

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 amount, accrual or receipt of interest on, the Bonds. See "TAX MATTERS" herein.

\$159,485,000**ABAG FINANCE AUTHORITY FOR NONPROFIT CORPORATIONS****Revenue Bonds
(Sharp HealthCare),
Series 2014A****Dated: Date of Delivery****Due: August 1, as set forth below**

The Revenue Bonds (Sharp Healthcare) Series 2014A 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, 2014 (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, 2014, 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 2014A 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 2014A 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®

Maturity Date (August 1)	Principal Amount	Interest Rate	Yield	Price	CUSIP
2016	\$2,050,000	3.000%	0.500%	106.127	00037CVD9
2017	1,900,000	4.000	0.800	110.927	00037CVE7
2018	1,350,000	5.000	1.190	116.535	00037CVF4
2019	2,395,000	5.000	1.500	118.312	00037CVG2
2020	4,105,000	5.000	2.000	118.119	00037CVH0
2021	7,565,000	5.000	2.400	117.681	00037CVJ6
2031	5,655,000	5.000	4.300*	105.396*	00037CVP2
2032	5,730,000	5.000	4.380*	104.762*	00037CVK3
2033	5,800,000	5.000	4.450*	104.210*	00037CVL1
2034	4,580,000	5.000	4.490*	103.897*	00037CVQ0
2034	1,275,000	4.500	4.614	98.500	00037CVM9

\$117,080,000 5.000% Term Bonds Due August 1, 2043 Price 102.193%* to Yield 4.710%* CUSIP 00037CVN7

* Price and yield to August 1, 2023 call date.

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 Underwriters, subject to prior sale and to the approval of the validity of the Bonds and certain other legal matters by Orrick, Herrington & Sutcliffe LLP, Bond Counsel to the Authority, the approval of certain matters for the Authority by its special counsel, Jones Hall, A Professional Law Corporation, San Francisco, California, for the Obligated Group by its special counsel, Hooper, Lundy & Bookman, P.C., San Diego, California, and for the Underwriters by their special counsel, Dentons US LLP, Chicago, Illinois. It is expected that the Bonds in book-entry form will be available for delivery to DTC on or about February 12, 2014.

Goldman, Sachs & Co.**Citigroup**

The date of this Official Statement is January 23, 2014.

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 Underwriters. 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 Underwriters. The Underwriters have provided the following sentence for inclusion in this Official Statement. The Underwriters have reviewed the information in this Official Statement in accordance with and as part of their responsibilities to investors under the federal securities laws as applied to the facts and circumstances of this transaction, but the Underwriters do 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 Underwriters 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 Underwriters or the Corporation and are included for convenience only. Neither the Authority, the Underwriters 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 Underwriters 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.

[THIS PAGE INTENTIONALLY LEFT BLANK]

TABLE OF CONTENTS

	Page
INTRODUCTORY STATEMENT	1
Purpose of the Official Statement.....	1
The Bonds.....	1
The Obligated Group and the Master Indenture	1
Security for the Bonds	2
Credit Provider Covenants.....	2
Outstanding Indebtedness and Obligations	3
Bondholders' Risks.....	3
Miscellaneous	3
THE AUTHORITY	3
PLAN OF FINANCE.....	4
THE BONDS	4
General	4
Description of Terms of Bonds	4
Redemption Provisions.....	5
Purchase in Lieu of Redemption	6
Book-Entry System.....	6
SECURITY FOR THE BONDS	6
General	6
The Master Indenture.....	7
Credit Provider Covenants.....	8
Bonds Not General Obligations.....	8
DEBT SERVICE REQUIREMENTS.....	9
ESTIMATED SOURCES AND USES OF FUNDS	10
BONDHOLDERS' RISKS	11
General	11
Utilization of Derivatives Markets	11
Economic Conditions and Financial Markets.....	12
Impact of Investment Performance.....	13
Affordable Care Act	13
California Health Care Reform.....	17
Budget Control Act of 2011	18
Jobs Creation Act.....	18
Nonprofit Health Care Environment	19
Patient Service Revenues.....	22
Commercial Insurance and Other Third-Party Plans.....	31
Regulation of the Health Care Industry	35
Corporate Compliance Program	40
Antitrust.....	41
Issues Related to the Health Care Market of the System.....	41
Tax-Exempt Status and Other Tax Matters	42
Other Risk Factors.....	45
Security and Enforceability	48
TAX MATTERS.....	51
CONTINUING DISCLOSURE.....	53
General	53
Notice of Certain Events.....	54

Annual Report.....	55
Failure to Comply.....	55
Amendment of the Continuing Disclosure Agreement.....	55
APPROVAL OF LEGALITY.....	56
INDEPENDENT AUDITORS.....	56
FINANCIAL ADVISOR.....	56
LITIGATION.....	56
The Members of the Obligated Group.....	56
The Authority.....	57
RATINGS.....	58
UNDERWRITING.....	58
MISCELLANEOUS.....	59

APPENDIX A – INFORMATION CONCERNING SHARP HEALTHCARE AND THE OBLIGATED GROUP.....	A-1
APPENDIX B – FINANCIAL STATEMENTS OF THE CORPORATION.....	B-1
APPENDIX C – SUMMARY OF PRINCIPAL DOCUMENTS.....	C-1
APPENDIX D – PROPOSED FORM OF OPINION OF BOND COUNSEL.....	D-1
APPENDIX E – BOOK-ENTRY ONLY SYSTEM.....	E-1

OFFICIAL STATEMENT

\$159,485,000

ABAG FINANCE AUTHORITY FOR NONPROFIT CORPORATIONS

**Revenue Bonds
(Sharp HealthCare),
Series 2014A**

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 \$159,485,000 aggregate principal amount of ABAG Finance Authority For Nonprofit Corporations (the “Authority”) Revenue Bonds (Sharp HealthCare), Series 2014A (the “Bonds”).

The Bonds

The Bonds will be issued pursuant to and secured by a Bond Indenture dated as of February 1, 2014 (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, 2014 (the “Loan Agreement”), between the Authority and the Corporation, and will be secured by payments under the Series 2014A 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. 34 dated as of February 1, 2014 (“Supplement No. 34” 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 2014A 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 2014A Obligation”) issued pursuant to Supplement No. 34. Pursuant to the Master Indenture, the Members of the Obligated Group agree to make payments on the Series 2014A 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 2014A Obligation. The Series 2014A 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 2014A Obligation” herein.

The obligations of the Members of the Obligated Group to pay amounts due on Obligations, including the Series 2014A 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. 34 contains certain additional covenants (the “Series 2014A Covenants”) that will be applicable while any of the Bonds are outstanding. The Series 2014A 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 2014A 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. 34 — Modifications to Certain Covenants of the Master Indenture While Obligation No. 34 is Outstanding” for a description of the Series 2014A 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 2014A Obligation.

Credit Provider Covenants

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”) are contained in the Master Indenture and certain Credit Provider credit agreements. 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 Credit Provider 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 2014A 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 and the refunding of the Refunded Bonds (defined below), approximately \$570.2 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.

On January 7, 2014, the Corporation defeased \$30.025 million of the Authority's Revenue Bonds (Sharp HealthCare) Series 2009B maturing in 2034 (the "Series 2009B 2034 Term Bonds") with cash reserves and certain other funds relating to the Series 2009B 2034 Term Bonds.

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 descriptions of provisions of the Bonds, the Bond Indenture, the Loan Agreement, the Master Indenture and the Series 2014A 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. 34 and the Series 2014A 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 "State"). 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) finance and/or refinance the acquisition, renovation, construction, improvement, furnishing and equipping of healthcare facilities owned and/or operated by certain Members and their affiliates, located in San Diego, California and (ii) refund all of the Authority's outstanding Revenue Bonds (San Diego Hospital Association), Series 2003C (the "Refunded Bonds").

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, 2014 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 Office of the Bond Trustee.

Redemption Provisions

Optional Redemption. The Bonds maturing on or after August 1, 2031 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 on or after August 1, 2023, 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, 2043 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, 2040, 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>
2040	\$26,105,000
2041	27,910,000
2042	30,765,000
2043*	32,300,000

*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 or the Corporation 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 2014A 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 2014A 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 2014A Obligation will be issued by the Corporation under and pursuant to the Original Master Indenture, as supplemented by Supplement No. 34. The Corporation and the other Members of the Obligated Group are required to make payments on the Series 2014A 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 2014A Obligation and after giving effect to the transactions described in “PLAN OF FINANCE” herein and the defeasance of the Series 2009B 2034 Term Bonds, the aggregate principal amount of Obligations related to Indebtedness issued and outstanding under the Master Indenture is expected to be approximately \$570.2 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. 34 — Modifications to Certain Covenants of the Master Indenture While Obligation No. 34 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 2014A 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 2014A Obligation, and the Series 2014A 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. 34 contains the Series 2014A Covenants that will be applicable while any of the Bonds are outstanding. The Series 2014A 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 2014A 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. 34 —Modifications to Certain Covenants of the Master Indenture While Obligation No. 34 is Outstanding” for a description of the Series 2014A Covenants.

Credit Provider Covenants

The Master Indenture and certain Credit Provider credit agreements contain Credit Provider Covenants on certain of 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 2014A 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 by sinking fund installment or at maturity 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 and the refunding of the Refunded Bonds.

Year Ending September 30	Series 2014A Principal	Series 2014A Interest	Debt Service on other Obligations ^{(1) (2) (3)}	Total
2014	--	\$ 3,712,308	\$ 41,987,522	\$ 45,699,830
2015	--	7,907,875	39,444,613	47,352,488
2016	\$ 2,050,000	7,907,875	37,256,175	47,214,050
2017	1,900,000	7,846,375	37,469,159	47,215,534
2018	1,350,000	7,770,375	38,097,093	47,217,468
2019	2,395,000	7,702,875	37,120,788	47,218,663
2020	4,105,000	7,583,125	35,527,547	47,215,672
2021	7,565,000	7,377,875	32,271,765	47,214,640
2022	--	6,999,625	39,103,873	46,103,498
2023	--	6,999,625	39,376,953	46,376,578
2024	--	6,999,625	39,644,345	46,643,970
2025	--	6,999,625	39,939,201	46,938,826
2026	--	6,999,625	36,217,089	43,216,714
2027	--	6,999,625	33,542,522	40,542,147
2028	--	6,999,625	33,671,178	40,670,803
2029	--	6,999,625	34,508,262	41,507,887
2030	--	6,999,625	29,731,956	36,731,581
2031	5,655,000	6,999,625	21,265,388	33,920,013
2032	5,730,000	6,716,875	21,470,749	33,917,624
2033	5,800,000	6,430,375	21,685,147	33,915,522
2034	5,855,000	6,140,375	21,919,647	33,915,022
2035	--	5,854,000	30,643,659	36,497,659
2036	--	5,854,000	28,789,982	34,643,982
2037	--	5,854,000	28,410,202	34,264,202
2038	--	5,854,000	28,411,859	34,265,859
2039	--	5,854,000	28,412,266	34,266,266
2040	26,105,000	5,854,000	1,956,112	33,915,112
2041	27,910,000	4,548,750	1,460,881	33,919,631
2042	30,765,000	3,153,250	--	33,918,250
2043	<u>32,300,000</u>	<u>1,615,000</u>	--	<u>33,915,000</u>
Total	<u>\$159,485,000</u>	<u>\$191,533,558</u>	<u>\$859,335,935</u>	<u>\$1,210,354,493</u>

* Actual rates will vary from these assumed rates.

- (1) Obligations outstanding as of September 30, 2013, except as described below. Assumes that all principal payments and mandatory sinking fund payments are paid as currently scheduled. The maximum annual debt service shown in this schedule may differ from the Maximum Annual Debt Service Requirement, as defined under the Master Indenture and as shown in Appendix A under the caption "HISTORICAL FINANCIAL INFORMATION – Debt Service Coverage Ratio."
- (2) Debt service on Other Obligations excludes \$30.025 million of Series 2009B Bonds which were cash defeased on January 7, 2014. Balloon Indebtedness has been smoothed pursuant to the Master Indenture provisions. The Series 1988, 2009A, 2009C, and 2009D bonds assume interest rates of 2.48%, 3.07% and 2.77% based on the twenty (20) year average of SIMFA as of September 30, 2013, plus applicable fees. The Series 2010A bonds assume an interest rate of 2.92% based on a twenty (20) year average of 30 day LIBOR as of September 30, 2013, plus applicable fees.
- (3) The debt service shown in this table reflects all the debt service obligations of the Obligated Group. Some of these obligations are not secured under the Master Indenture. See Note 6 to the audited combined financial statements of the Corporation included in APPENDIX B for additional information.

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 2014A Par Amount	\$159,485,000
Net Original Issue Premium	6,625,472
Refunded Bonds Reserve Fund	3,114,354
Obligated Group Funds	<u>1,769,377</u>

Total Sources of Funds: **\$170,994,203**

Uses of Funds:

Deposit to Project Fund	\$143,664,704
Refund Refunded Bonds	25,560,122
Costs of Issuance ⁽¹⁾	<u>1,769,377</u>

Total Uses of Funds: **\$170,994,203**

(1) Costs of issuance include legal, printing, rating agency, accounting, Bond Trustee and Authority fees, Underwriters' 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 2014A 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 Underwriters 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 or (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.

Economic Conditions and Financial Markets

The disruption of the credit and financial markets in the last several years led to volatility in the securities markets, significant volatility in investment portfolios, periodic disruption of access to the capital markets, increased business failures and consumer and business bankruptcies, and was a major cause of the economic recession in 2008 and 2009. In response to that disruption, the Dodd-Frank Wall Street Reform and Consumer Protection Act (the “Financial Reform Act”) was enacted in 2010. The Financial Reform Act includes broad changes to the existing financial regulatory structure, including the creation of new federal agencies to identify and respond to risks to the financial stability of the United States. Additional legislation is pending or under active consideration by Congress and regulatory action is being considered by various federal agencies and the Federal Reserve Board and foreign governments, which are intended to increase the regulation of domestic and global credit markets. The effects of the Financial Reform Act and these legislative, regulatory and other governmental actions, if implemented, are unclear.

The health of the economy has a direct impact on the System and also increases stress on the budgets of the states. In recent years, hospitals felt the impact of higher unemployment, reduced personal income earning expectations and diminished access to private insurance. Although the California economy has experienced an improvement during the recent year, the ability to sustain the improvements and avoid another economic downturn is subject to significant uncertainty. See “BONDHOLDERS’ RISKS – Patient Service Revenues--Medicaid Program--California State Budget” below for additional discussion.

Effects of a weaker economy on hospitals and physician practice operations have also resulted in (but are not limited to) lower patient volumes as patients defer elective health care services; rising charity care and bad debt expense; budget pressures on federal and state governments intensifying reviews of Medicare and Medicaid reimbursement rates; unfavorable changes in payor mix away from commercial payors; financial pressures and decreasing membership at health care insurers, contributing to lower commercial rate increases for health care providers; and increased difficulty attracting philanthropy.

The American Recovery and Reinvestment Act of 2009 (“ARRA”) includes several provisions that were intended to provide financial relief to the health care sector, including a requirement that states promptly reimburse healthcare providers under the Medicaid system and a subsidy to the recently unemployed for health insurance premium costs. ARRA also established a framework for the implementation of a nationally-based health information technology program, including incentive payments which commenced in 2011 to eligible healthcare providers to encourage implementation of health information technology and electronic health records. Assuming federal funding is available, such incentive payments are payable to eligible health care providers that comply with the applicable federal requirements, including demonstrating “meaningful use” of electronic health records, in each period over a four year period. Pursuant to ARRA, commencing in 2015, Medicare eligible providers that do not demonstrate “meaningful use” of electronic health records will receive downward adjustments in their Medicare reimbursement. The System demonstrated stage one “meaningful use” of electronic health records at all four of its acute care hospitals, and has received incentive payments available under ARRA.

See “RECENTLY COMPLETED AND CURRENT PROJECTS – Information Technology” in *APPENDIX A* for additional information on such payments. The Centers for Medicare & Medicaid Services (“CMS”), an agency of the United States Department of Health and Human Services (“HHS”), has commenced audits of providers that have received meaningful use payments. No Member of the Obligated Group has been audited in connection with its receipt of meaningful use payments; however a Non-Obligated Affiliate (as defined in APPENDIX A) was selected by CMS for audit and the audit is currently in progress.

Impact of Investment Performance

The System has significant holdings in a broad range of investments. Investment income (including both realized and unrealized gains on investments) has contributed to the System’s financial results over recent years. Market fluctuations have affected and will likely continue to affect the value of those investments and those fluctuations may be material. The state of the economy and market disruptions has exacerbated the market fluctuations. Reduction in investment income and the market value of its investments may have a negative impact on the System’s financial condition, including its ability to fund capital expenditures from cash and investments.

Affordable Care Act

In March 2010, the Patient Protection and Affordable Care Act (the “Affordable Care Act”) was enacted to overhaul the United States health care system and regulate many aspects of health care delivery and financing. Some of the provisions of the Affordable Care Act took effect immediately, while others will take effect or will be phased in over time. The Affordable Care Act will also require the promulgation of substantial regulations with significant effects on the health care industry and third-party payors. In response, third-party payors and suppliers and vendors of goods and services to health care providers are expected to impose new and additional contractual terms and conditions. Thus, the health care industry will be subjected to significant new statutory and regulatory requirements and contractual terms and conditions, and consequently to structural and operational changes and challenges, for a substantial period of time.

The constitutionality of the Affordable Care Act has been challenged in courts around the country. On June 28, 2012, the U.S. Supreme Court in its decision in *National Federation of Independent Business v. Sebelius* issued a ruling upholding certain provisions of the Affordable Care Act, including an “individual mandate” (generally requiring individuals to have a certain amount of health insurance coverage or pay a penalty, beginning in 2014), thus allowing implementation of the law to go forward. Attempts to amend and repeal provisions of the Affordable Care Act were introduced in previous Congressional sessions and certain amendments to the Affordable Care Act were contained in the American Taxpayer Relief Act of 2012 (the “Taxpayer Relief Act”) signed into law by President Obama on January 3, 2013. The ultimate outcomes of any legislative attempts to repeal, amend or eliminate or reduce funding for the Affordable Care Act are unknown.

A significant component of the Affordable Care 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 of their employees and, as a consequence, expansion of the base of consumers of health care services. The Affordable Care Act was designed, in substantial part, to make available, or subsidize the premium costs of, health care insurance for some of the millions of currently uninsured (or underinsured) consumers, and specifically those who fall below certain income levels. The Affordable Care Act proposes to accomplish that objective through various provisions, summarized as follows: (i) the creation of active markets (referred to as exchanges) in which individuals and small employers can purchase health care insurance for themselves and their families or

their employees and dependents, (ii) providing means-tested subsidies for premium costs to certain individuals and families based upon their income relative to federal poverty levels, (iii) mandating that individual consumers obtain and certain employers provide a minimum level of health care insurance, and providing for taxes on consumers and employers that do not comply with these mandates, (iv) expansion of private commercial insurance coverage generally through such reforms as prohibitions on denials of coverage for pre-existing conditions and elimination of lifetime or annual cost caps, and (v) expansion of existing public programs, including Medicaid, for individuals and families. An increase in utilization of health care services by those who are currently avoiding or rationing their health care can be expected and bad debt expenses and/or charity care provided may be reduced. Associated with increased utilization will be increased variable and fixed costs of providing health care services, which may or may not be offset by increased revenues.

In March 2012, the Congressional Budget Office (“CBO”) estimated that between 20 million and 23 million people will receive coverage through the new insurance exchanges, and over 17 million additional people will be enrolled in Medicaid and the Children’s Health Insurance Program (“CHIP”) by 2021 as a result of Affordable Care Act. However, about 6 million fewer people are projected to purchase individual coverage directly from insurers or obtain coverage through their employers, resulting in an estimated net increase in the number of people with private insurance coverage of about 16 million. Importantly, the CBO estimates do not reflect the Supreme Court’s decision in *National Federation of Independent Business v. Sebelius*, which precludes the Secretary of HHS from penalizing states that choose not to participate in the Medicaid expansion. See “BONDHOLDERS’ RISKS - California - California Health Care Reform” below for additional discussion. Providers operating in markets with large Medicaid and uninsured populations are anticipated to benefit from increased revenues resulting from increased utilization and reductions in bad debt or uncompensated care. The increase in utilization can also be expected to increase the cost of providing that care, which may or may not be balanced by increased revenues.

To the extent the provisions of the Affordable Care Act remaining after the Supreme Court’s decision in *National Federation of Independent Business v. Sebelius* produce the intended result, an increase in utilization of health care services by those who are currently avoiding or rationing their health care can be expected. Bad debt expenses may be reduced because reimbursement for otherwise uncompensated care will be received; however, the net impact of such an increase in utilization of health care services is difficult to predict, due to the rates of reimbursement under the Medicaid and Medicare programs, which could be further reduced. Associated with increased utilization will be increased variable and fixed costs of providing health care services, which may or may not be offset by increased revenues, and a risk of physician shortages, especially in specialties necessary to provide critical intervention or chronic disease management (e.g., primary care).

The Affordable Care Act also contains more than thirty-two sections related to health care fraud and abuse and program integrity as well as significant amendments to existing criminal, civil and administrative anti-fraud statutes. Increased compliance and regulatory requirements, disclosure and transparency obligations, quality of care expectations and extraordinary enforcement provisions that could greatly increase potential legal exposure are all aspects of the Affordable Care Act that could increase the System’s operating expenses.

With respect to charity care, the Affordable Care Act contains many features from previous tax exemption reform proposals, including a set of sweeping changes applicable to charitable hospitals exempt under Section 501(c)(3) of the Internal Revenue Code of 1986 (the “Code”). The Affordable Care Act: (a) imposes new eligibility requirements for 501(c)(3) hospitals, coupled with an excise tax for failures to meet certain of those requirements; (b) requires mandatory IRS review of the hospitals’ entitlement to exemption; (c) sets forth new reporting requirements including information related to

community health needs assessments and audited financial statements; (d) requires hospitals to adopt and publicize a financial assistance policy; limit charges to patients who qualify for financial assistance to the lowest amount charged to insured patients; and control the billing and collection processes; and (e) imposes further reporting requirements on the Secretary of the Treasury regarding charity care levels. Failure to satisfy these conditions may result in the imposition of fines and the loss of tax exempt status.

Some provisions of the Affordable Care Act may adversely affect the System's operations more significantly than others, or may not affect them. The demographics of the markets in which the System provides services, the mix of services that any hospital or other facility provides to its community and other factors that are unique to a hospital or other facility that are likely to affect operations, financial performance or financial conditions are described below. This listing is not intended to be, nor should it be intended to be considered to be comprehensive. The Affordable Care Act is complex and includes a myriad of new programs and initiatives and changes to existing programs, policies, practices and laws.

First, the annual Medicare market basket updates for hospitals will be reduced through September 30, 2019. The market basket updates are 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, certain reductions in market basket updates were 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 and operating income. 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 payments per discharge on a year-to-year basis.

Additionally, payments under "Medicare Advantage" programs (Medicare managed care) will be periodically reduced through September 30, 2019, which may result in increased premiums or out-of-pocket costs to Medicare beneficiaries enrolled in Medicare Advantage plans. Those beneficiaries may terminate their participation in such plans and opt for the traditional Medicare fee-for service program. The reduction in payments to Medicare Advantage programs may also lead to decreased payments to providers by managed care companies operating Medicare Advantage programs. All or any of these outcomes will have a disproportionately negative effect upon those providers with relatively high dependence upon Medicare managed care revenues. See APPENDIX A, "HISTORICAL FINANCIAL INFORMATION – Revenue Sources."

On October 1, 2012, a value-based purchasing program was established under the Medicare program to provide incentive payments to hospitals based on performance on quality and efficiency measures. These incentive payments are to be funded through a pool of money collected from all hospital providers. Depending on the performance of the System, its Medicare revenues could decrease under a value-based purchasing program.

Commencing October 1, 2013 and through 2020, a state's Medicaid DSH allotment from federal funds will be reduced. Initially, Medicare disproportionate share hospital ("DSH") payments will be reduced by 75%. DSH payments will be increased thereafter to account for the national rate of consumers who do not have health care insurance and receive uncompensated care. The Taxpayer Relief Act is expected to further reduce Medicare DSH payments to hospitals by \$4.2 billion over the next 10 years, by rebasing future allocations.

The Affordable Care Act provides for the expansion of Medicaid programs to a broader population with incomes up to 133% of federal poverty levels beginning in January 2014. In its decision in *National Federation of Independent Business v. Sebelius*, the U.S. Supreme Court determined that any expansion of Medicaid must be at the option of individual states and not a mandatory obligation. The

Court reasoned that permitting the federal government to condition the availability of current Medicaid funding on participation in the expanded Medicaid program equated to a mandate that states participate in the expanded Medicaid program. Although the federal government is expected to almost entirely fund the expanded Medicaid program through 2020, some state officials have expressed reluctance to participate, citing concerns that the administrative and other costs associated with enrolling and managing potentially millions of new individuals would add further stress to already depleted state resources. In the event a state chooses not to participate in the expanded Medicaid program, the net effect of the reforms contained in the Affordable Care Act could be significantly reduced. California has indicated that it will participate in the expanded Medicaid program. Providers operating in markets with large Medicaid and uninsured populations are anticipated to benefit from increased revenues resulting from increased utilization and reductions in bad debt or uncompensated care. The increase in utilization can also be expected to increase the cost of providing that care.

The Hospital Readmissions Reduction Program, which began in October 2012, reduces Medicare payments to hospitals that have a high rate of potentially preventable readmissions of Medicare patients for certain clinical conditions by specified percentages to account for such excess and “preventable” hospital readmissions. Commencing October 1, 2014, Medicare payments to certain hospitals that experience high levels of hospital-acquired conditions will be reduced by 1%.

As of July 1, 2011, federal payments to states for Medicaid services related to health care-acquired conditions are prohibited. The Affordable Care Act also introduced a requirement that health care insurers include quality improvement covenants in their contracts with hospital providers and report their progress on such actions to the Secretary of HHS. Commencing January 1, 2015, health care insurers participating in the health insurance exchanges will be allowed to contract only with hospitals that have implemented programs designed to ensure patient safety and enhance quality of care. The effect of these provisions upon the process of negotiating contracts with insurers or the costs of implementing such programs cannot be predicted.

With varying effective dates, the Affordable Care Act enhances the ability to detect and reduce waste, fraud, and abuse in public programs through 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 Affordable Care Act requires the development of a database to capture and share health care provider data across federal health care programs and provides for increased penalties for fraud and abuse violations and increased funding for anti-fraud activities.

The Affordable Care Act provides for the establishment of an Independent Payment Advisory Board (the “Board”) to develop proposals to improve the quality of care and to limit cost increases. Beginning January 15, 2019, if the Medicare growth rate exceeds the target growth rate as determined by the CMS Office of the Actuary, the Board is required to develop proposals to reduce the growth rate and require the Secretary of HHS to implement those proposals, unless Congress enacts legislation related to the proposals.

The Affordable Care Act also created a Center for Medicare and Medicaid Innovation (the “Innovation Center”) to test innovative payment and service delivery models and to implement 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

(“ACOs”) or combinations of provider organizations that voluntarily meet quality thresholds to share in the cost savings they achieve for the Medicare program, while paying penalties if certain quality and cost targets are not met. See APPENDIX A, “STRATEGIC INITIATIVES – Pioneer ACO” for information regarding the ACO formed by the Corporation and its affiliated medical groups (the “Pioneer ACO”) as part of the Pioneer Accountable Care Organization Model program created by the Innovation Center. The outcomes of these projects and programs, including the Pioneer ACO, and their effect on payments to providers and financial performance, cannot be predicted.

As a result of the foregoing, health care providers such as the System could face additional strains on their operations, financial performance and condition. Management and its professional advisors are analyzing the Affordable Care Act to assess the effects of the legislation and/or regulations 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 or promulgated regulations.

The Affordable Care Act has made several changes to the Medicare program, ranging from changes to amounts payable to providers through imposition, directly or indirectly, of quality assurance measures. The Affordable Care Act also amended certain provisions of the Federal False Claims Act and added provisions respecting the timing of the obligation to reimburse overpayments. Further, the Affordable Care Act authorizes the Secretary of HHS to exclude a provider’s participation in the Medicare, Medicaid and CHIP programs as well as to suspend payments to a provider pending an investigation of a credible allegation of fraud against the provider. The System expects that the level of review and audit to which it and other health care providers are subject will increase. To foster compliance with applicable laws, the System has a compliance program that is designed to detect and correct potential violations of laws and regulations related to its programs. The System also tracks enforcement trends, closely reviews government advisories concerning suspect practices, and regularly undertakes to educate its employees, associates and vendors concerning applicable laws and regulations. However, many of the laws and regulations affecting the System and its subsidiaries have not been interpreted by regulators or the courts or have been subject to varying interpretations.

As a result, regulators may contend that they have broad authority to assert claims for noncompliance and assert claims or penalties based upon their interpretation of those requirements. It is not possible to determine the impact, if any, such claims or penalties would have upon the System.

California Health Care Reform

The State of California has enacted several laws and taken other action to implement the Affordable Care Act within the required federal timeframes, including, the following:

- The State established a state health insurance exchange. As of January, 2013, the California Health Benefit Exchange commenced operation under the brand name “Covered California.” California began open enrollment on October 1, 2013, for health insurance plan coverage beginning on January 1, 2014. See “BONDHOLDERS’ RISKS - Commercial Insurance and Other Third-Party Plans--Health Plans and Managed Care--Health Insurance Exchanges” below for further information.
- The Legislature approved expansion of Medi-Cal coverage, effective January 1, 2014, to include adults with incomes up to 133% of the federal poverty level who are under age 65, not pregnant, and not otherwise currently eligible for Medi-Cal. In addition, legislation passed prohibiting insurers from denying health coverage based on preexisting conditions.

- California is participating in the “Bridge to Reform” program pursuant to a waiver granted by CMS under Section 1115 of the Social Security Act in an effort to implement the Affordable Care Act’s Medicaid expansion in 2014.
- The State is also running a dual-eligibles pilot program with federal funding. Although enrollment was scheduled to begin in October 2013, the California Department of Health Care Services delayed implementation until January 2014.

Budget Control Act of 2011

The Budget Control Act of 2011 (the “Budget Control Act”) limits the federal government’s discretionary spending caps at levels necessary to reduce expenditures by \$917 billion from the current federal budget baseline from federal fiscal years 2012 through 2021. Medicare, Social Security, Medicaid and other entitlement programs will not be affected by the limit on discretionary spending caps.

The Budget Control Act also created a Joint Select Committee on Deficit Reduction (the “Committee”), which was tasked with making recommendations to further reduce the federal deficit by \$1.5 trillion on or before November 23, 2011. After several months of negotiations, the Committee was unable to reach agreement on spending reductions. As a result of this failure, and in exchange for raising the debt ceiling, the Budget Control Act also set in place a protocol for mandatory spending cuts known as sequestration, including a 2% reduction in Medicare spending, beginning in January 2013. Medicaid is one of a number of programs exempted from sequestration. The Taxpayer Relief Act extended the date on which the 2% reduction in Medicare spending would become effective by 60 days to March 1, 2013. On March 26, 2013, the President signed into law the Consolidated and Further Continuing Appropriations Act of 2013, providing funds for the operation of the federal government through September 30, 2013 and off-setting some of the sequestration mandated reductions for federal fiscal year 2013. On October 16, 2013, following a 16-day partial shutdown of the federal government, Congress passed and the President signed the Continuing Appropriations Act, 2014, which funded the federal government until January 15, 2014 and temporarily suspended the United States’ debt ceiling limits.

The federal government has estimated that it will reach its congressional approved federal debt limit on or about February 7, 2014. A failure by Congress to increase the federal debt limit may impact the federal government’s ability to incur additional debt to satisfy its obligations. What impact, if any, this may have on the financial condition or operation of the System is not certain.

Because Congress may make changes to the budget in the future, it is impossible to predict the impact any spending cuts that are approved may have on the System. Further, with no long-term resolution in place for federal deficit reduction, hospital and physician reimbursement are likely to continue to be targets for reductions with respect to any interim or long-term federal deficit reduction efforts. These and any additional reductions in Medicare spending could have a material adverse effect upon the financial condition or operations of the System.

Jobs Creation Act

The Middle Class Tax Relief and Job Creation Act of 2012 (the “Jobs Creation Act”), as amended by the Taxpayer Relief Act, delays through the end of 2013 the implementation of certain scheduled cuts to physician payments mandated by the sustainable growth rate (“SGR”) formula that ties physician reimbursement to the gross domestic product. For 2013, Medicare physician reimbursement would have been cut by 26.5% but for this extension. The Jobs Creation Act provides that the approximately \$17 billion cost of delaying the scheduled cuts for physician payments be achieved by providing for cuts in other areas of health care, including reductions in Medicaid payments to hospitals with disproportionate share of uninsured patients, as well as reducing Medicare’s reimbursement to

providers for beneficiaries' unpaid coinsurance and deductible amounts after reasonable collection efforts. Prior to the enactments of the Jobs Creation Act, Medicare reimbursed hospital providers 70 percent of beneficiary bad debt; the Jobs Creation Act reduces that reimbursement level to 65 percent. Reductions in payments for treating Medicare beneficiaries may have a material adverse effect on the financial condition or operations of the System.

