment of information technology initiatives such as the EHR, and continued managerial discipline in containing direct operating costs despite volume increases. Additionally, a full year of operations of the Stephen Birch Center which opened in January 2009 and a full year of savings related to the closure of Sharp Cabrillo in April 2009 have contributed to profitability in Fiscal 2010.

In general, management attributes the strong operating results to the ability of management at all levels to implement various cost reduction programs and revenue enhancement activities while maintaining and enhancing the quality of care being provided at Sharp HealthCare's health facilities. Among the major cost reduction and revenue enhancement activities were:

- Successful implementation of contracting strategies focusing on improved HMO, PPO, and Medi-Cal reimbursement. Throughout Fiscals 2008, 2009, and 2010, management continued an aggressive contracting strategy with respect to its

capitated, PPO, and Medi-Cal contracts. The renegotiation of Sharp HealthCare's capitated contracts yielded premium revenue increases in excess of 7% annually. The PPO contracting strategy focused on changing the reimbursement methodology on all PPO contracts from per diem rates to a percentage discount from charges, which more reasonably compensates the hospitals for the care provided to patients under such contracts.

- A focus by management at all levels of the organization to maintain a safe environment for employees has resulted in a reduction in workers' compensation claims and medical costs in each of the three fiscal years.
- Commitment to *The Sharp Experience* resulted in increased employee satisfaction scores and decreased employee turnover, which was a key factor in reducing registry and traveler staff expenses and contributed to continued improvement in operations during Fiscals 2008 through 2010.
- Supply chain efficiency improvements, including physician preference standardization, distribution agreement reductions, remanufacturing efforts, and pharmacy management, provided supply expense reductions during a period of rising costs.
- Negotiation of long-term fixed price agreements contributed to reduced utility costs.
- Implementation of Lean-Six Sigma methods throughout Sharp HealthCare provided a myriad of cost reduction and efficiency results. One project, whose objective was to reduce out-of-network claims expenses related to Sharp HealthCare's capitated patients by moving patients into a Sharp HealthCare hospital to receive their inpatient care, has provided significant annual savings in Fiscals 2008, 2009, and 2010. Several other Lean-Six Sigma projects have been implemented and resulted in decreased staff turnover, improved work efficiency, increased turnaround time of available inpatient beds, reduced length of stay, and created staff and cost efficiencies through centralization of services.
- Cooperative support from physicians and other professionals in implementing clinical effectiveness initiatives designed to improve the quality of care in certain specialty areas through improved patient outcomes. Such initiatives, while improving quality, also resulted in decreased operating costs.
- Implementation of niche programs and services to meet specific community needs and opportunities such as a bariatrics program, a radiation surgery program, a surgical robotics program, wound care programs, and CT lung and body scanning.

Management believes its continued focus on operations and its ability to identify and act upon operating and strategic initiatives have resulted in positive operating results during periods of rising costs. Additionally, management believes that the market strength of Sharp HealthCare

and the quality of its services has allowed the organization to obtain favorable increases in its HMO, PPO, and Medi-Cal contract rates.

***Historical Non-operating Performance.*** The loss of \$9.0 million in Fiscal 2008 was comprised of \$17.2 million in investment income, offset by \$18.4 million in unrealized losses in Sharp HealthCare's investment portfolio as a result of a downturn in the equity markets, unfavorable mark-to-market adjustments on interest rate swaps of \$5.5 million, and expenses of \$2.3 million related to activities of the Sharp Foundation and Grossmont Foundation. In Fiscal 2009, non-operating income of \$16.0 was comprised of \$13.1 million in investment income, \$6.4 million in unrealized gains in Sharp HealthCare's investment portfolio as a result of the partial recovery of the equity markets, and favorable mark-to-market adjustments on interest rate swaps of \$0.5 million, offset by \$4.0 million in expenses related to the activities of the Sharp Foundation and Grossmont Foundation. The gain of \$29.6 million in Fiscal 2010 was comprised of \$13.7 million in investment income and \$20.6 million of unrealized gains in Sharp HealthCare's investment portfolio as a result of the recovery of the equity markets and increased equity investments, offset by unfavorable mark-to-market adjustments on interest rate swaps of \$0.3 million and expenses of \$4.4 million related to activities of the Sharp Foundation.

***Historical Financial Position.*** The Obligated Group has been investing in its infrastructure, medical equipment, and information systems during the past three years. Property, plant, and equipment, net of accumulated depreciation and amortization, increased \$71.1 million in Fiscal 2009 and an additional \$3.5 million in Fiscal 2010. In addition to routine replacement acquisitions, investments have consisted of significant facility expenditures for expansion and improvement, as well as information system infrastructure improvements, application acquisitions, and planning and design costs related to the EMR and EHR systems. Management believes that these initiatives will have a favorable financial and strategic impact on the Obligated Group's future operations as the facility enhancements and information systems applications and infrastructure improvements become operational. The property, plant, and equipment acquisitions have been funded primarily by the Obligated Group's cash flow from operations and available bond proceeds, which are included in assets limited as to use in the table on page A-43. Sharp HealthCare's significant strategic capital acquisitions and improvements are described in "RECENTLY COMPLETED AND CURRENT PROJECTS" herein.

In Fiscal 2009, net patient service revenue increased \$81.3 million, or 6.9%, which caused a corresponding increase in patient accounts receivable, net of allowances, of \$15.3 million, or 10.2%. Accounts receivable, net of allowances, decreased \$7.0 million, or (4.2%), in Fiscal 2010 compared with Fiscal 2009, primarily due to increased cash collections. Net patient service revenue increased 8.8% in Fiscal 2010 due to increased patient activity which caused an increase in accounts receivable, but was more than offset by a decrease in the collection period. Management believes that improvement in the collection period for accounts receivable had a favorable impact on the cash balances of the Obligated Group during Fiscal 2010. Days in accounts receivable were 46.5, 47.8, and 42.1 as of September 30, 2008, 2009, and 2010, respectively.

Combined cash and cash equivalents, short-term investments, and assets limited as to use increased \$145.5 million in Fiscal 2010 compared with Fiscal 2009, which was comprised of improved operating performance and unrealized gains on investments, partially offset by capital expenditures and debt service. The Obligated Group has been investing in its infrastructure,

medical equipment, and information systems during the past three years. Property, plant, and equipment, net of accumulated depreciation and amortization, increased \$76.2 million in Fiscal 2008, \$71.1 million in Fiscal 2009, and an additional \$3.5 million in Fiscal 2010. In addition to routine replacement acquisitions, investments have consisted of significant facility expenditures, as well as information system infrastructure improvements, application acquisitions, and planning and design costs related to the EMR and EHR systems. Management believes that these initiatives will have a favorable financial and strategic impact on the Obligated Group's future operations as the facility enhancements and information systems applications and infrastructure improvements become operational.

Long-term liabilities increased \$43.9 million in Fiscal 2009 compared to Fiscal 2008 related to the increase in the unfunded status of the defined benefit pension plan due to a decrease in the discount rate used to value the benefit obligation. Long-term liabilities remained consistent in Fiscal 2010 compared to Fiscal 2009 due to increased contributions to the defined benefit pension plan and increased market values on plan assets, offset by a decrease in the discount rate used to value the benefit obligation.

### **Retirement Plan**

Sharp HealthCare sponsors a voluntary retirement plan (the "SharpSaver"), which consists of a defined benefit cash balance plan and a defined contribution plan. A participating Sharp HealthCare employee has the opportunity to invest up to 6% of his or her salary into the SharpSaver on an after-tax basis, and Sharp HealthCare will match the employee's contribution up to 4.5% of the employee's salary for employees with less than 20 years of service or 5% for employees with 20 or more years of service. The first 1% of the employee's contribution is placed into the defined benefit plan, and Sharp HealthCare matches at 2% and provides the employee a guaranteed 6% return on his or her account balance. For every additional 1% an employee contributes up to the 6% maximum, Sharp HealthCare matches the employee's contribution at .5%, with the exception of employees with 20 or more years of service where Sharp HealthCare matches .5% for every 1% of employee contribution thereafter up to 5% and a 1% match on the 6% maximum employee contribution. Funds are placed in the defined contribution plan and are invested at the direction and risk of the employee. The defined contribution plan is 100% funded, including any non-vested employer contributions. As of September 30, 2009 and 2010, the defined benefit cash balance plan was 63% and 68% funded, respectively, under generally accepted accounting principles. For Employee Retirement Income Security Act of 1974 ("ERISA") funding purposes, the defined benefit cash balance plan was 84% and 83% funded as of January 1, 2009 and January 1, 2010, respectively.

### **ERISA Plans and Audits**

The Corporation maintains several employee welfare plans that are subject to various laws and regulations including ERISA. The Corporation's employee welfare plans are occasionally audited or examined by regulatory agencies including the Internal Revenue Service and the Department of Labor ("DOL"). Currently the DOL is auditing the Corporation's ERISA health care plan and a Voluntary Employees' Beneficiary Association ("VEBA") that the Corporation maintained to fund employee health care plan expenditures. The Corporation terminated the VEBA on August 1, 2006. The DOL has not completed its audit and the Corporation is unaware of any findings the DOL has made or may make. The Corporation

believes that it has substantially complied with laws and regulations applicable to its employee welfare plans but adverse findings by the DOL could result in significant fines, penalties, or actions, which could materially adversely affect the Obligated Group.

## **Investment Policy**

The Corporation's Board sets the investment strategy for cash and investments that are designated as long-term, in that they are not expected to be required for near-future operating or capital expenditures. Long-term investments exclude retirement funds and funds held under bond indentures. The investment policy issued by the Board defines investment objectives, establishes investment guidelines, outlines criteria and procedures for the on-going operation and evaluation of the Corporation's investment program, and provides a formal written document of the Corporation's expectations regarding its investment program. An independent company provides investment management services within the constraints provided by the Corporation's investment policy objectives and guidelines. The Corporation's Investment Committee reviews the strategy and performance of the various funds on a quarterly basis, and makes recommendations to the Board as determined prudent from such review. The Corporation's conservative investment policy provides for a targeted long-term investment mix of 50% to 70% fixed income investments and 30% to 50% equity investments. The Obligated Group's equity investments, which totaled \$139.0 million at September 30, 2010, are invested in indexed funds.

## **Capital Structure**

Management conducts periodic global risk assessments on Sharp HealthCare's capital structure, taking into account its credit position, operating projections, strategic initiatives, risk tolerance, and capital structure objectives. The results of the assessments are used by management in its capital structure initiatives, including its use of interest rate swaps and bank credit and liquidity facilities.

### ***Interest Rate Swaps***

- On May 1, 2002, the Corporation entered into an interest rate swap (the "Lehman Swap") with Lehman Brothers Special Financing, Inc. ("Lehman") with respect to the County of San Diego, California Certificates of Participation issued in 1998 (the "1998 Bonds"). The Lehman Swap hedged an initial notional amount of \$80.0 million at a fixed receiver rate of 4.66% for the entire swap term, amortized in accordance with the amortization of the 1998 Bonds, and was scheduled to expire on August 15, 2028. Under the Lehman Swap, the Corporation paid Lehman a fixed Securities Industry and Financial Markets Association ("SIFMA", previously the Bond Market Association index, or "BMA") municipal swap index rate of 1.5% through December 31, 2002 and then reverted to the floating SIFMA rate, for the remaining term of the Lehman Swap. The Lehman Swap generated cash flow of \$1.6 million in Fiscal 2008. As a result of the bankruptcy filing by Lehman Brothers Holdings, Inc., the guarantor on the Lehman Swap, the Corporation issued a notice of termination to Lehman on September 25, 2008. The early termination payment due the Corporation is \$1.8 million, which was recorded as a receivable in Fiscal 2008 with a corresponding

100% allowance for doubtful accounts as the Corporation has no assurance it will receive such amount from Lehman.

- In June 2003, the Corporation entered into a \$109.7 million floating-to-fixed rate swap with Citibank, N.A. New York (“Citibank”) (the “Citibank Swap”). The Citibank Swap was structured as a cash flow hedge and is intended to offset the variability of variable rate indebtedness. The Corporation has no collateral posting requirements under the Citibank Swap.
- In February 2004, the Corporation entered into an \$80.0 million fixed-spread basis swap with Citibank (the “Citibank Basis Swap”). The Citibank Basis Swap was entered into to reduce interest expense on a portion of Sharp HealthCare’s outstanding fixed rate debt by assuming tax risk on this debt. The Citibank Basis Swap is non-amortizing and was not structured as a hedge on any specific debt instrument. The Corporation has no collateral posting requirements under the Citibank Basis Swap.
- In August 2006, the Corporation entered into an \$80.0 million yield curve swap with Citibank (the “Citibank Yield Curve Swap”) with an effective date of August 3, 2007. The Citibank Yield Curve Swap was entered into as an overlay to the existing Citibank Basis Swap. Given the flatness of the yield curve at execution of the Citibank Yield Curve Swap, it provided an opportunity to potentially increase cash flow associated with the Citibank Basis Swap when the yield curve steepened and returned to a historically upward sloping curve. The Citibank Yield Curve Swap is non-amortizing and was not structured as a hedge on any specific debt instrument. However, a benefit of the Citibank Yield Curve Swap is its hedge against the economics of the Citibank Basis Swap during low interest rate environments. The Corporation has no collateral posting requirements under the Citibank Yield Curve Swap.

See Note 6 to the Audited Combined Financial Statements included in Appendix B for additional information regarding the Corporation’s interest rate swaps.

### ***Bank Credit and Liquidity Facilities***

As of September 30, 2010, Sharp HealthCare had the following bank credit and liquidity facilities:

- A \$50.0 million single bank line of credit facility for working capital, capital expenditures, and other general corporate purposes, which expires in September 2011. As part of the workers’ compensation insurance agreement, letters of credit have been provided as collateral, totaling \$32.4 million as of September 30, 2010, which are considered a decrease in the available \$50.0 million line of credit.
- A bank liquidity facility to provide credit enhancement and liquidity support for the \$60.0 million Series 2009A Variable Rate Revenue Bonds (“Series 2009A Bonds”). The bank liquidity facility was executed in February

2009 by a bank letter of credit that expires in February 2012. The Series 2009A Bonds remarket weekly and may be put at the option of the bondholders every seven days.

- A bank liquidity facility to provide credit enhancement and liquidity support for the \$99.9 million Series 2009C and Series 2009D Variable Rate Revenue Bonds (“Series 2009C and D Bonds”). The bank liquidity facility was executed in September 2009 by a bank letter of credit that expires in September 2012. The Series 2009C and D Bonds remarket weekly and may be put at the option of the bondholders every seven days.

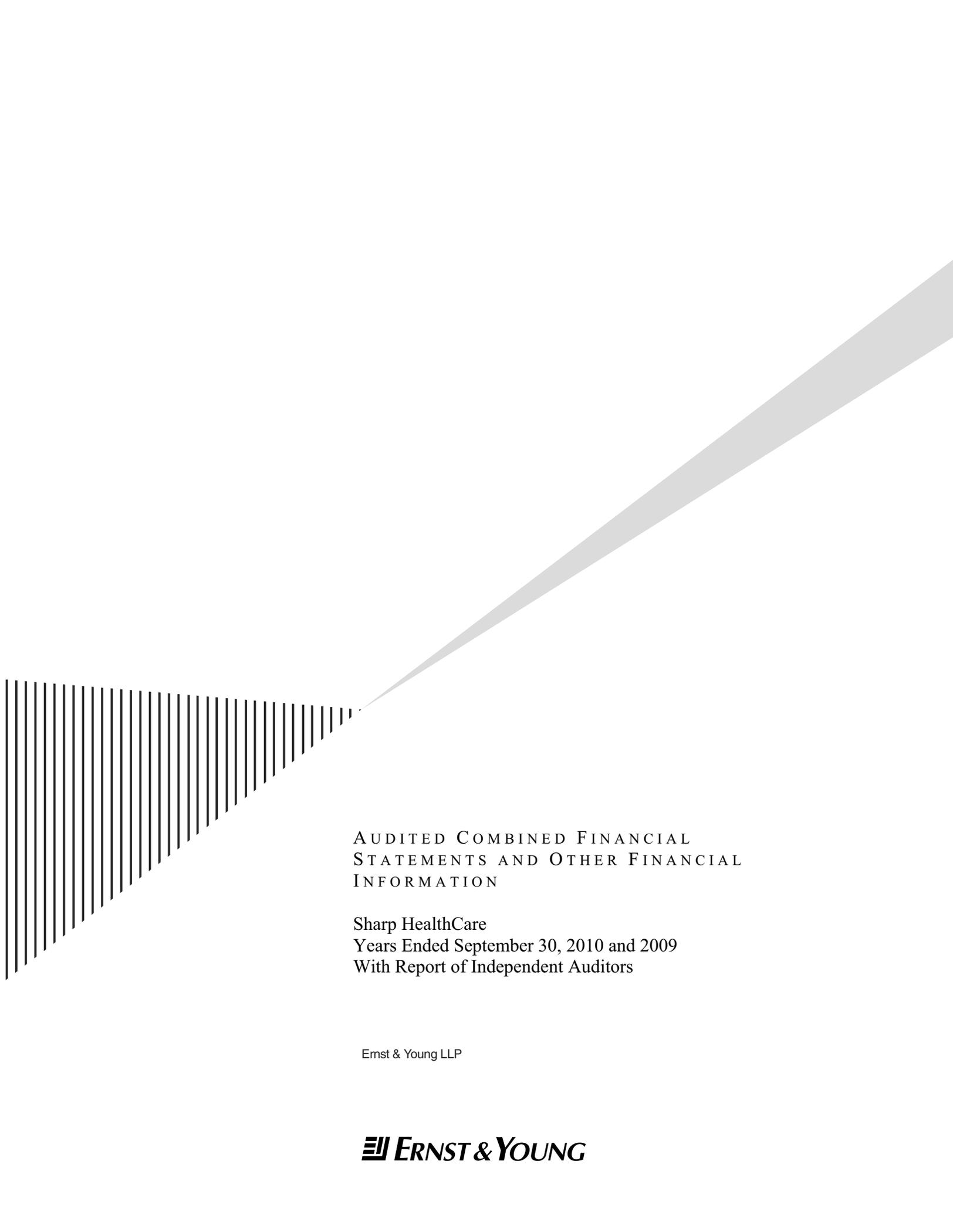
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**APPENDIX B**

**FINANCIAL STATEMENTS OF THE CORPORATION**

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AUDITED COMBINED FINANCIAL  
STATEMENTS AND OTHER FINANCIAL  
INFORMATION

Sharp HealthCare  
Years Ended September 30, 2010 and 2009  
With Report of Independent Auditors

Ernst & Young LLP

 **ERNST & YOUNG**

# Sharp HealthCare

## Combined Financial Statements and Other Financial Information

Years Ended September 30, 2010 and 2009

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## Report of Independent Auditors

Board of Directors  
Sharp HealthCare

We have audited the accompanying combined balance sheets of Sharp HealthCare (the Company) as of September 30, 2010 and 2009, and the related combined statements of operations, changes in net assets, and cash flows for the years then ended. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. We were not engaged to perform an audit of the Company's internal control over financial reporting. Our audits included consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the combined financial position of Sharp HealthCare at September 30, 2010 and 2009, and the combined results of their operations and their cash flows for the years then ended in conformity with accounting principles generally accepted in the United States.



December 15, 2010

# Sharp HealthCare

## Combined Balance Sheets

	<b>September 30</b>	
	<b>2010</b>	<b>2009</b>
	<i>(In Thousands)</i>	
<b>Assets</b>		
Current assets:		
Cash and cash equivalents	\$ 154,749	\$ 150,611
Short-term investments	42,770	75,624
Accounts receivable, net of allowance for doubtful accounts of \$173,026 in 2010 and \$151,361 in 2009	177,397	181,607
Inventories	31,641	31,172
Prepaid expenses and other	33,114	30,317
Total current assets	439,671	469,331
Assets limited as to use:		
Designated for property	519,236	330,092
Under bond indentures	51,774	62,977
Other restricted investments	38,039	30,608
Under self-insurance programs	8,043	7,017
Total assets limited as to use	617,092	430,694
Property and equipment, net	790,670	786,965
Unamortized financing costs	4,448	7,792
Other assets	36,751	40,032
Total assets	\$ 1,888,632	\$ 1,734,814
<b>Liabilities and net assets</b>		
Current liabilities:		
Accounts payable and accrued liabilities	\$ 163,687	\$ 145,319
Accrued compensation and benefits	100,623	93,040
Current portion of long-term debt	18,673	19,657
Estimated settlements payable to government programs, net	1,043	9,036
Accrued interest	3,065	3,062
Discontinued operations	996	521
Total current liabilities	288,087	270,635
Long-term liabilities	135,998	135,489
Reserves for professional liability	13,000	13,700
Long-term debt	489,799	508,975
Total liabilities	926,884	928,799
Net assets:		
Unrestricted	906,360	752,484
Temporarily restricted	48,884	47,704
Permanently restricted	6,504	5,827
Total net assets	961,748	806,015
Total liabilities and net assets	\$ 1,888,632	\$ 1,734,814

*See accompanying notes.*

# Sharp HealthCare

## Combined Statements of Operations

	<b>September 30</b>	
	<b>2010</b>	<b>2009</b>
	<i>(In Thousands)</i>	
<b>Revenues:</b>		
Net patient service	\$ 1,431,551	\$ 1,313,705
Premium	720,599	684,289
Other	66,667	58,914
<b>Total revenues</b>	<b>2,218,817</b>	<b>2,056,908</b>
<b>Expenses:</b>		
Salaries and wages	863,128	813,551
Employee benefits	200,366	181,011
Medical fees	271,324	244,372
Purchased services	225,828	225,075
Supplies	279,904	271,591
Maintenance, utilities, and rentals	96,358	91,252
Depreciation and amortization	81,899	77,771
Business insurance	7,056	12,840
Interest	24,849	22,011
Provision for doubtful accounts	41,929	33,789
Other	25,669	32,411
<b>Total expenses</b>	<b>2,118,310</b>	<b>2,005,674</b>
Income from operations	100,507	51,234
Other non-operating loss	(4,053)	(3,125)
Investment income	38,460	21,364
Income from continuing operations	134,914	69,473
Income from discontinued operations	132	1,480
Excess of revenues over expenses	135,046	70,953
Net assets transferred from related party	9,344	24,701
Net assets released from restrictions used for purchase of property, plant, and equipment	8,737	6,803
Pension-related changes other than net periodic pension cost	29	(42,499)
Other changes in net assets	720	872
<b>Increase in unrestricted net assets</b>	<b>\$ 153,876</b>	<b>\$ 60,830</b>

*See accompanying notes.*

## Sharp HealthCare

### Combined Statements of Changes in Net Assets

	<b>September 30</b>	
	<b>2010</b>	<b>2009</b>
	<i>(In Thousands)</i>	
Unrestricted net assets:		
Excess of revenues over expenses	\$ 135,046	\$ 70,953
Net assets transferred from related party	9,344	24,701
Net assets released from restrictions used for purchase of property, plant, and equipment	8,737	6,803
Pension-related changes other than net periodic pension cost	29	(42,499)
Other	720	872
Increase in unrestricted net assets	<u>153,876</u>	<u>60,830</u>
Temporarily restricted net assets:		
Contributions	10,550	14,014
Investment income	1,146	488
Change in net unrealized gains on investments	1,038	1,241
Net assets released from restrictions	(12,344)	(9,954)
Other	790	(3,330)
Increase in temporarily restricted net assets	<u>1,180</u>	<u>2,459</u>
Permanently restricted net assets:		
Contributions	677	232
Increase in permanently restricted net assets	<u>677</u>	<u>232</u>
Increase in net assets	<u>155,733</u>	<u>63,521</u>
Net assets, beginning of the year	<u>806,015</u>	<u>742,494</u>
Net assets, end of the year	<u><u>\$ 961,748</u></u>	<u><u>\$ 806,015</u></u>

*See accompanying notes.*

# Sharp HealthCare

## Combined Statements of Cash Flows

	<b>September 30</b>	
	<b>2010</b>	<b>2009</b>
	<i>(In Thousands)</i>	
<b>Operating activities</b>		
Increase in net assets	\$ 155,733	\$ 63,521
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Income from discontinued operations	(132)	(1,480)
Net assets transferred from related party	(9,344)	(24,701)
Provision for doubtful accounts	41,929	33,789
Non-cash gains	211	(275)
Depreciation and amortization	81,899	77,771
Deferred financing cost and other amortization	2,431	2,927
Change in fair value of interest and basis rate swaps	311	655
Restricted contributions and investment income, net	(12,373)	(14,734)
Pension-related changes other than net periodic pension cost	(29)	42,499
Changes in assets and liabilities:		
(Increase) decrease in:		
Accounts receivable	(37,719)	(47,198)
Inventories	(469)	(2,196)
Short-term investments	32,854	19,287
Assets limited to use	(186,398)	(153,956)
Prepaid expenses and other	(2,797)	(5,159)
Increase (decrease) in:		
Accounts payable and accrued liabilities, long-term liabilities, and other liabilities	18,209	19,527
Accrued compensation and benefits	7,583	11,607
Estimated settlements payable to government programs, net	(7,993)	10,499
Net cash provided by operating activities of continued operations	83,906	32,383
Net cash provided by operating activities of discontinued operations	607	1,297
Net cash provided by operating activities	84,513	33,680
<b>Investing activities</b>		
Acquisition of property and equipment, net of retirements	(75,842)	(115,359)
Decrease in other assets	2,624	2,691
Net cash used in investing activities	(73,218)	(112,668)
<b>Financing activities</b>		
Current maturities and payments on long-term debt	(19,323)	(18,448)
Payments under capital lease obligations	(207)	(305)
Extinguishment of long-term debt	-	(17,225)
Proceeds from the issuance of long-term debt	-	124,766
Restricted contributions and investment income, net	12,373	14,734
Net cash (used in) provided by financing activities	(7,157)	103,522
Net increase in cash and cash equivalents	4,138	24,534
Cash and cash equivalents, beginning of the year	150,611	126,077
Cash and cash equivalents, end of the year	\$ 154,749	\$ 150,611

# Sharp HealthCare

## Combined Statements of Cash Flows (continued)

	<b>September 30</b>	
	<b>2010</b>	<b>2009</b>
	<i>(In Thousands)</i>	
<b>Supplemental disclosures of cash flow information</b>		
Capital lease obligations for building and equipment	<b>\$ (20)</b>	<b>\$ 201</b>
Cash paid for interest	<b>\$ 24,491</b>	<b>\$ 15,583</b>
Repayment of Series 2007 A and B Variable Rate Revenue Refunding Bonds by incurring Series 2009 C and D Variable Rate Revenue Refunding Bonds	<b>\$ –</b>	<b>\$ 99,880</b>
Repayment of Series 2003 A and B Insured Hospital Revenue Bonds by incurring Series 2009 A Variable Rate Revenue Refunding Bonds and 2009 B Revenue Bonds	<b>\$ –</b>	<b>\$ 72,500</b>
Net assets transferred from related party	<b>\$ 9,344</b>	<b>\$ 24,701</b>
Purchase of medical office building by assumption of mortgage	<b>\$ –</b>	<b>\$ 8,652</b>

*See accompanying notes.*

# Sharp HealthCare

## Notes to Combined Financial Statements

September 30, 2010

### 1. Summary of Significant Accounting Policies

#### Organization

Sharp HealthCare (SHC) is a California nonprofit public benefit corporation with corporate offices in San Diego, California. SHC, together with its affiliated entities (collectively Sharp), constitute a regional integrated health care delivery system which does business as Sharp HealthCare, primarily serving the residents of San Diego County. The combined financial statements of Sharp include the accounts of the following:

- Sharp Memorial Hospital (SMH), including Stephen Birch Healthcare Center, Sharp Mary Birch Hospital for Women & Newborns, Sharp Cabrillo (closed in April 2009), Sharp Outpatient Pavilion, Sharp Mesa Vista Hospital, and Sharp Vista Pacifica
- Sharp Chula Vista Medical Center (SCVMC)
- Sharp Grossmont Hospital (SGH)
- Sharp Coronado Hospital and HealthCare Center (SCHHC)
- Sharp Health Plan (SHP)
- Continuous Quality Insurance SPC (CQI SPC)
- Sharp HealthCare Foundation (SHF)
- Grossmont Hospital Foundation (GHF)

SHC, SMH, SCVMC, and SGH are collectively the “Obligated Group” under certain bond indentures (see Note 6).

