**NEW ISSUE—BOOK-ENTRY ONLY**

**RATING: Moody's: A3**
**(See "RATING" herein)**

*In the opinion of Quint & Thimmig LLP, San Francisco, California, Bond Counsel, subject to compliance by the District with certain covenants, under present law, interest on the Bonds is excludable from gross income of the owners thereof for federal income tax purposes and is not included as an item of tax preference in computing the federal alternative minimum tax for individuals and corporations, but such interest is taken into account in computing an adjustment used in determining the federal alternative minimum tax for certain corporations. In addition, in the opinion of Bond Counsel, interest on the Bonds is exempt from personal income taxation imposed by the State of California. See "LEGAL MATTERS—Tax Matters" herein.*

# $23,875,000*
# SAN GORGONIO MEMORIAL HEALTHCARE DISTRICT
# (RIVERSIDE COUNTY, CALIFORNIA)
# 2013 GENERAL OBLIGATION REFUNDING BONDS

**Dated: Date of Delivery** **Due: August 1 as shown below**

The issuance of general obligation bonds in an aggregate amount not to exceed $108,000,000 by the San Gorgonio Memorial Healthcare District (the "District") was authorized at an election of the registered voters of the District held on March 28, 2006, by more than two-thirds (76%) of the persons voting on the measure. Pursuant to the laws of the State of California (the "State"), the District issued an initial series of such bonds in the amount of $25,000,000 on August 3, 2006 (the "2006 Bonds"), issued a second series of such bonds in the amount of $25,000,000 on August 19, 2008 (the "2008 Bonds"), and issued a third series of such bonds in the amount of $58,000,000 on August 11, 2009 (the "2009 Bonds"). The District is issuing this series of such bonds in the amount of $23,875,000*, known as the San Gorgonio Memorial Healthcare District (Riverside County, California), 2013 General Obligation Refunding Bonds (the "Bonds"). See "THE BONDS - Authority for Issuance" herein.

Proceeds of the Bonds will be used to advance refund a portion of the 2006 Bonds. See "REFINANCING PLAN" herein.

The Bonds represent the general obligation of the District. The District is empowered and obligated to cause to be levied *ad valorem* taxes, without limitation of rate or amount, upon all property within the District subject to taxation by the District (except certain personal property which is taxable at limited rates), for the payment of interest on and principal of the Bonds when due.

The Bonds will be issued in book-entry form only and will be initially issued and registered in the name of Cede & Co. as nominee for The Depository Trust Company, New York, New York ("DTC"). DTC will act as securities depository of the Bonds. Individual purchases of the Bonds will be made in book-entry form only. Purchasers will not receive physical delivery of the Bonds purchased by them. Payments of the principal of and interest on the Bonds will be made by The Bank of New York Mellon Trust Company, N. A., Los Angeles, California, as the paying agent, registrar and transfer agent (the "Paying Agent"), to DTC for subsequent disbursement through DTC Participants (defined herein) to the beneficial owners of the Bonds. See "THE BONDS - Book-Entry System" herein.

The Bonds will be dated the date of their delivery, and will accrue interest from such date, which interest is payable semiannually on each February 1 and August 1, commencing August 1, 2013. The Bonds are issuable in denominations of $5,000 or any integral multiple thereof.

**The Bonds are subject to redemption prior to their respective maturity dates as described herein. See "THE BONDS - Redemption Provisions" herein.**

The following firm served as financial advisor to the District on this financing:

## G.L. Hicks Financial, LLC

**MATURITY SCHEDULE•**

| Maturity (August 1) | Principal Amount | Interest Rate | Price or Yield | CUSIP† | Maturity (August 1) | Principal Amount | Interest Rate | Price or Yield | CUSIP† |
|---|---|---|---|---|---|---|---|---|---|
| 2014 | $240,000 | | | | 2026 | $1,020,000 | | | |
| 2015 | 280,000 | | | | 2027 | 1,100,000 | | | |
| 2016 | 330,000 | | | | 2028 | 1,195,000 | | | |
| 2017 | 375,000 | | | | 2029 | 1,290,000 | | | |
| 2018 | 435,000 | | | | 2030 | 1,410,000 | | | |
| 2019 | 490,000 | | | | 2031 | 1,535,000 | | | |
| 2020 | 545,000 | | | | 2032 | 1,665,000 | | | |
| 2021 | 610,000 | | | | 2033 | 1,810,000 | | | |
| 2022 | 675,000 | | | | 2034 | 1,960,000 | | | |
| 2023 | 755,000 | | | | 2035 | 2,115,000 | | | |
| 2024 | 835,000 | | | | 2036 | 2,285,000 | | | |
| 2025 | 920,000 | | | | | | | | |

*Bids for the purchase of the Bonds will be received by the District on February 26, 2013, until 9:00 A.M., Pacific Standard Time. The Bonds will be sold pursuant to the terms of sale set forth in the Official Notice of Sale, dated February 12, 2013.*

*This cover page contains certain information for reference only. It is not a summary of this issue. Investors must 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 issued, subject to approval as to their legality by Quint & Thimmig LLP, San Francisco, California, Bond Counsel. Certain legal matters will be passed on for the District by its counsel, Jennings, Strouss & Salmon, PLC, Phoenix, Arizona, which firm has also acted as Disclosure Counsel to the District. It is anticipated that the Bonds, in book-entry form, will be available for delivery through the facilities of DTC on or about March 12, 2013.

The date of this Official Statement is February __, 2013.

* Preliminary, subject to change.

† CUSIP date herein are provided by CUSIP Service Bureau, which is managed on behalf of the American Banker's Association by Standard & Poor's. Standard & Poor's is a business unit of the McGraw Hill Companies, Inc. The CUSIP numbers are provided for convenience and reference only.

**SAN GORGONIO MEMORIAL HEALTHCARE DISTRICT**
**RIVERSIDE COUNTY, CALIFORNIA**

**BOARD OF DIRECTORS**

Dorothy Ellis, Chair — N. Irwin Reeves, Vice Chair

Joe Dotan, MD, Secretary — Lynn Bogh Baldi, Treasurer

Ludwig Cibelli, MD, Member

**DISTRICT SENIOR MANAGEMENT**

Mark S. Turner, FACHE, Chief Executive Officer
David Recupero, Chief Financial Officer
Patricia Brown, Chief Nursing Officer
Lynn Gomez, Executive Director of Human Resources

**PROFESSIONAL SERVICES**

**District Legal Counsel and Disclosure Counsel**
Jennings, Strouss & Salmon, PLC
Phoenix, Arizona

**Independent Auditors**
Dingus, Zarecor & Associates PLLC
Spokane Valley, Washington

**Bond Counsel**
Quint & Thimmig LLP
San Francisco, California

**Financial Advisor**
G.L. Hicks Financial, LLC
Provo, Utah

**Registrar, Transfer and Paying Agent**
The Bank of New York Mellon Trust Company, N.A.
Los Angeles, California

## GENERAL INFORMATION ABOUT THIS OFFICIAL STATEMENT

**Use of Official Statement**. This Official Statement is submitted in connection with the sale of the Bonds referred to herein and may not be reproduced or used, in whole or in part, for any other purpose. This Official Statement is not to be construed as a contract with the purchasers of the Bonds.

**Estimates and Forecasts**. When used in this Official Statement and in any continuing disclosure by the District, in any press release and in any oral statement made with the approval of an authorized officer of the District, the words or phrases "will likely result," "are expected to", "will continue", "is anticipated", "estimate", "project," "forecast", "expect", "intend" and similar expressions identify "forward looking statements" within the meaning of the Private Securities Litigation Reform Act of 1995. Such statements are subject to risks and uncertainties that could cause actual results to differ materially from those contemplated in such forward-looking statements. Any forecast is subject to such uncertainties. Inevitably, some assumptions used to develop the forecasts will not be realized and unanticipated events and circumstances may occur. Therefore, there are likely to be differences between forecasts and actual results, and those differences may be material. The information and expressions of opinion herein are subject to change without notice, and neither the delivery of this Official Statement nor any sale made hereunder shall, under any circumstances, give rise to any implication that there has been no change in the affairs of the District since the date hereof.

**Limit of Offering**. No dealer, broker, salesperson or other person has been authorized by the District to give any information or to make any representations in connection with the offer or sale of the Bonds other than those contained herein and if given or made, such other information or representation must not be relied upon as having been authorized by the District or the Financial Advisor. 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 a person in any jurisdiction in which it is unlawful for such person to make such an offer, solicitation or sale.

**Resolution**. Reference is made to the Resolution, copies of which are available upon request of the District.

*This Official Statement has been "deemed final" as of its date by the District pursuant to Rule 15c2-12 of the Securities and Exchange Commission. The District has also undertaken to provide continuing disclosure on certain matters, including annual financial information and specific enumerated events, as more fully described herein under "MISCELLANEOUS - Continuing Disclosure."*

**THE BONDS HAVE NOT BEEN REGISTERED UNDER THE SECURITIES ACT OF 1933, AS AMENDED, IN RELIANCE UPON AN EXCEPTION FROM THE REGISTRATION REQUIREMENTS CONTAINED IN SUCH ACT. THE BONDS HAVE NOT BEEN REGISTERED OR QUALIFIED UNDER THE SECURITIES LAWS OF ANY STATE. THESE SECURITIES HAVE NOT BEEN RECOMMENDED BY A FEDERAL OR STATE SECURITIES COMMISSION OR REGULATORY AUTHORITY. FURTHERMORE, THE FOREGOING AUTHORITIES HAVE NOT CONFIRMED THE ACCURACY OR DETERMINED THE ADEQUACY OF THIS DOCUMENT. ANY REPRESENTATION TO THE CONTRARY IS A CRIMINAL OFFENSE.**

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**$23,875,000***
**SAN GORGONIO MEMORIAL HEALTHCARE DISTRICT**
**(RIVERSIDE COUNTY, CALIFORNIA)**
**2013 GENERAL OBLIGATION REFUNDING BONDS**

## INTRODUCTION

This Official Statement, including the cover page, the Table of Contents and the APPENDICES hereto (the "Official Statement"), is provided to furnish information with respect to the sale and delivery by the San Gorgonio Memorial Healthcare District (the "District") of $23,875,000* aggregate principal amount of its 2013 General Obligation Refunding Bonds (the "Bonds").

This Introduction is not a summary of this Official Statement. It is only a brief description of and guide to, and is qualified by, more complete and detailed information contained in the entire Official Statement, including the cover page and APPENDICES hereto, and the documents summarized or described herein. A full review should be made of the entire Official Statement. The offering of the Bonds to potential investors is made only by means of the entire Official Statement.

### The District

The District, a local health care district formed in 1947, is a political subdivision of the State of California organized pursuant to the Local Health Care District Law (formerly the Local Hospital District Law) as set forth in the California Health and Safety Code (the "District Law"). The geographic area that composes the District (includes the voting residents who elect the District's Board of Directors and passed the District's general obligation bond measure) encompasses approximately 340 square miles in the northwest portion of Riverside County (the "County") and includes the cities of Banning and Beaumont, a portion of the city of Calimesa as well as the neighboring unincorporated areas of Cabazon, Cherry Valley and Whitewater. The 2012 population of the cities of Banning and Beaumont and Riverside County has been estimated to be approximately 30,000, 39,000 and 2,228,000, respectively. The permanent resident population of the District is approximately 85,000. The District owns San Gorgonio Memorial Hospital. See "THE DISTRICT" and "DISTRICT FINANCIAL MATTERS" herein.

### The Hospital

The San Gorgonio Memorial Hospital facility (the "Hospital") is a 77-bed general acute care hospital located in Banning, California. It is owned by the District and leased and operated by a nonprofit public benefit corporation also named San Gorgonio Memorial Hospital. See "THE HOSPITAL" herein.

### The Corporation

The District leases the Hospital to San Gorgonio Memorial Hospital (the "Corporation"), a charitable Section 501(c)(3) organization formed as a California nonprofit public benefit corporation. See "THE CORPORATION" herein.

### The Plan of Finance

Net proceeds of the Bonds will be used to advance refund a portion of the 2006 Bonds. See "REFINANCING PLAN" herein. See also "THE PROJECT" herein.

### Sources of Payment for the Bonds

The Bonds are general obligations of the District, and the District has the power, is obligated and covenants to cause to be levied *ad valorem* taxes upon all property within the District subject to taxation by the District, without limitation of rate or amount, for the payment when due of the principal of and interest on the Bonds. See "THE BONDS - Security for the Bonds" and "THE DISTRICT" herein.

* Preliminary, subject to change.

In addition, pursuant to Section 32127 of the District Law, the District is required to use moneys in its maintenance and operation fund whenever *ad valorem* taxes are insufficient to pay such principal and interest.

**Description of the Bonds**

The Bonds will be dated the date of their delivery, will be in denominations of $5,000 each, or integral multiples thereof, and will bear interest at the rate or rates shown on the cover page hereof, with interest payable semiannually on each February 1 and August 1, commencing August 1, 2013 (each an "Interest Payment Date"), during the term of the Bonds.

The Bonds will be issued in fully registered form only and will be initially 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. Individual purchases of interests in the Bonds will be available to purchasers of the Bonds (the "Beneficial Owners") under the book-entry system maintained by DTC, only through brokers and dealers who are or act through DTC Participants as described herein under "THE BONDS - Book-Entry System."

The Bonds maturing on or after August 1, 2021*, may be redeemed prior to maturity at the option of the District beginning on August 1, 2020*, and thereafter, at the redemption price of 100% of the par amount of Bonds redeemed, plus accrued interest. See "THE BONDS - Redemption Provisions" herein.

**Tax Matters**

In the opinion of Quint & Thimmig LLP, San Francisco, California, Bond Counsel, subject to compliance by the District with certain covenants, under present law, interest on the Bonds is excludable from gross income of the owners thereof for federal income tax purposes and is not included as an item of tax preference in computing the federal alternative minimum tax for individuals and corporations, but such interest is taken into account in computing an adjustment used in determining the federal alternative minimum tax for certain corporations. In addition, in the opinion of Bond Counsel, interest on the Bonds is exempt from personal income taxation imposed by the State of California. See "LEGAL MATTERS—Tax Matters" herein.

**Professionals Involved in the Offering**

All proceedings in connection with the issuance of the Bonds are subject to the approval of Bond Counsel. Bond Counsel will supply a legal opinion approving the validity of the Bonds. See "LEGAL MATTERS - Approval of Legality" herein. The Bank of New York Mellon Trust Company, N.A., Los Angeles, California, will act as paying agent and registrar for the Bonds (the "Paying Agent"). Jennings, Strouss & Salmon, PLC, Phoenix, Arizona, will act as the District's legal counsel ("District Counsel") and will also act as disclosure counsel ("Disclosure Counsel") to the District in connection with the Bonds. G.L. Hicks Financial, LLC, Provo, Utah, will act as financial advisor ("Financial Advisor") to the District for the Bonds.

**Offering and Delivery of the Bonds**

The Bonds are offered when, as and if issued, subject to approval as to their legality by Bond Counsel. It is anticipated that the Bonds in book-entry only form will be available for delivery through the facilities of DTC on or about March 12, 2013.

**Bondholders' Risks**

The Bonds are general obligations of the District and the District has the power and is obligated to cause to be levied and collected by the County annual *ad valorem* taxes for payment when due of the principal of and interest on the Bonds upon all property within the District subject to taxation by the District (except certain personal property which is taxable at limited rates) without limitation as to rate or amount. In the event *ad valorem* taxes are insufficient to pay principal and interest on the Bonds, the District is required to use moneys in its maintenance and operations fund to pay debt service on the Bonds. For more complete information regarding the District's financial

* Preliminary, subject to change.

condition and taxation of property within the District, see "DISTRICT FINANCIAL MATTERS" herein. See also "THE BONDS – Security for the Bonds" and "APPENDIX E – HEALTHCARE RISK FACTORS" herein.

**Other Information; Continuing Disclosure**

This Official Statement speaks only as of its date, and the information contained herein is subject to change. There follows in this Official Statement descriptions of the Bonds, the Resolution (hereinafter defined) and the District. The descriptions and summaries herein do not purport to be comprehensive or definitive and reference is made to each such document for the complete details of all terms and conditions. All statements herein are qualified in their entirety by reference to each such document and, with respect to certain rights and remedies, to laws and principles of equity relating to or affecting creditors' rights generally.

The District will undertake, pursuant to the Resolution and a continuing disclosure certificate, to provide annually financial information and notices of the occurrence of certain enumerated events. See "MISCELLANEOUS - Continuing Disclosure" herein.

## THE BONDS

**Authority for Issuance**

The Bonds are general obligation bonds issued pursuant to Chapter 4 of Division 23 (commencing with Section 32300) of the California Health and Safety Code and the provisions of a Resolution of the Board of Directors of the District adopted on January 8, 2013 (the "Resolution"). District voters authorized the issuance of $108,000,000 of general obligation bonds by approximately 76% of the votes cast by eligible voters within the District on March 28, 2006. The District sold $25,000,000 in general obligation bonds on July 11, 2006, which bonds were delivered on August 3, 2006 (the "2006 Bonds"), sold $25,000,000 in general obligation bonds on July 24, 2008, which bonds were delivered on August 19, 2008 (the "2008 Bonds"), and sold $58,000,000 in general obligation bonds on July 22, 2009, which bonds were delivered on August 11, 2009 (the "2009 Bonds").

**Description of the Bonds**

Interest on the Bonds accrues from the date of delivery and is payable on each Interest Payment Date. The Bonds are issuable in denominations of $5,000 or any integral multiple thereof.

Principal on the Bonds is payable in lawful money of the United States of America upon surrender of the Bonds at the principal corporate trust office of the Paying Agent. Interest on the Bonds will be paid by check of the Paying Agent mailed to the person registered as the owner thereof as of the 15th day of the month preceding each Interest Payment Date to the address listed on the registration books of the District maintained by the Paying Agent for such purpose. See the Maturity Schedule on the cover and "THE BONDS - Debt Service Schedule."

**Purpose of the Issue**

Proceeds of the Bonds will be used to advance refund a portion of the 2006 Bonds. See "THE REFINANCING PLAN" herein. See also "THE PROJECT" herein.

**Book-Entry System**

The Depository Trust Company, New York, New York, will act as securities depository for the Bonds. The Bonds will be issued as fully-registered bonds 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, and will be deposited with DTC. See 'APPENDIX D – BOOK-ENTRY SYSTEM" for a more complete discussion of DTC and the Book-Entry System.

**Sources and Uses of Funds**

The following table sets forth the estimated sources and uses of funds related to the Bonds and to pay for costs associated with the Project.

**Estimated Sources of Funds:**

| | |
|---|---|
| Principal Amount of Bonds | $_____ |
| Original Issue Premium | _____ |
| Total Sources of Funds | $_____ |

**Estimated Uses of Funds:**

| | |
|---|---|
| Deposit to Escrow Fund | $_____ |
| Deposit to Costs of Issuance Fund [(1)] | _____ |
| Underwriter's Discount | _____ |
| Total Uses of Funds | $_____ |

[(1)] Includes legal, financial advisory, consulting and Paying Agent fees, printing and other costs of issuance.

**Redemption Provisions**

*Optional Redemption*. Bonds maturing on or after August 1, 2121[*], are subject to redemption prior to their respective stated maturities, at the option of the District, in whole or in part on any date on or after August 1, 2020[*], at redemption prices equal to the principal amount of Bonds redeemed, plus accrued interest to the date fixed for redemption.

*General*. In the event of any redemption, the Paying Agent will give notice thereof by mailing a copy of the redemption notice by registered mail, postage prepaid, to the registered owner of any Bond to be redeemed at the address shown on the registration books of the District maintained by the Paying Agent, as registrar, not less than thirty (30) nor more than sixty (60) calendar days prior to the redemption date; provided, however, that failure of any owner to receive such notice, or any defect therein, shall not affect the validity of the proceedings for redemption of any Bond.

**Defeasance**

If at any time the District shall pay or cause to be paid or there shall otherwise be paid to the Beneficial Owners of all outstanding Bonds all of the principal of and interest on the Bonds at the times and in the manner provided in the Resolution, or monies and securities are deposited in advance with the Paying Agent sufficient to pay or redeem all outstanding Bonds at a date certain, then such owners shall cease to be entitled to the obligation of the District to cause Riverside County to levy and collect taxes on behalf of the District, and such obligation and all agreements and covenants of the District and of the County to such owners under the Bonds shall thereupon be satisfied and discharged and shall terminate, except only that in the event of the advance deposit of monies and securities the District shall remain liable for payment of all principal, interest and premium, if any, on the Bonds, but only out of monies or securities on deposit with the Paying Agent.

[*] Preliminary, subject to change.

**Debt Service Schedule**

The following table summarizes the annual debt service requirements for the Bonds, the 2008 Bonds and the 2009 Bonds and the aggregate debt service for all three bond issues:

| Year Ending (August 1,) | The Bonds | | | 2008 Bonds and 2009 Bonds | Aggregate Debt Service on the Bonds, 2008 Bonds and 2009 Bonds |
|---|---|---|---|---|---|
| | Principal Payment | Interest Payment | Total Debt Service | Total Debt Service | |
| 2013 | | | | $5,521,091.25 | |
| 2014 | | | | 5,789,341.25 | |
| 2015 | | | | 5,890,641.25 | |
| 2016 | | | | 5,999,741.25 | |
| 2017 | | | | 6,113,141.25 | |
| 2018 | | | | 6,216,791.25 | |
| 2019 | | | | 6,325,691.25 | |
| 2020 | | | | 6,442,016.25 | |
| 2021 | | | | 6,552,241.25 | |
| 2022 | | | | 6,671,028.75 | |
| 2023 | | | | 6,792,203.75 | |
| 2024 | | | | 6,914,753.75 | |
| 2025 | | | | 7,033,698.75 | |
| 2026 | | | | 7,156,018.75 | |
| 2027 | | | | 7,275,643.75 | |
| 2028 | | | | 7,399,668.75 | |
| 2029 | | | | 7,523,493.75 | |
| 2030 | | | | 7,650,868.75 | |
| 2031 | | | | 7,777,598.75 | |
| 2032 | | | | 7,914,348.75 | |
| 2033 | | | | 8,046,973.75 | |
| 2034 | | | | 8,180,423.75 | |
| 2035 | | | | 8,314,050.00 | |
| 2036 | | | | 8,438,915.00 | |
| 2037 | | | | 8,573,297.50 | |
| 2038 | | | | 8,704,193.75 | |
| 2039 | | | | 6,094,320.00 | |

**Registration**

The Bonds are to be issued as fully registered Bonds payable to the registered owners thereof. Transfer of ownership of a fully registered Bond or Bonds shall be made by exchanging the same for a new registered Bond or Bonds of the same maturity and in the same aggregate principal amount. All of such exchanges shall be made in such manner and upon such reasonable terms as may from time to time be determined and prescribed by the District. While the Bonds are in book-entry form, the Bonds will be registered in the name of Cede & Co. as nominee for DTC or in the name of any successor securities depository. See “THE BONDS - Book-Entry System” herein.

**Security for the Bonds**

The Bonds are general obligations of the District and the District has the power and is obligated to cause to be levied and collected by the County annual *ad valorem* taxes for payment when due of the principal of and interest on the Bonds upon all property within the District subject to taxation by the District (except certain personal property which is taxable at limited rates) without limitation as to rate or amount.

A reduction in the assessed valuation of taxable property located in the District, such as may be caused by deflation of property values, economic recession, or other economic crisis, a relocation out of the District by one or more major property owners, or the complete or partial destruction of such property caused by, among other events, an earthquake, wildfire, flood or other natural disaster, could cause a reduction in the assessed value of the District's tax roll and necessitate an unanticipated increase in the annual tax levy necessary to pay debt service on its general obligation bonds. A significant decrease in assessed valuation or a declaration of bankruptcy by the District, could delay the payment of debt service on the District's general obligation bonds. The District calculates the tax rate on an annual basis. If in any given fiscal year there are not sufficient funds on deposit to pay debt service on the general

obligation bonds for such fiscal year, the District is required to provide funds from its operations to make up any deficiencies to provide for payment of the general obligation bonds. While the levy of *ad valorem* tax to pay debt service of the Bonds and other general obligation bonds is not limited as to rate or amount, the risks discussed in this paragraph could affect a tax payor's willingness or ability to pay *ad valorem* taxes.

Over the past several years, the real estate market has seen an increased rate of mortgage delinquencies and foreclosures and, there has been a slowdown in new home and other construction. In addition, there has been a decline in the year over year rate of growth and even declines of assessed valuations in the District. For example, the total assessed valuation of real property in the District for the fiscal year 2010-11 decreased by approximately 7% as compared to fiscal year 2009-10, and the total assessed valuation for the fiscal year 2011-12 decreased by approximately 4% as compared to fiscal year 2010-11. Also, there has been an increase in property owner requests for temporary reductions in assessed valuation. However, the total assessed valuation of real property in the District for the fiscal year 2012-13 increased by approximately 2% as compared to fiscal year 2011-12. Moreover, the tax delinquencies for the District's *ad volorem* taxes has decreased from a high of 9.7% in the fiscal year 2007-08 to a low of 3.9% in the fiscal year 2011-12, the most current year for which information is available.

Pursuant to Section 32127 of the District Law, the District is required to use moneys in its maintenance and operation fund whenever *ad valorem* taxes are insufficient to pay such principal and interest on the Bonds. The healthcare operations of the District are subject to their own risks. See "APPENDIX E – Healthcare Risk Factors" attached to this Official Statement.

## THE PROJECT

On March 28, 2006, general obligation bonds totaling $108,000,000 were authorized for issuance by the District upon the vote of more than two-thirds of the registered voters of the District voting on Measure "A." These general obligations bonds have been issued for the total authorized amount (comprised of the 2006 Bonds, the 2008 Bonds and the 2009 Bonds, also referred to herein as the "General Obligation Bonds"). The Bonds will be used to refund all but the August 1, 2013, maturity of the 2006 Bonds.

Proceeds from the 2006 Bonds, the 2008 Bonds and the 2009 Bonds have been used to finance the construction, expansion, equipping and renovation of the Hospital and related facilities (the "Project"). Work on the Project began in July 2006, has been undertaken in phases and is nearing completion. Major components of the Project include architectural design; cost estimating; permitting; purchase of a 64-slice CT scanner, a fluoroscopy machine and new information system; construction of an access road and helipad; replacement of underground utilities, construction of a cooling tower, parking lot and 30,000 gallon emergency sewer holding tank, steam boilers, heat exchangers, generators and natural gas storage; construction of a 39,536 square foot, two-story building with mechanical room for the Emergency Department and Intensive Care Unit, expected to open by April 2013.

For a more complete description of the Project see the Annual Report of the San Gorgonio Memorial Hospital District Measure "A" Community Oversight Committee, dated August 2012, attached as APPENDIX F.

## REFINANCING PLAN

A portion of the proceeds from the sale of the Bonds will be deposited into an escrow fund (the "Escrow Fund") to be created and maintained by The Bank of New York Mellon Trust Company, N.A., as escrow bank (the "Escrow Bank"). A portion of the moneys deposited in the Escrow Fund will be invested in U.S. Treasury Securities – State and Local Government (the "SLGS"), so that the interest thereon and the maturing principal thereof, together with uninvested cash, will be sufficient to redeem the outstanding 2006 Bonds maturing on and after August 1, 2014 (the "Refunded 2006 Bonds"), in full on August 1, 2013, at a redemption price equal to 100% of the principal amount of the Refunded 2006 Bonds.

The mathematical accuracy of the calculation as to the sufficiency of SLGS and cash in the Escrow Fund to meet the payment and redemption requirements of the Refunded 2006 Bonds will be verified by Grant Thornton LLP, Minneapolis, Minnesota (the "Verification Agent"). See "MISCELLANEOUS – Verification" herein.

## STATE CONSTITUTIONAL LIMITATIONS ON DISTRICT REVENUES AND EXPENDITURES

*The principal of and interest on the Bonds are payable from the proceeds of an ad valorem tax levied by the County for the payment thereof See "THE BONDS – Security for the Bonds" herein. Articles XIIIA, XIIIB, XHIC and XIIID of the Constitution, and certain other provisions of law discussed below, are included in this section to describe the potential effect of these Constitutional and statutory measures on the ability of the District to levy taxes and spend tax proceeds for operating and other purposes, and it should not be inferred from the inclusion of such materials that these laws impose any limitation on the ability of the District to levy ad valorem taxes for payment of the Bonds. The ad valorem tax levied by the County for payment of the Bonds was approved by the District's voters in compliance with Article XIIIA, Article XHIC, and all applicable laws.*

### Article XIIIA of the California Constitution

Article XIIIA ("Article XIIIA") of the State Constitution, adopted and known as Proposition 13, limits the amount of *ad valorem* taxes on real property to 1% of "full cash value" as determined by the county assessor. Article XIIIA defines "full cash value" to mean "the county assessor's valuation of real property as shown on the 1975-76 bill under "full cash value," or thereafter, the appraised value of real property when purchased, newly constructed or a change in ownership has occurred after the 1975 assessment," subject to exemptions in certain circumstances of property transfer or reconstruction. The "full cash value" is subject to annual adjustment to reflect increases, not to exceed 2% for any year, or decreases in the consumer price index or comparable local data, or to reflect reductions in property value caused by damage, destruction or other factors.

Article XIIIA requires a vote of two-thirds of the qualified electorate of a city, county, special district (such as the District) or other public agency to impose special taxes, while totally precluding the imposition of any additional *ad valorem*, sales or transaction tax on real property. Article XIIIA exempts from the 1% tax limitation any taxes above that level required to pay debt service (a) on any indebtedness approved by the voters prior to July 1, 1978, or (b), as the result of an amendment approved by State voters on July 3, 1986, on any bonded indebtedness approved by two-thirds percent of the votes cast by the voters for the acquisition or improvement of real property on or after July 1, 1978, or (c) bonded indebtedness incurred by a school district or community college district for the construction, reconstruction, rehabilitation or replacement of school facilities or the acquisition or lease of real property for school facilities, approved by 55% or more of the votes cast on the proposition, but only if certain accountability measures are included in the proposition. The tax for payment of the Bonds falls within the exception described in (b) of the immediately preceding sentence. In addition, Article XIIIA requires the approval of two-thirds of all members of the state legislature to change any state taxes for the purpose of increasing tax revenues.

Both the United States Supreme Court and the California State Supreme Court have upheld the general validity of Article XIIIA.

### Legislation Implementing Article XIIIA

Legislation has been enacted and amended a number of times since 1978 to implement Article XIIIA. Under current law, local agencies are no longer permitted to levy directly any property tax (except to pay voter-approved indebtedness). The 1% property tax is automatically levied by the affected county and distributed according to a formula among taxing agencies. The formula apportions the tax roughly in proportion to the relative shares of taxes levied prior to 1979.

Increases of assessed valuation resulting from reappraisals of property due to new construction, change in ownership or from the annual adjustment not to exceed 2% are allocated among the various jurisdictions in the "taxing area" based upon their respective "situs." Any such allocation made to a local agency continues as part of its allocation in future years.

### Unitary Property

Some amount of property tax revenue of the District is derived from utility property which is considered part of a utility system with components located in many taxing jurisdictions ("unitary property"). Under the State Constitution, such property is assessed by the State Board of Equalization ("SBE") as part of a "going concern" rather than as individual pieces of real or personal property. State-assessed unitary and certain other property is

allocated to the counties by SBE, taxed at special county-wide rates, and the tax revenues distributed to taxing jurisdictions (including the District) according to statutory formulae generally based on the distribution of taxes in the prior year.

The California electric utility industry has been undergoing significant changes in its structure and in the way in which components of the industry are regulated and owned. Sale of electric generation assets to largely unregulated, nonutility companies may affect how those assets are assessed, and which local agencies are to receive the property taxes. The District is unable to predict the impact of these changes on its utility property tax revenues, or whether legislation may be proposed or adopted in response to industry restructuring, or whether any future litigation may affect ownership of utility assets or the State's methods of assessing utility property and the allocation of assessed value to local taxing agencies, including the District.

**Article XIIIB of the California Constitution**

In addition to the limits Article XIIIA imposes on property taxes that may be collected by local governments, certain other revenues of the State and most local governments are subject to an annual "appropriation limit" imposed by Article XIIIB of the State Constitution which effectively limits the amount of such revenues those entities are permitted to spend. Article XIIIB, as subsequently amended by Propositions 98 and 111, limits the annual appropriations of the State and of any city, county, school district, authority or other political subdivision of the State to the level of appropriations of the particular governmental entity for the prior fiscal year, as adjusted for changes in the cost of living and in population and for transfers in the financial responsibility for providing services and for certain declared emergencies.

The appropriations of an entity of local government subject to Article XIIIB limitations include the proceeds of taxes levied by or for that entity and the proceeds of certain state subventions to that entity. "Proceeds of taxes" include, but are not limited to, all tax revenues and the proceeds to the entity from (a) regulatory licenses, user charges and user fees (but only to the extent that these proceeds exceed the reasonable costs in providing the regulation, product or service), and (b) the investment of tax revenues.

