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State of California
DEPARTMENT OF JUSTICE

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December 10, 2020

Jean Tom, Partner
Davis Wright Tremaine LLP
505 Montgomery Street, Suite 800
San Francisco, CA 94111
Email: jeantom@dwt.com

Sent via email and USPS

RE: Proposed Change in Control and Governance of Huntington Hospital

Dear Ms. Tom:

Pursuant to Corporations Code section 5920 *et seq.*, the Attorney General hereby conditionally consents to the proposed change in governance and control of the Pasadena Hospital Association ("PHA"), Ltd, operating Huntington Memorial Hospital, pursuant to the terms of the Affiliation Agreement dated July 15, 2020 between PHA, a California nonprofit public benefit corporation, and Cedars-Sinai Medical Center, a California nonprofit public benefit corporation.

Corporations Code section 5920 and California Code of Regulations, title 11, section 999.5, subdivision (f) set forth factors that the Attorney General shall consider in determining whether to consent to a proposed transaction between a nonprofit corporation and a nonprofit corporation or entity. The Attorney General has considered such factors and consents to the proposed transaction subject to the attached conditions that are incorporated by reference herein.

Sincerely,

[original signed]

ANITA GARCIA VELASCO
Deputy Attorney General

For XAVIER BECERRA
Attorney General

Attorney General's Conditions to Change in Control and Governance of Huntington Memorial Hospital and Approval of Affiliation Agreement by and between the Pasadena Hospital Association, the Collis P. and Howard Huntington Trust and Cedars-Sinai Health System.

I.

These Conditions shall be legally binding on the following entities: Pasadena Hospital Association (PHA), a California nonprofit public benefit corporation that owns and operates Huntington Memorial Hospital,[1] Cedars-Sinai Health System (Cedars-Sinai), a California non-profit public benefit corporation, the Collis P. and Howard Huntington Trust (Trust), a California charitable trust, any other subsidiary, parent, general partner, limited partner, member, affiliate, successor, successor in interest, assignee, or person or entity serving in a similar capacity of PHA, Cedars-Sinai, Trust or any entity succeeding thereto as a result of consolidation, affiliation, merger, or acquisition of all or substantially all of the real property or operating assets of Huntington Memorial Hospital or the real property on which Huntington Memorial Hospital is located, any and all current and future owners, lessees, licensees, or operators of Huntington Memorial Hospital, and any and all current and future lessees and owners of the real property on which Huntington Memorial Hospital is located.

II.

The transaction approved by the Attorney General consists of the Affiliation Agreement, attached hereto as Exhibit 1, by and between PHA, Cedars-Sinai, and the Trust dated July 15, 2020, and any and all amendments, agreements, or documents referenced in or attached to as an exhibit or schedule to the Affiliation Agreement.

All of the entities listed in Condition I shall fulfill the terms of these agreements or documents including, but not limited to, any exhibits or schedules to the Affiliation Agreement, and shall notify the Attorney General in writing of any proposed modification or rescission of any of the terms of these agreements or documents. Such notifications shall be provided at least sixty days prior to their effective date in order to allow the Attorney General to consider whether they affect the factors set forth in Corporations Code Section 5923 and obtain the Attorney General's approval.

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[1] Throughout this document, the term "Huntington Memorial Hospital" shall mean the general acute care hospital located at 100 West California Boulevard, Pasadena, CA 91105 and any other clinics, laboratories, units, services, or beds included on the license issued to "Pasadena Hospital Association" by the California Department of Public Health, effective July 1, 2020, unless otherwise indicated.

III.

For ten (10) fiscal years from the Closing Date of the Affiliation Agreement, PHA, Trust, Cedars-Sinai, and all future owners, managers, lessees, licensees, or operators of Huntington Memorial Hospital shall be required to provide written notice to the Attorney General sixty (60) days prior to entering into any agreement or transaction to do any of the following:

a) Sell, transfer, lease, exchange, option, convey, manage, or otherwise dispose of Huntington Memorial Hospital; or

b) Transfer control, responsibility, management, or governance of Huntington Memorial Hospital. The substitution or addition of a new corporate member or members of PHA, Trust, or Cedars-Sinai that transfers the control of, responsibility for, or governance of Huntington Memorial Hospital shall be deemed a transfer for purposes of this Condition. The substitution or addition of one or more members of the governing bodies of Huntington or Cedars-Sinai, or any arrangement, written or oral, that would transfer voting control of the members of the governing bodies of PHA, Trust, or Cedars-Sinai, shall also be deemed a transfer for purposes of this Condition.

IV.

For ten (10) years from the closing date of the Affiliation Agreement, Huntington Memorial Hospital shall be operated and maintained as a licensed general acute care hospital (as defined in California Health and Safety Code Section 1250) and shall maintain and provide 24-hour emergency and trauma medical services at no less than current[2] licensure, designations and certification with the same types and/or levels of services, including the following:

a) Fifty (50) Emergency Treatment Stations;

b) Designation as a Level II Trauma Center;

c) Designation as a 5150 Receiving Facility (as defined by Welfare and Institutions Code section 5150), for behavioral health patients under involuntary evaluation;

d) Designation as an Emergency Department Approved for Pediatrics (EDAP);

e) Designation as a Paramedic Base Station; and

f) Certification as an Advanced Comprehensive Stroke Center.

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[2] The term "current" or "currently" throughout this document means as of July 1, 2020.

V.

For ten (10) years from the closing date of the Affiliation Agreement, Huntington Memorial Hospital shall maintain and provide the following healthcare services at current licensure and designation with the current types and/or levels of services:

a) Cardiac services, including three (3) cardiac catheterization labs and the designation as a STEMI Receiving Center;

b) Critical care services, including a minimum of thirty (30) intensive care/coronary care beds;

c) Neonatal intensive care services, including a Level III Neonatal Intensive Care Unit with a minimum of twenty-eight (28) neonatal intensive care beds;

d) Neurology and neurosurgery services;

e) Women's health services, including full reproductive health services, and mammography services;

f) Pediatric services, including a designated area with at least ten (10) general acute care beds for pediatric patients;

g) Oncology services;

h) Behavioral health and psychiatric acute care services, including a minimum of forty-one (41) psychiatric acute care beds including twelve (12) psychiatric intensive care beds and three (3) seclusion rooms all with locked capabilities;

i) Orthopedic surgical services;

j) Advanced robotic surgical services; and

k) Perinatal services, including a minimum of forty (40) perinatal beds.

PHA and Cedars-Sinai shall not place all or any portion of the above-listed licensed-bed capacity or services in voluntary suspension or surrender its license for any of these beds or services.

VI.

For at least ten (10) years from the Closing Date, PHA shall maintain the same types and/or levels of women's healthcare services and mammography services, currently provided at the location below or an equivalent location:

a) Jim and Eleanor Randall Breast Center, located at 625 S. Fair Oaks Blvd., Pasadena, California;

VII.

For five (5) years from the closing date of the Affiliation Agreement, PHA shall maintain and provide the following outpatient healthcare services at current licensure and designation with the current types and/or levels of services at the locations below or a location at or nearby Huntington Memorial Hospital:

a) Admitting/Registration/Pre-Op (Preoperative) Testing services, located at 625 S. Fair Oaks Blvd., Suite #355, Pasadena, California;

b) Cancer services/Radiation therapy/CT (Computive Tomography) services, located at 625 S. Fair Oaks Blvd., Suite #100, Pasadena, California;

c) Heart & Vascular Lab, located at 625 S. Fair Oaks Blvd., Suite #345, Pasadena, California;

d) Rehabilitation-Physical, Occupational or Speech Therapy services, located at 630 South Raymond Ave., Suite 340 and Suite 120, Pasadena, California; and

e) Senior Care Network services, located at 837 S. Fair Oaks Ave., Pasadena, California.

VIII.

For ten (10) years from the closing date of the Affiliation Agreement, PHA and Cedars-Sinai shall:

a) Be certified to participate in the traditional Medi-Cal program at Huntington Memorial Hospital and provide the same types and/or levels of emergency and non-emergency services at Huntington Memorial Hospital to Medi-Cal beneficiaries as required in these Conditions;

b) Maintain and have Medi-Cal Managed Care contracts with L.A. Care Health Plan or its successor and Health Net Community Solutions Inc. or its successor to provide the same types and/or levels of emergency and non-emergency services at Huntington Memorial Hospital to Medi-Cal beneficiaries (both Traditional Medi-Cal and Medi-Cal Managed Care) as required in these Conditions, on the same terms and conditions as other similarly situated hospitals offering substantially the same services, without any loss, interruption of service or diminution in quality, or gap in contracted hospital coverage, unless the contract is terminated by either party for cause or not extended or renewed by a Medi-Cal Managed Care Plan on its own initiative; and

c) Maintain its participation in the Medicare program, by maintaining a Medicare Provider Number and providing the same types and/or levels of emergency and non-emergency services to Medicare beneficiaries, both traditional Medicare and Medicare Managed Care, on the same terms and conditions as other similarly situated hospitals.

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IX.

For five (5) fiscal years from the Closing Date, PHA and Cedars-Sinai shall provide an annual amount of Charity Care (as defined below) at Huntington Memorial Hospital equal to or greater than $4,924,930 (the Minimum Charity Care Amount). For purposes hereof, the term "charity care" shall mean the amount of charity care costs (not charges) incurred by PHA and Cedars-Sinai in connection with the operation and provision of services at Huntington Memorial Hospital. The definition and methodology for calculating "Charity Care" and the methodology for calculating "costs" shall be the same as that used by the Office of Statewide Health Planning Development (OSHPD) for annual hospital reporting purposes.[3]

PHA and Cedars-Sinai's obligation under this Condition shall be prorated on a daily basis if the closing date of the Affiliation Agreement is a date other than the first day of PHA's fiscal year.

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

If the actual amount of charity care provided at Huntington Memorial Hospital for any fiscal year is less than the Minimum Charity Care Amount (as adjusted pursuant to the above-referenced Consumer Price Index) required for such fiscal year, PHA or Cedars-Sinai shall pay an amount equal to the deficiency to one or more tax-exempt entities that provide direct healthcare services to residents in Huntington Memorial Hospital's service area (36 ZIP codes), as defined on page 50 of the Huntington Memorial Hospital Health Care Impact Statement, dated September 28, 2020, and attached hereto as Exhibit 2. Such payment(s) shall be made within six months following the end of such fiscal year.

X.

Within ninety (90) days from the closing date of the Affiliation Agreement, PHA and Cedars-Sinai shall take the following steps to ensure that patients at Huntington Memorial Hospital are informed about Huntington Memorial Hospital's Financial Assistance Policy:

a) A copy of the Financial Assistance Policy and the plain language summary of the Financial Assistance Policy must be posted in a prominent location in the emergency room, admissions area, and any other location in Huntington Memorial Hospital where there is a high volume of patient traffic, including waiting rooms, billing offices, and outpatient service settings;

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

b) A copy of the Financial Assistance Policy, and the plain language summary of the Financial Assistance Policy must be posted in a prominent place on Huntington Memorial Hospital's website;

c) If requested by a patient, a copy of the Financial Assistance Policy , Application for Financial Assistance , and the plain language summary of the Financial Assistance Policy shall be sent by mail, or provided in person, or by any other means, at no cost to the patient;

d) As necessary and at least on an annual basis, Huntington Memorial Hospital will place an advertisement regarding the Financial Assistance Policy at Huntington Memorial Hospital in a newspaper of general circulation in the communities served by Huntington Memorial Hospital, or issue a press release published on the Huntington Memorial Hospital website, or other mediums, including but not limited to, advertisements on social media platforms, where reasonable, to widely publicize the availability of the Financial Assistance Policy, or to the communities served by Huntington Memorial Hospital;

e) Huntington Memorial Hospital will work with affiliated organizations, physicians, community clinics, other health care providers, houses of worship, and other community-based organizations to notify members of the community (especially those who are most likely to require financial assistance) about the availability of financial assistance at Huntington Memorial Hospital; and

f) By January 1, 2022 all staff that interacts with patients and their families concerning payment of services shall be given annual training to make patients and their families aware of and informed of the Financial Assistance Policy.

XI.

For five (5) fiscal years from the closing date of the Affiliation Agreement, PHA and Cedars-Sinai shall provide an annual amount of Community Benefit Services at Huntington Memorial Hospital equal to or greater than $30,351,088 (the Minimum Community Benefit Services Amount) exclusive of any funds from grants.

PHA and Cedars-Sinai's obligation under this Condition shall be prorated on a daily basis if the effective date of the Affiliation Agreement is a date other than the first day of PHA's fiscal year.

For the second fiscal year and each subsequent fiscal year, the Minimum Community Benefit Services Amount shall be increased (but not decreased) by an amount equal to the Annual Percent increase, if any, in the 12 Months Percent Change: All Items Consumer Price Index for Los Angeles-Long Beach-Anaheim, CA Base Period: 1982-84=100 (as published by U.S. Bureau of Labor Statistics).

If the actual amount of community benefit services provided at Huntington Memorial Hospital for any fiscal year is less than the Minimum Community Benefit Services Amount (as adjusted pursuant to the above-referenced Consumer Price Index) required for such fiscal year, Huntington or Cedars-Sinai shall pay an amount equal to the deficiency to one or more tax-

exempt entities that provide community benefit services for residents in Huntington Memorial Hospital's service area (36 ZIP codes), as defined on page 50 of the Huntington Memorial Hospital Health Care Impact Statement, dated September 28, 2020, and attached hereto as Exhibit 2. Such payment(s) shall be made within six months following the end of such fiscal year.

The following community benefit programs shall continue to be offered and/or supported for at least five (5) years from the Closing Date:

a) Community Education and Support Groups;

b) Community Organization Support;

c) Community Outreach Services;

d) Education for Nursing/ Nursing Students Program;

e) Education for Other Health Professions;

f) Huntington Ambulatory Care Center;

g) Huntington Health eConnect; and

h) Huntington Health Services Library, either in physical or remote form.

XII.

For five (5) years from the closing date of the Affiliation Agreement unless otherwise indicated, Huntington Memorial Hospital shall maintain all contracts, including any superseding, successor, or replacement contracts, and any amendments and exhibits thereto, with the County of Los Angeles or its subdivisions, departments, or agencies for services at Huntington Memorial Hospital including the following:

a) Trauma Center Service Agreement between the County of Los Angeles and the Hospital, for the provision of trauma center designation services;

b) Master Agreement and all its components between the County of Los Angeles and the Hospital for Specialty Care Center Designations;

c) Mental Health Services Agreement, Contract Allowable Rate - Fee For Service, Medi-Cal Acute Psychiatric Inpatient Hospital Services between the County of Los Angeles and the Hospital for reimbursement of Psychiatric Inpatient Hospital Services for Medi-Cal beneficiaries;

d) Master Agreement between the County of Los Angeles and the Hospital for designation as a Comprehensive Stroke System;

e) Master Agreement No. H-708207 between the County of Los Angeles and the Hospital for Specialty Care Center Designations as amended by Amendment No. 1; and

f) Social Program Agreement (Contract # CP-05-377) dated March 5, 2020, between the County of Los Angeles and the Hospital, regarding a $5,000 grant for health and social service initiatives and programs.

XIII.

For five (5) years from the Closing Date, PHA and Cedars-Sinai shall maintain the Hospital Services Agreement (including Amendment I through Amendment VI) with Shriners Hospitals for Children on the same terms and conditions as indicated in the agreement and related amendments; unless the contract is terminated by either party for cause or not extended or renewed by Shriners Hospitals on their own initiative without cause.

XIV.

For ten (10) years from the closing date of the Affiliation Agreement, PHA and Cedars-Sinai shall commit the necessary investments required to meet and maintain OSHPD seismic compliance requirements at Huntington Memorial Hospital under the Alfred E. Alquist Hospital Facilities Seismic Safety Act of 1983, as amended by the California Hospital Facilities Seismic Safety Act, (Health & Saf. Code, §§129675-130070) and as such Acts may be subsequently amended, modified, or replaced.

XV.

PHA and Cedars-Sinai shall maintain privileges for current medical staff at Huntington Memorial Hospital who are in good standing as of the closing date of the Affiliation Agreement. Further, the closing of the Affiliation Agreement shall not change the medical staff officers, committee chairs, or independence of the medical staff, and such persons shall remain in good standing for the remainder of their tenure as medical staff officers or committee chairs at Huntington Memorial Hospital.

XVI.

There shall be no discrimination against any lesbian, gay, bisexual, transgender, or queer individuals at Huntington Memorial Hospital. This prohibition must be explicitly set forth in PHA and Cedars-Sinai's written policies applicable at Huntington Memorial Hospital, adhered to, and strictly enforced.

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XVII.

PHA and Cedars-Sinai shall continue Huntington Memorial Hospital's participation in the California Department of Health Care Services' Hospital Quality Assurance Fee Program as set forth in California law and the provider bulletins dated August 26, 2014 and May 13, 2016 (located at http://www.dhcs.ca.gov/provgovpart/Pages/HQAF.aspx).

XVIII.

Within three (3) years from the Closing Date, PHA and Cedars-Sinai shall install Epic software for an enterprise integrated electronic health records system at Huntington Memorial Hospital. Cedars-Sinai will fund the capital costs of this project from sources other than PHA cash reserves, pursuant to the Affiliation Agreement, attached hereto as Exhibit 1.

XIX.

PHA and Cedars-Sinai shall fund the $560 million long-range strategic capital plan for Huntington Memorial Hospital through December 31, 2029, pursuant to the Affiliation Agreement, attached hereto as Exhibit 1.

XX.