SHC has certain contractual obligations with its affiliates that govern its operations and the use of certain assets. All significant transactions among Sharp’s combined entities have been eliminated in the accompanying combined financial statements.

#### Use of Estimates

The preparation of Sharp’s combined financial statements in conformity with accounting principles generally accepted in the United States (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 combined financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

# Sharp HealthCare

## Notes to Combined Financial Statements (continued)

### 1. Summary of Significant Accounting Policies (continued)

#### Cash and Cash Equivalents

Cash and cash equivalents include investments in highly liquid debt instruments with original maturities of three months or less. Sharp routinely invests its surplus operating funds in money market mutual funds. These funds generally invest in highly liquid U.S. government and agency obligations.

#### Short-Term Investments

Short-term investments are classified as trading and include corporate and government obligation securities, which are included in professionally managed portfolios, and are measured at fair value in the balance sheet. The maturities of these securities do not exceed one year. Investment income or loss (including unrealized and realized gains and losses) is included in the combined excess of revenues over expenses.

#### Inventories

Inventories, consisting principally of supplies, are stated at the lower of average cost or market value.

#### Derivative and Hedging Instruments

Sharp recognizes all derivatives on its combined balance sheets at fair value. Derivatives that are not hedges are adjusted to fair value through the combined statements of operations. If the derivative is a hedge, depending on the nature of the hedge, changes in the fair values of the derivatives are offset against either the change in fair value of assets or liabilities. The ineffective portion of a derivative's change in fair value, if any, is immediately recognized in the combined excess of revenues over expenses.

In 2003, Sharp entered into a floating-to-fixed interest rate swap which is designed to hedge the variability of the cash flows for Sharp's variable rate revenue bonds. In 2004, Sharp entered into a fixed-spread basis swap. The interest rate swap is designed to improve Sharp's cash position through the term of the contract. In 2006, Sharp entered into a fixed-spread yield curve swap. The yield curve swap is designed to hedge the variability of cash flows on Sharp's variable rate bonds and variable rate swap agreements in exchange for an improved cash position through the term of the contract (see Note 6).

# Sharp HealthCare

## Notes to Combined Financial Statements (continued)

### 1. Summary of Significant Accounting Policies (continued)

#### Assets Limited as to Use

Assets limited as to use invested in equity securities with readily determined fair values and investments in debt securities are measured at fair value in the balance sheet and are classified as trading. Investment income or loss (including unrealized and realized gains and losses) is included in the combined excess of revenues over expenses unless the income or loss is restricted by donor or law.

Assets limited as to use primarily include amounts held by trustees under indenture agreements and designated assets set aside by Sharp's Board of Directors (the Board) for future capital improvements, over which the Board retains control and may at its discretion subsequently use for other purposes. Assets limited as to use consist of the following:

***Designated for property*** – The Board has designated cash resources not required for operations as funded depreciation to be used for future capital improvements. With Board approval, this designation may be changed and such funds used for other purposes – \$28,429,000 at September 30, 2010, and \$33,753,000 at September 30, 2009, of such assets are pledged as collateral for notes payable and other liabilities.

***Under bond indentures*** – In accordance with the terms of Sharp's various bond indentures, certain bond proceeds and principal and interest payments have been deposited with a trustee and are limited as to use in accordance with the related indentures.

***Other restricted investments*** – Certain cash and investments are limited as to use for future community benefit and for other purposes.

***Under self-insurance programs*** – Certain cash and investments are restricted under Sharp's professional liability self-insurance program.

#### Property and Equipment

Property and equipment acquisitions are recorded at cost. Depreciation is provided over the estimated useful life of each class of depreciable asset from three to 40 years and is computed using the straight-line method. Equipment under capital lease obligations is amortized on the straight-line method over the shorter of the lease term or the estimated useful life of the equipment. Such amortization is included in depreciation and amortization in the combined financial statements. 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.

# Sharp HealthCare

## Notes to Combined Financial Statements (continued)

### **1. Summary of Significant Accounting Policies (continued)**

Gifts of long-lived assets such as land, buildings, or equipment are reported as unrestricted support 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.

#### **Unamortized Financing Costs**

Costs incurred in obtaining long-term financing are amortized over the terms of the related obligations using the effective interest method.

#### **Temporarily and Permanently Restricted Net Assets**

Temporarily restricted net assets are those whose use by Sharp has been limited by donors to a specific time period or purpose. Permanently restricted net assets have been restricted by donors to be maintained by Sharp in perpetuity.

#### **Accounting for the Impairment or Disposal of Long-Lived Assets**

Sharp accounts for the impairment or disposal of long-lived assets using a future cash flow model to determine whether assets have been impaired. Sharp regularly reviews long-lived assets for circumstances which could indicate carrying values may not be recoverable. No impairments were recorded in 2010 or 2009.

#### **Income from Operations**

Sharp's primary purpose is to provide diversified health care services to the community served by its affiliates. Only those activities directly associated with the furtherance of this purpose are considered operating activities and classified as operating revenues and expenses. Items excluded from income from operations consist of investment income, gains and losses on disposition of property and equipment, changes in the fair value of interest rate swaps, and net income from the foundations.

# Sharp HealthCare

## Notes to Combined Financial Statements (continued)

### **1. Summary of Significant Accounting Policies (continued)**

#### **Excess of Revenues over Expenses**

The accompanying combined statements of operations include excess of revenues over expenses and other changes in unrestricted net assets. Changes in unrestricted net assets which are excluded from excess of revenues over expenses, consistent with industry practice, include permanent transfers of assets to and from affiliates for other than goods and services, long-lived assets acquired using contributions which by donor restriction were to be used for the purposes of acquiring such assets, and pension-related changes other than net periodic pension cost.

#### **Net Patient Service Revenues**

Sharp has agreements with third-party payors that provide for payments to Sharp at amounts different from its established rates. Payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges, and per diem payments. Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods, as final settlements are determined. In the opinion of management, adequate provision has been made for such adjustments.

#### **Premium Revenues**

Sharp has agreements with various employers and health maintenance organizations to provide medical services to subscribing participants. Under these agreements, Sharp receives monthly capitation payments based on the number of participants who have selected Sharp, regardless of services actually performed by Sharp.

#### **Other Revenues**

Other revenues include unrestricted donations, retail pharmacy gross profits, management services, and joint venture income.

# Sharp HealthCare

## Notes to Combined Financial Statements (continued)

### 1. Summary of Significant Accounting Policies (continued)

#### Health Care Service Costs

Sharp contracts with certain health care providers for the provision of medical services to eligible members. These services include primary care and specialty physician services, inpatient and outpatient facility services, pharmacy, and other medical services. Providers are paid on capitated, per diem, and structured fee-for-service bases.

Health care service costs (included in medical fees and purchased services in the accompanying combined statements of operations) are accrued in the period in which the services are provided to enrollees, based in part on estimates, including estimates of medical services provided but not yet reported to Sharp.

#### Charity Care

Sharp provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Because Sharp does not pursue collection of amounts determined to qualify as charity care, such amounts are not reported as revenue. Net patient service revenue reported is net of charity care charges foregone of approximately \$294,604,000 in 2010 and \$269,642,000 in 2009.

#### Donor-Restricted Gifts

Unconditional promises to give cash and other assets to Sharp are reported at fair value at the date the promise is received. Conditional promises to give and indications or intentions to give are reported at fair value at the date the gift becomes unconditional. The gifts are reported as either temporarily or permanently restricted support if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the combined statements of operations as other operating revenues. Donor-restricted contributions whose restrictions are met within the same year as received are reported as unrestricted contributions in the combined financial statements.

# Sharp HealthCare

## Notes to Combined Financial Statements (continued)

### 1. Summary of Significant Accounting Policies (continued)

#### Income Taxes

The principal operations of Sharp are exempt from taxation pursuant to Section 501(c)(3) of the Internal Revenue Code and related California provisions.

Sharp 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. Sharp records a liability for unrecognized tax benefits from uncertain tax positions as discrete tax adjustments in the first interim period that the more likely than not threshold is not met. Sharp 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 September 30, 2010 and 2009, no such assets or liabilities were recorded.

#### Recent Accounting Pronouncements

In May 2009, the Financial Accounting Standards Board (FASB) established the framework for financial accounting and reporting for not-for-profit mergers and acquisitions, and amended the guidance for FASB Accounting Standards Codification (ASC) 350, *Intangibles-Goodwill and Other*, to make it applicable to not-for-profit entities. The accounting for mergers and acquisitions is effective for mergers and acquisitions on or after December 15, 2009. Further, in connection with the adoption of FASB ASC 350, Sharp will no longer amortize any goodwill recorded in connection with mergers and acquisitions, but will be subject to an annual impairment test. FASB ASC 350 will be effective for Sharp for the year ending September 30, 2011. Sharp does not anticipate the adoption of FASB ASC 350 to have a material effect on the combined financial statements.

In August 2010, the FASB issued Accounting Standards Update (ASU) 2010-23, *Healthcare Entities (Topic 954), Measuring Charity Care for Disclosures*, which requires that cost be used as a measurement for charity care disclosure purposes and that cost can be identified as the direct and indirect costs of providing the charity care. It also requires disclosure of the method used to identify or determine such costs. The adoption of ASU 2010-23 is required for Sharp on October 1, 2011, and is not expected to have a material impact on Sharp's combined financial statements.

# Sharp HealthCare

## Notes to Combined Financial Statements (continued)

### 1. Summary of Significant Accounting Policies (continued)

In August 2010, the FASB issued ASU 2010-24, *Healthcare Entities (Topic 954), Presentation of Insurance Claims and Related Insurance Recoveries*, which clarifies that a health care entity should not net insurance recoveries against a related claim liability. Additionally, the amount of the claim liability should be determined without consideration of insurance recoveries. The adoption of ASU 2010-24 is effective for Sharp beginning September 1, 2011, and management is currently evaluating the effect of this guidance on its combined financial statements.

### Reclassifications

Certain 2009 amounts in the combined financial statements have been reclassified to conform to the 2010 presentation.

### 2. Fair Value Measurements

FASB ASC 820 clarifies that fair value is an exit price, representing the amount that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants. As such, fair value is a market-based measurement that should be determined based on assumptions that market participants would use in pricing an asset or liability. As a basis for considering such assumptions, FASB ASC 820 establishes a three-tier fair value hierarchy, which prioritizes the inputs used in measuring fair value as follows:

- Level 1: Pricing is based on observable inputs such as quoted prices in active markets. Financial assets and liabilities in Level 1 include U.S. Treasury securities and listed equities.
- 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 or liabilities. Financial assets and liabilities in this category generally include corporate bonds, U.S. government agency securities, commercial paper, fixed income funds, mortgage-backed securities, interest rate swaps, and commingled plan trust funds.

# Sharp HealthCare

## Notes to Combined Financial Statements (continued)

### 2. Fair Value Measurements (continued)

- Level 3: Pricing inputs are generally unobservable and include situations where there is little, if any, market activity for the investment. The inputs into the determination of fair value require management's judgment or estimation of assumptions that market participants would use in pricing the assets or liabilities. The fair values are therefore determined using factors that involve considerable judgment and interpretations, including not but limited to private and public comparables, third-party appraisals, discounted cash flow models, and fund manager estimates. Sharp does not hold any financial assets that would be included in this category.

Assets and liabilities measured at fair value are based on one or more of three valuation techniques noted in FASB ASC 820 as identified below. The valuation techniques are as follows:

- (a) Market approach. Prices and other relevant information generated by market transactions involving identical or comparable assets or liabilities. This technique was utilized for all Level 1 investments.
- (b) Cost approach. Amount that would be required to replace the service capacity of an asset (replacement cost). This technique was utilized for all Level 2 investments except for the interest rate swaps.
- (c) Income approach. Techniques to convert future amounts to a single present amount based on market expectations (including present value techniques, option-pricing, and excess earnings model). This technique was utilized for the interest rate swaps.

Sharp's investments in partnerships, limited liability companies, and similarly structured entities amounting to approximately \$6,703,000 and \$5,397,000 as of September 30, 2010 and 2009, respectively, are accounted for using the equity method of accounting, which is not a fair value measurement.

## Sharp HealthCare

### Notes to Combined Financial Statements (continued)

#### 2. Fair Value Measurements (continued)

The following table provides the composition of certain investment assets as of September 30, 2010. Only assets and liabilities measured at fair value are shown in the three-tier fair value hierarchy.

September 30, 2010	Quoted Prices In Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
<i>(In Thousands)</i>			
Cash and cash equivalents	\$ 154,749	\$ 154,749	\$ —
Short-term investments:			
U.S. Treasury obligations	\$ 23,131	\$ 23,131	\$ —
Corporate bonds	6,590	—	6,590
U.S. government agencies	5,603	—	5,603
Commercial paper	5,979	—	5,979
Interest receivable	1,467	—	1,467
	\$ 42,770	\$ 23,131	\$ 19,639
Assets limited as to use:			
Designated for property:			
Cash and cash equivalents	\$ 3,802	\$ 3,802	\$ —
Equities	147,383	147,383	—
U.S. Treasury obligations	69,284	69,284	—
Corporate bonds	209,660	—	209,660
U.S. government agencies	86,793	—	86,793
Interest receivable	2,314	—	2,314
	\$ 519,236	\$ 220,469	\$ 298,767

# Sharp HealthCare

## Notes to Combined Financial Statements (continued)

### 2. Fair Value Measurements (continued)

	September 30, 2010	Quoted Prices In Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
<i>(In Thousands)</i>				
Under bond indentures:				
Cash and cash equivalents	\$ 661	\$ 661	\$ —	\$ —
U.S. Treasury obligations	26,304	26,304	—	—
Corporate bonds	1,178	—	1,178	—
U.S. government agencies	15,644	—	15,644	—
Commercial paper	7,765	—	7,765	—
Interest receivable	222	—	222	—
	<u>\$ 51,774</u>	<u>\$ 26,965</u>	<u>\$ 24,809</u>	<u>\$ —</u>
Other restricted investments:				
Cash and cash equivalents	\$ 2,858	\$ 2,858	\$ —	\$ —
Equities	19,331	19,331	—	—
U.S. Treasury obligations	3,938	3,938	—	—
Corporate bonds	6,083	—	6,083	—
U.S. government agencies	2,353	—	2,353	—
Fixed income funds	2,779	—	2,779	—
Mortgage-backed securities	697	—	697	—
	<u>\$ 38,039</u>	<u>\$ 26,127</u>	<u>\$ 11,912</u>	<u>\$ —</u>

# Sharp HealthCare

## Notes to Combined Financial Statements (continued)

### 2. Fair Value Measurements (continued)

	September 30, 2010	Quoted Prices		
		In Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
<i>(In Thousands)</i>				
Under self-insurance programs:				
U.S. Treasury obligations	\$ 2,141	\$ 2,141	\$ —	\$ —
Corporate bonds	3,894	—	3,894	—
U.S. government agencies	2,008	—	2,008	—
	<u>\$ 8,043</u>	<u>\$ 2,141</u>	<u>\$ 5,902</u>	<u>\$ —</u>
Interest rate swaps	\$ 3,850	\$ —	\$ 3,850	\$ —
	<u>\$ 3,850</u>	<u>\$ —</u>	<u>\$ 3,850</u>	<u>\$ —</u>

The following table provides the composition of certain investment assets as of September 30, 2009. Only assets and liabilities measured at fair value are shown in the three-tier fair value hierarchy.

	September 30, 2009	Quoted Prices		
		In Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
<i>(In Thousands)</i>				
Cash and cash equivalents	\$ 150,611	\$ 150,611	\$ —	\$ —
Short-term investments:				
Cash and cash equivalents	\$ 3,400	\$ 3,400	\$ —	\$ —
U.S. Treasury obligations	43,623	43,623	—	—
Corporate bonds	19,025	—	19,025	—
U.S. government agencies	1,533	—	1,533	—
Commercial paper	5,893	—	5,893	—
Interest receivable	2,150	—	2,150	—
	<u>\$ 75,624</u>	<u>\$ 47,023</u>	<u>\$ 28,601</u>	<u>\$ —</u>

# Sharp HealthCare

## Notes to Combined Financial Statements (continued)

### 2. Fair Value Measurements (continued)

	September 30, 2009	Quoted Prices In Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
<i>(In Thousands)</i>				
Assets limited as to use:				
Designated for property:				
Cash and cash equivalents	\$ 9,364	\$ 9,364	\$ —	\$ —
Equities	63,926	63,926	—	—
U.S. Treasury obligations	55,472	55,472	—	—
Corporate bonds	130,757	—	130,757	—
U.S. government agencies	69,172	—	69,172	—
Commercial paper	495	—	495	—
Interest receivable	906	—	906	—
	<u>\$ 330,092</u>	<u>\$ 128,762</u>	<u>\$ 201,330</u>	<u>\$ —</u>
Under bond indentures:				
Cash and cash equivalents	\$ 18,115	\$ 18,115	\$ —	\$ —
U.S. Treasury obligations	3,716	3,716	—	—
Corporate bonds	875	—	875	—
U.S. government agencies	32,134	—	32,134	—
Commercial paper	7,802	—	7,802	—
Interest receivable	335	—	335	—
	<u>\$ 62,977</u>	<u>\$ 21,831</u>	<u>\$ 41,146</u>	<u>\$ —</u>
Other restricted investments:				
Cash and cash equivalents	\$ 2,558	\$ 2,558	\$ —	\$ —
Equities	17,724	17,724	—	—
U.S. Treasury obligations	3,299	3,299	—	—
Corporate bonds	4,533	—	4,533	—
U.S. government agencies	1,947	—	1,947	—
Mortgage-backed securities	547	—	547	—
	<u>\$ 30,608</u>	<u>\$ 23,581</u>	<u>\$ 7,027</u>	<u>\$ —</u>

# Sharp HealthCare

## Notes to Combined Financial Statements (continued)

### 2. Fair Value Measurements (continued)

	<b>September 30, 2009</b>	<b>Quoted Prices In Active Markets for Identical Assets (Level 1)</b>	<b>Significant Other Observable Inputs (Level 2)</b>	<b>Significant Unobservable Inputs (Level 3)</b>
<i>(In Thousands)</i>				
Under self-insurance programs:				
U.S. Treasury obligations	\$ 1,933	\$ 1,933	\$ —	\$ —
Corporate bonds	3,293	—	3,293	—
U.S. government agencies	1,791	—	1,791	—
	<b>\$ 7,017</b>	<b>\$ 1,933</b>	<b>\$ 5,084</b>	<b>\$ —</b>
Interest rate swaps	\$ 3,513	\$ —	\$ 3,513	\$ —
	<b>\$ 3,513</b>	<b>\$ —</b>	<b>\$ 3,513</b>	<b>\$ —</b>

### 3. Net Patient Service Revenue

Sharp has agreements with third-party payors that provide for payments to Sharp at amounts different from its established rates.

The Medicare program reimburses Sharp at prospectively determined rates for the major portion of inpatient and outpatient services rendered to patients, primarily on the basis of Medicare Severity Diagnosis Related Groups (MS-DRGs) and Ambulatory Payment Classification Groups (APCs), respectively.

Nonacute inpatient services, defined capital costs, and certain outpatient costs are paid based on a cost reimbursement methodology. When paid under cost reimbursement, Sharp is reimbursed at the interim rate with final settlement determined after submission of annual cost reports and audits by the fiscal intermediaries. The Medi-Cal program reimburses Sharp primarily on prospectively determined rates for inpatient and outpatient services.

# Sharp HealthCare

## Notes to Combined Financial Statements (continued)

### 3. Net Patient Service Revenue (continued)

Revenue from the Medicare and Medi-Cal programs accounted for approximately 31% and 19%, respectively, of Sharp's gross patient charges for the year ended September 30, 2010, and 31% and 18%, respectively, of Sharp's gross patient charges for the year ended September 30, 2009. Laws and regulations governing Medicare and Medi-Cal programs are complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term.

Net patient service revenue includes changes in estimate which increased revenue by \$13,618,000 in 2010 and decreased revenue by \$6,484,000 in 2009 which includes the impact of settlements of prior years' reimbursement from Medicare, Medi-Cal, and Champus programs. The 2010 change in estimate above is primarily the result of the impact of Medicare appeal settlements. Included in the 2009 amount above is the impact to disproportionate share (DSH) reimbursement based on the Supplemental Security Income (SSI) ratio for 2007 published in the Federal Register during 2009. The most current year published results are used by both the Centers for Medicare and Medicaid Services (CMS) and Sharp to estimate the DSH payments for the applicable year and all future years. The 2007 results showed a decrease in Sharp's SSI percentages, ranging from -4.2% to -6.0% for the three Sharp hospitals that qualify for DSH reimbursement. This decrease equates to an estimated reduction in total DSH payments of \$5,400,000 for 2007 and \$5,900,000 for 2008 which were recorded in 2009 and are included in the disclosed net prior year settlement amounts for 2009.

Sharp also has entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payment to Sharp under these agreements includes prospectively determined rates per discharge, discounts from established charges, and prospectively determined daily rates.

Sharp grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of receivables from significant payors was as follows:

	<b>September 30</b>	
	<b>2010</b>	<b>2009</b>
Medicare	<b>14%</b>	13%
Medi-Cal	<b>15%</b>	16%
Private Pay	<b>28%</b>	25%

## Sharp HealthCare

### Notes to Combined Financial Statements (continued)

#### 4. Investment Income

Investment income for assets limited as to use, short-term investments, and cash equivalents are comprised of the following:

	<b>Year Ended September 30</b>	
	<b>2010</b>	<b>2009</b>
	<i>(In Thousands)</i>	
Interest income	\$ 12,580	\$ 11,063
Unrealized gains, net	22,389	7,284
Realized gains, net	3,491	3,017
	<u>\$ 38,460</u>	<u>\$ 21,364</u>

#### 5. Property and Equipment

Property and equipment consists of the following:

	<b>September 30</b>	
	<b>2010</b>	<b>2009</b>
	<i>(In Thousands)</i>	
Land and improvements	\$ 50,309	\$ 50,119
Buildings and improvements	896,935	837,952
Equipment and furniture	716,752	662,147
Construction-in-progress	53,527	97,820
	<u>1,717,523</u>	<u>1,648,038</u>
Less accumulated depreciation and amortization	<u>(926,853)</u>	<u>(861,073)</u>
	<u>\$ 790,670</u>	<u>\$ 786,965</u>

Depreciation and amortization expense for the years ended September 30, 2010 and 2009, amounted to approximately \$81,250,000 and \$77,752,000, respectively. Included in these amounts is amortization for buildings and equipment under capital lease obligations. Sharp has approximately \$8,160,000 and \$7,971,000 at September 30, 2010 and 2009, respectively, of buildings and equipment under capital lease, at cost. Sharp has outstanding commitments to complete construction-in-progress totaling approximately \$62,244,000 at September 30, 2010.