Appropriations subject to limitation do not include (a) refunds of taxes, (b) appropriations for debt service, such as the Bonds, (c) appropriations required to comply with certain mandates of the courts or the federal government, (d) appropriations of certain special districts, (e) appropriations for all qualified capital outlay projects as defined by the legislature, (f) appropriations derived from certain fuel and vehicle taxes and (g) appropriations derived from certain taxes on tobacco products.

Article XIIIB includes a requirement that all revenues received by an entity of government other than the State in a fiscal year and in the fiscal year immediately following it in excess of the amount permitted to be appropriated during that fiscal year and the fiscal year immediately following it shall be returned by a revision of tax rates or fee schedules within the next two subsequent fiscal years.

The State and each local government entity has its own appropriation limit. Each year, the limit is adjusted to allow for changes, if any, in the cost of living, the population of the jurisdiction, and any transfer to or from another governmental entity of financial responsibility for providing the services.

**Article XIIIC and Article XIIID of the California Constitution**

On November 5, 1996, the voters of the State of California approved Proposition 218, popularly known as the "Right to Vote on Taxes Act." Proposition 218 added to the California Constitution Articles XIIIC and XIIID (respectively, "Article XIIIC" and "Article XIIID"), which contain a number of provisions affecting the ability of local agencies to levy and collect both existing and future taxes, assessments, fees and charges.

According to the "Title and Summary" of Proposition 218 prepared by the California Attorney General, Proposition 218 limits "the authority of local governments to impose taxes and property-related assessments, fees and charges." Among other things, Article XIIIC establishes that every tax is either a "general tax" (imposed for general governmental purposes) or a "special tax" (imposed for specific purposes), prohibits special purpose government agencies such as hospital districts from levying general taxes, and prohibits any local agency from imposing, extending or increasing any special tax beyond its maximum authorized rate without a two-thirds percent vote; and also provides that the initiative power will not be limited in matters of reducing or repealing local taxes,

assessments, fees and charges. Article XIIIC further provides that no tax may be assessed on property other than *ad valorem* property taxes imposed in accordance with Articles XIII and XIIIA of the California Constitution and special taxes approved by a two-thirds percent vote under Article XIIIA, Section 4. Article XIIID deals with assessments and property-related fees and charges, and explicitly provides that nothing in Article XIIIC or XIIID will be construed to affect existing laws relating to the imposition of fees or charges as a condition of property development.

The District does not impose any taxes, assessments, or property-related fees or charges which are subject to the provisions of Proposition 218. It does receive a portion of the basic one percent *ad valorem* property tax levied and collected by the County pursuant to Article XIIIA of the California Constitution.

**Future Initiatives**

Article XIIIA, Article XIIIB, and Proposition 218 were each adopted as measures that qualified for the ballot pursuant to California's initiative process. From time to time other initiative measures could be adopted, further affecting District revenues or the District's ability to expend revenues. The nature and impact of these measures cannot be anticipated by the District.

## THE DISTRICT

The District is a political subdivision of the State of California, created in 1947 by vote of registered voters of the then proposed District. The District was organized to finance the cost of constructing, remodeling and expanding the Hospital and operates under The Local Health Care District Law of the State of California, constituting Division 23 of the California Health and Safety Code. The District leases the Hospital and its improvements to the Corporation for an amount approximately equal to the debt service requirements of the District on its outstanding revenue bonds. The District covers an area of approximately 340 square miles and is located in the northwest portion of Riverside County. The permanent resident population of the District is approximately 85,000 persons.

Cities and communities located within the District’s boundaries includes the cities of Banning and Beaumont, portions of the city of Calimesa as well as the neighboring unincorporated areas of Cabazon, Cherry Valley and Whitewater. The District is a political agency and collects operating property tax revenues annually based upon the assessed value of taxable real property located within the District’s boundaries. The District is able to use its operating tax revenues for general operating purposes, although they are not pledged to the Paying Agent for repayment of the Bonds.

**Board of Directors**

The District is governed by a Board of Directors (the “Board”) which consists of five members, each elected to four-year staggered terms. The Board has ultimate responsibility for District policies, strategic planning, as well as fiduciary responsibility for protecting and enhancing the District's assets. Regular Board meetings are held monthly and are open to the public pursuant to California’s Brown Act. All Board members are elected at large within the District. The current members of the Board, including their titles, occupations, dates on which their current terms expire and total years as Board members, are set forth in the following table:

| Name and Title | Occupation | Term in Office Expires | Board Member Since |
|---|---|---|---|
| Dorothy Ellis, Chair | Retired Nurse Executive | 12/2016 | 06/2004 |
| N. Irwin Reeves, Vice Chair | Retired Clinical Lab Scientist | 12/2014 | 12/2006 |
| Joe Dotan, MD, Secretary | Retired Physician | 12/2016 | 12/2008 |
| Lynn Bogh Baldi, Treasurer | Construction | 12/2014 | 04/2010 |
| Ludwig Cibelli, MD, Member | Physician | 12/2014 | 06/2012 |

Source: District records.

## THE CORPORATION

The District leases the Hospital to the Corporation, a California nonprofit public benefit corporation exempt from federal income taxation as an organization described in Section 501(c)(3) of the Internal Revenue Code. The lease was entered into in 1990 upon the formation of the Corporation, for the purpose of operating the Hospital and providing a broader community involvement to its governing body. The lease terminates on June 30, 2020, at which time the Hospital and its operation revert to the District, unless the lease is otherwise extended or renewed. The Corporation's governing body is a board of directors comprised of the five elected Board members of the District, the Chief of the Hospital's Medical Staff, plus seven additional members elected at large from the Hospital's service area. The board of directors hires a management company and selects the Chief Executive Officer to manage the Hospital's operations and appoints physicians to an organized medical staff. The current members of the board of directors of the Corporation, including their titles, occupations, dates on which their current terms expire and total years as a member of the board of directors, are set forth in the following table:

| Name and Title | Occupation | Term in Office Expires | Board Member Since |
|---|---|---|---|
| Jerilynn Kaibel, DC, Chair | Chiropractor | 06/2015 | 02/2007 |
| Dorothy Ellis, Vice Chair [1] | Retired Nurse Executive | 12/2016 | 06/2004 |
| DeNae Reagins, Secretary | Computer Company Owner | 06/2015 | 06/2007 |
| Olivia Hershey, Treasurer | Retired Human Resources Executive | 06/2014 | 06/2004 |
| Lynn Bogh Baldi [1] | Construction | 12/2014 | 04/2010 |
| Devin Borna, MD [2] | Physician | 06/2013 | 07/2011 |
| Ludwig Cibelli, MD [1] | Physician | 12/2014 | 06/2012 |
| Joe Dotan, MD[1] | Retired Physician | 12/2016 | 12/2008 |
| Farzad Farrokhi, MD | Physician | 06/2014 | 03/2011 |
| Ed Hiett | Retired Manager | 06/2014 | 06/2010 |
| Estelle Lewis | Local Business Owner | 06/2014 | 05/2010 |
| Mary Ann Martin Andreas | Morongo Band of Mission Indians | 06/2014 | 06/2003 |
| N. Irwin Reeves [1] | Retired Clinical Lab Scientist | 12/2014 | 12/2006 |

Source: Corporation records.
(1) Serves on the board of directors of the Corporation as a member of the Board of the District.
(2) Serves on the board of directors of the Corporation as Chief of the Hospital's Medical Staff.

The Corporation has committed to maintain and operate the Hospital for the benefit of the communities served by the District, and to maintain the Hospital as a nonprofit community-based hospital.

## THE HOSPITAL

The District began construction of the Hospital in 1949. The Hospital was completed and dedicated on March 4, 1951. The Hospital is currently a 77-bed general acute care hospital (approximately 86,000 square feet) licensed by the State of California Department of Health Services and located in the city of Banning, just adjacent to the Beaumont city limit, approximately one-quarter mile north of Interstate 10. This location is approximately 80 miles east of the city of Los Angeles and approximately 25 miles west of the city of Palm Springs. The Corporation is licensed by the State of California Department of Health Services to operate the Hospital. The Hospital is a community-based hospital dedicated to providing acute primary care services to the residents of the San Gorgonio Pass area (the District's boundaries and neighboring area). The Hospital has been designated by the State of California as a rural hospital and presently qualifies for disproportionate share provider status with respect to Medicare reimbursement, with the nearest acute care hospital located approximately 20 miles to the west of the Hospital in the city of Moreno Valley, California. The present complement of licensed beds constitutes the only licensed acute care beds available in the District's primary service area.

The Hospital was managed from 1990 to 2010 by Brim Healthcare, Inc. ("Brim"), and since November, 2010 has been managed by EPIC Management L.P., a California Limited Partnership ("EPIC") whose current management contract is in effect through November 17, 2020, unless otherwise terminated, renewed or extended. EPIC is a California-based limited partnership providing management and consulting services to Southern California physician groups and IPAs, including Beaver Medical Group, San Gorgonio Memorial Hospital, Pinnacle

Medical Group, Redlands-Yucaipa Medical Group, Alliance Desert Physicians, Tri-Valley Medical Group, Loma Linda University-Beaver Urgent Care and Inland Women's Care Associates. EPIC's clients have over 200 physicians that provide health services to over 150,000 patients throughout the Inland Empire. Over 1,000 medical and administrative professionals are employed by EPIC Management in locations throughout Redlands, Highland, Yucaipa, Banning, Beaumont and Colton. EPIC is responsible for the day-to-day operations of the Hospital, and provides various management support services in the discharge of its obligations under the management contract. For the years ended June 30, 2011 and 2012, the Corporation paid EPIC approximately $163,000 and $494,000 respectively, in management and consulting fees which are included in professional fees in the financial statements contained in APPENDIX B. Under the management contract EPIC is eligible for a bonus which could increase its annual management fees by as much as 20% above the base management fee. Any such bonus is subject to approval by the Corporation's board of directors.

In addition to the Project, the District completed construction of an approximate 15,000 square foot Women's Center and obstetrics unit as an addition to the Hospital in 2002. The Women's Center was built at a total cost of $3.5 million with funding originating from community contributions and District reserves and provides birthing suites specially designed for labor, delivery and recovery. Additional recent improvements to the Hospital are the addition of new state of the art digital mammography unit and improved information technology systems helping the Hospital successfully qualify for Phase I meaningful use criteria resulting in $2.1 million in government incentive payments received as of September 30, 2012.

**Senior Management**

The day-to-day operations and long term management of the Hospital are coordinated by the following key administrative officers:

*Mark S. Turner, FACHE, Chief Executive Officer*. Mr. Turner has been employed by the Corporation as Chief Executive Officer since November 2010. Mr. Turner began his service as Chief Executive Officer of the Hospital on July 15, 2009, as an employee of Brim, replacing an interim Chief Executive Officer who served since March 2009. Mr. Turner was employed by Brim from 1991 to November 2010. He served as Senior Vice President of Operations, Business Development at Brim's headquarters in Brentwood, Tennessee, from 2006 until taking the position as Chief Executive Officer of the Hospital. From 2000 to 2006 he held the position of Regional Vice President of Operations, Brim Regional Office, Madison, Wisconsin. Through Brim Mr. Turner served as the Chief Executive Officer of Ojai Valley Community Hospital, a 103-bed hospital and skilled nursing facility in Ojai, California, from 1996 to 2000. From 1991 to 1996 he was Brim's Regional Finance Director in Madison, Wisconsin. Mr. Turner held senior accountant and manager positions with national and regional certified public accounting firms from 1983 to 1991. In all, Mr. Turner has had over twenty-five years of management and financial experience in progressively more responsible positions in the healthcare industry.

Mr. Turner earned his Bachelor of Science degree in Business Administration from the University of Wisconsin in 1983 and his Masters of Business Administration from the University of Wisconsin in 2004. His professional recognitions include Certified Public Accountant; Board Certified in Healthcare Management, American College of Healthcare Executives; and Certified Healthcare Financial Professional, Healthcare Financial Management Association. Mr. Turner has held membership and leadership roles in numerous healthcare associations. He has also actively engaged in civic and community programs and organizations.

*David Recupero, Chief Financial Officer*. Mr. Recupero has served in his present capacity since October 2008. Earlier in 2008 he served for nine months as Chief Financial Officer at 80-bed Ridgecrest Hospital, Ridgecrest, California. Prior to his tenure at the Hospital, Mr. Recupero also has held the position of Chief Financial Officer for the past 24 years at the following for profit and not-for-profit health facilities: Ottumwa Regional Health Center, a 221-bed acute care hospital in Ottumwa, Iowa (2001-2008); War Memorial Hospital, a 86-bed general acute care hospital in Sault Ste. Marie, Michigan (1996-2001); Northern Montana Healthcare Inc., a 107-bed general acute care hospital in Havre, Montana (1994-1996); and Pullman Memorial Hospital, a 42-bed general acute care hospital in Pullman, Washington (1989-1994). He earned his Bachelor of Science degree in Business Administration with an emphasis in Finance from the University of Wisconsin-Milwaukee in 1982 and his Masters of Public Health – Health Services Management from the University of California, Los Angeles in 1986.

**Employees**

As of December 31, 2012, the Corporation employed 369 full-time equivalent employees. Included in this group are registered nurses, licensed vocational nurses, technicians, specialists, environment and food service personnel, and various management, supervisory and clerical personnel. None of the Corporation's employees are covered by collective bargaining agreements. Management is not aware of any pending union activity at the Hospital and believes that relations with its employees are good.

**Medical Staff**

As of December 31, 2012, the Hospital's medical staff consisted of 169 physicians (includes 57 active staff). Approximately 82% of the active medical staff are board certified. The medical staff includes 112 physicians who are provisional staff, emergency, associate, courtesy or consulting staff members. Active medical staff members are the primary admitters to the Hospital. The medical staff has an average tenure of approximately 14 years.

**Affiliates**

***San Gorgonio Memorial Hospital Foundation***. The San Gorgonio Memorial Hospital Foundation (the "Foundation") is an independent California nonprofit 501(c)(3) public benefit corporation organized for the charitable purpose of promoting and supporting the Hospital. The Foundation was organized in 1982, and in late 1995, its first Director of Development was hired to oversee and coordinate the Foundation's activities. The Foundation then embarked on a capital campaign to contribute a total of approximately $3.1 million in community wide contributions towards the construction and equipping of the Women's Center at the Hospital. The Foundation's general funds, which represent the Foundation's unrestricted resources, will be distributed to the District and/or the Corporation in amounts and in periods determined by the Foundation's board of trustees, who may also restrict the use of the general funds for Hospital plant replacement or expansion or other specific purposes. The Foundation has over 1,200 donors and an advisory board of approximately 20 trustees. The Foundation has raised over $8,000,000 for the Hospital since 1996. The Foundation is not liable for repayment of the Bonds.

***San Gorgonio Memorial Hospital Auxiliary***. The San Gorgonio Memorial Hospital Auxiliary (the "Auxiliary") was formed in 1951 and has been an active supporter of the Hospital since that time. The Auxiliary provides volunteer support to the Hospital in several areas, including fundraising, office staff assistance, operating the Hospital's gift shop, operating the Hospital's Thrift Shop, staffing of health fairs, staffing the Hospital's lobby and assisting patients, among other services. Auxiliary volunteers provide in excess of 25,000 hours annually in support of the Hospital and its patients. All monetary proceeds generated by the Auxiliary are, in turn, donated to the Foundation to support the Hospital. The Auxiliary is not liable for repayment of the Bonds.

***Other Contracts***. The Corporation contracts with various other medical providers to provide clinical, radiology and professional services in the areas of non-invasive cardiology, pathology, anesthesia and emergency medicine. The District has begun to plan for and evaluate potential affiliations as part of its overall strategic planning.

**Service Area and Competition**

The Hospital is the only acute care hospital within its primary service area. The Hospital's primary service area consists of approximately the same geographic area as the District, which is comprised of the northwestern one-third of Riverside County and includes the communities of Banning, Beaumont, Calimesa, Cabazon, Cherry Valley and Whitewater. The Hospital serves a semi-rural population with approximately 90% of its discharges coming from within its primary service area. Riverside County is located in southern California and has a current population of approximately 2,228,000.

The Hospital's primary competitors include Redlands Community Hospital, located approximately 23 miles west of the Hospital, and Loma Linda University Medical Center, located approximately 30 miles west of the Hospital. The Corporation refers patients to Loma Linda University Medical Center and St. Bernardine's Medical Center located in San Bernardino, California, for services which are not provided at the Hospital. Services not provided at the Hospital include high-risk obstetric and pediatric cases, angioplasty, invasive cardiology, neurosurgery, vascular and cancer related cases.

## Services

The Corporation presently offers a range of basic medical, surgical and obstetrical services at the Hospital in addition to its general and administrative services. Medical and surgical services currently include the following:

| **Medical Services** | | |
|---|---|---|
| Behavioral Health | Intensive Care | Pain Management |
| Cardiac Rehabilitation | Internal Medicine | Pharmacy |
| CT Scan | Laboratory, Clinical | Physical Therapy |
| Diagnostic Radiology | Laboratory, Pathology | Pulmonary Testing |
| EEG & EMG | Mammography | Respiratory Therapy |
| Emergency Services | Nephrology | Skilled Nursing |
| General (FP/GP) | Newborn Nursery | Telemetry |
| Gynecology | Nuclear Medicine | Ultrasound |
| Hematology | Obstetrics | Urgent Care |
| **Surgical Services** | | |
| Anesthesiology | Gynecology | Urology |
| Gastro Intestinal | Orthopedics | Vascular |
| General | Otolaryngology | |

Source: Hospital records.

In addition, the Hospital provides 24-hour emergency medical care with a licensed physician on duty at all times. The Corporation also operates outpatient psychiatric care and transitional care services.

## Accreditations, Memberships and Designations

The Hospital has been fully accredited since it was opened in 1951. Its most recent three year accreditation from The Joint Commission continues through June 1, 2015. At this time, management of the Hospital does not anticipate any difficulty in renewing its accreditation.

The Hospital is an eligible provider under Medicare, Medi-Cal, Blue Cross and other commercial insurance programs and holds a membership in the American Hospital Association, California Healthcare Association and Association of California Healthcare Districts. The Hospital is a disproportionate share provider for Medicare purposes and is designated as a rural hospital.

## Bed Complement

The Hospital has a current licensed capacity of 77 beds. With the Project as now designed, the licensed bed capacity would increase to 87 beds upon completion of the Project. The Hospital's licensed bed count classified by service type is as follows:

| Service | Current Licensed Beds | Project Related Changes Additions | Project Related Changes Deletions | Licensed Beds at Project Completion |
|---|---|---|---|---|
| Medical/Surgical | 40 | 0 | 0 | 40 |
| Intensive Care | 6 | 10 | 0 | 16 |
| Perinatal/Obstetrics | 15 | 0 | 0 | 15 |
| Skilled Nursing/Transitional Care | 16 | 0 | 0 | 16 |
| Total | 77 | 10 | 0 | 87 |

Source: State of California, Department of Health Services license and management estimates.

**Certain Financial Information**

The following summaries of the combined statements of operations and changes in net assets of San Gorgonio Health Care System (the "System"), comprised of the combined operations of the District and the Corporation, are qualified by reference to and should be read in conjunction with the audited financial statements for the fiscal year ended June 30, 2012, included as APPENDIX B, including the notes thereto, and "Management's Analysis of Financial Performance" below. Collectively the District and the Corporation combine to function as the System. The statement of operations and changes in net assets for the years ended June 30, 2011 and June 30, 2012, are derived from audited financial statements not included herein.

The following summaries of combined statements of operations and changes in net assets of the System for the six-month periods ended December 31, 2011, and December 31, 2012, were derived from the unaudited financial statements of the System. These financial statements have been prepared in accordance with generally accepted accounting principles on a basis consistent with the accounting policies reflected in the audited financial statements summarized below. They do not, however, include all of the information and footnotes required by generally accepted accounting principles for complete financial statements. The unaudited financial statements include all adjustments, consisting primarily of normal recurring accruals, which System management considers necessary for a fair presentation of the results of such periods. The results of an interim period should not be considered indicative of the results for a full year.

| | Fiscal Year Ended June 30 | | | | Six Months Ended December 31 | |
|---|---|---|---|---|---|---|
| | 2009 (audited) | 2010 (audited) | 2011 (audited) | 2012 (audited) | 2011 (unaudited) | 2012 (unaudited) |
| Net patient service revenue | $39,962,108 | $43,262,798 | $49,848,384 | $55,484,174 | $25,026,800 | $25,024,468 |
| Grant revenue | 265,695 | 484,749 | 790,452 | 581,755 | 109,054 | 257,485 |
| District taxes for operations | 2,896,233 | 2,733,938 | 2,754,123 | 2,874,257 | 1,377,372 | 1,425,964 |
| Interest income | 6,892 | 3,224 | 25,972 | 23,068 | 25,340 | 10,444 |
| Other operating income | 291,276 | 345,511 | 340,236 | 2,416,849 | 1,048,826 | 1,643,634 |
| Total revenues | 43,422,204 | 46,830,220 | 53,759,167 | 61,380,103 | 27,587,392 | 28,361,996 |
| Total expenses | 46,731,125 | 49,189,945 | 53,049,311 | 61,276,982 | 28,699,531 | 30,025,800 |
| Net Operating Income | (3,308,921) | (2,359,725) | 709,856 | 103,121 | (1,112,139) | (1,663,805) |
| District taxes non-operating | 2,454,663 | 6,573,510 | 6,530,246 | 6,379,133 | 3,387,839 | 3,120,740 |
| Net assets released | 1,489,084 | 126,183 | 149,110 | 486,750 | 0 | 0 |
| Extraordinary Item | 0 | 0 | (231,862) | | | |
| Change in interest in Foundation | (187,075) | 44,931 | 7,182 | (334,808) | 0 | 0 |
| Change in Net Assets | 447,751 | 4,384,899 | 7,161,532 | 6,634,196 | 2,275,701 | 1,456,936 |
| Beginning Net Assets | 6,513,833 | 6,961,584 | 11,346,483 | 18,511,015 | 18,511,015 | 25,145,211 |
| Ending Net Assets | $6,961,584 | $11,346,483 | $18,511,015 | $25,145,211 | $20,786,716 | $26,602,147 |

Source: Audited and unaudited financial statements of the System, as indicated above. For the fiscal years ended June 30, 2009 through June 30, 2012, the System's interest in the Foundation's net assets is recorded in the System's audited financial statements.

**Total Unrestricted Funds and Days Cash on Hand**

The following table provides total unrestricted funds and days cash on hand for the System as of June 30 in the years 2009 through 2012, and as of December 31, 2012. Marketable securities are carried at market.

| (000s omitted) | As of June 30 | | | | As of December 31 |
|---|---|---|---|---|---|
| | 2009 (audited) | 2010 (audited) | 2011 (audited) | 2012 (audited) | 2012 (unaudited) |
| Cash and Short-Term Investments | $1,923 | $1,389 | $1,291 | $1,750 | $1,058 |
| Cash from the Foundation | 823 | 923 | 841 | 636 | 770 |
| Total Unrestricted Funds | $2,746 | $2,312 | $2,132 | $2,386 | $1,828 |
| Daily Expenses | $ 103 | $ 97 | $ 102 | $ 122 | $ 115 |
| Days Cash on Hand[(1)] | 27 | 24 | 21 | 19 | 16 |

Source: Audited and unaudited financial statements of the System, as indicated above. As of June 30, 2011 and 2012, the System's interest in the Foundation's net assets is recorded in the System's audited financial statements.

(1) Determined by adding cash and cash equivalents plus board designated funds for capital replacement; and dividing that sum by total operating expenses minus depreciation and amortization and minus provision for bad debts expenses divided by 365 and 184 for the six months ended December 31, 2012 (daily expenses).

**Management's Analysis of Financial Performance**

The System has three years of combined positive net increase in net assets as reflected in the audited financial statements from June 30, 2010 through June 30, 2012. The combined net increase for this three-year period totals $18,180,627, averaging $6,060,209 per year. For the first six months of the fiscal year ending on June 30, 2013, the System's net increase is $1,456,936.

Since entering into a management contract with EPIC the District has shown a steady increase in financial performance and strength. Net operating income or loss improved from a net loss of $2.4 million in the fiscal year ended June 30, 2010 to a net gain of $0.1 million in the fiscal year ended June 30, 2012. Earnings before interest, depreciation and amortization (commonly referred to as EBIDA), an approximation of cash flow from operations, increased by approximately $700,000 (from approximately $3.9 million to $4.6 million) from the fiscal year ended June 30, 2011 to the fiscal year ended June 30, 2012.

One key factor contributing to the recent improvement in the District's financial performance came from increases in Hospital's patient volumes resulting from the recruitment of new physicians into the community with the assistance of EPIC. Net patient revenues increased by nearly $5.5 million in the fiscal year ended June 30, 2012 or a 14% growth rate from the prior year.

Two key profitability ratios that measure cost efficiency are cost per adjusted discharge and FTEs per adjusted occupied beds. Both show favorable trends and a moderation of discretionary operating expenses since the fiscal year ended June 30, 2009.

Cost per adjusted discharge indicates the average cost the Hospital incurs to care for each adjusted inpatient episode of care. An adjusted discharge is calculated by dividing inpatient revenue into total revenue multiplied by inpatient discharges. The cost per adjusted discharge increased only $240 (from $6,670 to $6,847) or 3.6% from the fiscal year ended June 30, 2011 to the fiscal year ended June 30, 2012.

Paid FTEs per adjusted occupied bed is a traditional measure of a hospital's labor productivity. Controlling FTEs per adjusted occupied bed is an important element of managing labor costs. The Hospital's FTE per adjusted occupied bed has actually dropped slightly from 2008 to 2012, from 4.87 to 4.86. The rural hospital benchmark is 5.71. The Hospital continues to adhere to a productivity monitoring system based on department productivity targets. The purpose of the productivity system is to match labor resources to Hospital volumes.

Overall inpatient census had been declining in recent years but reversed in fiscal year 2011 and 2012. New surgeons in gynecology and orthopedic surgery, and increased referrals to existing general surgeons have helped surgical volumes. Emergency room visits have increased 27% since fiscal year 2008 and 6% over the past year. Emergency room visits are important because historically approximately 78% of the Hospital's admissions come by way of the emergency room. The increase from fiscal year 2011 to 2012 was 1,137 days or 9.2%. Financial improvements in fiscal year 2012 resulting from increased patient volumes are highlighted below.

| | |
|---|---|
| Emergency Visits | 6% |
| Inpatient Acute Days | 9% |
| Outpatient Surgeries | 16% |
| Newborn deliveries | 15% |
| Physical Therapy Visits | 28% |
| Mammography Exams | 99% |

Accounts payable declined from a high of $8.9 million in December 2008 to $2.4 million as of June 30, 2012. This large reduction was possible due to increased operational cash flow and faster collection of net accounts receivable. Key financial indicators for the fiscal year ended June 30, 2012 or as of June 30, 2012, are highlighted below.

| | |
|---|---|
| Net Days of Revenue in Accounts Receivable | 50 days |
| Accounts Payable Payment Period | 34 days |
| Days Cash on Hand | 19 days |
| Debt Service Coverage Ratio | 4.1x |

Management believes the financial results for the fiscal year ended June 30, 2013, will show that the District's EBIDA will decline to slightly under $3.0 million due to temporary loss of government IT subsidies that are scheduled to reoccur again in fiscal year 2014, and fiscal year 2015.

**Hospital Utilization**

The table below presents selected statistical indicators of inpatient and outpatient activity for the Hospital during the four fiscal years ended June 30, 2009, 2010, 2011 and 2012, and the six-month periods ended December 31, 2011 and 2012:

| | Fiscal Year Ended June 30 | | | | Six Months Ended Dec. 31 | |
|---|---|---|---|---|---|---|
| | **2009** | **2010** | **2011** | **2012** | **2011** | **2012** |
| Licensed Beds | 77 | 77 | 77 | 77 | 77 | 77 |
| Acute Patient Days | 13,443 | 12,121 | 12,288 | 13,425 | 6,742 | 6,039 |
| Acute Discharges | 3,702 | 3,076 | 2,969 | 3,249 | 1,705 | 1,753 |
| Acute Average Length of Stay (Days) | 3.6 | 3.9 | 4.1 | 4.1 | 4.0 | 3.4 |
| Total Patient Days | 15,874 | 14,151 | 14,345 | 15,302 | 7,826 | 6,728 |
| Total Occupancy Percentage | 56% | 50% | 51% | 54% | 55% | 47% |
| Inpatient Surgeries | 500 | 623 | 641 | 869 | 359 | 484 |
| Emergency Room Visits | 25,718 | 22,598 | 30,771 | 32,648 | 16,009 | 16,980 |
| Outpatient Visits [(1)] | 34,868 | 38,726 | 40,005 | 40,568 | 20,051 | 20,966 |
| Outpatient Surgeries | 649 | 715 | 915 | 1,098 | 545 | 615 |

Source: Hospital records.
[(1)] Exclusive of emergency, outpatient surgery visits and home health visits.

**Sources of Patient Service Revenue**

The Hospital participates in the Medicare and Medi-Cal programs. The percentage of gross patient revenues derived from Medicare, Medi-Cal, insurance and all other sources for each of the past four fiscal years and the six-month periods ended December 30, 2011 and 2012 is set forth below. Because of varying contractual allowances to third-party payors, net patient revenues do not correspond directly to gross patient revenues.

| | Fiscal Year Ended June 30 | | | | Six Months Ended Dec. 31 | |
|---|---|---|---|---|---|---|
| | 2009 | 2010 | 2011 | 2012 | 2011 | 2012 |
| Medicare | 54% | 51% | 51% | 50% | 48% | 46% |
| Medi-Cal | 22 | 24 | 24 | 23 | 24 | 24 |
| Insurance | 17 | 17 | 15 | 18 | 17 | 20 |
| All Other | 7 | 8 | 10 | 9 | 11 | 10 |
| Total | 100% | 100% | 100% | 100% | 100% | 100% |

Source: Hospital records.

Medicare is a federal program, administered by the Centers for Medicare and Medicaid Services, available to individuals age 65 or over and certain disabled persons. Medicaid is a federal and state jointly funded program, known as Medi-Cal in California, under which the Hospital furnishes services to program eligible persons. Inpatient acute care services rendered to Medicare program beneficiaries are paid at prospectively determined rates per discharge diagnosis. These rates vary according to a patient classification system that is based on clinical, diagnostic and other factors. Outpatient services are paid based on a prospective payment system subject to various limitations and formulas. Traditional Medi-Cal inpatient services are reimbursed upon a per-diem basis based on a contract with the State Department of Health Services. Traditional outpatient services rendered are reimbursed on a State of California fee schedule. The Hospital has no capitated arrangement with any health plans to treat Medi-Cal patients.

Adults who do not meet Medi-Cal eligibility criteria but who are medically indigent, as defined by California law, are eligible for medical services under the state funded County Medical Services Program ("CMSP"). The Corporation bills the State of California directly for CMSP patients treated at the Hospital. The CMSP contract accounts for less than 1% of gross patient revenues generated at the Hospital.

The Corporation has contracts with approximately 20 prepaid plans and preferred provider discount contractors which comprise approximately 39% of its total net revenues. The basis for payment to the Corporation under these agreements includes prospectively determined rates per discharge, discounts from established rates and prospectively determined daily rates.

A physician medical group, Beaver Medical Clinic, constructed an approximate 20,000 square foot medical office complex on property adjacent to the Hospital. The complex opened in 1995 and provides space for approximately 20 rotating physician specialists. Beaver Medical Clinic has also leased an additional 20,000 square foot medical office complex on adjacent property since 2006, housing approximately 20 primary care physicians. Because of the close proximity of the Beaver Medical Clinic medical office complex, the Hospital has enjoyed an increase in patient revenues pursuant to the Corporation's provider agreement with that organization. Under this provider agreement the Corporation is compensated based on a discounted fixed rate per day and discounted fee for service payments depending on the nature of the services.

**Public and Professional Liability Insurance Considerations**

The Hospital's operations are currently covered under comprehensive liability insurance through a pooled self-insurance program insuring the Hospital and all its employees, while acting within the scope of their duties, against malpractice liability with limits of $20,000,000, on a claims-made and reported basis. The Hospital's current comprehensive liability insurance contract is in continuous effect until July 1, 2013. Management believes this contract will be renewed at that time without difficulty. The Hospital contracts such insurance through a joint powers authority ("BETA Healthcare Group Risk Management Authority") under California law authorizing governmental agencies, such as local health care districts, to join together for insurance purposes. Currently 91

participants representing health care districts, city, county and nonprofit hospitals participate in BETA Healthcare Group Risk Management Authority.

BETA Healthcare Group Risk Management Authority is funded by monthly contributions paid by the members participating in BETA Healthcare Group Risk Management Authority. The contributions are used to fund a reserve for expected losses to be paid by BETA Healthcare Group Risk Management Authority on a pooled, self-insured basis. The amount of the monthly contribution to be paid by a member is based on independent actuarial computations taking into account factors such as, among others, total number of beds, outpatient and inpatient visits, surgeries, deductible and loss experience of the member. The reserve for claims and claims expense has been determined using the developed loss and loss expense method. For the fiscal year ended June 30, 2012, the District paid $684,799

in net contributions to BETA Healthcare Group Risk Management Authority.