Upon closing, the Trust will gift to PHA the legal title to the land Huntington Memorial Hospital occupies;

Additionally, the Trust shall contribute two types of annual distributions to Huntington Memorial Hospital through the year 2029, so long as the Huntington Memorial Hospital and its tax-exempt affiliates continue to be tax-exempt, the Huntington Memorial Hospital continues operating as a general acute care hospital, Cedars-Sinai continues to be the sole member of PHA, and Cedars-Sinai complies with its obligations under the Affiliation Agreement:

a) The Trust will make annual distributions to fund the general medical education program at Huntington Memorial Hospital. In 2021, the amount of this annual distribution is $5,300,000. The amount of this distribution will increase in subsequent years by 2.5% per year; and

b) The Trust will make annual distributions to fund the Huntington Memorial Hospital projects selected by the Trust and approved by the PHA Board. The annual amount of this distribution will be 2.5% of the market value of certain cash and marketable securities owned by the Trust (that have a minimum hold or exit provision of less than six (6) months).

These provisions are pursuant to the Affiliation Agreement, attached hereto as Exhibit 1.

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XXI.

For ten (10) calendar years, with an option to renew for five (5) calendar years, beginning January 15, 2021, PHA and Cedars-Sinai shall comply with the competitive impact conditions as set out in Exhibit 3. The report by the competitive impact expert is attached hereto as Exhibit 4.

XXII.

For ten (10) fiscal years from the closing date of the Affiliation Agreement, PHA and Cedars-Sinai shall submit to the Attorney General, no later than six months after the conclusion of each fiscal year, a report describing, in detail, compliance with each Condition set forth herein. The Chairman(s) of the Board of Directors of PHA and Cedars-Sinai and the Chief Executive Officers of Huntington Memorial Hospital and Cedars-Sinai Medical Center shall each certify that the report is true, accurate, and complete, and provide documentation of the review and approval of the report by these Boards of Directors.

XXIII.

At the request of the Attorney General, all of the entities listed in Condition I shall provide such information as is reasonably necessary for the Attorney General to monitor compliance with these Conditions and the terms of the transaction as set forth herein. The Attorney General shall, at the request of a party and to the extent provided by law, keep confidential any information so produced to the extent that such information is a trade secret or is privileged under state or federal law, or if the private interest in maintaining confidentiality clearly outweighs the public interest in disclosure.

XXIV.

Once the Affiliation Agreement is closed, all of the entities listed in Condition I are deemed to have explicitly and implicitly consented to the applicability and compliance with each and every Condition and to have waived any right to seek judicial relief with respect to each and every Condition.

The Attorney General reserves the right to enforce each and every Condition set forth herein to the fullest extent provided by law. In addition to any legal remedies the Attorney General may have, the Attorney General shall be entitled to specific performance, injunctive relief, and such other equitable remedies as a court may deem appropriate for breach of any of these Conditions. Pursuant to Government Code Section 12598, the Attorney General's office shall also be entitled to recover its attorney fees and costs incurred in remedying each and every violation.

Exhibit 1

Final

CEDARS-SINAI HEALTH SYSTEM,
a California nonprofit public benefit corporation

and

PASADENA HOSPITAL ASSOCIATION, LTD.,
a California nonprofit public benefit corporation
d/b/a Huntington Hospital

and

COLLIS P. AND HOWARD HUNTINGTON MEMORIAL HOSPITAL TRUST

AFFILIATION AGREEMENT

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AFFILIATION AGREEMENT

THIS AFFILIATION AGREEMENT (this "***Agreement***") is made and effective as of July 15, 2020 (the "***Execution Date***") among Cedars-Sinai Health System, a California nonprofit public benefit corporation ("***Parent***"), Pasadena Hospital Association Ltd., a California nonprofit public benefit corporation doing business as Huntington Hospital ("***Huntington***"), and the Trustees of the Collis P. and Howard Huntington Memorial Hospital Trust (the "***Trust***"). Parent, Huntington and the Trust are referred to herein individually as a "***Party***" and collectively as the "***Parties***."

RECITALS

WHEREAS, Parent is a California nonprofit public benefit corporation and organized exclusively for the benefit of and to support nonprofit health care organizations organized for the purpose of establishing, maintaining, sponsoring and promoting activities relating to the improvement of human health and well-being;

WHEREAS, Parent is the sole corporate member of: (i) Cedars-Sinai Medical Center, a California nonprofit public benefit corporation ("***CSMC***"), which owns and operates acute care hospitals located at 8700 Beverly Boulevard, Los Angeles, California, 90048 ("***CSMC Hospital***") and 4650 Lincoln Boulevard, Marina Del Rey, California 90292, and (ii) Torrance Health Association, Inc., a California nonprofit public benefit corporation ("***THA***"), which owns and operates an acute care hospital located at 3330 Lomita Boulevard, Torrance, California 90505. CSMC and THA also provide various outpatient services in their respective communities through hospital-based and community-based clinics, ambulatory surgical centers, and other health care related businesses and facilities and wholly owned and partially owned subsidiaries;

WHEREAS, Huntington is a California nonprofit public benefit corporation that has been engaged in the charitable mission of delivering healthcare services in the San Gabriel Valley for over 125 years with the support of the Trust. Huntington owns and operates an acute care hospital located at 100 W California Boulevard, Pasadena, California 91105 ("***Huntington Hospital***") and provides various outpatient services in Huntington's community through other health care related businesses and facilities and wholly owned and partially owned subsidiaries;

WHEREAS, the Parties desire for Huntington to affiliate with Parent on the terms and conditions set forth in this Agreement (the "***Affiliation***") for the purpose of Huntington joining Parent's integrated healthcare delivery system in order to benefit patients by increasing access to, and improving outcomes and the quality of care of, healthcare within Parent's and Huntington's communities and to further Parent's and Huntington's mission of advancing quality of care and furthering the charitable activities of Parent and Huntington in a manner consistent with the Parties' charitable missions and purposes;

WHEREAS, to implement the Affiliation, the Parties contemplate, among other things, that Parent will become the sole voting member of Huntington and that Parent and Huntington will amend and restate their organizational documents to address certain structural and governance matters, as set forth herein; and

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

NOW, THEREFORE, in consideration of the mutual promises and benefits to be derived from this Agreement, the Parties, intending to be legally bound, hereby agree as follows:

Article I

DEFINITIONS AND INTERPRETATION

1.1 Definitions. As used in this Agreement, the following terms have the meanings given:

"Action" shall mean any action, complaint, suit, litigation, proceeding, arbitration, mediation, labor dispute, arbitral action, governmental audit, criminal prosecution or unfair labor practice charge or complaint.

"Affiliate Hospital Organization" means Huntington, CSMC, THA and any other entities defined as Affiliate Hospital Organizations in the bylaws of Parent, as such are amended from time to time.

"Affiliation" is defined in the Recitals to this Agreement and includes the actions contemplated in Section 2.1 and Section 3.1 of this Agreement.

"AG Consent" is defined in Section 13.13(b).

"Agreement" is defined in the Preamble to this Agreement.

"Attorney General" is defined in Section 7.1(a).

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

"Capital Plan Period" is defined in Section 14.1(a).

"CARP" is defined in Section 13.11.

"Claims and Losses" means Actions, executions, judgments, duties, debts, dues, accounts, bonds, Contracts and covenants (whether express or implied), damages (including direct, consequential, punitive or any other kind of damages), penalties, fines, liens, costs and expenses (including reasonable attorneys' fees and costs), losses, liabilities, legal or administrative proceedings, claims and demands whatsoever whether in law or in equity (whether based upon contract, tort or otherwise).

"Closing" is defined in Section 11.1.

"Closing Date" is defined in Section 11.1.

"Closure or Sale of Hospital Unwind Event" is defined in Section 13.2(a).

"Code" means the Internal Revenue Code of 1986, as amended.

"Competing Transaction" is defined in Section 7.7(b).

"Congress Services Corporation" means Congress Services Corporation, a California corporation.

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

"Control" (including, with correlative meanings, the terms "controlled by" and "under common control with") means the power or possession of the power, direct or indirect, to direct or cause the direction of the management and policies of an entity, whether through the ownership of securities, election or appointment of directors, by contract or otherwise.

"Court Approval" means such court approval of the actions to be taken by the Trust in connection with the Affiliation as determined necessary by the Trust.

"CSMC" is defined in the Recitals to this Agreement.

"CSMC Hospital" is defined in the Recitals to this Agreement.

"Disclosure Schedules" means the Huntington Schedules, Trust Schedules and Parent Schedules.

"Dispute" is defined in Section 16.10.

"Dispute Notice" is defined in Section 16.10.

"DOL" is defined in Section 4.9(b).

"Drop Dead Date" is defined in Section 9.1(d).

"Effective Time" is defined in Section 11.1.

"EHR Project" is defined in Section 14.2(a).

"EHR Project Capital Costs" is defined in Section 14.2(d).

"EHR Project Committee" is defined in Section 14.2(b).

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

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

"Enforceability Exceptions" means exceptions to enforceability resulting from applicable bankruptcy, reorganization, insolvency, moratorium or other Laws affecting the enforcement of creditors' rights generally and by general principles of equity, regardless of whether such enforceability is considered in a proceeding at law or in equity.

"Environmental Claim" means any written or threatened, claim, action, cause of action, investigation or notice by any Person alleging potential liability arising out of, based on or resulting from (a) the presence, release, or threatened release, of any Hazardous Materials in violation of Environmental Law or an Environmental License, or in an amount or concentration requiring remedial action under Environmental Laws, at or from any location owned or operated by a Huntington Entity, the Trust or a Parent Entity, as applicable, or (b) any violation or alleged violation of any Environmental Law.

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

"Environmental Licenses" means any and all Licenses issued pursuant to Environmental Laws.

"Epic" is defined in Section 14.1(a).

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

"ERISA Affiliate" means an any person or entity that directly controls, is controlled by, or is under common control with a Person if it is considered a single employer with such Person under ERISA Section 4001(b) or Section 414 of the Code, or part of the same "controlled group" as such Person for purposes of ERISA Section 302(d)(3).

"Funding Commitment" is defined in Section 14.1(b).

"Execution Date" is defined in the Preamble to this Agreement.

"GAAP" means United States generally accepted accounting principles.

"GME Distributions" is defined in Section 13.10(a).

"Governing Documents" means (a) if a corporation, the articles of incorporation and bylaws; (b) if a general partnership, the partnership agreement and any statement of partnership; (c) if a limited partnership, the limited partnership agreement and the certificate of limited partnership; (d) if a limited liability company, the articles of organization and operating agreement; (e) if another type of entity, any other charter or similar document adopted or filed in connection with the creation, formation or organization of the entity; (f) if a trust, the declaration of trust or trust agreement and any related court orders; and (g) any amendment or restatement to any of the foregoing.

"Government Authorizations" means all Licenses, consents or approvals of any Governmental Entity that are required for each Huntington Entity to continue operating the Huntington Operations after the consummation of the Affiliation described herein.

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

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

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

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

"Health System" means the integrated healthcare delivery system comprised of Parent, Huntington, THA, CSMC and other Affiliate Hospital Organizations.

"HHP" means The Huntington Medical Foundation, a California nonprofit public benefit corporation d/b/a Huntington Health Physicians.

"HMRI Lease" means that certain Standard Industrial/Commercial Single-Tenant Lease – Net, dated as of July 1, 2012, including an Addendum thereto, as amended by amendments dated

as of June 30, 2015 and March 15, 2017, by and between the Trust, as lessor, and Huntington Medical Research Institutes, a California nonprofit corporation, as lessee, pertaining to real property located at 734 South Fairmount Avenue, Pasadena, California.

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

"Huntington" is defined in the Preamble to this Agreement.

"Huntington Amended Articles" is defined in Section 2.1.

"Huntington Amended Bylaws" is defined in Section 2.1.

"Huntington Assets" means any and all assets owned by a Huntington Entity and used in the ordinary course of the Huntington Operations taken as a whole or in the individual operations of any Huntington Entity, including: (i) the Huntington Real Property, (ii) all tangible personal property owned by Huntington and used in connection with the Huntington Operations, of every kind and nature, including all furniture, fixtures, equipment, machinery, vehicles, and owned or licensed computer systems, (iii) all inventories of useable supplies, drugs, food, janitorial and office supplies, maintenance and shop supplies, and other disposables and consumables owned by any Huntington Entity and used in connection with the Huntington Operations, and (iv) all goodwill and other intangible assets of a Huntington Entity, and all marks, names, trademarks, service marks, patents, patent rights, assumed names, logos, copyrights, trade secrets and similar intangibles (including variants of and applications for any of the foregoing) owned by a Huntington Entity used in the ordinary course of the Huntington Operations taken as a whole or in the individual operations of Huntington Hospital or any Huntington Entity. The term "Huntington Assets" excludes any assets of the Trust.

"Huntington Consolidated Group" means Huntington, HHP and Congress Services Corporation. After the Closing, the Huntington Consolidated Group will include any entity that is consolidated on the audited financial statements of Huntington, and will exclude any entity that is not consolidated on the audited financial statements of Huntington. Notwithstanding anything to the contrary, the Huntington Consolidated Group specifically excludes the Trust.

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

"Huntington Entities" means: (i) Huntington, (ii) HHP, (iii) Congress Services Corporation, a California corporation, and (iv) Huntington Ambulatory Surgery Center, LLC, a California limited liability company. The Huntington Entities specifically exclude the Trust.

"Huntington Entity Insurance Policies" is defined in Section 4.14(a).

"Huntington Entity Intellectual Property Assets" is defined in Section 4.13.

"Huntington Financial Statements" means the audited consolidated balance sheet of the Huntington Consolidated Group as of December 31, 2019, and the consolidated statements of operations of the Huntington Consolidated Group for the year then ended; and the unaudited interim consolidated balance sheet of the Huntington Consolidated Group as of May 31, 2020, and the unaudited interim consolidated statements of operations of the Huntington Consolidated Group for the 5-month period then ended.

"Huntington Healthcare Service" means any licensed or license-exempt healthcare service provided by any Huntington Entity.

"Huntington Hospital" is defined in the Recitals to this Agreement.

"Huntington Hospital Land" means the land on which the main campus of the Huntington Hospital is situated, as described on Exhibit G, attached hereto and incorporated herein.

"Huntington Hospital Land Deed" is defined in Section 8.2(d).

"Huntington's Knowledge" means the actual knowledge of the Chief Executive Officer, Chief Financial Officer or Chief Strategy Officer of a Huntington Entity.

"Huntington Nominated Directors" is defined in Section 3.1(b).

"Huntington Operations" means any and all operations conducted by any Huntington Entity, whether at Huntington Hospital or elsewhere, including, without limitation, all Huntington Healthcare Services.

"Huntington Real Property" means: (i) the Huntington Hospital Land and (ii) all real property interests owned by any Huntington Entity, and all of Huntington's and a Huntington Entity's interests therein, and all right, title and interest of Huntington and a Huntington Entity in all appurtenances, options, easements, servitudes, rights-of-way and other rights associated therewith.

"Huntington Schedules" is defined in the introductory language in Article IV.

"Huntington Strategic Capital Plan" is defined in Section 14.1(a).

"Huntington Subsidiary" means each Huntington Entity as well as any entity that, directly or indirectly through one or more intermediaries, is Controlled by Huntington. Without limiting the generality of the foregoing, "Huntington Subsidiary" shall include those entities of which Huntington is a corporate member and those entities in which Huntington owns more than

fifty-percent (50%) of the voting securities. The Huntington Subsidiaries specifically exclude the Trust.

"Huntington Unwind Event" is defined in Section 13.3.

"Illegality Dispute" is defined in Section 13.1.

"Illegality Unwind Event" is defined in Section 13.1.

"Imaging Center JVs" is defined in Section 10.2(j).

"Interim Period" means the period of time between the Execution Date and the Closing Date or earlier termination of this Agreement.

"Law" or "Laws" means all laws, codes, regulations, rules, orders, common law and ordinances including, but not limited to: state corporate practice of medicine Laws and regulations, state professional fee-splitting laws and regulations, the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Affordability Reconciliation Act (the "Affordable Care Act"), the federal Anti-kickback Statute (42 U.S.C. § 1320a-7b(b)), the Stark Law (42 U.S.C. § 1395nn), any applicable state fraud and abuse prohibitions, including those that apply to all payors (governmental, commercial insurance and self-payors), the Anti-Inducement Law (42 U.S.C. § 1320a-7a(a)(5)), the civil False Claims Act (31 U.S.C. §§ 3729 et seq.), the administrative False Claims Law (42 U.S.C. § 1320a-7b(a)), the civil monetary penalty laws (42 U.S.C. § 1320a-7a), and any other local, state or federal law, regulation, guidance document, manual provision, program memorandum, opinion letter, or other public issuance.

"Licenses" means licenses, permits, authorizations, certifications, accreditations, registrations and franchises.

"Lookback Period" means the four-year period ending on the Execution Date.

"Lot Line Adjustment" is defined in Section 8.2(a).

"Master Lease" means, collectively, the Lease dated as of April 13, 1942 by and between the Trust, as lessor, and Huntington, as lessee, as amended by amendments dated June 23, 1942, February 23, 1945, June 18, 1946, December 1, 1952, January 5, 1959, September 6, 1968, December 28, 1972, July 22, 1982, November 5, 1985, September 27, 1990, November 19, 1992, August 12, 1996, September 18, 1997, April 28, 2005, May 1, 2014 and April1, 2018.