# Sharp HealthCare

## Notes to Combined Financial Statements (continued)

### 5. Property and Equipment (continued)

On May 29, 1991, Sharp leased the Grossmont Hospital (the Hospital) existing campus land, buildings, and equipment from the Grossmont Healthcare District (the District). The lease provides for a 30-year term ending May 29, 2021, at \$1 per year. Unless extended, the buildings, improvements, and equipment acquired by the Hospital since the inception of the lease will revert to the District at the end of the lease term.

The Hospital and the District initiated, in 2006, a project for the construction of three shelled floors in the Emergency and Critical Care Center, central plant upgrades, infrastructure improvements, and facility renovations (the Project). The Project is funded using the proceeds of general obligation (GO) bonds. In July 2007, \$85,500,000 in GO bonds were issued by the District. The next offering of the GO bonds is expected in 2011. Sharp considers the District to be a related party based upon these relationships between Sharp and the District.

The Hospital is not required to make any payments to the District with respect to the contribution to the Project of assets constructed using the GO bond proceeds. Therefore, the GO bonds have not been included in the combined financial statements as a liability of Sharp. The portion of the Project funded with the GO bonds is being recognized as a transfer of net assets from the District as the Project is completed. In fiscal 2010 and 2009, the Hospital recorded \$9,344,000 and \$24,701,000, respectively, of construction in progress and a related transfer of net assets for the portion of the Project completed during the year with proceeds of the GO bonds.

### 6. Long-Term Debt

Long-term debt consists of the following:

	<b>September 30</b>	
	<b>2010</b>	<b>2009</b>
	<i>(In Thousands)</i>	
Series 2009B Revenue Bonds (Series 2009B Bonds) collateralized by revenues of the Obligated Group. Principal due in annual amounts ranging from \$1,640,000 in 2022 to \$24,900,000 in 2039. Interest payable semiannually at rates ranging from 6.000% to 6.375%. The borrowing amount is net of the unamortized original issue discount of \$2,614,000 at September 30, 2010. The bonds include issuer call features totaling \$30,025,000 and \$109,975,000 in 2014 and 2019, respectively.	<b>\$ 137,386</b>	<b>\$ 137,291</b>

## Sharp HealthCare

### Notes to Combined Financial Statements (continued)

#### 6. Long-Term Debt (continued)

	September 30	
	2010	2009
	<i>(In Thousands)</i>	
<p>Series 2009C and Series D Variable Rate Revenue Bonds (Series 2009C and D Bonds), collateralized by a three-year direct-pay letter of credit reimbursement agreement between Obligated Group and a bank. Principal is due in annual amounts ranging from \$145,000 in 2022 to \$11,805,000 in 2035. Letter of Credit is renewable in 2012. Interest is payable monthly at a variable rate (0.25% at September 30, 2010).</p>	<b>\$ 99,880</b>	\$ 99,880
<p>County of San Diego Certificates of Participation issued in 1998 collateralized by revenues of the Obligated Group. Principal due in annual installments ranging from \$3,695,000 in 2011 to \$5,705,000 in 2028. Interest payable semiannually at rates ranging from 4.70% to 5.25% through 2028. The borrowing amount is net of the unamortized original issue discount of \$767,000 at September 30, 2010.</p>	<b>82,408</b>	86,700
<p>Series 2001A Revenue Bonds collateralized by revenues of the Obligated Group. Principal due in annual amounts ranging from \$4,235,000 in 2011 to \$7,225,000 in 2020. Interest payable annually at rates ranging from 5.500% to 6.125% through 2020. The borrowing amount is net of the unamortized original issue discount of \$24,000 at September 30, 2010.</p>	<b>56,086</b>	60,100
<p>Series 2009A Variable Rate Revenue Bonds (Series 2009A Bonds) collateralized by a three-year direct-pay letter of credit reimbursement agreement between Obligated Group and a bank. Principal due in annual amounts ranging from \$3,125,000 in 2011 to \$5,360,000 in 2024. Letter of Credit is renewable in 2012. Interest is payable monthly at a variable rate (0.26% at September 30, 2010).</p>	<b>54,010</b>	57,065

## Sharp HealthCare

### Notes to Combined Financial Statements (continued)

#### 6. Long-Term Debt (continued)

	September 30	
	2010	2009
	<i>(In Thousands)</i>	
Series 2003C Revenue Bonds collateralized by revenues of the Obligated Group. Principal due in annual amounts ranging from \$580,000 in 2011 to \$16,265,000 in 2021. Interest payable annually at rates ranging from 5.125% to 5.375% through 2021. The borrowing amount is net of the unamortized original issue discount of \$71,000 at September 30, 2010.	<b>\$ 26,449</b>	\$ 27,145
Reverse Repurchase Agreement collateralized by U.S. Treasury securities. Principal due in February 2013. Interest payable quarterly at a variable rate (0.637% at September 30, 2010).	<b>15,500</b>	15,500
Series 1988A Insured Hospital Revenue Bonds collateralized by revenues of the Obligated Group. Principal due in annual amounts ranging from \$1,200,000 in 2011 to \$1,900,000 in 2018. Interest payable every 35 days at a variable rate (0.486% at September 30, 2010).	<b>12,300</b>	13,400
Tax-Exempt Financing collateralized by equipment. Interest and principal paid in monthly installments at a rate of 3.86% through 2011.	<b>5,422</b>	12,412
Medical office building mortgage collateralized by the building. Interest and principal paid in monthly installments at a rate of 5.390% through 2014 when a final principal payment of \$7,735,000 is due.	<b>8,388</b>	8,549
Capital lease obligations at a 6.00% imputed rate of interest collateralized by leased building or equipment.	<b>6,698</b>	6,924
Other debt including the fair value of interest rate swaps	<b>3,945</b>	3,666
Total	<b>508,472</b>	528,632
Less current portion	<b>(18,673)</b>	(19,657)
	<b>\$ 489,799</b>	\$ 508,975

## Sharp HealthCare

### Notes to Combined Financial Statements (continued)

#### **6. Long-Term Debt (continued)**

In 2009, Sharp issued Series 2009A Bonds in the amount of \$60,000,000. The Series 2009A Bonds proceeds were used to redeem the line of credit that was utilized to refund the Series 2003A and B Bonds in the amounts of \$44,900,000 and \$15,100,000 respectively. The Series 2009A Bonds are variable rate revenue bonds priced weekly by bid with interest paid monthly computed on the basis of a 365- or 366-day year for the actual number of days elapsed.

In 2009, Sharp issued Series 2009B Bonds in the amount of \$140,000,000 that had an original issue discount of \$2,734,000. The Series 2009B Bonds proceeds are being utilized to reimburse construction projects at SMH, fund ongoing capital project expenditures, redeem the \$12,500,000 line of credit used to refund the Series 2003A and B Bonds, and to fund a debt service reserve fund in the amount of approximately \$12,393,000.

In 2009, Sharp issued Series 2009C and D Bonds in the amounts of \$50,000,000 and \$49,880,000, respectively. The proceeds were utilized to refinance the Series 2007A and B Bonds in the amounts of \$57,065,000 and \$42,815,000, respectively. The Series 2009C and D Bonds are variable rate revenue bonds priced weekly by bid with interest paid monthly computed on the basis of a 365- or 366-day year for the actual number of days elapsed.

On January 30, 2009, Sharp purchased a medical office building and assumed the \$8,652,000 mortgage collateralized by the building.

Under the terms of the 2001A, 2003C, and 2009B Revenue Bonds, Sharp is required to maintain certain deposits with a trustee. Such deposits are included with assets limited as to use. Sharp's loan agreements include, among other things, certain financial covenants, limitations on additional indebtedness, and limitations on sales/leaseback transactions. Sharp was in compliance with such covenants and limitations at September 30, 2010 and 2009.

## Sharp HealthCare

### Notes to Combined Financial Statements (continued)

#### 6. Long-Term Debt (continued)

Scheduled principal payments on long-term debt and payments on capital lease obligations for years ending September 30 are as follows (in thousands):

	<b>Long-Term Debt</b>	<b>Capital Lease Obligations</b>
2011	\$ 18,478	\$ 195
2012	13,680	208
2013	29,782	220
2014	22,601	226
2015	15,435	205
Thereafter	401,425	5,644

A summary of interest cost on borrowed funds follows:

	<b>Year Ended September 30</b>	
	<b>2010</b>	<b>2009</b>
	<i>(In Thousands)</i>	
Interest cost:		
Capitalized	\$ 579	\$ 1,920
Charged to operations	24,849	22,011
	<b>\$ 25,428</b>	<b>\$ 23,931</b>

#### Interest Rate Swaps

During 2003, Sharp entered into a floating-to-fixed interest rate swap on the Series 2003A and B Bonds which were refunded in 2009. The swap agreement hedges an initial notional amount of \$109,650,000 at a fixed payer rate of 3.01% for the entire swap term which expires on August 1, 2024, and will receive 59% of one-month LIBOR plus 0.14%, for the remaining term of the swap. Settlements are made weekly. Cash paid on the interest rate swap was \$2,314,000 in 2010 and \$2,084,000 in 2009, which increased Sharp's overall cost of borrowing and was included in interest expense. In September 2008, Sharp HealthCare voluntarily discontinued the use of shortcut accounting on its floating-to-fixed interest rate swap on the Series 2003A and B Bonds. The historical mark to market activity was to be amortized into non-operating income over the term of the bonds. Due to refunding of the Series 2003A and B Bonds that occurred in 2009, the historical mark to market activity was reclassified to non-operating income in 2009 resulting in a

## Sharp HealthCare

### Notes to Combined Financial Statements (continued)

#### 6. Long-Term Debt (continued)

\$1,221,000 favorable adjustment. The change in fair value of the swap decreased non-operating income by \$2,326,000 in 2010 and \$3,882,000 in 2009.

During 2004, Sharp entered into a fixed-spread basis swap with a bank. The swap arrangement hedges an initial notional amount of \$80,000,000 at a fixed payer rate of one-month BMA for the entire swap term which expires on February 3, 2024, and will receive 67% of one-month LIBOR plus 0.55%. Settlements are made quarterly. Cash received on the interest rate swap was \$399,000 in 2010 and \$201,000 in 2009, which reduced Sharp's overall cost of borrowing and was offset against interest expense. The change in fair value of the swap increased non-operating income by \$265,000 in 2010 and \$725,000 in 2009.

During 2006, Sharp entered into a fixed-spread yield curve swap with a bank. The yield curve transaction entails Sharp paying Citibank 67% of one-month LIBOR and receiving 67% of ten-year LIBOR less a market determined fixed spread. Under the terms of the agreement, Sharp may terminate the swap at any time. Cash received on the interest rate swap was \$1,309,000 in 2010 and \$940,000 in 2009, which reduced Sharp's overall cost of borrowing and was offset against interest expense. The change in fair value of the swap increased non-operating income by \$1,750,000 in 2010 and \$2,397,000 in 2009.

#### 7. Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are available for the following purposes:

	<b>September 30</b>	
	<b>2010</b>	<b>2009</b>
	<i>(In Thousands)</i>	
Purchase of equipment	\$ 13,961	\$ 16,394
Hospital programs	13,353	11,845
Hospital departments	9,954	8,973
Health education	6,718	6,052
Research	4,088	3,915
Indigent care	810	525
Total	\$ 48,884	\$ 47,704

# Sharp HealthCare

## Notes to Combined Financial Statements (continued)

### **7. Temporarily and Permanently Restricted Net Assets (continued)**

Permanently restricted net assets of \$6,504,000 and \$5,827,000 at September 30, 2010 and 2009, respectively, represent investments to be held in perpetuity, the income from which is expendable to support health care services.

### **8. Endowments**

Sharp's endowments consist of 44 separate endowment funds included in assets limited as to use established for a variety of purposes. Its endowment includes both donor-restricted endowment funds and funds designated by the Board of Directors of Sharp's affiliated foundations to function as endowments. As required by GAAP, net assets associated with endowment funds, including funds designated by the Board of Directors to function as endowments, are classified and reported based on the existence or absence of donor-imposed restrictions.

On September 30, 2008, California Senate Bill No. 1329 was signed into law which enacted the Uniform Prudent Management of Institutional Funds Act (UPMIFA) for California. California also adopted one of the "optional" provisions of the act, creating a rebuttable presumption of imprudence for spending more than 7% of the value of an endowment fund in one year (based on a three-year rolling average). The Board has interpreted UPMIFA as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. As a result of this interpretation, Sharp classifies as permanently restricted net assets (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to the permanent endowment, and (c) 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. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure by Sharp in a manner consistent with the standard of prudence prescribed by UPMIFA. In accordance with UPMIFA, Sharp considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds: (1) the duration and preservation of the fund, (2) the purposes of Sharp and the donor-restricted endowment fund, (3) general economic conditions, (4) the possible effect of inflation and deflation, (5) the expected total return from income and the appreciation of investments, (6) other resources of Sharp, and (7) the investment policies of Sharp.

## Sharp HealthCare

### Notes to Combined Financial Statements (continued)

#### 8. Endowments (continued)

The endowment net asset composition as of September 30, 2010, by fund type was as follows:

	<b>Temporarily Restricted</b>	<b>Permanently Restricted</b>	<b>Total</b>
<i>(In Thousands)</i>			
Board-designated endowment funds	\$ 607	\$ –	\$ 607
Donor-restricted endowment funds	3,845	6,504	10,349
<b>Total funds</b>	<b>\$ 4,452</b>	<b>\$ 6,504</b>	<b>\$ 10,956</b>

The endowment net asset composition as of September 30, 2009, by fund type was as follows:

	<b>Temporarily Restricted</b>	<b>Permanently Restricted</b>	<b>Total</b>
<i>(In Thousands)</i>			
Board-designated endowment funds	\$ 547	\$ –	\$ 547
Donor-restricted endowment funds	2,583	5,827	8,410
<b>Total funds</b>	<b>\$ 3,130</b>	<b>\$ 5,827</b>	<b>\$ 8,957</b>

Sharp has adopted investment and spending policies for endowment assets that attempt to provide a stream of funding to programs supported by its endowment while balancing the risk of investment loss with long-term preservation of purchasing power. Endowment assets include those assets of donor-restricted funds that Sharp must hold in perpetuity or for a donor-specified period as well as board-designated funds.

Sharp targets a diversified asset allocation that places greater emphasis on equity-based investments to achieve its long-term return objectives within prudent risk constraints. Sharp's spending policy is to annually appropriate for distribution no more than 4% per year of each endowment fund's average fair value (based on a two-year rolling average).

## Sharp HealthCare

### Notes to Combined Financial Statements (continued)

#### 8. Endowments (continued)

	<b>Temporarily Restricted</b>	<b>Permanently Restricted</b>	<b>Total</b>
	<i>(In Thousands)</i>		
Endowment net assets, October 1, 2008	\$ 3,114	\$ 5,595	\$ 8,709
Investment return:			
Investment income	135	–	135
Net depreciation (realized and unrealized)	(85)	–	(85)
Total investment return	50	–	50
Contributions	75	232	307
Appropriation of endowment asset for expenditure	(109)	–	(109)
Endowment net assets, September 30, 2009	3,130	5,827	8,957
Investment return:			
Investment income (loss)	453	(3)	450
Net appreciation (realized and unrealized)	785	–	785
Total investment return	1,238	(3)	1,235
Contributions	150	680	830
Appropriation of endowment asset for expenditure	(66)	–	(66)
Endowment net assets, September 30, 2010	<b>\$ 4,452</b>	<b>\$ 6,504</b>	<b>\$ 10,956</b>

#### 9. Functional Expenses

Sharp provides general health care services to residents within its geographic locations. Expenses related to providing these services are as follows:

	<b>Year Ended September 30</b>	
	<b>2010</b>	<b>2009</b>
	<i>(In Thousands)</i>	
Hospital patient services	<b>\$ 1,514,132</b>	\$ 1,430,285
Clinic patient services	<b>317,887</b>	295,406
General and administrative	<b>174,008</b>	167,351
Purchased services under capitated agreements	<b>112,283</b>	112,632
	<b>\$ 2,118,310</b>	<b>\$ 2,005,674</b>

## Sharp HealthCare

### Notes to Combined Financial Statements (continued)

#### 10. Pension Plans

Sharp sponsors a voluntary retirement plan (the Plan) which consists of a defined benefit cash balance plan and a defined contribution plan. Under the defined contribution element of the Plan, Sharp made matching contributions of \$12,368,000 in 2010 and \$10,626,000 in 2009.

The following sets forth the funded status of the Sharp's defined benefit pension plan at September 30:

	<b>2010</b>	<b>2009</b>
	<i>(In Thousands)</i>	
Change in benefit obligation:		
Benefit obligation at beginning of year	\$ <b>202,292</b>	\$ 147,742
Service cost	<b>8,173</b>	3,727
Interest cost	<b>10,960</b>	11,441
Actuarial loss	<b>21,131</b>	48,536
Benefits paid	<b>(9,592)</b>	(9,154)
Benefit obligation at end of year	<b>232,964</b>	202,292
Change in plan assets:		
Fair value of plan assets at beginning of year	<b>128,190</b>	113,692
Actual return on plan assets	<b>15,784</b>	4,304
Plan participants' contributions	<b>5,154</b>	4,802
Employer contributions	<b>19,128</b>	14,546
Benefits paid	<b>(9,592)</b>	(9,154)
Fair value of plan assets at end of year	<b>158,664</b>	128,190
Funded status	<b>\$ (74,300)</b>	\$ (74,102)

The net liability, recognized in the balance sheet in long-term liabilities, was \$74,300,000 and \$74,102,000 at September 30, 2010 and 2009, respectively.

# Sharp HealthCare

## Notes to Combined Financial Statements (continued)

### 10. Pension Plans (continued)

Included in unrestricted net assets at September 30 are the following amounts that have not yet been recognized in net periodic pension cost:

	<b>2010</b>	<b>2009</b>
	<i>(In Thousands)</i>	
Prior service cost	\$ <b>5,581</b>	\$ 6,826
Net actuarial loss	<b>97,456</b>	96,233
	<b>\$ 103,037</b>	\$ 103,059

Additional information for the plan:

	<b>September 30</b>	
	<b>2010</b>	<b>2009</b>
	<i>(In Thousands)</i>	
Projected benefit obligation	\$ <b>232,964</b>	\$ 202,292
Accumulated benefit obligation	<b>214,251</b>	185,587
Fair value of plan assets	<b>158,664</b>	128,190

Net periodic pension cost includes the following components for the years ended September 30:

	<b>2010</b>	<b>2009</b>
	<i>(In Thousands)</i>	
Service cost	\$ <b>8,173</b>	\$ 3,727
Interest cost	<b>10,960</b>	11,441
Expected return on plan assets	<b>(10,805)</b>	(9,610)
Recognized net actuarial loss	<b>9,774</b>	5,299
Amortization of prior service cost	<b>1,245</b>	1,245
Net periodic pension cost	<b>\$ 19,347</b>	\$ 12,102

## Sharp HealthCare

### Notes to Combined Financial Statements (continued)

#### 10. Pension Plans (continued)

Weighted-average assumptions used to determine benefit obligations were:

	<b>September 30</b>	
	<b>2010</b>	<b>2009</b>
Discount rate	<b>4.89%</b>	5.63%
Rate of compensation increase	<b>4.50%</b>	5.00%

Weighted-average assumptions used to determine net periodic pension cost were:

	<b>September 30</b>	
	<b>2010</b>	<b>2009</b>
Discount rate	<b>5.63%</b>	7.87%
Expected return on plan assets	<b>8.00%</b>	8.00%
Rate of compensation increase	<b>4.50%</b>	5.00%

The expected rate of return on plan assets is updated annually, taking into consideration the plan's asset allocation, historical returns on the types of assets held in the pension trust, and the current economic environment.

#### Plan Assets

The Plan's assets are invested in an institutional trust company commingled employee benefit plan trust (Commingled Plan Trust). As of September 30, 2010 and 2009, the Plan's target allocation and the allocation of investments in the Commingled Plan Trust were as follows:

	<b>Target allocation</b>	<b>2010</b>	<b>2009</b>
Asset category:			
Equity securities	61% – 69%	<b>64%</b>	66%
Fixed income	31% – 39%	<b>36</b>	34
Total		<b>100%</b>	100%

# Sharp HealthCare

## Notes to Combined Financial Statements (continued)

### 10. Pension Plans (continued)

Plan assets are managed according to an investment policy adopted by Sharp's Retirement Committee. Professional investment managers are retained to manage plan assets. The primary objective of the Plan is to generate a consistent total investment return sufficient to pay present and future Plan benefits to retirees. The investment policy includes an asset allocation that includes equities and fixed income instruments. The target mix represents a long-term asset allocation strategy for the Plan. Although the Retirement Committee will seek to maintain the target mix over the long-term, short-term deviations may occur due to market impact and cash flow. The timing and degree of rebalancing of the actual portfolio will be determined by the Retirement Committee.

Financial assets and financial liabilities measured at fair value are grouped in three levels, based on the markets in which the assets and liabilities are traded and the reliability of the assumptions used to estimate fair value. These levels and associated valuation methodologies are described in Note 2. All of the Plan's investments in the Commingled Plan Trust are in the Level 2 fair value group at September 30, 2010 and 2009.

#### Contributions

Sharp expects to contribute \$7,114,000 to the Plan in 2011.

#### Estimated Future Benefit Payments

The following benefit payments, which reflect expected future service, as appropriate, are expected to be paid (in thousands):

2011	\$ 12,268
2012	13,823
2013	14,688
2014	15,140
2015	16,233
2016 – 2020	100,048

# Sharp HealthCare

## Notes to Combined Financial Statements (continued)

### 11. Commitments and Contingencies

#### Leases

Sharp leases various equipment and facilities under operating leases expiring at various dates through 2023. Total rental expense in 2010 and 2009 for all operating leases was \$27,659,000 and \$26,362,000, respectively.

The following is a schedule by year of future minimum lease payments (in thousands) under operating leases as of September 30, 2010, that have initial or remaining lease terms in excess of one year.

2011	\$ 20,971
2012	17,180
2013	14,435
2014	11,144
2015	10,179
Thereafter	<u>21,340</u>
	<u>\$ 95,249</u>

#### Legal Matters

The health care industry is subject to numerous laws and regulations of federal, state and local governments. These laws and regulations are subject to ongoing government review and interpretations, and include matters such as licensure, accreditation, and reimbursement for patient services. Compliance with these laws and regulations is required for participation in government health care programs. Government activity has increased with respect to investigations and allegations concerning possible violations of regulations by health care providers, which could result in the imposition of significant fines and penalties as well as significant repayment of previously billed and collected revenues for patient services. Sharp believes it is in compliance with current laws and regulations.

In the normal course of business, Sharp is involved in legal proceedings. Sharp accrues a liability for such matters when it is probable that a liability has been incurred and the amount can be reasonably estimated. The accrual for a litigation loss contingency might include, for example, estimates of potential damages, outside legal fees, interest penalties, and other directly related costs expected to be incurred.

# Sharp HealthCare

## Notes to Combined Financial Statements (continued)

### 11. Commitments and Contingencies (continued)

#### Professional Liability and Stop-Loss Insurance

CQI SPC is a wholly owned captive insurance company which insures a portion of the medical malpractice (professional liability) claims of certain affiliates of Sharp. Malpractice losses are accrued based on estimates of the ultimate costs for both reported claims and claims incurred but not reported. Sharp's liability is limited to \$3,000,000 per individual claim and \$13,500,000 in the aggregate each year. Sharp has obtained excess loss insurance covering claims above these amounts up to \$40,000,000.

General and professional liability costs have been accrued based upon an actuarial determination. Accrued malpractice losses have been discounted at 3.0% at September 30, 2010 and 2009.

Claims, including alleged malpractice, have been asserted against Sharp and are currently in various stages of litigation. Additional claims may be asserted against Sharp arising from services provided to patients through September 30, 2010. In management's opinion, however, the estimated liability accrued at September 30, 2010, is adequate to provide for potential losses resulting from pending or threatened litigation. It is management's opinion that the ultimate disposition of such litigation will not have a material adverse effect on the combined financial position, results of operations, or cash flows of Sharp.

#### Sharp Health Plan

SHP is required to meet certain financial responsibility regulations of the California Department of Managed Healthcare (DMHC). Pursuant to these regulations, SHP maintains a reserve totaling \$300,000 on deposit with various financial institutions. In addition, SHP is required to maintain two times the normal requirement of tangible net equity, as defined in regulations of the DMHC. At September 30, 2010 and 2009, SHP was required to maintain tangible net equity totaling \$7,031,000 and \$6,968,000, respectively. SHP's tangible net equity was \$30,385,000 at September 30, 2010, and \$26,294,000 at September 30, 2009. Management believes they are in compliance with these requirements at September 30, 2010 and 2009.

# Sharp HealthCare

## Notes to Combined Financial Statements (continued)

### 11. Commitments and Contingencies (continued)

#### Unemployment Claims and Workers' Compensation

Sharp has elected to self-insure for unemployment claims through various group plans. Prior to January 1, 1996, Sharp was also self-insured for workers' compensation claims. Since 1996, Sharp has purchased high deductible insurance policies and has been responsible for workers' compensation claims up to amounts covered by these insurance policies (Sharp was responsible for individual claims up to \$1,000,000 in 2010 and 2009). For workers' compensation, Sharp accrues for the unpaid portion of claims that have been reported and estimates of claims that have been incurred but not reported, based on an actuarial study. Accrued workers' compensation losses have been discounted at 2.2% and 1.90% at September 30, 2010 and 2009, respectively.