The Taxpayer Relief Act also continues a number of Medicare policies known as "extenders." Those extenders include a wide variety of policies, including special provisions for some low-volume hospitals and charges for ambulance and physical therapy costs. The \$30 billion cost of these provisions is expected to be partially offset by a reduction of payments to hospitals over the next decade, including an estimated \$10.5 billion reduction in the projected Medicare hospital payments over 10 years for inpatient or overnight care (through a downward adjustment in annual base payment increases), and a reduction in the Medicaid disproportionate share payments to hospitals by an additional \$4.2 billion over the next decade. These cuts are on top of those made to hospitals as part of the Affordable Care Act.

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 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 organization and operation, 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.

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, the volume and definition of charity 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, 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.

IRS Form 990 for Tax-Exempt Organizations. IRS Form 990 is used by most Section 501(c)(3) tax-exempt organizations to submit information required by the federal government. The Form 990 now requires detailed disclosure of compensation practices, corporate governance, loans to management and others, joint ventures and other types of transactions, political campaign activities, and

information in other areas the IRS deems to be compliance risk areas. The Form 990 also requires the disclosure of information on community benefit as well as reporting of information related to tax-exempt bonds, including compliance with the arbitrage rules and rules limiting private use of bond-financed facilities and compliance with the safe harbor guidance in connection with management contracts and research contracts. The Form 990 is intended to provide enhanced transparency as to the operations of exempt organizations. It is likely that the IRS will use the detailed information to assist in its enhanced enforcement efforts.

Executive Compensation. A major California health care trade union recently filed a petition with the State Attorney General to include an initiative on the November 2014 ballot that would cap annual salaries of nonprofit hospital executives at \$450,000 per year, the amount paid to the President of the United States. The union reported that the annual pay for the 10 highest paid nonprofit hospital executives in California averaged \$2.6 million in 2011, with one executive drawing more than \$7.8 million. The ongoing scrutiny of executive compensation and/or potential further regulation of salaries may adversely impact the ability of the Obligated Group to recruit or retain key members of senior management.

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 through operating, fundraising, and investment activities and/or the use of endowments and charitable gifts.

California Auditor Investigation. In August 2011, the California Joint Legislative Audit Committee (“JLAC”) authorized the California Bureau of State Audits to conduct an audit: (i) to determine whether nonprofit hospitals are providing a public benefit that meets existing legal criteria to justify tax-exempt status and (ii) to assess the impact of purchases and consolidations of nonprofit hospitals. The audit report, issued in August 2012, noted that due to data limitations, the auditor could not determine whether changes in prices resulted from changes in the ownership or operation of a hospital. The audit, however, identified significant differences in practices among hospitals relating to the provision of community benefits. The audit also noted that amendments to State law would be required if California desires to: (i) make tax-exempt status dependent on the amount of community benefits provided by a hospital, (ii) establish a standard methodology for calculating the community benefits delivered by the hospital, or (iii) impose a penalty for hospitals that fail to comply with community benefit plan reporting standards. Legislation proposed in 2013 would (1) establish uniform standards for transparency and accountability on charity care and community benefit, and (2) require private hospitals to justify their non-profit exemption if their operating revenues exceed 10% of their operating expenses. Although the proposed legislation has not been enacted, the complete impact of the audit is uncertain. It is possible that the results of the audit will continue to receive increased legislative scrutiny and/or result in further regulation of the operation of nonprofit hospitals in California.

Financial Assistance and Charity Care. The California Health and Safety Code requires 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. Legislative proposals would modify the requirements relating to the provision of financial assistance and charity care by nonprofit hospitals. See “BONDHOLDERS’ RISKS - Nonprofit Healthcare Environment--California Auditor Investigation” above for further discussion. Although such proposed amendments have not been enacted, the computation and amount of financial assistance and charity care required to be provided by nonprofit hospitals may continue to be subject to additional scrutiny and further regulation in upcoming years.

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. 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 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 what are alleged to be large classes of plaintiffs, such actions may have material adverse consequences on hospitals and health systems in the future. Members of the Obligated Group are subject to several class action lawsuits, see “LITIGATION” herein.

In January 2009, the California Supreme Court ruled that the practice of emergency room physicians “balance billing” health plan patients for the difference between the physician’s charges for emergency medical services rendered to a health plan patient and the amount that a health plan 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 room 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 alleged balance billed amounts. Although a recent California court decision recognizes that a hospital may not be responsible for balance billing activities conducted by an independent medical group contractor, management of the System is unable to predict the outcome of any such lawsuit (if filed) 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 legal action to limit 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. In addition, a major California health care trade union recently filed a petition with the state Attorney General to include an initiative on the November 2014 ballot that would prohibit hospitals from charging more than 25% above the cost of providing patient care. As a result of increased public scrutiny, the pricing strategies of hospitals may possibly be perceived negatively by consumers, and hospitals may be forced to reduce fees for their services. Decreased utilization could result from any health benefit purchaser exclusions, and hospitals’ revenues may be negatively affected. 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. Also, the same major California health care trade union described above filed another petition with the State Attorney General to include an initiative on the November 2014 ballot to limit the compensation that may be paid to executives of non-profit health care organizations such as the Members of the Obligated Group.

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. 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, has 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 the Corporation, Memorial, Chula Vista and Grossmont met the requirements for the property tax exemption. During the current year, legislation was introduced that would potentially eliminate the property tax-exemption for hospitals that failed to meet specified financial criteria, including those relating to limits on surplus revenues and the level of charity care. Although the proposed legislation did not pass, there can be no assurance that these types of challenges will not continue to 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 on Corporation’s ability to make payments under the Loan Agreement and the Obligated Group’s ability to make payments on the Series 2014A 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, health maintenance organizations (“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 the System’s 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 27.5% and 26.9% of the net patient service revenues of the Obligated Group were derived from the Medicare program for the fiscal years ended September 30, 2012 and 2013, 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 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. In federal fiscal year 2008 CMS also implemented a documentation and coding adjustment to account for changes in payments under the Medicare Severity Diagnosis Related Group, or MS-DRG system that are not related to changes in case mix. CMS was given the authority to retrospectively determine if the documentation and coding adjustments were adequate to account for changes in payments not related to changes in case mix. The Taxpayer Relief Act extends that authority through federal fiscal year 2017 in order to recoup any overpayments that occurred during the transition to the MS-DRG system, which is expected to reduce payments to hospitals by approximately \$10.5 billion for such period.

The Affordable Care Act will reduce the annual Medicare market basket updates from federal fiscal year 2010 through federal fiscal year 2019. The Affordable Care Act also provides that annual

Medicare market basket updates will be subject to productivity adjustments, further reducing Medicare payments to hospitals. 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. Changes in the payments received for all services, including specialty services, could have an adverse effect on the Obligated Group. For further information regarding the Affordable Care Act and its provisions, see “BONDHOLDERS’ RISKS –Affordable Care Act” herein.

As required by the DRA, hospitals that do not participate in the Hospital Inpatient Quality Reporting Program (formerly known as the Reporting Hospital Quality Data for Annual Payment Update or RHQDAPU) program (the “Hospital Quality Initiative”) will receive the market basket update less 2.0%. CMS continues to update the quality measures that hospitals must report in order to qualify for the full market basket update. The System’s hospitals participate in the Hospital Quality Initiative.

The Affordable Care Act establishes a value-based purchasing program to link payments to quality and efficiency. In federal fiscal year 2013, HHS was directed to implement a value-based purchasing program for inpatient hospital services. Beginning in federal fiscal year 2013, CMS reduced the inpatient PPS payment amount for all discharges by between one and two percent and the total amount collected from these reductions will be pooled and used to fund payments to reward hospitals that meet certain quality performance standards established by HHS. The Affordable Care Act provides HHS with considerable discretion over the value-based purchasing program. On April 29, 2011, CMS issued a final rule establishing the value-based purchasing program for hospital inpatient services. Under this final rule, CMS estimated it would distribute \$850 million in federal fiscal year 2013 to hospitals based on their overall performance on a set of quality measures that have been linked to improved clinical processes of care and patient satisfaction. For payments in federal fiscal year 2013, hospitals were scored based on a weighted average of patient experience scores using the Hospital Consumer Assessment of Healthcare Providers and Systems survey and 12 clinical process-of-care measures. CMS scores each hospital based on achievement (relative to other hospitals) and improvement ranges (relative to the hospital’s own past performance) for each applicable measure. Because the Affordable Care Act provides that the pool will be fully distributed, hospitals that meet or exceed the quality performance standards will receive greater reimbursement under the value-based purchasing program than they otherwise would have. Hospitals that do not achieve the necessary quality performance will receive reduced Medicare inpatient hospital payments. The System is unable to predict how value-based purchasing will affect its results of operations, however the program could negatively impact the revenues of the System.

CMS has updated the hospital inpatient PPS for federal fiscal year 2014 by 0.7% for hospitals that participate in the Hospital Quality Initiative. This reflects a hospital market basket update of 2.5% reduced by several factors mandated by the Affordable Care Act and offsets due to added costs included in the final rule. Hospitals that do not successfully participate in the Hospital Quality Initiative will receive a reduction of 2.0%. The updates included in the final rule do not include any payment reductions due to the congressionally mandated reductions in Medicare spending due to sequestration. The hospital inpatient PPS for federal fiscal year 2014 also adopted a “2-midnight” benchmark to be used to determine the medical necessity of an inpatient admission. Under this rule, Medicare Part A payment is presumed to be appropriate only if the admitting physician certifies that a patient will require a stay in the hospital lasting at least two midnights, and clearly documents in the medical record that he or she is admitting the patient to the hospital on that expectation. Management of the Obligated Group is unable to predict

whether or not physicians will timely complete the required certifications, or what effect, if any, the new requirement will have on hospital revenues.

The Secretary of HHS is required to review annually the DRG categories to take into account any new procedures, to reclassify DRGs and to 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 System will be paid amounts that will adequately reflect changes in the cost of providing health care or in the cost of making health care technology available to patients. Since the implementation of the MS-DRG system, CMS has created new DRGs and revised or deleted others in order to better recognize the severity of illness for each patient. By law, 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.

The final IRF rule issued by CMS for federal fiscal year 2009 (the “2009 IRF Rule”) recalculated the weights assigned to the case mix groups using more recent data from rehabilitation hospitals about the types of patients they were treating and the resources required. Additionally, as required by the Medicare, Medicaid and SCHIP Reauthorization Act of 2007 (“MMSEA”), the 2009 IRF Rule retained 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 2009 IRF Rule implemented 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. Effective with the 2014 IRF Final rule, CMS has revised the list of diagnosis codes that are used to determine presumptive compliance under the “60 percent rule”.

The 2014 IRF Final rule provides an overall increase of IRF PPS rates of 1.8%. This rate increase reflects a 2.6% market basket increase, a 0.5% productivity adjustment and a 0.3% rate cut, each as mandated by the Affordable Care Act. As required by the Affordable Care Act, the annual IRF PPS rates will be reduced by 2% for facilities that fail to report quality data. The final rule also updates case-mix group relative weights and allows IRF’s to expand during a cost reporting period (not just at the beginning of a cost reporting period).

Psychiatric Services. Inpatient psychiatric services are reimbursed on a PPS basis, as mandated by the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999. The inpatient psychiatric facility PPS (“IPF PPS”) applies to both freestanding psychiatric hospitals and certified psychiatric units in general acute care hospitals. The 2014 IPF PPS final rule, effective October 1, 2014, provides for a market basket update of 2.6%, with a 0.5% productivity adjustment and a 0.1% rate cut, each as mandated by the Affordable Care Act.

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.

The OPSS rates are adjusted annually (on a calendar year schedule) based on the hospital inpatient market basket percentage increase. In the 2014 OPSS final rule, CMS authorizes an overall market basket increase of 1.7% reflecting a 2.5% market basket increase, offset by a productivity adjustment of 0.5% and a Affordable Care Act reduction of 0.3%. Hospitals that fail to report data related to the 25 quality measures adopted by CMS will have their market basket percentage increase reduced by two percentage points. CMS has also proposed significant coding changes and categorization of services in order to incentivize more efficient care and accurate payments. There can be no assurance that the hospital OPSS rate, which bases payment on APC groups rather than on individual services, will be sufficient to cover the actual costs of the System allocable to Medicare patient care.

In addition to the APC rate, there is a predetermined beneficiary coinsurance amount for each APC group. CMS estimates that the overall beneficiary coinsurance for OPSS services will be 21.7% in 2014. There can be no assurance that the beneficiary will pay this amount.

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. The Balanced Budget Act of 1997 included certain provisions that were intended to limit the increase of Medicare payments for physician services to ensure that the yearly increase does not exceed the growth in the U.S. Gross Domestic Product. Annually, CMS determines the Medicare Sustainable Growth Rate (the “SGR”) and then compares the SGR targets 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. Each year since 2003, Congress has provided temporary relief from the scheduled “negative” updates that would have reduced physician payments. In 2012, Congress again intervened to avoid the accumulated effect of the Congressional override of scheduled “negative” updates. Those interventions expired on January 1, 2013, the date of which Congress approved the Taxpayer Relief Act, which further delayed a 27% cut to the SGR formula until January 1, 2014. Legislation has been passed to further delay a cut to the SGR formula until April 1, 2014, with a 0.5% update in the SGR formula between January 1, 2014 through March 31, 2014. Congress is currently considering legislation to permanently repeal the SGR formula. Absent additional congressional action to permanently repeal or

further delay a cut to the SGR formula, health systems that have large physician practices could be adversely impacted.

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. As required by the DRA, agencies that do not submit data to CMS relating to certain quality indicators will have their market basket update percentage reduced by 2%. The Affordable Care Act requires, beginning in 2015, that the home health market basket annual update be subject to a productivity adjustment. CMS projects Medicare payments to home health agencies in calendar year 2014 will be reduced by 1.05%. This reflects the combined effects of a market basket increase of 2.3%, offset by a reduction of approximately 2.7% to the PPS rates to account for case-mix adjustments mandated by the Affordable Care Act and an approximately 0.6% decrease due to refinement of the home health diagnosis code groups. The reduction in 2014 PPS rates implements rebasing the case-mix weights as mandated in the Affordable Care Act, which will occur over a four-year period.

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 certain requirements for on-site provider-based facilities and clarified certain 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. 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 (and the Obligated Group does 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 Affordable Care 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. There can be no assurance that the 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. All or any of these outcomes will have a disproportionately negative effect upon those providers (including Members of the Obligated Group) with relatively high dependence upon Medicare managed care revenues. For further information regarding the Affordable Care Act and its provisions, see “BONDHOLDERS’ RISKS – Affordable Care Act” 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, potentially subjecting providers, including the Members of 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, is subject from time to time to audits and other investigations relating to various aspects of its 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 designated the use of recovery audit contractors (“RAC Contractors”) to search for improper Medicare payments in Arizona, Florida, California, Massachusetts, New York and South Carolina. RAC Contractors retrospectively review provider claims for the following types of services: hospital inpatient and outpatient, skilled nursing facility, physician, ambulance and laboratory, as well as durable medical equipment. As required by the 2006 Tax Act, permanent RAC programs have been implemented in all 50 states.

The RAC program was expanded through the Affordable Care Act to Medicare Part C (Medicare Advantage plans), Medicare Part D (prescription drug coverage) and Medicaid. CMS solicited comments on the Medicare Part C and Part D RAC programs and was expected to roll out its Medicare Part D RAC program during the third quarter of 2011, however a program has not been implemented as of the date of this Official Statement. States were originally expected to implement their Medicaid RAC programs by April 1, 2011, however this deadline was delayed. CMS published a final rule on September 16, 2011, detailing plans for Medicaid RAC program implementation, which final rule became effective January 1, 2012. California’s RAC program contract was effective as of April 2013.

The System has had several Medicare RAC audits conducted involving routine areas of higher risk such as medical necessity, 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 began in 2010. Management cannot anticipate the amount or volume of future Medicare and Medi-Cal 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 dependents. 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 nationwide Medicaid cuts of approximately \$4.8 billion over a five-year period.

For the fiscal years ended September 30, 2012 and 2013, the Obligated Group received approximately 14.0% and 14.2%, 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 assurance 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, 2013, the Obligated Group received State DSH payments totaling approximately \$12.1 million for two of the Obligated Group's hospitals, and federal DSH payments totaling approximately \$46.0 million for three of the Obligated Group's hospitals. Under the Affordable Care Act, 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. The 75% reduction in DSH payments that would otherwise be paid through Medicare will be effectively pooled, and this pool will be reduced further each year by a formula that reflects reductions in the national level of uninsured who are under 65 years of age. Each DSH hospital will then be paid, out of the reduced DSH payment pool, an amount allocated based upon its level of uncompensated care. It is difficult to predict the full impact of the Medicare DSH reductions. There is no assurance that any of the System's hospitals will receive DSH payments in the future, and no assurance that payments for disproportionate share will not be further decreased or eliminated in the future.

For further information regarding the Affordable Care Act and its provisions, see “BONDHOLDERS’ RISKS – Affordable Care Act” herein.

California Hospital Provider Fee. The Medi-Cal Hospital Provider Rate Stabilization Act and the Quality Assurance Fee Act of 2009 impose a quality assurance fee on California’s general acute care hospitals, excluding designated public hospitals and certain other exempt hospitals. The amount of the quality assurance fee owed by each California hospital is determined based upon each hospital’s managed care, fee-for-service and Medi-Cal total patient days. The fee proceeds earn federal matching funds for Medi-Cal that are used to increase Medi-Cal payments to hospitals, make supplemental payments to Medi-Cal managed care plans, and pay for health care coverage for children and certain costs of administering the quality assurance fee program.

Under the program, some California hospitals received more money in increased Medi-Cal reimbursement than the quality assurance fees paid, while other California hospitals received 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, were net “beneficiaries,” who received more funds than the fees that they paid and were not net “contributors,” of the fee program for the fiscal year ended September 30, 2011. See APPENDIX A, “HISTORICAL FINANCIAL INFORMATION – Management’s Discussion of Financial Performance.”

In October 2013, the Governor approved Senate Bill 239 which provides for the further extension of the quality assurance fee program through December 31, 2016. The quality assurance fee program has been extended several times since its original enactment in 2009, and certain industry groups are seeking to make the fee permanent. The extension of the fee will be beyond the current expiration date is uncertain.

California State Budget. During recent years many states, including California, have faced severe financial challenges, including issues arising from the 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.

The growth of the California economy during the past year, in combination with constraints imposed on prior year spending activities, have resulted in an improvement in the overall economic outlook for California in comparison with recent years. A recent estimate by the non-partisan Legislative Analyst’s Office indicates a \$2.2 billion surplus for fiscal year 2013-2014. The State’s continued fiscal recovery, however, is dependent on a number of assumptions that are subject to uncertainty, including assumptions relating to continuing economic growth and growth in stock prices. Thus, another economic downturn within the next few years could quickly result in a return to significant operating deficits. The existence of such constraints and/or failure by the California legislature to approve budgets prior to the start of each new fiscal year may also result in a temporary hold on or delay of Medi-Cal reimbursement. See APPENDIX A – “HISTORICAL FINANCIAL INFORMATION—Revenue Sources.”

Effective July 1, 2013, the DRG payment methodology replaced the previous payment method of negotiated rates for Medi-Cal contract hospitals and cost-based reimbursement for non-contract hospitals. California mandated the design and implementation of a DRG system in October 2010 in order to encourage access to care, reward efficiency, improve transparency, promote fairness by paying similarly across hospitals for similar care, simplify the payment process, encourage administrative efficiency and base payments on patient acuity and hospital resources rather than length of stay.

In 2011, budget-related legislation authorized a reduction in certain Medi-Cal provider payments by up to 10%. The implementation of the budget cuts were delayed by injunctions until the injunctions were lifted in June 2013 pursuant to a federal court ruling. In November 2013, the Legislative Analyst's Office estimated that the payment reductions would result in \$365 million General Fund savings in 2013-14, \$700 million in annual General Fund savings associated with the payment reductions in 2014-15 and 2015-16 (including the retroactive recoupment of payments back to June 2011) and roughly \$500 million in annual savings thereafter. Such changes to reimbursement rates and reduced revenue would negatively affect the Obligated Group.

The State budget for fiscal year 2013-2014 includes \$16.1 billion in Medi-Cal program spending. The amount represents a 7.8% increase over the \$14.9 billion in revised Medi-Cal spending levels for fiscal year 2012-2013. The change in spending reflects the various spending reductions that will be offset by the inclusion of \$1.7 billion in federal funds relating to the expansion in Medi-Cal population under the Affordable Care Act to include adults with incomes up to 133 percent of the federal poverty level. The federal government will pay 100 percent of the costs of health care services provided to the newly eligible Medi-Cal population for three years. Beginning January 1, 2017, however, the federal share of costs associated with the expansion will be decreased over a three-year period until the State pays for 10% of the expansion and the federal government pays the remaining 90%.

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 "Economic Conditions and Financial Markets" and "Affordable Care Act" 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. 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 System has 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 civil monetary penalties ("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, including Members of the Obligated Group, 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, 2012 and 2013, managed care revenues payments (excluding capitated contracts) constituted approximately 35.5% and 35.1%, 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 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 years ended September 30, 2012 and 2013, capitated managed care contracts constituted approximately 27.5% and 26.9%, 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) that hospitals and health care systems, including the System, face.

New ICD-10 Coding System. Managed care health plans, commercial payors and health care providers, including the Obligated Group, are required to transition to a new ICD-10 coding system, which greatly expands the number and detail of billing codes used for inpatient claims. Pursuant to the current regulations, use of the ICD-10 coding system will be required beginning on October 1, 2014. Transition to the ICD-10 coding system will require a significant investment in technology and software, as well as staff training, and it is possible that the Obligated Group could experience disruptions to, or delays in, reimbursement from payors for the services that the Obligated Group renders due to technical problems, coding errors, or other implementation issues involving its systems or the systems and implementation effort of managed care health plans, other commercial payors and their business partners.

The new ICD-10 coding system could result in lower levels of reimbursement to the Obligated Group than the existing system coding (ICD-09). If the Obligated Group experiences difficulties implementing and maintaining the new ICD-10 coding system, costs beyond its expectations or delays/reductions in its reimbursement from payors, the business, results of operation, and cash flow could be adversely affected.

Health Insurance Exchanges. Beginning in 2014, the Affordable Care Act imposes the use and availability of state-based exchanges, such as Covered California in the State of California, in which health insurance can be purchased by certain groups and segments of the population, the extension of subsidies and tax credits for premium payments by some consumers and employers, and the imposition upon commercial insurers of certain terms and conditions that must be included in contracts with providers. In addition, the Affordable Care Act imposes many new obligations on states related to health insurance. It is unclear how the increased federal oversight of state health care may affect future state oversight or affect the Obligated Group. The effects of these changes upon the financial condition of any third party payor that offers health insurance, rates paid by third-party payors to providers and, thus, the revenues of the Obligated Group, and upon the operations, results of operations and financial condition of the Obligated Group cannot be predicted.

Healthcare.gov, the health care exchange website created by the federal government under the provisions of the Affordable Care Act, launched on October 1, 2013. The website is designed to allow residents of the thirty-six U.S. states which opted not to create their own state exchanges or to enter into a partnership with the federal government to purchase health insurance or qualify for Medicaid coverage. The website has been marred by serious technological problems since its launch, making it difficult for individuals to purchase health insurance. Under the Affordable Care Act, uninsured Americans have until March 31, 2014 to purchase insurance through the health care exchanges or other venues, or face a financial penalty. Several proposals have been introduced in Congress to extend the purchase period and delay the implementation of such penalties, and to allow Americans to keep existing health insurance plans that do not meet the Affordable Care Act's minimum standards for coverage. The ultimate outcomes of such legislative proposals are unknown at this time, and it is unclear how the difficulties with Healthcare.gov may affect other provisions of the Affordable Care Act or the Obligated Group.

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 on 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, and in many instances already is, 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 2014A Obligation. Among other things, providers 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 of providers 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 in such programs. Those convicted of two health care-related crimes for which mandatory exclusion is the penalty will be excluded from such programs for a minimum of ten years. The Secretary of HHS may 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 civil monetary penalties: (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) the practice of submitting claims for payment for medically unnecessary services. Violation of such prohibited practices due to civil neglect could amount to civil monetary penalties ranging from \$50,000 to \$1.5 million for all identical violations in a calendar year and/or imprisonment if the imprisonment was obtained or used with intent to sell, transfer or use the information for commercial advantage, personal gain or malicious harm. Management of the System does not expect that the prohibited practices provisions of HIPAA will affect the System in a material respect.

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 (“Protected Health Information” or “PHI”).

HHS promulgated privacy regulations under HIPAA (the “Privacy Rule”) that protect the privacy of PHI maintained by health care providers (including hospitals), health plans, and health care clearinghouses (collectively, “Covered Entities”) and provides individuals with certain rights regarding their PHI (including, for example, access to PHI, amending PHI, and receiving an accounting of disclosures of PHI). Security regulations also have been promulgated under HIPAA (the “Security Rule”). The Security Rule requires Covered Entities to have certain administrative, technical, and

physical safeguards in place to ensure the confidentiality, integrity, and availability of all electronic PHI they create, receive, maintain, or transmit. Additionally, HHS promulgated regulations to standardize the electronic transfer of information pursuant to certain enumerated transactions (the “Transactions and Code Sets Rule”).

The 2009 Health Information Technology for Economic and Clinical Health Act (the “HITECH Act”) significantly changed the landscape of federal privacy and security laws regarding PHI. The HITECH Act (i) extended the reach of HIPAA, certain provisions of the Privacy Rule, and the Security Rule, (ii) imposed a breach notification requirement on HIPAA covered entities and their business associates, (iii) limited certain uses and disclosures of PHI, (iv) increased individuals’ rights with respect to PHI, and (v) increased enforcement of, and penalties for, violations of the privacy and security of PHI.

The HITECH Act breach notification requirement created a federal breach notification law that mirrors protections that many states have passed in recent years. This requirement provides that the System must notify patients of any unauthorized access, acquisition, or disclosure of their unsecured PHI that poses significant risk of financial, reputational or other harm to a patient. In addition, a new breach notification requirement was established requiring reporting to the Secretary of HHS and, in some cases, local media outlets, of certain unauthorized access, acquisition, or disclosure of unsecured PHI that poses significant risk of financial, reputational or other harm to a patient.

On January 17, 2013 HHS issued an omnibus final rule interpreting and implementing various provisions of the HITECH Act, including a final breach notification rule. In addition, the facilities of the System remain subject to any state laws that relate to the reporting of data breaches that are more restrictive than the regulations issued under HIPAA and the requirements of the HITECH Act.

Any violation of HIPAA, the HITECH Act, or the regulations promulgated under either is subject to HIPAA civil and criminal penalties that include monetary penalties and/or imprisonment. The System believes that all of its health care facilities are in substantial compliance with HIPAA, the HITECH Act, and the rules promulgated thereunder, however there can be no assurance that a violation of HIPAA or the HITECH Act will not occur in the future.

State Privacy Laws. California’s Confidentiality of Medical Information Act requires health care providers to keep medical information private and secure and to not disclose PHI without a patient’s consent with certain exceptions. In addition, Assembly Bill 211 and Senate Bill 541 effective on January 1, 2009, 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. The Office of Health Information Integrity has been established to enforce Assembly Bill 211 and may impose fines that can range from \$1,000 up to a maximum of \$250,000 per violation. State law also provides civil remedies to individuals whose medical information has been disclosed in violation of the law, including a \$1,000 nominal damages award without proof of actual damages. As a result, any unauthorized disclosure by the Obligated Group of medical information in violation of the law could result in substantial liability which could have a material adverse impact on the Obligated Group.

Senate Bill 541 applies to clinics, health facilities, home health agencies and hospice and requires those facilities to prevent unlawful or unauthorized access to, and use or disclosure of, patient medical information. Senate Bill 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 health care program anti-kickback statute (“Anti-Kickback Statute”) is a broad criminal statute that prohibits one person from “knowingly and willfully” giving (or offering to give) “remuneration” to another person if the payment is intended to “induce” the recipient to: (1) “refer” an individual to a person for the furnishing, or arranging for the furnishing, of any item or service for which payment may be made, in whole or in part, under a federal health care program (*i.e.*, a “covered item or service”); (2) “purchase,” “order,” or “lease” any covered item or service; (3) “arrange for” the purchase, order, or lease of any covered item or service; or (4) “recommend” the purchase, order, or lease of any covered item or service. The Anti-Kickback Statute also prohibits the solicitation or receipt of remuneration for any of these purposes.

Because the Anti-Kickback Statute is so broad, it covers a variety of common and non-abusive arrangements. Recognizing this overbreadth, Congress and HHS-OIG — the lead enforcement agency with respect to the Anti-Kickback Statute — have established a large number of statutory exceptions and regulatory safe harbors (collectively, “safe harbors”). An arrangement that fits squarely into a safe harbor is immune from prosecution under the Anti-Kickback Statute. The safe harbors tend to be narrow, however, and HHS-OIG takes the position that immunity is afforded only to those arrangements that “precisely meet” all of the conditions of a safe harbor. Moreover, safe harbors do not exist for every type of arrangement that does (or may) implicate the Anti-Kickback Statute.

Where the Anti-Kickback Statute has been violated, the government may proceed criminally or civilly. If the government proceeds criminally, a violation of the Anti-Kickback Statute is a felony punishable by up to five years imprisonment, a fine of up to \$25,000, and mandatory exclusion from participation in all federal health care programs. If the government proceeds civilly, it may impose a civil monetary penalty (CMP) of \$50,000 per violation and an assessment of not more than three times the total amount of “remuneration” involved, and it may exclude the offering or receiving party from participation in all federal health care programs. Many states, including California, have enacted laws similar to, and in some cases broader than the Anti-Kickback Statute. See “State ‘Fraud’ and ‘False Claims’ Laws” below.

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 Statute. However, in light of the narrowness of the safe harbors and the scarcity of case law interpreting the Anti-Kickback Statute, there can be no assurances that the System will not be found to have violated the Anti-Kickback Statute 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 civil False Claims Act (“FCA”) provides that any person who “knowingly presents, or causes to be presented” a “false or fraudulent claim for payment or approval” to the United States, and its agents and contractors, is liable for a civil penalty ranging from \$5,500 to \$11,000 per claim, plus three times the amount of damages sustained by the government. Under the FCA’s so-called “reverse false claims” provisions, liability also could arise for “using” a false record or statement to “conceal,” “avoid” or “decrease” an “obligation to pay or transmit money or property to the Government.” The FCA also empowers and provides incentives to private citizens (commonly referred to as *qui tam* relators or whistleblowers) to file suit on the government’s behalf. The *qui tam* relator’s share of any recovery can be between 15% and 25% in cases in which the government intervenes, and 25% to 30% in cases in which the government does not intervene. 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.

Recent amendments to the FCA in the Fraud Enhancement and Recovery Act of 2009 (“FERA”) and the Affordable Care Act expand the reach of the FCA. FERA expanded the FCA’s reverse false claims provisions, imposing liability on any person who “knowingly conceals” or “knowingly and improperly avoids or decreases” an “obligation to pay or transmit money or property to the Government,” whether the person uses a false record or statement to do so or not. FERA also clarified that an “obligation” can arise from the retention of an overpayment. Section 6402 of the Affordable Care Act further addresses the retention of overpayments by defining the term overpayment and the circumstances and timing under which an overpayment needs to be returned to the government before it becomes an “obligation” under the FCA. FERA and the Affordable Care Act also amend certain jurisdictional bars to the FCA, effectively narrowing the public disclosure bar and expanding the definition of “original source,” thus potentially broadening the field of potential whistleblowers. While the System makes every effort to be in compliance with applicable federal health care program requirements, there can be no assurance that the System will not be subject to an investigation, a lawsuit or ultimate liability, which could have a material and adverse effect upon the Obligated Group’s operations and financial condition.

Restrictions on Referrals. The federal physician self-referral law and its implementing regulations (commonly referred to as the “Stark Law”) prohibits a physician from referring patients to an entity for the furnishing of designated health services (“DHS”) covered by Medicare if the physician (or one of his immediate family members) has a financial relationship with the entity, unless an exception applies. Designated health services include: clinical laboratory services; physical therapy services; occupational therapy services; outpatient speech language pathology services; radiology services, including magnetic resonance imaging, computerized axial tomography scans and ultrasound services; radiation therapy services and supplies; durable medical equipment and supplies; 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 Stark Law also prohibits the furnishing entity from submitting a claim for reimbursement or otherwise billing Medicare or any other person or entity for improperly referred DHS.

An entity that submits a claim for reimbursement in violation of the Stark Law must refund any amounts collected and may be (1) subject to a civil penalty of up to \$15,000 for each prohibited self-referred service and (2) excluded from participation in federal health care programs. In addition, a physician or entity that has participated in a “scheme” to circumvent the operation of the Stark Law is subject to a civil penalty of up to \$100,000 and possible exclusion from participation in federal health care programs.

CMS has established a voluntary self-disclosure program under which hospitals and other entities may report Stark violations and seek a reduction in potential refund obligations. However, the program is relatively new and therefore it is difficult to determine at this time whether it will provide significant monetary relief to hospitals that discover inadvertent Stark law violations. The Obligated Group Members may make self-disclosures under this program as appropriate from time to time.

Management of the System believes that the System is currently in material compliance with the Stark law provisions. However, in light of the technical nature of the Stark law, 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 repayment obligation or sanction imposed would have a material adverse effect on the operations of the System or the financial condition of the System.