"Material Adverse Change" means, with respect to a Party, an event, change or circumstance, which, individually or together with any other event, change or circumstance, has or is reasonably expected to have a material and adverse effect on, or cause a material and adverse change in, the financial condition, business or results of operations of the Party (the Huntington Entities, taken as a whole, or the Parent Entities, taken as a whole, or the Trust, as applicable) or on the ability of the Party to consummate the Affiliation; provided, however, that none of the following (or any results thereof), alone or in combination, will constitute or be considered or taken into account in determining the existence of a Material Adverse Change:

(i) changes in the financial or operating performance due to or caused by the announcement, pendency or consummation of the Affiliation, or the execution of this Agreement or the performance of obligations hereunder, or seasonal changes;

(ii) the failure to meet any revenue, earnings or other projections, forecasts or predictions, provided that the cause of any such failure may be taken into account when determining the existence of a Material Adverse Change;

(iii) any condition appearing in the Disclosure Schedules as of the Execution Date, provided that a change in such condition occurring after the Execution Date, even if communicated by way of an update to the Disclosure Schedule, may be taken into account when determining the existence of a Material Adverse Change;

(iv) requirements, reimbursement rates, policies or procedures of third-party payors or accreditation commissions or organizations that are generally applicable to hospitals or health care facilities;

(v) general business, industry or economic conditions, including such conditions related to the Party;

(vi) local, regional, national or international political or social conditions, including the engagement or continuation of the United States in hostilities or the escalation thereof, or the occurrence or the escalation of any military or terrorist attack upon the United States, or any of its territories, possessions, or diplomatic or consular offices or upon any military installation, equipment or personnel of the United States, whether or not pursuant to the declaration of a national emergency or war, or the occurrence of any military or terrorist attack;

(vii) changes in financial, banking or securities markets in the United States or any other country (including any disruption thereof and any decline in the price of any security or commodity or any market index);

(viii) changes in, adoption of, or change in the interpretation or adoption of any applicable Law or GAAP;

(ix) pandemics, earthquakes, hurricanes, floods or other natural disasters, including a declaration or continuation of a state or national emergency;

(x) the effects of or response to novel coronavirus or COVID-19;

(xi) any action taken by, or with the consent of, the other Party; or

(xii) any action by a Party or any of its trustees, directors, officers, employees or representatives required to be taken, or expressly permitted to be taken, by this Agreement.

Notwithstanding the foregoing, changes or effects that pertain to the actions or events described in clauses (iii) – (ix) above may constitute, be considered or taken into account in determining the existence of a Material Adverse Change to the extent such changes or effects have a materially

disproportionate effect on the Party compared to other Persons in the industries and geographic regions in which the Party does business.

"Meet and Confer" is defined in Section 16.10.

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

"NDA" is defined in Section 7.6.

"New Huntington Organizational Documents" is defined in Section 2.1.

"New Parent Organizational Documents" is defined in Section 3.1(a).

"Nonrecourse Person" is defined in Section 15.5(b).

"Notice of Illegality" is defined in Section 13.1.

"Parent" is defined in the Preamble to this Agreement.

"Parent Amended Articles" is defined in Section 3.1(a).

"Parent Amended Bylaws" is defined in Section 3.1(a).

"Parent Assets" means any and all assets owned by a Parent Entity and used in the ordinary course of the Parent Operations taken as a whole or in the individual operations of any Parent Entity, including: (i) the Parent Real Property, (ii) all tangible personal property owned by Parent and used in connection with the Parent Operations, of every kind and nature, including all furniture, fixtures, equipment, machinery, vehicles, and owned or licensed computer systems, (iii) all inventories of useable supplies, drugs, food, janitorial and office supplies, maintenance and shop supplies, and other disposables and consumables owned by any Parent Entity and used in connection with the Parent Operations, and (iv) all goodwill and other intangible assets of a Parent Entity, and all marks, names, trademarks, service marks, patents, patent rights, assumed names, logos, copyrights, trade secrets and similar intangibles (including variants of and applications for any of the foregoing) owned by a Parent Entity and used in the ordinary course of the Parent Operations taken as a whole or in the individual operations of CSMC Hospital or any Parent Entity.

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

Parent Entity or any ERISA Affiliate, (ii) under which any current or former employee or director of any Parent Entity has any present or future right to benefits, and (iii) with respect to which any Parent Entity has any liability.

"Parent Entity" means Parent and CSMC.

"Parent Entity Insurance Policies" is defined in Section 6.14(a).

"Parent Entity Intellectual Property Assets" is defined in Section 6.13.

"Parent Financial Statements" means Parent's audited consolidated balance sheet as of June 30, 2019, and Parent's audited consolidated income statement for the year then ended; and Parent's unaudited consolidated balance sheet as of May 31, 2020, and Parent's unaudited consolidated income statement for the 11-months then ended.

"Parent Healthcare Service" means any licensed or license-exempt healthcare service provided by any Parent Entity.

"Parent's Knowledge" means the actual knowledge of the Chief Executive Officer, Chief Financial Officer or Chief Strategy Officer of a Parent Entity.

"Parent Operating Expenses Payments" is defined in Section 13.4.

"Parent Operations" means any and all operations conducted by any Parent Entity, whether at CSMC Hospital or elsewhere, including, without limitation, all Parent Healthcare Services.

"Parent Real Property" means all real property interests owned by any Parent Entity, and all of Parent's and a Parent Entity's interests therein, and all right, title and interest of Parent and a Parent Entity in all appurtenances, options, easements, servitudes, rights-of-way and other rights associated therewith.

"Parent Schedules" is defined in the introductory language in Article VI.

"Party" is defined in the Preamble to this Agreement.

"PBGC" is defined in Section 4.9(b).

"Permitted Liens" means (i) statutory liens for current taxes and assessments not yet due and payable or which are being contested in accordance with applicable law; (ii) statutory, mechanics', carriers', workmen's, repairmen's and similar statutory liens not yet due or payable or which are being contested in good faith, or the value of which are not material in relationship to the value of the encumbered asset; (iii) matters set forth on Exhibit H, attached hereto and incorporated herein; (iv) matters shown on the Surveys (1) which do not materially adversely affect the use of the Huntington Hospital Land for the purpose for which it is used as of the Closing Date or (2) which do not materially impair the title or marketability, or materially adversely affect the value of the Huntington Hospital Land for its current use; and (v) the HMRI Lease.

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

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

"Pre-Closing Communications" is defined in Section 16.16.

"Prior Counsel" is defined in Section 16.16.

"Project Distributions" is defined in Section 13.10(b).

"Protected Persons" is defined in Section 12.5.

"Quality Risk Event" is defined in Section 13.11.

"Reimbursement Agreement" is defined in Section 10.3(i).

"Releasing Parties" is defined in Section 15.5(c).

"Related Person" of any Person means another Person that directly or indirectly, through one or more intermediaries, Controls, is Controlled by, or is under common Control with, such first Person.

"Restricted Assets" is defined in Section 13.6.

"Section 5920" is defined in Section 7.1(a).

"SEC" is defined in Section 4.9(b).

"Sixty Days Expenses" means, for each fiscal year of Huntington, a dollar amount equal to sixty (60) times the fraction in which (i) the numerator is the total expenses of the Huntington Consolidated Group (excluding depreciation and amortization), in each case based on the audited consolidated statements of operations of the Huntington Consolidated Group from the preceding fiscal year, and (ii) the denominator is three hundred and sixty-five (365). The prior fiscal year's Sixty Days Expenses will be used for the current fiscal year until the prior fiscal year's final audited consolidated statements of operations is delivered to Huntington. For example, Sixty Days Expenses for fiscal year ending in 2021 will equal sixty (60) times the fraction in which the numerator is the total expenses of the Huntington Consolidated Group (excluding depreciation and amortization), in each case based on the fiscal year ending in 2020 audited consolidated income statement of the Huntington Consolidated Group, and the denominator is three hundred and sixty-five (365).

"Surveys" is defined in Section 8.2(b).

"State" means the State of California.

"Tax" means (a) (i) any federal, state, local or foreign income, gross receipts, franchise, estimated, alternative minimum, add-on minimum, sales, use, transfer, real property gains, registration, value added, excise, natural resources, severance, stamp, occupation, windfall profits, environmental (under Section 59A of the Code), customs, duties, real property, personal property, capital stock, social security (or similar), unemployment, disability, payroll, license, employee, service, ad valorem, profits, capital, premium, production, consumption, commercial rent, capital gains, business privilege, recording, inventory, merchandise, intangibles, transaction, title, business, deduction at source or other withholding (including withholding liability as a representative taxpayer), or other tax, (ii) any impost, fee, levy, charge, or assessment, in each case, in the nature of taxes, (iii) any liability under unclaimed property, escheat or any similar Law, and (iv) any interest, penalties or additions in respect of the foregoing (whether disputed or not) or in respect to failure to comply with any requirement with respect to Tax Returns and (b) any liability for the payment of any amounts of the type described in clause (a) as a result of any Contract to pay or assume any such amounts or to indemnify any other Person for such amounts, any transferee or successor liability, the operation of Law (including pursuant to Treasury Regulations Section 1.1502-6 or any similar provision of state, local or foreign Law) or otherwise.

"Tax-Exempt Status Unwind Event" is defined in Section 13.3.

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

"THA" is defined in the Recitals to this Agreement.

"Title Company" is defined in Section 8.2(d).

"Title Commitment" is defined in Section 8.2(e).

"Title Policy" is defined in Section 8.2(e).

"Total Capital Plan Costs" is defined in Section 14.1(a).

"Transaction Documents" means the New Huntington Organizational Documents, the New Parent Organizational Documents and each of the other documents, certificates and instruments to be delivered under this Agreement.

"Trust" is defined in the Preamble to this Agreement.

"Trust Distributions" means GME Distributions and Project Distributions.

"Trust Monetary Liens" is defined in Section 8.2(c).

"Trust Party End Date" is defined in Section 16.17(a).

"Trust Released Parties" is defined in Section 12.4.

"Trust Schedules" is defined in the introductory language in Article V.

"Trust Securities Portfolio" is defined in Section 13.10(b).

"Trust's Knowledge" means the actual knowledge of any trustee of the Trust. For purposes of this Agreement, any reference to a "trustee of the Trust" means Jaynie Studenmund, Armando L. Gonzalez, Michelle Quinones Chino, Paul Johnson, and Wayne Brandt.

"Unrestricted Cash on Hand" means cash, cash equivalents and marketable securities of the Huntington Consolidated Group other than: (i) Trust Distributions; (ii) cash equivalents pledged or held as collateral or a security deposit; (iii) gifts, grants, bequests, donations or contributions, to the extent specifically restricted by the donor to a particular purpose; (iv) amounts drawn and unrepaid from any line of credit; and (v) cash and cash equivalents that are subject to any restrictions. A restriction to use cash, cash equivalents or marketable securities to fund an expenditure in the Huntington Strategic Capital Plan will not be treated as a restriction under clause (iii) or (v) of this definition.

1.2 Rules of Interpretation.

(a) In this Agreement and its schedules and exhibits: "Include" and its permutations will be deemed to be followed by the words "without limitation." In any determination of a period of time, "from" means "from and including" and "to" means "to but excluding." Reference to a "copy" of any document means a copy that is complete and correct. Reference to a list, or any like compilation, means that the list or compilation is complete and correct. Reference to a notice or report means a written notice or written report. Words denoting any gender will include all genders (including the neutral gender). References to the singular include references to the plural and vice versa. Where specific language is used to clarify by example a general statement, the specific language does not modify, limit or restrict in any manner the construction of the general statement to which it relates. All references to a day or days will be deemed to refer to a calendar day or calendar days, as applicable, unless otherwise specifically provided and whenever action is required on a day that is not a Business Day such action may be validly taken on the next Business Day. Reference to a contract is a reference to such contract as amended, restated, modified, supplemented or waived. References to a Section, Attachment, Schedule or Exhibit refers to such Section, Attachment, Schedule or Exhibit of this Agreement, unless otherwise specified. The terms "hereby," "hereof," "herein," "hereinafter," "hereunder" and derivative words refer to this entire Agreement, unless the context otherwise requires. The contents of the Attachments, Schedules and Exhibits are an integral part of this Agreement and reference to "this Agreement" includes the Attachments, Schedules and Exhibits. If a Party or its representative transmits a document to the other Party and such document is accessible to the other Party, such document will be deemed to have been "delivered," "furnished" or "made available" (or any phrase of similar import) to the other Party and its representatives. The headings and captions used in this Agreement, the table of contents to this Agreement and descriptions of the Schedules are for convenience of reference only and do not constitute a part of this Agreement and will not be deemed to limit, characterize or in any way affect any provision of this Agreement.

(b) Disclosure of any fact or item in the Disclosure Schedules will not necessarily mean that such item or fact, individually or in the aggregate, is material or adverse to the business, results of operations or financial condition of the Party, or that such item or fact has

had or is expected to have a Material Adverse Change or that such item or fact is required to be disclosed pursuant to this Agreement. The disclosure of any information concerning an item or fact in the Disclosure Schedules does not imply that any other, undisclosed item or fact that has a greater significance or value is material.

Article II

HUNTINGTON MEMBERSHIP

2.1 Membership of Huntington. On the terms and subject to the conditions of this Agreement, at the Closing, effective as of the Effective Time, Huntington shall (a) cause the amendment of its articles of incorporation in the form attached hereto as Attachment 2.1(a) (the "***Huntington Amended Articles***") to be filed with the California Secretary of State and (b) cause the amendment of its bylaws in the form attached hereto as Attachment 2.1(b) (the "***Huntington Amended Bylaws***" and collectively with the Huntington Amended Articles, the "***New Huntington Organizational Documents***") to provide that Parent is the sole member (as defined in Section 5056(a) of the California Corporations Code) of Huntington.

Article III

PARENT ORGANIZATIONAL DOCUMENTS AND TRUST ACTIONS

3.1 Parent Organizational Documents.

(a) On the terms and subject to the conditions of this Agreement, at the Closing, effective as of the Effective Time, Parent shall: (i) cause the amendment of its articles of incorporation in the form attached hereto as Attachment 3.1(a)(i) (the "***Parent Amended Articles***") to be filed with the California Secretary of State and (ii) cause the amendment of its bylaws in the form attached hereto as Attachment 3.1(a)(ii) (the "***Parent Amended Bylaws***" and collectively with the Parent Amended Articles, the "***New Parent Organizational Documents***").

(b) The Parties acknowledge that, pursuant to the Parent Amended Bylaws, prior to the Closing Date: (i) Huntington shall nominate three (3) individuals (the "***Huntington Nominated Directors***") to serve on the Board of Directors of Parent as of the Effective Time, and (ii) Parent shall elect the Huntington Nominated Directors to serve on the Board of Directors of Parent as of the Effective Time and for the terms agreed to by Huntington and Parent.

3.2 Trust Actions. On the terms and subject to the conditions of this Agreement, at the Closing, the Trust shall transfer the Huntington Hospital Land to Huntington pursuant to Section 8.2. Before and after the Closing, the Trust will retain ownership of all other assets of the Trust.

Article IV

REPRESENTATIONS AND WARRANTIES OF HUNTINGTON

Except as otherwise set forth on the schedules prepared by Huntington, dated as of the Execution Date and updated pursuant to Section 7.2 (collectively, "***Huntington Schedules***"), Huntington represents and warrants to Parent as of the Execution Date, as follows:

4.1 Organization, Power, Absence of Conflicts.

(a) Organization and Good Standing of Huntington. Huntington is a nonprofit corporation duly incorporated, validly existing and in good standing under the laws of the State and has all requisite corporate power and authority to carry on its business in the State as now conducted and to own or lease and operate the Huntington Assets now owned or leased and operated by it. Huntington is not licensed, qualified or admitted to do business in any jurisdiction other than the State, and there is no other jurisdiction in which the ownership, use or leasing of any Huntington Asset, or the conduct or nature of the Huntington Operations, makes such licensing, qualification or admission necessary.

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

(i) Huntington has all requisite corporate power and authority to execute, deliver and enter into this Agreement, to consummate the Affiliation and to perform its obligations hereunder. The execution and delivery of this Agreement, and the consummation of the Affiliation, have been duly authorized by all necessary corporate action on the part of Huntington, as required by Law. No other corporate proceeding on the part of Huntington is necessary to authorize this Agreement and the Affiliation. This Agreement has been duly executed and delivered by Huntington and (assuming that this Agreement constitutes the valid and binding agreement of the other Parties) is a legal, valid and binding obligation of Huntington, enforceable against Huntington in accordance with its terms, except to the extent of the Enforceability Exceptions.

(ii) The execution and delivery by Huntington of this Agreement does not, and the consummation of the Affiliation does not, (A) result in any breach or contravention of, or permit the acceleration of the maturity of, any material Encumbrances of any Huntington Entity, (B) result in the creation of any material Encumbrances on the Huntington Assets (other than Encumbrances created pursuant to the terms of this Agreement and the other agreements and documents executed in connection with the consummation of the Affiliation), (C) conflict with, or result in any violation or breach of any provision of the Governing Documents of any Huntington Entity, or (D) conflict with or result in a breach of, or give rise to a right of termination or amendment of or loss of benefit under, or accelerate the performance required by the terms of any judgment, court order or consent decree, or any material Contract or constitute a default thereunder for any Huntington Entity; except, in the case of clauses (A), (B), (C) and (D) above, for any matter which is not, individually or in the aggregate, reasonably expected to constitute a Material Adverse Change of Huntington.

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

4.2 Third-Party Rights. Except for this Agreement, the Master Lease, the HMRI Lease and Permitted Liens, there are no Contracts with, or rights of, any Person to acquire, directly or indirectly, any material Huntington Assets, or any interest therein.

4.3 Legal Compliance.

(a) To Huntington's Knowledge, no Huntington Entity is or, during the Lookback Period, has been in material violation of any Laws. To Huntington's Knowledge, during the Lookback Period, each Huntington Entity has timely filed all reports, data and other information required to be filed with Governmental Entities. To Huntington's Knowledge, during the Lookback Period, no Huntington Entity has received written notice of any proceeding or investigation by Governmental Entities against the Huntington Entity alleging or based upon a material violation of any Laws that is currently pending. To Huntington's Knowledge, no Huntington Entity has been threatened by any Person with any proceeding or investigation by Governmental Entities against the Huntington Entity alleging a violation of any Laws with respect to the Huntington Operations.