As of June 30, 2012, BETA Healthcare Group Risk Management Authority had a reserve for claims and claims expenses relating to the Hospital of $274,557. Since 1984, BETA Healthcare Group Risk Management Authority has paid claims and claims expenses on behalf of the District totaling $7,075,856.

Management of the Hospital is unaware of any claim paid on its behalf which was not covered by insurance. The District does not currently have pending any malpractice or professional liability claims or lawsuits for compensatory damages not covered by insurance. In California, special districts like the District are not subject to punitive damage awards. Property damage is covered by Lexington Insurance Company.

**Employees' Retirement Plan**

The Corporation reinstated its tax-sheltered annuity (TSA) program on January 1, 2012. The program covers substantially all employees with at least three months of service. The Corporation makes biweekly contributions on a matching basis to individual TSA accounts based on a percentage of each employee's gross salary. Expense under the TSA program totaled $0 and $289,458 in 2011 and 2012, respectively.

**City of Banning, City of Beaumont and Riverside County**

During the past 22 years the populations of Riverside County, the city of Beaumont and the city of Banning have increased 90%, 301% and 46%, respectively, while the population of the State of California increased 27% over the same period. Population figures as reported for the 1990, 2000 and 2010 census reports and estimates for 2012 for the city of Banning, the city of Beaumont, Riverside County and the State of California are as follows:

| | 1990 | 2000 | 2010 | 2012 | Percent Increase |
|---|---|---|---|---|---|
| City of Banning | 20,570 | 23,562 | 29,603 | 29,965 | 46% |
| City of Beaumont | 9,685 | 11,384 | 36,877 | 38,851 | 301% |
| Riverside County | 1,170,413 | 1,545,387 | 2,189,641 | 2,227,577 | 90% |
| California | 29,760,021 | 33,871,648 | 37,253,956 | 37,678,563 | 27% |

Source: California State Department of Finance. The 1990, 2000 and 2010 figures are census figures reported as of April 1, in each of those years. The 2012 figures are estimates reported by the Department of Finance as of January 1, 2012.

Although the area served by the Hospital is known primarily for agriculture, other industries such as government, retail and manufacturing industries play a significant role in the local economy. Unemployment in the city of Banning and Riverside County during December 2012 was 12.52% and 11.1%, respectively, while unemployment for the State of California for the same period was 9.7%.

| | City of Banning | Riverside County | State of California |
|---|---|---|---|
| Civilian Labor Force | 12,000 | 946,700 | 18,489,600 |
| Employed | 10,500 | 841,900 | 16,689,200 |
| Unemployed | 1,500 | 104,800 | 1,800,400 |
| Percentage Unemployment | 12.5% | 11.1% | 9.7% |

Source: State Employment Development Department, December 2012.

**Capital Expenditures**

Aside from construction and equipping costs related to the Project, total capital expenditures of approximately $1,500,000 are expected to occur over the next three years, beginning with fiscal year ending June 30, 2013. The Project will help the District and the Corporation meet the growing demands of an increasing population as well as meet most of the regulatory seismic requirements of California Senate Bill 1953 affecting the Hospital through 2030. Funding for the Project will include a combination of operating cash flows, community donations and proceeds from the General Obligation Bonds. As for the remaining $1,500,000 of planned capital expenditures over the next three years, these represent regular annual expenditures made in connection with the normal routine maintenance of equipment and equipment replacements for the Hospital. These annual recurring capital expenditures are planned to be funded from the proceeds of equipment leases, cash reserves and community based contributions.

## DISTRICT FINANCIAL MATTERS

The Riverside County Assessor's Office assesses all real property in the District for tax purposes except public utility property which is assessed countywide by the State Board of Equalization. The Board of Equalization's Utility Roll is comprised of State assessed properties of regulated public utilities and companies such as telephone and gas companies.

**Property Tax Collection Procedures**

In California, property which is subject to *ad valorem* taxes is classified as "secured" or "unsecured." The "secured roll" is that part of the assessment roll containing state-assessed public utilities' property and locally assessed property, the taxes on which are a lien on real property sufficient, in the opinion of the county assessor, to secure payment of the taxes. A tax placed on unsecured property does not become a lien against such unsecured property, but may become a lien on certain other property owned by the taxpayer. Every tax which becomes a lien on secured property has priority over all other liens arising pursuant to State law on such secured property, regardless of the time of the creation of the other liens. Secured and unsecured properties are entered separately on the assessment roll maintained by the County assessor. The method of collecting delinquent taxes is substantially different for the two classifications of property.

Property taxes on the secured roll are due in two installments, on November 1 and February 1 of each year. If unpaid, such taxes become delinquent after December 10 and April 10, respectively, and a 10% penalty attaches to any delinquent payment. In addition, property on the secured roll with respect to which taxes are delinquent is sent to collection on or about June 30. Such property may thereafter be redeemed by payment of the delinquent taxes and a delinquency penalty, plus a redemption penalty of 1-1/2% per month to the time of redemption. If taxes are unpaid for a period of five years or more, the property is deeded to the State and is then subject to sale by the County tax collector. The exclusive means of enforcing the payment of delinquent taxes in respect to property on the secured roll is the sale of the property securing the taxes to the State for the amount of taxes which are delinquent.

Generally, property taxes are levied for each fiscal year on taxable real and personal property situated in the taxing jurisdiction as of the preceding January 1. California Revenue and Tax Code Sections 75.10 *et seq.*, however, provide for the supplemental assessment and taxation of property as of the occurrence of a change of ownership or completion of new construction.

Property taxes on the unsecured roll are due on the January 1 lien date and become delinquent if unpaid on the following August 31. A 10% penalty is also attached to delinquent taxes in respect to property on the unsecured roll, and further, an additional penalty of 1-1/2% per month accrues with respect to such taxes beginning the first day of the third month following the delinquency date. The taxing authority has four ways of collecting unsecured personal property taxes: (1) a civil action against the taxpayer; (2) filing a certificate in the office of the County clerk specifying certain facts in order to obtain a judgment lien on certain property of the taxpayer; (3) filing a certificate of delinquency of record in the County recorder's office, in order to obtain a lien on certain property of the taxpayer and (4) seizure and sale of personal property, improvements or possessory interests belonging or assessed to the assessee.

**Unitary Taxation for Utility Property**

Revenue and Taxation Code Section 100 requires the establishment in each county of one county-wide tax rate area with the assessed value of all unitary and operating non-unitary property being assigned to this tax rate area. The result is a single assessed valuation figure for most utility property (nonoperating, non-unitary property is still broken down by revenue district) owned by each utility within the County without any breakdown for individual taxing jurisdictions.

**Assessed Valuations**

California law exempts $7,000 of the assessed valuation of an owner-occupied dwelling and 100% of the value of business inventories from taxation. State law also provides for reimbursements to local agencies based on their share of the revenues derived from the application of the maximum tax rate applied to business inventories, with adjustments to reflect increases in population and the consumer price index.

Revenue estimates to be lost to local taxing agencies due to such exemptions is reimbursed from State sources. Such reimbursements are based upon total taxes due upon such exempt values and are not reduced by any amount for estimated delinquencies.

The District has a 2012-13 assessed valuation of $5,892,615,057, which accounts for approximately 2.9% of the County's assessed valuation of $205,136,768,340, as of the same period. Assessed values of property within the District have increased by approximately 216% from 1998-99 to 2012-13, while assessed values for the County have increased by approximately 169% over the same period. The summary below shows a fifteen-year history of the total secured and unsecured assessed property valuations for the District and total assessed valuations for Riverside County.

**Assessed Valuations [(1)]**

| Fiscal Year | Local Secured | Utility | Unsecured | District Assessed Valuations | County Assessed Valuations |
|---|---|---|---|---|---|
| 1998-99 | $1,738,210,281 | $3,480,185 | $121,388,723 | $1,863,079,189 | $ 76,315,688,007 |
| 1999-00 | 1,764,980,259 | 2,520,940 | 188,245,139 | 1,955,746,338 | 81,367,642,126 |
| 2000-01 | 1,839,452,985 | 2,320,093 | 165,533,700 | 2,007,306,778 | 89,655,344,299 |
| 2001-02 | 1,996,419,174 | 2,478,881 | 171,312,145 | 2,170,210,200 | 99,049,269,825 |
| 2002-03 | 2,181,170,151 | 2,411,179 | 175,137,421 | 2,358,718,751 | 110,020,472,952 |
| 2003-04 | 2,532,512,790 | 2,972,849 | 352,605,237 | 2,888,090,876 | 122,844,382,408 |
| 2004-05 | 3,092,351,106 | 3,498,584 | 416,676,112 | 3,512,525,802 | 140,852,260,063 |
| 2005-06 | 3,882,089,888 | 3,330,770 | 467,875,256 | 4,353,295,914 | 167,993,839,105 |
| 2006-07 | 5,341,232,036 | 3,369,405 | 419,087,478 | 5,763,688,919 | 205,744,450,510 |
| 2007-08 | 6,770,508,457 | 1,425,365 | 453,067,050 | 7,225,000,872 | 239,495,914,020 |
| 2008-09 | 6,856,353,527 | 1,425,365 | 474,366,177 | 7,332,145,069 | 243,093,830,193 |
| 2009-10 | 6,030,443,796 | 1,425,365 | 455,983,841 | 6,487,853,002 | 217,161,424,754 |
| 2010-11 | 5,567,613,824 | 1,425,365 | 467,129,831 | 6,036,169,020 | 207,831,314,499 |
| 2011-12 | 5,370,803,102 | 828,589 | 425,669,452 | 5,797,301,143 | 205,754,734,033 |
| 2012-13 | 5,516,985,013 | 422,003 | 375,208,041 | 5,892,615,057 | 205,136,768,340 |

Source: California Municipal Statistics, Inc.

(1) Based on 100% of full cash value before redevelopment increment.

**Tax Levies and Delinquencies**

Taxes are collected by the Riverside County Tax Collector for property falling within the District's taxing boundaries. Taxes and assessments on the secured roll are payable in two installments on November 1 and February 1 of each fiscal year, and become delinquent on December 10 and April 10, respectively. Taxes on unsecured property are assessed and payable as of the January lien date and become delinquent the following August 31.

The following tables show a twelve-year history (ending with the fiscal year 2011-12) of the secured tax charge, the tax amount delinquent and percentage of taxes delinquent each year as of June 30, for the County (from fiscal year 2000-01 to fiscal year 2006-07) and for the District (from fiscal year 2007-08 to fiscal year 2011-12). Similar information was not available for the District for the fiscal year 2012-13.

**Secured Tax Charges and Delinquencies Riverside County**

| Fiscal Year | Secured Tax Charge [1] | Delinquent as of June 30 Amount | Percent |
|---|---|---|---|
| 2000-01 | $1,107,808,176 | $ 36,247,300 | 3.27% |
| 2001-02 | 1,205,221,256 | 44,007,374 | 3.65 |
| 2002-03 | 1,374,241,584 | 47,129,893 | 3.43 |
| 2003-04 | 1,536,936,984 | 36,633,711 | 2.38 |
| 2004-05 | 1,782,872,673 | 58,623,875 | 3.29 |
| 2005-06 | 2,127,175,419 | 87,330,341 | 4.11 |
| 2006-07 | 2,612,026,215 | 187,282,280 | 7.17 |

Source: California Municipal Statistics, Inc.

[1] Represents all taxes collected within the County. The property tax method employed in the County allocates taxes based on total property tax billed under California Revenue and Taxation Code Sections 4701-4717 (commonly referred to as the "Teeter Plan"). The Teeter Plan provides an alternate procedure for the collection and distribution of tax levies on the secured tax roll made by a county on behalf of itself and political subdivisions for which the county serves as tax collecting agency. The Teeter Plan allocates property taxes based on total property tax billed. At year end, the County would advance cash to each taxing jurisdiction in an amount equal to their current year delinquent taxes when collected.

**Secured Tax Charges and Delinquencies of the District**

| Fiscal Year | Secured Tax Charge [1] | Delinquent as of June 30 Amount | Percent |
|---|---|---|---|
| 2007-08 | $2,189,996.92 | $213,837.54 | 9.76% |
| 2008-09 | 2,270,138.29 | 218,390.32 | 9.62 |
| 2009-10 | 6,558,305.25 | 405,479.14 | 6.18 |
| 2010-11 | 5,368,626.23 | 278,420.31 | 5.19 |
| 2011-12 | 5,427,595.92 | 210,910.40 | 3.89 |

Source: California Municipal Statistics, Inc.

[1] District's general obligation bond debt service levy.

## Tax Rates

The base tax rate for all taxing entities within a particular tax code area is $1 per $100 (1%) of assessed valuation in accordance with the State Constitution. To this may be added whatever tax rates are necessary to meet debt service on indebtedness approved by the voters. The Board of the District annually conveys in August to the County Tax Collector the rate to be levied for the debt service on the Bonds. The table below provides the total tax rates for the Tax Rate Area 1-007, a tax rate area within the District, for the ten fiscal years ending with the fiscal year 2012-13.

**Typical Total Tax Rates**

| Fiscal Year | General | Beaumont Unified School District | San Gorgonio Memorial HCD | San Gorgonio Pass Water Agency | Total |
|---|---|---|---|---|---|
| 2003-04 | 1.00000 | 0.03696 | 0 | 0.17000 | 1.20696 |
| 2004-05 | 1.00000 | 0.03564 | 0 | 0.17000 | 1.20564 |
| 2005-06 | 1.00000 | 0.01903 | 0 | 0.17000 | 1.18903 |
| 2006-07 | 1.00000 | 0.01416 | 0.03272 | 0.17000 | 1.21688 |
| 2007-08 | 1.00000 | 0.01293 | 0.03365 | 0.17000 | 1.21565 |
| 2008-09 | 1.00000 | 0.01499 | 0.03365 | 0.17000 | 1.21864 |
| 2009-10 | 1.00000 | 0.04605 | 0.10676 | 0.17000 | 1.32281 |
| 2010-11 | 1.00000 | 0.04980 | 0.09914 | 0.17000 | 1.31894 |
| 2011-12 | 1.00000 | 0.07841 | 0.10365 | 0.18500 | 1.36706 |
| 2012-13 | 1.00000 | 0.08486 | 0.11572 | 0.18500 | 1.38558 |

Source: California Municipal Statistics, Inc.

## District Budget

The fiscal year of the System begins on July 1 and ends on June 30 of the following year. The System prepares and adopts a final budget on or before June 30 for each fiscal year. Operating and capital budgets are adopted each year to reflect estimated revenues, expenditures and capital investments. At the close of each fiscal year, the System engages certified public accountants to audit the System's combined financial statements.

## Direct and Overlapping Bonded Debt

Set forth below is a direct and overlapping debt report (the "Debt Report") prepared by California Municipal Statistics, Inc., and dated December 12, 2012. The Debt Report is included for general information purposes only. The District has not reviewed the Debt Report for completeness or accuracy and makes no representations in connection therewith.

The Debt Report generally includes long-term obligations sold in the public credit markets by public agencies whose boundaries overlap the boundaries of the District in whole or in part. Such long-term obligations are generally not payable from future revenues of the District (except as indicated) nor are they necessarily obligations secured by land within the District. In many cases long-term obligations issued by a public agency are payable only from the general fund or other revenues of such public agency.

**SAN GORGONIO MEMORIAL HEALTHCARE DISTRICT**

2012-13 Assessed Valuation: $5,892,615,057

| DIRECT AND OVERLAPPING TAX AND ASSESSMENT DEBT: | % Applicable | Debt 12/1/12 | |
|---|---|---|---|
| Desert and San Bernardino Valley Joint Community College Districts | 0.019 & 0.079% | $ 395,122 | |
| Banning Unified School District | 99.946 | 45,574,377 | |
| Beaumont Unified School District | 98.122 | 60,218,190 | |
| Palm Springs Unified School District | 0.054 | 170,555 | |
| **San Gorgonio Memorial Healthcare District** | **100.** | **107,770,000** | (1) |
| City of Beaumont Community Facilities District No. 93-1 | 100. | 199,954,342 | |
| City of Banning 1915 Act Bonds | 100. | 2,485,000 | |
| TOTAL DIRECT AND OVERLAPPING TAX AND ASSESSMENT DEBT | | $416,567,586 | |
| OVERLAPPING GENERAL FUND DEBT: | | | |
| Riverside County General Fund Obligations | 2.922% | $19,023,628 | |
| Riverside County Pension Obligations | 2.922 | 10,447,319 | |
| Riverside County Board of Education Certificates of Participation | 2.922 | 113,958 | |
| Mt. San Jacinto Community College District General Fund Obligations | 9.259 | 1,106,451 | |
| Beaumont Unified School District Certificates of Participation | 98.122 | 5,737,779 | |
| Yucaipa-Calimesa Joint Unified School District Certificates of Participation | 0.776 | 103,868 | |
| City of Banning Certificates of Participation | 100. | 3,295,000 | |
| Other Cities General Fund and Pension Obligations | Various | 95,268 | |
| TOTAL GROSS OVERLAPPING GENERAL FUND DEBT | | $39,923,271 | |
| Less: Riverside County supported obligations | | 362,208 | |
| TOTAL NET OVERLAPPING GENERAL FUND DEBT | | $39,561,063 | |
| OVERLAPPING TAX INCREMENT DEBT: | | | |
| Banning Redevelopment Agency | 100. % | $38,840,000 | |
| Riverside County Redevelopment Agency | 2.934 - 49.850 | 21,181,092 | |
| TOTAL OVERLAPPING TAX INCREMENT DEBT | | $60,021,092 | |
| GROSS COMBINED TOTAL DEBT | | $516,511,949 | (2) |
| NET COMBINED TOTAL DEBT | | $516,149,741 | |

(1) Excludes general obligation bonds to be sold.

(2) Excludes tax and revenue anticipation notes, enterprise revenue, mortgage revenue and non-bonded capital lease obligations.

Ratios to 2012-13 Assessed Valuation:

| | |
|---|---|
| **Direct Debt ($107,770,000)** | **1.83%** |
| Total Direct and Overlapping Tax and Assessment Debt | 7.07% |
| Gross Combined Total Debt | 8.77% |
| Net Combined Total Debt | 8.76% |

Ratios to Redevelopment Incremental Value ($918,657,183):

| | |
|---|---|
| Total Overlapping Tax Increment Debt | 6.53% |

Source: California Municipal Statistics, Inc.

## Largest Taxpayers

The twenty largest taxpayers in the District as shown on the 2012-13 secured tax roll, and the approximate amounts of their aggregate level for all taxing jurisdictions within the District are shown below. These twenty largest taxpayers had a total tax levy value of $770,888,773 or 13.97% of the District's 2012-13 secured assessed value.

**SAN GORGONIO MEMORIAL HEALTHCARE DISTRICT**
**Largest 2012-13 Local Secured Taxpayers**

| | Property Owner | Primary Land Use | 2012-13 Assessed Valuation | % of Total [1] |
|---|---|---|---|---|
| 1. | Chelsea GCA Realty Partnership | Outlet Stores | $179,559,087 | 3.25% |
| 2. | Nestle Waters North America Inc. | Industrial | 171,706,595 | 3.11 |
| 3. | Shell Wind Energy Inc. | Power Generation | 45,301,294 | 0.82 |
| 4. | CT Beaumont Partners | Industrial | 36,173,000 | 0.66 |
| 5. | High Desert Partners | Commercial Land | 35,372,284 | 0.64 |
| 6. | Individual | Shopping Center | 32,000,000 | 0.58 |
| 7. | Pardee Homes | Residential Development | 26,170,063 | 0.47 |
| 8. | Cathay Bank | Commercial Land | 24,328,860 | 0.44 |
| 9. | San Gorgonio Land | Vacant | 23,754,780 | 0.43 |
| 10. | Wal Mart Real Estate Business Trust | Commercial | 23,148,731 | 0.42 |
| 11. | Mesa Verde RE Ventures | Vacant | 22,648,238 | 0.41 |
| 12. | Dura Plastic Products Inc. | Industrial | 20,371,520 | 0.37 |
| 13. | MLD Banning Investors | Assisted Living Facility | 18,951,429 | 0.34 |
| 14. | Lowes HIW Inc. | Commercial | 18,085,467 | 0.33 |
| 15. | RRM Properties Ltd. | Industrial | 16,752,606 | 0.30 |
| 16. | KHovnanian Four Seasons at Beaumont | Residential Redevelopment | 16,634,509 | 0.30 |
| 17. | Richmond American Homes of Maryland Inc. | Residential Redevelopment | 16,532,957 | 0.30 |
| 18. | Baldi Bros. | Industrial | 15,953,529 | 0.29 |
| 19. | Kohl's Dept. Stores Inc. | Commercial | 13,964,686 | 0.25 |
| 20. | Home Depot USA Inc. | Commercial | 13,479,138 | 0.24 |
| | | | $770,888,773 | 13.97% |

Source: California Municipal Statutes, Inc.
[1] 2012-13 Local Secured Assessed Valuation: $5,516,985,013

## Largest Employers

Riverside County enjoys a diverse labor pool as a result of its role as a regional manufacturing, service and retail center. Riverside County's agricultural employment distribution affects the County's job market and unemployment rates. Because of the need to retrain workers as the economy evolves, the city and County utilize a network of job training providers to ensure the maintenance of an abundant and qualified work force. The County is a growing regional manufacturing center that provides ample land zoned for industrial use that is governed by an industrial development policy that promotes growth in industrial expansion and employment opportunities. The following table summarizes the fifteen largest employers in Riverside County.

**Riverside County**
**Largest Employers**

| Company | Product/Service | Employees |
|---|---|---|
| County of Riverside | County Government | 17,702 |
| March Air Reserve Base | Government/Military | 9,000 |
| Stater Brothers Markets | Grocery Retailers | 6,900 |
| University of California Riverside | College/University | 5,790 |
| Wal-Mart | Retail Store | 5,360 |
| Corona-Norco Unified School District | Education | 4,686 |
| Kaiser Permanente Riverside | Healthcare | 4,000 |
| Pechanga Resort & Casino | Casino/Resort | 4,000 |
| Riverside Unified School District | Education | 3,796 |
| Moreno Valley Unified School District | Education | 3,500 |
| Hemet Unified School District | Education | 3,238 |
| Abbott Vascular | Medical & Biotech Manufacturer | 2,938 |
| Temecula Valley Unified School District | Education | 2,730 |
| Eisenhower Medical Center | Healthcare | 2,517 |
| City of Riverside | City Government | 2,500 |

Source: County of Riverside Economic Development Agency

## Commercial Activity

The city of Banning is the retail center for the District and experienced a 24% decline in retail sales from 2008 to 2010, and Riverside County experienced an 11% decline in retail sales over the same period. The following table summarizes the total number of sales tax permits and total taxable sales in the city of Banning and Riverside County for the calendar years 2008, 2009 and 2010. Information is not yet available for the full year of 2011.

**City of Banning and Riverside County**
**Taxable Transactions and Total Outlets**
**2008-2010**

| | 2008 | 2009 | 2010 |
|---|---|---|---|
| **City of Banning** | | | |
| Sales Tax Permits | 510 | 451 | 471 |
| Taxable Sales | $193,333,000 | $156,232,000 | $146,742,000 |
| **Riverside County** | | | |
| Sales Tax Permits | 46,272 | 42,765 | 45,688 |
| Taxable Sales | $26,003,595,000 | $22,227,877,000 | $23,152,780,000 |

Source: State Board of Equalization.

### Agriculture

The Riverside County region is agriculturally diverse and productive. Nursery stock, milk, table grapes, avocados, grapefruit, hay, bell peppers, dates, lemons, cotton, tangerines, cattle, calves and eggs are a few of the top agricultural products grown in the region which form the basis of Riverside County's economy. Riverside County grows over 100 commercial crops and ranks as the fourteenth most productive agricultural county in California. Riverside County is one of the leading growers of nursery products and producers of milk and creamery products in the United States. The following table summarizes historical agricultural production within Riverside County for the years 2008 through 2011.

**Riverside County**
**Estimated Value Agricultural Production**
**(000s Omitted)**

| | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|
| Citrus | $ 135,760 | $ 101,652 | $ 140,501 | $ 119,943 |
| Tree & Vine | 173,678 | 191,683 | 164,994 | 232,650 |
| Vegetables | 266,415 | 221,287 | 292,002 | 278,628 |
| Field & Seed | 123,545 | 69,700 | 81,328 | 149,198 |
| Nursery | 230,416 | 206,500 | 169,341 | 200,155 |
| Apiculture | 5,637 | 5,018 | 4,,632 | 4,844 |
| Aquaculture | 12,078 | 5,244 | 4,922 | 4,808 |
| Livestock & Poultry | 321,061 | 214,673 | 235,926 | 292,030 |
| Totals | $1,268,590 | $1,015,757 | $1,093,646 | $1,282,256 |

Source: Riverside County Agricultural Commissioner.

## LEGAL MATTERS

### No Material Litigation

There is no action, suit or proceeding known to be pending or threatened, restraining or enjoining the issuance of the Bonds or questioning or affecting the validity of the Bonds or the proceedings or authority under which they are to be issued. Neither the creation, organization nor existence of the District is being contested.

### Legality for Investment in California

Under provisions of the California Financial Code, the Bonds are legal investments for commercial banks in California to the extent that the Bonds, in the informed opinion of the bank, are prudent for the investment of funds of depositors, and under provisions of the California Government Code, are eligible for security for deposits of public moneys in California.

### Tax Matters

Federal tax law contains a number of requirements and restrictions which apply to the Bonds, including investment restrictions, periodic payments of arbitrage profits to the United States, requirements regarding the proper use of bond proceeds and the facilities financed therewith, and certain other matters. The District has covenanted to comply with all requirements that must be satisfied in order for the interest on the Bonds to be excludable from gross income for federal income tax purposes. Failure to comply with certain of such covenants could cause interest on the Bonds to become includable in gross income for federal income tax purposes retroactively to the date of issuance of the Bonds.

Subject to the District's compliance with the above-referenced covenants, under present law, in the opinion of Quint & Thimmig LLP, San Francisco, California, Bond Counsel, interest on the Bonds (i) is excludable from the gross income of the owners thereof for federal income tax purposes, (ii) is not included as an item of tax preference in computing the federal alternative minimum tax for individuals and corporations, and (iii) is not taken into account in computing "adjusted current earnings" as described below.

The Internal Revenue Code of 1986, as amended (the "Code"), includes provisions for an alternative minimum tax ("AMT") for corporations in addition to the corporate regular tax in certain cases. The AMT for a corporation, if any, depends upon the corporation's alternative minimum taxable income ("AMTI"), which is the corporations' taxable income with certain adjustments. One of the adjustment items used in computing the AMTI of a corporation (with certain exceptions) is an amount equal to 75% of the excess of such corporation's "adjusted current earnings" over an amount equal to its AMTI (before such adjustment item and the alternative tax net operating loss deduction). "Adjusted current earnings" would generally include certain tax-exempt interest, but not interest on the Bonds.

In rendering its opinion, Bond Counsel will rely upon certifications of the District with respect to certain material facts within their respective knowledge. Bond Counsel's opinion represents its legal judgment based upon its review of the law and the facts that it deems relevant to render such opinion and is not a guarantee of a result.

Ownership of the Bonds may result in collateral federal income tax consequences to certain taxpayers, including, without limitation, corporations subject to the branch profits tax, financial institutions, certain insurance companies, certain S corporations, individual recipients of Social Security or Railroad Retirement benefits and taxpayers who may be deemed to have incurred (or continued) indebtedness to purchase or carry tax-exempt obligations. Prospective purchasers of the Bonds should consult their tax advisors as to applicability of any such collateral consequences.

The issue price (the "Issue Price") for each maturity of the Bonds is the price at which a substantial amount of such maturity of the Bonds is first sold to the public. The Issue Price of a maturity of the Bonds may be different from the price set forth, or the price corresponding to the yield set forth, on the cover page hereof.

Owners of Bonds who dispose of Bonds prior to the stated maturity (whether by sale, redemption or otherwise), purchase Bonds in the initial public offering, but at a price different from the Issue Price, or purchase Bonds subsequent to the initial public offering, should consult their own tax advisors.

If a Bond is purchased at any time for a price that is less than the Bond's stated redemption price at maturity (the "Reduced Issue Price"), the purchaser will be treated as having purchased a Bond with market discount subject to the market discount rules of the Code (unless a statutory *de minimis* rule applies). Accrued market discount is treated as taxable ordinary income and is recognized when a Bond is disposed of (to the extent such accrued discount does not exceed gain realized) or, at the purchaser's election, as it accrues. Such treatment would apply to any purchaser who purchases a Bond for a price that is less than its Revised Issue Price. The applicability of the market discount rules may adversely affect the liquidity or secondary market price of such Bond. Purchasers should consult their own tax advisors regarding the potential implications of market discount with respect to the Bonds.

An investor may purchase a Bond at a price in excess of its stated principal amount. Such excess is characterized for federal income tax purposes as "bond premium" and must be amortized by an investor on a constant yield basis over the remaining term of the Bond in a manner that takes into account potential call dates and call prices. An investor cannot deduct amortized bond premium relating to a tax-exempt bond. The amortized bond premium is treated as a reduction in the tax-exempt interest received. As bond premium is amortized, it reduces the investor's basis in the Bond. Investors who purchase a Bond at a premium should consult their own tax advisors regarding the amortization of bond premium and its effect on the Bond's basis for purposes of computing gain or loss in connection with the sale, exchange, redemption or early retirement of the Bond.

There are or may be pending in the Congress of the United States legislative proposals, including some that carry retroactive effective dates, that, if enacted, could alter or amend the federal tax matters referred to above or affect the market value of the Bonds. It cannot be predicted whether or in what form any such proposal might be enacted or whether, if enacted, it would apply to bonds issued prior to enactment. Prospective purchasers of the Bonds should consult their own tax advisors regarding any pending or proposed federal tax legislation. Bond Counsel expresses no opinion regarding any pending or proposed federal tax legislation.

The Internal Revenue Service (the "IRS") has an ongoing program of auditing tax exempt obligations to determine whether, in the view of the IRS, interest on such tax exempt obligations is includable in the gross income of the owners thereof for federal income tax purposes. It cannot be predicted whether or not the IRS will commence an audit of the Bonds. If an audit is commenced, under current procedures the IRS may treat the Issuer as a taxpayer

and the Bondholders may have no right to participate in such procedure. The commencement of an audit could adversely affect the market value and liquidity of the Bonds until the audit is concluded, regardless of the ultimate outcome.

Payments of interest on, and proceeds of the sale, redemption or maturity of, tax exempt obligations, including the Bonds, are in certain cases required to be reported to the IRS. Additionally, backup withholding may apply to any such payments to any Bond owner who fails to provide an accurate Form W 9 Request for Taxpayer Identification Number and Certification, or a substantially identical form, or to any Bond owner who is notified by the IRS of a failure to report any interest or dividends required to be shown on federal income tax returns. The reporting and backup withholding requirements do not affect the excludability of such interest from gross income for federal tax purposes.

In the further opinion of Bond Counsel, interest on the Bonds is exempt from California personal income taxes.

Ownership of the Bonds may result in other state and local tax consequences to certain taxpayers. Bond Counsel expresses no opinion regarding any such collateral consequences arising with respect to the Bonds. Prospective purchasers of the Bonds should consult their tax advisors regarding the applicability of any such state and local taxes.

The complete text of the final opinion that Bond Counsel expects to deliver upon the issuance of the Bonds is set forth in APPENDIX A—"FORM OF FINAL OPINION OF BOND COUNSEL."

**Approval of Legality**

The validity of the Bonds and certain other legal matters are subject to the approving opinion of Quint & Thimmig LLP, San Francisco, California, as Bond Counsel.

## RATING

Moody's has assigned the rating of "A3" (stable outlook) to the Bonds based upon the District's own credit and the source of payment for the Bonds. No application was made to any other rating agency for the purpose of obtaining additional ratings on the Bonds.

Such rating reflects only the views of Moody's, and any explanation of the significance of such rating may only be obtained from Moody's. Generally, rating agencies base their ratings on information and materials furnished to them and on investigations, studies and assumptions by the rating agencies. The District furnished to Moody's certain information and materials that have not been included in this Official Statement.

There is no assurance that the rating mentioned above will remain in effect for any given period of time or that the rating might not be lowered or withdrawn entirely by Moody's, if in its judgment circumstances so warrant. The Underwriter has undertaken no responsibility either to bring to the attention of the owners of the Bonds any proposed change in or withdrawal of the rating or to oppose any such proposed revision or withdrawal. Any such downward change in or withdrawal of the rating might have an adverse effect on the market price or marketability of the Bonds.

## MISCELLANEOUS

**Underwriting**

The Bonds are being purchased pursuant to the terms of the public bid dated February 26, 2013, for re-offering by _____ (the "Underwriter"). The Underwriter has agreed to purchase the Bonds for $_____, which includes the principal amount of $_____, plus an original issue premium of $_____, and less the Underwriter's discount of $_____. The Underwriter will be obligated to purchase all the Bonds if any are purchased.