Non-Obligated Affiliate Compliance. The Corporation, other Members of the Obligated Group and certain Non-Obligated Affiliates 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. 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 Non-Obligated Affiliate self-disclosed this issue to CMS pursuant to the authority granted to CMS to accept such self-disclosures under the Affordable Care Act. As of the date of this Official Statement, CMS has not made a determination with respect to this self disclosure. There can be no assurance as to the response of CMS, however, management of the System does not anticipate that the results of such 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 should a violation occur, 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 the Stark Law). These prohibitions, while similar in public policy and scope to the federal laws, have not in all instances been vigorously enforced to date. California Attorney General Kamala Harris, however, has indicated that her office will increase its use of the previously dormant state False Claims Act. 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 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 strives to be in compliance with Medicare billing requirements, there can be no assurance that the Obligated Group will not be subject to an investigation, repayment obligations, penalty assessments or other liabilities under applicable billing laws and regulations.

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. The Members of the Obligated Group are at all times subject to such initiatives.

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 before refusing to accept a patient, including conducting a medical screening examination of all patients who present on hospital property and request examination and treatment for an emergency medical condition, or who have a request made on his or her behalf. 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. Members of the Obligated Group strive to comply with the EMTALA requirements, but no assurance can be made that violations of EMTALA will not occur. Any EMTALA violation could have a material and adverse effect on the operations and financial condition of the Members of the Obligated Group.

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. While the System’s facilities are currently appropriately certified and accredited, 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 responsible for investigating and may be subject to liability for remedying any hazardous substances that may exist on their property or 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.

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. Management believes the Obligated Group is in material compliance with these recommendations.

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.

On December 14, 2011, the Corporation received a subpoena from the Office of the California Attorney General regarding the Attorney General's investigation of anticompetitive contracting practices by hospital groups. Several other hospital systems in California have received a similar subpoena and request for documents. The Corporation intends to cooperate with the Office of the Attorney General in its investigation, but is unable to predict the effect, if any, that such inquiry or any resulting action by the Attorney General may have on the operations or financial condition of the Obligated Group.

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.

In addition to relationships with other hospitals and physicians, the System actively considers investments, ventures, affiliations, development and acquisition of other health care-related entities. Any such initiative may involve significant capital commitments to non-Obligated Group entities and/ or capital or operating risk, including, potentially insurance risk, in a business in which the System may have less expertise than in hospital operations. There can be no assurance that such projects, if pursued, would not lead to material adverse consequences to the System.

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. Such competition 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 by other providers.

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 such as the Obligated Group's facilities.

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, typically 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, including the Obligated Group's facilities, 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. Because 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 (which cannot be cited or relied upon as legal precedent), 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 activities regarding tax-exempt health care organizations. The IRS often 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 financings, partnerships and joint ventures, retirement plans and employee benefits, employment taxes, political contributions and other matters.

If the IRS were to find that any Member 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 in cases where grounds for such revocation exist. Loss of tax-exempt status by any of the Members of the Obligated Group could result in loss of tax exemption of the Bonds and of other tax-exempt debt of the Members of the Obligated Group, and would likely trigger defaults in covenants regarding the Bonds and other related tax-exempt debt and obligations. 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. However, the grounds for imposition of intermediate sanctions could also provide the basis, in appropriate cases, for revocation of the organization’s tax-exempt status.

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 to the Members of the Obligated Group and their operations and financial condition.

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 applicable to it. 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 tax-exempt status of the Bonds is based on the continued compliance by the Authority, the Corporation and any other users of property financed or refinanced with proceeds of the Bonds with certain covenants relating generally to (i) restrictions on the use of the facilities financed or refinanced with the proceeds of the Bonds, (ii) arbitrage limitations, (iii) rebate of certain excess investment earnings to the federal government and (iv) status of users of the properties financed or refinanced with the proceeds of the Bonds as organizations described in Section 501(c)(3) of the Code. In the event that the Bonds become subject to federal income taxation retroactive to the date of issuance, such Bonds are not subject to redemption solely as a consequence thereof.

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 by the IRS 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.

Charity Care. Hospitals are permitted to acquire tax exempt status under the Code because the provision of health care historically has been treated as a “charitable” enterprise. This treatment arose before most Americans had health insurance, when charitable donations were required to fund the health care provided to the sick and disabled. Some commentators and others have taken the position that, with the onset of employer health insurance and governmental reimbursement programs, there is no longer any justification for special tax treatment for the health care industry, and the availability for tax exempt status should be eliminated. Management of the System cannot predict the likelihood of such a dramatic change in the law. Increasingly, federal and state tax authorities are demanding that tax exempt hospitals justify their tax exempt status by documenting their charitable care and other community benefits. See “BONDHOLDERS’ RISKS – Nonprofit Health Care Environment -- Financial Assistance and Charity Care” and “– Tax-Exempt Status and Other Tax Matters -- Code Section 501(r)” herein.

Schedule H to the Form 990 asks whether the organization has a charity care policy and asks for a description of that policy. This schedule also requires an organization to report the community benefits that it provides, including the cost of providing charity care and other benefits. Since the reporting of this information on the Form 990 makes this information more readily available, it is possible that such reporting will lead to additional IRS compliance efforts.

Code Section 501(r). The provisions of the Affordable Care Act provided for a new Code Section 501(r), which adds certain requirements that non-profit hospital organizations must meet in order to attain or to maintain Section 501(c)(3) tax-exempt status. Among other things, a hospital must: (i) establish a written financial assistance policy (“FAP”) and a policy relating to emergency medical care meeting the requirements of Code Section 501(r)(4); (ii) limit the amounts charged for emergency or other medically necessary care provided to individuals eligible for assistance under the hospital’s FAP to not more than the amounts generally billed to individuals who have insurance covering such care (“AGB”); and (iii) make reasonable efforts to determine whether an individual is FAP-eligible before engaging in extraordinary collection actions. Management of the System believes that it is currently in material compliance with the requirements of Section 501(r).

On April 3, 2013, the IRS released proposed regulations regarding the requirements of Section 501(r) applicable to tax-exempt hospital organizations and on April 5, 2013 such proposed regulations were published. These proposed regulations provide guidance on the community health needs assessment requirements and related excise tax and reporting obligations, clarify the consequences for failing to meet the various requirements under Section 501(r) and state that minor omissions and inadvertent errors will not result in loss of tax-exempt status, provided that certain specified correction and disclosure steps are taken. Comments regarding the new proposed rule were due to the IRS by July 5, 2013. IRS Notice 2014-2 confirms that hospital organizations may rely on the proposed regulations published April 5, 2013 pending the publication of final regulations or other applicable guidance.

A failure to comply with the provisions of Section 501(r) and the final regulations could result in a loss of Section 501(c)(3) tax-exempt status. For further information regarding the Affordable Care Act, see “BONDHOLDERS’ RISKS – Affordable Care Act” 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 proximity to active earthquake faults. A significant earthquake in California could destroy or disable the hospital facilities of the Members of the Obligated Group.

Compliance with Seismic Standards. The State Alfred E. Alquist Hospital Facilities Seismic Safety Act of 1983 establishes, under the jurisdiction of OSHPD, a program of seismic safety building standards for certain hospitals constructed on and after March 7, 1973. Under prior law, a general acute care hospital building that was determined to have a potential risk of collapse or pose risk of significant loss of life could be used only for non-acute care hospital purposes after January 1, 2008, except that OSHPD could grant a 5-year extension until 2013 or an additional 2-year extension until 2015 under prescribed circumstances.

The enactment of Senate Bill 90 in April, 2011 provides OSHPD with the authority to further extend the compliance deadline for many hospitals until 2020. OSHPD reviews the extension requests on a case by case basis based on consideration of various criteria, including: (i) the structural integrity of the building, (ii) community access to care if the hospital building were to close, and (iii) financial capacity of the hospital to complete the construction in a timely manner. Senate Bill 90 became effective upon the approval by CMS on June 22, 2012 of California's hospital provider fee program. See "BONDHOLDERS' RISKS — Patient Service Revenues — Medicaid Program — California Hospital Provider Fee" herein.

The Obligated Group will assess the need for and the benefit of the extensions over time if circumstances warrant. Three of System's four hospital campus sites have now satisfied seismic regulations until 2030. Management of the Obligated Group expects to meet the seismic requirements for its remaining hospital buildings by the 2015 compliance date. 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 2014A 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 \$180.1 million will be subject to variable interest rate exposure, which amount does not include variable rate bonds which are subject to swap agreements where the Obligated Group pays a fixed rate to a counterparty. 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.

Markets for the Bonds. Subject to prevailing market conditions, the Underwriters intend, but are 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. Nonprofit health care providers and their employees are under the jurisdiction of the National Labor Relations Board ("NLRB"). As of September 30, 2013, the Obligated Group had approximately 11,515 full-time equivalent employees, 4,423 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. Also, a petition has been filed with the State Attorney General to be included on the November 2014 ballot which would substantially increase the current \$250,000 limit on general damages applicable to medical professional liability claims. If such a ballot measure were to become law, the cost of professional

liability insurance for the Obligated Group would likely increase substantially. 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) Inability of the System to meet or continue to comply with legal, regulatory, professional and private licensing and accreditation requirements, all or some of which may be subject to renewal based on inspection or other criteria.
- (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 or insolvency of an indemnity/commercial insurer, managed care plan or other payor.
- (d) Any increase in the quantity of indigent care provided which is mandated by law or required due to increased needs of the community in order to maintain the charitable status of the System.
- (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 as the Members of the Obligated Group generally carry.
- (f) The occurrence of a natural or man-made disaster, a pandemic or epidemic, or terrorist action 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 2014A 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. To the extent permitted by law, 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 2014A 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 another 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 2014A Obligation may not be enforceable under any of the following circumstances:

(i) to the extent payments on the Series 2014A 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 2014A 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 2014A 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 2014A 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 2014A 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 and 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 as provided in the Master Indenture. 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 any Member 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. 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 amounts treated as 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 depend 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.

Current and 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, in whole or in part, 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. For example, legislative proposals have been made in recent years that would limit the exclusion from gross income of interest on obligations like the Bonds to some extent for taxpayers who are individuals and whose income is subject to higher marginal income tax rates. The introduction or enactment of any such legislative proposals or clarification of the Code or court decisions may also affect, perhaps significantly, the market price for, or marketability of, the Bonds. Prospective purchasers of the Bonds should consult their own tax advisors regarding the potential impact of any pending or proposed federal or state tax legislation, regulations or litigation, as to which Bond Counsel is expected to express 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 Members of the Obligated Group 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 Members of the Obligated Group 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 Members of the Obligated Group 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 Members of the Obligated Group 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. Bank National 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, 2014, (ii) 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, 2014, and (iii) notices of the occurrence of certain listed events (described below). "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 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 Underwriters 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 Obligated Group has timely filed or caused to be filed with EMMA the financial and operating information and event notices required to date by the Master Continuing Disclosure Agreement; except for debt service coverage information for 2009 which has since been made available at EMMA.

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, Jones Hall, A Professional Law Corporation, San Francisco, California, for the Obligated Group by its special counsel, Hooper, Lundy & Bookman, P.C., San Diego, California, and for the Underwriters by their special counsel, Dentons 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, 2013 and 2012 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 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 their 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, or 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 are vigorously defending the lawsuit. In July of 2013, the California Court of Appeals upheld the trial court's decision to deny class certification, however, the litigation has not been dismissed.

The Corporation and other Members of the Obligated Group have been served with two lawsuits (one of which has been stayed) seeking class action status on behalf of non-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 are vigorously defending the lawsuits. Recently the trial court denied class certification with respect to certain claims made in the active lawsuit but granted certification with respect to other claims. If there is ultimately an adverse decision against the Members of the Obligated Group, such 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. The trial court recently denied class certification and the plaintiffs have appealed that ruling. If on appeal 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.

The Corporation has been served with a lawsuit seeking class action status alleging the Corporation has violated the Telephone Consumer Protection Act (47 U.S.C. Section 227 *et seq.*) by placing calls to cellular telephones of patients without first obtaining their prior express consent. The Corporation believes that it has complied with the Telephone Consumer Protection Act and is vigorously defending the lawsuit. If the matter is certified as a class action and there is an adverse decision to the Corporation, such 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 or governmental inquiry 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 "AA-" and "A1", 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 Goldman, Sachs & Co. ("Goldman Sachs") and Citigroup Global Markets Inc. (collectively, the "Underwriters"). Pursuant to the Bond Purchase Agreement for the Bonds, the Underwriters have agreed to purchase the Bonds at a purchase price of \$166,110,472.40, including net original issue premium of \$6,625,472.40. The Obligated Group will pay the Underwriters a fee of \$1,037,126.75 for their services in immediately available funds on the date of Closing. The Bond Purchase Agreement for the Bonds provides that the Underwriters will purchase all of the Bonds, if any are purchased, and contains the agreements of the Obligated Group to indemnify the Underwriters and the Authority against certain liabilities.

The Underwriters and their respective affiliates are full service financial institutions engaged in various activities, which may include sales and trading, commercial and investment banking, advisory, investment management, investment research, principal investment, hedging, market making, brokerage and other financial and non-financial activities and services.

In the ordinary course of their various business activities, the Underwriters and their respective affiliates, officers, directors and employees may purchase, sell or hold a broad array of investments and actively trade securities, derivatives, loans, commodities, currencies, credit default swaps and other financial instruments for their own account and for the accounts of their customers, and such investment and trading activities may involve or relate to assets, securities and/or instruments of the Obligated Group (directly, as collateral securing other obligations or otherwise) and/or persons and entities with relationships with the Obligated Group. The Underwriters and their respective affiliates may also communicate independent investment recommendations, market color or trading ideas and/or publish or express independent research views in respect of such assets, securities or instruments and may at any time hold, or recommend to clients that they should acquire, long and/or short positions in such assets, securities and instruments.

Goldman Sachs, one of the Underwriters of the Bonds, has entered into a master dealer agreement (the "Master Dealer Agreement") with Incapital LLC ("Incapital") for the distribution of certain municipal securities offerings, including the Bonds, to Incapital's retail distribution network at the initial public offering prices. Pursuant to the Master Dealer Agreement, Incapital will purchase Bonds from Goldman Sachs at the initial public offering prices less a negotiated portion of the selling concession applicable to any Bonds that Incapital sells.

Citigroup Global Markets Inc., an Underwriter of the Bonds, has entered into a retail distribution agreement with UBS Financial Services Inc. ("UBSFS"). Under this distribution agreement, Citigroup Global Markets Inc. may distribute municipal securities to retail investors through the financial advisor

network of UBSFS. As part of this arrangement, Citigroup Global Markets Inc. may compensate UBSFS for their 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. 34 and the Series 2014A 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. 34 and the Series 2014A 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

APPENDIX A

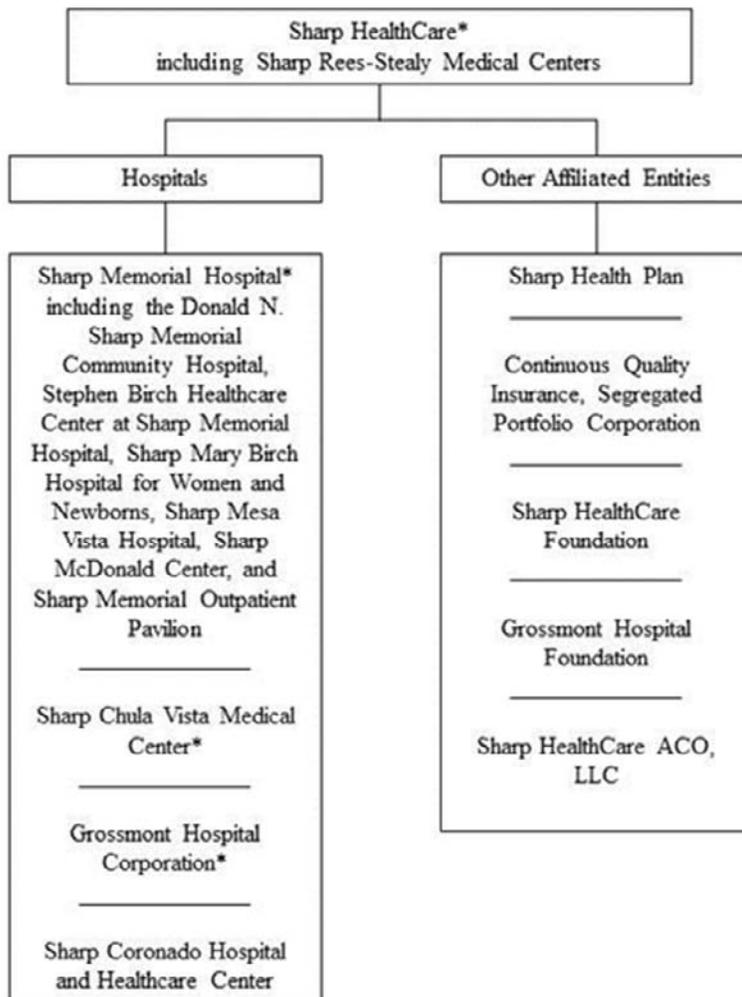
**INFORMATION CONCERNING SHARP
HEALTHCARE AND THE OBLIGATED GROUP**

TABLE OF CONTENTS

	<u>Page</u>
OVERVIEW OF THE SHARP HEALTHCARE SYSTEM	A-1
General.....	A-1
Historical Perspective	A-2
Mission, Goals, and Vision.....	A-3
Obligated Group	A-3
STRATEGIC INITIATIVES	A-4
Overview.....	A-4
Population Health Management.....	A-5
Pioneer ACO.....	A-6
Physician Alignment and Integration	A-7
Quality and Patient Safety Improvement Initiatives.....	A-8
Contracting and Payment Transformation.....	A-9
AWARDS AND HONORS	A-9
GOVERNANCE	A-12
Corporate Governance	A-12
Affiliated Entities Governance	A-13
Management.....	A-13
HEALTH CARE OPERATIONS OF THE OBLIGATED GROUP.....	A-14
Utilization	A-14
Sharp Memorial	A-16
Sharp Chula Vista	A-18
Sharp Grossmont.....	A-20
Corporation	A-22
Accreditations, Licenses, and Memberships.....	A-23
HISTORICAL FINANCIAL INFORMATION	A-23
Summary of Revenues and Expenses	A-23
Revenue Sources.....	A-24
Summary Balance Sheets.....	A-25
Liquidity.....	A-26
Debt Service Coverage Ratio.....	A-27
Capitalization	A-28
Management’s Discussion of Financial Performance	A-28
Retirement Plan and Employee Benefits	A-32
Investment Policy	A-32
Capital Structure	A-33

Community Benefit.....	A-35
RECENTLY COMPLETED, CURRENT, AND FUTURE PROJECTS.....	A-37
Information Technology.....	A-37
Capital Planning and Seismic Upgrade Activities.....	A-39
Sharp Memorial.....	A-39
Sharp Grossmont.....	A-41
Sharp Chula Vista.....	A-42
Sharp Rees-Stealy.....	A-43
Sharp HealthCare.....	A-44
MARKET CHARACTERISTICS AND COMPETITION.....	A-44
General.....	A-44
Market Characteristics.....	A-45
Market Share and Competition.....	A-45
MANAGEMENT OF SHARP HEALTHCARE.....	A-48
ADDITIONAL INFORMATION.....	A-54
Non-Obligated Affiliates.....	A-54
Employees.....	A-56
Nurse Staffing.....	A-57
Insurance.....	A-58

SHARP.



* 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 3.2 million¹. 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 (“HMO”)

As of September 30, 2013, Sharp HealthCare was licensed for 2,110 beds, had approximately 2,600 physicians on medical staffs and in affiliated medical groups, employed more than 16,000 people, and reported approximately \$2.9 billion in assets.

With a commitment to serving the community, Sharp HealthCare provides the entire continuum of care offering ambulatory, acute, and post-acute care services. In the year ended September 30, 2013, Sharp HealthCare served over 83,000 inpatients and nearly 803,000 outpatients, treated nearly 245,000 emergency cases, provided over 1.2 million physician visits, brought more than 15,000 new lives into this world, and performed over 40,000 surgeries. Sharp HealthCare has a level two trauma center, one of the largest intensive care units (“ICU”) in California, and a nationally recognized hospice program. With more than 39 sub-specialties of medicine and surgery, Sharp HealthCare has a long history of being an innovator and leader in areas such as cardiovascular, orthopedic, and oncology services, treatment of multi-organ transplantation, hyperbaric medicine, and minimally invasive robotics surgery. Sharp HealthCare has two affiliated medical groups representing 360 primary care and 1,104 specialist physicians and strong physician integration in managing the patient’s care across the care continuum. Sharp Health Plan provides health care coverage to small and large businesses, including Sharp HealthCare employees and their dependents, for a total of more than 70,500 HMO enrollees. As health care transitions to population health management, Sharp HealthCare

¹ Source: Truven Health Analytics Market Expert; Nielsen Claritas, Inc.; U.S. Census Bureau (2013 population).

has been a leader in accepting capitation since 1985 and has decades of experience as a highly-integrated health care delivery system.

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"), Grossmont Hospital Foundation ("Grossmont Foundation"), and Sharp HealthCare ACO, LLC ("Sharp ACO"). The Corporation is the sole member of the aforementioned affiliated entities with the exception of Grossmont Foundation, whose sole member is Sharp Grossmont; Continuous Quality Insurance, where the Corporation is the sole shareholder; and Sharp ACO, which is one-third owned by the Corporation and each of its two affiliated medical groups. 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 McDonald Center ("Sharp McDonald Center"), and Sharp Memorial Outpatient Pavilion ("Sharp Outpatient Pavilion"). The Obligated Group (as defined 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 2014A Bonds (the "Bonds").

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 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.

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.

Obligated Group

Approximately 78% 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 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 88.3% of Sharp HealthCare’s total revenues, 96.7% of income from operations, and 92.8% of its net assets, as of and for the fiscal year ended September 30, 2013. These percentages reflect combined financial results prior to combining eliminations resulting from services provided by Sharp HealthCare affiliates to other affiliated entities. 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, Continuous Quality Insurance, an off-shore captive insurance company, and Sharp ACO, an accountable care organization. Measured in terms of annual revenues, the largest of the Corporation’s Non-Obligated Affiliates is Sharp Health Plan, which on a stand-alone basis accounted for 9.2% of Sharp HealthCare’s total revenues for the year ended September 30, 2013. 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 2014A Obligation and, therefore, with respect to the Bonds.

STRATEGIC INITIATIVES

Overview

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 by making a difference in the community and supporting the stewardship of the environment.

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 annually in Sharp HealthCare’s Five-Year Operating, Cash, and Capital Plan (the “Five-Year Plan”) that acts as a feasibility study for Sharp HealthCare’s strategic 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 a key enterprise risk for the organization. Management and the Board evaluated Sharp HealthCare’s strategic plan and developed additional 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 strategically aligned physicians through two affiliated medical groups, Sharp HealthCare management believes the organization is well positioned for health care reform.

Population Health Management

Sharp HealthCare has a long history of population health management. As an integrated delivery system participating in full-risk capitation for nearly three decades, much of Sharp HealthCare’s success in managed care can be attributed to its care management and population health management initiatives. Sharp HealthCare provides services along the full continuum of care and has an established infrastructure to support its population health activities, including hospital electronic medical records (“EMR”), ambulatory electronic health records (“EHR”), a data warehouse, analytic tools, a patient portal, telemedicine and telehealth, a health information exchange, a nurse call center, and numerous other tools, services, and programs. Sharp

HealthCare continues to invest in population health initiatives and its Five-Year Plan includes further infrastructure and programmatic enhancements.

In April 2013, Sharp HealthCare entered into a collaboration agreement with MinuteClinic. MinuteClinic owns and operates 10 retail clinics in the County which provide low acuity, limited health care services on a walk-in basis. The affiliation includes joint marketing, access to Sharp HealthCare physicians, development of patient education and wellness programs, and electronic integration of information. Sharp Health Plan and MinuteClinic entered into a separate agreement to offer MinuteClinic as a covered service for a defined set of clinical issues.

Pioneer ACO

The Affordable Care Act authorized the Centers for Medicare & Medicaid Services (“CMS”), through CMS’ Innovation Center, to contract directly with groups of providers of health care services to test innovative payment and service delivery models in an effort to reduce Medicare expenditures while preserving or enhancing the quality of care provided to Medicare beneficiaries. One of the programs created by CMS in this effort is known as Pioneer Accountable Care Organization (“Pioneer ACO”). Under the Pioneer ACO model, CMS provides incentives for participating health care providers who coordinate care for patients. Providers who band together through this model are required to meet quality standards based upon, among other measures, patient outcomes and care coordination among the provider team.

In 2012 the Corporation, together with its affiliated medical groups, Sharp Community Medical Group (“SCMG”) and Sharp Rees-Stealy Medical Group, Inc. (“SRSMG”), formed the Sharp ACO. Sharp ACO was chosen by the Innovation Center to be a Pioneer ACO and Sharp ACO entered into an agreement with CMS to participate in the Pioneer ACO model (“Pioneer Agreement”). Under the terms of the Pioneer Agreement, Sharp ACO is financially accountable for the cost of care provided to certain Medicare beneficiaries that are assigned to Sharp ACO. If Sharp ACO is able to reduce the cost of care provided to the assigned Medicare beneficiaries in an annual period covered by the Pioneer Agreement (and provided Sharp ACO also satisfies defined quality and service standards), Sharp ACO is eligible to receive a percentage of that cost savings (“Shared Savings Payment”). If the cost of care provided to the assigned Medicare beneficiaries in an annual period increases, then Sharp ACO is responsible to pay CMS a portion of those increased costs (“Increased Cost Payment”). The Corporation has a one third ownership interest in the Sharp ACO and would be responsible for its share of any Increased Cost Payments. For calendar 2012, the first year of operations for Sharp ACO, Sharp ACO had neither a Shared Savings Payment nor Increased Cost Payment. Because CMS has not yet issued the final settlement for calendar 2013, the Corporation does not yet know whether it is eligible for a Shared Savings Payment or if it has incurred an Increased Cost Payment for 2013. Any such Shared Savings Payment or Increased Cost Payment could be material to Sharp ACO. Pursuant to the Pioneer Agreement, Sharp ACO is obligated to guarantee its ability to pay CMS for twenty-five percent (25%) of the total Increased Cost Payments for which it could be potentially liable in a given year. Sharp ACO has calculated the amount of that guarantee to be approximately \$4.4 million for calendar year 2013. Calendar 2014 is the third performance year under the Pioneer Agreement. The Pioneer Agreement provides Sharp ACO with the right to terminate the Pioneer Agreement at any time and if the termination is made during the first six

months of any annual period, Sharp ACO will not be responsible for an Increased Cost Payment or eligible for a Shared Savings Payment for that annual period.

Physician Alignment and Integration

General. In the early 1980s, the Corporation’s management and board recognized the importance of becoming an integrated health care delivery system to further its mission of improving the health of the San Diego community. Management and the board began executing a plan to align physicians, hospitals, and other health care service organizations to establish an integrated network of providers focused on creating exceptional patient experiences across the care continuum. During this time and throughout the 1990s, management also concentrated on standardizing and centralizing the administrative and management functions of the growing Sharp HealthCare organization, to further support integration and infrastructure systemization with early adoption of a common information technology (“IT”) platform, master patient index, in-house registry service, and other initiatives designed to support effective operations. In the early 1990s, Sharp HealthCare founded Sharp Health Plan, to include the payor and financing mechanism into its growing delivery system. Today, management believes its integrated structure and physician alignment positions it well for continued success as healthcare reimbursement increasingly shifts to pay-for-performance and value-based purchasing.

The state of California (the “State”) has a ban on the corporate practice of medicine, thus precluding most hospitals from hiring physician providers. Accordingly, Sharp HealthCare’s two affiliated medical groups, SRSMG and SCMG, are an integral component of its integrated delivery system growth strategy.

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, 2013.

	<u>Sharp Memorial</u>	<u>Sharp Chula Vista</u>	<u>Sharp Grossmont</u>
Total Providers ⁽¹⁾	1,122	524	672
% Board Certified	90%	85%	84%
Average Age	51	50	51

Source: Corporation records.

(1) Physicians may be on the medical staff of multiple hospitals.

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, 2013.

- **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 (see “AWARDS AND HONORS” herein for additional information on awards received by SRSMG). SRSMG is composed of 164 primary care physicians and mid-level

providers who are supported by 361 specialist and sub-specialist physicians and mid-level providers representing virtually every medical specialty. SRSMG average enrollment was 154,929* for the twelve months ended September 30, 2013. 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. Sharp Rees-Stealy facilities have recently expanded to include new locations in Sorrento Mesa and Del Mar. See “RECENTLY COMPLETED, CURRENT, AND FUTURE PROJECTS – Sharp Rees-Stealy” herein for the detailed description of this expansion.

- **SCMG.** SCMG is an association of private practice primary care physicians and specialists in the County operating as an Independent Practice Association (“IPA”). SCMG was formed in 1989 and today is San Diego’s largest IPA. SCMG is composed of over 196 primary care physicians and 743 specialists. SCMG average enrollment was 77,422* for the twelve months ended September 30, 2013. 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.

Physicians play an important role in Sharp HealthCare’s strategic planning process and Board governance. To further intensify engagement with Sharp HealthCare, affiliated physicians take part in Physician Leadership Academy, a two-year endeavor with The Advisory Board.

Sharp HealthCare is constantly working with its affiliated medical groups to further enhance integration, invest in their ambulatory presence with new medical office buildings, and evaluate growth opportunities for independent physicians seeking alignment with medical groups. This is consistent with Sharp HealthCare’s 28-year history of medical group integration.

Quality and Patient Safety Improvement Initiatives

Sharp HealthCare is continuously working to improve the quality and safety of patient care. Sharp HealthCare’s goal is to perform at the top decile in all quality metrics, including value-based purchasing, clinical process, and outcome measures. Sharp HealthCare seeks to standardize all processes around the seven areas most prone to risk in patient safety by implementing the “ALWAYS” initiative that hardwires the processes Sharp HealthCare expects to happen for every patient, every time to ensure that all patients receive safe care.

Sharp HealthCare is implementing “Crimson”, a new software tool designed to provide physicians with their unique and specific quality performance data. Sharp HealthCare believes this will lead to enhanced physician collaboration ultimately resulting in greater effectiveness and improved quality of care.

* There are enrollment duplicates between Sharp Health Plan, SRSMG, and SCMG of 56,703 for the twelve months ended September 30, 2013.

Another initiative is to increase the number and use of clinical decision support rules available in the EMR and EHR to improve patient safety, as well as innovate and advance a comprehensive care continuum delivery model.

Contracting and Payment Transformation

Sharp HealthCare has over 25 years' experience with population-based payments, including full-risk capitation, shared risk arrangements, accountable care organizations (commercial and Medicare), bundled payments, pay-for-performance, and other value-based payment arrangements. In the past three years, management credits much of its enrollment growth to Sharp HealthCare's success in narrow network products, including the commercial products offered by Sharp Health Plan. In 2013, Sharp Health Plan was selected as one of 13 health plans to participate in Covered California's individual marketplace and one of six health plans to participate in Covered California's SHOP marketplace for small businesses, both developed as part of the Affordable Care Act. Medical insurance provided under Covered California became effective on January 1, 2014. See "BONDHOLDERS' RISKS – Commercial Insurance and Other Third-Party Plans – Health Insurance Exchanges" in this Official Statement.

AWARDS AND HONORS

- 2007 Malcolm Baldrige National Quality Award
- Ethisphere's 2013 World's Most Ethical Companies list
- 2012 Top Integrated Health Care Network in California by SDI Health
- 2013 Most Wired by *Hospitals & Health Networks*
- 2013 Sharp Coronado, Sharp Grossmont, and Sharp Memorial named among the nation's top performers by The Joint Commission
- Sharp Memorial and Sharp Coronado Designated as Planetree Patient-Centered Hospital
- 2013 Press Ganey Awards
- 2010 Morehead Apex Workplace of Excellence
- Sharp Memorial and Sharp Grossmont Achieve MAGNET® Designation for Nursing Excellence
- 2011 Outstanding Patient Experience Award from HealthGrades to Sharp Coronado and Sharp Memorial
- Elite Status given to SRSMG and SCMG by the California Association of Physician Groups ("CAPG")
- 2010 SRSMG named Acclaim Award honoree by the American Medical Group Association ("AMGA")

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 focus; measurement, analysis, and knowledge management; workforce focus; operations focus; and results. Since the award's inception in 1987, Sharp HealthCare is one of two health care providers in the State and one of only 18 health care organizations nationally to receive the award.

Sharp HealthCare was named to Ethisphere's 2013 World's Most Ethical Companies list, which recognizes companies that "practice and demonstrate industry leadership, forcing peers to follow suit or fall behind." Sharp HealthCare was the only San Diego company named to the list. Fellow 2013 recipients include Intel, Marriott, and Whole Foods, among others. The Ethisphere Institute is an independent center of research, best practices, and thought leadership that promotes best practices in corporate ethics and compliance and enables organizations to improve governance, mitigate risk, and enhance relationships with employees, business partners, investors, and the broad regulatory community.

In 2012, Sharp HealthCare was named the top integrated health care network in California and the 13th in the nation in an annual survey conducted by SDI Health, a leading health care data analyst. Sharp HealthCare has placed among the top in the State for 14 consecutive years in this national survey, which is announced by *Modern Healthcare* magazine. 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.

Sharp HealthCare was recognized as one of the nation's "Most Wired" health systems according to the results of the 2013 Most Wired Survey in *Hospitals & Health Networks* magazine. Sharp HealthCare has been named to the survey in 13 of the 15 years since the program was created. Additionally, *ComputerWorld* ranked Sharp HealthCare 6th in its annual listing of the nation's top 100 places to work in information technology ("IT") in 2013, and *InformationWeek* magazine selected Sharp HealthCare as one of the nation's 500 most innovative users of IT for its 2011 "InformationWeek 500" list.