(b) To Huntington's Knowledge, each Huntington Entity has (i) developed a compliance plan for being in compliance with the Health Information Laws, and (ii) used commercially reasonable efforts to implement those provisions of such compliance plan in all respects necessary to ensure that the applicable Huntington Operations are not in violation of the Health Information Laws.

(c) Each Huntington Entity and each Huntington Healthcare Service meets all requirements of participation, claims submission and payment of the Government Payment Programs and, to Huntington's Knowledge, other third-party payment programs and is a party to valid participation agreements for payment by such Government Payment Programs and, to Huntington's Knowledge, other third-party payment programs, as applicable. No Huntington Entity nor, to Huntington's Knowledge, any of their respective officers, directors, employees, agents or contractors is currently excluded from participation in any Government Payment Program.

(d) Each Huntington Entity and Huntington Healthcare Service, as applicable, is qualified for participation in and has current and valid provider Contracts with, the Government Payment Programs and/or their fiscal intermediaries or paying agents and is not in material violation of the conditions of participation therein. To Huntington's Knowledge, there are no material Government Payment Program recoupments or material recoupments of any

third-party payor being sought, requested, claimed, or threatened against any Huntington Entity. To Huntington's Knowledge, (i) there is no Action or investigation pending, received or threatened against any Huntington Entity which relates in any way to a violation of any Law pertaining to the Government Payment Programs or which is reasonably expected to result in the imposition of material penalties on or the exclusion of any Huntington Entity or any Huntington Healthcare Service from participation in any Government Payment Programs, and (ii) no Huntington Entity is engaged in any activities which are cause for civil penalties or mandatory or permissive exclusion from any Government Payment Program. No Huntington Entity is a party to any corporate integrity agreements, deferred prosecution agreements, monitoring agreements, consent decrees, settlement orders, plans of correction or similar agreements imposed by any Governmental Entity.

(e) No Huntington Entity, as applicable, is in material violation of any Laws regarding the selection, deselection, and credentialing of contracted providers, including verification of licensing status and eligibility for reimbursement under the Government Payment Programs. Each Huntington Entity's contracted providers are properly licensed and hold appropriate clinical privileges, as applicable, for the services which they provide, and, with respect to providers that perform services eligible for reimbursement under any Government Payment Program, are not debarred or excluded from any such Government Payment Program.

(f) During the Lookback Period all material reports, data, and information required to be filed by any Huntington Entity in connection with any Government Payment Program have been timely filed and were true and complete at the time filed (or were corrected in or supplemented by a subsequent filing). There are no Actions or appeals pending (and no Huntington Entity has made any filing or submission that, to Huntington's Knowledge, is reasonably expect to result in any Actions or appeals) before any court, regulatory body, administrative agency, governmental body, arbitrator or other Governmental Entity (including governmental administrative contractors) with respect to any Government Payment Program reports or claims filed by any Huntington Entity during the Lookback Period or with respect to any disallowances by any regulatory body, administrative agency, governmental body or other authority (including governmental administrative contractors) in connection with any audit taking place during the Lookback Period. No material validation review or program integrity review related to any Huntington Entity or any Huntington Healthcare Service has been conducted by any regulatory body, administrative agency, governmental body or other authority (including governmental administrative contractors) in connection with any Government Payment Program within the past five (5) years and, to Huntington's Knowledge, no such reviews are scheduled, pending, or threatened against or affecting any Huntington Entity or any Huntington Healthcare Service.

(g) Each Huntington Entity holds all Licenses set forth on Schedule 4.3(g) that are necessary for its respective part of the Huntington Operations. All such Licenses are in good standing and, to Huntington's Knowledge, are not subject to meritorious challenge. To Huntington's Knowledge, the Huntington Operations and Huntington Healthcare Services are not in material violation of such Licenses.

4.4 Huntington Financial Statements. Copies of the Huntington Financial Statements have been made available to Parent. The Huntington Financial Statements fairly present in all

material respects the financial condition and results of operations of the Huntington Operations as of the respective dates thereof and for the period therein referred to, subject to normal recurring year-end adjustments and the absence of notes; and the Huntington Financial Statements reflect the consistent application of GAAP throughout the periods involved.

4.5 Absence of Material Change. Since the date of the last Huntington Financial Statements, to Huntington's Knowledge, there has not been any event, change, occurrence or circumstance that has had or is reasonably expected to have a Material Adverse Change of Huntington.

4.6 Real Property.

(a) The Huntington Real Property comprises all of the real property owned or leased by the Huntington Entities.

(b) To Huntington's Knowledge, no Huntington Entity has received from any Governmental Entity any written notice of condemnation relating to the Huntington Real Property or any part thereof.

(c) Except for those tenants in possession of the Huntington Real Property under Contracts, to Huntington's Knowledge there are no Persons in possession of, or claiming any possession, adverse or not, to or other interest in, any portion of the Huntington Real Property other than a Huntington Entity, whether as lessees, tenants at sufferance, trespassers or otherwise. To Huntington's Knowledge, during the Lookback Period no Huntington Entity has received any written notice of any material default or breach on the part of the landlord under any lease of Huntington Real Property which has not been cured, nor does there exist any such default or breach on the part of the landlord.

(d) Schedule 4.6(d) identifies all those construction or capital projects currently in progress with respect to the Huntington Real Property for which all final approvals needed from Governmental Entities have not been obtained.

4.7 Environmental Matters.

(a) To Huntington's Knowledge, (i) no Huntington Entity is subject to any Action or any other material liability arising under any Environmental Laws and (ii) no circumstances exist that are reasonably expected to constitute a material violation of Environmental Laws by any Huntington Entity. During the three (3) year period prior to the Execution Date, to Huntington's Knowledge, no Huntington Entity has received any written communication from any Person alleging that any Huntington Entity is in violation of Environmental Laws.

(b) No Huntington Entity is in material violation of Environmental Laws, and during the three (3) year period prior to the Execution Date, there has been no material Environmental Claim pending or, to Huntington's Knowledge, threatened against any Person whose liability for any Environmental Claim has been retained or assumed either contractually or by operation of law by a Huntington Entity.

4.8 Employment Matters.

(a) Employee and Employee Relations.

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

(ii) To Huntington's Knowledge, no employees of any Huntington Entity are represented by, or are demanding recognition of, a labor union or employee organization with respect to their work at the Huntington Operations.

(iii) To Huntington's Knowledge, there are no other union organizing or collective bargaining activities by or with respect to any employees of any Huntington Entity with respect to such employment.

(iv) To Huntington's Knowledge, Huntington is not and during the Lookback Period has not been in material violation of any material obligations under any Plant Closure Laws as a result of the Huntington Operations.

(b) Pending Proceedings. There are no active, pending or, to Huntington's Knowledge, threatened material administrative or judicial proceedings under Title VII of the Civil Rights Act of 1964, the Age Discrimination in Employment Act, the Fair Labor Standards Act, the Occupational Safety and Health Act, the National Labor Relations Act, the Fair Employment and Housing Act, the California Labor Code, ERISA or any other foreign, federal, state or local law (including common law), ordinance or regulation relating to current employees or contingent workers, or former employees or contingent workers, of any Huntington Entity. No employee or independent contractor of a Huntington Entity is entitled to receive any compensation, payment, or remuneration from any Party as a result of the execution and delivery of this Agreement or the occurrence of the Closing.

4.9 Employee Benefit Plans.

(a) Schedule 4.9 sets forth a list of the Huntington Employee Benefit Programs.

(b) Each Huntington Employee Benefit Program that is intended to qualify under Section 401(a) of the Code has received a favorable determination or opinion letter from the IRS regarding its qualification thereunder, and to Huntington's Knowledge no event has occurred during the Lookback Period and no condition exists that is reasonably expected to result in the loss of such tax-qualified status or the imposition of any liability, penalty or tax under ERISA, the Code or any other Laws. To Huntington's Knowledge, with respect to each Huntington Employee Benefit Program, all material reports, returns, notices, and other documentation that are required to have been filed with or furnished by Huntington to the IRS, the United States Department of Labor (the "***DOL***"), the Pension Benefit Guaranty Corporation (the "***PBGC***"), the Securities and Exchange Commission (the "***SEC***") or any other Governmental Entity, or to the participants or beneficiaries of such Huntington Employee Benefit Program, during the Lookback Period have been filed or furnished on a timely basis.

(c) With respect to each Huntington Employee Benefit Program, Huntington has made available to Parent (if applicable to such Huntington Employee Benefit Program): (i) all documents embodying or governing such Huntington Employee Benefit Program, including summary plan descriptions, and any funding medium for such Huntington Employee Benefit Program (including plan documents, trust agreements and amendments thereto); (ii) the most recent IRS determination or opinion letter with respect to such Huntington Employee Benefit Program under Code Section 401(a); (iii) Form 5500 annual reports for the last three (3) plan years for all Huntington Employee Benefit Programs that require such filings; and (iv) any insurance policy related to such Huntington Employee Benefit Program.

(d) Each Huntington Employee Benefit Program has been established, operated, and administered in all material respects in accordance with the requirements of Law, including ERISA and the Code, and is being administered and operated in all material respects in accordance with its terms, and is being administrated in a manner that avoids the imposition of material penalties imposed by Law, including penalty taxes. No Huntington Employee Benefit Program is subject to Title IV of ERISA or is a Multiemployer Plan, within the meaning of ERISA Section 3(37) and no Huntington Entity or any ERISA Affiliate has within the past six (6) years sponsored, maintained, contributed to or had any liability in respect to any employee benefit plan subject to Title IV of ERISA or any Multiemployer Plan.

(e) Neither any Huntington Employee Benefit Program fiduciary nor any Huntington Employee Benefit Program has engaged in any transaction in violation of Section 406 of ERISA or any "prohibited transaction" (as defined in Section 4975(c)(1) of the Code), which transaction is not exempt under Section 4975(d) of the Code or Section 408 of ERISA and which is reasonably expected to result in material liability to Huntington under ERISA or the Code. To Huntington's Knowledge, no Huntington Entity or ERISA Affiliate or any Person appointed or otherwise designated to act on behalf of such Huntington Entity or such ERISA Affiliate, has engaged in any transactions in connection with any Huntington Employee Benefit Program that is reasonably expected to result in the imposition of a material penalty pursuant to Section 502(i) of ERISA, material damages pursuant to Section 409 of ERISA or a material Tax pursuant to Section 4975(a) of the Code.

(f) To Huntington's Knowledge, no administrative investigation, audit or other administrative proceeding by the DOL, the PBGC, the Internal Revenue Service or any other Governmental Entity is pending, with respect to any Huntington Employee Benefit Program. There is no pending, or to Huntington's Knowledge, threatened, legal action, proceeding, or investigation, other than routine claims for benefits, concerning any of the Huntington Employee Benefit Programs, or, any fiduciary or service provider thereof. No Huntington Entity has liability by virtue of its being a member of a controlled group with a person who has liability under the Code or ERISA.

(g) No Employee Welfare Benefit Plan which is a group health plan (within the meaning of Section 5000(b)(1) of the Code) is in material violation of the requirements of Section 4980B of the Code and Part 6 of Subtitle B of Title I of ERISA. As presently constituted, no Huntington Employee Benefit Program provides for health or welfare benefits (other than as required pursuant to Section 4980B of the Code or pursuant to State health continuation laws) to any current or future retiree or former employee beyond the month of termination. No

Huntington Entity is in material violation of requirements to report to the Internal Revenue Services under the Affordable Care Act, and the Internal Revenue Service has not imposed any penalties or assessments as a result of such reporting obligations.

(h) The execution and delivery of this Agreement and the consummation of the Affiliation do not result in (A) any increase in severance pay otherwise due upon any termination of employment after the Execution Date; (B) the acceleration of the time of payment or vesting or result in any funding of compensation or benefits; (C) any payment, compensation or benefit becoming due, or increase in the amount of any payment, compensation or benefit due, to any current or former employee of any Huntington Entity; (D) any new obligation pursuant to any Huntington Employee Benefit Program; (E) payment of compensation that results in an "excess parachute payment" within the meaning of Section 280G of the Code; or (F) any limitation or restriction on the right of any Huntington Entity to merge, amend or terminate any Huntington Employee Benefit Program.

(i) No Huntington Employee Benefit Program that is a "nonqualified deferred compensation plan" (as defined under Section 409A of the Code) has been operated and administered in material violation of Section 409A of the Code, and no compensation is includable in the gross income of any current or former employee, officer, director or consultant of any Huntington Entity or any ERISA Affiliate as a result of the operation of Section 409A of the Code with respect to any applicable arrangements or agreements in effect prior to the Closing. No agreements to provide Code Section 409A gross-ups are in place with respect to any employee or director of a Huntington Entity.

4.10 Litigation. There are no material Actions pending or, to Huntington's Knowledge, threatened in writing against any Huntington Entity or, to Huntington's Knowledge, with respect to any Huntington Assets. To Huntington's Knowledge, there are no material investigations pending or threatened in writing against any Huntington Entity. There is no pending or, to Huntington's Knowledge, threatened in writing, litigation, arbitration or other proceeding involving any Huntington Entity or, to Huntington's Knowledge, Huntington Assets before any court, arbitrator or governmental, regulatory or administrative body or authority that is reasonably expected to prevent or materially delay or adversely affect the consummation of the Affiliation.

4.11 Tax and Tax Exempt Status.

(a) Huntington and HHP are recognized as exempt from federal income taxation under Code Section 501(a) as organizations described in Code Section 501(c)(3), and are also recognized as exempt from State income taxation.

(b) Each Huntington Entity has filed or caused to be filed, on a timely basis, all Tax Returns that were required to be filed during the Lookback Period by such Huntington Entity in accordance with applicable Law. All such Tax Returns are true, correct and complete in all material respects. Each Huntington Entity has paid all Taxes due and payable by such Huntington Entity (whether or not shown on any Tax Return).

(c) There are no audits or administrative or judicial Tax Actions that are being conducted with respect to a Huntington Entity, and during the Lookback Period no Huntington Entity has received any written notices from any Governmental Entity that any such Tax Action is currently pending.

(d) There exists no outstanding notice of deficiency or proposed Tax assessment against a Huntington Entity.

(e) All Taxes that a Huntington Entity was required by applicable Law to withhold or collect during the Lookback Period have been duly withheld or collected and, to the extent required by applicable Law, have been paid to the proper Governmental Entity.

(f) No Huntington Entity is a party to any Tax allocation, sharing, indemnity, or reimbursement agreement or arrangement that is primarily related to Taxes, and no Huntington Entity is liable for the Taxes of any other Person as a transferee or successor.

4.12 Certain Affiliations.

(a) The Affiliation does not confer any personal financial benefit on any officer, director, employee, doctor, medical group or other entity affiliated with Huntington or any family member of any such person as identified in California Corporations Code section 5227(b)(2).

(b) No officer, trustee or director of Huntington (or any family member of such persons as identified in California Corporations Code section 5227(b)(2)) or any Affiliate of Huntington has any personal financial interest in any company, firm, partnership, or business entity (other than salary and directors/trustees' fees) currently doing business with Huntington or any Affiliate of Huntington.

4.13 Intellectual Property. Each Huntington Entity owns or has sufficient right to use all Huntington Entity Intellectual Property Assets (as defined below) that are necessary for the operation of the business of such Huntington Entity as it is currently conducted. For purposes of this Agreement, "***Huntington Entity Intellectual Property Assets***" means, for each Huntington Entity: (i) the name of the Huntington Entity, all fictional business names, trade names, registered and unregistered trademarks, service marks and applications for same; (ii) all patents and patent applications; (iii) all copyrights in both published works and unpublished works; (iv) all rights in mask works; and (v) all know-how, trade secrets, confidential information, customer lists, software, technical information, data, process technology, plans, drawings and blueprints and other intellectual property rights owned, used or licensed by the Huntington Entity as licensee or licensor.

4.14 Insurance.

(a) Schedule 4.14 includes a list of all insurance policies (including the policy type, carrier, retention, term and claim limits) to which a Huntington Entity is a party and that provide coverage to a Huntington Entity or the business of a Huntington Entity, or any director, manager or officer of a Huntington Entity (the "***Huntington Entity Insurance Policies***"). All Huntington Entity Insurance Policies: (i) are valid, outstanding, and enforceable, subject to the

Enforceability Exceptions; (ii) are sufficient for compliance in all material respects with all applicable Contracts to which a Huntington Entity is a party; and (iii) except for workers compensation insurance maintained by a Huntington Entity, do not provide for any retrospective premium adjustment or other experienced-based liability on the part of a Huntington Entity. The consummation of the Affiliation by Huntington does not result in a default under any of the Huntington Entity Insurance Policies.

(b) Each Huntington Entity has paid all premiums due, and has otherwise performed all of its obligations in all material respects, under each Huntington Entity Insurance Policy to which the Huntington Entity is a party or that provides coverage to the business of the Huntington Entity or any officers, directors or managers thereof.

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

4.16 Membership. Huntington has no members (as defined in Section 5056 of the California Corporations Code), and Huntington is the sole member of HHP.

4.17 Due Diligence. Huntington has used good faith efforts to make available to Parent the information in a Huntington Entity's possession that is responsive to that certain Due Diligence Request list originally provided by Parent to Huntington on March 13, 2020, that certain follow-up due diligence request list dated April 16, 2020 and that certain follow-up due diligence request list dated May 15, 2020. To Huntington's Knowledge, all such information made available does not contain any untrue statement of material fact.