#### Seismic Standards (Unaudited)

Sharp has made significant progress toward meeting earthquake retrofit requirements for its health care facilities under a State of California law. The new Stephen Birch tower at SMH meets all new code requirements. In addition, many of the other hospitals have been further assessed and reclassified, and have received extensions for compliance until 2030. Only two of the remaining hospital buildings in the Sharp system require additional seismic improvements. These two hospital buildings received an extension for compliance with seismic standards through January 1, 2015, and expect to apply for additional extensions as permitted by law.

#### Credit Facilities

Sharp has a \$50,000,000 line of credit with a bank which expires on September 30, 2011, of which \$17,600,000 and \$16,100,000 was available at September 30, 2010 and 2009, respectively. As part of the workers' compensation insurance agreement, letters of credit have been provided as collateral. The total letters of credit used as collateral totaled \$32,400,000 and \$33,900,000 as of September 30, 2010 and 2009, respectively. These letters of credit are each considered a decrease in the available \$50,000,000 line of credit with the bank. There are no amounts outstanding as of September 30, 2010 and 2009.

Sharp has a bank liquidity facility to provide credit enhancement and liquidity support for the \$60,000,000 of Series 2009A Bonds. The bank liquidity facility was executed in February 2009 by a bank letter of credit that expires in February 2012. The letter of credit used as collateral totaled \$54,631,000 at September 30, 2010.

# Sharp HealthCare

## Notes to Combined Financial Statements (continued)

### 11. Commitments and Contingencies (continued)

Sharp has a bank liquidity facility to provide credit enhancement and liquidity support for the \$99,880,000 of Series 2009C and D Bonds. The bank liquidity facility was executed in September 2009 by a bank letter of credit that expires in September 2012. The total letters of credit used as collateral totaled \$101,391,000 at September 30, 2010.

### 12. Fair Value of Financial Instruments

The following methods and assumptions were used by Sharp in estimating fair value of its financial instruments:

*Cash and cash equivalents:* The carrying amount reported in the balance sheet for cash and cash equivalents approximates fair value.

*Estimated settlements payable to government programs:* The carrying amount reported in the balance sheet for estimated third-party payor settlements approximates its fair value.

*Short-term investments and assets limited as to use:* Fair values, which are the amounts reported in the balance sheet, are based on quoted market prices.

*Accounts payable and accrued expenses:* The carrying amount reported in the balance sheet for accounts payable and accrued expenses approximates its fair value.

*Accrued compensation and benefits:* The carrying amount reported in the balance sheet for accrued compensation and benefits approximates its fair value.

*Long-term debt:* Fair values are computed using an estimated pricing analysis based on the individual bond terms.

# Sharp HealthCare

## Notes to Combined Financial Statements (continued)

### 12. Fair Value of Financial Instruments (continued)

The carrying amounts and fair values of Sharp's financial instruments are as follows (in thousands):

	September 30, 2010		September 30, 2009	
	Carrying Value	Fair Value	Carrying Value	Fair Value
Cash and cash equivalents	\$ 154,749	\$ 154,749	\$ 150,611	\$ 150,611
Short-term investments	42,770	42,770	75,624	75,624
Estimated settlements payable to government programs, net	(1,043)	(1,043)	(9,036)	(9,036)
Assets limited as to use	617,092	617,092	430,694	430,694
Accounts payable and accrued liabilities	163,687	163,687	145,319	145,319
Accrued compensation and benefits	100,623	100,623	93,040	93,040
Long-term debt	508,472	502,626	528,632	549,970

### 13. Discontinued Operations

On July 31, 2008, Sharp sold Sharp Mission Park Medical Centers (SMP) to Scripps Health (Scripps), an unrelated health care provider. Scripps paid Sharp \$10,000,000 related to the sale.

As of September 30, 2010 and 2009, SMP qualified for treatment as discontinued operations under FASB ASC 360 and ASC 205. Accordingly, the operating results and gain on disposal of SMP have been classified as discontinued operations in the combined statements of operations for all years presented. In addition, net assets and liabilities of SMP were considered discontinued operations in the balance sheet and have been segregated into "discontinued operations" in the current liabilities section of the balance sheet. Sharp recorded changes in estimate of \$132,000 and \$1,480,000 in 2010 and 2009, respectively, as gains on discontinued operations related to previous years' operations of SMP.

### 14. Subsequent Events

In preparing these combined financial statements, management has evaluated and disclosed all material subsequent events up to December 15, 2010, which is the date that the combined financial statements were issued.

## Other Financial Information

## Report of Independent Auditors on Other Financial Information

Board of Directors  
Sharp HealthCare

Our audit was conducted for the purpose of forming an opinion on the combined financial statements taken as a whole. The combining balance sheet, combining statement of operations, combining statement of changes in net assets, combining balance sheet – obligated group, combining statement of operations – obligated group, and combining statement of changes in net assets – obligated group are presented for the purpose of additional analysis and are not a required part of the combined financial statements. Such information has been subjected to the auditing procedures applied in our audit of the combined financial statements and, in our opinion, is fairly presented in all material respects in relation to the combined financial statements taken as a whole.

*Ernst & Young LLP*

December 15, 2010

# Sharp HealthCare

## Combining Balance Sheet (In Thousands)

September 30, 2010

	Sharp HealthCare	Sharp Memorial Hospital	Sharp Chula Vista Medical Center	Grossmont Hospital Corporation	Sharp Coronado Hospital and HealthCare Center	Sharp Health Plan	Continuous Quality Insurance	Sharp HealthCare Foundation	Grossmont Hospital Foundation	Combined Totals	Combining Eliminations	Totals
<b>Assets</b>												
Current assets:												
Cash and cash equivalents	\$ 110,936	\$ 1,019	\$ 1,521	\$ 20,708	\$ 709	\$ 15,160	\$ 417	\$ 1,924	\$ 2,355	\$ 154,749	\$ -	\$ 154,749
Short-term investments	29,893	-	-	11,769	-	-	-	1,108	-	42,770	-	42,770
Accounts receivable, net	9,688	87,558	25,420	43,728	6,596	1,634	75	4,691	218	179,608	(2,211)	177,397
Intercompany receivables	-	543,546	94,452	3,046	-	-	-	-	47	641,091	(641,091)	-
Inventories	4,159	11,951	5,038	9,056	1,437	-	-	-	-	31,641	-	31,641
Prepaid expenses and other	24,980	3,100	1,542	2,640	422	396	4	26	4	33,114	-	33,114
Total current assets	179,656	647,174	127,973	90,947	9,164	17,190	496	7,749	2,624	1,082,973	(643,302)	439,671
Assets limited as to use:												
Designated for property	390,738	-	-	102,584	-	25,914	-	-	-	519,236	-	519,236
Under bond indentures	28	40,233	9,155	2,358	-	-	-	-	-	51,774	-	51,774
Other restricted investments	-	-	-	-	-	1,010	-	28,533	8,496	38,039	-	38,039
Under self-insurance programs	-	-	-	-	-	-	8,043	-	-	8,043	-	8,043
Total assets limited as to use	390,766	40,233	9,155	104,942	-	26,924	8,043	28,533	8,496	617,092	-	617,092
Property and equipment, net	148,908	371,737	50,603	205,226	13,667	498	-	31	-	790,670	-	790,670
Unamortized financing costs	93	3,048	732	575	-	-	-	-	-	4,448	-	4,448
Other assets	16,054	42	1,860	983	199	94	652	23,725	1,534	45,143	(8,392)	36,751
Beneficial interest in foundations	47,120	-	-	12,136	-	-	-	-	-	59,256	(59,256)	-
Total assets	\$ 782,597	\$ 1,062,234	\$ 190,323	\$ 414,809	\$ 23,030	\$ 44,706	\$ 9,191	\$ 60,038	\$ 12,654	\$ 2,599,582	\$ (710,950)	\$ 1,888,632

# Sharp HealthCare

## Combining Balance Sheet (continued) (In Thousands)

September 30, 2010

	Sharp HealthCare	Sharp Memorial Hospital	Sharp Chula Vista Medical Center	Grossmont Hospital Corporation	Sharp Coronado Hospital and HealthCare Center	Sharp Health Plan	Continuous Quality Insurance	Sharp HealthCare Foundation	Grossmont Hospital Foundation	Combined Totals	Combining Eliminations	Totals
<b>Liabilities and net assets</b>												
Current liabilities:												
Accounts payable and accrued liabilities	\$ 111,528	\$ 18,875	\$ 7,430	\$ 13,020	\$ 1,970	\$ 12,462	\$ 52	\$ 130	\$ 4	\$ 165,471	\$ (1,784)	\$ 163,687
Intercompany payable	631,590	–	–	–	8,503	356	19	594	–	641,062	(641,062)	–
Accrued compensation and benefits	27,875	32,797	12,136	22,749	3,681	1,047	–	335	55	100,675	(52)	100,623
Current portion of long-term debt	2,058	10,224	3,295	2,902	194	–	–	–	–	18,673	–	18,673
Estimated settlements payable to government programs, net	–	(488)	2,240	(2,636)	1,927	–	–	–	–	1,043	–	1,043
Accrued interest	156	2,335	447	127	–	–	–	–	–	3,065	–	3,065
Discontinued operations	996	–	–	–	–	–	–	–	–	996	–	996
<b>Total current liabilities</b>	<b>774,203</b>	<b>63,743</b>	<b>25,548</b>	<b>36,162</b>	<b>16,275</b>	<b>13,865</b>	<b>71</b>	<b>1,059</b>	<b>59</b>	<b>930,985</b>	<b>(642,898)</b>	<b>288,087</b>
Long-term liabilities	66,461	24,225	6,733	29,634	1,943	456	–	11,859	459	141,770	(5,772)	135,998
Reserves for professional liability	4,000	–	–	–	–	–	9,000	–	–	13,000	–	13,000
Long-term debt	38,019	337,165	66,208	48,388	424	–	–	–	–	490,204	(405)	489,799
<b>Total liabilities</b>	<b>882,683</b>	<b>425,133</b>	<b>98,489</b>	<b>114,184</b>	<b>18,642</b>	<b>14,321</b>	<b>9,071</b>	<b>12,918</b>	<b>518</b>	<b>1,575,959</b>	<b>(649,075)</b>	<b>926,884</b>
Net assets:												
Unrestricted net (deficit) assets	(145,967)	637,101	91,834	290,314	4,191	30,385	120	2,239	1,826	912,043	(5,683)	906,360
Temporarily restricted net assets	41,348	–	–	8,339	197	–	–	40,348	8,339	98,571	(49,687)	48,884
Permanently restricted net assets	4,533	–	–	1,972	–	–	–	4,533	1,971	13,009	(6,505)	6,504
<b>Total net (deficit) assets</b>	<b>(100,086)</b>	<b>637,101</b>	<b>91,834</b>	<b>300,625</b>	<b>4,388</b>	<b>30,385</b>	<b>120</b>	<b>47,120</b>	<b>12,136</b>	<b>1,023,623</b>	<b>(61,875)</b>	<b>961,748</b>
<b>Total liabilities and net assets</b>	<b>\$ 782,597</b>	<b>\$ 1,062,234</b>	<b>\$ 190,323</b>	<b>\$ 414,809</b>	<b>\$ 23,030</b>	<b>\$ 44,706</b>	<b>\$ 9,191</b>	<b>\$ 60,038</b>	<b>\$ 12,654</b>	<b>\$ 2,599,582</b>	<b>\$ (710,950)</b>	<b>\$ 1,888,632</b>

# Sharp HealthCare

## Combining Statement of Operations (In Thousands)

September 30, 2010

	Sharp HealthCare	Sharp Memorial Hospital	Sharp Chula Vista Medical Center	Grossmont Hospital Corporation	Sharp Coronado Hospital and HealthCare Center	Sharp Health Plan	Continuous Quality Insurance	Sharp HealthCare Foundation	Grossmont Hospital Foundation	Combined Totals	Combining Eliminations	Totals
<b>Revenues:</b>												
Net patient service	\$ 100,179	\$ 794,142	\$ 253,060	\$ 486,181	\$ 71,069	\$ –	\$ –	\$ –	\$ –	\$ 1,704,631	\$ (273,080)	\$ 1,431,551
Premium	617,392	–	–	–	–	193,710	–	–	–	811,102	(90,503)	720,599
Other	203,367	9,556	3,612	7,290	3,147	–	3,024	–	–	229,996	(163,329)	66,667
<b>Total revenues</b>	<b>920,938</b>	<b>803,698</b>	<b>256,672</b>	<b>493,471</b>	<b>74,216</b>	<b>193,710</b>	<b>3,024</b>	<b>–</b>	<b>–</b>	<b>2,745,729</b>	<b>(526,912)</b>	<b>2,218,817</b>
<b>Expenses:</b>												
Salaries and wages	212,586	299,024	109,133	203,601	33,220	5,564	–	–	–	863,128	–	863,128
Employee benefits	54,509	66,476	23,229	47,300	7,599	1,253	–	–	–	200,366	–	200,366
Medical fees	173,911	11,427	3,927	9,080	560	173,957	–	–	–	372,862	(101,538)	271,324
Purchased services	98,123	51,406	22,726	45,704	5,750	5,375	181	–	–	229,265	(3,437)	225,828
Supplies	25,777	125,211	40,771	76,595	11,416	134	–	–	–	279,904	–	279,904
Maintenance, utilities, and rentals	48,595	24,682	5,969	16,059	3,077	726	–	–	–	99,108	(2,750)	96,358
Depreciation and amortization	32,629	33,570	10,245	22,035	3,289	455	9	–	–	102,232	(20,333)	81,899
Business insurance	574	2,869	894	2,352	267	100	3,280	–	–	10,336	(3,280)	7,056
Interest	1,956	18,982	4,923	2,192	3	1	–	–	–	28,057	(3,208)	24,849
Provision for doubtful accounts	3,531	13,224	8,029	16,263	882	–	–	–	–	41,929	–	41,929
Purchased services from affiliate	268,328	65,756	24,708	45,173	6,676	1,842	82	–	–	412,565	(412,565)	–
Other	12,777	4,474	2,144	3,931	641	1,650	52	–	–	25,669	–	25,669
<b>Total expenses</b>	<b>933,296</b>	<b>717,101</b>	<b>256,698</b>	<b>490,285</b>	<b>73,380</b>	<b>191,057</b>	<b>3,604</b>	<b>–</b>	<b>–</b>	<b>2,665,421</b>	<b>(547,111)</b>	<b>2,118,310</b>
(Loss) income from operations	(12,358)	86,597	(26)	3,186	836	2,653	(580)	–	–	80,308	20,199	100,507
Other non-operating (loss) income	(3,390)	(224)	15	(1,059)	17	45	–	(31)	497	(4,130)	77	(4,053)
Investment income	24,317	15,433	7,217	7,018	1,260	1,714	580	1,115	82	58,736	(20,276)	38,460
Income from continuing operations	8,569	101,806	7,206	9,145	2,113	4,412	–	1,084	579	134,914	–	134,914
Gain on discontinued operations, net	132	–	–	–	–	–	–	–	–	132	–	132
Excess of revenues over expenses	8,701	101,806	7,206	9,145	2,113	4,412	–	1,084	579	135,046	–	135,046
Net assets transferred from related party	–	–	–	9,344	–	–	–	–	–	9,344	–	9,344
Net assets released from restrictions used for purchase of property, plant, and equipment	555	4,878	1,620	1,684	–	–	–	–	–	8,737	–	8,737
Pension related changes other than net periodic pension cost	855	555	(667)	(593)	(55)	(66)	–	–	–	29	–	29
Other	(197)	30	–	614	1,935	–	–	(1,282)	–	1,100	(380)	720
<b>Increase (decrease) in unrestricted net assets</b>	<b>\$ 9,914</b>	<b>\$ 107,269</b>	<b>\$ 8,159</b>	<b>\$ 20,194</b>	<b>\$ 3,993</b>	<b>\$ 4,346</b>	<b>\$ –</b>	<b>\$ (198)</b>	<b>\$ 579</b>	<b>\$ 154,256</b>	<b>\$ (380)</b>	<b>\$ 153,876</b>

# Sharp HealthCare

## Combining Statement of Changes in Net Assets (In Thousands)

September 30, 2010

	Sharp HealthCare	Sharp Memorial Hospital	Sharp Chula Vista Medical Center	Grossmont Hospital Corporation	Sharp Coronado Hospital and HealthCare Center	Sharp Health Plan	Continuous Quality Insurance	Sharp HealthCare Foundation	Grossmont Hospital Foundation	Combined Totals	Combining Eliminations	Totals
Unrestricted net assets:												
Excess of revenues over expenses	\$ 8,701	\$ 101,806	\$ 7,206	\$ 9,145	\$ 2,113	\$ 4,412	\$ -	\$ 1,084	\$ 579	\$ 135,046	\$ -	\$ 135,046
Net assets transferred from related party	-	-	-	9,344	-	-	-	-	-	9,344	-	9,344
Net assets released from restrictions used for purchase of property, plant, and equipment	555	4,878	1,620	1,684	-	-	-	-	-	8,737	-	8,737
Pension related changes other than net periodic pension cost	855	555	(667)	(593)	(55)	(66)	-	-	-	29	-	29
Other	(197)	30	-	614	1,935	-	-	(1,282)	-	1,100	(380)	720
Increase (decrease) in unrestricted net assets	9,914	107,269	8,159	20,194	3,993	4,346	-	(198)	579	154,256	(380)	153,876
Temporarily restricted net assets:												
Contributions	-	-	-	-	-	-	-	8,229	2,321	10,550	-	10,550
Investment income	-	-	-	-	-	-	-	740	406	1,146	-	1,146
Change in net realized gains (losses) on investments	-	-	-	-	-	-	-	571	467	1,038	-	1,038
Net assets released from restrictions	-	-	-	-	-	-	-	(9,458)	(2,886)	(12,344)	-	(12,344)
Other	1,363	-	-	309	(492)	-	-	1,282	-	2,462	(1,672)	790
Increase (decrease) in temporarily restricted net assets	1,363	-	-	309	(492)	-	-	1,364	308	2,852	(1,672)	1,180
Permanently restricted net assets:												
Contributions	-	-	-	-	-	-	-	5	672	677	-	677
Other	5	-	-	672	-	-	-	-	-	677	(677)	-
Increase in permanently restricted net assets	5	-	-	672	-	-	-	5	672	1,354	(677)	677
Increase in net assets	11,282	107,269	8,159	21,175	3,501	4,346	-	1,171	1,559	158,462	(2,729)	155,733
Net (deficit) assets, beginning of year	(111,368)	529,832	83,675	279,450	887	26,039	120	45,949	10,577	865,161	(59,146)	806,015
Net (deficit) assets, end of year	\$ (100,086)	\$ 637,101	\$ 91,834	\$ 300,625	\$ 4,388	\$ 30,385	\$ 120	\$ 47,120	\$ 12,136	\$ 1,023,623	\$ (61,875)	\$ 961,748

## Sharp HealthCare

### Combining Balance Sheet – Obligated Group (In Thousands)

September 30, 2010

	Sharp HealthCare	Sharp Memorial Hospital	Sharp Chula Vista Medical Center	Grossmont Hospital Corporation	Combined Totals	Combining Eliminations	Totals
<b>Assets</b>							
Current assets:							
Cash and cash equivalents	\$ 110,936	\$ 1,019	\$ 1,521	\$ 20,708	\$ 134,184	\$ –	\$ 134,184
Short-term investments	29,893	–	–	11,769	41,662	–	41,662
Accounts receivable, net	9,688	87,558	25,420	43,728	166,394	(1,584)	164,810
Intercompany receivables	(631,302)	543,546	94,452	–	6,696	3,051	9,747
Estimated settlements receivable from government programs, net	–	488	(2,240)	2,636	884	–	884
Inventories	4,159	11,951	5,038	9,056	30,204	–	30,204
Prepaid expenses and other	24,980	3,100	1,542	2,640	32,262	–	32,262
Total current assets	(451,646)	647,662	125,733	90,537	412,286	1,467	413,753
Assets limited as to use:							
Designated for property	390,738	–	–	102,584	493,322	–	493,322
Under bond indentures	28	40,233	9,155	2,358	51,774	–	51,774
Total assets limited as to use	390,766	40,233	9,155	104,942	545,096	–	545,096
Property and equipment, net	148,908	371,737	50,603	205,226	776,474	–	776,474
Unamortized financing costs	93	3,048	732	575	4,448	–	4,448
Other assets	16,054	42	1,860	983	18,939	–	18,939
Beneficial interest in foundations	47,120	–	–	12,136	59,256	–	59,256
Total assets	<u>\$ 151,295</u>	<u>\$ 1,062,722</u>	<u>\$ 188,083</u>	<u>\$ 414,399</u>	<u>\$ 1,816,499</u>	<u>\$ 1,467</u>	<u>\$ 1,817,966</u>

## Sharp HealthCare

### Combining Balance Sheet – Obligated Group (continued) (In Thousands)

September 30, 2010

	Sharp HealthCare	Sharp Memorial Hospital	Sharp Chula Vista Medical Center	Grossmont Hospital Corporation	Combined Totals	Combining Eliminations	Totals
<b>Liabilities and net assets</b>							
Current liabilities:							
Accounts payable and accrued liabilities	\$ 111,816	\$ 18,875	\$ 7,430	\$ 13,020	\$ 151,141	\$ (1,584)	\$ 149,557
Intercompany payable	–	–	–	(3,046)	(3,046)	3,051	5
Accrued compensation and benefits	27,875	32,797	12,136	22,749	95,557	–	95,557
Current portion of long-term debt	2,058	10,224	3,295	2,902	18,479	–	18,479
Accrued interest	156	2,335	447	127	3,065	–	3,065
Discontinued operations	996	–	–	–	996	–	996
Total current liabilities	142,901	64,231	23,308	35,752	266,192	1,467	267,659
Long-term liabilities	66,461	24,225	6,733	29,634	127,053	–	127,053
Reserves for professional liability	4,000	–	–	–	4,000	–	4,000
Long-term debt	38,019	337,165	66,208	48,388	489,780	–	489,780
Total liabilities	251,381	425,621	96,249	113,774	887,025	1,467	888,492
Net assets:							
Unrestricted net (deficit) assets	(145,967)	637,101	91,834	290,314	873,282	–	873,282
Temporarily restricted net assets	41,348	–	–	8,339	49,687	–	49,687
Permanently restricted net assets	4,533	–	–	1,972	6,505	–	6,505
Total net (deficit) assets	(100,086)	637,101	91,834	300,625	929,474	–	929,474
Total liabilities and net assets	\$ 151,295	\$ 1,062,722	\$ 188,083	\$ 414,399	\$ 1,816,499	\$ 1,467	\$ 1,817,966

## Sharp HealthCare

### Combining Statement of Operations – Obligated Group (In Thousands)

September 30, 2010

	Sharp HealthCare	Sharp Memorial Hospital	Sharp Chula Vista Medical Center	Grossmont Hospital Corporation	Combined Totals	Combining Eliminations	Totals
<b>Revenues:</b>							
Net patient service	\$ 100,179	\$ 794,142	\$ 253,060	\$ 486,181	\$ 1,633,562	\$ (263,538)	\$ 1,370,024
Premium	617,392	-	-	-	617,392	-	617,392
Other	203,367	9,556	3,612	7,290	223,825	(152,641)	71,184
<b>Total revenues</b>	<b>920,938</b>	<b>803,698</b>	<b>256,672</b>	<b>493,471</b>	<b>2,474,779</b>	<b>(416,179)</b>	<b>2,058,600</b>
<b>Expenses:</b>							
Salaries and wages	212,586	299,024	109,133	203,601	824,344	-	824,344
Employee benefits	54,509	66,476	23,229	47,300	191,514	-	191,514
Medical fees	173,911	11,427	3,927	9,080	198,345	(7,211)	191,134
Purchased services	98,123	51,406	22,726	45,704	217,959	(2,672)	215,287
Supplies	25,777	125,211	40,771	76,595	268,354	-	268,354
Maintenance, utilities, and rentals	48,595	24,682	5,969	16,059	95,305	(2,750)	92,555
Depreciation and amortization	32,629	33,570	10,245	22,035	98,479	(21,159)	77,320
Business insurance	574	2,869	894	2,352	6,689	-	6,689
Interest	1,956	18,982	4,923	2,192	28,053	(3,456)	24,597
Provision for doubtful accounts	3,531	13,224	8,029	16,263	41,047	-	41,047
Purchased services from affiliate	268,328	65,756	24,708	45,173	403,965	(398,610)	5,355
Other	12,777	4,474	2,144	3,931	23,326	-	23,326
<b>Total expenses</b>	<b>933,296</b>	<b>717,101</b>	<b>256,698</b>	<b>490,285</b>	<b>2,397,380</b>	<b>(435,858)</b>	<b>1,961,522</b>
(Loss) income from operations	(12,358)	86,597	(26)	3,186	77,399	19,679	97,078
Other nonoperating (losses) gains, net	(3,390)	(224)	15	(1,059)	(4,658)	-	(4,658)
Investment income	24,317	15,433	7,217	7,018	53,985	(19,679)	34,306
<b>Income from continuing operations</b>	<b>8,569</b>	<b>101,806</b>	<b>7,206</b>	<b>9,145</b>	<b>126,726</b>	<b>-</b>	<b>126,726</b>
Gain on discontinued operations, net	132	-	-	-	132	-	132
<b>Excess of revenues over expenses</b>	<b>8,701</b>	<b>101,806</b>	<b>7,206</b>	<b>9,145</b>	<b>126,858</b>	<b>-</b>	<b>126,858</b>
Net assets transferred from related party	-	-	-	9,344	9,344	-	9,344
Net assets released from restrictions used for purchase of property, plant, and equipment	555	4,878	1,620	1,684	8,737	-	8,737
Pension-related changes other than net periodic pension cost	855	555	(667)	(593)	150	-	150
Other	(197)	30	-	614	447	-	447
<b>Increase in unrestricted net assets</b>	<b>\$ 9,914</b>	<b>\$ 107,269</b>	<b>\$ 8,159</b>	<b>\$ 20,194</b>	<b>\$ 145,536</b>	<b>\$ -</b>	<b>\$ 145,536</b>

## Sharp HealthCare

### Combining Statement of Changes in Net Assets – Obligated Group (In Thousands)

September 30, 2010

	Sharp HealthCare	Sharp Memorial Hospital	Sharp Chula Vista Medical Center	Grossmont Hospital Corporation	Combined Totals	Combining Eliminations	Totals
Unrestricted net assets:							
Excess of revenues over expenses	\$ 8,701	\$ 101,806	\$ 7,206	\$ 9,145	\$ 126,858	\$ –	\$ 126,858
Net assets transferred from related party	–	–	–	9,344	9,344	–	9,344
Net assets released from restrictions used for purchase of property, plant, and equipment	555	4,878	1,620	1,684	8,737	–	8,737
Pension related changes other than net periodic pension cost	855	555	(667)	(593)	150	–	150
Other	(197)	30	–	614	447	–	447
Increase in unrestricted net assets	9,914	107,269	8,159	20,194	145,536	–	145,536
Temporarily restricted net assets:							
Beneficial interest in foundations	1,363	–	–	309	1,672	–	1,672
Increase in temporarily restricted net assets	1,363	–	–	309	1,672	–	1,672
Permanently restricted net assets:							
Beneficial interest in foundations	5	–	–	672	677	–	677
Increase in permanently restricted net assets	5	–	–	672	677	–	677
Increase in net assets	11,282	107,269	8,159	21,175	147,885	–	147,885
Net (deficit) assets, beginning of year	(111,368)	529,832	83,675	279,450	781,589	–	781,589
Net (deficit) assets, end of year	\$ (100,086)	\$ 637,101	\$ 91,834	\$ 300,625	\$ 929,474	\$ –	\$ 929,474

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**APPENDIX C**

**SUMMARY OF PRINCIPAL DOCUMENTS**

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## APPENDIX C

### SUMMARY OF PRINCIPAL DOCUMENTS

The following is a summary of certain provisions of the Master Indenture, Supplemental Master Indenture No. 30, the Bond Indenture and the Loan Agreement which are not described elsewhere in this Official Statement. These summaries do not purport to be comprehensive and reference should be made to each of said documents for a full and complete statement of their provisions.