**Continuing Disclosure**

The District has covenanted for the benefit of bondholders and Beneficial Owners of the Bonds to disseminate certain financial information and operating data relating to the District, and to provide notices of the occurrence of certain enumerated events. See "APPENDIX C - FORM OF CONTINUING DISCLOSURE CERTIFICATE." These covenants have been made in order to assist the Underwriter in complying with Rule 15c2-12 promulgated by the Securities and Exchange Commission. The District has continuing disclosure obligations with respect to revenue bonds issued by it in 1998 and with respect to the 2006 Bonds, the 2008 Bonds and the 2009 Bonds. The District has represented that, as of the date of this Official Statement, it is material compliance with the reporting obligations applicable to the District for the past five years.

**Verification**

The Verification Agent, upon delivery of the Bonds, will deliver a report of the mathematical accuracy of certain computations, contained in schedules provided to the Verification Agent on behalf of the District, relating to (i) the sufficiency of the anticipated amount of proceeds of the Bonds and other funds available to pay, when due, the principal, whether at maturity or upon prior redemption, interest and redemption premium requirements of the Refunded 2006 Bonds and (ii) the "yield" of the deposits in the Escrow Fund and on the Bonds considered by Bond Counsel in connection with the opinion rendered by such firm that the Bonds are not "arbitrage bonds" within the meaning of section 148 of the Internal Revenue Code of 1986, as amended.

The report of the Verification Agent will include the statement that the scope of their engagement is limited to verifying mathematical accuracy, of the computations contained in such schedules provided to them, and that they have no obligation to update their report because of events occurring, or data or information coming to their attention, subsequent to the date of their report.

**Additional Information**

The summaries or descriptions of provisions of the Bonds, the Resolution 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. Reference is made to said documents for full and complete statements of the provisions of such documents. The APPENDICES attached hereto are a part of this Official Statement. Copies, in reasonable quantity, of the Resolution may be obtained during the offering period upon request to the Financial Advisor at (801) 225-0731 and thereafter upon request to the principal corporate trust office of the Paying Agent.

The District has authorized and consented to the execution and distribution of this Official Statement. This Official Statement is not to be construed as a contract or agreement between the District and the purchasers or owners of any of the Bonds.

SAN GORGONIO MEMORIAL HEALTHCARE DISTRICT

By: _____

Title: Board Chair

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**APPENDIX A**

**FORM OF BOND COUNSEL OPINION**

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# APPENDIX A

# FORM OF FINAL OPINION OF BOND COUNSEL

[Letterhead of Quint & Thimmig LLP]

[Closing Date]

Board of Directors of the
San Gorgonio Memorial Healthcare District
600 North Highland Springs Avenue
Banning, California 92220

***OPINION:*** $23,875,000* San Gorgonio Memorial Healthcare District (Riverside County, California) 2013 General Obligation Refunding Bonds

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Members of the Board of Directors:

We have acted as bond counsel to the San Gorgonio Memorial Healthcare District (the "District") in connection with the issuance by the District of $23,875,000* principal amount of San Gorgonio Memorial Healthcare District (Riverside County, California) 2013 General Obligation Refunding Bonds (the "Bonds"), pursuant to Article 9 of Chapter 3 (commencing with section 53550) of Division 2 of Title 5 of the California Government Code (the "Act"), Resolution No. 2013-01, adopted by the Board of Directors (the "Board") of the District on January 8, 2013 (the "Resolution"). We have examined the law and such certified proceedings and other papers as we deemed necessary to render this opinion.

As to questions of fact material to our opinion, we have relied upon representations of the Board contained in the Resolution and in the certified proceedings and certifications of public officials and others furnished to us, without undertaking to verify such facts by independent investigation.

Based upon our examination, we are of the opinion, as of the date hereof, that:

1. The District is duly created and validly existing as a healthcare district with the power to issue the Bonds and to perform its obligations under the Resolutions and the Bonds.

2. The Resolution has been duly adopted by the District and creates a valid first lien on the funds pledged under the Resolution for the security of the Bonds.

3. The Bonds have been duly authorized, executed and delivered by the District and are valid and binding general obligations of the District. The District is required under the Act to levy a tax upon all taxable property in the District for the interest and redemption of all outstanding bonds of the District, including the Bonds. The Bonds are payable from an *ad valorem* tax levied without limitation as to rate or amount.

4. Subject to the District's compliance with certain covenants, interest on the Bonds is excludable from gross income of the owners thereof for federal income tax purposes and is not included as an item of tax preference in computing the alternative minimum tax for individuals and corporations under the Internal Revenue Code of 1986, as amended, but is taken into account in computing an adjustment used in determining the federal alternative minimum tax for certain corporations. Failure to comply with certain of such District covenants could cause interest on the Bonds to be includible in gross income for federal income tax purposes retroactively to the date of issuance of the Bonds.

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* Preliminary, subject to change.

5. The interest on the Bonds is exempt from personal income taxation imposed by the State of California.

Ownership of the Bonds may result in other tax consequences to certain taxpayers, and we express no opinion regarding any such collateral consequences arising with respect to the Bonds.

The rights of the owners of the Bonds and the enforceability of the Bonds and the Resolution may be subject to the bankruptcy, insolvency, reorganization, moratorium and other similar laws affecting creditors' rights heretofore or hereafter enacted and also may be subject to the exercise of judicial discretion in accordance with general principles of equity.

In rendering this opinion, we have relied upon certifications of the District and others with respect to certain material facts. Our opinion represents our legal judgment based upon such review of the law and the facts that we deem relevant to render our opinion and is not a guarantee of a result. This opinion is given as of the date hereof and we assume no obligation to revise or supplement this opinion to reflect any facts or circumstances that may hereafter come to our attention or any changes in law that may hereafter occur.

Respectfully submitted,

**APPENDIX B**

**AUDITED FINANCIAL STATEMENTS OF THE SYSTEM FOR THE FISCAL YEAR ENDED JUNE 30, 2012 AND JUNE 30, 2011**

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# San Gorgonio
# Health Care System

Combined Financial Statements and
Independent Auditors' Report

June 30, 2012 and 2011

DINGUS | ZARECOR & ASSOCIATES PLLC
Certified Public Accountants

**San Gorgonio Health Care System**
**Table of Contents**

DINGUS | ZARECOR & ASSOCIATES PLLC
Certified Public Accountants

# INDEPENDENT AUDITORS' REPORT

Board of Directors
San Gorgonio Health Care System
Banning, California

We have audited the accompanying combined balance sheets of San Gorgonio Health Care System (the System) (a nonprofit organization) as of June 30, 2012 and 2011, and the related combined statements of operations and changes in net assets and cash flows for the years then ended. These combined financial statements are the responsibility of the System's management. Our responsibility is to express an opinion on these financial statements based on our audits.

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

In our opinion, the combined financial statements referred to above present fairly, in all material respects, the financial position of the System as of June 30, 2012 and 2011, and the changes in its net assets and its cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

Our audits were conducted for the purpose of forming an opinion on the combined financial statements as a whole. The combining balance sheets; combining statements of operations and changes in net assets; statement of earnings before interest, depreciation and amortization; and statement of property tax receipts and disbursements on pages 26, 27, 28 and 29, respectively, are presented for purposes of additional analysis and are not required parts 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 audit 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 of America. In our opinion, the information is fairly stated in all material respects in relation to the combined financial statements as a whole.

*Dingus, Zarecor & Associates PLLC*

Spokane Valley, Washington
October 25, 2012



12015 East Main, Suite A | Spokane Valley, WA 99206 | 509.242.0874 | www.dzacpa.com

**San Gorgonio Health Care System**
**Combined Balance Sheets**
**June 30, 2012 and 2011**

| **ASSETS** | **2012** | **2011** |
|---|---|---|
| *Current assets* | | |
| Cash and cash equivalents | **$ 1,329,828** | $ 1,291,127 |
| Current portion of assets limited as to use | **4,770,134** | 1,010,177 |
| Receivables: | | |
| Patient accounts, net of allowance for doubtful accounts of $7,926,858 and $7,203,451, respectively | **7,635,595** | 7,006,317 |
| Taxes | **2,270,567** | 2,085,306 |
| Intergovernmental Transfer Program refund | - | 887,727 |
| Electronic health records incentive payment | **1,351,049** | - |
| Grants | **407,944** | - |
| Malpractice insurance recoveries | **274,558** | - |
| Inventories | **955,699** | 939,909 |
| Prepaid expenses and other current assets | **104,523** | 48,565 |
| Total current assets | **19,099,897** | 13,269,128 |
| *Interest in net assets of San Gorgonio Memorial Hospital Foundation, Inc.* | **759,260** | 1,094,068 |
| *Assets limited as to use, less current portion* | **27,139,454** | 49,970,783 |
| *Property and equipment, net of accumulated depreciation* | **104,703,538** | 81,039,686 |
| *Bond issuance cost, net of amortization* | **674,206** | 708,321 |
| **Total assets** | **$ 152,376,355** | $ 146,081,986 |

*See accompanying notes to combined financial statements.*

**San Gorgonio Health Care System**
**Combined Balance Sheets (Continued)**
**June 30, 2012 and 2011**

| LIABILITIES AND NET ASSETS | 2012 | 2011 |
|---|---|---|
| *Current liabilities* | | |
| Current maturities of notes payable and capital lease obligation | **$ 1,141,546** | $ 584,638 |
| Current maturities of bonds payable | **115,000** | 75,000 |
| Accounts payable | **2,372,145** | 2,676,330 |
| Construction accounts payable | **1,909,756** | 3,302,556 |
| Patient refunds payable | **432,694** | 485,531 |
| Accrued payroll and related liabilities | **1,464,584** | 1,224,264 |
| Bank line of credit | **2,408,396** | 2,708,396 |
| Third-party payor settlements payable | **267,000** | 754,028 |
| Malpractice claims payable | **274,558** | - |
| Accrued interest payable | **2,801,796** | 2,787,726 |
| Total current liabilities | **13,187,475** | 14,598,469 |
| *Notes payable and capital lease obligation, less current maturities* | **5,801,100** | 4,595,752 |
| *Bonds payable, less current maturities* | **108,242,569** | 108,376,750 |
| Total liabilities | **127,231,144** | 127,570,971 |
| *Net assets* | | |
| Unrestricted | **24,385,951** | 17,416,947 |
| Temporarily restricted | **708,260** | 1,043,068 |
| Permanently restricted | **51,000** | 51,000 |
| Total net assets | **25,145,211** | 18,511,015 |
| **Total liabilities and net assets** | **$ 152,376,355** | $ 146,081,986 |

*See accompanying notes to combined financial statements.*

**San Gorgonio Health Care System**
**Combined Statements of Operations and Changes in Net Assets**
**Years Ended June 30, 2012 and 2011**

| | 2012 | 2011 |
|---|---|---|
| *Unrestricted revenues, gains, and other support* | | |
| Net patient service revenue | **$ 55,484,174** | $ 49,848,384 |
| Electronic health records incentive payment | **2,131,132** | - |
| Other revenues: | | |
| Grant revenue | **581,755** | 790,452 |
| District taxes for operations | **2,874,257** | 2,754,123 |
| Interest income | **23,068** | 25,972 |
| Other operating income | **285,717** | 340,236 |
| Total unrestricted revenues, gains, and other support | **61,380,103** | 53,759,167 |
| *Operating expenses* | | |
| Salaries and wages | **22,537,032** | 19,568,430 |
| Employee benefits | **4,521,921** | 3,481,424 |
| Medical and other professional fees | **2,152,360** | 2,333,634 |
| Purchased services | **3,973,461** | 3,068,436 |
| Supplies | **6,649,570** | 5,207,764 |
| Utilities | **680,950** | 588,465 |
| Repairs and maintenance | **382,453** | 259,462 |
| Rents and leases | **408,571** | 259,063 |
| Insurance | **684,799** | 675,343 |
| Provision for bad debts | **12,164,809** | 13,149,598 |
| Depreciation and amortization | **4,087,707** | 2,803,559 |
| Interest | **469,144** | 450,178 |
| Other | **2,564,205** | 1,203,955 |
| Total operating expenses | **61,276,982** | 53,049,311 |
| *Excess of unrestricted revenues, gains, and other support over operating expenses (balances carried forward)* | **$ 103,121** | $ 709,856 |

*See accompanying notes to combined financial statements.*

**San Gorgonio Health Care System**
**Combined Statements of Operations and Changes in Net Assets (Continued)**
**Years Ended June 30, 2012 and 2011**

| | 2012 | 2011 |
|---|---|---|
| *Excess of unrestricted revenues, gains, and other support over operating expenses (balances brought forward)* | **$ 103,121** | $ 709,856 |
| *District taxes for capital expenditures* | **6,379,133** | 6,530,246 |
| *Net assets released from restrictions used for purchases of property and equipment* | **486,750** | 160,904 |
| *Change in unrestricted net assets before extraordinary item* | **6,969,004** | 7,401,006 |
| *Extraordinary item - loss on bond discount and issue costs* | - | (231,862) |
| Increase in unrestricted net assets | **6,969,004** | 7,169,144 |
| *Change in temporarily restricted net assets* | | |
| Net assets released from restrictions used for purchases of property and equipment | - | (11,794) |
| Change in interest in temporarily restricted net assets of San Gorgonio Memorial Hospital Foundation, Inc. | **(334,808)** | 7,182 |
| Decrease in temporarily restricted net assets | **(334,808)** | (4,612) |
| Change in net assets | **6,634,196** | 7,164,532 |
| Net assets, beginning of year | **18,511,015** | 11,346,483 |
| **Net assets, end of year** | **$ 25,145,211** | **$** 18,511,015 |

*See accompanying notes to combined financial statements.*

**San Gorgonio Health Care System**
**Combined Statements of Cash Flows**
**Years Ended June 30, 2012 and 2011**

| | 2012 | 2011 |
|---|---|---|
| ***Increase (Decrease) in Cash and Cash Equivalents*** | | |
| *Cash flows from operating activities* | | |
| Cash received from and on behalf of patients | **$ 43,037,949** | $ 37,382,653 |
| Cash received from electronic health records incentive payment | **780,083** | - |
| Cash received from interest income | **23,068** | 25,972 |
| Cash received from grants | **173,811** | 861,254 |
| Cash received from other revenue | **229,763** | 340,236 |
| Cash paid for employee salaries and benefits | **(26,818,633)** | (23,820,394) |
| Cash paid for interest expense | **(440,140)** | (1,463,446) |
| Cash paid for other expenses | **(17,816,348)** | (15,144,916) |
| Net cash used in operating activities | **(830,447)** | (1,818,641) |
| *Cash flows from investing activities* | | |
| Acquisition of property and equipment | **(29,144,359)** | (32,703,712) |
| Proceeds from sale of investments | **-** | 811,825 |
| Transfers to assets limited as to use | **(5,279,519)** | (1,106,824) |
| Transfers from assets limited as to use | **24,350,891** | 26,406,511 |
| Net cash used in investing activities | **(10,072,987)** | (6,592,200) |
| *Cash flows from financing activities* | | |
| Cash received from District taxes | **9,068,129** | 8,735,309 |
| Cash received from contributions restricted for purchase of property and equipment | **486,750** | 149,110 |
| Cash received from issuance of long-term debt | **2,750,000** | 5,300,000 |
| Proceeds from line of credit | **700,000** | 3,008,396 |
| Repayment of line of credit | **(1,000,000)** | (2,540,469) |
| Repayment of note payable and capital lease obligation | **(987,744)** | (269,269) |
| Repayment of bonds payable | **(75,000)** | (6,070,000) |
| Net cash provided by financing activities | **10,942,135** | 8,313,077 |
| Net increase (decrease) in cash and cash equivalents | **38,701** | (97,764) |
| Cash and cash equivalents, beginning of year | **1,291,127** | 1,388,891 |
| **Cash and cash equivalents, end of year** | **$ 1,329,828** | $ 1,291,127 |

*See accompanying notes to combined financial statements.*

**San Gorgonio Health Care System**
**Combined Statements of Cash Flows (Continued)**
**Years Ended June 30, 2012 and 2011**

| | 2012 | 2011 |
|---|---|---|
| ***Reconciliation of Change in Net Assets to Net Cash Used in Operating Activities*** | | |
| Change in net assets | **$ 6,634,196** | $ 7,164,532 |
| *Adjustments to reconcile change in net assets to net cash used in operating activities* | | |
| Depreciation and amortization | **4,087,707** | 2,803,559 |
| Provision for bad debts | **12,164,809** | 13,149,598 |
| Extraordinary loss on bond discount and issue costs | **-** | 231,862 |
| Undistributed portion of change in interest in net assets of San Gorgonio Memorial Hospital Foundation, Inc. | **334,808** | (7,182) |
| Net assets released from restrictions used for purchases of property and equipment | **(486,750)** | (149,110) |
| Tax revenue from the District | **(9,253,390)** | (9,284,369) |
| Amortization of bond premiums and discounts | **(19,181)** | (14,818) |
| Amortization of bond issuance costs | **34,115** | (57,471) |
| Decrease (increase) in | | |
| Patient receivables | **(12,794,087)** | (13,572,280) |
| Third-party payor settlements | **-** | 295,990 |
| Electronic health records incentive payment receivable | **(1,351,049)** | - |
| Intergovernmental Transfer Program refund | **887,727** | (887,727) |
| Grants receivable | **(407,944)** | - |
| Inventories | **(15,790)** | (165,817) |
| Prepaid expenses and other current assets | **(55,958)** | 101,255 |
| Increase (decrease) in | | |
| Accounts payable | **(304,185)** | (1,413,430) |
| Patient refunds payable | **(52,837)** | 485,531 |
| Accrued payroll and related liabilities | **240,320** | (770,540) |
| Third-party payor settlements payable | **(487,028)** | 325,028 |
| Accrued interest payable | **14,070** | (53,252) |
| **Net cash used in operating activities** | **$ (830,447)** | $ (1,818,641) |

*See accompanying notes to combined financial statements.*

## 1. Reporting Entity and Summary of Significant Accounting Policies:

### a. Reporting Entity

The combined financial statements of San Gorgonio Health Care System are comprised of San Gorgonio Health Care District (the District) and San Gorgonio Memorial Hospital (the Hospital). Collectively, the two entities combine to function as San Gorgonio Health Care System (the System).

The District, a political subdivision of the state of California, owns a healthcare facility in Banning, California. The District is governed by a five-member elected Board from within the geographic boundaries of the healthcare district. The District leases the healthcare facility to the Hospital and jointly, with the Hospital, participates in managing the System.

The Hospital is a tax-exempt corporation formed under Section 501(c)(3) of the Internal Revenue Code. It leases and operates the healthcare facilities. The Hospital is governed by the five elected District Board members and by nine additional appointed Board members for the combined total Board.

The combined financial statements combine the accounts of the District and the Hospital. Significant inter-related transactions have been eliminated in the combination.

### b. Summary of Significant Accounting Policies

***Use of estimates*** – The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America 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 financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

***Income tax status*** – The System is exempt from federal income tax. Accordingly, no provision for income tax is necessary. The System evaluates uncertain tax positions whereby the effect of the uncertainty would be recorded if the outcome was considered probable and reasonably estimable. As of June 30, 2012 and 2011, the System had no uncertain tax positions requiring accrual.

***Cash and cash equivalents*** – Cash and cash equivalents include highly liquid investments with an original maturity of three months or less.

## 1. Reporting Entity and Summary of Significant Accounting Policies (continued):

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

***Fair value measurements*** – Fair value is defined as the price that would be received to sell an asset or paid to transfer a liability (i.e., the "exit price") in an orderly transaction between market participants at the measurement date.

The System classified its investments as of June 30, 2012 and 2011, based upon an established fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to unobservable inputs (Level 3 measurements).

The three levels of the fair value hierarchy are described below:

**Level 1** – Unadjusted quoted prices in active markets that are accessible at the measurement date for identical, unrestricted assets or liabilities.

**Level 2** – Quoted prices in markets that are not considered to be active or financial instruments without quoted market prices, but for which all significant inputs are observable, either directly or indirectly. The System did not have any Level 2 investments in the years ended June 30, 2012 or 2011.

**Level 3** – Prices or valuations that require inputs that are both significant to the fair value measurement and unobservable.

***Investments*** – Investments in equity securities with readily determinable fair values and all investments in debt securities are measured at fair value in the combined balance sheets based on quoted market prices (Level 1 input for fair value measurement). Investments under capital guarantee agreements are measured at fair value in the combined balance sheets based on unobservable inputs (Level 3 input for fair value measurement). Investment income or loss (including realized gains and losses on investments, interest, and dividends) is included in the excess of revenues (expenses) unless the income or loss is restricted by donor or law. Unrealized gains and losses on investments are excluded from the excess of revenues (expenses) unless the investments are trading securities.

***Assets limited as to use*** – Assets limited as to use consist of cash and cash equivalents held by a trustee under a bond indenture agreement, amounts restricted under grant agreement for capital purchases, amounts held as collateral under a loan agreement, investments held by a trustee under a bond indenture agreement, and investments held under a guaranteed investment contract. Amounts required to meet current obligations have been classified as current assets in the combined balance sheets.

***Patient accounts receivable*** – Receivables arising from revenue from services to patients are reduced by allowances for uncollectible accounts and contractual adjustments based on experience, third-party payor contractual reimbursement arrangements, and any unusual circumstances which may affect the ability of patients to meet their obligations. Accounts deemed uncollectible are charged against these allowances. Accounts are determined to be delinquent if they are not resolved within 90-120 days of billing.

***Inventories*** – Inventories are stated at replacement cost, which approximates the market price. Inventories consist of medical supplies and pharmaceuticals sold to patients and other minor supply items.

## 1. Reporting Entity and Summary of Significant Accounting Policies (continued):

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

***Property and equipment*** – It is the System's policy to capitalize equipment over $5,000; lesser amounts are expensed. Property and equipment are recorded at cost. Depreciation is provided over the estimated useful life of each class of depreciable asset. Depreciation expense includes the amortization of capital lease obligations. Depreciation is computed using the straight-line method over the following estimated useful service lives:

| | |
|---|---|
| Land improvements | 7 to 25 years |
| Buildings and improvements | 5 to 40 years |
| Equipment | 3 to 20 years |

Gifts of long-lived assets such as land, buildings, or equipment are reported at fair value as of the date of the gift and as unrestricted contributions, but are excluded from the excess of expenses over revenues. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or assets that must be used to acquire long-lived assets are reported as restricted contributions.

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.

***Bond issuance costs*** – Bond issuance costs are capitalized expenses associated with the original issuance of the bonds. These costs are amortized based on the bonds-outstanding method over the term of the bond issue.

***Excess of revenues over expenses (expenses over revenues)*** – The combined statements of operations and changes in net assets include excess of revenues over expenses (expenses over revenues). Changes in unrestricted net assets which are excluded from excess of revenues over expenses (expenses over revenues) consistent with industry practice, include unrealized gains and losses on investments other than trading securities, contributions of long-lived assets (including assets acquired using contributions which by donor restrictions were to be used for the purposes of acquiring such assets), and property taxes collected by Riverside County and used by the System to make monthly debt service payments.

***Temporarily and permanently restricted net assets*** – Temporarily restricted net assets are those whose use by the System 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 the System in perpetuity.

***Net patient service revenue*** – Net patient service revenue is reported as 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.

## 1. Reporting Entity and Summary of Significant Accounting Policies (continued):

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

***Donor-restricted gifts*** – Unconditional promises to give cash and other assets to the System are reported at fair value at the date the promise is received. The gifts are reported as restricted contributions 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, the restricted contributions are reclassified as unrestricted contributions and reported in the combined statements of operations as unrestricted contributions released from restrictions. Donor-restricted contributions whose restrictions are met within the same year as received are reported as unrestricted contributions in the combined statements of operations.

***Implementation of accounting standards –*** The System has adopted the accounting guidance in Financial Accounting Standards Board Accounting Standards Update (ASU) No. 2010-24, *Presentation of Insurance Claims and Related Insurance Recoveries*. ASU No. 2010-24 requires healthcare entities to record a malpractice claims liability without consideration of insurance recoveries. The amount expected to be indemnified by a malpractice insurance carrier may then be recognized as an insurance receivable, net of any applicable valuation allowance. Previously, healthcare entities were permitted to net the liability and receivable. Adoption of ASU No. 2010-24 had no effect on the combined statements of operations and changes in net assets or on the beginning balance of net assets of the System for the year ended June 30, 2012.

***Reclassifications*** – Certain reclassifications have been made in the 2011 combined financial statements to conform to the classifications used in the 2012 combined financial statements with no effect on the previously reported change in net assets.

***Subsequent events*** – Subsequent events have been reviewed through October 25, 2012, the date on which the combined financial statements were available to be issued.

## 2. San Gorgonio Hospital Foundation, Inc.:

The San Gorgonio Hospital Foundation, Inc. (the Foundation) was established to solicit contributions for the System and to support healthcare services in the area of Banning, California. The Foundation has a separate Board of Directors from the System, but exists primarily to support the System. The Foundation contributed approximately $487,000 and $149,000 to the System in 2012 and 2011, respectively.

The System records its interest in the net assets of the Foundation that have been collected by the Foundation for the System but not yet distributed to the System.

| | | 2012 | | 2011 |
|---|---|---|---|---|
| *Temporarily restricted net assets are available for the following purposes:* | | | | |
| Equipment and furnishings | **$** | - | $ | 685 |
| Various hospital support needs | | **708,260** | | 1,042,383 |
| | **$** | **708,260** | $ | 1,043,068 |
| *Permanently restricted net assets, the income from which is expendable to support healthcare services:* | | | | |
| Endowment | **$** | **51,000** | $ | 51,000 |

## 3. Assets Limited As To Use:

The following tables set forth by level within the fair value hierarchy a summary of assets whose use is limited or restricted measured at fair value on a recurring basis at June 30, 2012 and 2011:

| | Fair Value Measurements at June 30, 2012, Using | | |
|---|---|---|---|
| | **Quoted Prices in Active Markets for Identical Assets (Level 1)** | **Significant Unobservable Inputs (Level 3)** | **Total** |
| *Cash and cash equivalents* | | | |
| Under bond indenture for capital additions | **$ 451,667** | $ - | 451,667 |
| Under bond indenture for future debt service | **4,281,064** | - | 4,281,064 |
| Under bank financing reserve requirement | **196** | - | 196 |
| Held as collateral for loan | **759,079** | - | 759,079 |
| Restricted by grantor for capital additions | **21,798** | - | 21,798 |
| Restricted by lendor for capital additions | **2,750,569** | - | 2,750,569 |
| Total cash and cash equivalents limited as to use | **8,264,373** | - | 8,264,373 |
| *Investments* | | | |
| Under guaranteed investment contract | - | 23,645,215 | 23,645,215 |
| Total corporate bond investments limited as to use | - | 23,645,215 | 23,645,215 |
| Total assets limited as to use | **8,264,373** | 23,645,215 | 31,909,588 |
| Less amounts needed to match current obligations | **(4,770,134)** | - | (4,770,134) |
| **Assets limited as to use** | **$ 3,494,239** | $ 23,645,215 | **27,139,454** |

## 3. Assets Limited As To Use (continued):

| | Fair Value Measurements at June 30, 2011, Using | | |
|---|---|---|---|
| | **Quoted Prices in Active Markets for Identical Assets (Level 1)** | **Significant Unobservable Inputs (Level 3)** | **Total** |
| *Cash and cash equivalents* | | | |
| Under bond indenture for capital additions | **$ 79,712** | $ - | $ 79,712 |
| Under bond indenture for future debt service | **5,220,169** | - | 5,220,169 |
| Under bank financing reserve requirement | **196** | - | 196 |
| Held as collateral for loan | **361,521** | - | 361,521 |
| Restricted by grantor for capital additions | **656** | - | 656 |
| Total cash and cash equivalents limited as to use | **5,662,254** | - | 5,662,254 |
| *Investments* | | | |
| Under guaranteed investment contract | - | 45,318,706 | 45,318,706 |
| Total corporate bond investments limited as to use | - | 45,318,706 | 45,318,706 |
| Total assets limited as to use | **5,662,254** | 45,318,706 | 50,980,960 |
| Less amounts needed to match current obligations | **(1,010,177)** | - | (1,010,177) |
| **Assets limited as to use** | **$ 4,652,077** | $ 45,318,706 | $ **49,970,783** |

The Level 3 valuations are based on an estimate of the net present value of future cash flows from the investments using the stated interest rate on the investments and the current inflation rate. There were no changes in the valuation techniques during the year.

The change in the Level 3 investment value during the years ended June 30, 2012 and 2011, was as follows:

| | |
|---|---|
| July 1, 2010 | **$ 58,485,906** |
| Interest income | **974,397** |
| Transfers out of account for construction expenses | **(14,141,597)** |
| June 30, 2011 | **45,318,706** |
| | |
| July 1, 2011 | **45,318,706** |
| Interest income | **591,104** |
| Transfers out of account for construction expenses | **(22,264,595)** |
| June 30, 2012 | **$ 23,645,215** |

## 4. Net Patient Service Revenue:

The System renders services to patients under contractual arrangements with the Medicare and Medi-Cal programs, in addition to various health maintenance and preferred provider organizations.

- *Medicare* – Inpatient acute care services and outpatient services rendered to Medicare program beneficiaries are paid at prospectively determined rates. These rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. The System is reimbursed for some items at a tentative rate with final settlement determined after submission of annual cost reports by the System and audits thereof by the Medicare fiscal intermediary.

- *Medi-Cal* – Traditional Medi-Cal inpatient and outpatient services are paid on a cost basis as defined by the state of California subject to certain limitations. The System is reimbursed at a tentative rate with final settlement determined after submission of annual cost reports by the System and audits thereof by Medi-Cal. The System has no capitated arrangement with any health plans to treat Medi-Cal patients as of June 30, 2012.

- *Other* – Agreements with health maintenance and preferred provider organizations provide for per diem or discounted payments for inpatient services and negotiated discounts from standard charges for outpatient services.

Revenue from the Medicare and Medi-Cal programs accounted for approximately 48% and 22%, 50% and 24%, respectively, of the System's net patient service revenue for each of the years ended June 30, 2012 and 2011.

Laws and regulations governing the Medicare and Medi-Cal programs are extremely 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 decreased by approximately $201,000 and $348,000 in 2012 and 2011, respectively, due to final cost report settlements differing from original estimates.

The System provides charity care to patients who are financially unable to pay for the health care services they receive. The System's policy is not to pursue collection of amounts determined to qualify as charity care. Accordingly, the System does not report these amounts in net operating revenues or in the allowance for doubtful accounts. The System determines the costs associated with providing charity care by aggregating the applicable direct and indirect costs, including salaries, wages and benefits, supplies, and other operating expenses, based on data from its costing system. The costs of caring for charity care patients for the years ended June 30, 2012 and 2011, were approximately $764,000 and $458,000, respectively. Funds received from gifts and grants to subsidize charity services provided for the years ended June 30, 2012 and 2011, were approximately $244,000 and $-0-, respectively.

## 4. Net Patient Service Revenue (Continued):

Net patient service revenue was as follows for the years ended June 30, 2012 and 2011:

| | 2012 | 2011 |
|---|---|---|
| Gross patient service revenue | **$ 196,404,089** | $ 165,188,754 |
| Less charity care | **(3,006,758)** | (1,863,375) |
| | **193,397,331** | 163,325,379 |
| *Contractual adjustments* | | |
| Medicare | **53,821,102** | 48,245,881 |
| Medi-Cal | **12,315,846** | 15,634,746 |
| Other | **71,776,209** | 49,596,368 |
| | **137,913,157** | 113,476,995 |
| **Net patient service revenue** | **$ 55,484,174** | $ 49,848,384 |

## 5. Electronic Health Records Incentive Payment:

The System has received an incentive payment of approximately $780,000 from the Medi-Cal program and recorded a receivable from the Medicare program of approximately $1,351,000 for the meaningful use of electronic health records. The amount recorded is based on the System meeting the meaningful use criteria and the days and discharge data for the year ended June 30, 2012. The amount recorded is an estimate and subject to audit by the Medicare intermediary. The revenue is reported as operating income.

## 6. Notes Payable and Capital Lease Obligation:

The System had notes payable and capital lease obligation financing as follows at June 30, 2012 and 2011:

| | 2012 | 2011 |
|---|---|---|
| PNC Equipment Finance loan, payable in monthly installments of $48,105, plus interest at 1.92%. The loan matures September 2016; collateralized by System equipment. | **$ 2,349,297** | $ - |
| Capital lease obligation for two vehicles for patient transportation in the original amount of $41,524, payable in monthly installments of $1,070, including interest at 10.89%, through March 2013; collateralized by the vehicles. | **6,165** | 19,950 |
| Siemens loan, payable in monthly installments of $65,345, plus interest at 4.3%. The loan matures March 2019; collateralized by System equipment, net patient accounts receivable, and unspent Proposition 13 funds. | **4,587,184** | 5,160,440 |
| | **6,942,646** | 5,180,390 |
| *Less current maturities* | **(1,141,546)** | (584,638) |
| | **$ 5,801,100** | $ 4,595,752 |

The Siemens loan proceeds were used to retire the 1998 revenue bonds. The loan requires that the Proposition 13 tax revenue be held in a separate and distinct bank account. This account had a balance of $759,079 at June 30, 2012. The loan also requires the System to maintain certain financial ratios and other financial covenants and to obtain approval from Siemens before entering into certain types of additional indebtedness. The System was in compliance with all related covenants at June 30, 2012.