Article V

REPRESENTATIONS AND WARRANTIES OF TRUST

Except as otherwise set forth on the schedules prepared by the Trust, dated as of the Execution Date and updated pursuant to Section 7.2 (collectively, "***Trust Schedules***"), the Trust represents and warrants to Parent and Huntington as of the Execution Date, as follows:

5.1 Power, Absence of Conflicts.

(a) The Trust is a trust under the laws of the State and has all requisite trust power and authority to carry on its business in the State as now conducted and to own the assets and properties now owned or leased and operated by the Trust. The Trust is not licensed, qualified or admitted to do business in any jurisdiction other than the State, and there is no other jurisdiction in which the ownership, use or leasing of any asset or property owned by the Trust, or the conduct or nature of the business operated by the Trust, makes such licensing, qualification or admission necessary. The Trust has provided Parent with complete and correct copies of the Testamentary Trust under the Will of Henry E. Huntington and court orders that set forth the terms of the Trust, the Trust's powers and purposes, and the governance of the Trust.

(b) Subject to receipt of the Court Approval: the Trust has all requisite trust power and authority to conduct its business as now being conducted, to execute, deliver and enter into this Agreement, to consummate the Affiliation and to perform its obligations hereunder; the execution and delivery of this Agreement, and the consummation of the Affiliation, have been duly authorized by all necessary trust action on the part of the Trust, as required by Law; no other trust proceeding on the part of the Trust is necessary to authorize this Agreement and the Affiliation; and this Agreement has been duly executed and delivered by the Trust and (assuming that this Agreement constitutes a valid and binding agreement of the other Parties) is a legal, valid and binding obligation of the Trust, enforceable against the Trust in accordance with its terms, except to the extent of the Enforceability Exceptions.

(c) Subject to receipt of the Court Approval, the execution and delivery of this Agreement by the Trust does not, and the consummation of the Affiliation does not, (A) result in any breach or contravention of, or permit the acceleration of the maturity of, any material Encumbrances of the Trust encumbering the Huntington Hospital Land, (B) result in the creation of any material Encumbrances on any assets or properties owned by the Trust (other than Encumbrances created pursuant to the terms of this Agreement and the other agreements and documents executed in connection with the consummation of the Affiliation), (C) conflict with, or result in any violation or breach of any provision of the Governing Documents of the Trust, or (D) conflict with or result in a breach of, or give rise to a right of termination or amendment of or loss of benefit under, or accelerate the performance required by the terms of any judgment, court order or consent decree, or any material Contract or constitute a default thereunder for the Trust; except, in the case of clauses (A), (B), (C) and (D) above, for any matter which is not, individually or in the aggregate, reasonably expected to constitute a Material Adverse Change of the Trust.

5.2 Third-Party Rights. Aside from this Agreement, the Master Lease, the HMRI Lease and Permitted Liens, there are no Contracts with, or rights of, any Person to acquire, directly or indirectly, the Trust's interest in the Huntington Hospital Land, or any material interest therein.

5.3 Huntington Hospital Land.

(a) The Huntington Hospital Land comprises all of the real property owned or leased by the Trust that is currently being used by a Huntington Entity in its operations.

(b) The Trust has not received written notice within the Lookback Period of condemnation or similar proceeding relating to a government taking relating to the Huntington Hospital Land or any part thereof, other than ordinary course requirements by Governmental Entities in connection with development and construction projects or public works or infrastructure that do not have a material adverse effect on the use or value of the Huntington Hospital Land as currently being used.

(c) The Trust has leased the Huntington Hospital Land pursuant to the Master Lease and the HMRI Lease, and has no rights of possession or occupancy of the Huntington Hospital Land. To the Trust’s Knowledge, the Trust has not received any written notice of any material default or breach on the part of the landlord under the Master Lease or the HMRI Lease

which has not been cured, nor does there exist any such default or breach on the part of the landlord.

(d) The Trust is not engaged in any construction or capital projects currently in progress with respect to the Huntington Hospital Land.

5.4 Environmental Matters. With respect to the Huntington Hospital Land, to the Trust's Knowledge, (i) the Trust is not subject to any pending Action or any other material liability arising under any Environmental Laws and (ii) no circumstances exist that are reasonably expected to constitute a material violation of Environmental Laws by the Trust. During the three (3) year period prior to the Execution Date, the Trust has not received any written communication from any Person alleging that the Trust or Huntington is in violation of Environmental Laws.

5.5 Litigation. There are no material Actions pending or, to the Trust's Knowledge, threatened in writing against the Trust or, to the Trust's Knowledge, with respect to the Huntington Hospital Land. To the Trust's Knowledge, there are no material investigations pending or threatened in writing against the Trust or with respect to the Huntington Hospital Land. There is no pending or, to the Trust's Knowledge, threatened in writing, litigation, arbitration or other proceeding involving the Trust with respect to the Huntington Hospital Land before any court, arbitrator or governmental, regulatory or administrative body or authority that is reasonably expected to prevent or materially delay or adversely affect the consummation of the Affiliation or the transfer of the Huntington Hospital Land contemplated herein.

5.6 Tax and Tax Exempt Status. The Trust is recognized as exempt from federal income taxation under Code Section 501(a) as an organization described in Code Section 501(c)(3) and is recognized as exempt from State income taxation.

5.7 Certain Affiliations.

(a) The Affiliation does not confer any personal financial benefit on any officer, director, employee, doctor, medical group or other entity affiliated with the Trust or any family member of any such person as identified in California Corporations Code section 5227(b)(2).

(b) No trustee of the Trust (or any family member of such persons as identified in California Corporations Code section 5227(b)(2)) or any Affiliate of the Trust has any personal financial interest in any company, firm, partnership, or business entity (other than salary and directors/trustees' fees) currently doing business with the Trust or any Affiliate of the Trust.

Article VI

REPRESENTATIONS AND WARRANTIES OF PARENT

Except as otherwise set forth on the schedules prepared by Parent, dated as of the Execution Date and updated pursuant to Section 7.2 (collectively, "***Parent Schedules***"), Parent represents and warrants to Huntington and the Trust as of the Execution Date, as follows:

6.1 Organization, Power, Absence of Conflicts

(a) Organization and Good Standing of Parent. Parent is a nonprofit corporation duly incorporated, validly existing and in good standing under the laws of the State and has all requisite corporate power and authority to carry on its business in the State and to own or lease and operate the Parent Assets now owned or leased and operated by it. Parent is not licensed, qualified or admitted to do business in any jurisdiction other than the State as now conducted, and there is no other jurisdiction in which the ownership, use or leasing of any Parent Asset, or the conduct or nature of the Parent Operations, makes such licensing, qualification or admission necessary.

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

(i) Parent has all requisite corporate power and authority, to execute, deliver and enter into this Agreement, to consummate the Affiliation and to perform its obligations hereunder. The execution and delivery of this Agreement, and the consummation of the Affiliation, have been duly authorized by all necessary corporate action on the part of Parent, as required by Law. No other corporate proceeding on the part of Parent is necessary to authorize this Agreement and the Affiliation. This Agreement has been duly executed and delivered by Parent and (assuming that this Agreement constitutes the valid and binding agreement of the other Parties) is a legal, valid and binding obligation of Parent, enforceable against Parent in accordance with its terms, except to the extent of the Enforceability Exceptions.

(ii) The execution and delivery by Parent of this Agreement does not, and the consummation of the Affiliation does not, (A) result in any breach or contravention of, or permit the acceleration of the maturity of, any material Encumbrances of any Parent Entity, (B) result in the creation of any material Encumbrances on the Parent Assets (other than Encumbrances created pursuant to the terms of this Agreement and the other agreements and documents executed in connection with the consummation of the Affiliation), (C) conflict with, or result in any violation or breach of any provision of the Governing Documents of any Parent Entity, or (D) conflict with or result in a breach of, or give rise to a right of termination or amendment of or loss of benefit under, or accelerate the performance required by the terms of any judgment, court order or consent decree, or any material Contract or constitute a default thereunder for any Parent Entity; except, in the case of clauses (A), (B), (C) and (D) above, for any matter which is not, individually or in the aggregate, reasonably expected to constitute a Material Adverse Change of Parent.

(c) Organization and Good Standing of CSMC. CSMC is a nonprofit corporation duly incorporated, validly existing and in good standing under the laws of the State

and has all requisite corporate power and authority to carry on its business in the State and to own or lease and operate the Parent Assets now owned or leased and operated by it. CSMC is not licensed, qualified or admitted to do business in any jurisdiction other than the State, and there is no other jurisdiction in which the ownership, use or leasing of any Parent Asset, or the conduct or nature of the Parent Operations, makes such licensing, qualification or admission necessary.

6.2 Third-Party Rights. There are no Contracts with, or rights of, any Person to acquire, directly or indirectly, any material Parent Assets, or any interest therein.

6.3 Legal Compliance.

(a) To Parent's Knowledge, no Parent Entity is or, during the Lookback Period, has been in material violation of any Laws. To Parent's Knowledge, during the Lookback Period, each Parent Entity has timely filed all reports, data and other information required to be filed with Governmental Entities. To Parent's Knowledge, during the Lookback Period, no Parent Entity has received written notice of any proceeding or investigation by Governmental Entities against the Parent Entity alleging or based upon a material violation of any Laws that is currently pending. To Parent's Knowledge, no Parent Entity has been threatened by any Person with any proceeding or investigation by Governmental Entities against the Parent Entity alleging a violation of any Laws with respect to the Parent Operations.

(b) To Parent's Knowledge, each Parent Entity has (i) developed a compliance plan for being in compliance with the Health Information Laws, and (ii) during the Lookback Period, has used commercially reasonable efforts to implement those provisions of such compliance plan in all respects necessary to ensure that the applicable Parent Operations are not in violation of the Health Information Laws.

(c) Each Parent Entity and each Parent Healthcare Service meets all requirements of participation, claims submission and payment of the Government Payment Programs and, to Parent's Knowledge, other third-party payment programs and is a party to valid participation agreements for payment by such Government Payment Programs and, to Parent's Knowledge, other third-party payment programs, as applicable. No Parent Entity nor, to Parent's Knowledge, any of their respective officers, directors, employees, agents or contractors is currently excluded from participation in any Government Payment Program.

(d) Each Parent Entity and Parent Healthcare Service, as applicable, is qualified for participation in and has current and valid provider Contracts with, the Government Payment Programs and/or their fiscal intermediaries or paying agents and is not in material violation of the conditions of participation therein. To Parent's Knowledge, there are no material Government Payment Program recoupments or material recoupments of any third-party payor being sought, requested, claimed, or threatened against any Parent Entity. To Parent's Knowledge: (i) there is no Action or investigation pending, received or threatened against any Parent Entity which relates in any way to a violation of any Law pertaining to the Government Payment Programs or which is reasonably expected to result in the imposition of material penalties on or the exclusion of any Parent Entity or any Parent Healthcare Service from participation in any Government Payment Programs, and (ii) no Parent Entity is engaged in any activities which are cause for civil penalties or mandatory or permissive exclusion from any

Government Payment Program. No Parent Entity is a party to any corporate integrity agreements, deferred prosecution agreements, monitoring agreements, consent decrees, settlement orders, plans of correction or similar agreements imposed by any Governmental Entity.

(e) No Parent Entity, as applicable, is in material violation of any Laws regarding the selection, deselection, and credentialing of contracted providers, including verification of licensing status and eligibility for reimbursement under the Government Payment Programs. Each Parent Entity's contracted providers are properly licensed and hold appropriate clinical privileges, as applicable, for the services which they provide, and, with respect to providers that perform services eligible for reimbursement under any Government Payment Program, are not debarred or excluded from any such Government Payment Program.

(f) During the Lookback Period, all material reports, data, and information required to be filed by any Parent Entity in connection with any Government Payment Program have been timely filed and were true and complete at the time filed (or were corrected in or supplemented by a subsequent filing). There are no Actions or appeals pending (and no Parent Entity has made any filing or submission that, to Parent's Knowledge, is reasonably expected to result in any Actions or appeals) before any court, regulatory body, administrative agency, governmental body, arbitrator or other Governmental Entity (including governmental administrative contractors) with respect to any Government Payment Program reports or claims filed by any Parent Entity, during the Lookback Period, or with respect to any disallowances by any regulatory body, administrative agency, governmental body or other authority (including governmental administrative contractors) in connection with any audit taking place during the Lookback Period. No material validation review or program integrity review related to any Parent Entity or any Parent Healthcare Service has been conducted by any regulatory body, administrative agency, governmental body or other authority (including governmental administrative contractors) in connection with any Government Payment Program within the past five (5) years and, to Parent's Knowledge, no such reviews are scheduled, pending, or threatened against or affecting any Parent Entity or any Parent Healthcare Service.

(g) Each Parent Entity holds all material Licenses necessary for such Parent Entity's operations and the assets involved in such Parent Entity's operations. All such Licenses are in good standing and, to Parent's Knowledge, are not subject to meritorious challenge. To Parent's Knowledge, the Parent Operations and Parent Healthcare Services are not in material violation of such Licenses.

6.4 Parent Financial Statements. Copies of the Parent Financial Statements have been made available to Huntington. The Parent Financial Statements fairly present in all material respects the financial condition and results of operations of the Parent Operations as of the respective dates thereof and for the period therein referred to, subject to normal recurring year-end adjustments and the absence of notes; and the Parent Financial Statements reflect the consistent application of GAAP throughout the periods involved.

6.5 Absence of Material Change. Since the date of the last Parent Financial Statements, to Parent's Knowledge, there has not been any event, change, occurrence or

circumstance that has had or is reasonably expected to have a Material Adverse Change of Parent.

6.6 Real Property.

(a) The Parent Real Property comprises all of the real property owned or leased by the Parent Entities.

(b) To Parent's Knowledge, no Parent Entity has received from any Governmental Entity any written notice of condemnation relating to the Parent Real Property or any part thereof.

(c) Except for those tenants in possession of the Parent Real Property under Contracts, to Parent's Knowledge there are no Persons in possession of, or claiming any possession, adverse or not, to or other interest in, any portion of the Parent Real Property other than a Parent Entity, whether as lessees, tenants at sufferance, trespassers or otherwise. To Parent's Knowledge, during the Lookback Period no Parent Entity has received any written notice of any material default or breach on the part of the landlord under any lease of Parent Real Property which has not been cured, nor does there exist any such default or breach on the part of the landlord.

(d) Schedule 6.6(d) identifies all those construction or capital projects currently in progress with respect to the Parent Real Property for which all final approvals needed from Governmental Entities have not been obtained.

6.7 Environmental Matters.

(a) To Parent's Knowledge, (i) no Parent Entity is subject to any Action or any other material liability arising under any Environmental Laws and (ii) no circumstances exist that are reasonably expected to constitute a material violation of Environmental Laws by any Parent Entity. During the three (3) year period prior to the Execution Date, to Parent's Knowledge, no Parent Entity has received any written communication from any Person alleging that any Parent Entity is in violation of Environmental Laws.

(b) No Parent Entity is in material violation of Environmental Laws, and during the three (3) year period prior to the Execution Date, there has been no material Environmental Claim pending or, to Parent's Knowledge, threatened against any Person whose liability for any Environmental Claim has been retained or assumed either contractually or by operation of law by a Parent Entity.

6.8 Employment Matters.

(a) Employee and Employee Relations.

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

(ii) To Parent's Knowledge, no employees of any Parent Entity are represented by, or are demanding recognition of, a labor union or employee organization with respect to their work at the Parent Operations.

(iii) To Parent's Knowledge, there are no other union organizing or collective bargaining activities by or with respect to any employees of any Parent Entity with respect to such employment.

(iv) To Parent's Knowledge, Parent is not, and during the Lookback Period has not been, in material violation of any material obligations under any Plant Closure Laws as a result of the Parent Operations.

(b) Pending Proceedings. There are no active, pending or, to Parent's Knowledge, threatened material administrative or judicial proceedings under Title VII of the Civil Rights Act of 1964, the Age Discrimination in Employment Act, the Fair Labor Standards Act, the Occupational Safety and Health Act, the National Labor Relations Act, the Fair Employment and Housing Act, the California Labor Code, ERISA or any other foreign, federal, state or local law (including common law), ordinance or regulation relating to current employees contingent workers, or former employees or contingent workers, of any Parent Entity. No employee or independent contractor of a Parent Entity is entitled to receive any compensation, payment, or remuneration from any Party as a result of the execution and delivery of this Agreement or the occurrence of the Closing.

6.9 Employee Benefit Plans.

(a) Parent does not maintain any employee benefit program.

(b) Each Parent Employee Benefit Program that is intended to qualify under Section 401(a) of the Code has received a favorable determination or opinion letter from the IRS regarding its qualification thereunder, and, to Parent's Knowledge, no event has occurred during the Lookback Period and no condition exists that is reasonably expected to result in the loss of such tax-qualified status or the imposition of any liability, penalty or tax under ERISA, the Code or any other Laws. To Parent's Knowledge, with respect to each Parent Employee Benefit Program, all material reports, returns, notices, and other documentation that are required to have been filed with or furnished by Parent to the IRS, the DOL, the PBGC, the SEC, or any other Governmental Entity, or to the participants or beneficiaries of such Parent Employee Benefit Program, during the Lookback Period, have been filed or furnished on a timely basis.

(c) With respect to each Parent Employee Benefit Program, Parent has made available to Huntington (if applicable to such Parent Employee Benefit Program): (i) all documents embodying or governing such Parent Employee Benefit Program, including summary plan descriptions, and any funding medium for such Parent Employee Benefit Program (including plan documents, trust agreements and amendments thereto); (ii) the most recent IRS determination letter with respect to such Parent Employee Benefit Program under Code Section 401(a); (iii) Form 5500 annual reports for the last three (3) plan years for all Parent Employee Benefit Programs that require such filings; and (iv) any insurance policy related to such Parent Employee Benefit Program.