In 2013, Sharp Coronado, Sharp Grossmont, and Sharp Memorial were named three of the nation's top performers on key quality measures by The Joint Commission, a leading accreditor of health care organizations in America. The three Sharp HealthCare hospitals were recognized by The Joint Commission for exemplary performance in using evidence-based clinical processes that are shown to improve care for certain conditions. The clinical processes focus on care for heart attack, pneumonia, surgery, children's asthma, stroke, and venous thromboembolism, as well as inpatient psychiatric services.

In 2007, Sharp Coronado was one of five hospitals nationwide to receive the Planetree Patient-Centered Hospital Designation. It was also the only hospital in California to have met the 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 2013, Sharp Coronado was again re-designated as a Planetree Patient-Centered Hospital. Sharp Memorial was designated as a Planetree Patient-Centered Hospital in 2012, and in 2013 was named one of the "100 Great Hospitals" by *Becker's Hospital Review*, a leading magazine for hospital business news and analyses for hospital and health system executives.

Sharp HealthCare was named the 2010 Morehead Apex Workplace of Excellence. Each year, Morehead awards the health care industry's top achiever by objectively identifying the highest performer and acknowledging its contributions to health care. Additionally, Sharp HealthCare won the Crystal Workplace Excellence Award from the San Diego Society for

Human Resource Management in 2008, 2009, and 2011. The Workplace Excellence Awards recognize small and large companies from various industries that implement 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 Magnet designation for their excellence in nursing practices and quality patient care in 2006 and 2008, respectively. Magnet status is reviewed every four years by the ANCC and both Sharp Grossmont and Sharp Memorial attained re-designation in 2011 and 2012, respectively.

Sharp Coronado and Sharp Memorial received the 2011 Outstanding Patient Experience Award from HealthGrades, a leading health care data research company. In 2010 and 2011, respectively, the Surgical and Medical ICU at Sharp Grossmont received Beacon Awards for Critical Care Excellence by the American Association of Critical-Care Nurses. The accolade recognizes units that demonstrate best practice methods in the areas of professional practice, patient outcomes, and the health of the work environment. 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 2013, seven Sharp HealthCare entities were recognized for achievement in a range of quality measures by the Press Ganey organization, a leading national health care consulting group that partners with more than 10,000 hospitals across the country. A total of nine Guardian of Excellence Awards and four Beacon of Excellence Awards were received from Press Ganey. Award categories include Patient Satisfaction, Physician Engagement and Employee Engagement. Sharp entities that were recognized include: Sharp Chula Vista Medical Center, Sharp Coronado Hospital, Sharp HealthCare, Sharp Mary Birch Hospital for Women & Newborns, Sharp Memorial Hospital, Sharp Mesa Vista Hospital and Sharp Rees-Stealy Medical Centers. In 2009, Sharp Coronado and Sharp Mary Birch received Best Place to Practice awards from Press Ganey. Sharp Mary Birch received the same honor in 2010.

In 2013 SRSMG and SCMG were awarded Elite Status, the highest possible designation for quality care given by CAPG, as part of its 2013 Standards of Excellence program. CAPG is one of the nation’s largest professional organizations of managed care physician groups. Also, SRSMG was recognized by the Integrated Healthcare Association (“IHA”) as a “Top Performer” and as “Most Improved” in the Pay for Performance Program. The California Office of the Patient Advocate awarded SRSMG the highest rating of four stars in both quality and service in its 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 AMGA’s 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.

GOVERNANCE

Corporate Governance

Board of Directors. The Corporation is governed by a 25-member Board of Directors (the “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-year terms (up to a maximum of nine years of consecutive service) from a slate of nominees presented. Up to one-third of the members of the Board may be physicians. At present a total of six 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. 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 are currently two vacancies on the Board.

NAME/TITLE	OCCUPATION	TERM EXPIRATION
James B. Smith III, Chair	Business Consultant	2016
Henry M. Killmar, Immediate Past Chair	Retired Banker	Ex Officio
Robert Kelly, Vice Chairman	President, Philanthropic Foundation	2015
Timothy Considine, Secretary	Consultant, Certified Public Accounting Firm	2016
Richard Freeman, Treasurer	Business Consultant	2016
Michael W. Murphy, President	President and Chief Executive Officer, Sharp HealthCare	Ex Officio
Deirdre Alpert	Retired Legislator, Community Leader	2014
Donald C. Balfour, M.D.	Physician	Designated Director
Hugo Barrera, M.D.	Physician	Designated Director
VAdm. Walter J. Davis, Jr., USN (ret)	Retired United States Navy Admiral	2015
Barbara DeMichele	Banking, Public Relations Consultant, Community Leader	Designated Director
John M. Dunn	Sr. VP, Legal and Compliance, General Counsel	2016
Margaret Elizondo, M.D.	Physician	2015
William Geppert	Business/Community Leader	2016
Peter Hanson, M.D.	Physician	Designated Director
Scott McMillin	Chairman of Corky McMillin Companies	2015
Cary Miller	Retired Attorney/Legal Counsel	Designated Director
Lori Moore, R.N.	Real Estate Investment	2015
Michael A. Morton	Chairman, Restaurant Chain	2015

NAME/TITLE	OCCUPATION	TERM EXPIRATION
Regina Petty	Attorney, Law Firm Partner	2015
Kenneth Roth, M.D.	Physician	Ex Officio
Geoffrey M. Stiles, M.D.	Physician	2015
Julie Meier Wright	Business/Community Leader	2016

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).

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. The Investment Committee is a subcommittee of the Finance Committee and provides recommendations and advice on the Corporation’s investments.

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

Affiliated Entities Governance

The 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 individuals 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 IT, 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. See “MANAGEMENT” herein for a description of the members of Sharp HealthCare’s executive team.

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.

Utilization

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

UTILIZATION
Year Ended September 30,

	2011	2012	2013
SHARP MEMORIAL			
Licensed Beds	1,009	1,033	1,046
Maintained Beds ⁽¹⁾	733	788	811
Patient Days ⁽²⁾	192,940	192,230	195,094
Discharges ⁽²⁾	36,545	36,938	37,090
Observation Stays	6,717	7,187	7,338
Acute Average Length of Stay ⁽⁴⁾	5.3	5.2	5.3
Occupancy ⁽³⁾	72.1%	66.7%	65.9%
Outpatient Visits	411,278	409,514	404,271
Births	8,705	8,890	8,923
Emergency Room Visits	63,290	69,573	73,531
SHARP CHULA VISTA			
Licensed Beds	343	343	343
Maintained Beds ⁽¹⁾	343	341	343
Patient Days ⁽²⁾	100,359	100,572	97,872
Discharges ⁽²⁾	15,434	15,269	14,598
Observation Stays	661	1,018	1,636
Acute Average Length of Stay ⁽⁴⁾	4.5	4.6	4.6
Occupancy ⁽³⁾	80.2%	80.6%	78.2%
Outpatient Visits	104,526	97,262	109,107
Births	2,948	2,868	2,704
Emergency Room Visits	50,868	52,658	56,562
SHARP GROSSMONT			
Licensed Beds	536	540	540
Maintained Beds ⁽¹⁾	509	509	4884
Patient Days ⁽²⁾	119,234	121,214	123,273
Discharges ⁽²⁾	28,530	29,556	28,755
Observation Stays	6,205	7,314	7,879
Acute Average Length of Stay ⁽⁴⁾	4.1	4.1	4.3
Occupancy ⁽³⁾	64.2%	65.1%	69.8%
Outpatient Visits	238,256	234,654	235,834
Births	3,511	3,510	3,772
Emergency Room Visits	89,116	97,135	101,825
TOTAL – OBLIGATED GROUP HOSPITALS			
Licensed Beds	1,888	1,916	1,929
Maintained Beds ⁽¹⁾	1,585	1,638	1,638
Patient Days ⁽²⁾	412,533	414,016	416,239
Discharges ⁽²⁾	80,509	81,763	80,443
Observation Stays	13,583	15,519	16,853
Acute Average Length of Stay ⁽⁴⁾	4.7	4.7	4.8
Occupancy ⁽³⁾	71.3%	69.1%	69.6%
Outpatient Visits	754,060	741,430	749,212
Births	15,164	15,268	15,399
Emergency Room Visits	203,274	219,366	231,918
SHARP REES-STEALY			
Average Enrollment	143,438	148,256	154,929
Physician Visits	1,136,898	1,133,198	1,207,574
Physician Offices	21	22	21
Urgent Care Facilities	5	5	5
Primary Care Physician FTEs ⁽⁵⁾	152.3	155.0	162.6
Specialist Physician FTEs ⁽⁵⁾	197.9	194.6	214.2

- (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.
(4) Acute Average Length of Stay includes acute care, psychiatric and rehabilitation.
(5) Physician FTEs include midlevel professionals.

Sharp Memorial

General. The collective Sharp HealthCare facilities operated by Sharp Memorial include the 675 bed¹ quaternary care Memorial Hospital and Stephen Birch Center, the 206 bed women's hospital Sharp Mary Birch, the 149 bed psychiatric facility Sharp Mesa Vista, the 16 bed chemical dependency recovery hospital Sharp McDonald Center, 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. In 2013, Sharp Memorial was recognized by The Joint Commission as a top performer on the measure sets for heart attack, heart failure, pneumonia, and surgical care.

Programs and Services. Sharp Memorial provides a broad range of programs and services to patients in its service area. Memorial Hospital and the Stephen Birch Center are Magnet hospitals 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 (“ACoSCoC”) 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 Sharp Memorial, with four cardiac catheterization laboratories, has treated patients with heart conditions such as congestive heart failure, heart attacks, hypertension, angina/chest pain, transcatheter aortic valve replacement, and other cardiac diseases. Every year Sharp HealthCare physicians and staff perform more than 8,700 cardiac catheterizations and 890 open-heart surgeries. Sharp Memorial 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. Sharp Memorial has the largest mechanical assist device program on the West Coast. Sharp Memorial 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.² In 1987, Memorial Hospital

¹ Represents licensed beds, of which 368 beds are maintained and available for use.

²Source: United Network for Organ Sharing (UNOS).

was the first hospital on the West Coast to use the mechanical Jarvik-7 heart for patients awaiting a transplant. Sharp Memorial has become nationally known for its mechanical assist device program and is one of two centers on the west coast that participates in national research for this procedure. Sharp Memorial is the only Medicare-approved heart transplant program in the County. In addition to heart transplant, Sharp Memorial has certification to perform kidney and kidney-pancreas transplants, as well as bone marrow transplants through a joint program with the University of California San Diego (“UCSD”) Health System.

- *Trauma Services.* Sharp Memorial 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 2,100 adult trauma patients are evaluated and treated annually at Sharp Memorial.
- *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, 84-bed Neonatal Intensive Care Unit (“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. Currently, approximately 8,900 births occur annually at Sharp Mary Birch, ranking it number one in California. In 2013, Sharp Mary Birch launched the Neonatal Research Institute with a grant from the National Institute of Health (“NIH”), Sharp HealthCare’s first NIH grant.
- *Chemical Dependency Treatment.* The 16-bed freestanding Alcohol and Drug Treatment Center at Sharp McDonald Center 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, Sharp Memorial'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 11 surgery suites, 24 chemotherapy treatment areas, radiation therapy, 64-slice computer tomography ("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 Hospital- San Diego ("Rady Children's"), a nonprofit public benefit corporation not affiliated with Sharp Healthcare, 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 ICU, and the adjacent 100-bed Birch Patrick, which provides short- and long-term care for individuals requiring daily living assistance, respite care, and post-surgical rehabilitation and has a five-star overall rating from CMS Nursing Home Compare. The hospital was founded in 1944 as Chula Vista Hospital to operate a nursing home and became licensed to operate an acute care hospital the following year. The hospital continued to expand over the years and was renamed Chula Vista Community Hospital, an 88-bed facility, in 1956, became incorporated as Community Hospital of Chula Vista in 1965, and 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. Today, Sharp Chula Vista has the largest inpatient market share in the South Bay area of the County.

In 2014, Sharp Chula Vista will begin to execute a multi-year, multi-phase Master Site Plan to add a parking garage, loop access road, and eventually a 100-bed patient tower to meet the growing needs of the local community.

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 a recently expanded 48-bed emergency department, intensive care, medical/surgical inpatient care, surgery, cancer treatment, cardiac services (including open-heart surgery), obstetrics, NICU, orthopedics, and a broad range of outpatient services. Sharp Chula Vista also offers the region's only comprehensive Bloodless Medicine and Surgery Center, with a medical director and program manager, for patients who wish to avoid the use of blood and blood products, and provides outreach to the community through a variety of educational programs and screenings on topics such as heart health, cancer, diabetes, childbirth, robotic surgery, and more. Listed below are descriptions of selected major programs and services provided at Sharp Chula Vista.

- *Cancer Treatment.* In 2012, Sharp Chula Vista opened the Douglas & Nancy Barnhart Cancer Center, a facility offering the most advanced radiation treatment technology in the region. Sharp Chula Vista is the only hospital in the South Bay region of the County certified the Commission on Cancer as a Community Hospital Cancer Program and the National Accreditation Program for Breast Centers. The cancer treatment program offers a full range of cancer services, including surgery, oncology, infusion therapy, nuclear medicine, radiation therapy, and patient navigation.
- *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 to provide surgical, endoscopy, and special procures. The adjacent 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 5.4% in its primary service area over the next five years¹.

Sharp Grossmont

General. Sharp Grossmont was formed by the Corporation in 1991 and operates and leases a 540-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. In 2013, Sharp Grossmont was recognized by The Joint Commission as a top performer on the measure sets for heart attack, heart failure, pneumonia, and surgical care.

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 (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 desire and intent to extend the term of the Lease. Representatives from the District and the Corporation met several times during 2013 to discuss the terms of a potential lease extension. In December 2013, the District indicated to the Corporation its intent to proceed with the lease extension negotiations.

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 general obligation bonds (“GO Bonds”) issued or to be issued by the District to fund renovations and expansion of Grossmont Hospital. See “RECENTLY COMPLETED, CURRENT, AND FUTURE PROJECTS – Sharp Grossmont.”

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 2014A Obligation. Furthermore, the long-term debt allocated to Sharp Grossmont will become the responsibility of the District. As of September 30, 2013, Sharp Grossmont constituted 22.2% of the Obligated Group’s total assets, 28.2% of the Obligated Group’s net assets, and 19.1% of the Obligated Group’s cash, cash equivalents, short-term

¹ Source: Thompson-Reuters Market Expert; Nielsen Claritas, Inc.; U.S. Census Bureau.

investments, and total assets limited as to use. As of September 30, 2013, Sharp Grossmont had 8.2% of the Obligated Group's long-term debt. For the year ended September 30, 2013, Sharp Grossmont generated 20.6% of the Obligated Group's total net revenues and 23.6% 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 102,000 people receive treatment¹. 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.

- *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 the 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. In 2012, Sharp Grossmont opened a third cardiac catheterization lab.
- *Women's Health.* The 48-bed Women's Center specializes in gynecology, obstetrics, and neonatology, and includes a 24-bed Level II NICU. In 2014, Sharp Grossmont will begin a renovation project of the women's center.
- *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. In 2013, the American Hospital Association ("AHA") honored Sharp HealthCare as a Circle of Life Award winner for its

¹ Source: OSHPD Emergency Department Encounters by Facility Report, Calendar Year 2012.

innovative hospice program designed to improve the care for patients near the end of life or with life-limiting conditions.

- *Pediatrics.* In 2008, Sharp Grossmont entered into an agreement 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 contract has been continuously renewed, with the most recent renewal occurring in June 2013. The agreement was extended for an additional two-year period and expires April 30, 2015.
- *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. A PETCT suite was opened in the imaging center in December 2013, replacing the leased services that are currently provided.
- 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 1.2 million for the year ended September 30, 2013. See "HISTORICAL FINANCIAL INFORMATION—Revenue Sources—Physician Network and Managed Care". 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 2012, 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 Sharp Chula Vista and Sharp Grossmont in March 2012 and Memorial Hospital in May 2012. Each hospital received full accreditation along with The Joint Commission’s Gold Seal of Approval and a three-year accreditation. Sharp Coronado was surveyed by The Joint Commission in April 2012 and received full three year accreditation and The Joint Commission Gold Seal of Approval. During 2011, Sharp McDonald Center and Sharp Mesa Vista were surveyed by The Joint Commission in March and June, respectively. Each hospital received full accreditation along with The Joint Commission’s Gold Seal of Approval and a three-year accreditation.

Sharp Memorial, Sharp Mesa Vista, Sharp McDonald Center, Sharp Chula Vista, and Sharp Grossmont are each licensed to conduct and provide health care services by the State 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 the Healthcare Association of San Diego and Imperial Counties (“HASDIC”), the California Hospital Association (“CHA”), and the AHA.

HISTORICAL FINANCIAL INFORMATION

Financial and statistical information relating solely to the Obligated Group is included in this Section. The Obligated Group Members accounted for 88.3% of Sharp HealthCare’s total revenues, 96.7% of income from operations, and 92.8% of its net assets, as of and for the fiscal year ended September 30, 2013. 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 2014A 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, 2011, 2012, and 2013 have been derived from unaudited Supplementary 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, 2012 and 2013, related notes, and unaudited Supplementary 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, 2011, 2012, and 2013 are referred to as Fiscal 2011, Fiscal 2012, and Fiscal 2013, respectively.

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

	Year Ended September 30,		
	2011	2012	2013
Revenues:			
Net Patient Service ⁽¹⁾	\$1,540,001	\$1,647,262	\$1,719,440
Premium	693,370	736,436	771,495
Other	81,501	98,901	99,159
Total Revenues	<u>2,314,872</u>	<u>2,482,599</u>	<u>2,590,094</u>
Expenses:			
Operating Expenses	2,008,075	2,142,339	2,253,699
Depreciation/Amortization	84,772	88,776	96,008
Interest Expense	24,595	24,349	23,274
Total Expenses	<u>2,117,442</u>	<u>2,255,464</u>	<u>2,372,981</u>
Income from Operations	197,430	227,135	217,113
Other Income (Loss) ⁽²⁾	<u>(19,418)</u>	<u>73,236</u>	<u>75,165</u>
Excess of Revenues Over Expenses	<u>\$ 178,012</u>	<u>\$ 300,371</u>	<u>\$ 292,278</u>

⁽¹⁾ Fiscal 2011, Fiscal 2012 and Fiscal 2013 reflects the impact of the Medi-Cal Hospital Fee Program discussed in “BONDHOLDERS’ RISKS—Patient Service Revenues—Medicaid Program—California Hospital Provider Fee” in this Official Statement, which consists of revenues of \$120.0 million, \$144.8 million, and \$138.3 million, respectively; expenses of \$81.2 million, \$99.1 million, and \$103.3 million, respectively; and excess of revenues over expenses of \$38.8 million, \$45.7 million and \$35.0 million, respectively.

⁽²⁾ 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 Supplementary Information to the Audited Combined Financial Statements for the years ended September 30, 2011, 2012, and 2013. Fiscal 2012 and 2013 are 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—Patient Service Revenues” 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 2013, revenue from capitated contracts represented 32.0% of total net patient revenues, with 41.9% of Sharp HealthCare’s

capitated revenue generated through contracts with United Healthcare, covering both commercial and senior enrollees. See “BONDHOLDERS’ RISKS—Commercial Insurance and Other Third-Party Plans—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 2011, 2012, and 2013 were \$4.4 million, \$5.5 million, and \$12.1 million, respectively. These amounts are included in net patient revenue and represent payments made to Sharp Chula Vista for all three fiscal years and Sharp Grossmont for Fiscal 2013. The amounts received by the Obligated Group from the federal disproportionate share hospital program for Fiscals 2011, 2012, and 2013 were \$40.6 million, \$40.5 million, and \$46.0 million, respectively. These amounts are included in net patient revenue and represent payments made to Sharp Memorial, Sharp Chula Vista, and Sharp Grossmont for all three fiscal years. Pursuant to the provisions of the Affordable Care Act, disproportionate share hospital programs are scheduled to be substantially reduced, and therefore there is no certainty that these payments will be continued in the future. See “BONDHOLDERS’ RISKS—Affordable Care Act” and “—Patient Service Revenues—Medicaid Program” in this Official Statement.

Net Revenues By Payor Source. 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,		
	2011	2012	2013
Medicare Fee for Service and HMO	18.3%	17.4%	17.6%
Capitated Medicare	10.4	10.1	9.3
Medi-Cal Fee-for-Service and HMO ⁽¹⁾	13.1	14.0	14.2
Commercial Contracts – Capitated	21.8	21.9	22.7
Commercial Contracts – Fee-for-Service ⁽²⁾	35.5	35.5	35.1
County Medical Services ⁽³⁾	0.7	1.0	1.0
All Other ⁽⁴⁾	0.2	0.1	0.1
	100.0%	100.0%	100.0%

⁽¹⁾ Fiscals 2011, 2012 and 2013 reflects the impact of the Medi-Cal Hospital Fee Program discussed in “BONDHOLDERS’ RISKS—Patient Service Revenues—Medicaid Program—California Hospital Provider Fee” in this Official Statement.

⁽²⁾ Commercial contracts are negotiated on a per diem, per discharge, or percent discount basis.

⁽³⁾ Sponsored by the County for medically indigent adults.

⁽⁴⁾ 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, 2011, 2012, and 2013 have been derived from unaudited Supplementary 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, 2012 and 2013, related notes, and unaudited Supplementary Information that appear in Appendix B.

Summary Balance Sheets of the Obligated Group
(in thousands)

	Year Ended September 30,		
	2011	2012	2013
ASSETS			
Current Assets:			
Cash, Cash Equivalents and Short-term Investments	\$ 209,257	\$ 230,662	\$ 203,462
Accounts Receivable – Net	186,064	280,870	279,998
Other Current Assets	134,717	117,280	109,587
Total Current Assets	530,038	628,812	593,047
Assets Limited as to Use – Net	695,054	877,050	1,155,777
Property, Plant and Equipment – Net	845,909	927,005	975,795
Other Assets	85,506	87,049	102,512
Total Assets	\$2,156,507	\$2,519,916	\$2,827,131
LIABILITIES AND NET ASSETS			
Current Liabilities:			
Current Portion of Long-term Debt	\$ 11,660	\$ 8,223	\$ 19,458
Other Current Liabilities	286,090	335,874	303,428
Total Current Liabilities	297,750	344,097	322,886
Long-term Liabilities	129,755	122,961	111,489
Long-term Debt – Net	603,493	594,736	577,665
Total Net Assets	1,125,509	1,458,122	1,815,091
Total Liabilities and Net Assets	\$2,156,507	\$2,519,916	\$2,827,131

Source: Derived from the Supplementary Information to the Audited Combined Financial Statements as of September 30, 2011, 2012, and 2013. September 30, 2012 and 2013 are included in Appendix B.

Liquidity

The following table sets forth the days cash on hand of the Obligated Group as of September 30, 2011, 2012, and 2013.

	As of and for the Year Ended September 30,			
	(\$ in thousands)			
	2011	2012	2013	
			Historic	Pro Forma
Cash, Cash Equivalents, and Short-term Investments	\$ 209,257	\$ 230,662	\$ 203,462	\$ 203,462
Add: Assets Limited as to Use, Designated for Property	620,750	846,720	1,139,242	1,161,802
Total Cash and Unrestricted Investments (A)	\$ 830,007	\$1,077,382	\$ 1,342,704	\$1,365,264
Total Expenses	\$2,117,442	\$2,255,464	\$ 2,372,981	\$2,372,981
Less: Depreciation and Amortization	84,772	88,776	96,008	96,008
Adjusted Annual Expenses	2,032,670	2,166,688	2,276,973	2,276,973
÷ Calendar Days	365	366	365	365
Daily Operating Expenses (B)	\$ 5,569	\$ 5,920	\$ 6,238	\$ 6,238
Days Cash on Hand (A/B)	149.0	182.0	215.2	218.9

Source: Derived from the Supplementary Information to the Audited Combined Financial Statements and Corporation records for the years ended September 30, 2011, 2012, and 2013. Fiscal 2012 and 2013 are 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 excluding Obligations issued in connection with interest rate hedging agreements or to the providers of credit or liquidity enhancement) and other indebtedness for each of these periods. The pro forma column provides for an adjustment to the Fiscal 2013 amounts to give effect to the issuance of the Bonds, the refunding of the Refunded Bonds and the cash defeasance of the Series 2009B 2034 Term Bonds, as if such events had occurred as of September 30, 2013. Pro forma maximum annual debt service is the highest requirement from Fiscal 2013 forward, as adjusted for the aforementioned items.

	Year Ended September 30,				
	(\$ in thousands)				
	2011	2012	2013		
		Historic	Pro Forma		
Excess of Revenues Over Expenses	\$ 178,012	\$ 300,371	\$ 292,278	\$ 292,278	
Unrealized (Gains)/Losses on Investments	44,746	(53,927)	(43,028)	(43,028)	
Mark-to-Market (Gains)/Losses on Interest Rate Swaps	1,022	(1,658)	(3,081)	(3,081)	
Depreciation/Amortization	84,772	88,776	96,008	96,008	
Interest Expense	24,595	24,349	23,274	23,274	
Income Available for Debt Service	\$ 333,147	\$ 357,911	\$ 365,451	\$365,451	
Maximum Annual Debt Service Requirements	\$ 48,862	\$ 48,916	\$ 49,053	\$ 47,352	
Coverage Ratio	6.82x	7.32x	7.45x	7.72x	

Capitalization

The table below sets forth the capitalization of the Obligated Group for each of the three most recent fiscal years, including capitalized leases and other indebtedness. Outstanding values include unamortized original issue premium/discount. The pro forma column provides for an adjustment to the Fiscal 2013 amounts to give effect to the issuance of the Bonds, the refunding of the Refunded Bonds, and the cash defeasance of the Series 2009B 2034 Term Bonds, as if such events had occurred as of September 30, 2013.

	Year Ended September 30,				
	(\$ in thousands)				
	2011	2012	2013		
		Historic	Pro Forma		
Series 1988A Bonds	\$ 11,100	\$ 9,800	\$ 8,400	\$ 8,400	
1998 Certificates of Participation	51,335	-	-	-	
Series 2003C Bonds	25,877	25,334	24,846	-	
Series 2009A Bonds	50,885	47,625	44,260	44,260	
Series 2009B Bonds	137,488	137,591	137,694	107,647 ¹	
Series 2009C and D Bonds	99,880	99,880	99,880	99,880	
Series 2010A Bonds	29,075	28,325	27,550	27,550	
Series 2011A Bonds	78,118	78,089	78,057	78,057	
Series 2012A Bonds	-	47,861	47,438	47,438	
Series 2014A Bonds	-	-	-	166,110	
New Markets Tax Credit	39,315	39,315	39,315	39,315	
Other Long-term Debt ²	92,080	89,139	89,683	89,683	
Total Long-term Debt	615,153	602,959	597,123	708,340	
Add: Short-term Debt	-	-	-	-	
Total Debt (A)	615,153	602,959	597,123	708,340	
Unrestricted Net Assets	1,069,879	1,402,377	1,757,164	1,757,164	
Total Capitalization (B)	\$1,685,032	\$2,005,336	\$2,354,287	\$2,465,504	
Debt-to-Capitalization Ratio (A/B)	36.5%	30.1%	25.4%	28.7%	

⁽¹⁾ Reflects cash defeasance of the Series 2009B 2034 Term Bonds on January 7, 2014.

⁽²⁾ Includes capital lease obligations and certain other debt service obligations that are not secured under the Master Indenture. See Note 6 to the Audited Combined Financial Statements included in Appendix B for additional information. 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-23, the Obligated Group generated income from operations in Fiscal 2011, Fiscal 2012, and Fiscal 2013. 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 2011 to Fiscal 2013. As depicted in the table on page A-14, total patient days increased 0.4% in Fiscal 2012 due primarily to reduction in elective procedures resulting from economic conditions; however, outpatient visits increased 1.0% in Fiscal 2013. In comparison, total revenues increased by 7.2% in Fiscal 2010 and 4.3% in Fiscal 2013. Revenues include the Medi-Cal Hospital Fee Program, which contributed \$144.8 million in Fiscal 2012 and \$138.3 million in Fiscal 2013. The increase in total revenues is attributable to increased patient activity and successful contracting strategies by management, as further discussed below.

Operating expenses (other than interest, depreciation and amortization) increased 6.7% in Fiscal 2012 and 5.2% in Fiscal 2013, which include Medi-Cal Fee Program expenses of \$99.1 million in Fiscal 2012 and \$103.3 million in Fiscal 2013. The cost increases in Fiscal 2012 and Fiscal 2013 reflect the increased patient activity in addition to standard cost inflation. 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 5.5% and 6.2% in Fiscals 2012 and 2013, respectively. For Fiscal 2013, salary and employee benefit costs represent 46.4% of total revenues, an increase from 45.6% in Fiscal 2012. The Obligated Group's interest expense for Fiscal 2013 decreased by 4.4% from Fiscal 2012 due primarily to the write off of the 1998 Certificates of Participation cost of issuance in Fiscal 2012 due to refinancing of these obligations with the Series 2012A Bonds. Both Fiscal 2012 and 2013 reflect decreased rates on variable rate debt and scheduled reductions in principal. Favorable maximum rate formulas on 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 2013 indicate a continuation of profitability from operations. Total net patient service revenues for Fiscal 2013 were 4.4% higher than those experienced in Fiscal 2012. For the same period, operating expenses (other than interest, depreciation and amortization) increased by 5.2% and resulted in income from operations of \$217.1 million in Fiscal 2013, a decrease of \$10.0 million, or 4.4%, compared to Fiscal 2012. The reduction in income from operations is partially attributable to the Medi-Cal Fee Program. Fiscal 2013 includes the impact of the Medi-Cal Fee Program, which provided revenues of \$138.3 million, expenses of \$103.3 million, and a net of \$35.0 million. This is a reduction of \$10.7 million – from Fiscal 2012 which provided revenues of \$144.8 million, expenses of \$99.1 million, and a net of \$45.7 million from the Medi-Cal Fee Program.

Among the factors contributing to the strong financial results in Fiscal 2013 were the impact of the Medi-Cal Hospital Fee Program, increased patient volumes, realization of the continuing impact of favorable payor contract negotiations, returns on investment of IT initiatives such as the EHR and EMR systems, which qualified for incentive payments under the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), supply savings initiatives, and continued managerial discipline in containing direct operating costs despite volume increases.

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 2011, 2012, and 2013, management continued an aggressive contracting strategy with respect to its capitated, PPO, and Medi-Cal contracts. The renegotiation of Sharp HealthCare's capitated contracts in 2013 has yielded premium revenue increases in excess of 4% annually. Many of the capitated contracts include Sharp HealthCare in a narrow network, directing patients to Sharp HealthCare as a high quality, cost effective provider. The PPO contracts are reimbursed at a percentage discount from charges, which more reasonably compensates the hospitals for the care provided to patients under such contracts.
- 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 2011 through 2013.
- 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, the objective of which 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 savings. 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. In Fiscal 2011, non-operating losses of \$19.4 million were comprised of \$30.2 million in investment income, offset by \$44.7 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 \$1.0 million, and expenses of \$3.9 million primarily related to the activities of the Sharp Foundation and Grossmont Foundation. The gain of \$73.2 million in Fiscal 2012 was comprised of \$22.5 million in investment income and \$53.9 million of unrealized gains in Sharp HealthCare's investment portfolio as a result of the recovery of the equity markets and increased cash and investments, mark-to-market adjustments on interest rate swaps of \$1.7 million. This was partially offset by expenses of \$4.9 million primarily related to activities of the Sharp Foundation and Grossmont Foundation. The gain of \$75.2 million in Fiscal 2013 was comprised of \$32.4 million in investment income and \$43.0 million of unrealized gains in Sharp HealthCare's investment portfolio as a result of increases in the equity markets and increased cash and investments, and mark-to-market adjustments on interest rate swaps of \$3.1 million. This was partially offset by expenses of \$3.3 million primarily related to activities of the Sharp Foundation and Grossmont 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 \$81.1 million in Fiscal 2012 and an additional \$48.8 million in Fiscal 2013. 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-26. Sharp HealthCare's significant strategic capital acquisitions and improvements are described in "RECENTLY COMPLETED AND CURRENT PROJECTS" herein.

In Fiscal 2012, net patient service revenue increased 7.0% due to increased patient activity which caused a corresponding increase in patient accounts receivable, net of allowances, of \$19.4 million, or 11.0%. Net patient service revenue increased \$72.2 million, or 4.4%, in Fiscal 2013, which caused a corresponding increase in patient accounts receivable, net of allowances, of \$6.4 million, or 3.3%. Days in accounts receivable were 41.8, 43.5, and 43.0 as of September 30, 2011, 2012, and 2013, respectively.

Combined cash and cash equivalents, short-term investments, and assets limited as to use increased \$251.5 million in Fiscal 2013 compared with Fiscal 2012, which was comprised of

improved operating performance and investment income (including unrealized gains on investments), partially offset by capital expenditures and debt service.

Long-term liabilities decreased in Fiscal 2012 by \$6.8 million and in Fiscal 2013 by \$11.5 million due primarily to improved funded status of the defined benefit pension plan as a result of increased employer contributions, increased market values on plan assets, and an increase in the discount rate used to value the benefit obligation.