## 6. Note Payable and Capital Lease Obligation (continued):

Future principal payments on the note payable and capital lease obligation during succeeding years are as follows:

| Years Ending June 30, | Amount |
|---|---|
| 2013 | $ 1,141,546 |
| 2014 | 1,172,032 |
| 2015 | 1,210,036 |
| 2016 | 1,249,446 |
| 2017 | 849,763 |
| Thereafter | 1,319,823 |
| | **$ 6,942,646** |

As of June 30, 2012 and 2011, accumulated amortization on equipment acquired through a capital lease obligation with an original purchase price of $47,732 was $41,377 and $31,832, respectively.

## 7. Line of Credit:

Effective November 29, 2010, the System obtained a revolving line of credit, in the maximum amount of $4,000,000, limited to 50% of the System's net accounts receivable less than 90 days of age. The line of credit was used to refinance a previous line of credit. Beginning January 1, 2011, monthly payments of interest were required, at a rate of *The Wall Street Journal* Prime Rate plus 1%, with a minimum rate of 4.25%. The interest rate was 4.25% at June 30, 2011. The outstanding principal balance was due on December 1, 2011. The line of credit was collateralized by the System's accounts receivable and a certificate of deposit with an approximate balance of $2,000,000 provided and held by EPIC Management, L.P. Effective November 7, 2011, the System and the lender agreed to change the principal amount and extend the maturity of the line of credit. The principal amount was changed from $4,000,000 to $4,500,000. The maturity was changed to December 1, 2012. All other terms and conditions remained.

## 8. Bonds Payable:

In August 2006, the System issued $25,000,000 of aggregate principal amount San Gorgonio Memorial Health Care District General Obligation Bonds, Series A. Interest is payable semiannually. Principal payments began in the year ended June 30, 2011. The bonds mature in August 2036. Funds received from issuing the bonds are for the renovation and expansion of the System's facility. The bonds represent the general obligation of the District. The District is empowered and obligated to levy *ad valorem* taxes upon all property within the District subject to taxation by the District. The property taxes are collected by Riverside County and used by the District to make the bond principal and interest payments.

In August 2008, the System issued $25,000,000 of aggregate principal amount San Gorgonio Memorial Health Care District General Obligation Bonds, Series B. Interest is payable semiannually. Principal payments begin in the year ending June 30, 2014. The bonds mature in August 2038. Funds received from issuing the bonds are for the renovation and expansion of the System's facility. The funds are required to be kept separate and distinct from all other funds of the System. The bonds represent the general obligation of the District. The District is empowered and obligated to levy *ad valorem* taxes upon all property within the District subject to taxation by the District. The property taxes are collected by Riverside County and used by the District to make the bond principal and interest payments.

In August 2009, the System issued $58,000,000 of aggregate principal amount San Gorgonio Memorial Health Care District General Obligation Bonds, Series C. Interest is payable semiannually. Principal payments begin in the year ending June 30, 2015. The bonds mature in August 2039. Funds received from issuing the bonds are for the renovation and expansion of the System's facility. The funds are required to be kept separate and distinct from all other funds of the System. The bonds represent the general obligation of the District. The District is empowered and obligated to levy *ad valorem* taxes upon all property within the District subject to taxation by the District. The property taxes are collected by Riverside County and used by the District to make the bond principal and interest payments.

Interest cost on borrowed funds, net of interest earnings on such borrowed funds, is capitalized during the period of construction as a component of the cost of acquiring those assets. Total net interest costs capitalized during the year ended June 30, 2012, were $6,127,309, which included approximately $6,718,413 of capitalized interest expense and approximately $591,104 of capitalized interest income. Total net interest costs capitalized during the year ended June 30, 2011, were $12,302,543, which included $13,409,367 of capitalized interest expense and $1,106,824 of capitalized interest income.

## 8. Bonds Payable (continued):

Bonds payable consisted of the following at June 30, 2012 and 2011:

| | | **2012** | | **2011** |
|---|---|---|---|---|
| Series A 2006 San Gorgonio Memorial Health Care District General Obligation Bonds, interest from 4.25% to 5.00%, maturing August 2036. | $ | **24,885,000** | $ | 24,960,000 |
| Series B 2006 San Gorgonio Memorial Health Care District General Obligation Bonds, interest from 5.00% to 6.00%, maturing August 2038. | | **25,000,000** | | 25,000,000 |
| Series C 2006 San Gorgonio Memorial Health Care District General Obligation Bonds, interest from 6.50% to 7.20%, maturing August 2039. | | **58,000,000** | | 58,000,000 |
| | | **107,885,000** | | 107,960,000 |
| *Less current maturities* | | **(115,000)** | | (75,000) |
| *Plus bond premium and discount* | | **472,569** | | 491,750 |
| | **$** | **108,242,569** | $ | 108,376,750 |

The future minimum principal amounts of maturities for bonds payable are as follows:

| **Years Ending June 30,** | | **Amount** |
|---|---|---|
| 2013 | $ | 115,000 |
| 2014 | | 190,000 |
| 2015 | | 505,000 |
| 2016 | | 670,000 |
| 2017 | | 860,000 |
| Thereafter | | 105,545,000 |
| | **$** | **107,885,000** |

## 9. Property Taxes:

The Riverside County Treasurer acts as an agent to collect property taxes levied in the County for all taxing authorities. Taxes are levied annually on July 1 on property values listed as of the prior January 1. Assessed values are established by the Riverside County Assessor at 100% of fair market value. A revaluation of all property is performed annually.

Taxes are due in two equal installments on November 1 and February 1. The assessed property is subject to lien on the levy date and taxes are considered delinquent after December 10 and April 10.

For the year ended June 30, 2012, the System's general purpose tax levy was .04252166 per $10,000 on a total assessed valuation of $202,140,298,386, for a total regular levy of $859,534.

For the year ended June 30, 2011, the System's general purpose tax levy was .04345086 per $10,000 on a total assessed valuation of $204,812,536,109, for a total regular levy of $889,928.

During the year ended June 30, 2012, the system levied a special assessment fixed charge levy in the amount of $1,868,370. These funds are restricted for support of the System's emergency room.

During the year ended June 30, 2011, the system levied a special assessment fixed charge levy in the amount of $1,813,603. These funds are restricted for support of the System's emergency room.

The system is authorized to direct the County of Riverside, California, to levy an unlimited *ad valorem* tax on all taxable property within the District for the payment of the principal and interest on the System's General Obligation Bonds, Series A, B, and C. During the years ended June 30, 2012 and 2011, General Obligation (GO) bond levies were authorized. The GO bond levy rate was 10.365 per $10,000 on a total assessed valuation of $5,797,301,143, for a total levy of $6,008,903, for the year ended June 30, 2012. The GO bond levy rate was 9.914 per $10,000 on a total assessed valuation of $6,036,169,020, for a total levy of $5,984,258, for the year ended June 30, 2011.

Property taxes are recorded as revenue when levied. Since state law allows for sale of property for failure to pay taxes, no estimate of uncollectible taxes is made.

## 10. Property and Equipment:

Property and equipment consisted of the following at June 30, 2012 and 2011:

| | 2012 | 2011 |
|---|---|---|
| Land and land improvements | **$ 3,678,343** | $ 3,678,343 |
| Buildings and improvements | **43,219,198** | 24,883,883 |
| Equipment | **22,032,716** | 21,146,485 |
| | **68,930,257** | 49,708,711 |
| *Less accumulated depreciation* | **(28,541,488)** | (30,300,747) |
| | **40,388,769** | 19,407,964 |
| Construction in progress | **64,314,769** | 61,631,722 |
| **Net property, plant and equipment** | **$ 104,703,538** | $ 81,039,686 |

***Construction in progress*** – As of June 30, 2012, the System's construction in progress related to various remodeling, major repair, and expansion projects on the System's premises. The System has obtained $108,000,000 in bond financing to fund this project. As of June 30, 2012, the estimated cost to complete this project was approximately $22,000,000.

## 11. Retirement Plan:

The System has a tax sheltered annuity (TSA) program covering substantially all employees with at least one year of service. Effective January 2010, the System discontinued the employer TSA matching contributions. The program was restarted on January 1, 2012. Matching contributions were given at the discretion of management based on a percentage of gross salary. Discretionary contributions are given to employees with at least one year of service and 1,000 hours of service per calendar year. Expense under the TSA program amounted to approximately $289,000 and $-0- in 2012 and 2011, respectively.

## 12. Commitments and Contingencies:

***Management fees*** – Effective November 16, 2010, the System entered into a 10-year agreement with EPIC Management, L.P., a California limited partnership (EPIC) for the System's management services. EPIC provides administrative and financial management services at a cost of $272,000 for the first year increasing to $500,000 in the second contract year. This amount shall be adjusted annually for fluctuations in the consumer price index for "All Urban Consumers." The System was committed for approximately $4.3 million of remaining service fees over the life of the contract as of June 30, 2012. For the years ended June 30, 2012 and 2011, the System incurred management and consulting fees expense related to the management contract with EPIC of approximately $494,000 and $163,000, respectively.

***Risk management*** – The System is exposed to various risks of loss related to torts; theft of, damage to and destruction of assets; business interruption; errors and omissions; employee injuries and illnesses; natural disasters; employee disability and employee health, dental, and accident benefits. Commercial insurance coverage is purchased for claims arising from such matters other than those related to employee health benefits. Settled claims have not exceeded commercial insurance in any of the past three years.

***Medical malpractice claims –*** The System purchases malpractice liability insurance through Beta Healthcare Group (BHG). BHG provides protection on a "claims-made" basis whereby only malpractice claims reported to the insurance carrier in the current year are covered by the current policy. If there are unreported incidents which result in a malpractice claim for the current year, these will only be covered in the year the claim is reported to the insurance carrier if the System purchases claims-made insurance in that year or if the System purchases extended coverage (tail) insurance to cover claims incurred before but reported after cancellation or expiration of a claims-made policy. BHG's present liability limit is $20,000,000 per claim with an annual aggregate limit of $20,000,000. The policy has a $25,000 deductible per claim. No liability has been accrued for future coverage for acts occurring in this or prior years. It is possible that claims may exceed coverage obtained in any given year.

***Industry regulations*** – The healthcare industry is subject to numerous laws and regulations of federal, state, and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditations, government healthcare program participation requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse. Government activity continues with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by healthcare providers. Violations of these laws and regulations could result in expulsion from government healthcare programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. Management believes that the District is in compliance with fraud and abuse statutes, as well as other applicable government laws and regulations.

While no regulatory inquiries have been made, compliance with such laws and regulations can be subject to future government review and interpretation, as well as regulatory actions known or unasserted at this time.

## 12. Commitments and Contingencies (continued):

***Healthcare reform*** – As a result of recently enacted federal healthcare reform legislation, substantial changes are anticipated in the United States of America's healthcare system. Such legislation includes numerous provisions affecting the delivery of healthcare services, the financing of healthcare costs, reimbursement of healthcare providers, and the legal obligations of health insurers, providers, and employers. These provisions are currently slated to take effect at specified times over approximately the next decade. The federal healthcare reform legislation does not affect the 2012 financial statements.

## 13. Functional Expenses:

The System provides the following healthcare services to residents within its geographic location:

- Acute, intensive care, cardiac, and pediatric care
- Obstetric care
- Emergency services
- Outpatient surgery
- Other outpatient procedures

Expenses related to providing these services were as follows:

| | June 30, | |
|---|---|---|
| | **2012** | **2011** |
| Healthcare services | **$ 53,061,758** | $ 46,396,262 |
| General and administrative | **8,145,708** | 6,616,783 |
| Fundraising | **69,516** | 36,266 |
| | **$ 61,276,982** | $ 53,049,311 |

## 14. Concentration of Credit Risk:

***Cash and cash equivalents*** – The System invests its excess cash in deposits with a local bank. At various times during the year and at year end, the System had deposits in excess of Federal Deposit Insurance Corporation coverage. The System does not have a policy for managing credit risk for cash and cash equivalents.

***Patient accounts receivable*** – The System operates several lines of service at its location in Banning, and provides these services to patients who generally reside in the Banning, Beaumont, Cabazon, and Cherry Valley communities of Riverside County. The System grants credit without collateral to its patients and third-party payors. Patient accounts receivable from the government agencies administering the Medicare and the Medi-Cal programs and the private insurance companies operating and administering the Medi-Cal Managed Care program represent the only concentrated group of credit risk for the System and management does not believe that there are significant credit risks associated with these agencies and private insurance companies. Other contracted and private pay patient receivables consist of payors and individuals involved in diverse activities, subject to differing economic conditions and do not represent any concentrated credit risks to the System.

Significant concentration of patient accounts receivable at June 30, 2012 and 2011, was as follows:

| | **2012** | **2011** |
|---|---|---|
| Medicare | **40 %** | 40 % |
| Medi-Cal | **16** | 20 |
| Other third-party payors | **21** | 16 |
| Patients | **23** | 24 |
| | **100 %** | 100 % |

***Physicians*** – The System is dependent on local physicians practicing in its service area to provide admissions and utilize hospital services on an outpatient basis. A decrease in the number of physicians providing these services or change in their utilization patterns may have an adverse effect on hospital operations.

## 15. Extraordinary Item

Extinguishment of bonds payable in 2011 resulted in an extraordinary loss of $231,862 for the year ended June 30, 2011. This loss represents the write-off to expense of unamortized bond issuance costs of $102,440 and an unamortized bond discount of $129,422 related to the Series 1998 Bonds.

# SUPPLEMENTARY SCHEDULES

**San Gorgonio Health Care System**
**Combining Schedule – Balance Sheet**
**June 30, 2012**

| ASSETS | San Gorgonio Memorial Hospital | San Gorgonio Memorial Health Care District | Eliminations | Combined |
|---|---|---|---|---|
| *Current assets* | | | | |
| Cash and cash equivalents | $ 748,302 | $ 581,526 | $ - | $ 1,329,828 |
| Current portion of assets limited as to use | - | 4,770,134 | - | 4,770,134 |
| Receivables: | | | | |
| Patient accounts, net of allowance for doubtful accounts | 7,635,595 | - | - | 7,635,595 |
| Taxes | - | 2,270,567 | - | 2,270,567 |
| Electronic health records incentive payment | 1,351,049 | - | - | 1,351,049 |
| Grants | 407,944 | - | - | 407,944 |
| Malpractice insurance recoveries | 274,558 | - | - | 274,558 |
| Inventories | 955,699 | - | - | 955,699 |
| Prepaid expenses and other current assets | 100,772 | 3,751 | - | 104,523 |
| Total current assets | 11,473,919 | 7,625,978 | - | 19,099,897 |
| *Interest in net assets of San Gorgonio Memorial Hospital Foundation, Inc.* | - | 759,260 | - | 759,260 |
| *Assets limited as to use, less current portion* | - | 27,139,454 | - | 27,139,454 |
| *Property and equipment, net of accumulated depreciation* | - | 104,703,538 | - | 104,703,538 |
| *Bond issuance cost, net of amortization* | - | 674,206 | - | 674,206 |
| **Total assets** | $ 11,473,919 | $ 140,902,436 | $ - | $ 152,376,355 |
| **LIABILITIES AND NET ASSETS** | | | | |
| *Current liabilities* | | | | |
| Current maturities of long-term debt and capital lease obligation | $ - | $ 1,141,546 | $ - | $ 1,141,546 |
| Current maturities of bonds payable | - | 115,000 | - | 115,000 |
| Accounts payable | 2,068,874 | 303,271 | - | 2,372,145 |
| Construction accounts payable | - | 1,909,756 | - | 1,909,756 |
| Patient refunds payable | 432,694 | - | - | 432,694 |
| Accrued payroll and related liabilities | 1,464,584 | - | - | 1,464,584 |
| Bank line of credit | 2,408,396 | - | - | 2,408,396 |
| Third-party payor settlements payable | 267,000 | - | - | 267,000 |
| Malpractice claims payable | 274,558 | - | - | 274,558 |
| Accrued interest payable | - | 2,801,796 | - | 2,801,796 |
| Total current liabilities | 6,916,106 | 6,271,369 | - | 13,187,475 |
| *Long-term debt and capital lease obligation, less current maturities* | - | 5,801,100 | - | 5,801,100 |
| *Bonds payable, less current maturities* | - | 108,242,569 | - | 108,242,569 |
| Total liabilities | 6,916,106 | 120,315,038 | - | 127,231,144 |
| *Net assets* | | | | |
| Unrestricted | 4,557,813 | 19,828,138 | - | 24,385,951 |
| Temporarily restricted | - | 708,260 | - | 708,260 |
| Permanently restricted | - | 51,000 | - | 51,000 |
| Total net assets | 4,557,813 | 20,587,398 | - | 25,145,211 |
| **Total liabilities and net assets** | $ 11,473,919 | $ 140,902,436 | $ - | $ 152,376,355 |

*See accompanying independent auditors' report.*

**San Gorgonio Health Care System**
**Combining Schedule – Statement of Operations and Changes in Net Assets**
**Year Ended June 30, 2012**

| | San Gorgonio Memorial Hospital | San Gorgonio Memorial Health Care District | Eliminations | Combined |
|---|---|---|---|---|
| *Unrestricted revenues, gains, and other support:* | | | | |
| Net patient service revenue | **$ 55,484,174** | **$ -** | **$ -** | **$ 55,484,174** |
| Electronic health records incentive payment | **2,131,132** | - | - | **2,131,132** |
| Other revenues: | | | | |
| Grant revenue | **581,755** | - | - | **581,755** |
| District taxes for operations | - | **2,874,257** | - | **2,874,257** |
| Interest income | **557** | **22,511** | - | **23,068** |
| Other operating income | **293,161** | **776,713** | (784,157) | **285,717** |
| Total unrestricted revenues, gains, and other support | **58,490,779** | **3,673,481** | **(784,157)** | **61,380,103** |
| *Operating expenses* | | | | |
| Salaries and wages | **22,537,032** | - | - | **22,537,032** |
| Employee benefits | **4,521,921** | - | - | **4,521,921** |
| Medical and other professional fees | **1,950,339** | **202,021** | - | **2,152,360** |
| Purchased services | **3,871,632** | **101,829** | - | **3,973,461** |
| Supplies | **6,649,606** | **(36)** | - | **6,649,570** |
| Utilities | **680,950** | - | - | **680,950** |
| Repairs and maintenance | **382,453** | - | - | **382,453** |
| Rents and leases | **1,192,728** | - | (784,157) | **408,571** |
| Insurance | **684,799** | - | - | **684,799** |
| Provision for bad debts | **12,164,809** | - | - | **12,164,809** |
| Depreciation and amortization | - | **4,087,707** | - | **4,087,707** |
| Interest | **173,255** | **295,889** | - | **469,144** |
| Other | **2,399,310** | **164,895** | - | **2,564,205** |
| Total operating expenses | **57,208,834** | **4,852,305** | **(784,157)** | **61,276,982** |
| *Excess (deficiency) of unrestricted revenues, gains, and other support over operating expenses* | **1,281,945** | **(1,178,824)** | - | **103,121** |
| *District taxes for capital expenditures* | - | **6,379,133** | - | **6,379,133** |
| *Net assets released from restrictions used for purchases of property and equipment* | - | **486,750** | - | **486,750** |
| *Change in unrestricted net assets before gain (loss) on defeasance of debt* | **1,281,945** | **5,687,059** | - | **6,969,004** |
| *Gain (loss) on defeasance of debt* | **17,641,219** | **(17,641,219)** | - | - |
| Change in unrestricted net assets | **18,923,164** | **(11,954,160)** | - | **6,969,004** |
| *Change in temporarily restricted net assets* | | | | |
| Change in interest in temporarily restricted net assets of San Gorgonio Memorial Hospital Foundation, Inc. | - | **(334,808)** | - | **(334,808)** |
| Change in net assets | **18,923,164** | **(12,288,968)** | - | **6,634,196** |
| Net assets, beginning of year | **(14,365,351)** | **32,876,366** | - | **18,511,015** |
| **Net assets, end of year** | **$ 4,557,813** | **$ 20,587,398** | **$ -** | **$ 25,145,211** |

*See accompanying independent auditors' report.*

**San Gorgonio Health Care System**
**Earnings Before Interest, Depreciation and Amortization**
**Years Ended June 30, 2012 and 2011**

| | 2012 | 2011 |
|---|---|---|
| *Unrestricted revenues, gains, and other support:* | | |
| Net patient service revenue | **$ 55,484,174** | $ 49,848,384 |
| Electronic health records incentive payment | **2,131,132** | - |
| Other revenues | | |
| Grant revenue | **581,755** | 790,452 |
| District taxes for operations | **2,874,257** | 2,754,123 |
| Interest income | **23,068** | 25,972 |
| Other operating income | **285,717** | 340,236 |
| Total unrestricted revenues, gains, and other support | **61,380,103** | 53,759,167 |
| *Operating expenses* | | |
| Salaries and wages | **22,537,032** | 19,568,430 |
| Employee benefits | **4,521,921** | 3,481,424 |
| Medical and other professional fees | **2,152,360** | 2,333,634 |
| Purchased services | **3,973,461** | 3,068,436 |
| Supplies | **6,649,570** | 5,207,764 |
| Utilities | **680,950** | 588,465 |
| Repairs and maintenance | **382,453** | 259,462 |
| Rents and leases | **408,571** | 259,063 |
| Insurance | **684,799** | 675,343 |
| Provision for bad debts | **12,164,809** | 13,149,598 |
| Other | **2,564,205** | 1,203,955 |
| Total operating expenses | **56,720,131** | 49,795,574 |
| Earnings before interest, depreciation and amortization | **$ 4,659,972** | $ 3,963,593 |

*See accompanying independent auditors' report.*

The earnings before interest, depreciation and amortization schedule is derived from the combined statements of operations. However, it excludes the following line items:

- Depreciation and amortization
- Interest
- District taxes for capital expenditures
- Net assets released from restrictions used for purchases of property and equipment
- Extraordinary item – loss on bond discount and issue costs
- Change in interest in temporarily restricted net assets of San Gorgonio Memorial Hospital Foundation, Inc.

**San Gorgonio Health Care System**
**Property Tax Receipts and Disbursements**
**Year Ended June 30, 2012**

| | | |
|---|---|---|
| *Beginning Measure A cash* | **$** | **5,220,169** |
| *Measure A receipts* | | |
| Tax receipts | | **6,180,878** |
| *Interest income received on Measure A funds* | | **16,182** |
| *Measure A disbursements* | | |
| Bond principal payments | | **75,000** |
| Bond interest payments | | **6,719,585** |
| Total Measure A disbursements | | **6,794,585** |
| *Excess (deficiency) of Measure A receipts over disbursements* | | **(597,525)** |
| *Ending Measure A cash* | **$** | **4,622,644** |
| *Beginning Measure D cash* | **$** | **-** |
| *Measure D receipts* | | |
| Tax receipts | | **1,856,394** |
| *Measure D disbursements* | | |
| Emergency room salaries | | **1,643,644** |
| Emergency room purchased services | | **212,750** |
| Total Measure D disbursements | | **1,856,394** |
| *Excess (deficiency) of Measure D receipts over disbursements* | | **-** |
| *Ending Measure D cash* | **$** | **-** |
| *Beginning Proposition 13 and ABX 126 cash* | **$** | **-** |
| *Proposition 13 and ABX 126 receipts* | | |
| Tax receipts | | **994,397** |
| *Proposition 13 and ABX 126 disbursements* | | |
| Capital asset purchases | | **510,707** |
| Loan payments | | **241,026** |
| Purchased services | | **140,615** |
| Dues and subscriptions | | **48,380** |
| Repairs and maintenance | | **39,018** |
| Rentals and leases | | **11,532** |
| Other | | **3,119** |
| Total Proposition 13 and ABX 126 disbursements | | **994,397** |
| *Excess (deficiency) of Proposition 13 and ABX 126 receipts over disbursements* | | **-** |
| *Ending Proposition 13 and ABX 126 cash* | **$** | **-** |

*See accompanying independent auditors' report.*

**APPENDIX C**

**FORM OF CONTINUING DISCLOSURE CERTIFICATE**

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# APPENDIX C

# FORM OF CONTINUING DISCLOSURE CERTIFICATE

This Continuing Disclosure Certificate (the "Disclosure Certificate") is executed and delivered by the SAN GORGONIO MEMORIAL HEALTHCARE DISTRICT (the "District") in connection with the issuance by the District of its $23,875,000* San Gorgonio Memorial Healthcare District (Riverside County, California) 2013 General Obligation Refunding Bonds (the "Bonds"). The Bonds are being issued pursuant to a resolution adopted by the Board of Directors of the District on January 8, 2013 (the "Resolution"). The District covenants and agrees as follows:

Section 1. Definitions. In addition to the definitions set forth in the Resolution, which apply to any capitalized term used in this Disclosure Certificate, unless otherwise defined in this Section 1, the following capitalized terms shall have the following meanings when used in this Disclosure Certificate:

"*Annual Report*" shall mean any Annual Report provided by the District pursuant to, and as described in, Sections 3 and 4 of this Disclosure Certificate.

"*Beneficial Owner*" shall mean any person who (a) has the power, directly or indirectly, to vote or consent with respect to, or to dispose of ownership of, any Bonds (including persons holding Bonds through nominees, depositories or other intermediaries), or (b) is treated as the owner of any Bonds for federal income tax purposes.

"*Dissemination Agent*" shall mean G.L. Hicks Financial, LLC, or any successor Dissemination Agent designated in writing by the District and which has filed with the District a written acceptance of such designation. In the absence of such a designation, the District shall act as the Dissemination Agent.

"*EMMA*" or "*Electronic Municipal Market Access*" means the centralized on-line repository for documents to be filed with the MSRB, such as official statements and disclosure information relating to municipal bonds, notes and other securities as issued by state and local governments.

"*Listed Events*" shall mean any of the events listed in Section 5(a) or 5(b) of this Disclosure Certificate.

"*MSRB*" means the Municipal Securities Rulemaking Board, which has been designated by the Securities and Exchange Commission as the sole repository of disclosure information for purposes of the Rule, or any other repository of disclosure information which may be designated by the Securities and Exchange Commission as such for purposes of the Rule in the future.

"*Participating Underwriter*" shall mean the original underwriter of the Bonds, required to comply with the Rule in connection with offering of the Bonds.

"*Rule*" shall mean Rule 15c2-12 adopted by the Securities and Exchange Commission under the Securities Exchange Act of 1934, as the same may be amended from time to time.

Section 2. Purpose of the Disclosure Certificate. This Disclosure Certificate is being executed and delivered by the District for the benefit of the owners and Beneficial Owners of the Bonds and in order to assist the Participating Underwriter in complying with Securities and Exchange Commission Rule 15c2-12(b)(5).

Section 3. Provision of Annual Reports.

(a) *Delivery of Annual Report*. The District shall, or shall cause the Dissemination Agent to, not later than nine months after the end of the District's fiscal year (which currently ends on June 30), commencing with the report for the 2012-13 Fiscal Year, which is due not later than March 31, 2014, file with EMMA, in a readable PDF or other electronic format as prescribed by the MSRB, an Annual Report

* Preliminary, subject to change.

that is consistent with the requirements of Section 4 of this Disclosure Certificate. The filing of the official statement for the Bonds with EMMA shall satisfy the filing requirement for 2013. The Annual Report may be submitted as a single document or as separate documents comprising a package and may cross-reference other information as provided in Section 4 of this Disclosure Certificate; provided that the audited financial statements of the District may be submitted separately from the balance of the Annual Report and later than the date required above for the filing of the Annual Report if they are not available by that date.

(b) *Change of Fiscal Year*. If the District's fiscal year changes, it shall give notice of such change in the same manner as for a Listed Event under Section 5(c), and subsequent Annual Report filings shall be made no later than nine months after the end of such new fiscal year end.

(c) *Delivery of Annual Report to Dissemination Agent*. Not later than fifteen (15) Business Days prior to the date specified in subsection (a) (or, if applicable, subsection (b)) of this Section 3 for providing the Annual Report to EMMA, the District shall provide the Annual Report to the Dissemination Agent (if other than the District). If by such date the Dissemination Agent has not received a copy of the Annual Report the Dissemination Agent shall notify the District.

(d) *Report of Non-Compliance*. If the District is the Dissemination Agent and is unable to file an Annual Report by the date required in subsection (a) (or, if applicable, subsection (b)) of this Section 3, the District shall send a notice to EMMA substantially in the form attached hereto as Exhibit A. If the District is not the Dissemination Agent and is unable to provide an Annual Report to the Dissemination Agent by the date required in subsection (c) of this Section 3, the Dissemination Agent shall send a notice to EMMA in substantially the form attached hereto as Exhibit A.

(e) *Annual Compliance Certification.* The Dissemination Agent shall, if the Dissemination Agent is other than the District, file a report with the District certifying that the Annual Report has been filed with EMMA pursuant to Section 3 of this Disclosure Certificate, stating the date it was so provided and filed.

Section 4. Content of Annual Reports. The Annual Report shall contain or incorporate by reference the following:

(a) *Financial Statements.* Audited financial statements of the District for the preceding fiscal year, prepared in accordance generally accepted accounting principles. If the District's audited financial statements are not available by the time the Annual Report is required to be filed pursuant to Section 3(a), the Annual Report shall contain unaudited financial statements in a format similar to the financial statements contained in the final Official Statement, and the audited financial statements shall be filed in the same manner as the Annual Report when they become available.

(b) *Other Annual Information.* To the extent not included in the audited final statements of the District, the Annual Report shall also include financial and operating data with respect to the District for preceding fiscal year, substantially similar to that provided in the corresponding tables and charts in the official statement for the Bonds, as follows:

(i) Assessed value of taxable property in the District as shown on the recent equalized assessment role; and
(ii) Property tax levies, collections and delinquencies for the District, for the most recent completed fiscal year.

(c) *Cross References.* Any or all of the items listed above may be included by specific reference to other documents, including official statements of debt issues of the District or related public entities, which are available to the public on EMMA. The District shall clearly identify each such other document so included by reference.

If the document included by reference is a final official statement, it must be available from EMMA.

(d) *Further Information.* In addition to any of the information expressly required to be provided under paragraph (b) of this Section 4, the District shall provide such further information, if any, as may be

necessary to make the specifically required statements, in the light of the circumstances under which they are made, not misleading.

Section 5. Reporting of Listed Events.

(a) *Reportable Events.* The District shall, or shall cause the Dissemination Agent (if not the District) to, give notice of the occurrence of any of the following events with respect to the Bonds:

(1) Principal and interest payment delinquencies.

(2) Unscheduled draws on debt service reserves reflecting financial difficulties.

(3) Unscheduled draws on credit enhancements reflecting financial difficulties.

(4) Substitution of credit or liquidity providers, or their failure to perform.

(5) Defeasances.

(6) Rating changes.

(7) Tender offers.

(8) Bankruptcy, insolvency, receivership or similar event of the obligated person.

(9) Adverse tax opinions, the issuance by the Internal Revenue Service of proposed or final determinations of taxability, Notices of Proposed Issue (IRS Form 5701-TEB) or other material notices or determinations with respect to the tax status of the security, or other material events affecting the tax status of the security.

(b) *Material Reportable Events.* The District shall give, or cause to be given, notice of the occurrence of any of the following events with respect to the Bonds, if material:

(1) Non-payment related defaults.

(2) Modifications to rights of security holders.

(3) Bond calls.

(4) The release, substitution, or sale of property securing repayment of the securities.

(5) The 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.

(6) Appointment of a successor or additional trustee, or the change of name of a trustee.

(c) *Time to Disclose.* Whenever the District obtains knowledge of the occurrence of a Listed Event, the District shall, or shall cause the Dissemination Agent (if not the District) to, file a notice of such occurrence with EMMA, in an electronic format as prescribed by the MSRB, in a timely manner not in excess of 10 business days after the occurrence of the Listed Event. Notwithstanding the foregoing, notice of Listed Events described in subsections (a)(5) and (b)(3) above need not be given under this subsection any earlier than the notice (if any) of the underlying event is given to owners of affected Bonds under the Resolution.

Section 6. Identifying Information for Filings with EMMA. All documents provided to EMMA under this Disclosure Certificate shall be accompanied by identifying information as prescribed by the MSRB.

Section 7. Termination of Reporting Obligation. The District's obligations under this Disclosure Certificate shall terminate upon the defeasance, prior redemption or payment in full of all of the Bonds. If such termination occurs prior to the final maturity of the Bonds, the District shall give notice of such termination in the same manner as for a Listed Event under Section 5(c).

Section 8. Dissemination Agent.

(a) *Appointment of Dissemination Agent*. The District may, from time to time, appoint or engage a Dissemination Agent to assist it in carrying out its obligations under this Disclosure Certificate and may discharge any such agent, with or without appointing a successor Dissemination Agent. If the Dissemination Agent is not the District, the Dissemination Agent shall not be responsible in any manner for the content of any notice or report prepared by the District pursuant to this Disclosure Certificate. It is understood and agreed that any information that the Dissemination Agent may be instructed to file with EMMA shall be prepared and provided to it by the District. The Dissemination Agent has undertaken no responsibility with respect to the content of any reports, notices or disclosures provided to it under this Disclosure Certificate and has no liability to any person, including any Bondholder, with respect to any such reports, notices or disclosures. The fact that the Dissemination Agent or any affiliate thereof may have any fiduciary or banking relationship with the District shall not be construed to mean that the Dissemination Agent has actual knowledge of any event or condition, except as may be provided by written notice from the District.