(d) Each Parent Employee Benefit Program has been established, operated, and administered in all material respects in accordance with the requirements of Law, including ERISA and the Code, and is being administered and operated in all material respects in accordance with its terms, and is being administrated in a manner that avoids the imposition of material penalties imposed by Law, including penalty taxes. No Parent Employee Benefit Program is subject to Title IV of ERISA or is a Multiemployer Plan, within the meaning of ERISA Section 3(37) and no Parent Entity or any ERISA Affiliate has within the past six (6) years sponsored, maintained, contributed to or had any liability in respect to any employee benefit plan subject to Title IV of ERISA or any Multiemployer Plan.

(e) Neither any Parent Employee Benefit Program fiduciary nor any Parent Employee Benefit Program has engaged in any transaction in violation of Section 406 of ERISA or any "prohibited transaction" (as defined in Section 4975(c)(1) of the Code), which transaction is not exempt under Section 4975(d) of the Code or Section 408 of ERISA and which is reasonably expected to result in material liability under ERISA or the Code. To Parent's Knowledge, no Parent Entity or ERISA Affiliate or any Person appointed or otherwise designated to act on behalf of such Parent Entity or such ERISA Affiliate, has engaged in any transactions in connection with any Parent Employee Benefit Program that is reasonably expected to result in the imposition of a material penalty pursuant to Section 502(i) of ERISA, material damages pursuant to Section 409 of ERISA or a material Tax pursuant to Section 4975(a) of the Code.

(f) To Parent's Knowledge, no administrative investigation, audit or other administrative proceeding by the DOL, the PBGC, the Internal Revenue Service or any other Governmental Entity is pending, with respect to any Parent Employee Benefit Program. There is no pending, or to Parent's Knowledge, threatened, legal action, proceeding, or investigation, other than routine claims for benefits, concerning any of the Parent Employee Benefit Programs, or, any fiduciary or service provider thereof. No Parent Entity has liability by virtue of its being a member of a controlled group with a person who has liability under the Code or ERISA.

(g) No Employee Welfare Benefit Plan which is a group health plan (within the meaning of Section 5000(b)(1) of the Code) is in material violation of the requirements of Section 4980B of the Code and Part 6 of Subtitle B of Title I of ERISA. As presently constituted, no Parent Employee Benefit Program provides for health or welfare benefits (other than as required pursuant to Section 4980B of the Code or pursuant to State health continuation laws) to any current or future retiree or former employee beyond the month of termination. No Parent Entity is in material violation of requirements to report to the IRS under the Affordable Care Act, and the Internal Revenue Service has not imposed any penalties or assessments as a result of such reporting obligations.

(h) The execution and delivery of this Agreement and the consummation of the Affiliation do not result in (A) any increase in severance pay otherwise due upon any termination of employment after the Execution Date; (B) the acceleration of the time of payment or vesting or result in any funding of compensation or benefits; (C) any payment, compensation or benefit becoming due, or increase in the amount of any payment, compensation or benefit due, to any current or former employee of any Parent Entity; (D) any new obligation pursuant to any Parent Employee Benefit Program; (E) payment of compensation that results in an "excess

parachute payment" within the meaning of Section 280G of the Code; or (F) any limitation or restriction on the right of any Parent Entity to merge, amend or terminate any Parent Employee Benefit Program.

(i) No Parent Employee Benefit Program that is a "nonqualified deferred compensation plan" (as defined under Section 409A of the Code) has been operated and administered in material violation of Section 409A of the Code, and no compensation is includable in the gross income of any current or former employee, officer, director or consultant of any Parent Entity or any ERISA Affiliate as a result of the operation of Section 409A of the Code with respect to any applicable arrangements or agreements in effect prior to the Closing. No agreements to provide Code Section 409A gross-ups are in place with respect to any employee or director of a Parent Entity.

6.10 Litigation. There are no material Actions pending or, to Parent's Knowledge, threatened in writing against any Parent Entity or, to Parent's Knowledge, with respect to any Parent Assets. To Parent's Knowledge, there are no material investigations pending or threatened in writing against any Parent Entity. There is no pending or, to Parent's Knowledge, threatened in writing, litigation, arbitration or other proceeding involving any Parent Entity or, to Parent's Knowledge, Parent Assets before any court, arbitrator or governmental, regulatory or administrative body or authority that is reasonably expected to prevent or materially delay or adversely affect the consummation of the Affiliation.

6.11 Tax and Tax Exempt Status.

(a) Each Parent Entity is recognized as exempt from federal income taxation under Code Section 501(a) as an organization described in Code Section 501(c)(3) and is also recognized as exempt from State income taxation.

(b) Each Parent Entity has filed or caused to be filed, on a timely basis, all Tax Returns that were required to be filed during the Lookback Period by such Parent Entity, in accordance with applicable Law. All such Tax Returns are true, correct and complete in all material respects. Each Parent Entity has paid all Taxes due and payable by such Parent Entity (whether or not shown on any Tax Return).

(c) There are no audits or administrative or judicial Tax Actions that are being conducted with respect to a Parent Entity, and, during the Lookback Period, no Parent Entity has received any written notices from any Governmental Entity that any such Tax Action is currently pending.

(d) There exists no outstanding notice of deficiency or proposed Tax assessment against a Parent Entity.

(e) All Taxes that a Parent Entity was required by applicable Law to withhold or collect during the Lookback Period have been duly withheld or collected and, to the extent required by applicable Law, have been paid to the proper Governmental Entity.

(f) No Parent Entity is a party to any Tax allocation, sharing, indemnity, or reimbursement agreement or arrangement that is primarily related to Taxes, and no Parent Entity is liable for the Taxes of any other Person as a transferee or successor.

6.12 Certain Affiliations.

(a) The Affiliation does not confer any personal financial benefit on any officer, director, employee, doctor, medical group or other entity affiliated with Parent or any family member of any such person as identified in California Corporations Code section 5227(b)(2).

(b) No officer, trustee or director of Parent (or any family member of such persons as identified in California Corporations Code section 5227(b)(2)) or any Affiliate of Parent has any personal financial interest in any company, firm, partnership, or business entity (other than salary and directors/trustees' fees) currently doing business with Parent or any Affiliate of Parent.

6.13 Intellectual Property. Each Parent Entity owns or has sufficient right to use all Parent Entity Intellectual Property Assets (as defined below) that are necessary for the operation of the business of such Parent Entity as it is currently conducted. For purposes of this Agreement, "***Parent Entity Intellectual Property Assets***" means, for each Parent Entity: (i) the name of the Parent Entity, all fictional business names, trade names, registered and unregistered trademarks, service marks and applications for same; (ii) all patents and patent applications; (iii) all copyrights in both published works and unpublished works; (iv) all rights in mask works; and (v) all know-how, trade secrets, confidential information, customer lists, software, technical information, data, process technology, plans, drawings and blueprints and other intellectual property rights owned, used or licensed by the Parent Entity as licensee or licensor.

6.14 Insurance.

(a) All insurance policies to which a Parent Entity is a party or that provide coverage to a Parent Entity or the business of a Parent Entity, or any director, manager or officer of a Parent Entity (the "***Parent Entity Insurance Policies***"): (i) are valid, outstanding, and enforceable, subject to the Enforceability Exceptions; (ii) are sufficient for compliance in all material respects with all applicable Laws and Contracts to which a Parent Entity is a party; and (iii) except for workers compensation insurance maintained by a Parent Entity, do not provide for any retrospective premium adjustment or other experienced-based liability on the part of a Parent Entity. The consummation of the Affiliation by Parent does not result in a default under any of the Parent Entity Insurance Policies.

(b) Each Parent Entity has paid all premiums due, and has otherwise performed all of its obligations in all material respects, under each Parent Entity Insurance Policy to which the Parent Entity is a party or that provides coverage to the business of the Parent Entity or any officers, directors or managers thereof.

6.15 Operation of the Parent Operations. To Parent's Knowledge, the Parent Assets constitute all assets, properties, goodwill and businesses necessary to conduct the Parent

Operations, in the aggregate and with respect to each Parent Healthcare Service, in all material respects in the manner in which the Parent Operations are currently conducted.

6.16 Membership. Parent has no members (as defined in Section 5056 of the California Corporations Code), and Parent is the sole member of CSMC and THA.

Article VII

PRE-CLOSING COVENANTS

7.1 Consents and Approvals. During the Interim Period, the Parties will use their commercially reasonable efforts and cooperate with each other and provide all necessary information to obtain at the earliest practical date all consents, waivers and approvals from, and provide all notices to, all Governmental Entities and other Persons required to consummate the Affiliation as promptly as practicable. In furtherance of the foregoing:

(a) California Attorney General.

(i) As soon as reasonably practicable following the Execution Date, Huntington shall notify the California Attorney General (the "***Attorney General***") in writing of the proposed Affiliation in accordance with Section 5920 of the California Corporations Code ("***Section 5920***"). As of the Execution Date, Parent and Huntington hereby agree that Parent has reviewed and approved Huntington's proposed written notice to the Attorney General, and that Huntington shall submit to the Attorney General the written notice in substantially the same form as reviewed and approved by Parent. Huntington shall use commercially reasonable efforts to provide such other information as the Attorney General shall request, and shall generally use its commercially reasonable efforts to obtain the Attorney General's approval of the Affiliation. Parent shall provide such information and communications to the Attorney General as Huntington or the Attorney General may reasonably request and shall otherwise cooperate with Huntington in obtaining the Attorney General's approval of the transaction.

(ii) Participation; No Consent. Each Party shall be entitled to participate, to the extent practicable, in conversations with personnel in the Office of the Attorney General in connection with the Affiliation. If the Attorney General challenges, objects to, prohibits, enjoins, places conditions upon or fails to provide any consent or approval required to complete the transaction contemplated by this Agreement, the Parties shall mutually agree on: (i) the acceptance of any conditions imposed on the transaction by the Attorney General, (ii) the decision to pursue any remedies a Party may have against the Attorney General, and/or (iii) the decision to contest or appeal the Attorney General's challenge, objection to, prohibition, enjoyment of, or failure to approve the transaction. In the event the Parties agree to take any action set forth in the foregoing sentence, each Party shall bear its own costs and expenses pertaining thereto.

(b) HSR Act.

(i) To the extent required by Law, Parent and Huntington agree to file the appropriate Notification and Report Form pursuant to the HSR Act with respect to the Affiliation as soon as reasonably practicable after the Execution Date. After filing, Parent and

Huntington agree to respond promptly to any requests for additional information by any such Governmental Entity and keep the other promptly apprised of any communications with, and inquiries or requests for information from, such Governmental Entity. Each of Parent and Huntington will take such action as required to resolve without delay any objections any such Governmental Entity may have to the Affiliation. Parent and Huntington each agree to request early termination of the waiting period under the HSR Act. In addition, Parent and Huntington each agree to promptly make any other filing that may be required under any antitrust law or by any antitrust authority and effect all other filings with and notifications to the government agencies in any other jurisdiction where such filings and notifications are required.

(ii) Parent and Huntington shall each instruct their respective counsel to cooperate with each other and use commercially reasonable efforts to facilitate and expedite the identification and resolution of any issues under any antitrust law and, consequently, expiration or termination of the applicable HSR Act waiting period at the earliest practicable date. Parent and Huntington shall supply each other with copies of all correspondence, filings or communications with antitrust authorities, with respect to the Affiliation; provided, however, that to the extent any of the documents or information are commercially or competitively sensitive, a Party may satisfy its obligations by providing such documents or information to the other Party's outside antitrust counsel, with the understanding that such antitrust counsel shall not share such documents and information with its client.

(c) Contracts. The Parties will cooperate with each another in a commercially reasonable manner to determine whether any consents, approvals and/or waivers are required to be obtained from third parties to Contracts to which a Huntington Entity is a party. Huntington, with Parent's reasonable cooperation, shall cause each Huntington Entity to use commercially reasonable efforts to seek to obtain any such consents, approvals and/or waivers; provided, that nothing in this Agreement will obligate or be construed to obligate any Party or any Huntington Entity to make or cause to be made any payment or concession to any third party in order to obtain any such action, consent, approval and/or waiver.

7.2 Schedule Updates.

(a) From time to time prior to the Closing, Huntington, Parent and the Trust will supplement or amend their respective Disclosure Schedules reasonably promptly in order to keep such information therein timely, complete and accurate. The supplements and/or amendments to the Disclosure Schedules will be arranged in sections corresponding to the numbered and lettered sections of this Agreement, but the disclosures in any section of the supplements and/or amendments to the Disclosure Schedules will qualify any other section in this Agreement to the extent such disclosure reasonably appears to be relevant to such other section, whether or not a specific cross-reference appears and whether or not a reference to the Disclosure Schedules (or the phrase "except as set forth" or any similar phrase) appears in such representations and warranties.

(b) Parent may not refuse to close as a result of any such supplement, update or correction unless an event or matter disclosed in such supplement, update or correction has had or is reasonably expected to constitute a Material Adverse Change of Huntington that causes

the condition in Section 10.2(a) (with respect to certain breaches of the representations and warranties of Huntington) not to be satisfied as of the Closing Date.

(c) Huntington may not refuse to close as a result of any such supplement, update or correction unless an event or matter disclosed in such supplement, update or correction has had or is reasonably expected to constitute a Material Adverse Change of Parent that causes the condition in Section 10.3(a) (with respect to certain breaches of the representations and warranties of Parent) not to be satisfied as of the Closing Date.

7.3 Negative Covenants of Parent. During the Interim Period, Parent shall not (and shall not agree to) take any action which would cause Huntington or the Trust to be in breach of any covenant, representation or warranty contained in this Agreement, or which would have a material adverse effect on the ability of any Party hereto to perform their respective covenants and agreements under this Agreement and the documents and agreements contemplated hereby, without the prior written consent of Huntington.

7.4 Negative Covenants of Huntington and the Trust. During the Interim Period, Huntington and the Trust shall not (and shall not agree to), and Huntington shall ensure that each Huntington Entity does not, take any action which would cause Parent to be in breach of any covenant, representation or warranty contained in this Agreement, or which would have a material adverse effect on the ability of any Party hereto to perform their respective covenants and agreements under this Agreement and the documents and agreements contemplated hereby, without the prior written consent of Parent.

7.5 Conduct of the Huntington Operations.

(a) During the Interim Period, except as expressly contemplated by this Agreement or as Parent otherwise consents to in writing, which consent shall not be unreasonably delayed, conditioned or withheld, Huntington shall conduct, and shall cause each Huntington Entity to conduct, the Huntington Operations in the ordinary course of business consistent with past practices. Without limiting the generality of the foregoing, except as expressly contemplated by this Agreement, Huntington shall, and shall cause each Huntington Entity to, in the ordinary course of business and consistent with past practices:

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

(ii) not enter into or materially change the terms of any employment agreement with any Huntington Entity employee, or increase the compensation, bonus or benefits of any Huntington Entity employee, except in the ordinary course of business; and

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

(b) Notwithstanding anything Section 7.5(a) to the contrary, it is acknowledged and agreed that during the Interim Period, each Party will make such changes to its operations as such Party deems necessary or appropriate to respond to novel coronavirus and/or COVID-19 and/or any of their effects, as well as orders or advisories of the president of the United States, the governor of the State and/or other Governmental Entities, including any conduct or suspension of any of the Huntington Operations and/or Parent Operations. In no event will any such changes or any continuation of any such changes constitute a breach of Section 7.5(a).

7.6 Due Diligence. During the Interim Period, each of Huntington and Parent shall give, and shall cause each of their Related Persons to give, to the other Party and its representatives, reasonable access during normal business hours to such Party's (and such Party's Related Persons) corporate, financial, litigation, insurance and personnel files, books, accounts, records and all other relevant documents and information as representatives of the requesting Party may from time to time request for any purpose related to its due diligence review of the other Party in connection with Affiliation, all in such manner as to not unduly disrupt normal business activities and in compliance with Law and any contractual obligations relating to confidentiality. The access to and disclosure of all such books, contracts and records shall be subject to and continued to be governed by the terms and conditions of that certain Confidentiality Agreement between Parent and Huntington dated as of July 2, 2019 (the "***NDA***"). Additionally, during the Interim Period, the Trust shall give to Parent and its representatives reasonable access during normal business hours to information, documents, books and records in the Trust's custody or control with respect to the Huntington Hospital Land or other such records that Parent may from time to time request which may reasonably be necessary for Parent's evaluation of the Affiliation, which access and disclosure shall also be subject to the terms and conditions of the NDA.

7.7 No Negotiation. During the Interim Period:

(a) Huntington and its Related Persons will not directly or indirectly engage in a member substitution transaction, or a transaction that otherwise provides for one or more third parties to become the sole or controlling member of Huntington, with anyone but Parent; solicit, initiate, or encourage any proposal relating to any transaction similar to or adversely affecting the ability of Huntington to engage in the Affiliation with Parent, including any merger, sale or similar transaction; participate in any negotiations regarding or furnish to any other Person any non-public information with respect to any such proposal; encourage any effort by any Person to do any of the foregoing; approve, endorse or recommend any such proposal with any other parties; enter into any letter of intent or similar document or any contract or commitment with any other parties relating to any such proposal; or permit any of their respective directors, officers, employees, attorneys, advisors or representatives to do any of the foregoing.