### DEFINITIONS OF CERTAIN TERMS

The following is a summary of certain terms used in this Summary of Principal Documents. All capitalized terms not defined herein or elsewhere in this Official Statement have the meanings set forth in the Master Indenture or the Bond Indenture.

**Additional Indebtedness** means any Indebtedness (including all Obligations) incurred subsequent to the issuance of the first Obligation issued under the first Related Supplement executed pursuant to the Master Indenture.

**Balloon Indebtedness** means Long-term Indebtedness (or Short-Term Indebtedness intended to be refinanced upon or prior to its maturity so that such Short-Term Indebtedness and the Indebtedness intended to be used to refinance such Short-Term Indebtedness will be Outstanding for a total of more than 365 days as certified in an Officer's Certificate) 25% or more of the principal of which becomes due (either by maturity or mandatory redemption) during any period of 12 consecutive months, which portion of the principal is not required by the documents governing such Indebtedness to be amortized by redemption prior to such date.

**Beneficial Owner** means any Person which has or shares the power, directly or indirectly, to make investment decisions concerning ownership of any of the Bonds (including any Person holding Bonds through nominees, depositories or other intermediaries).

**Book Value** means, when used in connection with Property, Plant and Equipment or other Property of any Member, the value of such property, net of accumulated depreciation or amortization, as it is carried on the books of such Member and in conformity with generally accepted accounting principles, and when used in connection with Property, Plant and Equipment or other Property of the Obligated Group, means the aggregate of the recorded values so determined with respect to such Property of each Member determined in such a way that no portion of such value of Property of any Member is included more than once.

**Business Day** means any day on which banks located in New York, New York, and the city in which the Principal Office of the Bond Trustee is located are not required or authorized to be closed and on which The New York Stock Exchange is open.

**Capitalization** means, as of any date of calculation, the principal amount of all Indebtedness then Outstanding plus the fund balances (including any shareholder equity) of the Obligated Group for the last Fiscal Year for which audited financial statements are available, determined in accordance with generally accepted accounting principles.

**Code** means the Internal Revenue Code of 1986 as amended, or any successor statute thereto and any regulations promulgated thereunder.

**Completion Indebtedness** means any Long-term Indebtedness incurred for the purpose of financing the completion of construction or equipping of any project for which Long-term Indebtedness has theretofore been incurred in accordance with the provisions of the Master Indenture to the extent necessary to provide a completed and fully equipped facility of the type and scope contemplated at the time said Long-term Indebtedness was incurred, and in accordance with the general plans and specifications for such facility as originally prepared and approved in connection with the related financing, modified or amended only in conformance with the provisions of the documents pursuant to which the related financing was undertaken.

**Date of Issuance** means the date of original issuance of the Bonds, as estimated on the cover of this Official Statement.

**Debt Service Requirement** means, for any period of time for which such determination is made, the aggregate of the scheduled payments to be made with respect to principal (or mandatory sinking fund or installment purchase price or lease rental or similar payments) and interest on Outstanding Long-term Indebtedness of the Members during such period, taking into account at the option of the Corporation:

(a) With respect to Indebtedness represented by a Guaranty of obligations of a Person, the principal and interest deemed payable with respect to such Guaranty shall be deemed to be the lowest percentage of debt service requirements set forth below (determined after giving effect to any other paragraph of this definition at the election of the Corporation), if the debt service coverage ratio (determined in a manner as nearly as practicable to the determination of the Debt Service Requirement hereunder) of the Person primarily obligated on the obligations effectively guaranteed by such Guaranty for the immediately preceding Fiscal Year shall be greater than the amount specified opposite such percentage below:

<b>Debt Service Coverage Ratio of Accommodated Person</b>	<b>Percentage of Debt Service Requirements</b>
<b>2.0</b>	<b>20%</b>
<b>1.25</b>	<b>50%</b>
<b>Less than 1.1</b>	<b>100%</b>

Additionally, if at any time during the twenty-four months immediately preceding the date of computation of the Debt Service Requirement, payment of the principal of or interest on the guaranteed obligation has been demanded from the guarantor and if within thirty (30) days of the guarantor's receipt of such demand the Corporation has failed to deliver an Opinion of Counsel to the Trustee to the effect that the guarantor is not legally obligated to honor such demand, 100% of the annual debt service on the indebtedness being guaranteed shall be added to the computation of the Debt Service Requirement.

(b) With respect to Balloon Indebtedness, the amount of principal and interest deemed payable during such period shall be determined as if such Balloon Indebtedness were being repaid in substantially equal annual installments of principal and interest over a term over which the Members could reasonably be expected to borrow, not to exceed twenty-five (25) years from the date of incurrence of such Balloon Indebtedness, and bearing interest at an interest rate (determined as of the date of calculation of the Debt Service Requirement) equal to the Revenue Bond Index most recently published in The Bond Buyer.

(c) With respect to Variable Rate Indebtedness, if the actual interest rate on such Variable Rate Indebtedness cannot be determined for any period for which the Debt Service Requirement is being calculated, the amount of interest deemed payable on such Variable Rate Indebtedness during such period shall be assumed to be equal to the average interest rate per annum that was in effect (or, if such Variable Rate Indebtedness was not Outstanding during such eighteen month period, that would have been in effect) on such Variable Rate Indebtedness during any twelve (12) consecutive calendar months specified in an Officer's Certificate during the eighteen (18) calendar months immediately preceding the date of calculation of the Debt Service Requirement.

(d) With respect to Indebtedness payable from an Irrevocable Deposit, the amount of principal or interest taken into account during such period shall be assumed to equal only the principal or interest not payable from such Irrevocable Deposit and the investment income from such funds.

(e) With respect to Long-term Indebtedness incurred to finance or refinance the construction of capital improvements, principal and interest with respect to such Long-term Indebtedness shall be excluded from the determination of the Debt Service Requirement but only in proportion to the amount of principal and interest on such Long-term Indebtedness which is payable in the then current Fiscal Year from the proceeds of such Long-term Indebtedness.

(f) With respect to Long-term Indebtedness with respect to which a Financial Products Agreement has been entered into by a Member with a Qualified Provider, interest on such Long-term Indebtedness shall be included in the determination of the Debt Service Requirement by including for each Fiscal Year an amount equal to the amount of interest payable on such Long-term Indebtedness in such Fiscal Year at the rate or rates stated in such Long-term Indebtedness plus any Financial Product Payments payable in such Fiscal Year minus any Financial Product Receipts receivable in such Fiscal Year; provided that in no event shall any calculation made pursuant to this clause result in a number less than zero being included in the determination of the Debt Service Requirement and provided, further, if the actual interest rate on such Long-term Indebtedness or the actual amount of Financial Product Payments or Financial Product Receipts cannot be determined for the period for which the Debt Service Requirement is being calculated, the amount of interest deemed payable during such period on such Long-term Indebtedness shall be determined by applying the average interest rate per annum which was in effect (or, if such Long-term Indebtedness was not Outstanding during such eighteen month period, which would have been in effect) or the Financial Product Payments which would have been paid, or the Financial Product Receipts which would have been received, as the case may be, for any twelve (12) consecutive calendar months specified in an Officer's Certificate during the eighteen (18) calendar months immediately preceding the date of calculation of the Debt Service Requirement.

(g) With respect to Long-term Indebtedness with respect to which a Financial Products Agreement has been entered into by a Member with a counterparty that is not a Qualified Provider, interest on such Long-term Indebtedness shall be included in the determination of the Debt Service Requirement by including for each Fiscal Year an amount equal to the greater of (1) the amount of interest payable on such Long-term Indebtedness in such Fiscal Year at the rate or rates stated in such Long-term Indebtedness (provided that, if the actual interest rate on such Long-term Indebtedness cannot be determined for any period for which the Debt Service Requirement is being calculated, the amount of interest deemed payable on such Long-term Indebtedness during such period shall be determined pursuant to subsection (c) of this definition) and (2) the amount that would have been calculated under subsection (f) of this definition with respect to such Long-term Indebtedness and Financial Products Agreement if such counterparty were a Qualified Provider.

**Fair Market Value**, when used in connection with Property, means the fair market value of such Property as determined by any one of the following:

(1) an appraisal of the portion of such Property which is real property made within five years of the date of determination by a "Member of the Appraisal Institute" and by an appraisal of the portion of such Property which is not real property made within five years of the date of determination by any expert qualified in relation to the subject matter, provided that any such appraisal shall be performed by an Independent Consultant, adjusted for the period, not in excess of five years, from the date of the last such appraisal for changes in the implicit price deflator for the gross national product as reported by the United States Department of Commerce or its successor agency, or if such index is no longer published, such other index certified to be comparable and appropriate in an Officer's Certificate delivered to the Trustee; or

(2) a bona fide offer for the purchase of such Property made on an arm's-length basis within twelve months of the date of determination, as established by an Officer's Certificate; or

(3) an Authorized Representative of the Corporation (whose determination shall be made in good faith and set forth in an Officer's Certificate filed with the Master Trustee) if the fair market value of such Property is less than or equal to the greater of \$10,000,000 or 2.0% of Property, Plant and Equipment as shown on the most recent audited financial statements of the Members.

**Financial Products Agreement** means an interest rate swap, cap, collar, option, floor, forward or other hedging agreement, arrangement or security, however denominated, identified to the Master Trustee in an Officer's Certificate as having been entered into by a Member with a counterparty not for investment purposes but with respect to Indebtedness (which Indebtedness shall be specifically identified in the Officer's Certificate) for the purpose of (1) reducing or otherwise managing the Member's risk of interest rate changes or (2) effectively converting the Member's interest rate exposure, in whole or in part, from a fixed rate exposure to a variable rate exposure, or from a variable rate exposure to a fixed rate exposure or to another variable rate exposure.

**Financial Products Payments** means payments periodically required to be paid to a counterparty by a Member pursuant to a Financial Products Agreement.

**Financial Products Receipts** means amounts periodically required to be paid to a Member by a counterparty pursuant to a Financial Products Agreement.

**Fiscal Year** means that period adopted by the Corporation as its annual accounting period and which shall also be the Fiscal Year adopted by all other Members (unless any such Member is prevented by law or regulation from adopting such a fiscal year).

**Governing Body** means, when used with respect to any Member, its board of directors, board of trustees, or other board or group of individuals in which all of the powers of such Member are vested except for those powers reserved to the corporate membership thereof by the articles of incorporation or bylaws of such Member or under California law.

**Gross Revenues** means all revenues, income, receipts and money received by or on behalf of the Obligated Group from all sources, including (a) gross revenues derived from their operation and possession of each Member's facilities, including, but not limited to, the Property, Plant and Equipment, (b) gifts, grants, bequests, donations and contributions, exclusive of any gifts, grants, bequests, donations and contributions to the extent specifically restricted by the donor to a particular purpose inconsistent with their use for the payment of Required Payments, (c) proceeds derived from (i) condemnation proceeds, (ii) accounts receivable, (iii) securities and other investments, (iv) inventory and other tangible and intangible property, (v) medical reimbursement programs and agreements, (vi) insurance proceeds (other than insurance proceeds the application of which is limited pursuant to an agreement entered into in compliance with the provisions of the Master Indenture) and (vii) contract rights and other rights and assets now or hereafter owned by each Member and (d) rentals received from the lease of any Property.

**Holder or Bondholder** whenever used with respect to a Bond, means the Person in whose name such Bond is registered.

**Income Available For Debt Service** means, unless the context provides otherwise, with respect to the Members as to any period of time, their combined changes in net assets, or combined excess of revenues over expenses (excluding income from all Irrevocable Deposits), before depreciation, amortization and interest expense, as determined in accordance with generally accepted accounting principles; provided, that no determination thereof shall take into account:

(a) any gain or loss resulting from either the early extinguishment or refinancing of Indebtedness or the sale, exchange or other disposition of capital assets;

(b) gifts, grants, bequests, donations or contributions, and income therefrom, to the extent specifically permanently restricted by the donor or by law to a particular purpose inconsistent with their use for the payment of principal of, redemption premium and interest on Indebtedness or the payment of operating expenses;

(c) the net proceeds of insurance (other than business interruption insurance, stop-loss insurance, reinsurance and other such agreements) and condemnation awards;

(d) adjustments to the value of assets or liabilities resulting from changes in generally accepted accounting principles;

(e) unrealized gains or losses (other than write-downs of accounts receivable) that do not result in the receipt or expenditure of cash; and

(f) nonrecurring items (other than write-downs of accounts receivable) which do not involve the receipt, expenditure or transfer of assets.

**Indebtedness** means 25% of any Guaranty (other than any Guaranty by any Member of Indebtedness of any other Member) if such Guaranty has not been drawn upon within the preceding two years, or 100% of any Guaranty (other than any Guaranty by any Member of Indebtedness of any other Member) if such Guaranty has been drawn upon within the preceding two years, and any indebtedness or obligation of any Member of the Obligated Group (other than accounts payable and accruals) for borrowed money, as determined in accordance with generally accepted accounting principles, including obligations under conditional sales contracts or other title retention contracts, rental obligations under leases which are considered capital leases under generally accepted accounting principles, except for obligations of a Member to another Member; provided, however, that if more than one Member shall have incurred or assumed a Guaranty of a Person other than a Member, or if more than one Member shall be obligated to pay any obligation, for purposes of any computations or calculations under the Master Indenture, such Guaranty or obligation shall be included only one time.

**Industry Restrictions** means federal, state or other applicable governmental laws or regulations imposing restrictions and limitations on rates, fees or charges to be fixed, charged and collected by the Members.

**Insurance Consultant** means a person or firm (which may be an insurance broker or agent of a Member) who is not, and no member, director, officer or employee of which is, an officer or employee of any Member, designated by the Authorized Representative of the Corporation and qualified to survey risks and to recommend insurance coverage for hospitals, health-related facilities and services and organizations engaged in such operations.

**Investment Securities** means any of the following that at the time are legal investments under the laws of the State of California for moneys held under the Bond Indenture and then proposed to be invested therein:

- (a) United States Government Obligations;
- (b) bonds, debentures, notes or other evidences of indebtedness issued by any of the following agencies or any other like governmental or government-sponsored agencies that are hereafter created: Federal Farm Credit Bank; Federal Intermediate Credit Banks; Federal Financings Bank; Federal Home Loan Bank System; Federal Home Loan Mortgage Corporation; Federal National Mortgage Association; Tennessee Valley Authority; Student Loan Marketing Association; Export-Import Bank of the United States; Farmers Home Administration; Small Business Administration; Inter-American Development Bank; International Bank for Reconstruction and Development; Federal Land Banks; and Government National Mortgage Association;
- (c) direct and general obligations of any state of the United States of America or any municipality or political subdivision of such state, or obligations of any corporation, if such obligations are rated in one of the three highest Rating Categories by each Rating Agency then rating both the Bonds and such obligations (but in all cases by at least one Rating Agency then rating the Bonds);
- (d) commercial paper rated in the highest Rating Category by each Rating Agency then rating both the Bonds and such commercial paper (but in all cases by at least one Rating Agency then rating the Bonds);
- (e) negotiable or non-negotiable certificates of deposit, time deposits, or other similar banking arrangements, issued by any bank (including the Bond Trustee and its affiliates) or trust company or any savings and loan association, and either (i) the long-term obligations of such bank or trust company are rated in the highest Rating Category by each Rating Agency then rating both the Bonds and such obligations (but in all events by at least one Rating Agency then rating the Bonds), or (ii) the deposits or other arrangements are continuously secured as to principal, but only to the extent not insured by the Federal Deposit Insurance Corporation or similar corporation chartered by the United States of America, (1) by depositing with a bank or trust company, as collateral security, obligations described in paragraph (a) or (b) above in an aggregate principal amount equal to a least 105% of the amount so deposited or, with the approval of the Bond Trustee, other marketable securities eligible as securities for the deposit of trust funds under applicable regulations of the Comptroller of the Currency of the United States or applicable state law or regulations, having a market value (exclusive of accrued interest) not less than the amount of such deposit, or (2) if the furnishing of security as provided in clause (1) of this paragraph is not permitted by applicable law, in such other manner as may then be required or permitted by applicable state or federal laws and regulations regarding the security for, or granting a preference in the case of, the deposit of trust funds;

(f) repurchase agreements with respect to obligations listed in paragraph (a) or (b) above if entered into with a bank, a trust company or a broker or dealer (as defined by the Securities Exchange Act of 1934) that is a dealer in government bonds, that reports to, trades with and is recognized as a primary dealer by a Federal Reserve Bank, if such obligations that are the subject of such repurchase agreement are delivered to the Bond Trustee or are supported by a safekeeping receipt issued by a depository (other than the Bond Trustee) satisfactory to the Bond Trustee, provided that such repurchase agreement must provide that the value of the underlying obligations shall be maintained at a current market value, calculated no less frequently than monthly, of not less than the repurchase price;

(g) shares or certificates in any short-term investment fund that is maintained or utilized by the Bond Trustee and which fund invests solely in other Investment Securities or any money market fund including those for which the Bond Trustee or its affiliates provide investment advisory or other management services;

(h) investment agreements with any financial institution that at the time of investment has long-term obligations rated in one of the three highest Rating Categories by each Rating Agency then rating both the Bonds and such obligations (but in all cases by at least one Rating Agency then rating the Bonds);

(i) shares or certificates in any mutual fund invested solely in Investment Securities described in clauses (a)-(h) of this definition; and

(j) obligations (including asset-backed and mortgaged-backed obligations) of any corporation, partnership, trust or other entity which are rated in one of the three highest Rating Categories by each Rating Agency then rating both the Bonds and such obligations (but in all cases by at least one Rating Agency then rating the Bonds).

**Irrevocable Deposit** means the irrevocable deposit in trust of cash in an amount (or Government Obligations the principal of and interest on which will be an amount), and under terms sufficient to pay all or a portion of the principal of and/or premium, if any, and interest on, as the same shall become due, any Indebtedness which would otherwise be considered Outstanding. The trustee of such deposit may be the Master Trustee or any other trustee authorized to act in such capacity.

**Issuer** means ABAG Finance Authority for Nonprofit Corporations and its successors.

**Lien** means any mortgage or pledge of, or security interest in, or lien or encumbrance on, any Property or Gross Revenues of any Member (a) which secures any Indebtedness or any other obligation of any Member or (b) which secures any obligation of any Person other than the Corporation or any Member, and excluding liens applicable to Property in which any Member has only a leasehold interest unless the lien secures Indebtedness of any Member.

**Long-term Debt Service Coverage Ratio** means for any period of time the ratio determined by dividing Income Available for Debt Service for such period by Maximum Annual Debt Service.

**Long-term Indebtedness** means Indebtedness having an original maturity greater than one year or renewable at the option of a Member for a period greater than one year from the date of original incurrence or issuance thereof unless, by the terms of such Indebtedness, no Indebtedness is permitted to be outstanding thereunder for a period of at least 20 consecutive days during each calendar year.

**Master Indenture** means that certain master trust indenture, dated as of June 1, 1988, among the Corporation, Sharp Memorial Hospital, Sharp Chula Vista Medical Center and Grossmont Hospital Corporation and the Master Trustee, as originally executed and as it may from time to time heretofore or hereafter be supplemented, modified or amended in accordance with the terms thereof.

**Master Trustee** means U.S. Bank National Association, a national banking association, as trustee under the Master Indenture, or its successor.

**Maximum Annual Debt Service** means the highest Debt Service Requirement for the current or any succeeding Fiscal Year.

**Member** means the Corporation, Sharp Memorial Hospital, Sharp Chula Vista Medical Center and Grossmont Hospital Corporation and each other Person that is then obligated under the Master Indenture.

**Moody's** means Moody's Investors Service, a corporation organized and existing under the laws of the State of Delaware, its successors and their assigns, or, if such corporation shall be dissolved or liquidated or shall no longer perform the functions of a securities rating agency, any other nationally recognized securities rating agency designated by the Corporation by notice in writing to the Issuer and the Bond Trustee.

**Obligated Group** means all Members.

**Obligated Group Representative** means the Corporation or such other Person as designated by the Corporation with the Bond Trustee.

**Obligation** means any obligation of the Obligated Group issued under the Master Indenture, as a joint and several obligation of the Corporation and each other Member, which may be in any form set forth in a Related Supplement, including, but not limited to, bonds, obligations, debentures, loan agreements or leases. Reference to a Series of Obligations or to Obligations of a Series means Obligations or Series of Obligations issued pursuant to a single Related Supplement.

**Obligation No. 30** means the obligation issued under the Master Indenture and Supplement No. 30.

**Officer's Certificate** means a certificate signed by an Authorized Representative of the Corporation.

**Opinion of Bond Counsel** means a written opinion signed by a nationally recognized attorney or firm of attorneys acceptable to the Master Trustee and experienced in the field of public finance whose opinions are generally accepted by purchasers of bonds issued by or on behalf of a Government Issuer.

**Opinion of Counsel** means a written opinion of counsel (who may be counsel for the Issuer, the Bond Trustee or the Corporation) selected by the Corporation and, in the case of the Bond Indenture, not objected to by the Bond Trustee and, in the case of the Master Indenture, acceptable to the Master Trustee.

**Outstanding**, when used as of any particular time with reference to Bonds, means all Bonds theretofore, or thereupon being, authenticated and delivered by the Bond Trustee under the Bond Indenture except (1) Bonds theretofore canceled by the Bond Trustee or surrendered to the Bond Trustee for cancellation; (2) Bonds with respect to which all liability of the Issuer shall have been discharged in accordance with the Bond Indenture; and (3) Bonds for the transfer or exchange of or in lieu of or in substitution for which other Bonds shall have been authenticated and delivered by the Bond Trustee pursuant to the Bond Indenture.