(b) *Compensation of Dissemination Agent*. The Dissemination Agent shall be paid compensation by the District for its services provided hereunder in accordance with its schedule of fees as agreed to between the Dissemination Agent and the District from time to time and all expenses, legal fees and expenses and advances made or incurred by the Dissemination Agent in the performance of its duties hereunder. The Dissemination Agent shall not be deemed to be acting in any fiduciary capacity for the District, owners or Beneficial Owners, or any other party. The Dissemination Agent may rely, and shall be protected in acting or refraining from acting, upon any direction from the District or an opinion of nationally recognized bond counsel. The Dissemination Agent may at any time resign by giving written notice of such resignation to the District. The Dissemination Agent shall not be liable hereunder except for its negligence or willful misconduct.

(c) *Responsibilities of Dissemination Agent*. In addition of the filing obligations of the Dissemination Agent set forth in Sections 3(e) and 5, the Dissemination Agent shall be obligated, and hereby agrees, to provide a request to the District to compile the information required for its Annual Report at least 30 days prior to the date such information is to be provided to the Dissemination Agent pursuant to subsection (c) of Section 3. The failure to provide or receive any such request shall not affect the obligations of the District under Section 3.

Section 9. Amendment; Waiver. Notwithstanding any other provision of this Disclosure Certificate, the District may amend this Disclosure Certificate (and the Dissemination Agent shall agree to any amendment so requested by the District that does not impose any greater duties or risk of liability on the Dissemination Agent), and any provision of this Disclosure Certificate may be waived, provided that all of the following conditions are satisfied:

(a) *Change in Circumstances*. If the amendment or waiver relates to the provisions of Sections 3(a), 4 or 5(a) or (b), it 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 an obligated person with respect to the Bonds, or the type of business conducted.

(b) *Compliance as of Issue Date*. The undertaking, as amended or taking into account such waiver, would, in the opinion of a nationally recognized bond counsel, have complied with the requirements of the Rule at the time of the original issuance of the Bonds, after taking into account any amendments or interpretations of the Rule, as well as any change in circumstances.

(c) *Consent of Holders; Non-impairment Opinion*. The amendment or waiver either (i) is approved by the Bondholders in the same manner as provided in the Resolution for amendments to the Resolution with the consent of Bondholders, or (ii) does not, in the opinion of nationally recognized bond counsel, materially impair the interests of the Bondholders or Beneficial Owners.

If this Disclosure Certificate is amended or any provision of this Disclosure Certificate is waived, the District shall describe such amendment or waiver in the next following Annual Report and shall include, as applicable, a narrative explanation of the reason for the amendment or waiver and its impact on the type (or in the case of a change of accounting principles, on the presentation) of financial information or operating data being presented by the District. In addition, if the amendment relates to the accounting principles to be followed in preparing financial statements, (i) notice of such change shall be given in the same manner as for a Listed Event under Section 5(c), and (ii) the Annual Report for the year in which the change is made should present a comparison (in narrative form and also, if feasible, in quantitative form) between the financial statements as prepared on the basis of the new accounting principles and those prepared on the basis of the former accounting principles.

Section 10. Additional Information. Nothing in this Disclosure Certificate shall be deemed to prevent the District from disseminating any other information, using the means of dissemination set forth in this Disclosure Certificate or any other means of communication, or including any other information in any Annual Report or notice of occurrence of a Listed Event, in addition to that which is required by this Disclosure Certificate. If the District chooses to include any information in any Annual Report or notice of occurrence of a Listed Event in addition to that which is specifically required by this Disclosure Certificate, the District shall have no obligation under this Disclosure Certificate to update such information or include it in any future Annual Report or notice of occurrence of a Listed Event.

Section 11. Default. In the event of a failure of the District to comply with any provision of this Disclosure Certificate, any Bondholder or Beneficial Owner may take such actions as may be necessary and appropriate, including seeking mandate or specific performance by court order, to cause the District to comply with its obligations under this Disclosure Certificate. The sole remedy under this Disclosure Certificate in the event of any failure of the District to comply with this Disclosure Certificate shall be an action to compel performance.

Section 12. Duties, Immunities and Liabilities of Dissemination Agent. The Dissemination Agent shall have only such duties as are specifically set forth in this Disclosure Certificate, and no implied covenants or obligations shall be read into this Disclosure Certificate against the Dissemination Agent, and the District agrees to indemnify and save the Dissemination Agent, its officers, directors, employees and agents, harmless against any loss, expense and liabilities which it may incur arising out of or in the exercise or performance of its powers and duties hereunder, including the costs and expenses (including attorneys fees and expenses) of defending against any claim of liability, but excluding liabilities due to the Dissemination Agent's negligence or willful misconduct. The Dissemination Agent shall have the same rights, privileges and immunities hereunder as are afforded to the Paying Agent under the Resolution. The obligations of the District under this Section 12 shall survive resignation or removal of the Dissemination Agent and payment of the Bonds.

Section 13. Beneficiaries. This Disclosure Certificate shall inure solely to the benefit of the District, the Dissemination Agent, the Participating Underwriter and the owners and Beneficial Owners from time to time of the Bonds, and shall create no rights in any other person or entity.

Date: [Closing Date]

SAN GORGONIO MEMORIAL HEALTHCARE DISTRICT

By _____
Mark S. Turner
Chief Executive Officer

ACKNOWLEDGED:

G.L. HICKS FINANCIAL, LLC, as Dissemination Agent

By _____
Gary L. Hicks
President

**EXHIBIT A**

**NOTICE TO EMMA OF FAILURE TO FILE ANNUAL REPORT**

Name of Issuer: San Gorgonio Memorial Healthcare District

Name of Issue: San Gorgonio Memorial Healthcare District (Riverside County, California) 2013 General Obligation Refunding Bond

Date of Issuance: [Closing Date]

NOTICE IS HEREBY GIVEN that the Issuer has not provided an Annual Report with respect to the above-named Issue as required by the Continuing Disclosure Certificate dated [Closing Date], furnished by the Issuer in connection with the Issue. The Issuer anticipates that the Annual Report will be filed by _____.

Dated: _____

G.L. HICKS FINANCIAL, LLC, as
Dissemination Agent

By _____
Name _____
Title _____

cc: Paying Agent

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## APPENDIX D

## BOOK-ENTRY SYSTEM

The following information concerning DTC and DTC's book-entry system has been obtained from DTC and contains statements that are believed to accurately describe DTC, the method of effecting book-entry transfers of securities distributed through DTC and certain related matters, but the District and the Underwriters take no responsibility for the accuracy of such statements.

The Depository Trust Company, New York, New York, will act as securities depository for the Bonds. The Bonds will be issued as fully-registered Bonds 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 will be issued for each 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 assets 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 bonds. Direct Participants include both U.S. and non-U.S. securities brokers and dealers, banks, trust companies, clearing corporations, and certain other organizations. DTC is a wholly-owned subsidiary of The Depository Trust & Clearing Corporation ("DTCC"). DTCC is the holding company for DTC, National Securities Clearing Corporation and Fixed Income Clearing Corporation, all of which are registered clearing agencies. DTCC is owned by the users of its regulated subsidiaries. Access to the DTC system is also available to others such as both U.S. and non-U.S. securities brokers and dealers, banks, trust companies and clearing corporations that clear through or maintain a custodial relationship with a Direct Participant, either directly or indirectly ("Indirect Participants"). DTC has Standard & Poor's rating of AA+. The DTC Rules applicable to its Participants are on file with the Securities and Exchange Commission. More information 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 Participants' and Indirect Participants' records. Beneficial Owners will not receive written confirmation from DTC of their purchases, but Beneficial Owners are expected to receive written confirmations providing details of the transaction, as well as periodic statements of their holdings, from the Direct Participant 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 the Direct Participants and Indirect Participants acting on behalf of Beneficial Owners. Beneficial Owners will not receive bonds 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 the Bonds with DTC and their registration in the name of Cede & Co. or such other 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 Participants 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 transmission to them of notices of

significant events with respect to the Bonds, such as redemptions, tenders, defaults and proposed amendments to the security documents. Beneficial Owners of the Bonds may wish to ascertain that the nominee holding the Bonds for their benefit has agreed to obtain and transmit notices to Beneficial Owners, or in the alternative, Beneficial Owners may wish to provide their names and addresses to the registrar and request that copies of the notices be provided directly to them.

Redemption notices will 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 Bonds to be redeemed.

Neither DTC nor Cede & Co. (nor such other DTC nominee) will consent or vote with respect to the Bonds. Under its usual procedures, DTC mails an Omnibus Proxy to the Paying Agent 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).

Principal and interest payments with respect to 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 Trustee or Paying Agent on a payable date in accordance with their respective holdings shown on DTC's records. Payments by Direct Participants or Indirect 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 Direct Participant or Indirect Participant and not of DTC, the Paying Agent or the District, subject to any statutory or regulatory requirements as may be in effect from time to time. Payment of principal and interest to Cede & Co. (or such other nominee as may be requested by an authorized representative of DTC) is the responsibility of the Paying Agent, disbursement of such payments to Direct Participants shall be the responsibility of DTC, and disbursement of such payments to the Beneficial Owners shall be the responsibility of Direct Participants and Indirect Participants.

DTC may discontinue providing its services as securities depository with respect to the Bonds at any time by giving reasonable notice to the District or the Paying Agent. Under such circumstances, in the event that a successor securities depository is not obtained, definitive bonds are required to be printed and delivered.

The District may decide to discontinue use of the system of book-entry transfers through DTC (or a successor securities depository). In that event definitive bonds will be printed and delivered.

THE DISTRICT, THE UNDERWRITER, THE PAYING AGENT AND THEIR AGENTS AND COUNSEL WILL NOT HAVE ANY RESPONSIBILITY OR OBLIGATION TO ANY DTC PARTICIPANT, INDIRECT DTC 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 DTC PARTICIPANT; (III) THE PAYMENT BY DTC, ANY DTC PARTICIPANT OR INDIRECT DTC PARTICIPANT OF ANY AMOUNT DUE TO ANY BENEFICIAL OWNER IN RESPECT OF THE PRINCIPAL OR INTEREST WITH RESPECT TO THE BONDS; (IV) THE DELIVERY OR TIMELINESS OF DELIVERY BY DTC, ANY DTC PARTICIPANT OR INDIRECT DTC PARTICIPANT OF ANY NOTICE TO ANY BENEFICIAL OWNER WHICH IS REQUIRED OR PERMITTED UNDER THE TERMS OF THE RESOLUTION TO BE GIVEN TO BENEFICIAL OWNERS; (V) THE SELECTION OF BENEFICIAL OWNERS TO RECEIVE PAYMENTS IN THE EVENT OF ANY PARTIAL REDEMPTION OF THE BONDS; OR (VI) ANY CONSENT GIVEN OR OTHER ACTION TAKEN BY DTC OR ITS NOMINEE, CEDE & CO., AS THE REGISTERED OWNER OF THE BONDS.

## APPENDIX E

## HEALTHCARE RISK FACTORS

### General

The District is subject to a wide variety of federal and state regulatory actions and legislative and policy changes by those governmental and private agencies that administer Medicare, Medicaid and other payors and is subject to actions by, among others, the National Labor Relations Board, The Joint Commission, the Centers for Medicare and Medicaid Services ("CMS") of the U.S. Department of Health and Human Services ("DHHS"), State of California (the "State") Attorney General, and other federal, State and local government agencies. The future financial condition of the District could be adversely affected by, among other things, changes in the method, timing and amount of payments to the District by governmental and nongovernmental payors, the financial viability of these payors, increased competition from other healthcare entities, the costs associated with responding to governmental audits, inquiries and investigations, demand for healthcare, other forms of care or treatment, changes in the methods by which employers purchase healthcare for employees, capability of management, changes in the structure of how healthcare is delivered and paid for (e.g., accountable care organizations and other health reform payment mechanisms), future changes in the economy, demographic changes, availability of physicians, nurses and other healthcare professionals, malpractice claims and other litigation. These factors and others may adversely affect by the District's revenues.

In addition, future economic and other conditions, including inflation, demand for hospital services, the ability of the District to provide the services required or requested by patients, physicians' confidence in the Hospital and management, economic developments in the service area served by the Hospital, employee relations and unionization, competition, rates, increased costs, availability of professional liability insurance, hazard losses, third-party reimbursement and changes in governmental regulations may adversely affect revenues. There can be no assurance given that revenues realized by the District, or utilization of the Hospital will not decrease.

With respect to the financial condition of the District, see the audited financial statements of the District attached to the Official Statement as APPENDIX B."

### Significant Risk Areas Summarized

Certain of the primary risks associated with the operations of the District as a hospital and healthcare provider are briefly summarized in general terms below, and are explained in greater detail in subsequent sections. The occurrence of one or more of these risks could have a material adverse effect on the financial condition and results of operations of the District.

**Federal Healthcare Reform and Deficit Reduction**. The federal healthcare reform legislation has changed and will change how healthcare services are covered, delivered and reimbursed. These changes will result in lower hospital reimbursement from Medicare, utilization changes, increased government enforcement and the necessity for healthcare providers to assess, and potentially alter, their business strategy and practices, among other consequences. While most providers will receive reduced payments for care, millions of uninsured Americans will have coverage. Efforts to reduce the federal deficit and balance of the State budget will likely curb Medicare and Medi-Cal spending further to the detriment of providers.

**General Economic Conditions; Bad Debt, Indigent Care and Investment Performance**. Healthcare providers are economically influenced by the environment in which they operate. To the extent that (1) unemployment rates are high, (2) employers reduce their budgets for employee healthcare coverage or (3) private and public insurers seek to reduce payments to healthcare providers or curb utilization of healthcare services, healthcare providers may experience decreases in insured patient volume and reductions in payments for services. In addition, to the extent that State, county or city governments are unable to provide a safety net of medical services, pressure is applied to local healthcare providers to increase free care. Furthermore, economic downturns and lower funding of federal Medicare and Medi-Cal programs may increase the number of patients who are unable to pay for their medical and hospital services. These conditions may give rise to increases in healthcare providers' uncollectible accounts, or "bad debt," and, consequently, to reductions in operating income. Declines in investment

portfolio values may reduce or eliminate non-operating revenues. Investment losses (even if unrealized) may trigger debt covenants to be violated and may jeopardize hospitals' economic security. Losses in pension and benefit funds may result in increased funding requirements. Potential failure of lenders, insurers or vendors may negatively impact the results of operations and the overall financial condition of healthcare providers. Philanthropic support may also decrease or be delayed.

**Capital Needs vs. Capital Capacity**. Hospital and other healthcare operations are capital intensive. Regulation, technology and physician/patient expectations require constant and often significant capital investment. In California, seismic requirements mandated by the State may require that many hospital facilities be substantially modified, replaced or closed. Estimated construction costs are substantial and actual costs of compliance may exceed estimates. Total capital needs may exceed capital capacity. Furthermore, capital capacity of hospitals and health systems may be reduced as a result of recent credit market dislocations, and it is uncertain how long those conditions may persist.

**Technical and Clinical Developments**. New clinical techniques and technology, as well as new pharmaceutical and genetic developments and products, may alter the course of medical diagnosis and treatment in ways that are currently unanticipated, and that may dramatically change medical and hospital care. These could result in higher hospital costs, reductions in patient populations and/or new sources of competition for hospitals.

**Proliferation of Competition and Increasing Consumer Choice**. Hospitals increasingly face competition from specialty providers of care and ambulatory care facilities. This may cause hospitals to lose essential inpatient or outpatient market share. Competition may be focused on services or payor classifications for which hospitals realize their highest margins, thus negatively affecting programs that are economically important to hospitals. Specialty hospitals may attract specialists as investors and may seek to treat only profitable classifications of patients, leaving full-service hospitals with higher acuity and/or lower paying patient populations. These sources of competition may have a material adverse impact on hospitals, particularly where a group of a hospital's principal physician admitters may curtail their use of a hospital service in favor of competing facilities.

Hospitals and other healthcare providers face increased pressure to operate transparently and make available information about cost and quality of services. Consumers and payors accessing cost and quality information accumulated on various data-bases may shift business among providers or make different healthcare choices based on such information.

**Rate Pressure from Insurers and Major Purchasers**. Certain healthcare markets, including many communities in California, are strongly impacted by large health insurers and, in some cases, by major purchasers of health services. In those areas, health insurers may have significant influence over the rates, utilization and competition of hospitals and other healthcare providers. Rate pressure imposed by health insurers or other major purchasers, including managed care payors, may have a material adverse impact on hospitals and other healthcare providers, particularly if major purchasers put increasing pressure on payors to restrain rate increases. Business failures by health insurers also could have a material adverse impact on contracted hospitals and other healthcare providers in the form of payment shortfalls or delays, and/or continuing obligations to care for managed care patients without receiving payment. In addition, disputes with non-contracted payors may result in an inability to collect billed charges from these payors.

**Reliance on Medicare**. Inpatient hospitals rely to a high degree on payment from the federal Medicare program. Recent changes in the underlying laws and regulations, as well as in payment policy and timing, create uncertainty and could have a material adverse impact on hospitals' payment streams from Medicare. With healthcare and hospital spending reported to be increasing faster than the rate of general inflation, Congress and CMS are expected to take action in the future to decrease or restrain Medicare outlays for hospitals.

**Costs and Restrictions from Governmental Regulation**. Nearly every aspect of hospital operations is regulated, in some cases by multiple agencies of government. The level and complexity of regulation and compliance audits appear to be increasing, imposing greater operational limitations, enforcement and liability risks, and significant and sometimes unanticipated costs.

**Government "Fraud" Enforcement**. "Fraud" in government funded healthcare programs is a significant concern of federal and state regulatory agencies overseeing healthcare programs, and is one of the federal

government's prime law enforcement priorities. The federal government and, to a lesser degree, state governments impose a wide variety of extraordinarily complex and technical requirements intended to prevent over-utilization based on economic inducements, misallocation of expenses, overcharging and other forms of "fraud" in the Medicare and Medicaid programs, as well as other state and federally-funded healthcare programs. This body of regulation impacts a broad spectrum of hospital and other healthcare provider commercial activity, including billing, accounting, recordkeeping, medical staff oversight, physician contracting and recruiting, cost allocation, clinical trials, discounts and other functions and transactions.

Violations and alleged violations may be deliberate, but also frequently occur in circumstances where management is unaware of the conduct in question, as a result of mistake, or where the individual participants do not know that their conduct is in violation of law. Violations may occur and be prosecuted in circumstances that do not have the traditional elements of fraud, and enforcement actions may extend to conduct that occurred in the past. Violations carry significant sanctions. The government periodically conducts widespread investigations covering categories of services, or certain accounting or billing practices.

**Violations and Sanctions**. The government and/or private "whistleblowers" often pursue aggressive investigative and enforcement actions. The government has a wide array of civil, criminal, monetary and other penalties, including suspending essential hospital and other healthcare provider payments from the Medicare or Medicaid programs, or exclusion from those programs. Aggressive investigation tactics, negative publicity and threatened penalties can be, and often are, used to force healthcare providers to enter into monetary settlements in exchange for releases of liability for past conduct, as well as agreements imposing prospective restrictions and/or mandated compliance requirements on healthcare providers. Such negotiated settlement terms may have a materially adverse impact on hospital and other healthcare provider operations, financial condition, results of operations and reputation. Multi-million dollar fines and settlements for alleged intentional misconduct, fraud or false claims are not uncommon in the healthcare industry. These risks are generally uninsured. Government enforcement and private whistleblower suits may increase in the hospital and healthcare sector. Many large hospital and other healthcare provider systems have been and are liable to be adversely impacted.

**State Medicaid Program**s. The California Medicaid program, known as Medi-Cal is an important payor source to many hospitals and may become a proportionately larger source of revenue as federal healthcare reform is implemented, expanding Medicaid coverage to significant numbers of uninsured Americans. This program often pays hospitals and physicians at levels that may be below the actual cost of the care provided. As Medi-Cal is partially funded by the State, the financial condition of the State may result in lower funding levels and/or payment delays. These could have a material adverse impact on hospitals.

**Professional Staffing**. From time to time, a shortage of certain physician specialties, nurses and medical technicians exists which may have a primary impact on hospitals. The shortages are particularly acute in the fields of primary care and certain medical and surgical specialties. Such shortages may adversely affect hospitals, which rely on skilled healthcare practitioners to deliver care. Hospital operations, patient and physician satisfaction, financial condition, results of operations and future growth could be negatively affected by these shortages, resulting in a material adverse impact to hospitals.

**Labor Costs and Disruption**. The delivery of healthcare services is labor intensive. Labor costs, including salary, benefits and other liabilities associated with the workforce, have significant impact on hospital and healthcare provider operations and financial condition. Hospital and healthcare employees are increasingly organized in collective bargaining units, and may be involved in work actions of various kinds, including work stoppages and strikes. Overall costs of the hospital workforce are high, and turnover is high. Pressure to recruit, train and retain qualified employees is expected to accelerate. These factors may materially increase hospital costs of operation. Workforce disruption may negatively impact hospital revenues, expenses and employment recruitment efforts.

**Pension and Benefit Funds**. As large employers, health systems may incur significant expenses to fund pension and benefit plans for employees and former employees, and to fund required workers' compensation benefits. Plans are often underfunded or may become underfunded and funding obligations in some cases may be erratic or unanticipated and may require significant commitments of available cash needed for other purposes.

**Medical Liability Litigation and Insurance**. Medical liability litigation is subject to public policy determinations and legal and procedural rules that may be altered from time to time, with the result that the

frequency and cost of such litigation, and resultant liabilities, may increase in the future. Health systems may be affected by negative financial and liability impacts on physicians. Costs of insurance, including self-insurance, may increase dramatically.

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

**Facility Damage**. Hospitals and health systems are highly dependent on the condition and functionality of their physical facilities. Damage from earthquake, floods, fire, other natural causes, deliberate acts of destruction, or various facilities system failures may have a material adverse impact on operations, financial conditions and results of operations.

**Federal Budget Cuts**

On August 3, 2011, President Obama signed the Budget Control Act of 2011 (the "BCA"), The BCA limits the federal government's discretionary spending caps at levels necessary to reduce expenditures by $917 billion over 10 years from the federal budget baseline for federal fiscal years 2011 and 2012. Medicare, Social Security, Medicaid and other entitlement programs were not affected by the limit on discretionary spending caps.

The BCA also created a bipartisan joint congressional committee (the "Super Committee") to identify additional deficit reductions. Because the Super Committee failed to propose a plan to cut the deficit by an additional $1.2 trillion by the November 23, 2011, deadline, the BCA required automatic spending reductions of $1.2 trillion for fiscal years 2013 through 2021, minus any deficit reductions enacted by Congress and debt service costs. This portion of the so-called "fiscal cliff" could be avoided only if Congress took preventive action by the end of calendar year 2012.

The BCA also provided for a 26.5 % reduction in Medicare's sustainable growth rate ("SGR") formula for physician reimbursement, which would have become effective in 2013, absent congressional action prior to 2012 year end. The Middle Class Tax Relief and Job Creation Act of 2012, enacted in February 2012, froze physician payment rates at 2011 levels only until December 31, 2012.

On January 2, 2013, President Obama signed into law the American Taxpayer Relief Act of 2012, covering, among other matters, Medicare provider payments. The law includes a one-year Medicare physician fee schedule overriding the BCA reduction and delays until March 2013 the automatic, across-the-board cuts imposed by the BCA on Medicare provider reimbursements.

Since the law only pushes off the automatic cuts and difficult negotiations are expected in Congress over these cuts and related issues, the District is unable to predict what initiatives may be proposed by Congress or whether Congress will attempt to suspend or restructure the automatic budget cuts further. However, if effective, these reductions could have a material adverse effect on the financial condition of the District. Moreover, 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.

**California State Budget.**

California has faced in the past severe financial challenges, including erosion of general fund tax revenues, falling real estate values, slow economic growth and high unemployment. Shortfalls between revenues and spending have in the past and may in the future result in cutbacks to State and local government healthcare programs. Failure by the California legislature to approve budgets prior to the start of a new fiscal year can also result in a temporary hold on or delay of Medi-Cal reimbursement. However, the relatively recent addition of legislative incentives to pass the State budget on time makes this less likely than in the past.

The State of California's budget for the 2012-2013 fiscal year has provided for spending reductions in State health programs, including significant funding cuts to the Medi-Cal program. Additional cuts to the Medi-Cal program may occur as a result of revenue shortfalls in future fiscal years. It is impossible to predict what actions would be taken in future years by the California Legislature, the Governor or citizen initiative actions to address any significant financial problems. It is possible that any additional cuts in the levels and timing of healthcare provider reimbursement, including that to hospitals under Medi-Cal, could materially adversely affect the District.

Notably, however, on January 10, 2013, California's Governor Brown predicted a balanced budget over the next four fiscal years and indicated that the State should expect a surplus of about $785 million for the current fiscal year ending June 30, 2013, and a surplus of about $851 million under his proposed budget for the 2013-2014 fiscal year, beginning July 1, 2013. Included in his proposed budget is increased healthcare spending.

The financial challenges which California and the Medi-Cal program have faced in the past have negatively affected health care organizations in a number of ways. Despite current budget predictions, these challenges may return in the future. California then may enact legislation to reduce Medi-Cal payments, attempt to impose copayments on Medi-Cal recipients which could result in a reduction in provider reimbursement, or reduce covered benefits or restrict eligibility. The federal Patient Protection and Affordable Care Act allows for significant expansions to the Medicaid program and additional federal funding. Such funding is conditioned, however, on the State's maintaining specified beneficiary eligibility criteria, which may require additional State funding or prompt the State to reduce provider reimbursement. The BCA may also shift further funding responsibility from the federal government to state governments, creating new financial challenges. See "Significant Risk Areas Summarized -- General Economic Conditions, Bad Debt, Indigent Care and Investment Performance" and "— Business Relationships and Other Business Matters—Indigent Care" herein.

**Local Ballot Measures**

California local governments and districts face severe financial challenges that are expected to continue or worsen over the coming years. Shortfalls between revenues and spending have in the past and may in the future result in cutbacks in payments and reimbursements to local health care facilities. Health care districts are subject to ballot initiatives passed by voters living in the district. In response to perceived excesses in executive compensation, pension, and other benefits paid to district executives and service providers, taxpayers in certain health care districts in the State placed certain health care district initiatives on the November 2012 Ballot. If passed, these ballot measures would severely restrict the amount of compensation payable to district executives and health care providers. No initiatives affecting the District were on the November 2012 Ballot. However, it is impossible to predict what actions will be taken in future years by voters in the District to address budgetary shortfalls, increased tax burdens, and perceived compensation excesses. Any restriction on the District's ability to offer competitive compensation and other perquisites to attract and retain management and providers may have a material adverse impact on the operations and financial results of the District.

**Healthcare Regulation and Reform**

**Healthcare Regulation**. The health care industry in general is subject to regulation by a number of governmental and private agencies, including those which administer the Medicare and Medicaid programs discussed under the headings "Patient Service Revenues—Medicare" and "—Medicaid" herein. The health care industry is also affected by federal, state and local policies developed to regulate the manner in which health care is provided, administered and paid for nationally and locally. As a result, the health care industry is sensitive to frequent and substantial legislative and regulatory changes. Congress and the states have consistently attempted to curb the growth of federal spending on health care programs. In addition, Congress and other governmental agencies have focused on the provision of care to indigent and uninsured patients, prevention of "dumping" such patients on public hospitals in order to avoid the provision of non-reimbursed care, the unlawful payment of remuneration in exchange for referral of patients, the unauthorized use or disclosure of patients' protected health information, billing for services not in accordance with governmental requirements and other issues. It is unlikely that the District could attract sufficient numbers of private pay patients to become self-sufficient without reimbursement from governmental programs. Cost shifting to private sources of payment is not an option to offset declining federal and state reimbursement because private insurance companies have adopted cost containment measures similar to those used by government agencies. These cost containment mechanisms include "managed care" and capitated payment.

Despite these efforts, due to, among other things, the growing percentage of older persons in the population, improved technology and administrative costs in a highly regulated industry, health care expenditures as a percentage of the gross national product continue to rise. Consequently, it can be expected that aggressive cost containment measures and anti-fraud and abuse investigation and enforcement could have a material adverse effect on the District. Continued efforts in the form of statutory and regulatory activity to reduce the rate of increase in reimbursement for health care costs, particularly costs paid under the Medicare and Medicaid programs, can be expected.

The Medicare and Medicaid programs have been and continue to be affected by numerous legislative initiatives. In general, the purpose of much of the statutory and regulatory activity has been to reduce the rate of increase in health care costs, particularly costs paid under the Medicare and Medicaid programs. Diverse and complex mechanisms to limit the amount of money paid to health care providers under both the Medicare and Medicaid programs have been enacted, and have caused reductions in reimbursement from the Medicare program.

Numerous other proposals have been advanced by various parties to require or promote alternate methods of health care delivery, to establish health care cost containment measures, to provide alternatives for payment of health care costs under Medicare, Medicaid and private reimbursement programs, and to institute other changes in health care payment and reimbursement.

The District is subject to governmental regulation under the federal Medicare program and the joint federal and state Medicaid program. Health care providers, including the Hospital, have been and will continue to be affected by changes that have occurred during the last several years in the administration of the Medicare and Medicaid programs.

**Federal Healthcare Reform**. As a result of the Patient Protection and Affordable Care Act enacted in 2010, as amended, (the "ACA"), substantial changes have occurred and are anticipated in the United States healthcare system. The ACA has and will affect the delivery of healthcare services, the financing of healthcare costs, reimbursement of healthcare providers, and the legal obligations of health insurers, providers, employers and consumers. Some of the ACA's provisions have been implemented and other provisions are slated to take effect at specified times over approximately the next decade, and, therefore, the full consequences of the ACA on the healthcare industry will not be immediately realized. The ramifications of the ACA may also become apparent only following implementation or through later regulatory and judicial interpretations. The portion of the ACA which permits the federal government to withdraw existing Medicaid funds for failure of a state to comply with the ACA's Medicaid expansion requirements was nullified as a result of a 2011 United States Supreme Court decision. The balance of the ACA was upheld by that decision. However, the uncertainties regarding the implementation of the ACA create unpredictability for the strategic and business planning efforts of healthcare providers, which in itself constitutes a risk.

The changes in the healthcare industry brought about by the ACA will likely have both positive and negative effects, directly and indirectly, on the nation's hospitals and other healthcare providers, including the District. For example, the projected increase in the numbers of individuals with healthcare insurance occurring as a consequence of voluntary Medicaid expansion, creation of health insurance exchanges, subsidies for insurance purchase and the mandate for individuals to purchase insurance, could result in lower levels of bad debt and charity care and increased utilization or profitable shifts in utilization patterns for hospitals. The ACA also provides for substantial reductions in payments to Medicare providers, both through reduction in the annual market basket updates and reduction or elimination of reimbursement for preventable patient readmissions and hospital-acquired conditions. The ACA similarly mandates that states no longer reimburse providers for specified provider-preventable conditions. The ACA also significantly reduces both Medicare and Medicaid disproportionate share hospital funding between 2011 and 2020. A significant negative impact to the hospital industry overall will likely result from substantial scheduled, and cumulative, reductions in Medicare payments. Industry experts also expect that government cost reduction actions may be followed by similar actions by private insurers and other payors. Since approximately 50% of the revenues of the District (for fiscal year ended June 30, 2012) were from Medicare spending, the reductions may have a material adverse impact, and could offset any positive effects of the ACA. See also "Patient Service Revenues - The Medicare Program" below.

Healthcare providers will likely be further subject to decreased reimbursement as a result of implementation of recommendations of the Medicare payment advisory board, whose directive is to reduce Medicare cost growth. The advisory board's recommended reductions, beginning in 2014, will be automatically implemented unless Congress adopts alternative legislation that meets equivalent savings targets. Industry experts also expect that government cost reduction actions may be followed by similar reductions by private insurers and other payors.

The ACA also contemplates the formation of state "health insurance exchanges" that provide consumers with improved access to health insurance. Employers or individuals may shift their purchase of health insurance to new plans offered through exchanges, which may or may not reimburse providers at rates equivalent to rates that providers currently receive. The exchanges could also alter the health insurance markets in ways that cannot be predicted, and exchanges might, directly or indirectly, take on a rate-setting function that could negatively impact providers.

The ACA will likely affect some healthcare organizations differently from others, depending, in part, on how each organization adapts to the legislation's emphasis on directing more federal healthcare dollars to integrated provider organizations and providers with demonstrable achievements in quality care. The ACA proposes a value-based purchasing system for hospitals under which a percentage of payments will be contingent on satisfaction of specified performance measures related to common and high-cost medical conditions, such as cardiac, surgical and pneumonia care. The legislation also funds various demonstration programs and pilot projects and other voluntary programs to evaluate and encourage new provider delivery models and payment structures, including "accountable care organizations" and bundled provider payments. The outcomes of these projects and programs, including the likelihood of their being made permanent or expanded or their effect on healthcare organizations' revenues or financial performance cannot be predicted.