(b) Parent and its Related Persons will not directly or indirectly engage in a Competing Transaction (defined below); solicit, initiate, or encourage any proposal relating to a Competing Transaction; participate in any negotiations regarding or furnish to any other Person any non-public information with respect to a Competing Transaction; encourage any effort by any Person to do any of the foregoing; approve, endorse or recommend any Competing Transaction with any other parties; enter into any letter of intent or similar document or any contract or commitment with any other parties relating to any Competing Transaction; or permit any of their respective directors, officers, employees, attorneys, advisors or representatives to do any of the foregoing. In addition, during the Interim Period, neither Parent nor any of its Related Persons will directly or indirectly solicit, initiate, or encourage any physician on the medical staff of Huntington to move the physician's practices from Huntington; or permit any of their respective directors, officers, employees or representatives to do any of the foregoing; provided that nothing in this Section 7.7 specifically shall prohibit Parent or any of its Related Persons from (a) hiring a physician who applies to an advertisement placed in the ordinary course, (b) granting or renewing any physician's medical staff membership or privileges to practice medicine at any hospital or other facility affiliated with Parent that maintains an organized medical staff, or (c) engaging any physician to provide call coverage services in such physician's medical specialty at any hospital affiliated with Parent. "***Competing Transaction***" means a transaction that is directly or indirectly related to or dependent upon the Affiliation, upon which the Affiliation would be dependent, that would make the Affiliation impractical or unfeasible or that is a Change of Control transaction with a hospital in the service area of Huntington.

7.8 Interim Financials. During the Interim Period, (a) Huntington will make available to Parent the unaudited, internal consolidated monthly balance sheet and statement of operations of the Huntington Consolidated Group reasonably promptly after they are made available to management of Huntington, and (b) Parent will make available to Huntington the unaudited, internal consolidated monthly balance sheet and statement of operations of Parent reasonably promptly after they are made available to management of Parent.

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

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

Article VIII

ADDITIONAL COVENANTS AND AGREEMENTS

8.1 Government Authorizations and Court Approval. Huntington shall promptly apply for and use good faith efforts to obtain, as promptly as practicable, all material Government Authorizations that are necessary to consummate the Affiliation. The Trust shall petition the court as promptly as practicable and use good faith efforts to obtain the Court

Approval, and Huntington and Parent shall reasonably cooperate with the Trust in seeking the Court Approval.

8.2 Transfer of Huntington Hospital Land.

(a) The Trust shall use commercially reasonable efforts to obtain a lot line adjustment (as defined in Section 66412(d) of the California Government Code) isolating the Huntington Hospital Land into its own separate legally alienable parcel(s) prior to the Closing Date (the "***Lot Line Adjustment***").

(b) The Trust shall obtain, as soon as reasonably practicable after the Execution Date, current as built ALTA/NSPS Land Title surveys of the Huntington Hospital Land that are in form reasonably satisfactory to Parent and the Title Company (the "***Surveys***"), which Surveys shall be delivered to Parent and the Title Company at least sixty (60) days prior to the Closing Date. Parent shall reimburse Huntington for the direct out-of-pocket costs incurred by Huntington and/or the Trust in obtaining the Surveys provided that Parent has approved such costs in advance; provided, however, that the Trust will pay all of the costs related to any Lot Line Adjustment for the Huntington Hospital Land, including, without limitation, the costs of the surveys related to any such Lot Line Adjustment. The Surveys shall be certified to Parent, Huntington and the Title Company.

(c) The Trust shall (i) cause the satisfaction, release or reconveyance of any all liens, charges, security interests, deeds of trust, or mechanic's liens (if any) encumbering the Huntington Hospital Land, other than Permitted Liens (collectively, "***Trust Monetary Liens***") and provide Parent with copies of satisfactions, releases, reconveyances or UCC-3 Termination Statements, as applicable, evidencing the removal of all such liens, charges, security interests or other encumbrances prior to the Closing Date, and/or (ii) cause the Title Company to issue the Title Policy (as such terms are defined below) pursuant to Section 8.2(e) without exception for Trust Monetary Liens as of the Closing Date.

(d) Subject to the successful completion of the Lot Line Adjustment, prior to the Closing Date the Trust shall deliver to the National Commercial Services Office selected by Parent of First American Title Insurance Company (the "***Title Company***") a duly executed and notarized quitclaim deed, in a form reasonably satisfactory to Parent, distributing title to the Huntington Hospital Land to Huntington (the "***Huntington Hospital Land Deed***"). The Parties agree that the Huntington Hospital Land Deed will be in substantially the form of Exhibit I attached hereto and made a part hereof.

(e) The Trust shall cause the Title Company to issue prior to or at Closing (or unconditionally commit prior to or as of Closing to issue), pursuant to the terms of the Title Company's ALTA Commitment for Title Insurance File No. NCS-1012328-MIA, a copy of which is attached hereto as Exhibit J and made a part hereof (the "***Title Commitment***"), an ALTA Form 2006 Owner's Title Policy (the "***Title Policy***") in an amount satisfactory to Parent and the Title Company, with the Title Company insuring that good and marketable fee simple title to the Huntington Hospital Land is vested in Huntington as of the Closing Date, subject only to Permitted Liens. The Title Policy shall have all standard and general exceptions deleted so as to afford full "extended form coverage," shall otherwise be in a form reasonably satisfactory to Parent, including

such endorsements as Parent may reasonably require, as committed in the Title Commitment. At the Closing Parent shall reimburse Huntington and/or the Trust for the applicable title premium due the Title Company for the Title Policy.

(f) As of the Closing Date, the Trust and Huntington shall terminate the Master Lease in the form attached hereto as Exhibit K, and the Trust shall assign its rights under the HMRI Lease to Huntington in the form attached hereto as Exhibit L.

8.3 Further Assurances. Parent, Huntington and the Trust shall execute and deliver such instruments, in form and substance mutually agreeable to Parent, Huntington and the Trust (as applicable) that are reasonably required in order to carry out the terms of this Agreement or the Affiliation.

Article IX

TERMINATION OF AGREEMENT

9.1 Termination of Agreement.

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

(b) Breach of Covenant. By written notice to the other Parties:

(i) This Agreement may be terminated by Parent at any time prior to the Closing if Huntington or the Trust has materially breached any of their respective covenants set forth in this Agreement when performance is due and does not cure the failure within twenty (20) Business Days after receipt of written notice thereof from Parent.

(ii) This Agreement may be terminated by Huntington at any time prior to the Closing if Parent has materially breached any of its covenants set forth in this Agreement when performance is due and does not cure the failure within twenty (20) Business Days after receipt of written notice thereof from Huntington.

(c) Breach of Representation. By written notice to the other Parties:

(i) This Agreement may be terminated by Parent at any time prior to the Closing if Huntington or the Trust has materially breached any of their respective representations or warranties set forth in Article IV or Article V such that satisfaction of the condition in Section 10.2(a) by the Drop Dead Date becomes impossible.

(ii) This Agreement may be terminated by Huntington at any time prior to the Closing if Parent has materially breached any of its representations or warranties set forth in Article VI such that satisfaction of the condition in Section 10.3(a) by the Drop Dead Date becomes impossible.

(d) Failure of Condition. This Agreement may be terminated by Parent or Huntington if the Closing has not occurred on or before March 31, 2021 (the "***Drop Dead***

Date"); provided, however, that (i) Parent shall not be permitted to terminate this Agreement if the Closing is delayed beyond the Drop Dead Date by the breach of a covenant by Parent or the failure of a condition which was Parent's responsibility to fulfill; and (ii) Huntington shall not be permitted to terminate this Agreement if the Closing is delayed beyond the Drop Dead Date by the breach of a covenant by Huntington or the Trust or the failure of a condition which was Huntington's or the Trust's responsibility to fulfill.

9.2 Effect of Termination. If this Agreement is terminated as permitted by Section 9.1, such termination will be without liability of Parent, Huntington, the Trust or a Nonrecourse Person to any of the foregoing, except that the provisions of Section 1.2 (Rules of Interpretation), this Section 9.2 (Effect of Termination), Article XII (Protective Provisions), Article XV (Remedies) and Article XVI (Miscellaneous) and all provisions of the NDA will remain in full force and effect and survive any termination of this Agreement.

Article X

CONDITIONS TO CLOSING

10.1 Mutual Conditions. The respective obligations of Parent and Huntington to effect the Affiliation are subject to the satisfaction or waiver on or prior to the Closing Date of the following conditions:

(a) The waiting period pursuant to the HSR Act and any extensions thereof shall have expired or been terminated.

(b) The Attorney General shall have issued its approval of the Affiliation with terms of approval comparable to other recent nonprofit hospital acquisitions.

(c) No law that makes consummation of the Closing illegal will have been enacted, promulgated or issued by a government agency with authority to enforce such law.

(d) No order by a court or other Governmental Entity of competent jurisdiction preventing the consummation of the Affiliation will be in effect; provided that a party invoking this condition shall have used use all commercially reasonable efforts to have any such order vacated or invalidated.

(e) No Action challenging this Agreement or the Affiliation or seeking to prohibit, alter, prevent or materially delay the Affiliation will have been instituted and be pending; provided that a party invoking this condition must have used use all commercially reasonable efforts to have any such Action dismissed.

(f) All Government Authorizations that are listed in Annex 10.1(f) shall have been obtained.

(g) The consents and approvals of third parties listed in Annex 10.1(g) shall have been obtained.

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

(a) Accuracy of Representations and Warranties.

(i) The representations and warranties of Huntington set forth in Article IV, as amended in accordance with Section 7.2, shall be true and correct as of the Closing Date, as though then made, except (i) for changes contemplated by this Agreement, (ii) to the extent a representation or warranty is made as of a specific date and (iii) where the failure of any such representations or warranties to be true and correct is not reasonably expected to constitute a Material Adverse Change of Huntington.

(ii) The representations and warranties of Trust set forth in Article V, as amended in accordance with Section 7.2, shall be true and correct as of the Closing Date, as though then made, except (i) for changes contemplated by this Agreement, (ii) to the extent a representation or warranty is made as of a specific date and (iii) where the failure of any such representations or warranties to be true and correct is not reasonably expected to constitute a Material Adverse Change of Huntington.

(b) Performance of Covenants and Agreements.

(i) Huntington shall have performed in all material respects all covenants and agreements contained in this Agreement required to be performed by Huntington before the Closing, including Huntington's obligation to supplement or amend its Disclosure Schedules, as necessary, in accordance with Section 7.2.

(ii) The Trust shall have performed in all material respects all covenants and agreements contained in this Agreement required to be performed by the Trust before the Closing, including the Trust's obligation to supplement or amend its Disclosure Schedules, as necessary, in accordance with Section 7.2.

(c) Bring-Down Certificate.

(i) Huntington shall have delivered to Parent a bring-down certificate to the effect of Sections 10.2(a)(i) and (b)(i).

(ii) The Trust shall have delivered to Parent a bring-down certificate to the effect of Sections 10.2(a)(ii) and (b)(ii).

(d) Other Certificates. The Trust shall have delivered to Parent one or more certificates as to the authority of the trustees of the Trust to execute and deliver this Agreement.

(e) Approval of Documentation. The form and substance of all certificates, documents, consents (including the Court Approval) and agreements contemplated hereby and required to be delivered to Parent at the Closing shall be reasonably satisfactory to Parent's counsel.

(f) Huntington Material Adverse Change. There shall have been no Material Adverse Change of Huntington since the Execution Date.

(g) Deliveries at Closing. All of the deliverables described in Section 11.2 shall have been provided to Parent.

(h) Transfer of Huntington Hospital Land. Each of the following shall have occurred prior to or as of the Closing Date with respect to the distribution of the Huntington Hospital Land by the Trust to Huntington:

(i) The Lot Line Adjustment shall have been completed to the reasonable satisfaction of Parent.

(ii) Parent shall have received copies of the Surveys as contemplated in Section 8.2(b).

(iii) The Title Company shall have received the Huntington Hospital Land Deed fully executed and notarized, and the Huntington Hospital Land Deed shall be duly recorded in the Official Records of Los Angeles County prior to or at Closing. The Title Company shall also have received from the Trust payment of all costs associated with the recording of the Huntington Hospital Land Deed, including, without limitation, all recording costs and documentary transfer taxes applicable to the Huntington Hospital Land Deed, if any. Upon Closing the Title Company shall deliver a certified copy of the recorded Huntington Land Deed to Huntington with copies to the Trust and Parent.

(iv) The Title Company shall have received from the Trust (1) the original satisfactions, releases or re-conveyances for each of the Trust Monetary Liens, which shall be recorded by the Title Company prior to or on the Closing Date in the Official Records of Los Angeles County, together with payment from the Trust of the costs of recording the same, or such other documentation as required by the Title Company to issue the Title Policy without exception for Trust Monetary Liens at the time the Huntington Hospital Land Deed is recorded, and (2) such affidavits, FIRPTA certificates, recording receipts, notices, and any such other documentation reasonably required by the Title Company to issue the Title Policy subject only to the Permitted Liens pursuant to the terms of the Title Commitment.

(v) The Title Company shall have issued at Closing (or unconditionally committed to issue) as of the date the Huntington Hospital Land Deed records the Title Policy contemplated in Section 8.2(e).

(vi) The Title Company shall have received at Closing the original termination of the Master Lease, effective as of the date the Huntington Hospital Land Deed records, duly executed by and notarized for Huntington and the Trust, pursuant to Section 8.2(f), and the same shall be duly recorded in the Official Records of Los Angeles County substantially concurrently with the Huntington Land Deed. Upon Closing the Title Company shall deliver a certified copy of the recorded termination of the Master Lease to Huntington with copies to the Trust and Parent.

(vii) The Title Company shall have received at Closing the original assignment of the HMRI Lease, effective as of the date the Huntington Hospital Land Deed records, duly executed by the Trust and Huntington, pursuant to Section 8.2(f). Upon Closing the Title Company shall deliver the original assignment of the HMRI Lease to Huntington with a copy to the Parent.

(i) Court Approval. The Trust will have received the Court Approval.

(j) Imaging Center JVs. The non-competition and right of first opportunity provisions in the respective operating agreements of Huntington Outpatient Imaging Centers, LLC, and Huntington Hill Imaging, LLC (collectively, the "***Imaging Center JVs***") will have been amended, waived or otherwise modified to permit Huntington, Parent and their respective Related Persons to participate in imaging services after the Closing Date within the restricted areas defined in the operating agreements resulting from a transaction in which imaging services is only an incidental part of such transaction; provided that such permission need not apply to any imaging center owned, operated, affiliated or managed by RadNet, Inc. or its Affiliates.

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

(a) Accuracy of Representations and Warranties. The representations and warranties of Parent set forth in Article VI, as amended in accordance with Section 7.2, shall be true and correct as of the Closing Date, as though then made, except (i) for changes contemplated by this Agreement, (ii) to the extent a representation or warranty is made as of a specific date and (iii) where the failure of any such representations or warranties to be true and correct is not reasonably expected to constitute a Material Adverse Change of Parent.

(b) Performance of Covenants and Agreements. Parent shall have performed in all material respects all covenants and agreements contained in this Agreement required to be performed by Parent before the Closing, including the Parent's obligation to supplement or amend its Disclosure Schedules, as necessary, in accordance with Section 7.2.

(c) Bring-Down Certificate. Parent shall have delivered to Huntington a bring-down certificate to the effect of Sections 10.3(a) and (b).

(d) Court Approval. The Trust will have received the Court Approval.

(e) Title Policy. The Title Company shall have issued (or unconditionally committed to issue) the Title Policy contemplated in Section 8.2(e).

(f) Approval of Documentation. The form and substance of all certificates, documents, consents (including the Court Approval) and agreements contemplated hereby and required to be delivered to Huntington at the Closing shall be reasonably satisfactory to Huntington's counsel.

(g) Parent Material Adverse Change. There shall have been no Material Adverse Change of Parent since the Execution Date.

(h) Deliveries at Closing. All of the deliverables described in Section 11.3 shall have been provided to Huntington.

(i) Reimbursement Agreement. As of the Execution Date, contemporaneously with the execution and delivery of this Agreement, Parent and CSMC will have delivered to the Trust that certain Reimbursement Agreement (the "***Reimbursement Agreement***"), dated and effective as of the Execution Date, by and among Parent, CSMC and the Trust, executed by duly authorized officers of CSMC and Parent; and as of the Closing Date, such Reimbursement Agreement will remain in full force without modification.

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

(a) Huntington Conditions Precedent. The conditions precedent to Huntington's obligation as set forth in Section 10.1 and Section 10.3 shall have been satisfied or waived by Huntington.

(b) Court Approval. The Trust shall have received the Court Approval.

Article XI

CLOSING

11.1 Closing and Closing Date. Completion of the Affiliation (the "***Closing***") shall take place remotely via exchange of documents and signature pages on the date (the "***Closing Date***") that is as promptly as practical (but not more than five (5) Business Days) after satisfaction or waiver of the conditions in Article X. The Affiliation shall be treated as occurring at 12:01 AM on the day immediately following the Closing (the "***Effective Time***"). All proceedings to take place at the Closing shall be deemed to have been executed and taken simultaneously.

11.2 Deliveries by Huntington. At the Closing, Huntington shall deliver to Parent the following:

(a) The Huntington Amended Articles, ready to file with the California Secretary of State.

(b) The Huntington Amended Bylaws, certified as of the Closing Date by Huntington.

(c) A certificate of Huntington, dated as of the Closing Date, as to the adoption and continued effectiveness of, and attaching a copy of, the resolutions of the Board of Directors of Huntington approving the execution, delivery and performance of this Agreement and the Transaction Documents to which Huntington is a party.

(d) A certificate of Huntington, dated as of the Closing Date, as to the incumbency and signatures of the officers of Huntington executing this Agreement and the Transaction Documents to which Huntington is a party.

(e) A Certificate of Status, or comparable status, for each Huntington Entity, issued by the California Secretary of State, dated no more than fifteen (15) Business Days prior to the scheduled Closing Date.