**Permitted Encumbrances** means and includes:

(a) Any judgment lien or notice of pending action against any Member so long as such judgment or pending action is being contested and execution thereon is stayed or while the period for responsive pleading has not lapsed;

(b) (i) Rights reserved to or vested in any municipality or public authority by the terms of any right, power, franchise, grant, license, permit or provision of law, affecting any Property, to (A) terminate such right, power, franchise, grant, license or permit, provided that the exercise of such right would not materially impair the use of such Property or materially and adversely affect the value thereof, or (B) purchase, condemn, appropriate or recapture, or designate a purchaser of, such Property; (ii) any liens on any Property for taxes, assessment, levies, fees, water and sewer charges, and other governmental and similar charges and any liens of mechanics, materialmen, laborers, suppliers or vendors for work or services performed or materials furnished in connection with such Property, which are not due and payable or which are not delinquent or which, or the amount or validity of which,

are being contested and execution thereon is stayed or, with respect to liens of mechanics, materialmen and laborers, have been due for less than 60 days; (iii) easements, rights-of-way, servitudes, restrictions and other minor defects, encumbrances, and irregularities in the title to any Property which do not materially impair the use of such Property or materially and adversely affect the value thereof; and (iv) rights reserved to or vested in any municipality or public authority to control or regulate any Property or to use such Property in any manner, which rights do not materially impair the use of such Property in any manner, or materially and adversely affect the value thereof;

(c) Any Lien or encumbrance described in Exhibit A to the Master Indenture which was existing on the date of execution thereof;

(d) Any Lien in favor of the Master Trustee securing all Obligations other than Subordinated Indebtedness;

(e) Liens arising by reason of good faith deposits with any Member of the Obligated Group in connection with leases of real estate, bids or contracts (other than contracts for the payment of money), deposits by any Member of the Obligated Group to secure public or statutory obligations, or to secure, or in lieu of, surety, stay or appeal bonds, and deposits as security for the payment of taxes or assessments or other similar charges;

(f) Any Lien arising by reason of deposits with, or the giving of any form of security to, any governmental agency or any body created or approved by law or governmental regulation for any purpose at any time as required by law or governmental regulation as a condition to the transaction of any business or the exercise of any privilege or license, or to enable any Member to maintain self-insurance or to participate in any funds established to cover any insurance risks or in connection with workers' compensation, unemployment insurance, pension or profit sharing plans or other similar social security plans, or to share in the privileges or benefits required for companies participating in such arrangements;

(g) Any Lien arising by reason of any escrow established to pay debt service with respect to Indebtedness;

(h) Any Lien in favor of a trustee on the proceeds of Indebtedness prior to the application of such proceeds;

(i) Liens on moneys deposited by patients or others with any Member as security for or as prepayment for the cost of patient care;

(j) Liens on Property or Gross Revenues securing Indebtedness not evidenced by Obligations;

(k) Statutory rights of the United States of America by reason of federal funds made available under 42 U.S.C. Section 291 et seq. and similar rights under other federal and state statutes;

(l) Liens on Property acquired by any Member which Liens existed on such Property prior to the time of its acquisition by such Member;

(m) Liens granted by any Member to any other Member;

(n) The Lien created by the pledge of Gross Revenues under the Master Indenture;

(o) Liens on Property existing at the time a Person becomes a Member pursuant to the Master Indenture or existing at the time a Person is merged into a Member pursuant to the Master Indenture;

(p) The lease or license of the use of a part of Property in connection with the proper and economical use of such Property in accordance with customary and prudent business practice;

(q) Liens on Property due to rights of third-party payors for recoupment of amounts paid to any Member;

(r) Liens on accounts receivable securing Short-term Indebtedness; and

(s) Liens arising by virtue of a lease and leaseback or similar arrangements entered into by any Member with a Related Bond Issuer to the extent required in connection with the issuance of a series of Related Bonds.

**Property** means any and all right, title and interest in and to any and all property of the Obligated Group whether real or personal, tangible or intangible and wherever situated.

**Property, Plant and Equipment** means all Property of the Obligated Group which is considered property, plant and equipment of such Members under generally accepted accounting principles.

**Qualified Provider** means any financial institution or insurance company which is a party to a Financial Products Agreement if the unsecured long-term debt obligations of such financial institution or insurance company (or of the parent or a subsidiary of such financial institution or insurance company if such parent or subsidiary guarantees the performance of such financial institution or insurance company under such Financial Products Agreement), or obligations secured or supported by a letter of credit, contract, guarantee, agreement, insurance policy or surety bond issued by such financial institution or insurance company (or such guarantor parent or subsidiary), are rated in one of the three highest Rating Categories of a national rating agency at the time of the execution and delivery of the Financial Products Agreement.

**Rating Agency** means S&P and Moody's.

**Rating Category** means a generic securities rating category, without regard to any refinement or gradation of such rating category by a numerical modifier or otherwise.

**Record Date** means, for any interest payment date with respect to the Bonds, the fifteenth (15th) calendar day of the month preceding the month in which each interest payment date falls.

**Redemption Price** means, with respect to any Bond (or portion thereof), the principal amount of such Bond (or portion) plus the applicable premium, if any, payable upon redemption thereof pursuant to the provisions of such Bond and the Bond Indenture.

**Related Bonds** means the revenue bonds or other obligations or evidences of indebtedness issued or incurred by any Governmental Issuer, pursuant to a single Related Bond Indenture, the proceeds of which are loaned or otherwise made available to the Corporation or any other Member in consideration of the execution, authentication and delivery of an Obligation or Obligations to or for the order of such Government Issuer.

**Related Bond Indenture** means any indenture, bond resolution or other comparable instrument pursuant to which a series of Related Bonds are issued.

**Related Bond Issuer** means the Government Issuer of any issue of Related Bonds.

**Related Supplement** means an indenture supplemental to, and authorized and executed pursuant to the terms of, the Master Indenture.

**Required Payment** means any payment whether at maturity, by acceleration, upon proceeding for redemption or otherwise, required of any Member under the Master Indenture, any Related Supplement, any Obligation or otherwise in connection with a Financing, including, but not limited to, the payment of principal, interest, premium and lease payments.

**Revenues**, when used in connection with the Bonds, means all amounts received by the Issuer or the Bond Trustee for the account of the Issuer pursuant or with respect to the Loan Agreement or Obligation No. 30, including, without limiting the generality of the foregoing, Loan Repayments (including both timely and delinquent payments and any late charges, and whether paid from any source), prepayments, insurance proceeds, condemnation

proceeds, and all interest, profits or other income derived from the investment of amounts in any fund or account established pursuant to the Bond Indenture, but not including any Administrative Fees and Expenses or any moneys required to be deposited in the Rebate Fund established under the Bond Indenture.

**S&P** means Standard & Poor's Ratings Services, a division of The McGraw-Hill Companies, Inc., a corporation organized and existing under the laws of the State of New York, its successors and assigns, or, if such corporation shall be dissolved or liquidated or shall no longer perform the functions of a securities rating agency, any other nationally recognized securities rating agency designated by the Corporation by notice in writing to the Issuer and the Bond Trustee.

**Secured Indebtedness** means Indebtedness (including Obligations and Guaranties) secured by a Lien which is a Permitted Encumbrance pursuant to clause (c), (j), (l), (n), (o) or (r) of the definition of Permitted Encumbrances (above), other than a Lien securing Subordinated Indebtedness.

**Serial Bonds** means the Bonds falling due by their terms in specified years, for which no Sinking Fund Installments have been established.

**Short-term Indebtedness** means all Indebtedness having an original maturity less than or equal to one year and not renewable at the option of a Member for a term greater than one year from the date of original incurrence or issuance unless, by the terms of such Indebtedness, no Indebtedness is permitted to be outstanding thereunder for a period of at least 20 consecutive days during each calendar year.

**Sinking Fund Installment** means the amount required by the Bond Indenture to be paid by the Issuer on any single date for the retirement of Bonds.

**Subordinated Indebtedness** means Indebtedness incurred by a Member that by its terms is specifically subordinated with respect to any security therefor and with respect to right of payment to all Outstanding Obligations and all other obligations of a Member not containing such subordination provision.

**Supplemental Bond Indenture** means any indenture hereafter duly authorized and entered into between the Issuer and the Bond Trustee, supplementing, modifying or amending the Bond Indenture; but only if and to the extent that such Supplemental Bond Indenture is specifically authorized under the Bond Indenture.

**Supplement No. 30** means that certain supplemental master trust indenture, dated as of February 1, 2011, between the Corporation and the Master Trustee, pursuant to which Obligation No. 30 is issued.

**Term Bonds** means the Bonds payable at or before their specified maturity date or dates from Sinking Fund Installments established for the purpose and calculated to retire such Bonds or on before their specified maturity date or dates.

**Total Revenues** means, for the period of calculation in question, the total revenues of the Obligated Group determined in accordance with generally accepted accounting principles for the most recent Fiscal Year for which audited financial statements are available.

**United States Government Obligations** means (i) direct obligations of the United States of America (including obligations issued or held in book-entry form on the books of the Department of Treasury of the United States of America) and obligations the timely payment of the principal of and interest on which are fully guaranteed by the United States of America, and, (ii) certificates or other instruments which evidence ownership of the right to the payment of the principal of and interest on obligations described in clause (i) provided that such obligations are held in the custody of a bank or trust company in a special account separate from the general assets of such custodian or (iii) municipal obligations the timely payment of the principal of and interest on which is fully provided for by the deposit in trust or escrow of cash or obligations described in clauses (i) or (ii).

**Value**, when used with respect to Property, means the aggregate value of all such Property, with each component of such Property valued, at the option of the Corporation, at either its Fair Market Value or its Book Value.

**Variable Rate Indebtedness** means Indebtedness the interest on which is payable pursuant to a variable interest rate formula or other determination method rather than at a fixed rate of interest per annum to maturity.

## **MASTER INDENTURE**

The Master Indenture authorizes the issuance of Obligations by the Obligated Group. An Obligation is stated in the Master Indenture to be a joint and several obligation of the Corporation and each other Member of the Obligated Group.

The following are summaries of certain provisions of the Master Indenture. Other provisions are summarized in this Official Statement under the caption “SECURITY FOR THE BONDS – The Master Indenture.” These summaries do not purport to be complete or definitive and are qualified in their entireties by reference to the full terms of the Master Indenture. See also the description of certain provisions of the Master Indenture summarized under the caption “Supplemental Master Indenture For Obligation No. 30” below.

### **Authorization, Issuance and Form of Obligations**

Each Member authorizes to be issued from time to time Obligations or Series of Obligations, without limitation as to amount, except as provided in the Master Indenture or as may be limited by law, and subject to the terms, conditions and limitations established in the Master Indenture and in any Related Supplement.

### **Particular Covenants of the Corporation and Each Member**

**Payment of Principal and Interest.** Each Member jointly and severally covenants to pay or cause to be paid promptly all Required Payments, including the principal of, premium, if any, and interest on each Obligation issued under the Master Indenture at the place, on the dates and in the manner provided in the Master Indenture, in any Related Supplement and in said Obligations whether at maturity, upon proceedings for redemption, by acceleration or otherwise, and that each Member of the Obligated Group shall faithfully observe and perform all of the conditions, covenants and requirements of the Master Indenture and any Related Supplement, and that the time of such payment and performance is of the essence of the obligations issued under the Master Indenture.

**Insurance Required.** The Corporation and each Member, respectively, covenants and agrees that it will keep the Property, Plant and Equipment and all of its operations adequately insured at all times and carry and maintain such insurance in amounts which are customarily carried, subject to customary deductibles, and against such risks as are customarily insured against by other corporations in connection with the ownership and operation of facilities of similar character and size, including medical malpractice insurance. Insurance requirements of the Corporation and the Members shall be subject to the review of an Insurance Consultant at least every two years. The Corporation agrees that it will follow recommendations, in whole or in part, of such Insurance Consultant, subject to a good faith determination of the Corporation’s Governing Body that such recommendations are in the best interests of the Corporation. In lieu of maintaining insurance coverage, the Members shall have the right to adopt alternative risk management programs (with certain exceptions) which the Governing Body of the Corporation determines to be reasonable and which shall not have a material adverse impact on reimbursement from third party payors, all as may be approved, in writing, as reasonable and appropriate risk management by the Insurance Consultant and reviewed each year thereafter. Each Member, respectively, further covenants and agrees at all times to maintain worker’s compensation coverage as required by the State of California.

**Against Encumbrances.** Each Member, respectively, covenants and agrees that it will not create, assume or suffer to exist any Lien upon Gross Revenues of the Obligated Group or the Property of the Obligated Group and each Member, respectively, further covenants and agrees that, subject to the provisions of the Master Indenture described in the next paragraph, if such a Lien is created or assumed by any Member, it will obtain the written consent of the Governing Body of the Corporation and make or cause to be made effective a provision whereby all Obligations will be secured prior to or equally and ratably with any such Indebtedness or other obligation secured by

such Lien; provided, however, that notwithstanding the provisions of the Master Indenture, each Member may, subject to the provisions of the Master Indenture described in the next paragraph, create, assume or suffer to exist Permitted Encumbrances.

Each Member, respectively, covenants that Secured Indebtedness Outstanding will not in any event exceed 30% of combined unrestricted fund balances of the Obligated Group as of the end of the most recent Fiscal Year for which audited financial statements are available (including any shareholder equity).

The Master Trustee and the Members do not intend by any provision of the Master Indenture to create an equitable or legal lien or interest on or in any Property, Plant and Equipment of the Members or any of them.

**Limitations on Additional Indebtedness.** Each Member, respectively, agrees that it will not incur any Additional Indebtedness except as follows (and provided, in each case, that no Event of Default as required in the Master Indenture shall have occurred and be continuing):

- (1) Long-term Indebtedness, which may (but need not) be evidenced by Obligations; and
- (2) Short-term Indebtedness, which may be evidenced by Obligations; provided that for 20 consecutive days in any twelve-month period, the aggregate amount of Outstanding Short-term Indebtedness shall be no greater than 5% of Capitalization.

Indebtedness may be secured to the extent permitted by the provisions of the Master Indenture described above under the heading “Against Encumbrances.”

Each Member, respectively, agrees that the principal amount of all Indebtedness Outstanding shall not exceed 65% of Capitalization, and that the aggregate principal amount of all Short-term Indebtedness Outstanding shall not exceed 25% of Capitalization.

**Gross Revenue Fund.** See “SECURITY FOR THE BONDS – The Master Indenture – Pledge of Gross Revenues” for a description of the pledge of Gross Revenues in the Master Indenture.

**Sale, Lease or Other Disposition of Assets.** Each Member, respectively, covenants and agrees that it will not sell, lease or otherwise dispose of its Property (other than to another Member), if, after taking into account any such disposition, the principal amount of all Indebtedness Outstanding exceeds 55% of Capitalization, and if such sale, lease or other disposition of Property is of more than 55% of the Property of such Member, such Member shall file with the Master Trustee an Officer’s Certificate to the effect that the Corporation consents to such sale, lease or other disposition.

**Consolidation, Merger, Sale or Conveyance.** Each Member, respectively, covenants that it will not merge or consolidate with any other corporation not a Member or sell or convey all or substantially all of its assets to any Person not a Member unless:

- (a) after giving effect to the merger, consolidation, sale or conveyance, the successor or surviving corporation (hereinafter, the “Surviving Corporation”) will be the Member, or, if not, the Surviving Corporation shall be a corporation organized and existing under the laws of the United States of America or a state thereof and such Surviving Corporation shall become a Member pursuant to the Master Indenture and shall expressly assume in writing the due and punctual payment of all Required Payments of the disappearing Person under the Master Indenture, according to their tenor, and the due and punctual performance and observance of all of the covenants and conditions of the Master Indenture by the execution of a Related Supplement to the Master Indenture satisfactory to the Master Trustee, delivered to the Master Trustee by such Surviving Corporation;
- (b) there shall have been delivered to the Master Trustee an Officer’s Certificate to the effect that no Member, immediately after the date of the proposed merger, consolidation, sale or conveyance, would be in default in the performance or observance of any covenant or condition of the Master Indenture;

(c) so long as any Related Bonds are Outstanding, there shall have been delivered to the Master Trustee an Opinion of Bond Counsel, in form and substance satisfactory to the Master Trustee, to the effect that, under then existing law, the consummation of such merger, consolidation, sale or conveyance, whether or not contemplated on any date of the issuance of such Related Bonds, would not adversely affect the exclusion from gross income for federal income tax purposes of the interest payable thereon and that such merger, consolidation, sale or conveyance, and the assumption of rights and obligations thereafter, complies with the provisions of the Master Indenture;

(d) there shall have been delivered to the Master Trustee an Officer's Certificate to the effect that after such merger, consolidation, sale or conveyance, the principal amount of all Indebtedness Outstanding will not exceed 65% of Capitalization;

(e) in case of any such consolidation, merger, sale or conveyance, and upon such assumption of obligations, the Surviving Corporation shall be substituted for its predecessor in interest in all agreements, indentures and Obligations then in effect which affect or relate to any Financing, and the Surviving Corporation shall, upon the request of the Master Trustee, execute and deliver to the Master Trustee such documents and endorsements as the Master Trustee may reasonably require in order to effect such substitution including, without limitation, an Opinion of Counsel regarding compliance with the provisions of the Master Indenture. From and after the effective date of such substitution as determined by the Master Trustee, the Surviving Corporation shall, subject to the terms, conditions and limitations prescribed in the Master Indenture, be treated as though it were a Member of the Obligated Group as at the date of the execution of the Master Indenture and shall thereafter have the right to participate in Financings pursuant to the Master Indenture to the same extent as the Members of the Obligated Group; and all Financings undertaken on behalf of a Surviving Corporation in all respects have the same legal rank and benefit under the Master Indenture as though undertaken by the Obligated Group in the absence of such merger, consolidation, sale or conveyance; and

(f) if such consolidation, merger, sale or conveyance is with the Corporation, whether or not the Corporation is the Surviving Corporation, such transaction shall have been approved by a majority of the members of the Governing Body of the Corporation in office at the time that such merger or consolidation is considered.

**Membership in Obligated Group.** Additional Members may be added to the Obligated Group from time to time provided that:

(a) there shall have been delivered to the Master Trustee a copy of a resolution of the proposed new Member which authorizes the execution of the Master Indenture or a Related Supplement and compliance with the terms of the Master Indenture;

(b) there shall have been delivered to the Master Trustee a Related Supplement to the Master Indenture pursuant to which the proposed new Member agrees to become a Member, to be bound by the terms and restrictions imposed by the Master Indenture, to pledge its Gross Revenues pursuant to the Master Indenture, and to be bound by Indebtedness represented by the Obligations;

(c) there shall have been delivered to the Master Trustee an irrevocable power of attorney authorizing the execution of Obligations by the Corporation;

(d) there shall be delivered to the Master Trustee a written Opinion of Counsel to the proposed new Member, which opinion states that the proposed new Member has taken all necessary action to become a Member, and upon execution of a Related Supplement to the Master Indenture, such proposed new Member will be bound by the terms of the Master Indenture;

(e) there shall be delivered to the Master Trustee a description of any existing Long-Term Indebtedness of the proposed new Member and any Indebtedness which the proposed new Member plans to incur simultaneously with the execution of the Related Supplement;

(f) there shall be delivered to the Master Trustee an Opinion of Bond Counsel to the effect that the addition of such Member will not adversely affect the tax-exempt status of any Related Bonds, nor cause the Master Indenture nor the Obligations issued under the Master Indenture to be subject to registration under federal or state securities laws (or unless such registration, if required, has occurred) nor the Trust Indenture Act of 1939, as amended, nor cause a default with respect to the covenant regarding Additional Indebtedness set forth in the Master Indenture; and

(g) there shall have been delivered to the Master Trustee an Officer's Certificate to the effect that no Member, immediately after the addition of such new Member, would be in default in the performance or observance of any covenant or condition of the Master Indenture and specifically stating that the Members would not be in default with respect to the covenant regarding Additional Indebtedness set forth in the Master Indenture relating to Capitalization.

**Withdrawal from Obligated Group.** Any Member, with the exception of the Corporation, may withdraw from the Obligated Group, and be released from further liability or obligation under the provisions of the Master Indenture, including a release or termination of the security interest in such Member's Gross Revenues created in the Master Indenture provided that:

(a) there shall have been delivered to the Master Trustee an Officer's Certificate to the effect that the Corporation consents to such withdrawal and, immediately following withdrawal of such Member, no Member would be in default in the performance or observance of any covenant or condition of the Master Indenture and specifically stating that the Members would not be in default with respect to the covenant set forth in the Master Indenture;

(b) such Member has not executed any Outstanding Obligations and is not a party to a loan or similar agreement with a Related Bond Issuer with respect to Outstanding Related Bonds;

(c) there shall be delivered to the Master Trustee an Officer's Certificate to the effect that all Property of the withdrawing Member may be disposed of in accordance with the covenant regarding disposition of assets set forth in the Master Indenture.

## **Default**

**Events of Default.** Events of Default, as used in the Master Indenture, means any of the following events:

(a) Failure on the part of the Obligated Group to make due and punctual payment of the principal of or redemption premium, if any, or interest on an Obligation.

(b) Any Member shall fail duly to observe or perform any other covenant or agreement under the Master Indenture for a period of 60 days after the date on which written notice of such failure, requiring the same to be remedied, shall have been given to the Corporation by the Master Trustee or to the Corporation and the Master Trustee by the Holders of 25% in aggregate principal amount of Outstanding Obligations, except that, if such failure can be remedied but not within such 60-day period, such failure shall not become an Event of Default for so long as the Corporation shall diligently proceed to remedy same in accordance with and subject to any directions or limitations of time established by the Master Trustee (subject to the provisions of the Master Indenture).

(c) The Members shall default in the payment of Indebtedness for borrowed money (other than an Obligation) in an aggregate principal amount in excess of 1-1/2% of Capitalization, whether such Indebtedness now exists or shall hereafter be created, and any period of time for cure with respect thereto shall have expired, or an event of default as defined in any mortgage, indenture or instrument, under which there may be secured or evidenced any Indebtedness in excess of 1-1/2% of Capitalization, whether such Indebtedness now exists or shall hereafter be created, shall occur; provided, however, that such default shall not constitute an Event of Default within the meaning of the Master Indenture if within 30 days, or within the time allowed for service of a responsive pleading if any proceeding to enforce payment of the

Indebtedness is commenced (i) any Member in good faith commences proceedings to contest the existence or payment of such Indebtedness, and (ii) sufficient moneys are escrowed with a bank or trust company or a bond, all as is acceptable to the Master Trustee, is posted for the payment of such Indebtedness.

- (d) Certain events of bankruptcy or insolvency with respect to the Members.
- (e) An event of default shall exist under any Related Bond Indenture.

**Acceleration; Annulment of Acceleration.** Upon the occurrence and during the continuation of an Event of Default under the Master Indenture, the Master Trustee may, upon written request of the holders of not less than 25% in aggregate principal amount of Outstanding Obligations or of any holder if an Event of Default described above in subsection (a) under the heading “Default – Events of Default” has occurred and upon indemnification of the Master Trustee in accordance with the Master Indenture, shall, by notice to the Members, declare all Outstanding Obligations immediately due and payable, whereupon such Obligations shall become and be immediately due and payable, anything in the Obligations or the Master Indenture to the contrary notwithstanding. In such event, there shall be due and payable on the Obligations an amount equal to the aggregate principal amount of all such Obligations, plus all interest accrued thereon and, to the extent permitted by applicable law, which accrues on such principal and interest to the date of payment.

At any time after the principal of the Obligations shall have been so declared to be due and payable and before the entry of final judgment or decree in any suit, action or proceeding instituted on account of such default, if (i) the Obligated Group has paid or caused to be paid or deposited with the Master Trustee moneys sufficient to pay all matured installments of interest and interest on installments of principal and interest and principal or redemption prices and other payments then due (other than the principal or other payments then due only because of such declaration) of all Outstanding Obligations, (ii) the Obligated Group has paid or caused to be paid or deposited with the Master Trustee moneys sufficient to pay the charges, compensation, expenses, disbursements, advances and liabilities of the Master Trustee and any paying agents, (iii) all other amounts then payable by the Obligated Group under the Master Indenture shall have been paid or a sum sufficient to pay the same shall have been deposited with the Master Trustee, and (iv) every Event of Default (other than a default in the payment of the principal or other payments of such Obligations then due only because of such declaration) shall have been remedied, then the Master Trustee may annul such declaration and its consequences with respect to any Obligations or portions thereof not then due by their terms (subject to the provisions of the Master Indenture). No such annulment shall extend to or affect any subsequent Event of Default or impair any right consequent thereon.

**Holders’ Control of Proceedings.** If an Event of Default shall have occurred and be continuing, notwithstanding anything in the Master Indenture to the contrary, the holders of at least a majority in aggregate principal amount of Obligations then Outstanding shall have the right, at any time, by any instrument in writing executed and delivered to the Master Trustee, to direct the method and place of conducting any proceeding to be taken in connection with the enforcement of the terms and conditions of the Master Indenture or for the appointment of a receiver or any other proceedings under the Master Indenture, provided that such direction is not in conflict with any applicable law or the provisions of the Master Indenture (including indemnity to the Master Trustee as provided in the Master Indenture) and, in the sole judgment of the Master Trustee, is not unduly prejudicial to the interest of the holders not joining in such direction subject to the provisions of the Master Indenture and provided further that nothing in the Master Indenture shall impair the right of the Master Trustee in its discretion to take any other action under the Master Indenture which it may deem proper and which the Master Trustee does not deem inconsistent with such direction by holders.

## **Supplements and Amendments**

**Supplements Not Requiring Consent of Holders** The Master Indenture may be supplemented without the consent of or notice to any of the holders for one or more of the following purposes; (a) to cure any ambiguity or formal defect or omission in the Master Indenture; (b) to correct or supplement any provision which may be inconsistent with any other provision, or to make any other provisions with respect to matters or questions arising under the Master Indenture and which shall not materially and adversely affect the interests of the holders; (c) to grant or confer ratably upon all of the holders any additional rights, remedies, powers or authority, or to add to the covenants of and restrictions on the Members; (d) to qualify the Master Indenture under the Trust Indenture Act of

1939, as amended, or corresponding provisions of federal laws from time to time in effect; (e) to create and provide for the issuance of an Obligation or Series of Obligations as permitted under the Master Indenture; (f) to obligate a successor to the Corporation or other Member of the Obligated Group as provided in the Master Indenture; (g) to add a new Member as provided in the Master Indenture; (h) to allow a Member to withdraw from the Obligated Group as provided in the Master Indenture; or (i) to preserve the exclusion from gross income for federal income tax purposes of the interest on any Related Bonds.