The ACA contains amendments to existing criminal, civil and administrative anti-fraud statutes and increases in funding for enforcement and efforts to recoup prior federal healthcare payments to providers. Under the ACA, a broad range of providers, suppliers and physicians are required to adopt a compliance and ethics program. While the government has already increased its enforcement efforts, failure to implement certain core compliance program features provides new opportunities for regulatory and enforcement scrutiny, as well as potential liability if an organization fails to prevent or identify improper federal healthcare program claims and payments. See also "Regulatory Environment" below.

**California Healthcare Reform**. The State has passed several laws to implement the ACA. The State has established a state health insurance exchange, initially called the "California Health Benefit Exchange" now named "Covered California," as required by the ACA. In addition, 47 California counties are participating in the "Bridge to Reform" program, which implements the ACA's Medicaid expansion ahead of schedule. The California legislature is debating additional legislation related to the implementation of the ACA and reformation of individual coverage in the State, including provisions establishing essential health benefits and prohibiting insurers from denying health coverage to individuals of any age with pre-existing conditions. Any such legislation or regulation concerning healthcare reform could have a material adverse effect on the District.

**Changes in Federal and State Law**. From time to time, there are Presidential proposals, proposals of various federal committees, and legislative proposals in the Congress and in the states that, if enacted, could alter or amend the federal and state tax matters referred to herein or adversely affect the marketability or market value of the Bonds or otherwise prevent holders of the Bonds from realizing the full benefit of the tax exemption of interest on the Bonds. Further, such proposals may impact the marketability or market value of the Bonds simply by being proposed. It cannot be predicted whether or in what form any such proposal might be enacted or whether if enacted it would apply to bonds issued prior to enactment.

In addition, regulatory actions are from time to time announced or proposed and litigation is threatened or commenced which, if implemented or concluded in a particular manner, could adversely affect the market value, marketability or tax status of the Bonds. It cannot be predicted whether any such regulatory action will be implemented, how any particular litigation or judicial action will be resolved, or whether the Bonds would be impacted thereby.

**Bond Examinations**. IRS officials have recently indicated that more resources will be invested in audits of tax-exempt bonds, including arbitrage and rebate requirements and the private use of bond-financed facilities.

**Litigation Relating to Billing and Collection Practices**. Lawsuits have been filed in both federal and state courts alleging, among other things, that hospitals have failed to fulfill their obligations to provide charity care to uninsured patients and have overcharged uninsured patients. Some of these cases have since been dismissed by the courts and some hospitals and health systems have entered into substantial settlements. Cases are pending in various courts around the country and others could be filed. Some hospitals and health systems have entered into substantial settlements.

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

**Charity Care and Financial Assistance**. California law requires hospitals to maintain written policies about discount payment and charity care and provide copies of such policies to patients and California's Office of Statewide Health Planning and Development. California hospitals are also required to follow specified billing and collection procedures.

The foregoing are some examples of the challenges and examinations facing the healthcare industry 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 healthcare organizations. The challenges and examinations, and any resulting legislation, regulations, judgments, or penalties, could have a material adverse effect on hospitals and healthcare providers, including the District.

**Patient Service Revenues**

**The Medicare Program**. Medicare is the federal health insurance system under which hospitals are paid for services provided to eligible elderly and disabled persons. Medicare is administered by CMS, which delegates to the states the process for certifying hospitals to which CMS will make payment. In order to achieve and maintain Medicare certification, hospitals must meet CMS's "Conditions of Participation" on an ongoing basis, as determined by the State and/or The Joint Commission. The requirements for Medicare certification are subject to change, and, therefore, it may be necessary for hospitals to effect changes from time to time in their facilities, equipment, personnel, billing, policies and services. For the fiscal year ended June 30, 2012, Medicare payments represented approximately 50%, of the District's gross patient service revenue.

As the population ages, more people will become eligible for the Medicare program. Current projections indicate that demographic changes and continuation of current cost trends will exert significant and negative forces on the overall federal budget. The ACA institutes multiple mechanisms for reducing the costs of the Medicare program, including the following:

***Market Basket Reductions***. Generally, Medicare payment rates to hospitals are adjusted annually based on a "market basket" of estimated cost increases, which have averaged approximately 2% to 4% annually in recent years. The ACA required automatic 0.25% reductions in the "market basket" for federal fiscal years 2010 and 2011, and calls for reductions ranging from 0.10% to 0.75% each year through federal fiscal year 2019.

***Market -Productivity Adjustments***. Beginning in federal fiscal year 2012 and thereafter, the ACA provides for "market basket" adjustments based on national economic productivity statistics. This adjustment is anticipated to result in an approximately 1% additional annual reduction to the "market basket" update.

***Value-Based Purchasing***. Beginning in federal fiscal year 2013, Medicare inpatient payments to hospitals will be reduced by 1%, progressing to 2% by federal fiscal year 2017. New Medicare inpatient incentive payments commence in federal fiscal year 2013 based on performance on specified metrics; the new payments may be less than, equal to or more than the reductions for an individual hospital.

***Hospital Acquired Conditions Penalty***. Beginning in federal fiscal year 2015, Medicare inpatient payments to hospitals that are in the top quartile nationally for frequency of certain "hospital-acquired conditions" will be reduced by 1% of what would otherwise be payable to each hospital for the applicable federal fiscal year.

***Readmission Rate Penalty***. As of the beginning of federal fiscal year 2012, Medicare Inpatient PPS payments for certain hospitals have been reduced based on the dollar value of that hospital's percentage of preventable Medicare readmissions for certain medical conditions under the CMS "Hospital Readmissions Reduction Program." CMS has currently identified three conditions for the program: heart attack, heart failure, and pneumonia.

***DSH Payments***. Beginning in federal fiscal year 2014, hospitals receiving supplemental "DSH" payments from Medicare (i.e., those hospitals that care for a disproportionate share of low-income beneficiaries) are slated to have their DSH payments reduced by 75%. This reduction will be adjusted to add-back payments based on the volume of uninsured and uncompensated care provided by each such hospital, and is anticipated to be offset by a higher proportion of covered patients as other provisions of the ACA go into effect. Separately, beginning in federal fiscal year 2014, Medicaid DSH allotments to each state will also be reduced, based on a methodology to be determined by DHHS, accounting for statewide reductions in uninsured and uncompensated care. See also "Disproportionate Share Payments" below.

***Innovation and Cost Reductions***. The ACA provides rewards for innovation and cost reductions, including the establishment of a national Medicare pilot program to study the use of bundled payments by January 1, 2013. If the pilot program achieves the stated goals of improving or not reducing quality and reducing spending, then the pilot program will be expanded by January 1, 2016.

Hospitals also receive payments from health plans under the Medicare Advantage program. The ACA includes significant changes to federal payments to Medicare Advantage plans. Payments to plans were frozen for fiscal year 2011 and thereafter will transition to benchmark payments tied to the level of fee-for-service spending in the applicable county. These reduced federal payments could in turn affect the scope of coverage of these plans or cause plan sponsors to negotiate lower payments to providers.

Components of the 2008 federal stimulus package, the American Recovery and Reinvestment Act ("ARRA"), provide for Medicare incentive payments beginning in 2011 to hospital providers meeting designated deadlines for the installation and use of electronic health information systems. For those hospital providers failing to meet a 2016 deadline, Medicare payments will be significantly reduced. See also "Regulatory Environment - The HITECH Act."

***Physician Services.*** Payments for physician services, other than those performed in a rural health clinic which are reimbursed as described below, under Part B of the Medicare program are based on a national fee schedule. The fee schedule is based on a resource based relative value scale ("RBRVS"), whereby physician work for a service is assigned a value reflecting the relative resources such as time, intensity, and risk required to perform the service. Values are also assigned to each service for practice expenses – for example, billing, rent, office personnel, and supplies, and for malpractice expenses. Payments are calculated by multiplying the combined costs of a service by a conversion factor. The conversion factor is a monetary amount that is currently determined by CMS's Sustainable Growth Rate ("SGR") system. The SGR system annually takes into account changes in the Medicare fee-for-services enrollment, input prices, spending due to law and regulation, and gross domestic product. In recent years, CMS has proposed payment cuts for physician services. On December 15, 2010, the Medicare and Medicaid Extenders Act of 2010 ("MMEA") was signed into law, temporarily sparing hospitals, physicians and other health service providers from numerous significant payment cuts. On November 2, 2011, CMS announced that it would implement an across-the-board Medicare payment reduction of approximately 27% for physicians and non-physician practitioners starting on January 1, 2012. In December 2011, Congress passed a two-month extension on this payment cut. On February 17, 2012, Congress passed the Middle Class Tax Relief and Job Creations Act of 2012, which included a provision directing CMS to continue to pay physicians at 2011 rates through the end of

2012. Congress recently approved additional rate-freezing legislation through 2013. There is no guarantee that reimbursement for physician services will cover the cost of those services to beneficiaries.

***Hospital Inpatient Reimbursement***. Hospitals are generally paid for inpatient services provided to Medicare beneficiaries based on established categories of treatments or conditions known as diagnosis related groups ("DRGs"). The actual cost of care, including capital costs, may be more or less than the DRG rate. DRG rates are subject to adjustment by CMS, including reductions mandated by the ACA and the BCA and are subject to federal budget considerations. There is no guarantee that DRG rates, as they change from time to time, will cover actual costs of providing services to Medicare patients.

***Hospital Outpatient Reimbursement***. Hospitals are generally paid for outpatient services provided to Medicare beneficiaries based on established categories of treatments or conditions known as ambulatory payment classifications ("APC"). The actual cost of care, including capital costs, may be more or less than the reimbursements. There is no guarantee that APC rates, as they change from time to time, will cover actual costs of providing services to Medicare patients.

***Other Medicare Service Payments.*** Medicare payment for skilled nursing services, psychiatric services, inpatient rehabilitation services, general outpatient services and home health services are based on regulatory formulas or predetermined rates. There is no guarantee that these rates, as they may change from time to time, will be adequate to cover the actual cost of providing these services to Medicare patients.

***Reimbursement of Hospital Capital Costs.*** Hospital capital costs (including depreciation and interest) apportioned to Medicare patient use are paid by Medicare on the basis of a standard federal rate (based upon average national costs of capital), subject to limited adjustments specific to the hospital. There can be no assurance that future capital-related payments will be sufficient to cover the actual capital-related costs of the Hospital applicable to Medicare patient stays or will provide flexibility to meet changing capital needs.

***Medical Education Payments.*** Medicare currently pays for a portion of the costs of medical education at hospitals that have teaching programs. These payments are vulnerable to reduction or elimination. The direct and indirect medical education reimbursement programs have repeatedly emerged as targets in the legislative efforts to reduce the federal budget deficit.

***Medicare Bad Debt Reimbursement.*** Under Medicare, the costs attributable to the deductible and coinsurance amounts which remain unpaid by the Medicare beneficiary can be added to the Medicare share of allowable costs as cost reports are filed. Hospitals generally receive interim pass-through payments during the cost report year which were determined by the Medicare Administrative Contractor from the prior cost report filing. Bad debts must meet the following criteria to be allowable:

- the debt must be related to covered services and derived from deductible and coinsurance amounts;
- the provider must be able to establish that reasonable collection efforts were made;
- the debt was actually uncollectible when claimed as worthless; and
- sound business judgment established that there was no likelihood of recovery at any time in the future.

The amounts uncollectible from specific beneficiaries are to be charged off as bad debts in the accounting period in which the accounts are deemed to be uncollectible. In some cases, an amount previously written off as a bad debt and allocated to the program may be recovered in a subsequent accounting period. In these cases, the recoveries must be used to reduce the cost of beneficiary services for the period in which the collection is made. In determining reasonable costs for hospitals, the amount of bad debts otherwise treated as allowable costs is reduced by 30%. However, under discussion is an increase in the reduction to 35%. Amounts incurred by a hospital as reimbursement for bad debts are subject to audit and recoupment by the Medicare Administrative Contractor. Bad debt reimbursement has been a focus of Medicare Administrative Contractor audit/recoupment efforts in the past.

***Recovery Audit Contractor Program.*** CMS has implemented a Recovery Audit Contractor ("RAC") program on a nationwide basis where CMS contracts with private contractors to conduct post-payment reviews to detect and correct improper payments in the fee-for-service Medicare program and to implement actions that will prevent future improper payments. The ACA expands the RAC program's scope to include managed Medicare plans and Medicaid claims. CMS also employs Medicaid Integrity Contractors to perform post-payment audits of

Medicaid claims and identify overpayments. These programs tend to result in retroactively reduced payment and higher administration costs to hospitals.

The RAC operates to identify overpayments and underpayments made to providers. RACs may review the last three years of provider claims for the following types of services: hospital inpatient and outpatient, skilled nursing facility, physician, ambulance, laboratory and durable medical equipment.

The ACA mandated the expansion of the RAC program into Medicaid requiring states to contract by December 31, 2010, with one or more RACs to identify underpayments and overpayments and recoup overpayments for Medicaid services. Claims are reviewed using state Medicaid rules and the state may use its current appeal process.

Implementation of the State's Medi-Cal RAC began in 2012. A Request for Proposal for Medi-Cal RAC services in California was issued in October, 2011 with a proposal due date of December 22, 2011, which was subsequently extended to January, 2012. On March 29, 2012 California announced its intent to award the RAC contract to HMS. Initially CMS estimated that Medicaid RAC would recover $80 million in federal fiscal year 2011, $170 million in federal fiscal year 2012, $250 million in federal fiscal year 2013, $210 million in federal fiscal year 2014 and $300 million in federal fiscal year 2015. These estimates were published in the proposed rule that came out in November 2010 before the implementation delays were announced. As of this date, the District has not been contacted by HMS and has not experienced any Medi-Cal RAC activity.

***Recovery Audit Prepayment Review.*** In November 2011, CMS announced a new effort to curb unnecessary Medicare payments before they occur. The Recovery Audit Prepayment review demonstration project, originally scheduled to start in January, 2012, began in June 2012. This demonstration project will allow Medicare RACs to evaluate certain types of claims that typically have high rates of improper payments such as cardiac and orthopedic procedures. The purpose of this project is to shift Medicare's focus from "pay and chase" recovery methods to avoiding improper payments before they occur. The prepayment reviews will be carried out by four Medicare RAC contractors in eleven states including California. CMS believes that the Recovery Auditors will review 150,000 claims annually at the height of this demonstration. As of November 1, 2012, the District has not received any information from the RAC regarding this project.

**Medi-Cal Program**. Medi-Cal is the Medicaid program in California. Medicaid is a program of medical assistance, funded jointly by the federal government and the states, for certain needy individuals and their dependants. Under Medicaid, the federal government provides limited funding to states that have medical assistance programs that meet federal standards. Attempts to balance or reduce the federal budget along with balanced-budget requirements in the State will likely negatively impact Medi-Cal funding. Federal and State budget proposals contemplate significant cuts in Medi-Cal spending which will likely negatively impact provider reimbursement.

Most California hospitals are reimbursed for inpatient Medi-Cal services based on contracts between the hospital and Medi-Cal or based on cost reimbursement where there are no contracts. However, beginning July 1, 2013, general acute care hospitals, other than non-designated public hospitals like the Hospital, will be compensated under the State's new DRG system (discussed below). For the fiscal year ended June 30, 2012, the District received approximately 23% of its gross patient service revenues from services covered by Medi-Cal programs.

The ACA makes changes to Medicaid funding and potentially increases the number of Medicaid beneficiaries. Management of the Hospital cannot predict the effect of these changes to the Medi-Cal program on the operations, results from operations or financial condition of the District, nor can the District predict the State's decision whether or not voluntarily to comply with the Medicaid expansion provisions of the ACA.

In November 2010, CMS approved the State's new, 5-year, Section 1115 Medicaid Waiver which grants the State certain exemptions, exceptions and modifications from the standard federal Medicaid program (operated as Medi-Cal in California). Key elements of the waiver include expanding existing Medi-Cal coverage to cover as many as 500,000 uninsured individuals; expanding the existing Safety Net Care Pool to provide additional support to finance uncompensated care; providing for enrollment of seniors and persons with disabilities into managed care health plans to achieve better care coordination and management of chronic conditions; and implementing a series of improvements in public hospitals and their delivery systems to strengthen their infrastructure and prepare them for full implementation of health reform.

Separate from the aforementioned Medicaid Waiver, in 2009 the State implemented the CMS-approved Hospital Quality Assurance Fee program which provides for significant new supplemental Medi-Cal payments to participating hospitals. The program is funded by assessing certain California hospitals with a "provider fee" and then using this fee to draw down on additional federal matching funds. The provider fee and matching federal funds are then distributed back to hospitals as supplemental Medi-Cal payments, reduced by an administrative fee retained by the State and by monies used to help fund children's healthcare services. Public hospitals and non-designated public hospitals (like the District) were exempt from paying the fee but received supplemental payments. Although the program has continued for non-profit hospitals, it has been discontinued for public entities such as the District and the Hospital.

In November 2010, CMS approved the State's new, 5-year, Section 1115 Medicaid Waiver which grants the State certain exemptions, exceptions and modifications from the standard federal Medicaid program (operated as Medi-Cal in California). Key elements of the waiver include expanding existing Medi-Cal coverage to cover as many as 500,000 uninsured individuals; expanding the existing Safety Net Care Pool to provide additional support to finance uncompensated care; providing for enrollment of seniors and persons with disabilities into managed care health plans to achieve better care coordination and management of chronic conditions; and implementing a series of improvements in public hospitals and their delivery systems to strengthen their infrastructure and prepare them for full implementation of health reform.

Recent legislation has mandated that the California Department of Health Services develop a DRG payment system to be implemented for admissions on and after July 1, 2013. The system will only apply to those Medi-Cal fee-for-service aid categories and beneficiaries not already enrolled in a Medi-Cal Managed Care program. Under the State's model, the transition from fee-for-service to a DRG-based prospective payment system would be phased in over a four-year period and would limit a hospital's reimbursement reduction to 5% in the first year, an additional 5% in the second year, an additional 5% in the third year and then full reduction in the fourth year. However, the California Governor's "May Revise" of the State's fiscal year 2013 budget provided that non-designated public hospitals, like the District, will be exempt from the DRG-based prospective payment system and will alternatively be reimbursed under a Certified Public Expenditures ("CPE") model similar to that applied to designated public hospitals (e.g., University of California and county hospitals). Under a CPE model, the State no longer provides its 50% matching share of Medi-Cal funds paid to a hospital. Under a CPE model, a hospital will only receive funding from the federal government equal to 50% of the hospital's total eligible certified public expenditures (generally, unreimbursed cost of providing care to the covered population). However, under the current CPE program for designated public hospitals, the federal government also provides substantial supplemental funding through various payment pools (e.g., uncompensated care, safety net, delivery system improvement, etc.) that offsets virtually all payment shortfalls. As such, non-designated public hospitals are currently negotiating with the State to provide similar supplemental payment funds under its CPE model for district and municipal hospitals. While the District may be materially and adversely affected by this CPE model, it is possible that the availability of federal supplemental funds may mitigate some or substantially all of the loss in State funding.

On April 13, 2011, the Governor signed California Senate Bill 90 ("SB 90") and California Assembly Bill 113 ("AB 113") which created a six-month hospital fee program, established an intergovernmental transfer program for non-designated (district and municipal hospitals) and designated public hospitals, and included a comprehensive budget solution for hospitals. The six-month hospital fee program benefitted hospitals by approximately $858 million, and established a financing mechanism for non-designated and designated public hospitals that resulted in a net benefit of approximately $80 million for the same time period. The California Department of Health Care Services obtained necessary approvals from CMS and began to implement the programs in late 2011.

With respect to AB 113, it established the non-designated public hospital intergovernmental transfer program ("IGT") for the fee-for-service population of Medi-Cal beneficiaries, under which non-designated public hospitals would voluntarily elect to transfer funds to the State for the purpose of drawing down federal Medicaid funds to make supplemental payments to non-designated public hospitals. The District has benefitted from these supplemental payments. While the AB 113 IGT program was designed to extend beyond the fiscal year 2012 program year, this IGT program would be eliminated if the State implements the CPE payment program previously described above.

With respect to SB 90, a companion bill to AB 113, it established a similar IGT program for non-designated public hospitals for the Medi-Cal population enrolled in Medi-Cal managed care programs. Under the

Medi-Cal managed care IGT program, hospitals receive transfer amounts in the form of grants. The District has received and expects to receive managed care IGT grant funds through the 2014 program year.

**Medicare and Medicaid Audits**. Hospitals that participate in the Medicare and Medicaid programs are subject from time to time to audits and other investigations relating to various aspects of their operations and billing practices, as well as to retroactive audit adjustments with respect to reimbursements claimed under these programs. Medicare and Medicaid regulations also provide for withholding reimbursement payments in certain circumstances. New billing rules and reporting requirements for which there is no clear guidance from CMS or state Medicaid agencies could result in claims submissions being considered inaccurate. The penalties for violations may include an obligation to refund money to the Medicare or Medicaid program, payment of criminal or civil fines and, for serious or repeated violations, exclusion from participation in federal health programs.

Authorized by the HIPAA (as defined herein), the Medicare Integrity Program ("MIP") was established to deter fraud and abuse in the Medicare program. Funded separately from the general administrative contractor program, the MIP allows CMS to enter into contracts with outside entities and insure the "integrity" of the Medicare program. These entities, Medicare Zone Program Integrity Contractors ("ZPICs"), formerly known as program safeguard contractors, are contracted by CMS to review claims and medical charts, both on a prepayment and post-payment basis, conduct cost report audits and identify cases of suspected fraud. ZPICs have the authority to deny and recover payments as well as to refer cases to the Office of Inspector General. CMS is also planning to enable ZPICs to compile claims data from multiple sources in order to analyze the complete claims histories of beneficiaries for inconsistencies.

Medicare audits may result in reduced reimbursement or repayment obligations related to past alleged overpayments and may also delay Medicare payments to providers pending resolution of the appeals process. The ACA explicitly gives DHHS the authority to suspend Medicare and Medicaid payments to a provider or supplier during a pending investigation of fraud. The ACA also amended certain provisions of the False Claims Act to include retention of overpayments as a violation. It also added provisions respecting the timing of the obligation to identify, report and reimburse overpayments. The effect of these changes on existing programs and systems of the District cannot be predicted.

**Disproportionate Share Payments**. The federal Medicare and the California Medi-Cal programs each provide additional payment for hospitals that serve a disproportionate share of certain low income patients.

**Health Plans and Managed Care**. Most private health insurance coverage is provided by various types of "managed care" plans, including health maintenance organizations ("HMOs") and preferred provider organizations ("PPOs") that generally use discounts and other economic incentives to reduce or limit the cost and utilization of healthcare services. Medicare and Medicaid also purchase healthcare using managed care options. Payments to healthcare organizations 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 primary source of non-governmental payment for healthcare services, and healthcare organizations 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 healthcare organizations be able to provide the contracted services without significant operating losses, which may require multiple forms of cost containment.

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

Some HMOs employ a "capitation" payment method under which healthcare organizations are paid a predetermined periodic rate for each enrollee in the HMO who is "assigned" or otherwise directed to receive care from a particular healthcare organization. The healthcare organization may assume financial risk for the cost and scope of institutional care given. If payment is insufficient to meet the healthcare organization's actual costs of care,

or if utilization by such enrollees materially exceeds projections, the financial condition of the healthcare organization could erode rapidly and significantly.

Often, HMO contracts are enforceable for a stated term, regardless of losses and may require healthcare organizations to care for enrollees for a certain time period, regardless of whether the HMO is able to pay the healthcare organization. Healthcare organizations from time to time have disputes with HMOs, PPOs and other managed care payors concerning payment and contract interpretation issues. Such disputes may result in mediation, arbitration or litigation.

Failure to maintain contracts could have the effect of reducing a healthcare organization's market share and net patient service revenues. Conversely, participation may result in lower net income if participating healthcare organizations are unable to adequately contain their costs. In part to reduce costs, health plans are increasingly implementing, and offering to purchasing employers, tiered provider networks, which involve classification of a plan's network providers into different tiers based on care quality and cost. With tiered benefit designs, plan enrollees are generally encouraged, through incentives or reductions in copayments or deductibles, to seek care from providers in the top tier. Classification of a hospital in a non-preferred or lower tier by a significant payor may result in a material loss of volume. The new demands of dominant health plans and other shifts in the managed care industry may also reduce patient volume and revenue. Thus, managed care poses one of the most significant business risks (and opportunities) that healthcare organizations face.

Defined broadly, for the fiscal year ended June 30, 2011, payments from commercially-insured patients constituted approximately 18% of gross patient service revenues of the District. The District has no capitation-based contracts and, therefore, derived none of its revenues from such contracts.

**International Classification of Diseases, 10th Revision Coding System**

In 2009, CMS published the final rule adopting the International Classification of Diseases, 10th Revision coding system ("ICD-10"), requiring healthcare organizations to implement ICD-10 no later than October 2013. In February 2012, DHHS announced its intent to delay the ICD-10 compliance date. ICD-10 provides a common approach to the classification of diseases and other health problems, allowing the United States to align with other nations to better share medical information, diagnosis, and treatment codes. ICD-10 is not without risk as hospital staff will need to be retrained, processes redesigned, and computer applications modified as the current available codes and digit size will dramatically increase. Additionally, there is a potential for temporary coding and payment backlog, as well as potential increases in claims errors. Healthcare organizations will be dependent on outside software vendors, clearinghouses and third-party billing services to develop products and services to allow timely, full and successful implementation of ICD-10. Delays in the required implementation may occur if such ICD-10 products and services are not available to healthcare organizations from these outside sources well in advance of October 2013 to allow for adequate testing and installation.

**Negative Rankings Based on Clinical Outcomes, Cost, Quality, Patient Satisfaction and Other Performance Measures**

Health plans, Medicare, Medicaid, employers, trade groups and other purchasers of health services, private standard-setting organizations and accrediting agencies increasingly are using statistical and other measures in efforts to characterize, publicize, compare, rank and change the quality, safety and cost of healthcare services provided by hospitals and providers. The ACA shifts payments from paying for volume to paying for value, based on various health outcome measures. Published rankings such as "score cards," "pay for performance" and other financial and non-financial incentive programs are being introduced to affect the reputation and revenue of hospitals, the members of their medical staffs and other providers and to influence the behavior of consumers and providers such as the Hospital. Currently prevalent are measures of quality based on clinical outcomes of patient care, reduction in costs, patient satisfaction, and investment in health information technology. Measures of performance set by others that characterize a hospital or provider negatively may adversely affect its reputation and financial condition.

**Enforcement Affecting Clinical Research**

In addition to increasing enforcement of laws governing payment and reimbursement, the federal government has also stepped up enforcement of laws and regulations governing the conduct of clinical trials at hospitals. DHHS elevated and strengthened its Office of Human Research Protection, one of the agencies with responsibility for monitoring federally funded research. In addition, the National Institutes of Health significantly increased the number of facility inspections that these agencies perform. The Food and Drug Administration ("FDA") also has authority over the conduct of clinical trials performed in hospitals when these trials are conducted on behalf of sponsors seeking FDA approval to market the drug or device that is the subject of the research. Moreover, the Office of Inspector General (the "OIG"), in its "Work Plans" has included several enforcement initiatives related to reimbursement for experimental drugs and devices (including kickback concerns) and has issued compliance program guidance directed at recipients of extramural research awards from the National Institutes of Health and other agencies of the U.S. Public Health Service. These agencies' enforcement powers range from substantial fines and penalties to exclusion of researchers and suspension or termination of entire research programs.

Clinical trials are not conducted at the Hospital.

**Regulatory Environment**

**"Fraud" and "False Claims."** Healthcare "fraud and abuse" laws have been enacted at the federal and state levels to broadly regulate the provision of services to government program beneficiaries and the methods and requirements for submitting claims for services rendered to the beneficiaries. Under these laws, hospitals and others can be penalized for a wide variety of conduct, including submitting claims for services that are not provided, billing in a manner that does not comply with government requirements or submitting inaccurate billing information, billing for services deemed to be medically unnecessary, or billings accompanied by an illegal inducement to utilize or refrain from utilizing a service or product.

Federal and state governments have a broad range of criminal, civil and administrative sanctions available to penalize and remediate healthcare fraud, including the exclusion of a hospital from participation in the Medicare/Medicaid programs, civil monetary penalties and suspension of Medicare/Medicaid payments. Fraud and abuse cases may be prosecuted by one or more government entities and/or private individuals, and more than one of the available sanctions may be, and often are, imposed for each violation,

Laws governing fraud and abuse may apply to a healthcare organization and to nearly all individuals and entities with which a healthcare organization does business. Fraud investigations, settlements, prosecutions and related publicity can have a material adverse effect on healthcare organizations. See "Enforcement Activity" below. Major elements of these often highly technical laws and regulations are generally summarized below.

The ACA authorizes the Secretary of DHHS to exclude a provider's participation in Medicare and Medicaid, as well as suspend payments to a provider pending an investigation or prosecution of a credible allegation of fraud against the provider.

**False Claims Act**. The federal False Claims Act ("FCA") makes it illegal to knowingly submit or present a false, fictitious or fraudulent claim to the federal government. Because the term "knowingly" is defined broadly under the law to include not only actual knowledge but also deliberate ignorance or reckless disregard of the facts, the FCA can be used to punish a wide range of conduct. The ACA amends the FCA by expanding the number of activities that trigger FCA liability to include, among other things, failure to report and return identified overpayments within statutory limits. FCA investigations and cases have become common in the healthcare field and may cover a range of activity from submission of inflated billings, to highly technical billing infractions, to allegations of inadequate care. Penalties under the FCA are severe and can include damages equal to three times the amount of the alleged false claims, as well as substantial civil monetary penalties. Violation or alleged violation of the FCA most often results in settlements that require multi-million dollar payments and costly corporate integrity agreements. The FCA also permits individuals to initiate civil actions on behalf of the government in lawsuits called "*qui tam*" actions. *Qui tam* plaintiffs, or "whistleblowers," can share in the damages recovered by the government or recover independently if the government does not participate. The FCA has become one of the government's

primary weapons against healthcare fraud and suspected fraud. FCA violations or alleged violations could lead to settlements, fines, exclusion or reputation damage that could have a material adverse impact on a hospital.

**Anti-Kickback Law.** The federal "Anti-Kickback Law" prohibits anyone from soliciting, receiving, offering or paying any remuneration, directly or indirectly, overtly or covertly, in cash or in kind, in return for a referral of a patient for, or the ordering or recommending of the purchase (or lease) of any item or service that is paid by a federal healthcare program. The Anti-Kickback Law potentially implicates many common healthcare transactions between persons and entities with which a hospital does business, including hospital-physician joint ventures, medical director agreements, physician recruitment agreements, physician office leases and other transactions. The ACA amended the Anti-Kickback Law to provide that a claim that includes items or services resulting from a violation of the Anti-Kickback Law now constitutes a false or fraudulent claim for purposes of the FCA.

Violation or alleged violation of the Anti-Kickback Law most often results in settlements that require multi-million dollar payments and costly corporate integrity agreements. The Anti-Kickback Law can be prosecuted either criminally or civilly. Violation is a felony, subject to potentially substantial fines, imprisonment and/or exclusion from the Medicare and Medicaid programs, any of which would have a significant detrimental effect on the financial stability of most hospitals. in addition, significant civil monetary penalties or an "assessment" of three times the amount claimed may be imposed. Increasingly, the federal government is prosecuting violations of the Anti-Kickback Law under the FCA, based on the argument that claims resulting from an illegal kickback arrangement are also false claims for FCA purposes. See the discussion under the subheading "False Claims Act" above.

**Stark Referral Law.** The federal "Stark" statute prohibits the referral by a physician of Medicare and Medicaid patients for certain designated health services (including inpatient and outpatient hospital services, clinical laboratory services, and other imaging services) to entities with which the referring physician has a financial relationship unless the relationship fits within a stated exception. It also prohibits a hospital furnishing the designated services from billing Medicare for services performed pursuant to a prohibited referral. The government does not need to prove that the entity knew that the referral was prohibited to establish a Stark violation. If certain technical requirements are not satisfied, many ordinary business practices and economically desirable arrangements between hospitals and physicians may constitute improper "financial relationships" within the meaning of the Stark statute, thus triggering the prohibition on referrals and billing. Most providers of the designated health services with physician relationships have some exposure under the Stark statute for recruitment payments to physicians. Changes to the regulations issued under the Stark statute have rendered illegal a number of common arrangements under which physician-owned entities provide services and/or equipment to hospitals and may increase risk of violation due to lack of clarity of the technical requirements.

Medicare may deny payment for all services related to a prohibited referral and a hospital that has billed for prohibited services may be obligated to refund the amounts collected from the Medicare program. For example, if an office lease between a hospital and a large group of heart surgeons is found to violate Stark, the hospital could be obligated to repay CMS for the payments received from Medicare for all of the heart surgeries performed by all of the physicians in the group for the duration of the lease, a potentially significant amount. The government may also seek substantial civil monetary penalties, and in some cases, a hospital may be liable for fines up to three times the amount of any monetary penalty, and/or be excluded from the Medicare and Medicaid programs. Settlements, fines or exclusion for a Stark violation or alleged violation could have a material adverse impact on a hospital. Increasingly, the federal government is prosecuting violations of the Stark statute under the FCA, based on the argument that claims resulting from an illegal referral arrangement are also false claims for FCA purposes. See the discussion under the subheading "False Claims Act" above.