Retirement Plan and Employee Benefits

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, 2012 and 2013, the defined benefit cash balance plan was 78% and 86% 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 111% and 105% funded as of January 1, 2012 and January 1, 2013, respectively.

Additionally, the Corporation provides a comprehensive health and welfare benefit package for its employees which includes medical and vision benefits, dental benefits, life and long-term disability insurance, a paid leave program, and an education reimbursement program. Medical and vision benefits for employees and their dependents are purchased from Sharp Health Plan.

The Corporation’s total benefit program expense was approximately \$236.5 million and \$222.2 million for the years ended September 30, 2013 and 2012.

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 investment policy provides for a targeted long-term investment mix of 50% to 70% fixed income investments and 30% to 50% equity investments, which are invested in indexed funds. The following table sets forth the Obligated Group's short and long-term cash and investments as of September 30, 2013.

Short and Long-Term Cash and Investments	As of September 30, 2013 (\$ in thousands)
Cash	\$ 155,563
Short-term Investments	52,220
Long-term Investments - Equities	509,882
Long-term Investments - Fixed Income	621,334
Bond Funds	16,535
Other (including accrued interest)	<u>3,705</u>
Total	\$ 1,359,239

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

- 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 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, 2013, 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 2016. As part of the workers' compensation insurance agreement, letters of credit have been provided as collateral, totaling \$32.4 million as of September 30, 2013, which are considered a decrease in the available \$50.0 million line of credit.
- A letter of credit to provide credit enhancement and liquidity support for the Series 2009A Variable Rate Revenue Bonds ("Series 2009A Bonds"), originally issued in the amount of \$60.0 million. The letter of credit was executed in February 2009 and has an expiration date of May 2018. The Series 2009A Bonds remarket weekly and may be put at the option of the bondholders every seven days. As of September 30, 2013, the amount of the letter of credit available to be drawn totaled \$44.8 million.
- A letter of credit 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 letter of credit was executed in September 2009 and expires in September 2016. The Series 2009C and D Bonds remarket weekly and may be put at the option of the bondholders every seven days. As of September 30, 2013, the aggregate amount of the letters of credit available to be drawn totaled \$101.4 million.

New Markets Tax Credit Program

On June 22, 2011, the Corporation closed a \$39.3 million New Markets Tax Credit ("NMTC") financing transaction for construction of a medical office building and parking structure to replace the existing Sharp Rees-Stealy downtown medical center (the "Sharp Rees-Stealy Project"). NMTC is a federally-managed program developed to provide low income neighborhoods, which traditionally lack access to capital, with low cost financing to stimulate economic growth in these communities. The Sharp Rees-Stealy Project is located in a NMTC qualifying census tract, thus allowing the Corporation to take advantage of this financing opportunity. The term of the financing is seven years, after which time the Corporation expects

to net an approximate \$6.1 million gain on the funding for the Sharp Rees-Stealy Project from the forgiveness of debt.

Community Benefit

Enacted in September 1994, State Senate Bill 697 requires not-for-profit hospitals to file a report annually with the Office of Statewide Health Planning and Development (“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 loved ones, 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 Benefits for Vulnerable Populations** include van 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 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 Benefits for the Broader Community** include health education and information, free community support groups, participation in community health fairs and events addressing the unique needs of the community, providing flu vaccinations and health screenings, and participation in emergency and disaster planning efforts to protect the health and safety of the community. 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, as well as student/intern supervision, and time devoted to generalizable, health-related research projects that are made available to the broader health care community. 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 San Diego State University (“SDSU”) and other local colleges and universities. In addition, in 2012 Sharp HealthCare donated \$500,000 to SDSU’s College of Health and Human Services in order to establish the Sharp HealthCare Professional Education and Research Institute. The donation allowed for three new scholarships at SDSU, including SDSU’s new Doctor of Nursing Practice (“DNP”) program, which began in fall 2012. Scholarships will also be created for nursing students in the bachelor’s and master’s programs, as well as a general scholarship for students in SDSU’s College of Health and Human Services. The donation will provide a total of six students with scholarships each year, ranging from \$1,200 to \$2,000. The scholarships are a component of the Sharp HealthCare Professional Education and Research Institute, which includes the already established Sharp HealthCare Human Patient Simulation Center and the Nurses Now program. The new donation brings Sharp HealthCare’s total giving to the university to \$2.4 million, making Sharp HealthCare one of SDSU’s largest corporate contributors. Additionally, Sharp HealthCare continued its collaboration with Rady Children’s and Scripps Health (“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, 2012, Sharp HealthCare provided \$305.3 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 its fiscal year 2012:

<u>Economic Value of Community Benefits</u>	Estimated Fiscal 2012 Unreimbursed Costs (in millions)
Medical Care Services	\$294.8
Other Benefits for Vulnerable Populations	2.5
Other Benefits for the Broader Community	2.1
Health Research, Education, and Training Programs	<u>5.9</u>
Total Community Benefits	\$305.3

Source: Sharp HealthCare’s Fiscal Year 2012 Community Benefits Plan and Report (2013 is not yet available).

RECENTLY COMPLETED, CURRENT, AND FUTURE PROJECTS

Listed below are brief summaries of recently completed, current, and future projects affecting Sharp HealthCare's operations, as well as certain projects Sharp HealthCare is undertaking as part of its overall strategic plan.

Information Technology

Sharp HealthCare has long championed the use of innovative healthcare IT to enhance the quality, safety, and efficiency of care delivery and improve the patient experience. Listed below are summaries of the significant IT initiatives that have been recently undertaken or are currently under way.

- CMS has developed incentive programs to provide a financial reward for the meaningful use of qualified, certified EHR to achieve health and efficiency goals as outlined in the HITECH Act. Stage 1 sets the baseline for electronic data capture and information sharing and was implemented in fiscal years 2012 and 2013. 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 EHR incentive program are expected to be implemented in 2014 and 2016, respectively. Through September 30, 2013, Sharp Healthcare has recorded \$28.6 million in expected incentive payments, of which \$20.2 million has been received. The organization expects to record an additional \$7.8 million in incentive payments through September 30, 2015. In November 2004, Sharp Rees-Stealy selected the *Allscripts Healthcare Solutions' 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. An upgrade was completed in March 2011 to the Allscripts Enterprise release certified for incentive payments under the HITECH Act.
- In August 2006, the Corporation entered into a contract with Cerner Corporation ("Cerner") to implement the Cerner Millennium EMR information system in Sharp HealthCare hospitals. The EMR system allows physicians to utilize CPOE for patient treatment and has provided significant benefits to Sharp HealthCare, including reduced adverse drug events, reduced hospitalization costs, increased patient and employee satisfaction, and increased quality of care. The implementation was completed in all Sharp HealthCare hospitals by May 2011. The latest Cerner Millennium release certified for incentive payments under Stage 2 of the HITECH Act was implemented in August 2013, thereby enabling Sharp

HealthCare to apply for Stage 2 funding in 2014. Sharp HealthCare's Cerner EMR and Allscripts EHR 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 has been implemented to transmit key information, such as problems, medications, immunizations, allergies, and other data, between systems in a standard format.

- In January 2011, the Corporation's Board approved \$5.4 million for a hospital-wide bar-coding initiative, which has been funded through cash reserves. This initiative is designed to increase patient safety in the medication administration process, lab specimen collection process, and the mother-baby breast milk administration process, while also fulfilling CMS Stage 2 meaningful use requirements. The Cerner bar-coding suite of products supports the close integration necessary between the EMR and proposed bar-coding medication administration. The bar-coding implementation began in February 2011 and was completed in fall 2013.
- Many of Sharp HealthCare's future plans are deeply connected with the development of strategies to improve the overall quality of healthcare by leveraging existing EMR data to generate new, environmentally appropriate, best practice solutions. Among those is the implementation of the advanced patient portal, bringing more of the record to the patient online and providing alerting capability for diverse medical devices through the EMR. Sharp HealthCare has recently signed an agreement to participate in directing San Diego Regional Health Information Exchange ("SDRHIE") that has evolved into an independent, community-supported organization, San Diego Health Connect. By connecting their EHR systems through the exchange, healthcare providers will enable their patients to benefit from coordinated care and follow-up, leading to better care at lower costs. The SDRHIE will allow data to be shared in common formats, overcoming interoperability challenges, and will offer an aggregated view of treatment that is designed to help providers make the best decisions when time is of the essence. Other participants joining Sharp HealthCare include Kaiser Permanente San Diego Medical Center, Scripps, UCSD Health System, Rady Children's, VA San Diego Healthcare System, Family Health Centers of San Diego, and 14 community clinics coordinated through the Council of Community Clinics. Sharp HealthCare's participation in the San Diego Health Connect augments its efforts to facilitate health information exchange while ensuring the accuracy, privacy, and security of electronic health information. Additionally, Sharp HealthCare is evaluating technology to provide connection to the EHR by authorized caregivers and patients through mobile devices and remote medical devices. Sharp HealthCare makes continuous advances in business intelligence. These many initiatives contribute to improved quality, service, and cost-effectiveness, greatly increasing the value of the data stores Sharp HealthCare has built.

- Teletracking is being implemented at all Sharp hospitals to enhance efficiency, save cost, and generate revenue. Teletracking addresses patient throughput, capacity management, asset management, and inter-hospital patient transfer capability. Implementation of Capacity Managements Suite for centralized patient management is in process and will be completed at all hospitals by the end of 2014. It will ensure that the right patient is placed in the right bed and will monitor and facilitate discharge milestones.

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 fully satisfied seismic regulations until 2030. Those sites are Sharp Grossmont, Sharp Chula Vista, and Sharp Coronado. The fourth campus site is Sharp Memorial where three minor areas on the site require seismic upgrades prior to January 1, 2015. See "RECENTLY COMPLETED, CURRENT, AND FUTURE PROJECTS – Sharp Memorial" herein for a description of the Sharp Memorial seismic retrofitting project.

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.

As of September 30, 2013, Sharp HealthCare's capital plan for fiscal years 2014 through 2018 was approximately \$587.8 million, including seismic upgrade costs. Before any individual project is commenced or significant capital costs are incurred, the project 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 2018, it is management's current expectation that capital projects will be postponed or reduced in scope.

Sharp Memorial

- 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 ten operating suites and was designed with future inpatient bed capabilities of 32 beds. A \$10.6 million project to expand the Stephen Birch Center by 32 beds was completed in January 2011 and was funded through previously issued bonds and cash reserves.

- 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 also included remodeling the lobby and refurbishing the nurse stations and corridors. The cost of the project was \$9.7 million and was funded through previously issued bonds and cash reserves. The project was completed in July 2012.
- In May 2010, the Corporation's Board approved the expansion of Sharp Mary Birch to add 37 new beds to the hospital, including 23 NICU beds and 14 women's acute care unit beds. The cost of the project was \$24.6 million and was funded through previously issued bonds and cash reserves. The project was completed in October 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 are 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 2011 the Corporation's Board approved the seismic retrofit of the Memorial Hospital south tower and center tower. The retrofit brought the two buildings from a SPC-1 classification to a SPC-2 classification, allowing both buildings to be used for acute care services until 2030 in accordance with the State seismic regulations. At a fraction of the cost of new construction, this retrofitting pursuant to the HAZUS Re-assessment Program provides Sharp Memorial with 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. The project also included the modernization of the elevators in the south tower of Memorial Hospital, and the remodel of the fourth floor of the center tower into a 10-bed ICU. The cost of the project was \$40.7 million and was funded with previously issued bonds and cash reserves. The seismic retrofit part of the project was completed in August 2013; the balance of the work will be completed in early 2014. Three additional areas at Memorial

Hospital were identified in 2013 as needing seismic retrofit prior to 2015. Sharp HealthCare anticipates completing the work in calendar year 2014 at a cost of less than \$2.0 million. Upon completion, all Sharp HealthCare hospital buildings will be in compliance with the State seismic requirements through 2030.

- In March 2012, the Corporation’s Board approved the renovation of portions of Sharp Mesa Vista. The project includes the renovation of a patient care unit and addition of seven adult beds in the East Wing, construction of a mezzanine floor for administration in the area previously used as a gym, and renovation of the ground floor for pharmacy, electroconvulsive therapy, and out-patient services, renovation of the second floor of twenty-three senior citizen rooms in the Child and Adolescent Program building with improved nurse stations and access to an outdoor garden, and renovation of the main entrance to the hospital. The project budget is \$12.5 million and will be funded by cash reserves, philanthropy and a portion of the proceeds of the Bonds. Construction is scheduled to be completed by October 2014.
- In September 2012, the Corporation’s Board approved the renovation of the in-patient wing of the Memorial Rehabilitation Center. The renovation will increase the size of the patient rooms, provide thirty beds (with eighteen private rooms), and upgrade all of the features in the unit. The project budget is \$7.7 million and will be funded with cash reserves and a portion of the proceeds of the Bonds. The project is scheduled to be completed by May 2014.
- In July 2013, the Corporation’s Board approved the renovation of the surgery floor in Sharp Mary Birch. This project will renovate the pre- and post-surgery bays, the labor and delivery rooms and the waiting room. The estimated cost of the project is \$11.9 million and is being funded through previously issued bonds, cash reserves and a portion of the proceeds of the Bonds. The project is expected to be completed by January 2016.

Sharp Grossmont

- 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 (the “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 at Sharp Grossmont will be funded through proceeds from the GO Bonds. The Five-Year Plan includes \$22.2 million to equip and furnish the new and renovated spaces.

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 ICU 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 Heart and Vascular Center, which is expected to be operational in 2016 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 and \$136.9 million were issued in July 2007 and February 2011, respectively. The remaining GO Bonds are expected to be issued in 2014, and together with proceeds from the previous issuance of GO Bonds, up to the approved \$247 million, will be used to fund the above mentioned infrastructure improvements and facility renovations.

- In 2010, the Corporation's Board approved the remodel of space at Sharp Grossmont for construction of a new Cardiac Vascular and Cath Lab. The project cost was \$7 million, including the cost of two 64 slice CT scanners and an angio x-ray single plane C-arm. The project was completed in September 2012 and was funded through cash reserves.
- In August 2013, the Corporation's Board approved the renovation of the Women's Center to begin in 2014. The renovation will improve the physical environment, patient flow, and care environment of the Women's Center. The total budget of the project is \$1.8 million and is currently expected to be funded through cash reserves and a portion of the proceeds of the Bonds.

Sharp Chula Vista

- In October 2009, the Corporation's Board approved expansion of the Sharp Chula Vista emergency department. The project increased licensed emergency room treatment beds from 20 to 40 and created a four-bed observation unit. The cost of the project was \$12.2 million, which also included the purchase of a 16-slice CT scanner, furnishings, and other clinical and IT equipment to support the expanded space. The project was funded through previously issued bonds and cash reserves. The project was completed in January 2012.
- In February 2010, the Corporation's Board approved construction of a cancer center and a medical office building on the Sharp Chula Vista campus. The new Douglas & Nancy Barnhart Cancer Center was completed in September 2012. The total cost of the project was \$15.2 million, which included tenant improvements, clinical equipment, information systems, and furnishings, and was

funded through previously issued bonds, cash reserves, and philanthropy. Approximately 19,000 square feet of the 45,500 square foot building is leased by Sharp Chula Vista to relocate its radiation treatment center and infusion center from the hospital to this new and expanded space. The remaining 26,500 square feet provides office space for physicians on Sharp Chula Vista's medical staff. The medical office building is financed, built, owned, and managed by a third party.

- In October 2013, the Corporation's Board approved the construction of a new 720-stall parking structure, a new loop road, and utility loop at Sharp Chula Vista. This project is designed to support future development on the medical campus. The project budget is \$26.8 million. The project will be funded through cash reserves and a portion of the proceeds of the Bonds, and is scheduled to be completed in December 2015.

Sharp Rees-Stealy

- 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, 68,240 square foot medical office building and parking structure were completed in November 2012. The project cost was \$39.5 million and was funded through philanthropy, sale of excess land, cash reserves, and other sources. The building was designed to meet the Federal Leadership in Energy and Environmental Design ("LEED") Gold standards and certification is pending. See "HISTORICAL FINANCIAL INFORMATION—Capital Structure—New Markets Tax Credit Program" herein.
- In November 2010, the Corporation's Board approved execution of a 20-year lease for an office building in the Sorrento Mesa area of the County for expansion and relocation of Sharp Rees-Stealy clinic services. Additionally, the Sorrento Mesa building is used to augment Sharp HealthCare's existing data center in order to address the continued growth of Sharp HealthCare's computing infrastructure, as well as provide business continuity and redundancy in the event of a disaster. In June 2011, the Corporation's Board approved tenant improvements for the Sharp Rees-Stealy clinic services and data center. The project was completed in May 2012 and funded with cash reserves with a cost of \$19.9 million.
- In April 2012, the Corporation's Board approved the renovation of the Sharp Rees-Stealy Mira Mesa site. The site previously consisted of three leased buildings. With the opening of the Sharp Rees-Stealy Sorrento Mesa site, the lease holdings in Mira Mesa were reduced to two buildings. The renovation included the pediatric services and consolidation of women's radiology services. The project was completed in February 2013 with a cost of \$4.8 million, which was funded through cash reserves.
- In May 2012, the Corporation's Board approved a fifteen year lease of 28,941 square feet in Del Mar. This prominent location will become the latest Sharp

Rees-Stealy site and will specialize in primary care and OB/GYN services. In August 2012, the Corporate Board approved the plans for build-out of the space, with a project budget of \$8.6 million. The project is scheduled to be completed in early 2014 and is funded through cash reserves.

Sharp HealthCare

- In February 2011, to secure physician office space located adjacent to the Sharp Memorial campus, the Corporation executed a master lease agreement for three medical office buildings for a term of 15 years with the option to renew for two terms of five years. The associated assets and debt obligations of the capital leases were recorded in the financial statements at fair market value totaling \$56.9 million, including the estimated residual value of \$9.0 million. The long-term lease obligation is \$51.8 million and the current portion of the obligation is \$1.7 million at September 30, 2013.
- In November 2011, the Corporation's Board approved \$15.0 million for the acquisition of a two-story, 44,107 square-foot office building, known as the Tech Way Building, which is located adjacent to the Corporation's headquarters. The Tech Way Building acquisition closed on December 29, 2011 and was funded through cash reserves. In May 2012, the Corporation's Board approved a project budget of \$5.5 million for the interior renovation of the building. The project was funded through cash reserves and was completed in December 2012. The Tech Way Building has been used to accommodate growth in administrative services and also provides space for the Sharp Health Plan employees and operations.

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-45, through its subsidiaries and affiliated entities, Sharp Healthcare 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 2.8% between 2011 and 2013, and relative to 2011 will increase by 8.0% to more than 3.3 million by 2018.

	San Diego County Population		
	2011 (Estimated)	2013 (Estimated)	2018 (Projected)
Total Population	3,098,405	3,185,553	3,346,084
% Change from 2011	--	2.8%	8.0%

Source: Truven Health Analytics Market Expert; Nielsen Claritas, Inc.; U.S. Census Bureau.

According to Nielsen Claritas, Inc., current estimates for 2013 indicate the median household income in the County is \$62,981, which is 1.3% higher than the median for the State as a whole and 19.0% greater than the nation's median household income.

Market Share and Competition

As of December 31, 2011, there were 20 general acute care hospitals operating in the County, including those operated by Sharp HealthCare. The table on page A-46 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, 2011. 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-47 presents information about acute care hospitals located within the County for the year ended December 31, 2011.

SHARP

The Sharp HealthCare system includes four acute care hospitals, three specialty hospitals, two affiliated medical groups, a health plan and the full range of health care services throughout San Diego County.

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 McDonald Center

SKILLED NURSING LOCATIONS

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

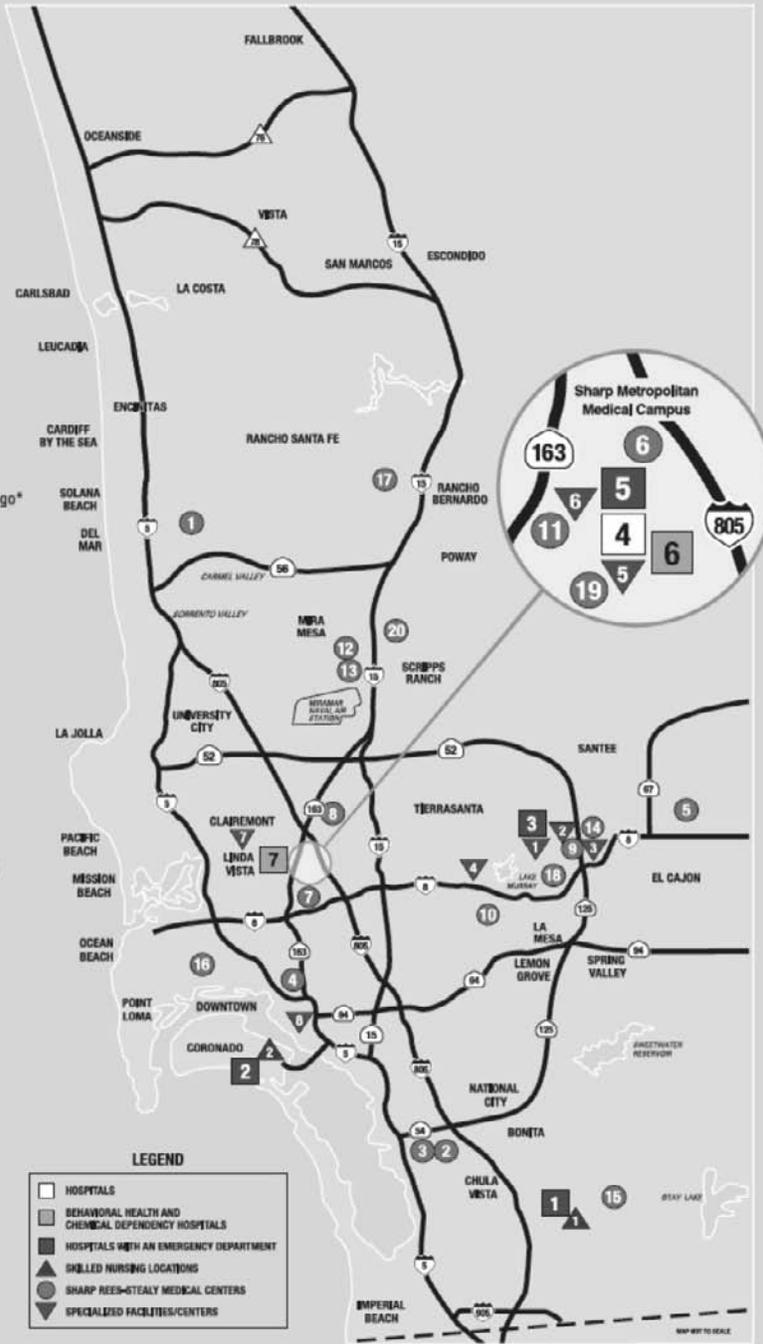
MEDICAL OFFICE LOCATIONS

** 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 Rehabilitation Services
- 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 Rehabilitation Services
- 14 Sharp Rees-Stealy Medical Center • Mt. Helix
- 15 Sharp Rees-Stealy Medical Center • Otay Ranch
- 16 Sharp Rees-Stealy Medical Center • Point Loma
- 17 Sharp Rees-Stealy Medical Center • Rancho Bernardo*
- 18 Sharp Rees-Stealy Medical Center • San Carlos
- 19 Sharp Rees-Stealy Medical Center • San Diego
- 20 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



LEGEND

- HOSPITALS
- BEHAVIORAL HEALTH AND CHEMICAL DEPENDENCY HOSPITALS
- HOSPITALS WITH AN EMERGENCY DEPARTMENT
- ▲ SKILLED NURSING LOCATIONS
- SHARP REES-STEALY MEDICAL CENTERS
- ▼ SPECIALIZED FACILITIES/CENTERS

CountyMapping.07.05.11 © 2011 SHC

San Diego County Hospitals Market Share Information ⁽¹⁾

Year Ended December 31, 2011

	<u>Discharges</u>	<u>Inpatient Market Share</u>	<u>Patient Days</u>	<u>Average Length of Stay (days)</u>	<u>Available Beds (avg.)</u>	<u>Occupancy Rate ⁽²⁾</u>
Sharp HealthCare						
Sharp Chula Vista Medical Center	14,801	5.2%	100,524	6.8	343	79.9%
Sharp Coronado Hospital and Healthcare Center	2,942	1.0%	45,698	15.5	175	74.7%
Sharp Grossmont Hospital	28,112	9.8%	112,394	4.0	510	63.5%
Sharp Memorial Hospital (incl. Sharp Mary Birch Hosp.)	30,064	10.5%	134,612	4.5	579	70.4%
Sharp Mesa Vista Hospital	4,901	1.7%	33,950	6.9	149	72.5%
Sharp McDonald Center	219	0.1%	2,983	13.6	14	64.6%
Total Sharp HealthCare	81,039	28.4%	430,161	5.3	1,770	70.8%
Scripps Health						
Scripps Green Hospital	9,638	3.4%	33,563	3.5	173	64.0%
Scripps Memorial Hospital - Encinitas	9,272	3.2%	39,775	4.3	158	73.3%
Scripps Memorial Hospital - La Jolla	15,660	5.5%	64,091	4.1	351	61.5%
Scripps Mercy Hospital (both campuses)	30,309	10.6%	135,542	4.5	651	63.4%
Total Scripps Health	64,879	22.7%	272,971	4.2	1,333	64.1%
Palomar Health						
Palomar Medical Center	19,762	6.9%	95,739	4.8	397	74.2%
Pomerado Hospital	6,754	2.4%	56,421	8.4	236	79.9%
Total Palomar Health	26,516	9.3%	152,160	5.7	633	76.3%
UCSD Health System						
UCSD Medical Center (both campuses)	22,582	7.9%	118,248	5.2	559	70.7%
Total UCSD Health System	22,582	7.9%	118,248	5.2	559	70.7%
All Other Hospitals						
Total, All Other Hospitals	90,638	31.7%	514,270	5.7	--	
TOTAL, SAN DIEGO COUNTY RESIDENTS	285,654	100.0%	1,487,810	5.2	6,939	65.9%

(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).

Sources: 2011 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 on 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 on the following page presents market share of County residents and Sharp HealthCare's historical competitive position relative to other providers in the service area.

Hospital/Health System ⁽¹⁾	2007	2008	2009	2010	2011
Sharp HealthCare	27.1%	27.1%	27.4%	28.1%	28.4%
Scripps Health	22.4%	22.4%	22.9%	22.9%	22.7%
Kaiser San Diego	9.8%	10.0%	10.2%	10.1%	9.7%
Palomar Health	10.4%	10.1%	9.5%	9.4%	9.3%
UCSD Health System	7.2%	7.3%	7.5%	7.8%	7.9%
Prime Healthcare Services ⁽²⁾	6.5%	6.5%	6.3%	6.0%	6.0%
Tri-City Medical Center	6.5%	6.1%	5.9%	5.7%	5.6%
Rady Children's Hospital - San Diego	4.2%	4.5%	4.4%	4.0%	4.6%
Total, All Other Hospitals	3.9%	4.0%	4.0%	4.0%	4.0%
out-migration to non-County hospitals	2.0%	2.0%	1.9%	1.9%	1.8%

(1) 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.

(2) Prime Healthcare Services ("Prime") owns two hospitals in San Diego County. Prime acquired Paradise Valley Hospital in 2007 and bought Alvarado Hospital Medical Center in 2010. Prime's Market Share figures for each year represent the total for these two campuses, but these hospitals were not under the control of Prime for each of the years reported here.

Source: 2007 - 2011 Office of Statewide Health Planning and Development Annual Hospital Discharge Data.

MANAGEMENT OF SHARP HEALTHCARE

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. A description of the Sharp HealthCare's senior executive team is below.

Michael W. Murphy (56), President and Chief Executive Officer. Mr. Murphy's career in health care spans more than 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 Sharp HealthCare, Mr. Murphy was a partner at Deloitte & Touche, an international public accounting and consulting firm, specializing in health care. He is a past Chairman of the Board of the Greater San Diego Regional Chapter of Commerce and is a member of the board of directors for the State Chamber. Mr. Murphy is a graduate of California State University at Long Beach and is a Certified Public Accountant.

Amy Adome, M.D. (39), Senior Vice President, Clinical Effectiveness. Dr. Adome joined Sharp HealthCare in April 2013. In her role as Senior Vice President, Dr. Adome is responsible for leading efforts to maintain and improve the quality of patient care across Sharp HealthCare. Dr. Adome works with a variety of groups within Sharp HealthCare including clinical research and physician services, institutional review board, continuing medical education, service lines and performance improvement. In addition, she works collaboratively with physicians, nurses and health professionals to develop, define, and deliver quality patient

care, using quality assessment and monitoring techniques. Prior to joining Sharp HealthCare, Dr. Adome held a number of progressive leadership roles east coast healthcare organizations (Mary Washington Healthcare, North Shore University Hospital), where she was responsible for building and leading corporate quality and patient safety programs. Dr. Adome received her medical degree from Makerere University in Uganda and worked as a primary care physician in Kenya before migrating to the United States to pursue a Master in Public Health with a concentration in Health Care Management from Harvard University in Boston.

Alison Fleury (51), Senior Vice President, Business Development, and Chief Executive Officer, Sharp ACO. 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 Senior Vice President, Business Development, in 1997 and Chief Executive Officer, Sharp ACO, in 2012. Ms. Fleury 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 Tribute to Women and Industry ("TWIN") Award in 2000 and was named one of San Diego's "Top 40 Under 40" by *San Diego Metropolitan* magazine in 2001. Ms. Fleury serves on the board of directors, finance committee, nominating 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, Ph.D. (58), Executive Vice President, Hospital Operations. Dr. Gross has been involved in the health care field for 36 years and has been associated with Sharp HealthCare since 1979. He began his career with Sharp HealthCare as a clinical nurse in the surgical ICU at Memorial Hospital, and progressively advanced 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. Dr. 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. Dr. Gross is past chair of the board of directors of CHA, a member of the board of directors of AHA, past chair and current member of the board of directors of HASDIC, a member of the board of directors of the American Heart Association, San Diego Chapter, immediate past chair of the board of directors of the Trauma Center Association of America, a member of the board of directors of the California HealthCare Foundation, a member of the West Health Medical Advisory Board, a member of the adjunct faculty at SDSU and University of San Diego ("USD"), and serves as Community Program Director for 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 from the College of Health and Human Services and the USD Author E. Hughes Career Achievement Award. Dr. Gross received the HASDIC Health Care Leadership Award in 1998 and 2007, is the recipient of the 2010 California Health Foundation and Trust Walker-Sullivan scholarship, and is the recipient of the 2012 CHA Award of Merit. Dr. 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.

Melissa Hayden Cook (51), Sharp Health Plan President and Chief Executive Officer. Melissa Hayden Cook has served Sharp Health Plan as president and Chief Executive Officer since 2005. She has more than 25 years of experience in the health care industry, serving for three years on Sharp Health Plan's Board of Directors and for seven years as senior vice president of marketing for Sharp HealthCare. Ms. Hayden Cook is a native San Diegan and USD graduate. She has set a community standard for wellness through the introduction of the Best Health wellness program. She is a member of the board of directors for Health Sciences High and Middle College ("HSHMC"), a charter school dedicated to developing the next generation of health care leaders. Ms. Hayden Cook sits on the board of the California Association of Health Plans ("CAHP") and is also a member of the CAHP Foundation board. She also serves on the board of the Health Plan Alliance, a national association of not-for-profit health plans. Ms. Hayden Cook has been recognized for her work in the health care industry. In 1996, she received the San Diego YWCA TWIN Award and in 2000, she was selected as one of *San Diego Metropolitan* magazine's "Top 40 under 40."

Stacey Hrountas (55), Sharp Rees-Stealy Chief Executive Officer. Promoted to her current position in 2012, Ms. Hrountas leads a staff of nearly 2,000 employees dedicated to the business systems for more than 450 primary care and specialty physicians of SRSMG. Ms. Hrountas has over 30 years of experience in the health care industry. She joined Sharp HealthCare in 1994 and has held several system-wide leadership positions including Vice President, Managed Care Contracting and Finance for Sharp HealthCare and its affiliated medical groups. Prior to joining Sharp HealthCare, Ms. Hrountas worked with Aetna Health Plans of San Diego, Mercy Physicians Medical Group, MetLife HealthCare Network, Travelers Health Network and Community Care Network. She served as chair of CHA's Managed Care Committee from 2009-2010 and chair of CAPG's Managed Care Committee. Ms. Hrountas holds a Bachelor of Science degree in Kinesiology from University of California, Los Angeles ("UCLA"), and a Master's degree in Public Health, in Health Services Administration from SDSU, Graduate School of Public Health. In May 2002, she was a YWCA TWIN Award recipient.

John Jenrette, M.D. (59), SCMG Chief Executive Officer. Dr. Jenrette has been at Sharp HealthCare since 1993. During this time he has served as Medical Director for Quality and Health Services Management at SCMG and then began in a full time capacity as Chief Medical Officer for SCMG in 1999. He began his role as Chief Executive Officer in August 2007. In addition to his responsibilities as Chief Executive Officer, Dr. Jenrette is a board member and past chairman of the board of directors of CAPG as well as chair of the Executive Management Committee for the California Advanced Primary Care Institute ("CAPCI"), the statewide foundation for the development and advancement of primary care in California. Prior to joining SCMG, Dr. Jenrette served as faculty to Northeastern Ohio University's College of Medicine, where he 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 and Doctorate of

Medicine from Ohio State University. His medical training and previous practice experience of 15 years is in family medicine and geriatrics.