**Supplements Requiring Consent of Obligation Holders.** The Master Indenture may also be amended for other purposes provided that there is first filed with the Master Trustee the written consent of the holders of not less than a majority in aggregate principal amount of all Obligations then Outstanding. No supplement shall be permitted, however, which would: (i) extend the stated maturity of or time for paying interest on any Obligation or reduce the principal amount of or the redemption premium or rate of interest or method of calculating interest payable on any Obligation without the consent of such holder of such Obligation; (ii) modify, alter, amend, add to or rescind any of the terms or provisions of the Master Indenture so as to affect the right of the holders of any Obligations in default as to payment to compel the Master Trustee to declare the principal of all Obligations to be due and payable, without the consent of the holders of all Obligations then Outstanding; or (iii) or reduce the aggregate principal amount of Obligations then Outstanding the consent of the holders of which is required to authorize such Related Supplements without the consent of the holders of all Obligations then Outstanding.

### **SUPPLEMENTAL MASTER INDENTURE FOR OBLIGATION NO. 30**

The following is a summary of certain provisions of Supplemental Master Indenture for Obligation No. 30 (“Supplement No. 30”). These summaries do not purport to be complete or definitive and are qualified in their entirety by reference to the full terms of Supplement No. 30.

#### **Payments on Obligation No. 30; Credits**

Principal of and interest and any applicable redemption premium on Obligation No. 30 are payable in any coin or currency of the United States of America which on the payment date is legal tender for the payment of public and private debts. Except as provided in Supplement No. 30 and described in the following paragraph with respect to credits, and the section of Supplement No. 30 regarding prepayment, payments on the principal of and premium, if any, and interest on Obligation No. 30 shall be made at the times and in the amounts specified in Obligation No. 30 by the Corporation depositing or causing to be deposited the same with or to the account of the Bond Trustee at or prior to the opening of business on the day such payments shall become due or payable (or the next succeeding Business Day if such day is not a Business Day) and giving notice to the Master Trustee and the Bond Trustee of each payment of principal, interest or premium on Obligation No. 30, that specifies the amount paid and identifying such payment as a payment on Obligation No. 30.

The Obligated Group shall receive credit for payment on Obligation No. 30, in addition to any credits resulting from payment or prepayment from other sources, as follows:

(i) On installments of interest on Obligation No. 30 in an amount equal to moneys deposited in the Interest Account created under the Bond Indenture, which amounts are available to pay interest on the Bonds and to the extent such amounts have not previously been credited against payments on Obligation No. 30 or any other Obligation;

(ii) On installments of principal of Obligation No. 30 in an amount equal to moneys deposited in the Principal Account created under the Bond Indenture, which amounts are available to pay principal of the Bonds and to the extent such amounts have not previously been credited on Obligation No. 30 or any other Obligation;

(iii) On installments of principal of and interest on Obligation No. 30 in an amount equal to, respectively, the principal amount of Bonds for the redemption or payment of which sufficient amounts (as determined by the Bond Indenture) in cash or United States Government Obligations are on deposit as provided in

the Bond Indenture to the extent such amounts have not been previously credited against payments on Obligation No. 30 or any other Obligation, and the interest on such Bonds from and after the date fixed for payment at maturity or redemption thereof. Such credits shall be made against the installments of principal of and interest on Obligation No. 30 which would have been used, but for such call for payment or redemption, to pay principal of and interest on such Bonds when due at maturity or upon mandatory redemption; and

(iv) On installments of principal of and interest on Obligation No. 30, in an amount equal to, respectively, the principal amount of Bonds delivered to the Bond Trustee for cancellation or purchased by the Bond Trustee and canceled, and the interest on such Bonds from and after the date interest thereon has been paid prior to cancellation. Such credits shall be made against the installments of principal of and interest on Obligation No. 30 which would have been used, but for such cancellation, to pay principal of and interest on such Bonds when due, and with respect to Bonds called for mandatory redemption, against principal installments that would have been used to pay Bonds of the same maturity.

### **Prepayment of Obligation No. 30**

So long as all amounts which have become due under Obligation No. 30 have been paid, the Corporation shall have the right, at any time and from time to time, to pay in advance and in any order of due dates all or part of the amounts to become due under Obligation No. 30. Prepayments may be made by payments of cash, deposit of United States Government Obligations or surrender of Bonds. All such prepayments (and the additional payment of any amount necessary to pay the applicable premium, if any, payable upon the redemption of Bonds) shall, at the request of and as determined by the Corporation, be credited against payments due under Obligation No. 30 or used for the redemption or purchase of Outstanding Bonds in the manner and subject to the terms and conditions set forth in the Bond Indenture. Notwithstanding any such prepayment or surrender of Bonds, as long as any Bonds remain Outstanding or any additional payments required to be made under Supplement No. 30 remain unpaid, the Obligated Group shall not be relieved of its obligations under Supplement No. 30.

### **Registration, Number, Negotiability and Transfer of Obligation No. 30**

Except as provided in Supplement No. 30 and as described in the following paragraph, so long as any Bond remains Outstanding, Obligation No. 30 shall consist of a single Obligation without coupons, registered as to principal and interest in the name of the Bond Trustee, and no transfer of Obligation No. 30 shall be registered under the Master Indenture except for transfers to a successor Bond Trustee.

Upon the principal of all Obligations then outstanding being declared immediately due and payable upon and during the continuance of an Event of Default, Obligation No. 30 may be transferred, if and to the extent the Bond Trustee requests that the restrictions of Supplement No. 30 described in the preceding paragraph on transfers be terminated.

### **Modifications to Certain Covenants of the Master Indenture While Obligation No. 30 is Outstanding**

Certain covenants set forth in the Master Indenture and summarized in this Appendix C above will be modified or supplemented by provisions in Supplemental Master Indenture for Obligation No. 30, as described below, unless subsequently modified or waived by the Holder of Obligation No. 30.

An additional covenant relating to the **Debt Service Coverage Ratio** of the Obligated Group is added so long as Obligation No. 30 remains Outstanding. It is summarized as follows:

(a) Each Member of the Obligated Group agrees to conduct its method of operations so that the Long-term Debt Service Coverage Ratio of the Obligated Group as a whole at the end of each Fiscal Year is not less than 1.25:1.0.

(b) Within 120 days after the end of each Fiscal Year (commencing with the first full Fiscal Year following the execution of Supplement No. 30) the Corporation shall compute Income Available for Debt Service and Maximum Annual Debt Service and promptly furnish to the Master Trustee a Certificate setting forth the results

of such computation. Each Member further covenants and agrees that if at the end of such Fiscal Year the Long-term Debt Service Coverage Ratio shall have been less than 1.25:1.0, it will promptly employ an Independent Consultant to make recommendations as to a revision of the rates, fees and charges of the Members or the methods of operation of the Members. Copies of the recommendations of the Independent Consultant shall be filed with the Master Trustee. Each Member shall, promptly upon its receipt of such recommendations, subject to applicable requirements or restrictions imposed by law, revise its rates, fees and charges or its methods of operation and shall take such other action as shall be in conformity with such recommendations.

If the Members comply in all material respects with the reasonable recommendations of the Independent Consultant in respect to said rates, fees, charges and methods of operation or collection, the Members will be deemed to have complied with the provisions of the covenant summarized here for such Fiscal Year notwithstanding that Income Available for Debt Service shall be less than the amount required as described in (a) above; and provided that (i) the Members shall not be excused from taking any action or performing any duty required under the Master Indenture, (ii) no other Event of Default shall be waived by the operation of the provision of this subsection (b) and (iii) in no event shall the Long-term Debt Service Coverage Ratio be less than 1.0:1.0.

(c) If a written report of an Independent Consultant is delivered to the Master Trustee stating that Industry Restrictions have made it impossible for the ratio described in subsection (a) above to be met, then such ratio shall be reduced to 1.0:1.0 for so long as such Industry Restrictions shall prevail, and shall apply to the actual debt service on all Long-term Indebtedness for such Fiscal Year rather than Maximum Annual Debt Service.

The last paragraph of the summary relating to “**Limitations on Additional Indebtedness**” summarized above under the caption “MASTER INDENTURE — Particular Covenants of the Corporation and Each Member” in this Appendix C is modified so long as Obligation No. 30 remains Outstanding as follows:

Each Member, respectively, agrees that the principal amount of all Indebtedness Outstanding shall not exceed 65% of Capitalization, and that the aggregate principal amount of Short-term Indebtedness shall not exceed 25% of Capitalization. Additionally, each Member agrees that it will not incur Additional Long-term Indebtedness unless either:

(1) the Long-term Debt Service Coverage Ratio for the most recent Fiscal Year for which audited financial statements are available immediately preceding the incurrence of such Indebtedness was at least equal to 1.25:1.0 and (2) the Long-term Debt Service Coverage Ratio for the most recent Fiscal Year for which audited financial statements are available immediately preceding the incurrence of such Indebtedness, adjusted to take into account the Indebtedness proposed to be incurred as if it had been incurred as of the first day of such Fiscal Year, was at least equal to 1.25:1.0; or

(2) such Long-term Indebtedness is issued to refund Long-term Indebtedness and the Trustee receive an Officer’s Certificate to the effect that the issuance of such Long-term Indebtedness would not increase Maximum Annual Debt Service by more than ten percent (10%); or

(3) such Long-term Indebtedness constitutes Subordinated Indebtedness; or

(4) such Long-term Indebtedness constitutes Completion Indebtedness and the Trustee receives an Officer’s Certificate to the effect that the issuance of such Completion Indebtedness would not increase Maximum Annual Debt Service by more than fifteen percent (15%); or

(5) an Officer’s Certificate is delivered to the Trustee stating that the aggregate principal amount of such Long-term Indebtedness, together with the aggregate principal amount of Long-term Indebtedness incurred pursuant to the provisions of this clause (5) and then Outstanding, does not, as of the date of incurrence, exceed 25% of Total Revenues.”

The summary relating to “**Sale, Lease or Other Disposition of Assets**” summarized above under the caption “MASTER INDENTURE — Particular Covenants of the Corporation and Each Member” in this Appendix C is modified so long as Obligation No. 30 remains Outstanding as follows:

Each Member, respectively, covenants and agrees that (i) it will not sell, lease or otherwise dispose of any of its Property (other than to another Member), if, after taking into account any such disposition, the principal amount of all Indebtedness Outstanding exceeds 50% of Capitalization, and (ii) if such sale, lease or other disposition of Property is more than 50% of the Property of such Member, such Member shall file with the Master Trustee an Officer's Certificate to the effect that the Corporation consents to such sale, lease or other disposition. Additionally, each Member, respectively, covenants and agrees that it will not sell, lease or otherwise dispose of any of its Property (other than to another Member) unless either:

(1) the Value of all Property sold, leased or otherwise disposed of in any Fiscal Year does not exceed five percent (5%) of the Value of all Property of the Obligated Group; or

(2) there shall have been delivered to the Master Trustee an Officer's Certificate to the effect that such Property is inadequate, obsolete, unsuitable, undesirable or unnecessary for the operation and functioning of the primary business of the Members; or

(3) there shall have been delivered to the Master Trustee an Officer's Certificate to the effect that the Value of the Property so disposed of by the Members in any Fiscal Year pursuant to the provision described in this clause (3) does not exceed five percent (5%) of Total Revenues; or

(4) there shall have been delivered to the Master Trustee an Officer's Certificate to the effect that the sale, lease or disposition is for Fair Market Value and will not impair the structural soundness, efficiency or economic value of the remaining Property of the Obligated Group; or

(5) there shall have been delivered to the Master Trustee an Officer's Certificate to the effect that the Members would be able to incur at least \$1.00 of additional Long-term Indebtedness pursuant to the provisions of the Master Indenture and Supplemental Master Indenture for Obligation No. 30 relating to Additional Indebtedness immediately following such sale, lease or other disposition.”

The following additional paragraph is added to the summary relating to each of “**Consolidation, Merger, Sale or Conveyance,**” **Membership in the Obligated Group**” and “**Withdrawal from Obligated Group**” summarized above under the caption “MASTER INDENTURE — Particular Covenants of the Corporation and Each Member” in this Appendix C so long as Obligation No. 30 remains Outstanding:

There shall have been delivered to the Master Trustee an Officer's Certificate to the effect that the Members would be able to incur at least \$1.00 of additional Long-term Indebtedness pursuant to the provisions of the Master Indenture and Supplemental Master Indenture for Obligation No. 30 relating to Additional Indebtedness immediately following the pertinent action or transaction.

## **BOND INDENTURE**

### **General**

The Bond Indenture sets forth the terms of the Bonds, the nature and extent of security, the various rights of the Holders of the Bonds, the rights, duties and immunities of the Bond Trustee and the rights and obligations of the Issuer. Certain provisions of the Bond Indenture are summarized below. Other provisions are summarized in this Official Statement under the captions “THE BONDS” and “SECURITY FOR THE BONDS.” The following is a summary of certain provisions of the Bond Indenture. This summary does not purport to be complete or definitive and reference is made to the Bond Indenture for the complete terms thereof.

### **Establishment of Funds and Accounts**

The Bond Indenture creates a Revenue Fund, an Interest Account, a Principal Account, a Redemption Fund, an Optional Redemption Account, a Special Redemption Account and a Rebate Fund, all of which are to be held by the Bond Trustee.

## **Pledge and Assignment**

Subject only to the provisions of the Bond Indenture permitting the application thereof for the purposes and on the terms and conditions set forth therein, there are pledged to secure the payment of the principal of and premium, if any, and interest on the Bonds in accordance with their terms and the provisions of the Bond Indenture, all of the Revenues and any other amounts held in any fund or account established pursuant to the Bond Indenture (other than the Rebate Fund). Said pledge shall constitute a lien on and security interest in such assets and shall attach, be perfected and be valid and binding from and after delivery by the Bond Trustee of the Bonds, without any physical delivery thereof or further act.

The Issuer transfers in trust, grants a security interest in and assigns to the Bond Trustee, for the benefit of the Holders from time to time of the Bonds, all of the Revenues and other assets pledged in the Bond Indenture (as described in the previous paragraph) and all of the right, title and interest of the Issuer in the Loan Agreement (except for (i) the right to receive any administrative fees and expenses to the extent payable to the Issuer, (ii) any rights of the Issuer to indemnification, (iii) the obligation of the Corporation to make deposits pursuant to the Tax Agreement and (iv) as otherwise expressly set forth in the Loan Agreement) and Obligation No. 30.

## **Revenue Fund**

All Revenues shall be promptly deposited by the Bond Trustee upon receipt thereof in a special fund designated as the "Revenue Fund" which the Bond Trustee is directed to establish, maintain and hold in trust, except as otherwise provided in the Bond Indenture and except that all moneys received by the Bond Trustee and required by the Loan Agreement or Obligation No. 30 to be deposited in the Redemption Fund shall be promptly deposited in such fund. All Revenues deposited with the Bond Trustee shall be held, disbursed, allocated and applied by the Bond Trustee only as provided in the Bond Indenture.

## **Allocation of Revenues**

On or before the 1st day of each February and August (but with respect to the Principal Account deposit, only on each August 1), beginning August 1, 2014, the Bond Trustee shall transfer from the Revenue Fund and deposit into the following respective accounts the following amounts, in the following order of priority, the requirements of each such account (including the making up of any deficiencies in any such account resulting from lack of Revenues sufficient to make any earlier required deposit) at the time of deposit to be satisfied before any transfer is made to any account subsequent in priority: (1) to the Interest Account, the amount of interest becoming due and payable on the next succeeding interest payment date on all Bonds then Outstanding, until the balance in such account is equal to such amount of interest and (2) to the Principal Account, the amount of principal becoming due and payable on the Outstanding Bonds (whether by maturity or Sinking Fund Installment), in each case on the next succeeding principal payment date, until the balance in each such account is equal to such amount of such principal or Sinking Fund Installment.

Any moneys remaining in the Revenue Fund after the foregoing transfers shall be transferred to the Corporation as an overpayment of Loan Repayments.

## **Interest Account**

All amounts in the Interest Account shall be used and withdrawn by the Bond Trustee solely for the purpose of paying interest on the Bonds as it shall become due and payable (including accrued interest on any Bonds purchased or redeemed prior to maturity pursuant to the Bond Indenture).

## **Principal Account**

All amounts in the Principal Account established under the Bond Indenture shall be used and withdrawn by the Bond Trustee solely for the purpose of paying the principal of the Bonds when due and (except that all amounts in a Sinking Account shall be used and withdrawn by the Bond Trustee to redeem or pay at maturity the applicable Term Bonds when due and payable).

## **Redemption Fund**

All amounts deposited in the Optional Redemption Account and in the Special Redemption Account shall be used and withdrawn by the Bond Trustee solely for the purpose of redeeming Bonds, in the manner and upon the terms and conditions specified in the Bond Indenture, at the next succeeding date of redemption for which notice has not been given and at the Redemption Prices then applicable to redemptions from the Optional Redemption Account and the Special Redemption Account, respectively; provided that, at any time prior to giving such notice of redemption, the Bond Trustee shall, upon direction of the Corporation, apply such amounts to the purchase of Bonds at public or private sale, as and when and at such prices (including brokerage and other charges, but excluding accrued interest, which is payable from the Interest Account) as the Obligated Group Representative may direct, except that the purchase price (exclusive of accrued interest) may not exceed the Redemption Price then applicable to such Bonds; and provided further that, in the case of the Optional Redemption Account, in lieu of redemption at such next succeeding date of redemption, or in combination therewith, amounts in such account may be transferred to the Revenue Fund and credited against Loan Repayments in order of their due date as set forth in a Request of the Corporation.

## **Rebate Fund**

To the extent required by the Bond Indenture and the Tax Agreement, certain amounts will be deposited in the Rebate Fund by the Corporation, and thereafter paid to the federal government to the extent required to satisfy the Rebate Requirements (as defined in the Tax Agreement). Any moneys remaining in a Rebate Fund after the payment of all such amounts, or provision made therefor, will be remitted to the Corporation.

## **Investment of Moneys in Funds and Accounts**

All moneys in any of the funds and accounts established pursuant to the Bond Indenture shall be invested by the Bond Trustee, upon direction of the Corporation, solely in Investment Securities. Investment Securities shall be purchased at such prices as the Corporation may direct. All Investment Securities shall be acquired subject to the limitations set forth in the Bond Indenture and such additional limitations or requirements consistent with the foregoing as may be established by Request of the Corporation. No Request of the Corporation shall impose any duty on the Bond Trustee inconsistent with its fiduciary responsibilities. In the absence of directions from the Corporation, the Bond Trustee shall invest in Investment Securities specified in subsection (g) of the definition thereof. Moneys in all funds and accounts established pursuant to the Bond Indenture shall be invested in Investment Securities maturing not later than the date on which it is estimated that such moneys will be required for the purposes specified in the Bond Indenture. Investment Securities purchased under a repurchase agreement may be deemed to mature on the date or dates on which the Bond Trustee may deliver such Investment Securities for repurchase under such agreement.

## **Continuing Disclosure**

The Corporation has undertaken all responsibility for compliance with continuing disclosure requirements, and the Issuer shall have no liability to the Holders of the Bonds or any other Person with respect to S.E.C. Rule 15c2-12. Notwithstanding any other provision of the Bond Indenture, failure of the Corporation or the Dissemination Agent (as defined in the Continuing Disclosure Agreement) to comply with the Continuing Disclosure Agreement shall not be considered an Event of Default; however, the Bond Trustee may (and, at the request of the Issuer or any Participating Underwriter (as defined in the Continuing Disclosure Agreement) or the Holders of at least 25% aggregate principal amount of Outstanding Bonds, shall) or any Holder or Beneficial Owner of Bonds may take such actions as may be necessary and appropriate, including seeking mandate or specific performance by court order, to cause the Corporation to comply with its obligations under the Continuing Disclosure Agreement or to cause the Bond Trustee to comply with its obligations under the Bond Indenture.

## **Events of Default**

Each of the following is an Event of Default under the Bond Indenture: (a) default in the due and punctual payment of the principal or Redemption Price of any Bond when and as the same shall become due and payable,

whether at maturity as therein expressed, by proceedings for redemption, by acceleration or otherwise or default in the redemption from the Sinking Account of any Bonds in the amounts and at the time provided therefor; (b) default in the due and punctual payment of any installment of interest on any Bond when and as such interest installment shall become due and payable; (c) default in any material respect by the Issuer in the observance of any of the other covenants, agreements or conditions on its part in the Bond Indenture or in the Bonds, if such default shall have continued for a period of 60 days after written notice thereof, specifying such default and requiring the same to be remedied, shall have been given to the Issuer and the Corporation by the Bond Trustee, or to the Issuer, the Corporation and the Bond Trustee by the Holders of not less than 25% in aggregate principal amount of the Bonds at the time Outstanding; or (d) a Loan Default Event. Upon actual knowledge of the existence of any Event of Default, the Bond Trustee shall notify the Corporation, the Issuer and the Master Trustee in writing as soon as practicable; provided, however, that the Bond Trustee need not provide notice of any Loan Default Event if the Corporation has expressly acknowledged the existence of such Loan Default Event in a writing delivered to the Bond Trustee, the Obligated Group Representative, the Issuer and the Master Trustee.

### **Remedies Upon Event of Default; Acceleration of Maturities**

If any Event of Default has occurred and is continuing the Bond Trustee may take the following remedial steps: (a) In the case of an Event of Default described in clause (a) or (b) of the preceding paragraph, the Bond Trustee may notify the Issuer and the Master Trustee of such Event of Default, and make a demand for payment under Obligation No. 30 and request the Master Trustee in writing to give notice pursuant to the Master Indenture to the Members of the Obligated Group declaring the principal of all obligations issued under the Master Indenture then outstanding to be due and immediately payable. Thereupon, the Bond Trustee shall declare the principal of all the Bonds then Outstanding, and the interest accrued thereon, to be due and payable immediately, and upon any such declaration the same shall become and shall be immediately due and payable, anything in the Bond Indenture to the contrary notwithstanding. In addition, the Bond Trustee may take whatever action at law or in equity is necessary or desirable to collect the payments due under Obligation No. 30; (b) In the case of an Event of Default described in clause (c) of the preceding paragraph, the Bond Trustee may take whatever action at law or in equity is necessary or desirable to enforce the performance, observance or compliance by the Issuer with any covenant, condition or agreement by the Issuer under the Bond Indenture; and (c) In the case of an Event of Default described in clause (d) of the preceding paragraph, the Bond Trustee may take whatever action the Issuer would be entitled to take, and shall take whatever action the Issuer would be required to take, pursuant to the Loan Agreement in order to remedy the Loan Default Event. Notwithstanding any other provision of the Bond Indenture or any right, power or remedy existing at law or in equity or by statute, the Bond Trustee shall not under any circumstance in which an Event of Default has occurred declare the entire unpaid aggregate principal amount of the Bonds Outstanding to be immediately due and payable except in accordance with the directions of the Master Trustee in the event that the Master Trustee shall have declared the principal amount of Obligation No. 30 and all interest due thereon immediately due and payable in accordance with the Master Indenture.

Any such declaration, however, is subject to the condition that if, at any time after such declaration and before any judgment or decree for the payment of the moneys due shall have been obtained or entered, the Issuer or the Corporation shall deposit with the Bond Trustee a sum sufficient to pay all the principal (including any Sinking Fund Installments) or redemption price of and installments of interest on the Bonds, payment of which is overdue, with interest on such overdue principal at the rate borne by the respective Bonds, and the reasonable charges and expenses of the Bond Trustee, and if the Bond Trustee has received notification from the Master Trustee that the declaration of acceleration of Obligation No. 30 has been annulled pursuant to the Master Indenture and any and all other defaults known to the Bond Trustee (other than in the payment of principal of and interest on the Bonds due and payable solely by reason of such declaration) shall have been made good or cured to the satisfaction of the Bond Trustee or provision deemed by the Bond Trustee to be adequate shall have been made therefor, then, and in every such case, the Bond Trustee shall, on behalf of the Holders of all of the Bonds, rescind and annul such declaration and its consequences and waive such default; but no such rescission and annulment shall extend to or shall affect any subsequent default, or shall impair or exhaust any right or power consequent thereon.

Notice of such declaration having been given as aforesaid, anything to the contrary contained in the Bond Indenture or in the Bonds to the contrary notwithstanding, interest shall cease to accrue on such Bonds from and after the date set forth in such notice (which shall be not more than seven days from the date of such declaration).

Nothing shall require the Bond Trustee to exercise any remedies in connection with an Event of Default unless the Bond Trustee shall have actual knowledge or shall have received written notice of such Event of Default.

### **Bond Trustee to Represent Bondholders**

If any Event of Default has occurred and is continuing, the Bond Trustee in its discretion may, and upon the written request of the Holders of not less than 25% in aggregate principal amount of the Bonds then Outstanding and receipt of indemnity to its satisfaction shall, proceed to protect or enforce its rights or the rights of such Holders by such appropriate action, suit, mandamus or other proceedings as it shall deem most effectual to protect and enforce any such right, at law or in equity, either for the specific performance of any covenant or agreement contained in the Bond Indenture, or in aid of the execution of any power granted in the Bond Indenture, or for the enforcement of any other appropriate legal or equitable right or remedy vested in the Bond Trustee or in such Holders under the Bond Indenture, the Loan Agreement, Obligation No. 30, the Act or any other law; and upon instituting such proceeding, the Bond Trustee shall be entitled, as a matter of right, to the appointment of a receiver of the Revenues and other assets pledged under the Bond Indenture, pending such proceedings.