**HIPAA.** The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") adds additional criminal sanctions for healthcare fraud and applies to all healthcare benefit programs, whether public or private. HIPAA also provides for punishment of a healthcare provider for knowingly and willfully embezzling, stealing, converting or intentionally misapplying any money, funds or other assets of a healthcare benefit program. A healthcare provider convicted of healthcare fraud could be subject to mandatory exclusion from Medicare.

HIPAA imposes civil monetary penalties for violations and criminal penalties for knowingly obtaining or using individually identified health information, The penalties may include imprisonment if the information was obtained or used with the intent to sell, transfer, or use for commercial advantage, personal gain, or malicious harm.

**The HITECH Act.** Provisions in the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), enacted as part of American Recovery and Reinvestment Act of 2009, increase the maximum civil monetary penalties for violations of HIPAA and grant enforcement authority of HIPAA to state attorneys general. The HITECH Act also (i) extends the reach of HIPAA beyond "covered entities," (ii) imposes a breach notification requirement on HIPAA covered entities, (iii) limits certain uses and disclosures of individually identifiable health information and (iv) restricts covered entities' marketing communications.

The HITECH Act also established programs under Medicare and Medicaid to provide incentive payments for the "meaningful use" of certified electronic health record ("EHR") technology. Beginning in 2011, the Medicare and Medicaid EHR incentive programs have provided incentive payments to eligible professionals and eligible hospitals for demonstrating meaningful use of certified EHR technology. Healthcare providers demonstrate their meaningful use of EHR technology by meeting objectives specified by CMS for using health information technology and by reporting on specified clinical quality measures. Beginning in 2015, hospitals and physicians who have not satisfied the performance and reporting criteria for demonstrating meaningful use will have their Medicare payments significantly reduced.

**Security Breaches and Unauthorized Releases of Personal Information.** State and local authorities are increasingly focused on the importance of protecting the confidentiality of individuals' personal information, including patient health information. Many states have enacted laws requiring businesses to notify individuals of security breaches that result in the unauthorized release of personal information. In some states, notification requirements may be triggered even where information has not been used or disclosed, but rather has been inappropriately accessed. State consumer protection laws may also provide the basis for legal action for privacy and security breaches and frequently, unlike HIPAA, authorize a private right of action. In particular, the public nature of security breaches exposes health organizations to increased risk of individual or class action lawsuits from patients or other affected persons, in addition to government enforcement. Failure to comply with restrictions on patient privacy or to maintain robust information security safeguards, including taking steps to ensure that contractors who have access to sensitive patient information maintain the confidentiality of such information, could consequently damage a healthcare provider's reputation and materially adversely affect business operations.

**Exclusions from Medicare or Medicaid Participation.** The government may exclude a healthcare provider from Medicare/Medicaid program participation that is convicted of a criminal offense relating to the delivery of any item or service reimbursed under Medicare or a state healthcare program, any criminal offense relating to patient neglect or abuse in connection with the delivery of healthcare, fraud against any federal, state or locally financed healthcare program or an offense relating to the illegal manufacture, distribution, prescription, or dispensing of a controlled substance. The government also may exclude individuals or entities under certain other circumstances, such as an unrelated conviction of fraud, or other financial misconduct relating either to the delivery of healthcare in general or to participation in a federal, state or local government program. Exclusion from the Medicare/Medicaid program means that a healthcare provider would be decertified and no program payments can be made. Any healthcare provider exclusion could be a materially adverse event. In addition, exclusion of healthcare organization's employees under Medicare or Medicaid may be another source of potential liability for hospitals and health systems based on services provided by those excluded employees.

**Administrative Enforcement.** Administrative regulations may require less proof of a violation than do criminal laws, and, thus, healthcare providers may have a higher risk of imposition of monetary penalties as a result of administrative enforcement actions.

**Compliance with Conditions of Participation.** CMS, in its role of monitoring participating providers' compliance with conditions of participation in the Medicare program, may determine that a provider is not in compliance with its conditions of participation. In that event, a notice of termination of participation may be issued or other sanctions potentially could be imposed.

**Enforcement Activity.** Enforcement activity against healthcare providers has increased, and enforcement authorities have adopted aggressive approaches. In the current regulatory climate, it is anticipated that many

hospitals and physician groups will be subject to an audit, investigation, or other enforcement action regarding the healthcare fraud laws mentioned above.

Enforcement authorities are often in a position to compel settlements by providers charged with, or being investigated for false claims violations by withholding or threatening to withhold Medicare, Medicaid and/or similar payments and/or by instituting criminal action. In addition, the cost of defending such an action, the time and management attention consumed, and the facts of a case may dictate settlement. Therefore, regardless of the merits of a particular case, a hospital could experience materially adverse settlement costs, as well as materially adverse costs associated with implementation of any settlement agreement. Prolonged and publicized investigations could be damaging to the reputation and business of a healthcare organization, regardless of outcome.

Certain acts or transactions may result in violation or alleged violation of a number of the federal healthcare fraud laws described above, and therefore penalties or settlement amounts often are compounded, Generally these risks are not covered by insurance.

**Liability Under 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 FCA or that are generally applicable false claims laws), anti-kickback (similar to the federal Anti-Kickback Law or that are generally applicable anti-kickback or fraud laws), and physician referral (similar to Stark). A violation of these laws could have a material adverse impact on a hospital for the same reasons as the federal statutes. See discussion under the subheadings "False Claims Act," "Anti-Kickback Law" and "Stark Referral Law" above.

**Privacy Requirements.** HIPAA, along with new privacy rules arising from federal and state statutes, addresses the confidentiality of individuals' health information. Disclosure of certain broadly defined protected health information is prohibited unless expressly permitted under the provisions of the HIPAA statute and regulations or authorized by the patient. Such confidentiality provisions extend not only to patient medical records, but also to a wide variety of healthcare clinical and financial settings where patient privacy restrictions often impose new communication, operational, accounting and billing restrictions. California has broadened its data security breach notification law to cover compromised medical and health insurance information. Together, these rules and regulations add costs and create potentially unanticipated sources of legal liability.

**EMTALA.** The Emergency Medical Treatment and Active Labor Act ("EMTALA") is a federal civil statute that requires hospitals to treat or conduct a medical screening for emergency conditions and to stabilize a patient's emergency medical condition before releasing, discharging or transferring the patient. A hospital that violates EMTALA is subject to civil penalties of up to $50,000 per offense and exclusion from the Medicare and Medicaid programs. In addition, the hospital may be liable for any claim by an individual who has suffered harm as a result of a violation.

**Licensing, Surveys, Investigations and Audits.** Hospitals are subject to numerous legal, regulatory, professional and private licensing, certification and accreditation requirements. These include, but are not limited to, requirements of state licensing agencies and The Joint Commission. Renewal and continuation of certain of these licenses, certifications and accreditations are based on inspections or other reviews generally conducted in the normal course of business of hospitals. Loss of, or limitations imposed on, hospital licenses or accreditations could reduce hospital utilization or revenues, reduce a hospital's ability to operate all or a portion of its facilities, affect the hospital's Medicare or Medi-Cal eligibility, impose administrative penalties, or require the repayment of amounts previously remitted to the hospital for services rendered.

**Environmental Laws and Regulations.** Hospitals are subject to a wide variety of federal, state and local environmental and occupational health and safety laws and regulations. These include, but are not limited to: air and water quality control requirements; waste management requirements; specific regulatory requirements applicable to asbestos and radioactive substances; requirements for providing notice to employees and members of the public about hazardous materials handled by or located at the hospital; and requirements for training employees in the proper handling and management of hazardous materials and wastes.

Hospitals may be subject to requirements related to investigating and remedying hazardous substances located on their property, including such substances that may have migrated off the property. Typical hospital operations include the handling, use, storage, transportation, disposal and/or discharge of hazardous, infectious,

toxic, radioactive, flammable and other hazardous materials, wastes, pollutants and contaminants. As such, hospital operations are particularly susceptible to the practical, financial and legal risks associated with the environmental laws and regulations. Such risks may result in damage to individuals, property or the environment; may interrupt operations and/or increase their cost; may result in legal liability, damages, injunctions or fines; may result in investigations, administrative proceedings, civil litigation, criminal prosecution, penalties or other governmental agency actions; and may not be covered by insurance.

**Business Relationships and Other Business Matters**

**Integrated Physician Groups.** Hospitals often own, control or have affiliations with relatively large physician groups. Generally, the sponsoring hospital will be the primary capital and funding source for such alliances and may have an ongoing financial commitment to provide growth capital and support operating deficits. As separate operating units, integrated physician practices and medical foundations sometimes operate at a loss and require subsidy from the related hospital. In addition, integrated delivery systems present business challenges and risks. Inability to attract or retain participating physicians may negatively affect managed care, contracting and utilization. The technological and administrative infrastructure necessary both to develop and operate integrated delivery systems and to implement new payment arrangements in response to changes in Medicare and other payor reimbursement is costly. Hospitals may not achieve savings sufficient to offset the substantial costs of creating and maintaining this infrastructure.

These types of alliances are likely to become increasingly important to the success of hospitals in the future as a result of changes to the healthcare delivery and reimbursement systems that are intended to restrain the rate of increases of healthcare costs, encourage coordinated care, promote collective provider accountability and improve clinical outcomes. The ACA authorizes several alternative payment programs for Medicare that promote, reward or necessitate integration among hospitals, physicians and other providers.

Whether these programs will achieve their objectives and be expanded or mandated as conditions of Medicare participation cannot be predicted. However, Congress and CMS have clearly emphasized continuing the trend away from the fee-for-service reimbursement model, which began in the 1980s with the introduction of the prospective payment system for inpatient care, and toward an episode-based payment model that rewards use of evidence-based protocols, quality and satisfaction in patient outcomes, efficiency in using resources, and the ability to measure and report clinical performance. This shift is likely to favor integrated delivery systems, which may be better able than stand-alone providers to realize efficiencies, coordinate services across the continuum of patient care, track performance and monitor and control patient outcomes. Changes to the reimbursement methods and payment requirements of Medicare, which is the dominant purchaser of medical services, are likely to prompt equivalent changes in the commercial sector, because commercial payors frequently follow Medicare's lead in adopting payment policies.

While payment trends may stimulate the growth of integrated delivery systems, these systems carry with them the potential for legal or regulatory risks. Many of the risks discussed in "Regulatory Environment" above, may be heightened in an integrated delivery system. The foregoing laws were not designed to accommodate coordinated action among hospitals, physicians and other healthcare providers to set standards, reduce costs and share savings, among other things. Although CMS and the agencies that enforce these laws are expected to institute new regulatory exceptions, safe harbors or waivers that will enable providers to participate in payment reform programs, there can be no assurance that such regulations will be forthcoming or that any regulations or guidance issued will sufficiently clarify the scope of permissible activity. State law prohibitions, such as the bar on the corporate practice of medicine, or state law requirements, such as insurance laws regarding licensure and minimum financial reserve holdings of risk-bearing organizations, may also introduce complexity, risk and additional costs in organizing and operating integrated delivery systems.

**Physician Financial Relationships.** In addition to the physician integration relationships referred to above, hospitals and health systems frequently have various additional business and financial relationships with physicians and physician groups. These are in addition to hospital physician contracts for individual services performed by physicians in hospitals. They potentially include: joint ventures to provide a variety of outpatient services; recruiting arrangements with individual physicians and/or physician groups; loans to physicians; medical office leases; equipment leases from or to physicians; and various forms of physician practice support or assistance. These and other financial relationships with physicians (including hospital physician contracts for individual

services) may involve financial and legal compliance risks for the hospitals involved. From a compliance standpoint, these types of financial relationships may raise federal and state "anti-kickback" and federal and state "Stark" issues (see "Regulatory Environment," above), as well as other legal and regulatory risks, and these could have a material adverse impact on hospitals.

**Other Affiliations and Acquisitions**. Large hospitals typically plan for and evaluate potential merger and affiliation opportunities as a regular part of their overall strategic planning and development process. Generally, discussions by hospitals with respect to affiliation, merger, acquisition, disposition or change of use are held on a confidential basis with other parties and may include the execution of nonbinding letters of intent. Currently, the District has no merger or material affiliation arrangements under discussion.

In addition, hospitals may consider investments, ventures, affiliations, development and acquisition of other healthcare related entities. These may include home healthcare, long-term care entities or operations, infusion providers, pharmaceutical providers and other healthcare enterprises which support the overall hospital operations. In addition, hospitals may pursue such transactions with health insurers, HMOs, PPOs, third-party administrators and other health insurance-related businesses.

Because of the integration occurring throughout the healthcare field, the District will consider such arrangements where there is a perceived strategic or operational benefit for the Hospital. All such initiatives may involve significant capital commitments and/or capital or operating risk (including, potentially, insurance risk) in a business in which the District may have less expertise than in hospital operations. There can be no assurance that these projects, if pursued, will not lead to material adverse consequences.

**Accountable Care Organization.** The ACA establishes a Medicare Shared Savings Program that seeks to promote accountability and coordination of care through the creation of Accountable Care Organizations ("ACOs"). The program will allow hospitals, physicians and others to form ACOs and work together to invest in infrastructure and redesign integrated delivery processes to achieve high quality and efficient delivery of services. ACOs that achieve quality performance standards will be eligible to share in a portion of the amounts saved by the Medicare program. DHHS has significant discretion to determine key elements of the program, including what steps providers must take to be considered an ACO, how to decide if Medicare program savings have occurred, and what portion of such savings will be paid to ACOs. It remains unclear whether providers will pursue federal ACO status or whether the required investment would be warranted by increased payment. Nevertheless, it is anticipated that private insurers may seek to establish similar incentives for providers, while requiring less infrastructural and organizational change. The potential impacts of these initiatives are unknown, but introduce greater risk and complexity to healthcare finance and operations.

**Hospital Pricing**. Inflation in hospital costs may evoke action by legislatures, payors or consumers. It is possible that legislative action at the state or national level may be taken with regard to the pricing of healthcare services.

California law requires every hospital to offer reduced rates to underinsured and uninsured patients that may have low to moderate income.

**Indigent Care.** Hospitals often treat large numbers of indigent patients who are unable to pay in full for their medical care. Treatment of such patients results in significant expenses being incurred by the hospitals without adequate compensation or repayment. Typically, inner-city hospitals and other healthcare providers may treat significant numbers of indigents. These hospitals and healthcare providers may be susceptible to economic and political changes that could increase the number of indigents or their responsibility for caring for this population. General economic conditions that affect the number of employed individuals who have health coverage affects the ability of patients to pay for their care. Similarly, changes in governmental policy, which may result in coverage exclusions under local, county, state and federal healthcare programs (including Medicare and Medicaid) may increase the frequency and severity of indigent treatment by such hospitals and other providers.

**Hospital Medical Staff.** The primary relationship between a hospital and physicians who practice in it is through the hospital's organized medical staff. Medical staff bylaws, rules and policies establish the criteria and procedures by which a physician may have his or her privileges or membership curtailed, denied or revoked. Physicians who are denied medical staff membership or certain clinical privileges or who have such membership or

privileges curtailed or revoked often file legal actions against hospitals and medical staffs. Such actions may include a wide variety of claims, some of which could result in substantial uninsured damages to a hospital. In addition, failure of the hospital governing body to adequately oversee the conduct of its medical staff may result in hospital liability to third parties.

**Physician Supply.** Sufficient community-based physician supply is important to hospitals. The costs of medical education, the demands of the profession and downward pressure on reimbursement may contribute to a decline in the number of individuals electing to practice medicine. Reimbursement for physician services may not fully cover the costs of physician compensation or may not support the costs of operating a medical practice and repaying medical education loans, especially in high-cost regions of the United States. Changes to physician compensation formulas by CMS could lead to physicians ceasing to accept Medicare and/or Medicaid patients. Regional differences in reimbursement by commercial and governmental payors, along with variations in the costs of living, may cause physicians to avoid locating their practices in communities with low reimbursement or high living costs. Hospitals may be required to invest additional resources for recruiting and retaining physicians, or may be required to increase the percentage of employed physicians in order to continue serving the growing population base and maintain market share. The physician-to-population ratio in certain parts of California is below the national average, and the shortage of physicians could become a significant issue for hospitals in California.

**Competition Among Healthcare Providers.** Competition from a wide variety of sources, including specialty hospitals, other hospitals and healthcare systems, inpatient and outpatient healthcare facilities, long-term care and skilled nursing services facilities, clinics, physicians and others, may adversely affect the utilization and/or revenues of hospitals. Existing and potential competitors may not be subject to various restrictions applicable to hospitals, and competition, in the future, may arise from new sources not currently anticipated or prevalent.

Freestanding ambulatory surgery centers may attract 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 reduced income. Competing ambulatory surgery centers, more likely a for-profit business, may not accept indigent patients or low paying programs and would leave these populations to receive services in the full-service hospital setting. Consequently, hospitals are vulnerable to competition from ambulatory surgery centers.

Additionally, scientific and technological advances, new procedures, drugs and appliances, preventive medicine and outpatient healthcare delivery may reduce utilization and revenues of hospitals in the future or otherwise lead the way to new avenues of competition. In some cases, hospital investment in facilities and equipment for capital-intensive services may be lost as a result of rapid changes in diagnosis, treatment or clinical practice brought about by new technology or new pharmacology.

**Antitrust.** Antitrust liability may arise in a wide variety of circumstances, including medical staff privilege disputes, payor contracting, physician relations, joint ventures, merger, affiliation and acquisition activities, certain pricing or salary setting activities, as well as other areas of activity. The application of the federal and state antitrust laws to healthcare is evolving (especially as the ACA is implemented), and therefore not always clear. Currently, the most common areas of potential liability are joint action among providers with respect to payor contracting and medical staff credentialing disputes.

Violation of the antitrust laws could result in criminal and/or civil enforcement proceedings by federal and state agencies, as well as actions by private litigants. In certain actions, private litigants may be entitled to treble damages, and in others, governmental entities may be able to assess substantial monetary fines.

**Employer Status.** Hospitals are major employers with mixed technical and nontechnical workforces. Labor costs, including salaries, benefits and other liabilities associated with a workforce, have significant impacts on hospital operations and financial condition. Developments affecting hospitals as major employers include: imposing higher minimum or living wages; enhancing occupational health and safety standards; and penalizing employers of undocumented immigrants. Legislation or regulation on any of the above or related topics could have a material adverse impact on the District.

**Labor Relations and Collective Bargaining**. Hospitals are large employers with a wide diversity of employees. Increasingly, employees of hospitals are becoming unionized, and many hospitals have collective bargaining agreements with one or more labor organizations. Employees subject to collective bargaining agreements may include essential nursing and technical personnel, as well as food service, maintenance and other trade personnel. Renegotiation of such agreements upon expiration may result in significant cost increases to hospitals. Employee strikes or other adverse labor actions may have an adverse impact on operations, revenue and hospital reputation.

None of the District's employees are covered by collective bargaining agreements.

**Wage and Hour Class Actions and Litigation**. Federal law and many states, including notably California, impose standards related to worker classification, eligibility and payment for overtime, liability for providing rest periods and similar requirements. Large employers with complex workforces, such as hospitals, are susceptible to actual and alleged violations of these standards. In recent years there has been a proliferation of lawsuits over these "wage and hour" issues, often in the form of large, sometimes multi-state, class actions. For large employers such as hospitals and health systems, such class actions can involve multi-million dollar claims, judgments and/or settlements.

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

**Healthcare Worker Classification.** Healthcare providers, like all businesses, are required to withhold income taxes from amounts paid to employees. If the employer fails to withhold the tax, the employer becomes liable for payment of the tax imposed on the employee. On the other hand, businesses are generally not required to withhold federal taxes from amounts paid to a worker classified as an independent contractor. The IRS has established criteria for determining whether a worker is an employee or an independent contractor for tax purposes. if the IRS were to reclassify a significant number of hospital independent contractors (e.g., physician medical directors) as employees, back taxes and penalties could be material.

**Staffing.** From time to time, the healthcare industry suffers from a scarcity of nursing personnel, respiratory therapists, pharmacists and other trained healthcare technicians. In addition, aging medical staffs and difficulties in recruiting individuals to the medical profession are predicted to result in future physician shortages. A. significant factor underlying this trend includes a decrease in the number of persons entering such professions. This is expected to intensify in the future, aggravating the general shortage and increasing the likelihood of hospital-specific shortages. In addition, state budget cuts to university programs may impact the training available for nursing personnel and other healthcare professionals. Competition for employees, coupled with increased recruiting and retention costs, will increase hospital operating costs, possibly significantly, and growth may be constrained. This trend could have a material adverse impact on the financial conditions and results of operations of hospitals. This scarcity may further be intensified if utilization of healthcare services increases as a consequence of the ACA's expansion of the number of insured consumers.

**Professional Liability Claims and General Liability Insurance.** In recent years, the number of professional and general liability suits and the dollar amounts of damage recoveries have increased in healthcare nationwide, resulting in substantial increases in malpractice insurance premiums, higher deductibles and generally less coverage. Professional liability and other actions alleging wrongful conduct and seeking punitive damages are often filed against healthcare providers. Insurance does not provide coverage for judgments for punitive damages; however, California District hospitals are not subject to punitive damages.

Beginning in 2008, CMS refused to reimburse hospitals for medical costs arising from certain "never events," which include specific preventable medical errors. Certain private insurers and HMOs followed suit. The occurrence of "never events" is more likely to be publicized and may negatively impact a hospital's reputation, thereby reducing future utilization and potentially increasing the possibility of liability claims.

Litigation also arises from the corporate and business activities of hospitals, from a hospital's status as an employer or as a result of medical staff or provider network peer review or the denial of medical staff or provider network privileges. As with professional liability, many of these risks are covered by insurance, but some are not. For example, some antitrust claims or business disputes are not covered by insurance or other sources and may, in whole or in part, be a District liability if determined or settled adversely.

There is no assurance that hospitals will be able to maintain coverage amounts currently in place in the future, that the coverage will be sufficient to cover malpractice judgments rendered against a hospital or that such coverage will be available at a reasonable cost in the future.

**Information Systems**

The ability to adequately price and bill healthcare services and to accurately report financial results depends on the integrity of the data stored within information systems, as well as the operability of such systems. Information systems require an ongoing commitment of significant resources to maintain, protect and enhance existing systems and develop new systems to keep pace with continuing changes in information processing technology, evolving systems and regulatory standards. There can be no assurance that efforts to upgrade and expand information systems capabilities, protect and enhance these systems, and develop new systems to keep pace with continuing changes in information processing technology will be successful or that additional systems issues will not arise in the future.

Electronic media are also increasingly being used in clinical operations, including the conversion from paper to electronic medical records, computerization of order entry functions and the implementation of clinical decision-support software. The reliance on information technology for these purposes imposes new expectations on physicians and other workforce members to be adept in using and managing electronic systems. It also introduces risks related to patient safety, and to the privacy, accessibility and preservation of health information. See "Regulatory Environment—HIPAA" above. Technology malfunctions or failure to understand and use information systems properly could result in the dissemination of or reliance on inaccurate information, as well as in disputes with patients, physicians and other healthcare professionals. Health information systems may also be subject to different or higher standards or greater regulation than other information technology or the paper-based systems previously used by healthcare providers, which may increase the cost, complexity and risks of operations. All of these risks may have adverse consequences on hospitals and healthcare providers.

**Seismic Requirements**

Earthquakes affecting California hospitals have prompted the State to impose new hospital seismic safety standards pursuant to California Senate Bill 1953. Under these new standards, generally by 2013 (or in some cases as extended to 2030), California hospitals will be required to meet stringent seismic safety criteria which may necessitate major renovation in certain facilities or even their partial or full replacement. The potential capital costs and negative operating effects of such a replacement could be material and adverse. The District expects to meet the seismic safety standards required through 2030 upon completion of Project construction.

A significant earthquake could have a material adverse effect on the District which could result in material damage and temporary or permanent cessation of operations at the Hospital. The geographic area in which the Hospital is located has not been earthquake prone in the past. The Hospital is not covered by earthquake insurance.

**Other Factors**

Additional factors which may affect future operations, and therefore revenues, of the District include the following, among others:

- A change in the federal income tax or other federal, State or local laws to require the District to render substantially greater services without charge or at a reduced charge;

- Unionization, employee strikes and other adverse labor actions or disputes with members of the medical staff;

- Shortages of professional and technical staff;
- Natural disasters, including floods, which could damage the Hospital or otherwise impair the operations of the Hospital and the general revenues from the Hospital;
- Decrease in the population within the service area of the Hospital;
- Increased unemployment or other adverse economic conditions which could increase the proportion of patients who are unable to pay fully for the cost of their healthcare; and
- Power outages.

**APPENDIX F**

**ANNUAL REPORT OF OVERSIGHT COMMITTEE**

***SAN GORGONIO MEMORIAL HEALTHCARE DISTRICT***
***MEASURE "A" COMMUNITY OVERSIGHT COMMITTEE***
***ANNUAL REPORT TO THE COMMUNITY***
***AUGUST 2012***

Measure "A" General Obligation bond of $108 million was passed in March 2006 to support the upgrade of San Gorgonio Memorial Hospital facilities. The bonds are being used to finance expansion, improvement, acquisition, construction, equipping and renovation of health facilities of the District. Following the bond passage, a Community Oversight Committee was appointed by the San Gorgonio Memorial Healthcare District Board of Directors. This committee is charged with reviewing and reporting on the proper expenditure of Measure "A" bond proceeds and advising the public whether the District is in compliance with requirements for how the bond proceeds are spent. This annual report will update you on progress to date.

Preconstruction costs for architectural drawings, cost estimates, Office of Statewide Health Planning and Development (OSHPD) and city fees, cost of bond issuance, Inspector of Record (I0R) fees, testing and inspection, surveys and soils reports before the construction could begin, total $1,826,327.

Three major pieces of hospital equipment were purchased, a 64-slice CT scanner, a fluoroscopy machine and a McKesson information technology (IT) system, which includes physician order entry. All are state-of-the-art and will help San Gorgonio Memorial Hospital successfully care for patients well into the future. The IT system meets the federal mandate for electronic record keeping. Damaged flooring was replaced in several locations within the current hospital. With construction costs and other fees for these installations, the total for this phase is $6,816,583.

Phase 0 is the new access road off Ramsey Street (Memorial Drive S) and the helipad. Moving of underground utilities started during this phase. Two new electrical interceptor vaults and a sewer monitoring manhole were installed as required by the City of Banning. This phase was completed for a total cost of $3,172,188.

Phase 1A continued the replacement and movement of underground utilities, as well as constructing a cooling tower and oxygen tank farm near the intersection of Highland Springs Avenue and Wilson Street. A modular building for linen storage and a lift serve as a temporary receiving area for all supplies during the remainder of construction. New parking lot lights for improved safety, a physician parking lot and drought-tolerant landscaping are part of this phase. A 30,000 gallon emergency sewer holding tank was installed that will serve all current and new facilities for the required 72 hours in case of disaster. The total costs for this phase are $7,893,851.

Phase 1B construction started with an underground utility tunnel housing utilities for current and planned future facilities. It is 9 feet tall so maintenance and engineering staff can easily walk and access electrical conduits, water pipes and medical gases for maintenance and repairs. It is fully protected with fire sprinklers, smoke detectors, fire alarms and is ventilated with outside air. The Central Utility Plant (CUP) is a single story building plus a mezzanine with a total floor area of 16,031 square feet. It contains two chillers, three steam boilers, heat exchanges, dedicated soft water exchange systems, two emergency generators and medical gas tank and cylinder storage. The Engineering staff offices are located on the mezzanine along with an information technology climate controlled room housing the hospital's computers and phone switch. This is a very sophisticated mechanical plant, with computerized operations and manual back-up protection. The CUP was certified for occupancy June 23, 2011. The old boiler, chiller and emergency generator in the adjacent building were removed. Wire was pulled from the helipad to the new CUP so street lights and helipad lights can be controlled from the new building rather than the helipad site. A 20,000 gallon underground diesel fuel oil tank was installed and connected to the emergency generators; this will provide the required 72 hours of electricity to current and future buildings in case of a disaster. Additional hospital projects completed with this phase were the construction of an Imaging pad in the parking lot off Wilson Street to allow mobile MRI, CT or other portable units to be brought on site for patient care. Two electric charging stations serving four electric vehicles are located in the same parking lot. Finally, a steam line connection from the new boilers to the

current hospital heat exchangers provides hot water to 80+ faucets in the hospital as well as steam for autoclaves. The cost for this phase is $26,614,334.

Phase 1C is a 39,536 square foot, two story building plus mechanical room on the roof. This facility is our first clinical building and has 23 private Emergency Department (ED) rooms, 5 fast track rooms and 16 private Intensive Care Unit (ICU) rooms. Construction began on structural elements in March 2010 and the full OSHPD permit was received in May 2010, allowing us to continue with all work. During the past year, the roof and exterior walls, waterproofing, exterior finishes and window installations were completed. Inside, utilities and medical gases were installed, anchorage of all above ceiling ductwork and pipes and all equipment secured, drywall installed and painted, casework installed. Finishes such as flooring, wall coverings, window shades, doors and plumbing fixtures are now being completed. During the next few months, all systems will be tested. OSHPD sign off is expected by the end of the year; licensing for patient care will occur during the first quarter of 2013 with an anticipated opening date of April 2013. The utility tunnel has been extended from Phase 1B and continues carrying the same utilities to the new ED/ICU and the future six story patient building. Related projects completed in this phase were placement of monument signs on Highland Springs Avenue and Wilson Street, a new 100 space parking lot with connecting stairs/ramp to the new ED entrance, stairs/ramp to the adjacent medical office buildings, and an access road to the new parking lot from Wilson Street (Memorial Drive N). A new vehicle entrance to the ED from Highland Springs Avenue (Memorial Drive W) will open with the ED. A mock-up room building featuring a typical ICU room and a typical ED room can be viewed during our monthly tours (3rd Wednesday at 4:00 pm; for more information, contact Molly Ellis at 951-663-9643). Cost of this phase is $38,488,673.

The kitchen expansion, Phase 1E-A, is needed to meet code requirements for additional beds. This is quite complex as dietary service must remain in operation to serve patients, staff and visitors; therefore it has been divided into 5 stages. OSHPD approval was received and construction started in March 2012. Coordination efforts between trades started the process; we are now building the infrastructure in Stage 1. This phase will complete in early 2015. Costs, which include fixed equipment, are estimated at $8,686,293.

After the ED/ICU building is occupied, a new loading dock, Phase 1D, will be constructed where the ambulance entrance is currently located. A 30,000 gallon underground water storage tank will be installed, completing all required elements for 72 hour disaster preparation. Cost for this phase is projected to be $2,315,656.
Concurrently with the loading dock, the current Emergency Department will be converted to materials management and housekeeping departments. Phase 1E-B is estimated to cost $2,283,251.

Following the relocation of materials management and housekeeping to their new spaces, the final phase will create office spaces for staff now located in temporary trailers. At the completion of Phase 1E-C, the trailers will be removed. The cost for this phase is $829,867.

The roof of the existing hospital was replaced in 2011. Multiple roofs had been added over 60 years since the original building opened; these were removed. Equipment which was no longer needed was removed; equipment that remained was lifted to remove all previous roofing materials down to the deck; new slabs were poured as needed. Asbestos was found throughout the current roof, necessitating specialized removal crews. Total costs are $3,241,421.

A humidifier to assure compliance with humidification standards in the operating room, recovery room and current ICU is being installed at a cost of $654,910.

Seismic compliance of the older hospital buildings through a HAZUS study is being sought. This will allow acute care operations to continue until 2030. Twenty-two samples of the hospital building structure were tested for strength and results submitted to OSHPD; verification of compliance is needed by the end of 2012. The testing cost and fees are $322,543.

Additionally, $4,854,103 was previously spent on drawings for the six-story patient building, Phase 2A. In September 2010, the San Gorgonio Memorial Healthcare District board of directors authorized HDR to complete construction drawings and submit them to OSHPD. This is a critical element of our master plan and permitting is expected to take two years; the documents were finalized and submitted in May 2011. Back check #2 comments are being reviewed and responses formulated. These new planning costs for Phase 2 are being paid out of interest income rather than Measure "A" principal.

All $108 million of bonds have been sold. As of June 30, 2012, total proceeds available for the project from Measure "A", including interest income, is $113,528,842; $88,978,390 has been spent to date and $24,550,453 remains to be spent.

Measure "A" funds cannot be used for movable equipment and furnishings which are needed to open the ED/ICU and the remaining phases. There is a requirement of approximately $2.4 million for these items which must be financed through other means.

It is the conclusion of the Measure "A" Oversight Committee that San Gorgonio Memorial Healthcare District is in compliance with bond requirements and bond funds for the San Gorgonio Memorial Hospital expansion project are being spent appropriately.

**Committee members:**

Dorothy Ellis, Chair
Bob Ewert
Vicki Grunewald
Donna Lester
Estelle Lewis
Ron Rader
Charla Sparks

**Staff:**

Kay Lang, Project Manager

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