Trisha Khaleghi (49), Sharp Mary Birch Chief Executive Officer. Ms. Khaleghi has been a Sharp HealthCare employee for 22 years and was promoted to her current position in 2012. Ms. Khaleghi joined Sharp HealthCare in 1991 as director of Oncology Services. In 2009, she assumed the role of vice president of Clinical Services at Sharp Memorial, which included surgery, pharmacy, radiology, and the Sharp Outpatient Pavilion, as well as the cardiology, transplant, and oncology service lines. Ms. Khaleghi is the chair of the Miracle Babies Committee and a member of the Council of Women's and Infants' Specialty Hospitals ("CWISH") Executive Steering Committee. In 2012, she was named to the Academy GE Fellows Program for Senior Executives, Chief Financial Officers, and Chief Medical Officers. Ms. Khaleghi is also affiliated with such organizations as CHA, AHA, and Surf Soccer Academy. She earned her Bachelor of Science Degree in Nursing and Masters of Science Degree in Nursing from the University of Kentucky. Ms. Khaleghi is a Registered Nurse.

John ("Rick") LeMoine, M.D. (66), 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 UCSD. 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 past chair of the Center for Hospital Medical Executives of CHA. Dr. LeMoine is a Critical Care Specialist and a Fellow of the American College of Physicians.

Kathi Lencioni (60), Sharp Mesa Vista and Sharp McDonald Center Chief Executive Officer. Ms. Lencioni was promoted to her current role in 2006. Ms. Lencioni is accountable for the operating results and continued growth of Sharp Mesa Vista and Sharp McDonald Center. Ms. Lencioni also has responsibility for Sharp HealthCare's Clinical Laboratories and system Centralized Pharmacy. Ms. Lencioni joined Sharp HealthCare in 2002 as the Vice President of Clinical Services and Operations at Sharp Grossmont. Prior to her work at Sharp HealthCare, Ms. Lencioni was the Vice President of Ambulatory and Clinical Services at Sarasota Memorial HealthCare System in Florida, an 845 bed medical center. Ms. Lencioni received her Bachelor of Science degree in Medical Technology from Illinois State University and her Master's in Public Health in Health Organization Management from the University of South Florida. Ms. Lencioni is a Fellow with the American College of Healthcare Executives ("ACHE"). Ms. Lencioni is on the Board of San Diego Organization for Healthcare Leaders, and the CHA Center for Behavioral Health. She will be the ACHE Regent for Southern California beginning in 2014. In January 2013, Ms. Lencioni began serving as a member of the Regional Policy Board 9 for the AHA representing Psychiatric Services.

Carlisle ("Ky") C. Lewis, III (57), 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 Healthcare Attorneys. Mr. Lewis is a board member of Continuous Quality Insurance.

William S. Littlejohn (55), 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. 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. A nationally recognized health care philanthropy professional, Mr. Littlejohn serves as chair of the 5,000 member 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, including serving as chair of the board of Santa Fe Christian Schools and St. Paul's Retirement Home Foundation, and has spoken and written extensively on all aspects of fundraising.

James H. Nuckols (57), Senior Vice President of Marketing and Communications. Mr. Nuckols has 30 years of marketing experience in healthcare and consumer markets. He joined Sharp HealthCare in January 2012. Mr. Nuckols' prior healthcare experiences include Chief Marketing Officer of TherapeuticsMD and Vice President/General Manager positions at three large healthcare service and technology companies; Carefusion, Cardinal Health and Hill-Rom. In the consumer realm, Mr. Nuckols served as President of The Sporting News and began his career at General Mills, where he managed several major brands including Wheaties and Nature Valley Granola. He received his Bachelor of Arts degree in Chemistry from the University of California, Riverside and a Masters of Business Administration from the Marriott School at Brigham Young University. Mr. Nuckols has announced his resignation effective spring 2014.

Ann Pumpian (58), 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, financial and cost 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 participates in the Health Management Academy Committee for Chief Financial Officers and CHA Chief Financial Officer Committee, and is a board member of the State Department of Managed Care Financial Solvency Standards Board, Sharp Health Plan, Continuous Quality Insurance, and Washington Pacific Insurance SPC. She is a past recipient of the Becker's Healthcare Leadership Award, 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 (56), 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, Fountain Valley Regional Hospital and Garden Grove Hospital, for 11 years. Mr. Smith is a fellow of the ACHE, 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 (68), 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 IT 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. 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 EHR. Mr. Spooner currently serves on the Boards of the National eHealth Collaborative, the San Diego Regional Health Information Exchange and the Council of Community Clinics Community Care Network. In 2011 he was named by *Information Week* magazine as one of the 25 leaders driving the health care IT revolution. He was recently the co-recipient of CHIME's inaugural Public Policy Award for his efforts in informing national Health IT ("HIT") policy. Mr. Spooner received his Bachelor of Science Degree in Business Administration from California State University, Chico in 1976. Mr. Spooner has announced his retirement effective in March 2014.

Susan Stone, Ph.D. (53), Sharp Coronado Chief Executive Officer. Dr. Stone was promoted to her current position in 2013. Dr. Stone joined Sharp HealthCare in 1986 holding numerous leadership positions including Chief Nursing Officer for two of Sharp HealthCare's seven hospitals, where she successfully led the 2007 and 2012 Planetree Designation efforts at Sharp Coronado and Sharp Memorial respectively, in addition to the 2013 Magnet Re-designation efforts at Sharp Memorial. Active in the Association for California Nurse Leaders ("ACNL"), she is currently a Southern California Regional Representative to the state Board of Directors and serves as a regional Nursing California Action Coalition Champion. Dr. Stone's patient-centered research has been featured in the peer-reviewed *Health Environments Research*

and Design Journal and she was a contributing author to the 2008 *Patient-Centered Care Improvement Guide*. She earned her Bachelor of Nursing Science degree at SDSU and Master and Doctorate of Philosophy in Nursing Science degrees at USD.

Michele Tarbet (61), 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 positions as Chief Nursing Officer and Chief Operating Officer in the Los Angeles area in both the for-profit and nonprofit sectors. Ms. Tarbet serves on the boards of directors for the East County Boys and Girls Club, the East County Chamber, and CHA's Governance Forum. She is past chair of the La Mesa Parks and Recreation Foundation and 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 (51), 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 over 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. Past president of the ACNL San Diego Chapter, Dr. Velez received the Excellence in Leadership Award in 2010 from the ACNL. He is a board member of the South Bay Chamber of Commerce, South Bay YMCA, Friends of Park and Recreation, and South County Economic Development Council. Dr. Velez is a Registered Nurse.

ADDITIONAL INFORMATION

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 2014A 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. For the twelve months ended September 30, 2013, Sharp Health Plan’s average enrollment was 69,552*, including more than 26,400 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. In May 2013, the National Committee for Quality Assurance (“NCQA”) awarded Sharp Health Plan the accreditation status of “Excellent”. Sharp Health Plan is one of only three California health plans to achieve the “Excellent” status, the highest level of NCQA accreditation.
- *Sharp Coronado* (formerly known as The Coronado Hospital) became affiliated with the Corporation in July 1994. Sharp Coronado operates a 181-bed hospital consisting of 59 acute care beds and a 122-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 the County.

Sharp Coronado is a member of the Planetree network and is one of 23 hospitals nationwide distinguished with the Planetree Patient-Centered Hospital Designation. It is also one of two hospitals in California to have met the criteria developed by Planetree, a nonprofit organization committed to patient-centered care through humanizing, personalizing, and demystifying the hospital experience. Furthermore, Sharp Coronado is one of four hospitals in the Planetree network to hold Planetree’s highest level of recognition – Designation with Distinction. 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 2012 and awarded the hospital its Gold Seal of Approval and a three-year accreditation. Additionally, Sharp Coronado holds Disease Specific Certifications from The

* There are enrollment duplicates between Sharp Health Plan, SRSMG, and SCMG of 56,703 for the twelve months ended September 30, 2013.

Joint Commission for Knee and Hip Replacements. 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). In the past decade, Sharp HealthCare has generated nearly \$200 million in philanthropy, and over the last decade the Sharp HealthCare Foundation has distributed \$136 million for capital, technology and programs. The goal for Sharp HealthCare Foundation's current philanthropic effort, INSPIRE: The Sharp HealthCare Campaign for Excellence, is to raise \$100 million across nearly two dozen initiatives.
- *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.
- *Sharp ACO* was chosen by the Innovation Center to be a Pioneer ACO and to participate in the Pioneer Agreement, under the terms of which Sharp ACO is financially accountable for the cost of care provided to certain Medicare beneficiaries that are assigned to it. This program enhances the engagement between patients and their medical providers in the coordination of care and services across all aspects of their health care needs.

Employees

As of September 30, 2013, Sharp HealthCare employed approximately 16,000 people, which calculates to be 12,088 full-time equivalent employees, approximately 11,515 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 October 1, 2011, 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") ratified a new

three-year collective bargaining agreement with Sharp HealthCare that expires on September 30, 2014. The union represents approximately 4,500 registered nurses employed by Sharp HealthCare in the hospital and outpatient facilities. The current agreement provides guaranteed annual wage changes during 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 economic recession 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. Various other community collaborations exist with high schools, community college nursing programs, and the development of HSHMC, a charter school 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 ratios require one nurse for every five patients on medical surgical units and telemetry units to maintain one nurse for every four patients. The mandated ratios must be maintained at all times, even when licensed staff takes 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 when necessary. Sharp HealthCare currently provides what management believes is adequate nurse staffing to meet the needs of its patients.

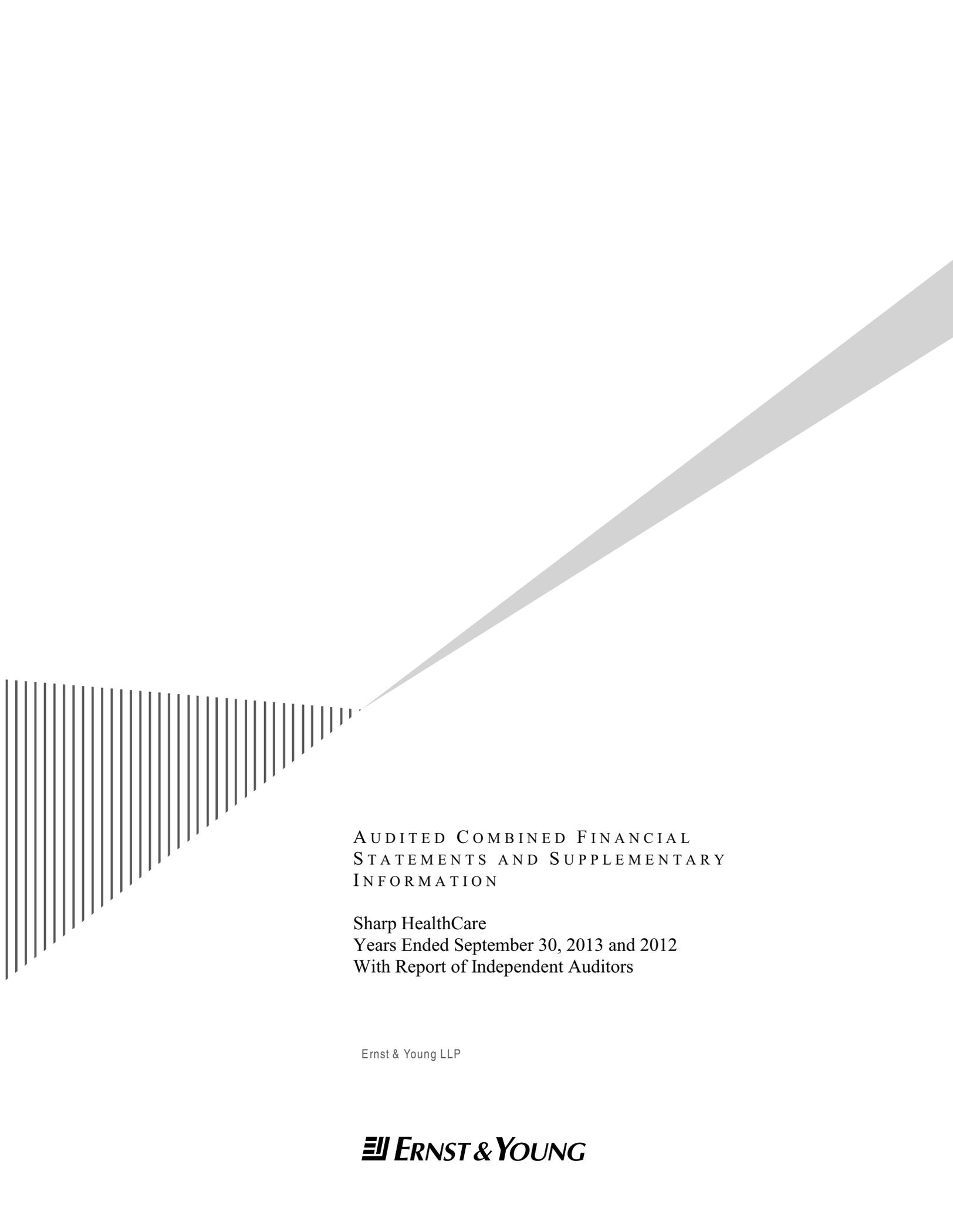
Insurance

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 \$17.625 million. Excess insurance through a commercial carrier provides limits to \$40.0 million. Continuous Quality Insurance also provides professional and general liability insurance to the Sharp Rees-Stealy and SRSMG, with per occurrence coverage of \$1 million per claim, \$3 million annual aggregate. Coverage for property, network risk, and corporate liability is provided through the commercial insurance market. Coverage for workers' compensation insurance is provided through a high deductible (\$1 million) per claim policy, also obtained through the commercial insurance market.

APPENDIX B

FINANCIAL STATEMENTS OF THE CORPORATION

[THIS PAGE INTENTIONALLY LEFT BLANK]



AUDITED COMBINED FINANCIAL
STATEMENTS AND SUPPLEMENTARY
INFORMATION

Sharp HealthCare
Years Ended September 30, 2013 and 2012
With Report of Independent Auditors

Ernst & Young LLP

 **ERNST & YOUNG**

Sharp HealthCare

Combined Financial Statements and Supplementary Information

Years Ended September 30, 2013 and 2012

Contents

Report of Independent Auditors.....	1
Audited Combined Financial Statements	
Combined Balance Sheets.....	3
Combined Statements of Operations	4
Combined Statements of Changes in Net Assets	5
Combined Statements of Cash Flows	6
Notes to Combined Financial Statements	8
Supplementary Information	
Combining Balance Sheet.....	48
Combining Statement of Operations.....	50
Combining Statement of Changes in Net Assets	51
Combining Balance Sheet – Obligated Group.....	52
Combining Statement of Operations – Obligated Group.....	54
Combining Statement of Changes in Net Assets – Obligated Group	55

Report of Independent Auditors

The Board of Directors
Sharp HealthCare

We have audited the accompanying combined financial statements of Sharp HealthCare, which comprise the combined balance sheets as of September 30, 2013 and 2012, and the related combined statements of operations and changes in net assets, and cash flows for the years then ended, and the related notes to the combined financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in conformity with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free of material misstatement, whether due to fraud or error.

Auditor's Responsibility

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.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

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, 2013 and 2012, and the combined results of their operations and their cash flows for the years then ended in conformity with U.S. generally accepted accounting principles.

Supplementary Information

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

Ernst + Young LLP

December 17, 2013

Sharp HealthCare
Combined Balance Sheets

	September 30	
	2013	2012
	<i>(In Thousands)</i>	
Assets		
Current assets:		
Cash and cash equivalents	\$ 175,334	\$ 174,127
Short-term investments	59,520	83,838
Accounts receivable, net of allowance for doubtful accounts of \$152,922 in 2013 and \$174,280 in 2012	295,870	297,833
Estimated settlements receivable from government programs, net	5,058	11,958
Inventories	40,049	37,113
Prepaid expenses and other	42,579	40,066
Total current assets	<u>618,410</u>	<u>644,935</u>
Assets limited as to use:		
Designated for property	1,175,106	880,412
Under bond indentures	16,535	30,330
Other restricted investments	43,142	42,409
Under self-insurance programs	11,869	11,411
Total assets limited as to use	<u>1,246,652</u>	<u>964,562</u>
Property and equipment, net	991,584	940,796
Unamortized financing costs	6,335	6,865
Other assets	73,762	69,156
Total assets	<u>\$ 2,936,743</u>	<u>\$ 2,626,314</u>
Liabilities and net assets		
Current liabilities:		
Accounts payable and accrued liabilities	\$ 184,474	\$ 229,836
Accrued compensation and benefits	139,129	127,973
Current portion of long-term debt	19,458	8,223
Accrued interest	3,296	3,251
Total current liabilities	<u>346,357</u>	<u>369,283</u>
Long-term liabilities	105,831	123,648
Reserves for professional and general liabilities	16,106	17,843
Long-term debt	577,665	594,736
Total liabilities	<u>1,045,959</u>	<u>1,105,510</u>
Net assets:		
Unrestricted	1,835,619	1,468,074
Temporarily restricted	49,122	47,168
Permanently restricted	6,043	5,562
Total net assets	<u>1,890,784</u>	<u>1,520,804</u>
Total liabilities and net assets	<u>\$ 2,936,743</u>	<u>\$ 2,626,314</u>

See accompanying notes.

Sharp HealthCare

Combined Statements of Operations

	Year Ended September 30	
	2013	2012
	<i>(In Thousands)</i>	
Revenues:		
Patient service	\$ 1,664,809	\$ 1,594,389
Provider tax revenue	145,329	153,373
Provision for doubtful accounts	(28,114)	(30,035)
Net patient service	<u>1,782,024</u>	<u>1,717,727</u>
Premium	953,194	896,916
Other	94,585	96,361
Total revenues	<u>2,829,803</u>	<u>2,711,004</u>
Expenses:		
Salaries and wages	1,008,827	951,601
Employee benefits	246,810	232,248
Medical fees	387,566	365,560
Purchased services	259,301	243,526
Supplies	318,658	307,486
Provider tax	106,087	101,083
Maintenance, utilities, and rentals	113,374	108,299
Depreciation and amortization	98,550	91,520
Business insurance	11,331	12,030
Interest	23,250	24,336
Other	30,610	31,170
Total expenses	<u>2,604,364</u>	<u>2,468,859</u>
Income from operations	225,439	242,145
Other nonoperating loss	(65)	(4,602)
Investment income	80,407	82,839
Excess of revenues over expenses	<u>305,781</u>	<u>320,382</u>
Net assets transferred from related-party	31,174	15,539
Net assets released from restrictions used for purchase of property, plant, and equipment	5,560	8,618
Pension-related changes other than net periodic pension cost	24,662	6,752
Other changes in net assets	368	20
Increase in unrestricted net assets	<u>\$ 367,545</u>	<u>\$ 351,311</u>

See accompanying notes.

Sharp HealthCare

Combined Statements of Changes in Net Assets

	Year Ended September 30	
	2013	2012
	<i>(In Thousands)</i>	
Unrestricted net assets:		
Excess of revenues over expenses	\$ 305,781	\$ 320,382
Net assets transferred from related-party	31,174	15,539
Net assets released from restrictions used for purchase of property and equipment	5,560	8,618
Pension-related changes other than net periodic pension cost	24,662	6,752
Other changes in net assets	368	20
Increase in unrestricted net assets	367,545	351,311
Temporarily restricted net assets:		
Contributions	8,740	10,733
Investment income	1,323	696
Change in net unrealized gains on investments	559	1,859
Net assets released from restrictions	(9,587)	(13,331)
Other changes in net assets	919	(372)
Increase (decrease) in temporarily restricted net assets	1,954	(415)
Permanently restricted net assets:		
Contributions	481	158
Increase in permanently restricted net assets	481	158
Increase in net assets	369,980	351,054
Net assets, beginning of the year	1,520,804	1,169,750
Net assets, end of the year	\$ 1,890,784	\$ 1,520,804

See accompanying notes.

Sharp HealthCare

Combined Statements of Cash Flows

	Year Ended September 30	
	2013	2012
	<i>(In Thousands)</i>	
Operating activities		
Increase in net assets	\$ 369,980	\$ 351,054
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Net assets transferred from related-party	(31,174)	(15,539)
Provision for doubtful accounts	(28,114)	(30,035)
Noncash (gains) losses	(531)	611
Depreciation of operating and nonoperating facilities	98,560	91,530
Amortization, including deferred financing costs	184	1,728
Change in fair value of interest and basis rate swaps	(3,081)	(1,658)
Restricted contributions and investment income, net	(10,544)	(11,587)
Pension-related changes other than net periodic pension cost	(24,662)	(6,752)
Changes in assets and liabilities:		
(Increase) decrease in:		
Accounts receivable	30,077	(70,536)
Inventories	(2,936)	(3,018)
Short-term investments	24,318	(12,105)
Assets limited to use	(282,090)	(200,481)
Prepaid expenses and other	(2,513)	23,139
Estimated settlements payable to government programs, net	6,900	(7,754)
Increase (decrease) in:		
Accounts payable and accrued liabilities, long-term liabilities and other liabilities	(40,209)	37,508
Accrued compensation and benefits	11,156	17,102
Net cash provided by operating activities	<u>115,321</u>	<u>163,207</u>
Investing activities		
Acquisition of property and equipment, net of retirements	(112,113)	(156,303)
(Increase) decrease in other assets	(4,607)	1,828
Net cash used in investing activities	<u>(116,720)</u>	<u>(154,475)</u>
Financing activities		
Payments on long-term debt	(6,311)	(61,924)
Payments under capital lease obligations	(1,627)	(1,365)
Proceeds from the issuance of long-term debt	-	51,085
Restricted contributions and investment income, net	10,544	11,587
Net cash provided by (used in) financing activities	<u>2,606</u>	<u>(617)</u>
Net increase in cash and cash equivalents	1,207	8,115
Cash and cash equivalents, beginning of the year	174,127	166,012
Cash and cash equivalents, end of the year	<u>\$ 175,334</u>	<u>\$ 174,127</u>

Sharp HealthCare

Combined Statements of Cash Flows (continued)

	Year Ended September 30	
	2013	2012
	<i>(In Thousands)</i>	
Supplemental disclosures of cash flow information		
Capital lease obligations for building and equipment	\$ 5,529	\$ 407
Cash paid for interest	\$ 25,273	\$ 25,378
Net assets transferred from related-party	\$ 31,174	\$ 15,539

See accompanying notes.

Sharp HealthCare

Notes to Combined Financial Statements

September 30, 2013

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 Outpatient Pavilion, Sharp Mesa Vista Hospital, and Sharp McDonald Center (formerly 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).

On January 1, 2012, SHC, together with its affiliated medical groups, Sharp Community Medical Group (SCMG), and Sharp Rees-Stealy Medical Group (SRSMG) formed the Sharp HealthCare ACO, a limited liability company (Sharp ACO). Sharp ACO was awarded a contract with the Centers for Medicare and Medicaid Services (CMS) as a Pioneer Accountable Care Organization (Pioneer ACO). SHC holds a one third percentage interest in Sharp ACO. The Pioneer ACO is a shared-savings model in which participating organizations are eligible for shared savings payments from CMS if they achieve medical cost savings while providing high quality, coordinated patient care for an assigned group of beneficiaries. Participating organizations also share risk in the form of increased cost payments with CMS for any increase in medical cost. For 2012, Sharp ACO’s performance was under a defined 2% threshold, so no shared savings payments were earned and no increased cost payments were due. Pursuant to the Pioneer Agreement, Sharp ACO is obligated to guarantee its ability to pay CMS for twenty five percent of the total increased cost payments for which it could be potentially liable in a given year. Sharp ACO borrowed \$4,398,000 and \$9,582,000 from SHC for the year ended September 30, 2013

Sharp HealthCare

Notes to Combined Financial Statements (continued)

1. Summary of Significant Accounting Policies (continued)

and 2012, respectively, to fund an escrow account to cover a portion of any potential medical cost increases of Sharp ACO. SHC recorded the loan in accounts receivable, net on the combined balance sheets.

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.

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.

Sharp HealthCare

Notes to Combined Financial Statements (continued)

1. Summary of Significant Accounting Policies (continued)

Derivative and Hedging Instruments

Sharp recognizes all derivatives on its combined balance sheets at fair value. Derivatives that are not effective hedges are adjusted to fair value through the combined statements of operations (see Note 6). At September 30, 2013 and 2012, the outstanding hedging instruments were not considered effective hedges.

Assets Limited as to Use

Assets limited as to use invested in debt and equity securities with readily determined fair values 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 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, and amounts held by trustees under indenture agreements. Assets limited as to use consist of the following:

Designated for property – Cash resources not required for operations have been designated as funded depreciation to be used for future capital improvements. This designation may be changed and such funds used for other purposes – \$28,766,000 at September 30, 2013, and \$29,488,000 at September 30, 2012, 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.

Sharp HealthCare

Notes to Combined Financial Statements (continued)

1. Summary of Significant Accounting Policies (continued)

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 3 to 40 years and is computed using the straight-line method. Property and 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.

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.

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 2013 or 2012.

Sharp HealthCare

Notes to Combined Financial Statements (continued)

1. Summary of Significant Accounting Policies (continued)

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 SHF and GHF (Foundations).

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.

Accounts receivable are reduced by an allowance for doubtful accounts. In evaluating the collectability of accounts receivable, Sharp analyzes its past history and identifies trends for each of its major payor sources of revenue to estimate the appropriate allowance for doubtful accounts. Management regularly reviews data about these major payor sources of revenue in evaluating the sufficiency of the allowance for doubtful accounts. For receivables associated with services provided to patients who have third-party coverage, Sharp analyzes contractually

Sharp HealthCare

Notes to Combined Financial Statements (continued)

1. Summary of Significant Accounting Policies (continued)

due amounts and provides an allowance for doubtful accounts, if necessary. For receivables associated with self-pay patients (which includes both patients without insurance and patients with deductible and copayment balances due for which third-party coverage exists for part of the bill), Sharp records a provision for doubtful accounts in the period of service on the basis of its past experience, which indicates that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The difference between the standard rates (or the discounted rates if negotiated) and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for doubtful accounts.

Sharp's allowance for doubtful accounts for self-pay patients was 94% and 96% of self-pay accounts receivable at September 30, 2013 and 2012, respectively. In addition, Sharp's self-pay write-offs decreased \$3,355,000 from \$40,825,000 for fiscal year 2012 to \$37,470,000 for fiscal year 2013. The decrease was the result of decreased revenues from self-pay patients in fiscal year 2013. Sharp has not changed its charity care or uninsured discount policies during fiscal years 2012 or 2013. Sharp does not maintain a material allowance for doubtful accounts from third-party payors, nor did it have significant write-offs from third-party payors.

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.

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.

Sharp HealthCare

Notes to Combined Financial Statements (continued)

1. Summary of Significant Accounting Policies (continued)

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's policy is to accept all patients regardless of their ability to pay. In assessing a patient's ability to pay, Sharp utilizes financial eligibility requirements or criteria. 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.

Charity care costs are calculated using a ratio of cost to gross charge methodology by department. Direct revenues and costs of each department were included in the calculation, in addition to a step down of overhead costs.

The cost of charity care is summarized for 2013 and 2012, as follows:

	Year Ended September 30	
	2013	2012
	<i>(In Thousands)</i>	
Charity care, at cost	\$ 47,642	\$ 58,072
Offsetting revenue	—	(16)
	<u>\$ 47,642</u>	<u>\$ 58,056</u>

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

Sharp HealthCare

Notes to Combined Financial Statements (continued)

1. Summary of Significant Accounting Policies (continued)

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.

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, 2013 and 2012, no such assets or liabilities were recorded.

Adoption of New Accounting Pronouncements

In May 2011, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) 2011-04, *Fair Value Measurement (Topic 820)*, which clarifies the intent of existing fair value measurement and disclosure requirements under Accounting Standards Codification (ASC) 820, *Fair Value Measurements and Disclosures*. Adoption of ASU 2011-04 did not have any significant impact on the combined financial statements at September 30, 2013 and 2012.

Recent Accounting Pronouncements

In December 2011, the FASB issued ASU 2011-11, *Balance Sheet (Topic 210)*, which requires additional disclosures relating to the offsetting of financial instruments. The adoption of ASU 2011-11 is effective for Sharp beginning October 1, 2013, 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 April 2013, the FASB issued ASU 2013-06, *Not-for-Profit Entities (Topic 958)*, which requires a recipient not-for-profit entity to recognize all contributed services received from personnel of an affiliate that directly benefit the recipient not-for-profit entity. The adoption of ASU 2013-06 is required for Sharp on October 1, 2014, and is not expected to have a material impact on Sharp's combined financial statements.

In July 2013, the FASB issued ASU 2013-11, *Income Taxes (Topic 740)*, which require unrecognized tax benefits to be offset against a deferred tax asset for a net operating loss carryforward, similar tax loss or tax credit carryforward in certain situations. The adoption of ASU 2013-11 is required for Sharp on October 1, 2015, and is not expected to have a material impact on Sharp's combined financial statements.

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 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 but not 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 \$10,687,000 and \$8,134,000 as of September 30, 2013 and 2012, 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, 2013. Only assets and liabilities measured at fair value on a recurring basis are shown in the three-tier fair value hierarchy.

	September 30, 2013	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>				
Short-term investments:				
U.S. Treasury obligations	\$ 12,515	\$ 12,515	\$ —	\$ —
Corporate bonds	29,088	—	29,088	—
U.S. government agencies	5,546	—	5,546	—
Commercial paper	12,037	—	12,037	—
Interest receivable	334	—	334	—
	<u>\$ 59,520</u>	<u>\$ 12,515</u>	<u>\$ 47,005</u>	<u>\$ —</u>
Assets limited as to use:				
Designated for property:				
Cash and cash equivalents	\$ 4,644	\$ 4,644	\$ —	\$ —
Equities	526,114	526,114	—	—
U.S. Treasury obligations	227,202	227,202	—	—
Corporate bonds	221,461	—	221,461	—
U.S. government agencies	124,540	—	124,540	—
Mortgage-backed securities and collateralized mortgage obligations	47,988	—	47,988	—
Commercial paper	18,899	—	18,899	—
Asset-backed securities	750	—	750	—
Interest receivable	3,508	—	3,508	—
	<u>\$ 1,175,106</u>	<u>\$ 757,960</u>	<u>\$ 417,146</u>	<u>\$ —</u>

Sharp HealthCare

Notes to Combined Financial Statements (continued)

2. Fair Value Measurements (continued)

	September 30, 2013	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 (continued):				
Under bond indentures:				
Cash and cash equivalents	\$ 1,229	\$ 1,229	\$ —	\$ —
U.S. Treasury obligations	3,141	3,141	—	—
Corporate bonds	961	—	961	—
U.S. government agencies	11,147	—	11,147	—
Interest receivable	57	—	57	—
	<u>\$ 16,535</u>	<u>\$ 4,370</u>	<u>\$ 12,165</u>	<u>\$ —</u>
Other restricted investments:				
Cash and cash equivalents	\$ 1,383	\$ 1,383	\$ —	\$ —
Equities	23,179	23,179	—	—
U.S. Treasury obligations	3,723	3,723	—	—
Fixed income funds	4,933	4,368	565	—
Corporate bonds	5,531	—	5,531	—
U.S. government agencies	1,886	—	1,886	—
Mortgage-backed securities and collateralized mortgage obligations	2,270	—	2,270	—
Commodities	144	—	144	—
Interest receivable	93	—	93	—
	<u>\$ 43,142</u>	<u>\$ 32,653</u>	<u>\$ 10,489</u>	<u>\$ —</u>
Under self-insurance programs:				
Cash and cash equivalents	\$ 3,003	\$ 3,003	\$ —	\$ —
Equities	1,889	1,889	—	—
U.S. Treasury obligations	2,165	2,165	—	—
Corporate bonds	2,648	—	2,648	—
U.S. government agencies	1,355	—	1,355	—
Mortgage-backed securities and collateralized mortgage obligations	429	—	429	—
Commercial paper	380	—	380	—
	<u>\$ 11,869</u>	<u>\$ 7,057</u>	<u>\$ 4,812</u>	<u>\$ —</u>

Sharp HealthCare

Notes to Combined Financial Statements (continued)

2. Fair Value Measurements (continued)

	September 30, 2013	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>			
Interest rate swap liabilities	\$ 133	\$ –	\$ 133	\$ –
	<u>\$ 133</u>	<u>\$ –</u>	<u>\$ 133</u>	<u>\$ –</u>

The following table provides the composition of certain investment assets as of September 30, 2012. Only assets and liabilities measured at fair value on a recurring basis are shown in the three-tier fair value hierarchy.