### **Bondholders' Direction of Proceedings**

Holders of a majority in aggregate principal amount of the Bonds then Outstanding under the Bond Indenture shall have the right, upon indemnifying the Bond Trustee to its satisfaction, to direct the method of conducting all remedial proceedings by the Bond Trustee under the Bond Indenture, provided such directions shall not be otherwise than in accordance with law or the provisions of the Bond Indenture, and that the Bond Trustee shall have the right to decline to follow any such direction which in the opinion of the Bond Trustee would be unjustly prejudicial to Bondholders not parties to such direction.

### **Limitation on Bondholders' Right to Sue**

No Holder of any Bond shall have the right to institute any suit, action or proceeding at law or in equity, for the protection or enforcement of any right or remedy under the Bond Indenture, the Loan Agreement, Obligation No. 30, the Act or any other applicable law with respect to such Bond, unless (a) such Holder shall have given to the Bond Trustee written notice of the occurrence of an Event of Default, (b) the Holders of not less than 25% in aggregate principal amount of the Bonds then Outstanding shall have made written request to the Bond Trustee to exercise the powers granted to it under the Bond Indenture or to institute such suit, action or proceeding in its own name; provided, however, that if more than one such request is received by the Bond Trustee from the Holders, the Bond Trustee shall follow the written request executed by the Holders of the greater percentage of Bonds then Outstanding in excess of 25%, (c) such Holder or Holders shall have tendered to the Bond Trustee indemnity satisfactory to it against costs, expenses and liabilities to be incurred in compliance with such request, and (d) the Bond Trustee shall have failed to comply with such request for a period of 60 days after such written request shall have been received by and the tender of indemnity shall have been made to the Bond Trustee.

### **Amendment of Indenture**

The Bond Indenture may be amended or supplemented from time to time, without the necessity of obtaining the consent of the Holders, but with the consent of the Corporation, for one or more of the following purposes: (a) to add to the covenants and agreements of the Issuer, to pledge or assign additional security for the Bonds or to surrender any right or power in the Bond Indenture reserved to or conferred upon the Issuer, provided, that no such covenant, pledge, assignment or surrender shall materially adversely affect the interests of the Holders of the Bonds; (b) to make such provisions for the purpose of curing any ambiguity, inconsistency or omission, or of curing or correcting any defective provision, contained in this Bond Indenture, or in regard to matters or questions arising under this Bond Indenture, as the Issuer or the Bond Trustee may deem necessary or desirable and not inconsistent with this Bond Indenture, and which shall not materially adversely affect the interests of the Holders of the Bonds; (c) to modify, amend or supplement the Bond Indenture in such manner as to permit the qualification of the Bond Indenture under the Trust Indenture Act of 1939, as amended, or any similar federal statute, and which shall not materially adversely affect the interests of the Holders of the Bonds; or (d) to maintain the exclusion from gross income of interest payable with respect to the Bonds.

The Bond Indenture may be modified or amended from time to time by a Supplemental Indenture with the written consent of Holders of a majority in aggregate principal amount of the Bonds Outstanding and the Corporation, provided, that no such modification or amendment shall (1) extend the fixed maturity of any Bond, or reduce the amount of principal thereof, or extend the time of payment or reduce the rate of interest thereon, or extend the time of payment of interest thereon, or reduce any premium payable thereon, without the consent of the Holder of each Bond so affected, or (2) reduce the aforesaid percentage of Bonds the consent of the Holders of which is required to effect any such modification or amendment, or permit the creation of any lien on the Revenues and other assets pledged under the Bond Indenture prior to or on a parity with the lien created by the Bond Indenture, or deprive the Holders of the Bonds of the lien created by the Bond Indenture on such Revenues and other assets (except as expressly provided in the Bond Indenture), without the consent of the Holders of all Bonds then Outstanding.

### **Defeasance**

The Bonds may be paid by the Issuer or the Bond Trustee on behalf of the Issuer in any of the following ways: (a) by paying or causing to be paid the principal or Redemption Price of and interest on all Bonds Outstanding, as and when the same become due and payable; (b) by depositing with the Bond Trustee, in trust, at or before maturity, moneys or specified securities in the necessary amount to pay when due or redeem all Bonds then Outstanding; or (c) by delivering to the Bond Trustee, for cancellation by it, all Bonds then Outstanding.

### **Liability of Issuer Limited to Revenues**

Notwithstanding anything in the Bond Indenture or in the Bonds, the Issuer shall not be required to advance any moneys derived from any source other than the Revenues and other assets pledged under the Bond Indenture for any of the purposes in the Bond Indenture, whether for the payment of the principal or Redemption Price of or interest on the Bonds or for any other purpose of the Bond Indenture.

## **LOAN AGREEMENT**

The Loan Agreement provides the terms of a loan of all or a portion of the proceeds of the Bonds by the Issuer to the Corporation and the repayment of such loan by such Corporation. The following is a summary of certain provisions of the Loan Agreement. This summary does not purport to be complete or definitive and reference is made to the Loan Agreement for the complete terms thereof.

### **Loan Repayments**

The Corporation agrees to pay, or cause to be paid, Loan Repayments in an amount sufficient to enable the Bond Trustee to make the transfers and deposits required at the times and in the amounts described in the Bond Indenture. Notwithstanding the foregoing, the Corporation agrees to make payments, or cause payments to be made, at the times and in the amounts required to be paid as principal or Redemption Price of or interest on the Bonds from time to time Outstanding under the Bond Indenture and other amounts required to be paid under the Bond Indenture, as the same shall become due whether at maturity, upon redemption, by declaration of acceleration or otherwise.

### **Additional Payments**

The Corporation also agrees to pay certain Additional Payments in connection with the issuance of the Bonds, including certain taxes and assessments charged to the Issuer or the Bond Trustee, all reasonable fees, charges, expenses and indemnities of the Issuer and the Bond Trustee under the Loan Agreement and under the Bond Indenture and the reasonable fees and expenses of experts engaged by the Issuer and the Bond Trustee and all other reasonable and necessary fees and expenses attributable to the Loan Agreement or Obligation No. 30.

### **Prepayment**

The Corporation shall have the right, so long as all amounts which have become due under the Loan Agreement have been paid, at any time or from time to time to prepay all or any part of the Loan Repayments and

the Issuer agrees that the Bond Trustee shall accept such prepayments when the same are tendered. Prepayments may be made by payments of cash, deposit of United States Government Obligations or surrender of Bonds. All such prepayments (and the additional payment of any amount necessary to pay the applicable premium, if any, payable upon the redemption of Bonds) shall be deposited upon receipt as specified by the Corporation and at the request of and as determined by the Corporation, credited against payments due under the Loan Agreement or used for the redemption or purchase of Outstanding Bonds in the manner and subject to the terms and conditions set forth in the Bond Indenture. Notwithstanding any such prepayment or surrender of Bonds, as long as any Bonds remain Outstanding or any Additional Payments required to be made under the Loan Agreement remain unpaid, the Corporation shall not be relieved of its obligations under the Loan Agreement.

### **Obligations Unconditional**

The obligations of the Corporation under the Loan Agreement are absolute and unconditional, notwithstanding any other provision of the Loan Agreement, Supplement No. 30, Obligation No. 30, the Master Indenture or the Bond Indenture. Until such Loan Agreement is terminated and all payments under such Loan Agreement are made, the Corporation: (a) will pay all amounts required under such Loan Agreement without abatement, deduction or setoff except as otherwise expressly provided in the Loan Agreement; (b) will not suspend or discontinue any payments due under the Loan Agreement for any reason whatsoever, including, without limitation, any right of setoff or counterclaim; (c) will perform and observe all its other agreements contained in the Loan Agreement; and (d) except as provided in the Loan Agreement, will not terminate the Loan Agreement for any cause, including, without limiting the generality of the foregoing, damage, destruction or condemnation of the health facilities financed with the proceeds of the Bonds or any part thereof, commercial frustration of purpose, any change in the tax or other laws of the United States of America or of the State of California, or any political subdivision of either thereof or any failure of the Issuer to perform and observe any agreement, whether express or implied, or any duty, liability or obligation arising out of or connected with the Loan Agreement. Nothing contained in the Loan Agreement shall be construed to release the Issuer from the performance of any of the agreements on its part contained in the Loan Agreement, and in the event the Issuer should fail to perform any such agreement on its part, the Corporation may institute such action against the Issuer as the Corporation may deem necessary to compel performance.

The rights of the Bond Trustee or any party or parties on behalf of whom the Bond Trustee is acting shall not be subject to any defense, setoff, counterclaim or recoupment whatsoever, whether arising out of any breach of any duty or obligation of the Issuer, the Master Trustee or the Bond Trustee owing to the Corporation, or by reason of any other indebtedness or liability at any time owing by the Issuer, the Master Trustee or by the Bond Trustee to the Corporation.

### **Events of Default**

The following events shall be Loan Default Events under the Loan Agreement: (1) if the Corporation shall fail to pay any payment required by the Loan Agreement or if the Obligated Group shall fail to make any payment required under Obligation No. 30 when due; (2) if any material representation or warranty made by the Corporation, or any Obligated Group Member, in any document, instrument or certificate furnished to the Bond Trustee or the Issuer in connection with the issuance of Obligation No. 30 or the Bonds shall at any time prove to have been incorrect in any respect as of the time made; (3) if the Corporation shall fail to observe or perform any other covenant, condition, agreement or provision in the Loan Agreement on its part to be observed or performed, or shall breach any warranty by the Corporation contained in the Loan Agreement, for a period of 60 days after written notice specifying such failure or breach and requesting that it be remedied, has been given to the Corporation by the Issuer or the Bond Trustee, except that, if such failure or breach can be remedied but not within such 60-day period, such failure or breach shall not become a Loan Default Event for so long as the Corporation shall diligently proceed to remedy the same in accordance with and subject to any directions or limitations of time established by the Bond Trustee; or (4) any Event of Default under the Bond Indenture or the Master Indenture shall occur.

**Remedies on Default**

If a Loan Default Event shall occur under the Loan Agreement, the Bond Trustee on behalf of the Issuer may, among other things, declare all installments of Loan Repayments payable for the remainder of the term of the Loan Agreement to be immediately due and payable. The Issuer or the Bond Trustee may also take whatever action, at law or in equity, to collect the payment required under the Loan Agreement then due or to otherwise enforce the performance and observance of any obligation, agreement or covenant of the Corporation contained in the Loan Agreement.

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**APPENDIX D**

**FORM OF OPINION OF BOND COUNSEL**

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[CLOSING DATE]

ABAG Finance Authority  
for Nonprofit Corporations  
Oakland, California

ABAG Finance Authority for Nonprofit Corporations  
Revenue Bonds (Sharp HealthCare), Series 2011A  
(Final Opinion)

Ladies and Gentlemen:

We have acted as bond counsel to ABAG Finance Authority for Nonprofit Corporations (the “Authority”) in connection with the issuance of \$77,710,000 aggregate principal amount of ABAG Finance Authority for Nonprofit Corporations Revenue Bonds (Sharp HealthCare), Series 2011A (the “Bonds”), issued pursuant to a bond indenture, dated as of February 1, 2011 (the “Bond Indenture”), between the Authority and U.S. Bank National Association, as trustee (the “Bond Trustee”). The Bond Indenture provides that the Bonds are issued for the purpose of making a loan of the proceeds thereof to Sharp HealthCare (the “Corporation”) pursuant to a loan agreement, dated as of February 1, 2011 (the “Loan Agreement”), between the Authority and the Corporation. Capitalized terms not otherwise defined herein shall have the meanings ascribed thereto in the Bond Indenture.

In such connection, we have reviewed the Bond Indenture; the Loan Agreement; the Tax Certificate and Agreement, dated the date hereof (the “Tax Certificate”), between the Authority and the Corporation; opinions of counsel to the Authority and the Corporation and the other Members of the Obligated Group; certificates of the Authority, the Bond Trustee, the Corporation and others; and such other documents, opinions and matters to the extent we deemed necessary to render the opinions set forth herein.

We have relied on the opinion of Hooper, Lundy & Bookman, Inc., special counsel to the Members of the Obligated Group, regarding, among other matters, the current qualification of the Members of the Obligated Group as organizations described in Section 501(c)(3) of the Internal Revenue Code of 1986 (the “Code”). We note that the opinion is subject to a number of qualifications and limitations. We have also relied upon representations of the Corporation regarding the use of the facilities financed with the proceeds of the Bonds in activities that are not considered unrelated trade or business activities of the Members of the Obligated Group within the meaning of Section 513 of the Code. We note that the opinion of special counsel to the Members of the Obligated Group does not address Section 513 of the Code. Failure of the Members of the Obligated Group to be organized and operated in accordance with the Internal Revenue Service’s requirements for the maintenance of their status as organizations described in Section 501(c)(3) of the Code, or use of the bond-financed facilities in activities that are

considered unrelated trade or business activities of the Members of the Obligated Group within the meaning of Section 513 of the Code, may result in interest on the Bonds being included in gross income for federal income tax purposes, possibly from the date of issuance of the Bonds.

The opinions expressed herein are based on an analysis of existing laws, regulations, rulings and court decisions and cover certain matters not directly addressed by such authorities. Such opinions may be affected by actions taken or omitted or events occurring after the date hereof. We have not undertaken to determine, or to inform any person, whether any such actions are taken or omitted or events do occur or any other matters come to our attention after the date hereof. Accordingly, this opinion speaks only as of its date and is not intended to, and may not, be relied upon in connection with any such actions, events or matters. Our engagement with respect to the Bonds has concluded with their issuance, and we disclaim any obligation to update this letter. We have assumed the genuineness of all documents and signatures presented to us (whether as originals or as copies) and the due and legal execution and delivery thereof by, and validity against, any parties other than the Authority. We have assumed, without undertaking to verify, the accuracy of the factual matters represented, warranted or certified in the documents, and of the legal conclusions contained in the opinions, referred to in the second and third paragraphs hereof. Furthermore, we have assumed compliance with all covenants and agreements contained in the Bond Indenture, the Loan Agreement and the Tax Certificate, including (without limitation) covenants and agreements compliance with which is necessary to assure that future actions, omissions or events will not cause interest on the Bonds to be included in gross income for federal income tax purposes. We call attention to the fact that the rights and obligations under the Bonds, the Bond Indenture, the Loan Agreement and the Tax Certificate and their enforceability may be subject to bankruptcy, insolvency, reorganization, arrangement, fraudulent conveyance, moratorium and other laws relating to or affecting creditors' rights, to the application of equitable principles, and to the exercise of judicial discretion in appropriate cases. We express no opinion with respect to any indemnification, contribution, penalty, choice of law, choice of forum, choice of venue, waiver or severability provisions contained in the foregoing documents, nor do we express any opinion with respect to the state or quality of title to or interest in any of the assets described in or as subject to the lien of the Bond Indenture or the accuracy or sufficiency of the description contained therein of, or the remedies available to enforce liens on, any such assets. Finally, we undertake no responsibility for the accuracy, completeness or fairness of the Official Statement, dated January 12, 2011, or other offering material relating to the Bonds and express no opinion with respect thereto.

ABAG Finance Authority  
for Nonprofit Corporations  
[Closing Date]  
Page 3

Based on and subject to the foregoing, and in reliance thereon, as of the date hereof, we are of the following opinions:

1. The Bonds constitute the valid and binding limited obligations of the Authority.
2. The Bond Indenture has been duly executed and delivered by, and constitutes the valid and binding obligation of, the Authority. The Bond Indenture creates a valid pledge, to secure the payment of the principal of and interest on the Bonds, of the Revenues and any other amounts held by the Bond Trustee in any fund or account established pursuant to the Bond Indenture, except the Rebate Fund, subject to the provisions of the Bond Indenture permitting the application thereof for the purposes and on the terms and conditions set forth in the Bond Indenture.
3. The Loan Agreement has been duly executed and delivered by, and constitutes a valid and binding agreement of, the Authority.
4. Interest on the Bonds is excluded from gross income for federal income tax purposes under Section 103 of the Code and is exempt from State of California personal income taxes. Interest on the Bonds is not a specific preference item for purposes of the federal individual or corporate alternative minimum taxes, although we observe that it is included in adjusted current earnings when calculating corporate alternative minimum taxable income. We express no opinion regarding other tax consequences related to the ownership or disposition of, or the accrual or receipt of interest on, the Bonds.

Faithfully yours,

ORRICK, HERRINGTON & SUTCLIFFE LLP

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**APPENDIX E**  
**BOOK-ENTRY ONLY SYSTEM**

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## BOOK-ENTRY SYSTEM

*The information provided in this APPENDIX E has been provided by DTC. No representation is made by the Authority, the Obligated Group or the Underwriter as to the accuracy or adequacy of such information provided by DTC or as to the absence of material adverse changes in such information subsequent to the date hereof.*

The Depository Trust Company, New York, New York, (“DTC”) will act as the securities depository for the Bonds. The Bonds will be issued as fully-registered securities registered in the name of Cede & Co. (DTC’s partnership nominee) or such other name as may be requested by an authorized representative of DTC. One fully-registered Bond certificate will be issued for each maturity of the Bonds, in the aggregate principal amount of such maturity, and will be deposited with DTC.

DTC, the world’s largest depository is a limited purpose trust company organized under the New York Banking Law, a “banking organization” within the meaning of the New York Banking Law, a member of the Federal Reserve System, a “clearing corporation” within the meaning of the New York Uniform Commercial Code, and a “clearing agency” registered pursuant to the provisions of Section 17A of the Securities Exchange Act of 1934. DTC holds and provides asset servicing for over 3.5 million issues of U.S. and non-U.S. equity issues, corporate and municipal debt issues, and money market instruments (from over 100 countries) that DTC’s participants (“Direct Participants”) deposit with DTC. DTC also facilitates the post trade settlement among Direct Participants of sales and other securities transactions in deposited securities, through electronic computerized book entry transfers and pledges between Direct Participants’ accounts. This eliminates the need for physical movement of securities certificates. Direct Participants include both U.S. and non-U.S. securities brokers and dealers, banks, trust companies, clearing corporations, and certain other organizations. DTC is a wholly owned subsidiary of The Depository Trust & Clearing Corporation (“DTCC”). DTCC is the holding company for DTC, National Securities Clearing Corporation and Fixed Income Clearing Corporation, all of which are registered clearing agencies. DTCC is owned by the users of its regulated subsidiaries. Access to the DTC system is also available to others such as both U.S. and non-U.S. securities brokers and dealers, banks, trust companies, and clearing corporations that clear through or maintain a custodial relationship with a Direct Participant, either directly or indirectly (“Indirect Participants”). DTC has Standard & Poor’s highest rating: AAA. The DTC Rules applicable to its Participants are on file with the Securities and Exchange Commission. More information about DTC can be found at [www.dtcc.com](http://www.dtcc.com) and [www.dtc.org](http://www.dtc.org).

Purchases of the Bonds under the DTC system must be made by or through Direct Participants, which will receive a credit for the Bonds on DTC’s records. The ownership interest of each actual purchaser of each Bond (“Beneficial Owner”) is in turn to be recorded on the Direct and Indirect Participants’ records. Beneficial Owners will not receive written confirmation from DTC of their purchase. Beneficial Owners are, however, expected to receive written confirmations providing details of the transaction, as well as periodic statements of their holdings, from the Direct or Indirect Participant through which the Beneficial Owner entered into the transaction. Transfers of ownership interests in the Bonds are to be accomplished by entries made on the books of Direct and Indirect Participants acting on behalf of Beneficial Owners. Beneficial Owners will not receive certificates representing their ownership interests in the Bonds, except in the event that use of the book-entry system for the Bonds is discontinued.

To facilitate subsequent transfers, all Bonds deposited by Direct Participants with DTC are registered in the name of DTC’s partnership nominee, Cede & Co., or such other name as may be requested by an authorized representative of DTC. The deposit of Bonds with DTC and their registration in the name of Cede & Co. or such other DTC nominee do not effect any change in beneficial ownership. DTC has no knowledge of the actual Beneficial Owners of the Bonds; DTC’s records reflect only the identity of the

Direct Participants to whose accounts such Bonds are credited, which may or may not be the Beneficial Owners. The Direct and Indirect Participants will remain responsible for keeping account of their holdings on behalf of their customers.

Conveyance of notices and other communications by DTC to Direct Participants, by Direct Participants to Indirect Participants, and by Direct Participants and Indirect Participants to Beneficial Owners will be governed by arrangements among them, subject to any statutory or regulatory requirements as may be in effect from time to time. Beneficial Owners of the Bonds may wish to take certain steps to augment the transmission to them of notices of significant events with respect to the Bonds, such as redemptions, tenders, defaults, and proposed amendments to the Bond Indenture, Loan Agreement or Master Indenture. For example, Beneficial Owners of Bonds may wish to ascertain that the nominee holding the Bonds for their benefit has agreed to obtain and transmit notices to Beneficial Owners. In the alternative, Beneficial Owners may wish to provide their names and addresses to the registrar and request that copies of notices be provided directly to them.

Redemption notices shall be sent to DTC. If less than all of the Bonds within a maturity are being redeemed, DTC's practice is to determine by lot the amount of the interest of each Direct Participant in such maturity to be redeemed.

Neither DTC nor Cede & Co. (nor any other DTC nominee) will consent or vote with respect to the Bonds unless authorized by a Direct Participant in accordance with DTC's MMI Procedures. Under its usual procedures, DTC mails an Omnibus Proxy to the Authority as soon as possible after the record date. The Omnibus Proxy assigns Cede & Co.'s consenting or voting rights to those Direct Participants to whose accounts the Bonds are credited on the record date (identified in a listing attached to the Omnibus Proxy).

Payment of principal, interest and redemption prices on the Bonds will be made to Cede & Co., or such other nominee as may be requested by an authorized representative of DTC. DTC's practice is to credit Direct Participants' accounts upon DTC's receipt of funds and corresponding detail information from the Bond Trustee or Authority, on a payable date in accordance with their respective holdings shown on DTC's records. Payments by Participants to Beneficial Owners will be governed by standing instructions and customary practices, as is the case with securities held for the accounts of customers in bearer form or registered in "street name," and will be the responsibility of such Participant and not of DTC nor its nominee, Bond Trustee, Master Trustee, the Obligated Group, or the Authority, subject to any statutory or regulatory requirements as may be in effect from time to time. Payment of principal, interest and redemption prices to Cede & Co. (or such other nominee as may be requested by an authorized representative of DTC) is the responsibility of the Bond Trustee. Disbursement of such payments to Direct Participants will be the responsibility of DTC, and disbursement of such payments to the Beneficial Owners will be the responsibility of Direct and Indirect Participants.

DTC may discontinue providing its services as depository with respect to the Bonds at any time by giving reasonable notice to the Authority or Bond Trustee. Under such circumstances, in the event that a successor depository is not obtained, Bond certificates are required to be printed and delivered.

The Authority may decide to discontinue use of the system of book-entry transfers through DTC (or a successor securities depository). Once the Authority has requested that holders withdraw securities from DTC, DTC will notify its Participants of such request and such Participants may utilize DTC's withdrawal process to withdraw their Bonds from DTC. In the event a Participant utilizes DTC's withdrawal process, Bond certificates will be printed and delivered.

For so long as the Bonds are registered in the name of DTC or its nominee, Cede & Co., the Authority, the Master Trustee and the Bond Trustee will recognize only DTC or its nominee, Cede & Co., as the registered owner of the Bonds for all purposes, including payments, notices and voting.

Under the Bond Indenture, payments made by the Bond Trustee to DTC or its nominee will satisfy the Authority's obligations under the Bond Indenture, the Corporation's obligations under the Loan Agreement and the Obligated Group's obligations under the Series 2009 Obligation, to the extent of the payments so made.

Prior to any discontinuation of the book-entry only system described above, the Bond Trustee and the Authority may treat DTC as, and deem DTC to be, the absolute owner of the Bonds for all purposes whatsoever, including, without limitation, (i) the payment of principal of, premium, if any, and interest on the Bonds, (ii) giving notices of redemption and other matters with respect to the Bonds, (iii) registering transfers with respect to the Bonds and (iv) the selection of Bonds for redemption.

***Neither the Authority, the Obligated Group, the Underwriter nor the Bond Trustee will have any responsibility or obligation to any DTC Participant, Indirect Participant or any Beneficial Owner or any other person with respect to: (i) the Bonds, (ii) the accuracy of any records maintained by DTC or any DTC Participant or Indirect Participant, (iii) the payment by DTC or any DTC Participant or Indirect Participant of any amount due to any Beneficial Owner in respect of the principal or redemption price of or interest on the Bonds, (iv) the delivery by DTC or any DTC Participant or Indirect Participant of any notice to any Beneficial Owner which is required or permitted under the terms of the Bond Indenture to be given to Bondholders, (v) the selection of the Beneficial Owners to receive payment in the event of any partial redemption of the Bonds, or (vi) any other action taken by DTC as Bondholder.***

The Authority, the Obligated Group, the Underwriter and the Bond Trustee cannot and do not give any assurances that DTC, the DTC Participants or the Indirect Participants will distribute to the Beneficial Owners of the Bonds (i) payments of principal or redemption price of or interest on the Bonds, (ii) certificates representing an ownership interest or other confirmation of Beneficial Ownership interests in the Bonds, or (iii) redemption or other notices sent to DTC or Cede & Co., its nominee, as the Registered Owner of the Bonds, or that they will do so on a timely basis or that DTC, DTC Participants or Indirect Participants will serve and act in the manner described in this Official Statement. The current "Rules" applicable to DTC are on file with the Securities and Exchange Commission, and the current "Procedures" of DTC to be followed in dealing with DTC Participants are on file with DTC.

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