	September 30, 2012	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>			
Short-term investments:				
Negotiable certificates of deposit	\$ 3,000	\$ 3,000	\$ –	\$ –
U.S. Treasury obligations	14,716	14,716	–	–
Corporate bonds	34,027	–	34,027	–
U.S. government agencies	15,912	–	15,912	–
Commercial paper	15,669	–	15,669	–
Interest receivable	514	–	514	–
	<u>\$ 83,838</u>	<u>\$ 17,716</u>	<u>\$ 66,122</u>	<u>\$ –</u>

Sharp HealthCare

Notes to Combined Financial Statements (continued)

2. Fair Value Measurements (continued)

	September 30, 2012	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	\$ 6,586	\$ 6,586	\$ —	\$ —
Equities	383,789	383,789	—	—
U.S. Treasury obligations	141,740	141,740	—	—
Corporate bonds	207,314	—	207,314	—
U.S. government agencies	91,524	—	91,524	—
Mortgage-backed securities and collateralized mortgage obligations	33,593	—	33,593	—
Commercial paper	12,382	—	12,382	—
Interest receivable	3,484	—	3,484	—
	<u>\$ 880,412</u>	<u>\$ 532,115</u>	<u>\$ 348,297</u>	<u>\$ —</u>
Under bond indentures:				
Cash and cash equivalents	\$ 3,326	\$ 3,326	\$ —	\$ —
U.S. Treasury obligations	3,248	3,248	—	—
Corporate bonds	9,476	—	9,476	—
U.S. government agencies	13,557	—	13,557	—
Mortgage-backed securities and collateralized mortgage obligations	554	—	554	—
Interest receivable	169	—	169	—
	<u>\$ 30,330</u>	<u>\$ 6,574</u>	<u>\$ 23,756</u>	<u>\$ —</u>

Sharp HealthCare

Notes to Combined Financial Statements (continued)

2. Fair Value Measurements (continued)

September 30, 2012	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 (continued):					
Other restricted investments:					
Cash and cash equivalents	\$ 1,675	\$ 1,675	\$ —	\$ —	\$ —
Equities	18,903	18,903	—	—	—
U.S. Treasury obligations	4,719	4,719	—	—	—
Fixed income funds	7,635	7,036	599	—	—
Corporate bonds	5,172	—	5,172	—	—
U.S. government agencies	1,898	—	1,898	—	—
Mortgage-backed securities and collateralized mortgage obligations	2,200	—	2,200	—	—
Commodities	120	120	—	—	—
Interest receivable	87	—	87	—	—
	\$ 42,409	\$ 32,453	\$ 9,956	\$ —	\$ —
Under self-insurance programs:					
Cash and cash equivalents	\$ 2,653	\$ 2,653	\$ —	\$ —	\$ —
U.S. Treasury obligations	1,693	1,693	—	—	—
Corporate bonds	3,357	—	3,357	—	—
U.S. government agencies	3,403	—	3,403	—	—
Commercial paper	305	—	305	—	—
	\$ 11,411	\$ 4,346	\$ 7,065	\$ —	\$ —
Interest rate swap liabilities	\$ 3,214	\$ —	\$ 3,214	\$ —	\$ —
	\$ 3,214	\$ —	\$ 3,214	\$ —	\$ —

Sharp HealthCare

Notes to Combined Financial Statements (continued)

3. Net Patient Service Revenue

Patient Service Revenues

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. Effective July 1, 2013, the Medi-Cal program began reimbursing Sharp on the basis of All Patient Refined Diagnosis Related Groups (APR-DRGs) for inpatient services.

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, 2013, and 31% and 18%, respectively, of Sharp's gross patient charges for the year ended September 30, 2012.

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 \$5,388,000 in 2013 and \$10,073,000 in 2012 and includes the impact of settlements of prior years' reimbursement from Medicare, Medi-Cal, and Champus programs.

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 HealthCare

Notes to Combined Financial Statements (continued)

3. Net Patient Service Revenue (continued)

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 net receivables from significant payors was as follows:

	September 30	
	2013	2012
Medicare	15%	12%
Medi-Cal	14%	12%
Private Pay and other	20%	23%

Provider Tax Revenue

California legislation established a program that imposes a Quality Assurance Fee (QA Fee) on certain general acute care hospitals in order to make supplemental and grant payments (Supplemental Payments) to hospitals up to the aggregate upper payment limit for various periods. There have been three such programs since inception. The first two programs were the 21-month program (21-Month Program) covering the period April 1, 2009 to December 31, 2010, and the six-month program (Six-Month Program) covering the period January 1, 2011 to June 30, 2011 (the Original Programs). The third program is the 30-month program (30-Month Program) covering the period from July 1, 2011 to December 31, 2013.

The programs are designed to make supplemental inpatient and outpatient Medi-Cal payments to private hospitals, including additional payments for certain facilities that provide high acuity care, sub-acute and trauma services to the Medi-Cal population. This hospital QA Fee program provides a mechanism for increasing payments to hospitals that serve Medi-Cal patients, with no impact on the state's General Fund (GF). Some of these payments will be made directly by the state, while others will be made by the Medi-Cal managed care plans, which will receive increased rates from the state in amounts equal to the Supplemental Payments. Outside of this legislation, the California Hospital Association (CHA) has created a private program, operated by the California Health Foundation and Trust (CHFT), which was established to alleviate disparities potentially resulting from the implementation of the Programs.

Sharp HealthCare

Notes to Combined Financial Statements (continued)

3. Net Patient Service Revenue (continued)

The Original Programs required full federal approval by the Centers for Medicare and Medicaid Services (CMS) in order for them to be fully enacted. If final federal approval was not ultimately obtained, provisions in the underlying legislation allowed for the QA Fee, previously assessed, and Supplemental Payments, previously received, to be returned and recouped, respectively. As such, revenue and expense recognition was not allowed until full CMS approval was obtained. Full CMS approvals for the 21-Month Program and Six-Month Program were obtained in December 2010 and December 2011, respectively.

During the year ended September 30, 2012, Sharp recognized Supplemental Payments for the 21-Month Program and Six-Month Program in the amount of \$77,000 and \$47,124,000, respectively, as Provider Tax Revenue. In addition, during the year ended September 30, 2012, Sharp recognized payments to the California Department of Health Care Services (DHCS) for the QA Fee in the amount of \$26,938,000 and pledge payments to the CHFT in the amount of \$943,000 as Provider Tax expense related to the Six-Month Program. During the year ended September 30, 2013, Sharp recognized remaining Supplemental Payments on the Six-Month Program of \$3,000 as Provider Tax revenue.

The 30-Month Program was signed into law by the Governor of California in September 2011. In June 2012, the legislation governing the 30-Month Program was amended to allow for the fee-for-service portion of the 30-Month Program to be administered separately from the managed care portion. CMS approved the fee-for-service portion of the 30-Month Program in June 2012 and approved the first twenty four months of the managed care portion of the 30-Month Program in June 2013. Approval of the final six months of the managed care portion is still pending.

Sharp recognized payments to DHCS for the QA Fee in the amount of \$65,912,000 in 2013 and \$70,708,000 in 2012 related to the fee-for-service portion of the 30-Month Program. Additionally, Sharp recognized pledge amounts to CHFT of \$1,995,000 in 2013 and \$2,494,000 in 2012 as Provider Tax expense related to the fee-for-service portion of the 30-Month Program. Sharp recognized Supplemental Payment revenue of \$94,528,000 in 2013 and \$106,172,000 in 2012 as Provider Tax revenue related to the fee-for-service portion of the 30-Month Program.

Sharp recognized payments to DHCS for the QA Fee in the amount of \$37,214,000 and pledge amounts to CHFT of \$966,000 as Provider Tax expense related to the July 1, 2011 through June 30, 2013, managed care portion of the 30-Month Program during the year ended September 30, 2013. Sharp recognized Supplemental Payment revenue of \$50,798,000 as Provider Tax revenue related to the July 1, 2011 through June 30, 2013, managed care portion of the 30-Month Program during the year ended September 30, 2013.

Sharp HealthCare

Notes to Combined Financial Statements (continued)

3. Net Patient Service Revenue (continued)

Sharp recorded \$10,000,000 in accounts payable and accrued liabilities for the 30-Month Program QA Fee and pledge payments owed for the portion of the 30-Month Program through September 30, 2013 that was not paid as of September 30, 2013, in the combined balance sheet as of September 30, 2013. Additionally, Sharp recorded \$46,018,000 in accounts receivable for the 30-Month Program Supplemental Payment revenue due for the portion of the 30-Month Program through September 30, 2013 that was not received as of September 30, 2013, in the combined balance sheet as of September 30, 2013.

Electronic Health Records Incentive Payments

The American Recovery and Reinvestment Act of 2009 included provisions for implementing health information technology under the Health Information Technology for Economic and Clinical Health Act (HITECH). The provisions were designed to increase the use of electronic health record (EHR) technology and establish the requirements for a Medi-Cal and Medicare incentive payment program beginning in 2012 for eligible providers that adopt and demonstrate meaningful use of certified EHR technology as defined by the regulations. Eligibility for annual Medicare incentive payments is dependent on providers demonstrating meaningful use of EHR technology in each period over a four-year period. Initial Medi-Cal incentive payments are available to providers that adopt, implement or upgrade certified EHR technology. Providers must continue to demonstrate meaningful use of such technology in subsequent years to qualify for additional Medicaid and Medicare incentive payments and to avoid potential penalties.

Sharp accounts for Medi-Cal and Medicare EHR incentive payments as a gain contingency. For the years ended September 30, 2013 and 2012, Medicare incentives of \$7,392,000 and \$8,985,000, respectively, were recognized in other revenues upon demonstration of compliance with the meaningful use criteria over the entire applicable compliance period and the end of the 12-month cost report period that will be used to determine the final incentive payment. Sharp also recognized Medi-Cal incentives of \$5,900,000 and \$6,342,000 for the years ended September 30, 2013 and 2012, respectively, in other revenues, upon demonstration of compliance with the criteria. Income from incentive payments is subject to retrospective adjustment as the incentive payments are calculated using Medicare cost report data that is subject to audit. Additionally, Sharp's compliance with meaningful use criteria is subject to audit by the federal government.

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:

	Year Ended September 30	
	2013	2012
	<i>(In Thousands)</i>	
Interest income	\$ 24,269	\$ 20,793
Unrealized gains, net	44,690	58,374
Realized gains, net	11,448	3,672
	\$ 80,407	\$ 82,839

5. Property and Equipment

Property and equipment consists of the following:

	September 30	
	2013	2012
	<i>(In Thousands)</i>	
Land and improvements	\$ 57,906	\$ 57,687
Buildings and improvements	1,166,753	1,032,930
Equipment and furniture	849,957	816,734
Construction-in-progress	105,212	128,981
	2,179,828	2,036,332
Less accumulated depreciation and amortization	(1,188,244)	(1,095,536)
	\$ 991,584	\$ 940,796

Sharp HealthCare

Notes to Combined Financial Statements (continued)

5. Property and Equipment (continued)

Depreciation and amortization expense for the years ended September 30, 2013 and 2012, amounted to approximately \$98,560,000 and \$91,530,000, respectively. Included in these amounts is amortization for buildings and equipment under capital lease obligations. Sharp has approximately \$64,690,000 at September 30, 2013 and 2012, of buildings and equipment under capital lease, at cost. Sharp has outstanding commitments to complete construction-in-progress totaling approximately \$30,304,000 at September 30, 2013.

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 being funded using the proceeds of general obligation (GO) bonds. In July 2007 and February 2011, \$85,500,000 and \$136,860,000, respectively, in GO bonds were issued by the District. The next offering of the GO bonds is expected in 2014. 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 2013 and 2012, the Hospital recorded \$31,174,000 and \$15,539,000, 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.

Sharp HealthCare

Notes to Combined Financial Statements (continued)

6. Long-Term Debt

Long-term debt consists of the following:

	September 30	
	2013	2012
	<i>(In Thousands)</i>	
<p>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 6.00% to 6.38%. The borrowing amount is net of the unamortized original issue discount of \$2,306,000 at September 30, 2013. The bonds include issuer call features totaling \$30,025,000 and \$109,975,000 in 2014 and 2019, respectively.</p>	\$ 137,694	\$ 137,591
<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 2016. Interest is payable monthly at a variable rate (0.10% at September 30, 2013).</p>	99,880	99,880
<p>Series 2011A Revenue Bonds (Series 2011A Bonds) collateralized by revenues of the Obligated Group. Principal due in annual amounts ranging from \$2,985,000 in 2014 to \$8,180,000 in 2030. Interest payable annually at rates ranging from 3.50% to 6.00%. The borrowing amount is net of the unamortized original issue premium of \$347,000 at September 30, 2013. The bonds include issuer call features totaling \$54,490,000 in 2021.</p>	78,057	78,089

Sharp HealthCare

Notes to Combined Financial Statements (continued)

6. Long-Term Debt (continued)

	September 30	
	2013	2012
	<i>(In Thousands)</i>	
<p>Series 2012A Revenue Bonds (Series 2012A Bonds) collateralized by revenues of the Obligated Group. Principal due in annual amounts ranging from \$5,080,000 in 2019 to \$5,055,000 in 2028. Interest payable annually at rates ranging from 4.0% to 5.0%. The borrowing amount is net of the unamortized original issue premium of \$4,503,000 at September 30, 2013. The bonds include issuer call features totaling \$30,735,000 in 2023.</p>	\$ 47,438	\$ 47,861
<p>Series 2009A Variable Rate Revenue Bonds (Series 2009A Bonds) collateralized by a direct-pay letter of credit reimbursement agreement between Obligated Group and a bank. Principal due in annual amounts ranging from \$3,485,000 in 2014 to \$5,360,000 in 2024. Letter of Credit is renewable in 2016. Interest is payable monthly at a variable rate (0.10% at September 30, 2013).</p>	44,260	47,625
<p>Series 2010A Variable Rate Revenue Bonds (Series 2010A Bonds) collateralized by revenues of the Obligated Group. Principal due in quarterly amounts ranging from \$190,000 to \$450,000 through 2035. Interest payable quarterly at a variable rate (0.87% at September 30, 2013).</p>	27,550	28,325
<p>Series 2003C Revenue Bonds collateralized by revenues of the Obligated Group. Principal due in annual amounts ranging from \$445,000 in 2014 to \$16,265,000 in 2021. Interest payable annually at rates ranging from 5.13% to 5.38% through 2021. The borrowing amount is net of the unamortized original issue discount of \$49,000 at September 30, 2013.</p>	24,846	25,334

Sharp HealthCare

Notes to Combined Financial Statements (continued)

6. Long-Term Debt (continued)

	September 30	
	2013	2012
	<i>(In Thousands)</i>	
Reverse Repurchase Agreement collateralized by U.S. Treasury securities. Principal due in April 2015. Interest payable quarterly at a variable rate (0.70% at September 30, 2013).	\$ 15,500	\$ 15,500
Series 1988A Insured Hospital Revenue Bonds collateralized by revenues of the Obligated Group. Principal due in annual amounts ranging from \$1,500,000 in 2014 to \$1,900,000 in 2018. Interest payable every 35 days at a variable rate (0.10% at September 30, 2013).	8,400	9,800
Construction loan agreement. Interest ranging from .90% to 1.26% payable quarterly. Principal due in quarterly installments beginning in 2018 to final maturity in 2041.	39,315	39,315
Medical office building mortgage collateralized by the building. Interest and principal paid in monthly amounts at a rate of 5.39% through 2014 when a final principal payment of \$7,735,000 is due.	7,834	8,024
Capital lease obligations at imputed rates of interest ranging from 5.46% to 7.27%, collateralized by leased building or equipment.	59,508	61,134
Other debt including the fair value of interest rate swaps	6,841	4,481
Total	597,123	602,959
Less current portion	(19,458)	(8,223)
	\$ 577,665	\$ 594,736

Sharp HealthCare

Notes to Combined Financial Statements (continued)

6. Long-Term Debt (continued)

In 2012, Sharp issued Series 2012A Bonds in the amount of \$46,665,000 that had a net original issue premium of \$5,225,000. The proceeds were utilized to refinance the 1998 COP Bonds in the amount of \$51,890,000.

In 2012, SGH entered into a Co-Generation and Energy Equipment Purchase Agreement (Co-Generation Agreement) with the District. Under the Co-Generation agreement, the District is financing an \$18,000,000 loan through a separate lease agreement with a bank for the purchase and installation of a co-generation unit and replacement energy equipment at SGH. The loan is repayable in monthly installments of principal and interest over nine years. The interest rate is 2.09% and the monthly installments are \$182,977. The Co-Generation agreement requires SGH to pay the bank directly an amount equal to the principal and interest amount the District is obligated to pay on the loan. Upon payment of all amounts due, the co-generation and energy equipment will be transferred to SGH as part of leasehold improvements pursuant to the May 29, 1991 lease (see Note 5).

As of September 30, 2013, the co-generation unit and energy equipment is still under construction at SGH. All lease payments paid by SGH on behalf of the District are recorded as prepaid rent and included in prepaid expenses and other on the combined balance sheet. Construction in progress and notes payable is recorded as the project incurs costs. At completion of the project, the Co-Generation agreement will be treated as a capital lease.

Under the terms of the 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, 2013 and 2012.

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):

	Long-Term Debt	Capital Lease Obligations
2014	\$ 17,574	\$ 1,885
2015	26,713	2,117
2016	11,440	2,404
2017	11,965	2,713
2018	12,819	3,046
Thereafter	448,441	38,329

Scheduled interest payments Sharp is obligated to make on capital lease obligations referenced in the table noted above total approximately \$28,696,000 at September 30, 2013.

A summary of interest cost on borrowed funds follows:

	Year Ended September 30	
	2013	2012
	<i>(In Thousands)</i>	
Interest cost:		
Capitalized	\$ 1,270	\$ 2,126
Charged to operations	23,250	24,336
	\$ 24,520	\$ 26,462

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 London Interbank Offered Rate (LIBOR) plus 0.14%, for the remaining term of the swap. Settlements are made weekly. Cash paid on the interest rate swap was \$1,941,000 in 2013 and \$2,039,000 in 2012, which increased Sharp's overall cost of borrowing and was included in interest expense. The change in fair value of the swap increased nonoperating income by \$2,941,000 in 2013 and decreased nonoperating income by \$505,000 in 2012.

Sharp HealthCare

Notes to Combined Financial Statements (continued)

6. Long-Term Debt (continued)

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 Bond Market Association (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 \$489,000 in 2013 and \$488,000 in 2012, which reduced Sharp's overall cost of borrowing and was offset against interest expense. The change in fair value of the swap decreased nonoperating income by \$1,009,000 in 2013 and increased nonoperating income by \$1,799,000 in 2012.

During 2006, Sharp entered into a fixed-spread yield curve swap with a bank. The swap arrangement hedges an initial notional amount of \$80,000,000 and 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 \$647,000 in 2013 and \$630,000 in 2012, which reduced Sharp's overall cost of borrowing and was offset against interest expense. The change in fair value of the swap increased nonoperating income by \$1,149,000 in 2013 and \$364,000 in 2012.

7. Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are available for the following purposes:

	September 30	
	2013	2012
	<i>(In Thousands)</i>	
Purchase of equipment	\$ 14,718	\$ 14,088
Hospital programs	12,506	10,743
Hospital departments	11,569	11,455
Health education	5,346	6,260
Research	4,590	4,185
Indigent care	393	437
Total	\$ 49,122	\$ 47,168

Permanently restricted net assets of \$6,043,000 and \$5,562,000 at September 30, 2013 and 2012, respectively, represent investments to be held in perpetuity, the income from which is expendable to support health care services.

Sharp HealthCare

Notes to Combined Financial Statements (continued)

8. Endowments

Sharp's endowments consist of 47 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, 2013, by fund type was as follows:

	Temporarily Restricted	Permanently Restricted	Total
<i>(In Thousands)</i>			
Board-designated endowment funds	\$ 2,296	\$ –	\$ 2,296
Donor-restricted endowment funds	4,946	6,043	10,989
Total funds	\$ 7,242	\$ 6,043	\$ 13,285

The endowment net asset composition as of September 30, 2012, by fund type was as follows:

	Temporarily Restricted	Permanently Restricted	Total
<i>(In Thousands)</i>			
Board-designated endowment funds	\$ 2,198	\$ –	\$ 2,198
Donor-restricted endowment funds	4,039	5,562	9,601
Total funds	\$ 6,237	\$ 5,562	\$ 11,799

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)

	Temporarily Permanently		Total
	Restricted	Restricted	
	<i>(In Thousands)</i>		
Endowment net assets, October 1, 2011	\$ 5,104	\$ 5,404	\$ 10,508
Investment return:			
Investment income	173	–	173
Net appreciation (realized and unrealized)	1,268	–	1,268
Total investment return	1,441	–	1,441
Contributions	(64)	158	94
Appropriation of endowment assets for expenditure	(244)	–	(244)
Endowment net assets, September 30, 2012	6,237	5,562	11,799
Investment return:			
Investment income	824	–	824
Net appreciation (realized and unrealized)	283	–	283
Total investment return	1,107	–	1,107
Contributions	8	481	489
Appropriation of endowment assets for expenditure	(110)	–	(110)
Endowment net assets, September 30, 2013	\$ 7,242	\$ 6,043	\$ 13,285

9. Functional Expenses

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

	Year Ended September 30	
	2013	2012
	<i>(In Thousands)</i>	
Hospital patient services	\$ 1,835,281	\$ 1,741,138
Clinic patient services	418,118	387,072
General and administrative	223,090	214,326
Purchased services under capitated agreements	127,875	126,323
	\$ 2,604,364	\$ 2,468,859

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 \$16,219,000 in 2013 and \$14,767,000 in 2012.

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

	2013	2012
	<i>(In Thousands)</i>	
Change in benefit obligation:		
Benefit obligation at beginning of year	\$ 291,433	\$ 243,382
Service cost	14,895	11,679
Interest cost	12,557	11,963
Actuarial (gain) loss	(9,905)	35,609
Benefits paid	(13,828)	(11,200)
Benefit obligation at end of year	295,152	291,433
Change in plan assets:		
Fair value of plan assets at beginning of year	228,580	173,564
Actual return on plan assets	15,830	39,217
Plan participants' contributions	6,473	5,964
Employer contributions	16,114	21,035
Benefits paid	(13,828)	(11,200)
Fair value of plan assets at end of year	253,169	228,580
Funded status	\$ (41,983)	\$ (62,853)

The net liability, recognized in the balance sheet in long-term liabilities, was \$41,983,000 and \$62,853,000 at September 30, 2013 and 2012, 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:

	2013	2012
	<i>(In Thousands)</i>	
Prior service cost	\$ 1,917	\$ 3,121
Net actuarial loss	63,721	87,173
	\$ 65,638	\$ 90,294

Additional information for the plan:

	September 30	
	2013	2012
	<i>(In Thousands)</i>	
Projected benefit obligation	\$ 295,152	\$ 291,433
Accumulated benefit obligation	277,738	272,306
Fair value of plan assets	253,169	228,580

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

	2013	2012
	<i>(In Thousands)</i>	
Service cost	\$ 14,895	\$ 11,679
Interest cost	12,557	11,963
Expected return on plan assets	(16,125)	(12,751)
Recognized net actuarial loss	7,369	8,710
Amortization of prior service cost	1,204	1,215
Net periodic pension cost	\$ 19,900	\$ 20,816

Sharp HealthCare

Notes to Combined Financial Statements (continued)

10. Pension Plans (continued)

Weighted-average assumptions used to determine benefit obligations were:

	September 30	
	2013	2012
Discount rate	5.11%	4.33%
Rate of compensation increase	3.50%	3.50%

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

	September 30	
	2013	2012
Discount rate	4.33%	4.92%
Expected return on plan assets	7.00%	7.25%
Rate of compensation increase	3.50%	3.50%

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.

The estimated net actuarial loss, prior service cost, and transition obligation for the defined benefit pension plans that will be amortized from net assets into net periodic pension cost during the 2014 fiscal year are \$4,105,000, \$1,204,000, and \$0, respectively.

Sharp HealthCare

Notes to Combined Financial Statements (continued)

10. Pension Plans (continued)

Plan Assets

The Plan's assets are invested in an institutional trust company commingled employee benefit plan trust (Commingled Plan Trust). The Plan's asset allocation utilizes a long range asset allocation strategy. The target asset allocation gradually shifts as the funded ratio increases from an initial mix of 65% equity securities and 35% fixed income when the Plan's funded ratio is less than 80% to an ultimate target of 40% equity securities and 60% fixed income when the Plan's funded ratio reaches 100%. As of September 30, 2013 and 2012, based on the Plan's funded ratio, the Plan's allocation of investments in the Commingled Plan Trust were as follows:

	<u>2013</u>	<u>2012</u>
Asset category:		
Equity securities	50%	62%
Fixed income	50	38
Total	<u>100%</u>	<u>100%</u>

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 measured at fair value are grouped in three levels, based on the markets in which the assets 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, 2013 and 2012.

Contributions

Sharp expects to contribute \$8,100,000 to the Plan in 2014.

Sharp HealthCare

Notes to Combined Financial Statements (continued)

10. Pension Plans (continued)

Estimated Future Benefit Payments

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

2014	\$ 20,470,000
2015	19,468,000
2016	19,303,000
2017	20,931,000
2018	20,943,000
2019 – 2023	109,875,000

11. Long-Term Liabilities

Long-term liabilities consist of the following:

	September 30	
	2013	2012
	<i>(In Thousands)</i>	
Defined benefit pension plan unfunded liability	\$ 41,983	\$ 62,853
Workers' compensation	35,298	34,541
Deferred liabilities	20,012	18,033
Other	8,538	8,221
	<u>\$ 105,831</u>	<u>\$ 123,648</u>

12. Commitments and Contingencies

Leases

Sharp leases various equipment and facilities under operating leases expiring at various dates through 2032. Total rental expense in 2013 and 2012 for all operating leases was \$31,795,000 and \$31,620,000, respectively.

Sharp HealthCare

Notes to Combined Financial Statements (continued)

12. Commitments and Contingencies (continued)

The following is a schedule by year of future minimum lease payments (in thousands) under operating leases as of September 30, 2013, that have initial or remaining lease terms in excess of one year.

2014	\$	24,767
2015		24,711
2016		21,023
2017		16,284
2018		14,399
Thereafter		112,765
	\$	<u>213,949</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 continues to increase 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.

Labor Matters

Not-for-profit health care providers and their employees are under the jurisdiction of the National Labor Relations Board. As of September 30, 2013, approximately 28% of Sharp employees are represented by unions. Such unionized employees are represented by Sharp

Sharp HealthCare

Notes to Combined Financial Statements (continued)

12. Commitments and Contingencies (continued)

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. The collective bargaining agreement with the union expires in 2014.

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 \$17,625,000 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, 2013 and 2012.

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, 2013. In management's opinion, however, the estimated liability accrued at September 30, 2013, 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, 2013 and 2012, SHP was required to maintain tangible net equity totaling \$10,525,000 and \$13,590,000, respectively. SHP's tangible net equity was \$47,214,000 at September 30, 2013, and \$39,962,000 at September 30, 2012. Management believes they are in compliance with these requirements at September 30, 2013 and 2012.

Sharp HealthCare

Notes to Combined Financial Statements (continued)

12. 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 2013 and 2012). 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 1.25% and 1.5% at September 30, 2013 and 2012, respectively. Workers' compensation liabilities of \$44,710,000 and \$44,436,000 at September 30, 2013 and 2012, respectively, are included in other current liabilities and long-term liabilities in the combined balance sheets.

Seismic Standards (Unaudited)

All of Sharp's major hospital buildings are in compliance with the earthquake retrofit requirements under a State of California law through 2030.

Credit Facilities

Sharp has a \$50,000,000 line of credit with a bank, which expires on September 1, 2016, of which \$17,600,000 was available at September 30, 2013 and 2012. 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 as of September 30, 2013 and 2012. 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, 2013 and 2012.

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 May 2016. The letter of credit used as collateral totaled \$44,769,000 at September 30, 2013.

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 2016. The total letters of credit used as collateral totaled \$101,391,000 at September 30, 2013.

Sharp HealthCare

Notes to Combined Financial Statements (continued)

12. Commitments and Contingencies (continued)

SHP has a bank credit facility that provides for the issuance of up to an aggregate of \$550,000 at September 30, 2013 and \$700,000 at September 30, 2012, under letters of credit. Such letters of credit are under irrevocable standby letters of credit. At September 30, 2013 and 2012, none of these letters have been drawn upon.

13. 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.

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.

Estimated settlements receivable from (payable to) government programs, net: The carrying amount reported in the balance sheet for estimated third-party payor settlements approximates its fair value.

Prepaid expenses and other: The carrying amount reported in the balance sheet for prepaid expenses and other approximates its fair value.

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)

13. Fair Value of Financial Instruments (continued)

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

	September 30, 2013		September 30, 2012	
	Carrying Value	Fair Value	Carrying Value	Fair Value
Cash and cash equivalents	\$ 175,334	\$ 175,334	\$ 174,127	\$ 174,127
Short-term investments	59,520	59,520	83,838	83,838
Estimated settlements receivable from government programs, net	5,058	5,058	11,958	11,958
Prepaid expenses and other	42,579	42,579	40,066	40,066
Assets limited as to use	1,246,562	1,246,562	964,562	964,562
Accounts payable and accrued liabilities	184,474	184,474	229,836	229,836
Accrued compensation and benefits	139,129	139,129	127,973	127,973
Current and long-term debt	597,123	621,016	602,959	645,288

14. Subsequent Events

In preparing these combined financial statements, management has evaluated and disclosed all material subsequent events up to December 17, 2013, which is the date that the combined financial statements were issued.

Supplementary Information

Sharp HealthCare

Combining Balance Sheet

(In Thousands)

As of September 30, 2013

	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
Assets												
Current assets:												
Cash and cash equivalents	\$ 139,001	\$ 1,081	\$ 1,960	\$ 8,894	\$ 906	\$ 19,157	\$ 408	\$ 1,146	\$ 2,781	\$ 175,334	\$ -	\$ 175,334
Short-term investments	39,459	-	-	13,067	-	5,085	-	1,909	-	59,520	-	59,520
Accounts receivable, net	20,831	137,443	46,116	76,611	9,670	3,782	-	2,822	403	297,678	(1,808)	295,870
Estimated settlements receivable from government programs, net	-	(781)	(1,146)	7,532	(547)	-	-	-	-	5,058	-	5,058
Intercompany receivables	-	1,041,479	110,887	374	9,892	-	13	-	85	1,162,730	(1,162,730)	-
Inventories	7,276	14,820	5,362	10,707	1,884	-	-	-	-	40,049	-	40,049
Prepaid expenses and other	34,835	3,054	1,998	5,012	305	371	5	33	4	45,617	(3,038)	42,579
Total current assets	241,402	1,197,096	165,177	122,197	22,110	28,395	426	5,910	3,273	1,785,986	(1,167,576)	618,410
Assets limited as to use:												
Designated for property	902,598	-	-	236,644	-	35,864	-	-	-	1,175,106	-	1,175,106
Under bond indentures	669	14,157	1,084	625	-	-	-	-	-	16,535	-	16,535
Other restricted investments	-	-	-	-	-	389	-	31,770	10,983	43,142	-	43,142
Under self-insurance programs	-	-	-	-	-	-	11,869	-	-	11,869	-	11,869
Total assets limited as to use	903,267	14,157	1,084	237,269	-	36,253	11,869	31,770	10,983	1,246,652	-	1,246,652
Property and equipment, net	251,961	406,838	68,924	248,072	14,562	1,049	-	178	-	991,584	-	991,584
Unamortized financing costs	1,984	3,182	726	443	-	-	-	-	-	6,335	-	6,335
Other assets	28,993	28	2,465	1,658	1,680	140	13,894	48,962	3,791	101,611	(27,849)	73,762
Beneficial interest in foundations	45,645	-	-	17,392	-	-	-	-	-	63,037	(63,037)	-
Total assets	\$ 1,473,252	\$ 1,621,301	\$ 238,376	\$ 627,031	\$ 38,352	\$ 65,837	\$ 26,189	\$ 86,820	\$ 18,047	\$ 4,195,205	\$ (1,258,462)	\$ 2,936,743

Sharp HealthCare

Combining Balance Sheet (continued) (In Thousands)

As of September 30, 2013

	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
Liabilities and net assets												
Current liabilities:												
Accounts payable and accrued liabilities	\$ 119,946	\$ 23,358	\$ 8,950	\$ 15,920	\$ 1,825	\$ 16,146	\$ 61	\$ 35	\$ 4	\$ 186,245	\$ (1,771)	\$ 184,474
Intercompany payable	1,132,186	-	-	-	-	582	-	29,912	-	1,162,680	(1,162,680)	-
Accrued compensation and benefits	42,236	43,659	16,210	30,492	4,476	1,631	-	432	80	139,216	(87)	139,129
Current portion of long-term debt	2,379	6,456	9,021	1,602	-	-	-	-	-	19,458	-	19,458
Accrued interest	469	2,305	426	96	-	-	-	-	-	3,296	-	3,296
Total current liabilities	1,297,216	75,778	34,607	48,110	6,301	18,359	61	30,379	84	1,510,895	(1,164,538)	346,357
Long-term liabilities	70,832	14,532	4,417	19,511	1,133	265	12,043	10,795	572	134,100	(28,269)	105,831
Reserves for professional and general liabilities	2,201	-	-	-	-	-	13,905	-	-	16,106	-	16,106
Long-term debt	124,354	348,416	57,545	47,350	-	-	-	-	-	577,665	-	577,665
Total liabilities	1,494,603	438,726	96,569	114,971	7,434	18,624	26,009	41,174	656	2,238,766	(1,192,807)	1,045,959
Net assets:												
Unrestricted	(63,720)	1,182,575	141,807	496,502	32,680	47,213	180	4,277	1,833	1,843,347	(7,728)	1,835,619
Temporarily restricted	37,400	-	-	14,484	(1,762)	-	-	36,400	14,484	101,006	(51,884)	49,122
Permanently restricted	4,969	-	-	1,074	-	-	-	4,969	1,074	12,086	(6,043)	6,043
Total net assets	(21,351)	1,182,575	141,807	512,060	30,918	47,213	180	45,646	17,391	1,956,439	(65,655)	1,890,784
Total liabilities and net assets	\$ 1,473,252	\$ 1,621,301	\$ 238,376	\$ 627,031	\$ 38,352	\$ 65,837	\$ 26,189	\$ 86,820	\$ 18,047	\$ 4,195,205	\$ (1,258,462)	\$ 2,936,743

Sharp HealthCare

Combining Statement of Operations

(In Thousands)

Year Ended September 30, 2013

	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
Revenues:												
Patient service revenue	\$ 131,353	\$ 950,709	\$ 271,433	\$ 581,669	\$ 69,362	\$ –	\$ –	\$ –	\$ –	\$ 2,004,526	\$ (339,717)	\$ 1,664,809
Provider tax revenue	–	52,767	36,171	49,355	7,036	–	–	–	–	145,329	–	145,329
Provision for doubtful accounts	(4,314)	(10,579)	(3,327)	(9,410)	(484)	–	–	–	–	(28,114)	–	(28,114)
Net patient service	127,039	992,897	304,277	621,614	75,914	–	–	–	–	2,121,741	(339,717)	1,782,024
Premium	771,495	–	–	–	–	320,392	–	–	–	1,091,887	(138,693)	953,194
Other	230,255	13,209	8,241	12,147	3,879	1,049	7,508	–	–	276,288	(181,703)	94,585
Total revenues	1,128,789	1,006,106	312,518	633,761	79,793	321,441	7,508	–	–	3,489,916	(660,113)	2,829,803
Expenses:												
Salaries and wages	261,884	342,166	125,190	236,687	35,154	7,746	–	–	–	1,008,827	–	1,008,827
Employee benefits	69,729	80,724	29,143	56,910	8,521	1,783	–	–	–	246,810	–	246,810
Medical fees	228,066	11,889	4,524	8,955	617	291,351	–	–	–	545,402	(157,836)	387,566
Purchased services	110,462	62,187	25,528	49,580	6,623	8,857	167	–	–	263,404	(4,103)	259,301
Supplies	43,362	141,538	39,338	83,523	10,613	291	–	–	–	318,665	(7)	318,658
Provider tax	–	39,078	24,697	39,532	2,780	–	–	–	–	106,087	–	106,087
Maintenance, utilities and rentals	60,463	28,662	7,669	16,059	3,153	940	–	–	–	116,946	(3,572)	113,374
Depreciation and amortization	39,147	42,192	12,841	22,971	3,145	479	6	–	–	120,781	(22,231)	98,550
Business Insurance	5,434	2,537	902	2,129	222	107	7,295	–	–	18,626	(7,295)	11,331
Interest	5,403	15,100	3,410	1,788	–	1	–	–	–	25,702	(2,452)	23,250
Purchased services from affiliate	328,716	84,461	30,417	56,318	6,738	2,894	27	–	–	509,571	(509,571)	–
Other	13,819	7,218	2,298	3,917	789	2,514	55	–	–	30,610	–	30,610
Total expenses	1,166,485	857,752	305,957	578,369	78,355	316,963	7,550	–	–	3,311,431	(707,067)	2,604,364
Income (loss) from operations	(37,696)	148,354	6,561	55,392	1,438	4,478	(42)	–	–	178,485	46,954	225,439
Other non-operating income (loss)	211	508	18	(958)	(53)	35	–	(106)	120	(225)	160	(65)
Investment income	57,525	34,621	13,086	14,656	2,607	2,614	42	1,743	627	127,521	(47,114)	80,407
Excess (deficit) of revenues over expenses	20,040	183,483	19,665	69,090	3,992	7,127	–	1,637	747	305,781	–	305,781
Net assets transferred from related party	–	–	–	31,174	–	–	–	–	–	31,174	–	31,174
Net assets released from restrictions used for purchase of property, plant and equipment	1,028	2,448	1,027	1,057	–	–	–	–	–	5,560	–	5,560
Pension related changes other than net periodic pension cost	6,653	8,912	2,486	5,829	658	124	–	–	–	24,662	–	24,662
Other changes in net assets	1,637	–	–	258	859	–	–	–	(667)	2,087	(1,719)	368
Increase (decrease) in unrestricted net assets	\$ 29,358	\$ 194,843	\$ 23,178	\$ 107,408	\$ 5,509	\$ 7,251	\$ –	\$ 1,637	\$ 80	\$ 369,264	\$ (1,719)	\$ 367,545

Sharp HealthCare

Combining Statement of Changes in Net Assets (In Thousands)

Year Ended September 30, 2013

	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 (deficit) of revenues over expenses	\$ 20,040	\$ 183,483	\$ 19,665	\$ 69,090	\$ 3,992	\$ 7,127	\$ –	\$ 1,637	\$ 747	\$ 305,781	\$ –	\$ 305,781
Net assets transferred from related party	–	–	–	31,174	–	–	–	–	–	31,174	–	31,174
Net assets released from restrictions used for purchase of property, plant and equipment	1,028	2,448	1,027	1,057	–	–	–	–	–	5,560	–	5,560
Pension related changes other than net periodic pension cost	6,653	8,912	2,486	5,829	658	124	–	–	–	24,662	–	24,662
Other changes in net assets	1,637	–	–	258	859	–	–	–	(667)	2,087	(1,719)	368
Increase (decrease) in unrestricted net assets	29,358	194,843	23,178	107,408	5,509	7,251	–	1,637	80	369,264	(1,719)	367,545
Temporarily restricted net assets:												
Contributions	–	–	–	–	–	–	–	5,099	3,641	8,740	–	8,740
Investment income	–	–	–	–	–	–	–	1,065	258	1,323	–	1,323
Change in net unrealized gains (losses) on other than trading securities	–	–	–	–	–	–	–	459	100	559	–	559
Net assets released from restrictions	–	–	–	–	–	–	–	(7,933)	(1,654)	(9,587)	–	(9,587)
Other	(1,310)	–	–	3,012	251	–	–	–	667	2,620	(1,701)	919
Increase (decrease) in temporarily restricted net assets	(1,310)	–	–	3,012	251	–	–	(1,310)	3,012	3,655	(1,701)	1,954
Permanently restricted net assets:												
Contributions	–	–	–	–	–	–	–	480	1	481	–	481
Other	480	–	–	–	–	–	–	–	–	480	(480)	–
Increase (decrease) in permanently restricted net assets	480	–	–	–	–	–	–	480	1	961	(480)	481
Increase (decrease) in net assets	28,528	194,843	23,178	110,420	5,760	7,251	–	807	3,093	373,880	(3,900)	369,980
Net assets, beginning of the year	(49,879)	987,732	118,629	401,640	25,158	39,962	180	44,839	14,298	1,582,559	(61,755)	1,520,804
Net assets, end of the year	\$ (21,351)	\$ 1,182,575	\$ 141,807	\$ 512,060	\$ 30,918	\$ 47,213	\$ 180	\$ 45,646	\$ 17,391	\$ 1,956,439	\$ (65,655)	\$ 1,890,784

Sharp HealthCare

Combining Balance Sheet – Obligated Group (In Thousands)

As of September 30, 2013

	Sharp HealthCare	Sharp Memorial Hospital	Sharp Chula Vista Medical Center	Grossmont Hospital Corporation	Combined Totals	Combining Eliminations	Totals
Assets							
Current assets:							
Cash and cash equivalents	\$ 139,001	\$ 1,081	\$ 1,960	\$ 8,894	\$ 150,936	\$ –	\$ 150,936
Short-term investments	39,459	–	–	13,067	52,526	–	52,526
Accounts receivable, net	20,831	137,443	46,116	76,611	281,001	(1,003)	279,998
Estimated settlements receivable from government programs, net	–	(781)	(1,146)	7,532	5,605	–	5,605
Intercompany receivables	(1,131,895)	1,041,479	110,887	–	20,471	447	20,918
Inventories	7,276	14,820	5,362	10,707	38,165	–	38,165
Prepaid expenses and other	34,835	3,054	1,998	5,012	44,899	–	44,899
Total current assets	(890,493)	1,197,096	165,177	121,823	593,603	(556)	593,047
Assets limited as to use:							
Designated for property	902,598	–	–	236,644	1,139,242	–	1,139,242
Under bond indentures	669	14,157	1,084	625	16,535	–	16,535
Other restricted investments	–	–	–	–	–	–	–
Under self-insurance programs	–	–	–	–	–	–	–
Total assets limited as to use	903,267	14,157	1,084	237,269	1,155,777	–	1,155,777
Property and equipment, net	251,961	406,838	68,924	248,072	975,795	–	975,795
Unamortized financing costs	1,984	3,182	726	443	6,335	–	6,335
Other assets	28,993	28	2,465	1,658	33,144	(4)	33,140
Beneficial interest in foundations	45,645	–	–	17,392	63,037	–	63,037
Total assets	\$ 341,357	\$ 1,621,301	\$ 238,376	\$ 626,657	\$ 2,827,691	\$ (560)	\$ 2,827,131

Sharp HealthCare

Combining Balance Sheet – Obligated Group (continued)

(In Thousands)

As of September 30, 2013

	Sharp HealthCare	Sharp Memorial Hospital	Sharp Chula Vista Medical Center	Grossmont Hospital Corporation	Combined Totals	Combining Eliminations	Totals
Liabilities and net assets							
Current liabilities:							
Accounts payable and accrued liabilities	\$ 120,237	\$ 23,358	\$ 8,950	\$ 15,920	\$ 168,465	\$ (1,003)	\$ 167,462
Intercompany payable	–	–	–	(374)	(374)	447	73
Accrued compensation and benefits	42,236	43,659	16,210	30,492	132,597	–	132,597
Current portion of long-term debt	2,379	6,456	9,021	1,602	19,458	–	19,458
Accrued interest	469	2,305	426	96	3,296	–	3,296
Total current liabilities	165,321	75,778	34,607	47,736	323,442	(556)	322,886
Long-term liabilities	70,832	14,532	4,417	19,511	109,292	(4)	109,288
Reserves for professional and general liabilities	2,201	–	–	–	2,201	–	2,201
Long-term debt	124,354	348,416	57,545	47,350	577,665	–	577,665
Total liabilities	362,708	438,726	96,569	114,597	1,012,600	(560)	1,012,040
Net assets:							
Unrestricted	(63,720)	1,182,575	141,807	496,502	1,757,164	–	1,757,164
Temporarily restricted	37,400	–	–	14,484	51,884	–	51,884
Permanently restricted	4,969	–	–	1,074	6,043	–	6,043
Total net assets	(21,351)	1,182,575	141,807	512,060	1,815,091	–	1,815,091
Total liabilities and net assets	\$ 341,357	\$ 1,621,301	\$ 238,376	\$ 626,657	\$ 2,827,691	\$ (560)	\$ 2,827,131

Sharp HealthCare

Combining Statement of Operations – Obligated Group

(In Thousands)

Year Ended September 30, 2013

	Sharp HealthCare	Sharp Memorial Hospital	Sharp Chula Vista Medical Center	Grossmont Hospital Corporation	Combined Totals	Combining Eliminations	Totals
Revenues:							
Patient service revenue	\$ 131,353	\$ 950,709	\$ 271,433	\$ 581,669	\$ 1,935,164	\$ (326,387)	\$ 1,608,777
Provider tax revenue	–	52,767	36,171	49,355	138,293	–	138,293
Provision for doubtful accounts	(4,314)	(10,579)	(3,327)	(9,410)	(27,630)	–	(27,630)
Net patient service	127,039	992,897	304,277	621,614	2,045,827	(326,387)	1,719,440
Premium	771,495	–	–	–	771,495	–	771,495
Other	230,255	13,209	8,241	12,147	263,852	(164,693)	99,159
Total revenues	1,128,789	1,006,106	312,518	633,761	3,081,174	(491,080)	2,590,094
Expenses:							
Salaries and wages	261,884	342,166	125,190	236,687	965,927	–	965,927
Employee benefits	69,729	80,724	29,143	56,910	236,506	–	236,506
Medical fees	228,066	11,889	4,524	8,955	253,434	(11,235)	242,199
Purchased services	110,462	62,187	25,528	49,580	247,757	(3,120)	244,637
Supplies	43,362	141,538	39,338	83,523	307,761	(7)	307,754
Provider tax	–	39,078	24,697	39,532	103,307	–	103,307
Maintenance, utilities and rentals	60,463	28,662	7,669	16,059	112,853	(3,027)	109,826
Depreciation and amortization	39,147	42,192	12,841	22,971	117,151	(21,143)	96,008
Business Insurance	5,434	2,537	902	2,129	11,002	–	11,002
Interest	5,403	15,100	3,410	1,788	25,701	(2,427)	23,274
Purchased services from affiliate	328,716	84,461	30,417	56,318	499,912	(494,623)	5,289
Other	13,819	7,218	2,298	3,917	27,252	–	27,252
Total expenses	1,166,485	857,752	305,957	578,369	2,908,563	(535,582)	2,372,981
Income (loss) from operations	(37,696)	148,354	6,561	55,392	172,611	44,502	217,113
Other non-operating income (loss)	211	508	18	(958)	(221)	–	(221)
Investment income	57,525	34,621	13,086	14,656	119,888	(44,502)	75,386
Excess of revenues over expenses	20,040	183,483	19,665	69,090	292,278	–	292,278
Net assets transferred from related party	–	–	–	31,174	31,174	–	31,174
Net assets released from restrictions used for purchase of property, plant and equipment	1,028	2,448	1,027	1,057	5,560	–	5,560
Pension-related changes other than net periodic pension cost	6,653	8,912	2,486	5,829	23,880	–	23,880
Other changes in net assets	1,637	–	–	258	1,895	–	1,895
Increase in unrestricted net assets	\$ 29,358	\$ 194,843	\$ 23,178	\$ 107,408	\$ 354,787	\$ –	\$ 354,787

Sharp HealthCare

Combining Statement of Changes in Net Assets – Obligated Group

(In Thousands)

Year Ended September 30, 2013

	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	\$ 20,040	\$ 183,483	\$ 19,665	\$ 69,090	\$ 292,278	\$ –	\$ 292,278
Net assets transferred from related-party	–	–	–	31,174	31,174	–	31,174
Net assets released from restrictions used for purchase of property, plant and equipment	1,028	2,448	1,027	1,057	5,560	–	5,560
Pension-related changes other than net periodic pension cost	6,653	8,912	2,486	5,829	23,880	–	23,880
Other changes in net assets	1,637	–	–	258	1,895	–	1,895
Increase in unrestricted net assets	29,358	194,843	23,178	107,408	354,787	–	354,787
Temporarily restricted net assets:							
Other changes in net assets	(1,310)	–	–	3,012	1,702	–	1,702
Increase in temporarily restricted net assets	(1,310)	–	–	3,012	1,702	–	1,702
Permanently restricted net assets:							
Other changes in net assets	480	–	–	–	480	–	480
Increase in permanently restricted net assets	480	–	–	–	480	–	480
Increase in net assets	28,528	194,843	23,178	110,420	356,969	–	356,969
Net assets (deficit), beginning of the year	(49,879)	987,732	118,629	401,640	1,458,122	–	1,458,122
Net assets (deficit), end of the year	\$ (21,351)	\$ 1,182,575	\$ 141,807	\$ 512,060	\$ 1,815,091	\$ –	\$ 1,815,091

Ernst & Young LLP

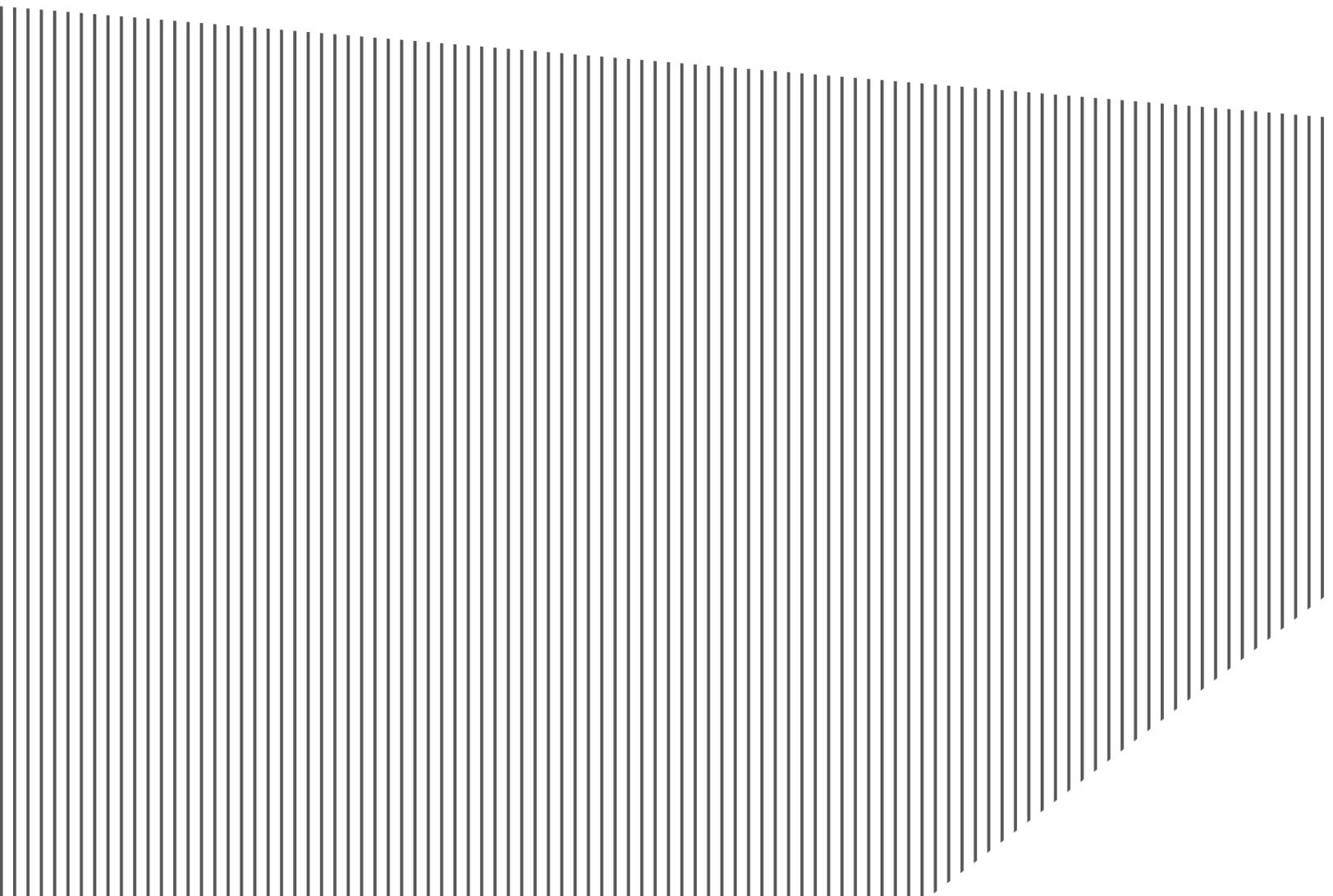
Assurance | Tax | Transactions | Advisory

About Ernst & Young

Ernst & Young is a global leader in assurance, tax, transaction and advisory services. Worldwide, our 167,000 people are united by our shared values and an unwavering commitment to quality. We make a difference by helping our people, our clients and our wider communities achieve their potential.

For more information, please visit www.ey.com.

Ernst & Young refers to the global organization of member firms of Ernst & Young Global Limited, each of which is a separate legal entity. Ernst & Young Global Limited, a UK company limited by guarantee, does not provide services to clients. This Report has been prepared by Ernst & Young LLP, a client serving member firm located in the United States.



[THIS PAGE INTENTIONALLY LEFT BLANK]

APPENDIX C

SUMMARY OF PRINCIPAL DOCUMENTS

[THIS PAGE INTENTIONALLY LEFT BLANK]

APPENDIX C

SUMMARY OF PRINCIPAL DOCUMENTS

The following is a summary of certain provisions of the Master Indenture, Supplemental Master Indenture No. 34, 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.

Additional Payments means the payments so designated and required to be made by the Corporation pursuant to the Loan Agreement.

Authorized Representative means, (1) with respect to the Issuer, the President, Chief Financial Officer or Secretary of the Issuer or any other person designated as an Authorized Representative of the Issuer by a Statement of the Issuer signed by said President, Chief Financial Officer or Secretary and filed with the Bond Trustee and (2) with respect to the Corporation, its President, Vice President, Chief Executive Officer, Chief Financial Officer, Secretary, Assistant Secretary, Treasurer or Assistant Treasurer, or any other person designated as an Authorized Representative of the Corporation in a Certificate of the Corporation, signed by said President, Vice President, Chief Executive Officer, Chief Financial Officer, Secretary, Assistant Secretary, Treasurer or Assistant Treasurer and filed with the Bond Trustee.

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.

“Certificate,” “Statement,” “Request” and “Requisition” of the Issuer or the Corporation means, respectively, a written certificate, statement, request or requisition signed in the name of the Issuer by an Authorized Representative of the Issuer, or in the name of the Corporation by an Authorized Representative of the Corporation, respectively. Any such instrument and supporting opinions or representations, if any, may, but need not, be combined in a single instrument with any other instrument, opinion or representation, and the two or more so combined shall be read and construed as a single instrument.

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.

Continuing Disclosure Agreement means any continuing disclosure agreement or certificate executed by the Corporation pursuant to the Loan Agreement which complies with S.E.C. Rule 15c2-12.

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:

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

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.

Guaranty means all loan commitments and all obligations of any Member guaranteeing in any manner whatever, whether directly or indirectly, any obligation of any other Person which would, if such other Person were a Member, constitute Indebtedness.

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

Holder whenever used with respect to an Obligation, means the registered owner of any Obligation in registered form or the bearer of any obligation in coupon form which is not registered or is registered to bearer.

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 at 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.

Loan Repayments means the payments so designated and required to be made by the Corporation pursuant to the Loan Agreement.

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.

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. 34 means the obligation issued under the Master Indenture and Supplement No. 34.

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 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 Master Indenture, acceptable to the Master Trustee.

Outstanding, for purposes of the Master Indenture when used with reference to Indebtedness, means, as of any date of determination, all Indebtedness theretofore issued or incurred and not paid and discharged other than (1) Obligations theretofore cancelled by the Master Trustee or delivered to the Master Trustee for cancellation, (2) Obligations in lieu of which other Obligations have been authenticated and delivered or have been paid pursuant to the provisions of a Related Supplement regarding mutilated, destroyed, lost or stolen Obligations unless proof satisfactory to the Master Trustee has been received that any such Obligation is held by a bona fide purchaser, (3) any Obligation held by any Member of the Obligated Group, (4) Indebtedness deemed paid and no longer outstanding pursuant to the terms thereof and (5) Indebtedness for which the payment of the principal amount thereof shall have been provided for by the deposit in an irrevocable escrow of Government Obligations in an amount sufficient to pay the principal of such Indebtedness as it shall become due and payable; provided, however, that if two or more obligations which constitute Indebtedness represent the same underlying obligation (as when an Obligation secures an issue of Related Bonds and another Obligation secures repayment obligations to a bank under a letter of credit or other credit facility which secures such Related Bonds) for purposes of the various financial covenants contained in the Master Indenture, but only for such purposes, only one of such Obligations shall be deemed Outstanding and the Obligation so deemed to be Outstanding shall be that Obligation which produces the greatest aggregate principal amount.

Outstanding, when used as of any particular time with reference to Bonds, means (subject to the provisions of the Bond Indenture with respect to disqualified Bonds) 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.

Person shall include an individual, association, unincorporated organization, corporation, partnership, joint venture, any state, the United States or any agency, instrumentality or political subdivision of any state or of the United States.

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. 34, 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 of the Issuer or the Bonds Trustee 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.

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.

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.

Supplement No. 34 means that certain supplemental master trust indenture, dated as of February 1, 2014, between the Corporation and the Master Trustee, pursuant to which Obligation No. 34 is issued.

Tax Agreement means the Tax Certificate and Agreement delivered by the Issuer and the Corporation at the time of issuance and delivery of the Bonds, as the same may be amended or supplemented in accordance with its terms.

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 that 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 entirety 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. 34” 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. 34

The following is a summary of certain provisions of Supplemental Master Indenture for Obligation No. 34 (“Supplement No. 34”). 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. 34.

Payments on Obligation No. 34; Credits

Principal of and interest and any applicable redemption premium on Obligation No. 34 are payable in any coin or currency of the United States of America that on the payment date is legal tender for the payment of public and private debts. Except as provided in Supplement No. 34 and described in the following paragraph with respect to credits, and the section of Supplement No. 34 regarding prepayment, payments on the principal of and premium, if any, and interest on Obligation No. 34 shall be made at the times and in the amounts specified in Obligation No. 34 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. 34, that specifies the amount paid and identifying such payment as a payment on Obligation No. 34.

The Obligated Group shall receive credit for payment on Obligation No. 34, in addition to any credits resulting from payment or prepayment from other sources, as follows:

(i) On installments of interest on Obligation No. 34 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. 34 or any other Obligation;

(ii) On installments of principal of Obligation No. 34 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. 34 or any other Obligation;

(iii) On installments of principal of and interest on Obligation No. 34 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. 34 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. 34 that would have been used, but for such 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. 34, 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. 34 that 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. 34

So long as all amounts that have become due under Obligation No. 34 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. 34. 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, credited against payments due under Obligation No. 34 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. 34 remain unpaid, the Obligated Group shall not be relieved of its obligations under Supplement No. 34.

Registration, Number, Negotiability and Transfer of Obligation No. 34

Except as provided in Supplement No. 34 and as described in the following paragraph, so long as any Bond remains Outstanding, Obligation No. 34 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. 34 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. 34 may be transferred, if and to the extent the Bond Trustee requests that the restrictions of Supplement No. 34 described in the preceding paragraph on transfers be terminated.

Modifications to Certain Covenants of the Master Indenture While Obligation No. 34 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. 34, as described below, unless subsequently modified or waived by the Holder of Obligation No. 34.

An additional covenant relating to the **Debt Service Coverage Ratio** of the Obligated Group is added so long as Obligation No. 34 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. 34) 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. 34 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 Master 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 Master 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 Master 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. 34 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. 34 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. 34 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. 34 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 Project Fund, 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. 34.

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. 34 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 or before 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 or Sinking Fund Installment becoming due and payable on the Outstanding Bonds on the next succeeding principal payment date or Sinking Fund Installment 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 to pay Sinking Fund Installments or pay the principal of the Bonds when due.

On each Sinking Fund Installment date established pursuant to the Bond Indenture, the Bond Trustee shall apply the Sinking Fund Installment required on that date to the redemption (or payment at maturity, as the case may be) of Bonds, upon the notice and in the manner provided in the Bond Indenture; provided that, at any time prior to giving such notice of such redemption, the Bond Trustee may apply moneys in the Principal Account 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 directed in writing by the Corporation, except that the purchase price (excluding accrued interest) shall not exceed the par amount of the Bonds so purchased. If, during the twelve-month period immediately preceding a Sinking Fund Installment payment date, the Bond Trustee has purchased Bonds with moneys in the Principal Account, or, during said period and prior to giving said notice of redemption, the Corporation has deposited Bonds with the Bond Trustee (together with a Request of the Corporation, to apply such Bonds to the Sinking Fund Installment due on said date), or Bonds were at any time

purchased or redeemed by the Bond Trustee from the Redemption Fund and allocable to said Sinking Fund Installment, such Bonds shall be applied, to the extent of the full principal amount thereof, to reduce said Sinking Fund Installment. All Bonds purchased or deposited pursuant to this subsection, if any, shall be cancelled by the Bond Trustee. Bonds purchased from the Principal Account, purchased or redeemed from the Redemption Fund, or deposited by the Corporation with the Bond Trustee shall be allocated first to the next succeeding Sinking Fund Installment, then as a credit against such future Sinking Fund Installments as the Corporation may specify in writing.

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 Corporation 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 responsibilities under the Bond Indenture. 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, 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, and upon receipt of indemnification satisfactory to it, 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 Supplement No. 34 with respect to continuing disclosure or to cause the Bond Trustee to comply with its obligations under the Bond Indenture.

Amendment of Loan Agreement

Except as provided in the paragraph below, the Issuer shall not amend, modify or terminate any of the terms of the Loan Agreement, or consent to any such amendment, modification or termination unless the written consent of the Holders of a majority in principal amount of the Bonds then Outstanding to such amendment, modification or termination is filed with the Bond Trustee, provided that no such amendment, modification or termination shall reduce the amount of Loan Repayments to be made to the Issuer or the Bond Trustee by the Corporation pursuant to the Loan Agreement, or extend the time for making such payments, without the written consent of all of the Holders of the Bonds then Outstanding.

Notwithstanding the provisions described in the paragraph above, the terms of the Loan Agreement may also be modified or amended from time to time and at any time by the Issuer without the necessity of obtaining the consent of any Bondholders, only to the extent permitted by law and only for any one or more of the following purposes: (1) to add to the covenants and agreements of the Issuer or the Corporation contained in the Loan Agreement other covenants and agreements thereafter to be observed, to pledge or assign additional security for the Bonds (or any portion thereof), or to surrender any right or power therein reserved to or conferred upon the Issuer or the Corporation, provided, that no such covenant, agreement, pledge, assignment or surrender shall materially adversely affect the interests of the Holders of the Bonds; (2) to make such provisions for the purpose of curing any ambiguity, inconsistency or omission, or of curing or correcting any defective provision, contained in the Loan Agreement, or in regard to matters or questions arising under the Loan Agreement, as the Issuer may deem necessary or desirable and not inconsistent with the Loan Agreement or the Bond Indenture, and which shall not materially adversely affect the interests of the Holders of the Bonds; or (3) to maintain the exclusion from gross income of interest payable with respect to the Bonds.

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 of any Bonds from Sinking Fund installments in the amount and 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 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. 34 and request the Master Trustee in writing to give notice pursuant to the Master Indenture to the Members 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. 34; (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. 34 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. 34 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. 34, 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. 34, 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 and 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. 34.

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 at the direction of the Corporation in (i) the Principal Account created under the Bond Indenture, (ii) the Optional Redemption Account created under the Bond Indenture, (iii) the Special Redemption Account created under the Bond Indenture or (iv) such other Bond Trustee escrow account as may be 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. 34, Obligation No. 34, 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 the Bond Trustee to the Corporation.

Events of Default

The following events shall be Loan Default Events under the Loan Agreement: (1) failure by the Corporation to pay in full any payment required under the Loan Agreement or of the Obligated Group to pay in full any payment required under Obligation No. 34 when due, whether on an interest payment date, at maturity, upon a date fixed for prepayment, by declaration, or otherwise pursuant to the terms of the Loan Agreement or Obligation No. 34; (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. 34 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.

[THIS PAGE INTENTIONALLY LEFT BLANK]

APPENDIX D

**PROPOSED FORM OF OPINION OF BOND
COUNSEL**

[THIS PAGE INTENTIONALLY LEFT BLANK]

APPENDIX D

PROPOSED FORM OF OPINION OF BOND COUNSEL

[Delivery Date]

ABAG Finance Authority
for Nonprofit Corporations
Oakland, California

ABAG Finance Authority for Nonprofit Corporations
Revenue Bonds (Sharp HealthCare), Series 2014A
(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 \$159,485,000 aggregate principal amount of ABAG Finance Authority for Nonprofit Corporations Revenue Bonds (Sharp HealthCare), Series 2014A (the “Bonds”), issued pursuant to a bond indenture, dated as of February 1, 2014 (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 stated purpose of making a loan of the proceeds thereof to Sharp HealthCare (the “Corporation”) pursuant to a loan agreement, dated as of February 1, 2014 (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 Agreement; opinions of counsel to the Authority and the 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, P.C., 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 or refinanced 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 or refinanced 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 letter speaks only as of its date and is not intended to, and may not, be relied upon or otherwise used 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 Agreement, 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 Agreement and their enforceability may be subject to bankruptcy, insolvency, receivership, 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, liquidated damages, penalty (including any remedy deemed to constitute a penalty), right of set-off, arbitration, judicial reference, choice of law, choice of forum, choice of venue, non-exclusivity of remedies, 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. Our services did not include financial or other non-legal advice. Finally, we undertake no responsibility for the accuracy, completeness or fairness of the Official Statement, dated January 23, 2014, or other offering material relating to the Bonds and express no opinion with respect thereto.

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 amount, accrual or receipt of interest on, the Bonds.

Faithfully yours,

ORRICK, HERRINGTON & SUTCLIFFE LLP

per

[THIS PAGE INTENTIONALLY LEFT BLANK]

APPENDIX E
BOOK-ENTRY ONLY SYSTEM

[THIS PAGE INTENTIONALLY LEFT BLANK]

BOOK-ENTRY ONLY 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 Underwriters 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 a Standard & Poor’s rating of AA+. 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.

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 Bond Trustee 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). In that event, Bond certificates will be printed and delivered to DTC.

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 2014A 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 UNDERWRITERS 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 Underwriters 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.

THE INFORMATION PROVIDED ABOVE HAS BEEN PROVIDED BY DTC. NO REPRESENTATION IS MADE BY THE AUTHORITY, THE BOND TRUSTEE, THE MASTER TRUSTEE, THE OBLIGATED GROUP OR THE UNDERWRITERS AS TO THE ACCURACY OR ADEQUACY OF SUCH INFORMATION PROVIDED BY DTC NOR AS TO THE ABSENCE OF MATERIAL ADVERSE CHANGES IN SUCH INFORMATION SUBSEQUENT TO THE DATE HEREOF.

[THIS PAGE INTENTIONALLY LEFT BLANK]

[THIS PAGE INTENTIONALLY LEFT BLANK]

[THIS PAGE INTENTIONALLY LEFT BLANK]