(f) An Entity Status Letter for each Huntington Entity from the Franchise Tax Board of California, dated no more than fifteen (15) Business Days prior to the scheduled Closing Date.

11.3 Deliveries by Parent. At the Closing, Parent shall deliver to Huntington the following:

(a) The Parent Amended Articles, ready to file with the California Secretary of State.

(b) The Parent Amended Bylaws, certified as of the Closing Date by Parent.

(c) A certificate of Parent, dated as of the Closing Date, as to the adoption and continued effectiveness of, and attaching a copy of, the resolutions of the Board of Directors of Parent approving the execution, delivery and performance of this Agreement and the Transaction Documents to which Parent is a party.

(d) A certificate of Parent, dated as of the Closing Date, as to the incumbency and signatures of the officers of Parent executing this Agreement and the Transaction Documents to which Parent is a party.

(e) A Certificate of Status, or comparable status, for each Parent Entity, issued by the California Secretary of State, dated no more than fifteen (15) Business Days prior to the scheduled Closing Date.

(f) An Entity Status Letter for each Parent Entity from the Franchise Tax Board of California, dated no more than fifteen (15) Business Days prior to the scheduled Closing Date.

Article XII

PROTECTIVE PROVISIONS

12.1 Non-Reliance.

(a) Parent acknowledges and agrees that the Parent Entities are accepting the Huntington Entities on an "as is, where is" basis, without any warranties, express or implied, and no one has made nor makes any representations or warranties, express or implied, about any of the Huntington Entities or Huntington Subsidiaries or any of their respective assets or liabilities, except for the representations and warranties made by Huntington to Parent set forth in Article

IV of this Agreement and the representations and warranties made by the Trust to Parent set forth in Article V of this Agreement. Parent acknowledges and agrees that Parent is solely responsible for its due diligence investigation relating to the Huntington Entities and their assets and liabilities; Parent and its representatives have been permitted access to books, records, facilities, equipment, contracts and other properties and assets of Huntington and have had a full opportunity to perform such due diligence investigation of the Huntington Entities and their assets, liabilities and business as they have required and to meet with representatives of Huntington to discuss these matters. Notwithstanding any such access, meetings and discussions, Parent acknowledges that none of the Parent Entities has received or is relying upon any representation or warranty, expressed or implied, by operation of law or otherwise, as to the accuracy or completeness of any information regarding the Huntington Entities or their respective assets, liabilities and business, furnished or made available to any Parent Entity or its representatives, except as to the representations and warranties made by Huntington to Parent set forth in Article IV of this Agreement and the representations and warranties made by the Trust to Parent set forth in Article V of this Agreement.

(b) Huntington and the Trust acknowledge that no Huntington Entity nor the Trust has received or is relying upon any representation or warranty, expressed or implied, by operation of law or otherwise, as to the accuracy or completeness of any information regarding the Parent Entities or their respective assets, liabilities and business, furnished or made available to any Huntington Entity, the Trust or their representatives, except as to the representations and warranties made by Parent to Huntington and the Trust set forth in Article VI of this Agreement.

12.2 AS-IS. HUNTINGTON HAS BEEN IN POSSESSION AND OCCUPANCY OF THE HUNTINGTON HOSPITAL LAND PURSUANT TO THE MASTER LEASE AND IS FULLY KNOWLEDGEABLE OF ALL ASPECTS OF THE HUNTINGTON HOSPITAL LAND. PARENT AND HUNTINGTON, EITHER INDEPENDENTLY OR THROUGH AGENTS, REPRESENTATIVES OR CONSULTANTS SELECTED BY EITHER OF THEM, MAY CONDUCT ALL INSPECTIONS, INVESTIGATIONS, TESTS, ANALYSES AND EVALUATIONS OF THE HUNTINGTON HOSPITAL LAND AS PARENT AND/OR HUNTINGTON DEEMS NECESSARY OR OTHERWISE APPROPRIATE, AT PARENT'S OR HUNTINGTON'S SOLE COST AND EXPENSE. PARENT AND HUNTINGTON EACH SPECIFICALLY ACKNOWLEDGES AND AGREES THAT THE TRUST IS TRANSFERRING AND HUNTINGTON IS ACCEPTING TITLE TO THE HUNTINGTON HOSPITAL LAND ON AN "AS IS, WHERE IS, WITH ALL FAULTS AND DEFECTS" BASIS AND THAT, EXCEPT AS SPECIFICALLY SET FORTH HEREIN OR IN ANY OTHER DOCUMENT DELIVERED BY THE TRUST TO PARENT OR HUNTINGTON PURSUANT TO THIS AGREEMENT, NEITHER PARENT NOR HUNTINGTON IS RELYING ON ANY REPRESENTATIONS OR WARRANTIES OF ANY KIND WHATSOEVER, EXPRESS OR IMPLIED, FROM THE TRUST, ITS AGENTS OR REPRESENTATIVES AS TO ANY MATTERS CONCERNING THE HUNTINGTON HOSPITAL LAND, INCLUDING WITHOUT LIMITATION: (i) the quality, nature, adequacy and physical condition and aspects of the Huntington Hospital Land and/or improvements thereon; (ii) the quality, nature, adequacy, and physical condition of soils, geology and any groundwater; (iii) the existence, quality, nature, adequacy and physical condition of utilities serving the Huntington Hospital Land; (iv) the development potential of the Huntington Hospital Land, and the Huntington Hospital Land's and/or improvements thereon use, habitability,

merchantability, or fitness, or the suitability, value or adequacy of the Huntington Hospital Land and/or improvements thereon for any particular purpose; (v) the zoning or other legal status of the Huntington Hospital Land or any other public or private restrictions on use of the Huntington Hospital Land; (vi) the compliance of the Huntington Hospital Land or improvements thereon with any applicable codes, laws, regulations, statutes, ordinances, covenants, conditions and restrictions of any governmental or quasi-governmental entity or of any other person or entity (including the Americans with Disabilities Act); (vii) the presence or release of any hazardous materials on, under or about the Huntington Hospital Land or any adjoining or neighboring property; (viii) the condition of title to the Huntington Hospital Land; (ix) the condition of the Huntington Hospital Land and/or improvements thereon; (x) the economics of the operation of the Huntington Hospital Land; or (xi) any other aspect, characteristic or feature regarding the Huntington Hospital Land and/or improvements thereon.

12.3 Natural Hazards Disclosure. Without limiting Section 12.2, the Parties acknowledge that the Disclosure Statutes (as defined below) provide that a seller of real property must make certain disclosures regarding certain natural hazards potentially affecting the property, as more particularly provided therein. As used in this Agreement, "Disclosure Statutes" means, without limitation, collectively, California Government Code Sections 8589.3, 8589.4 and 51183.5, California Public Resources Code Sections 2621.9, 2694 and 4136, and any other California statutes that require a seller to make disclosures concerning real property. The Parties acknowledge and agree that the Trust is not selling the Huntington Hospital Land and is therefore not a "seller" and not obligated to deliver to Parent or Huntington any disclosures; however, the Trust has agreed to deliver, or cause to be delivered, to Parent and Huntington a Natural Hazard Disclosure Report for the Huntington Hospital Land (the "***Report***") in accordance with California Civil Code Section 1103.2. The Report will be delivered to Parent and the Hospital as soon as the Trust can obtain the Report after the Execution Date. Parent and Huntington hereby agree as follows with respect to the Disclosure Statutes and the Report:

(a) The Trust shall not be liable for any error or inaccuracy in, or omission from, the information in the Report.

(b) The Report is being provided by the Trust for purposes of complying with the Disclosure Statutes if and to the extent applicable and shall not be deemed to constitute a representation or warranty by the Trust as to the presence or absence in, at or around of the Huntington Hospital Land of the conditions that are the subject of the Disclosure Statutes.

12.4 Release. Without limiting Sections 12.2 or 12.3 above, effective as of the Effective Time, Parent and Huntington, each on behalf of itself and its successors and assigns, waives its right to recover from, and forever releases and discharges the Trust and the Trust's Affiliates, and the partners, trustees, shareholders, directors, officers, members, managers, attorneys, employees and agents of each of them, and their respective heirs, successors, personal representatives and assigns (collectively, the "***Trust Released Parties***"), from any and all Claims and Losses, whether direct or indirect, known or unknown, foreseen or unforeseen, that may arise on account of or in any way be connected with the Huntington Hospital Land, any and all improvements thereon, and this Agreement as it relates to the foregoing. The waiver and release in the preceding sentence applies to, without limitation, the physical and structural condition of the Huntington Hospital Land, any and all improvements thereon, or any law or regulation

applicable thereto, as well as any information contained in any contracts, documents, agreements, records, files, surveys, reports and any other information pertaining to the foregoing. Nothing contained in this Section 12.4 shall in any way limit or restrict the right of any Party to bring a cause of action based on actual common law fraud with respect to representations and warranties of the Trust in Article V of this Agreement. With respect to the waiver and release set forth herein relating to claims unknown to or unsuspected by a Party, Parent and Huntington each hereby acknowledges that such waiver and release is being made after obtaining the advice of counsel and with full knowledge and understanding of the consequences and effects of such waiver, and that such waiver is made with the full knowledge, understanding and agreement that California Civil Code Section 1542 provides as follows, and that the protections afforded by said code section are hereby waived:

"A GENERAL RELEASE DOES NOT EXTEND TO CLAIMS THAT THE CREDITOR OR RELEASING PARTY DOES NOT KNOW OR SUSPECT TO EXIST IN HIS OR HER FAVOR AT THE TIME OF EXECUTING THE RELEASE AND THAT, IF KNOWN BY HIM OR HER, WOULD HAVE MATERIALLY AFFECTED HIS OR HER SETTLEMENT WITH THE DEBTOR OR RELEASED PARTY."

PS PS

REDACTED

Parent's Initials

Huntington's Initials

12.5 D&O Protections. For six (6) years after the Closing Date, Parent shall not take any action without the prior approval of Huntington that would result in Huntington failing to maintain insurance policies of the same type and nature of (and with terms that are not materially less favorable than and at coverage levels that are not lower than) the insurance policies set forth on Schedule 4.14. Additionally, for six (6) years after the Closing Date, Parent shall not take any action to amend the provisions set forth in Huntington's Governing Documents as of the Closing Date pertaining to the liability of Huntington's directors and officers or the indemnification of (and advancement of expenses to) directors, officers, employees, agents and representatives of Huntington, nor shall Parent take any action to prevent Huntington, in accordance with Huntington's Governing Documents and to the full extent permitted by law, from indemnifying, defending or holding harmless a current, former or future director, officer, employee, agent or representative of Huntington (collectively, the "***Protected Persons***) against losses in connection with any claim, based in whole or in part on or arising in whole or in part out of the fact that the Protected Person (or the person controlled by the Protected Person) is or was a director, officer, employee, agent or representative of Huntington.

Article XIII

POST-CLOSING RIGHTS AND OBLIGATIONS

13.1 Illegality. If at any time after the Closing Date, Huntington determines in good faith based on advice of qualified legal counsel that any federal, state, or local law or regulation renders the affiliation entered into pursuant to this Agreement illegal, then Huntington may give written notice thereof to Parent (***Notice of Illegality***) if such action is approved by the Huntington board of directors. If Parent disputes the conclusion set forth in the Notice of

Illegality, Parent shall notify Huntington of such dispute (the "***Illegality Dispute***") within ten (10) days after Parent's receipt of the Notice of Illegality. The Parties shall attempt to resolve such Illegality Dispute in accordance with the meet and confer process set forth in Section 16.10. If the Parties are unable to resolve the Illegality Dispute in accordance with the meet and confer process, the Parties may utilize any other available dispute resolution process (including, without limitation, binding arbitration) or seek any other available legal recourse to resolve the Illegality Dispute. In the event a final determination is made that the affiliation entered into pursuant to this Agreement is illegal, Parent and Huntington shall work together in good faith to alter their relationship to the minimum extent necessary to comply with applicable laws or regulations or otherwise resolve the legal problem. If, after diligent good faith efforts, Parent and Huntington are unable to mutually agree upon such alteration, or if such alteration is not legally possible, then Parent and Huntington shall work together in good faith to modify their organizational documents and take all other actions necessary and appropriate to terminate Parent's membership in Huntington and unwind the Affiliation between Parent and Huntington contemplated in this Agreement, the New Huntington Organizational Documents and the New Parent Organizational Documents. The Parties acknowledge and agree that in the event Parent's membership in Huntington is terminated pursuant to the terms set forth in this Section 13.1 (an "***Illegality Unwind Event***"), Huntington shall have the right to assume the assets and liabilities of Huntington and each Huntington Subsidiary pursuant to the terms set forth in Exhibit A attached hereto and incorporated herein.

13.2 Closure or Sale of Huntington Hospital.

(a) Closure or Sale of Huntington Hospital. The Parties acknowledge and agree that after the Closing Date, Parent shall, subject to the AG Consent and the terms of the New Huntington Organizational Documents, have the unilateral right to cause the closure, Change of Control (as defined below), sale, lease, transfer, exchange, disposition or change in use of all or substantially all of the assets of Huntington Hospital (including through the dissolution of Huntington) (each a "***Closure or Sale of Hospital Unwind Event***"), which shall be subject to the approval of the Board of Directors of Parent. If, after the Closing Date, Parent initiates, approves and affirmatively causes a Closure or Sale of Hospital Unwind Event, Huntington shall have the right to terminate Parent's membership in Huntington and assume the assets and liabilities of Huntington and each Huntington Subsidiary pursuant to the terms set forth on Exhibit A.

(b) For purposes of this Section 13.2, "Change of Control" means: (i) any transaction or series of related transactions (including, without limitation, merger or consolidation, sale, transfer or other disposition of equity, amendment to the articles of incorporation or bylaws or other applicable governing documents of such entity or other contract or arrangement) that results in another entity becoming the beneficial owner of more than fifty percent (50%) of the voting ownership interests of the entity that owns Huntington Hospital, (ii) the sale, lease, transfer, exchange, disposition or change in use of all or substantially all of the assets of Huntington Hospital, (iii) the substitution of a new corporate member or members that transfers the control of, responsibility for, or governance of Huntington Hospital; or (iv) a joint venture, management arrangement or similar transaction that results in another entity becoming the owner, operator or manager of all or substantially all of the assets of Huntington Hospital.

13.3 Change to Tax Exempt Status of Huntington Hospital. The Parties acknowledge and agree that if, after the Closing Date, Parent takes any action to cause a Tax Exempt Status Unwind Event (as defined below) without the prior approval of Huntington, Huntington shall have the right to terminate Parent's membership in Huntington and assume the assets and liabilities of Huntington and each Huntington Subsidiary pursuant to the terms set forth on Exhibit A. For purposes of this Section 13.3, "***Tax-Exempt Status Unwind Event***" means an action: (i) that results in the Huntington Hospital no longer being owned and operated by an organization that is tax exempt under Section 501(c)(3) of the Code that is also a public charity under Section 509(a) of the Code, or (ii) that could reasonably be expected to result in or present a material risk of revocation of the Code Section 501(c)(3) tax-exempt status of the Trust, based on the written reasoned opinion of nationally recognized Code Section 501(c)(3) tax counsel engaged by the Trust. An Illegality Unwind Event, Closure or Sale of Hospital Unwind Event, and Tax-Exempt Status Unwind Event shall be referred to herein collectively as a "***Huntington Unwind Event***".

13.4 Parent Operating Expenses. The Parties acknowledge and agree that after the Closing Date, Parent shall have the unilateral right to require all Affiliate Hospital Organizations (including Huntington, CSMC and THA) to make their share (as described below) of periodic payments to Parent to cover Parent's budgeted operating expenses ("***Parent Operating Expenses Payments***"), and Huntington shall make such Parent Operating Expenses Payments to Parent. The amount and timing of such payments shall be based on the financial need of Parent, which shall be determined by the Board of Directors of Parent from time to time. Notwithstanding the foregoing, the amount of the Parent Operating Expenses Payments made by Huntington to cover Parent's budgeted operating expenses (relative to the amounts paid by the other Affiliate Hospital Organizations) shall at all times be proportionate to the ratio of operating expenses incurred by Huntington relative to the other Affiliate Hospital Organizations (as measured by the then most recent approved operating budgets of Huntington and the other Affiliate Hospital Organizations).

13.5 Capital Contributions to Parent. Huntington shall make capital contributions to Parent from time to time after the Capital Plan Period in accordance with the terms set forth on Exhibit B, attached hereto and incorporated herein.

13.6 Gifts, Donations and Endowments. The Parties acknowledge and agree that after the Closing Date, Huntington shall have the right to approve: (i) a change in the control, management or administration of any gifts, grants, donations or endowments (collectively, the "***Restricted Assets***") received by Huntington or a Huntington Subsidiary, and/or (ii) the transfer to Parent of any Restricted Assets of Huntington or a Huntington Subsidiary that were designated by a donor after the Closing Date and only if California law and the restriction allow it to be transferred to Parent.

13.7 Identification as Affiliate. After the Closing Date, Huntington shall identify itself as an affiliate of Parent pursuant to the branding guidelines mutually agreed to by the Parties in good faith within one hundred eighty (180) days after the Closing Date.

13.8 Legacy Balance Sheets. The Parties shall memorialize the balance sheets of the Parties as of the Closing Date and the Parties acknowledge that such balance sheets shall be

referenced as needed in connection with the Parties' fulfillment of their post-Closing obligations set forth in this Agreement.

13.9 Employees and Employer Status. The Parties acknowledge and agree that employees of each Huntington Entity will, as of the Effective Time, remain employed by the Huntington Entity on the same terms as existed immediately prior to the Effective Time. Parent will not, as a condition to closing or for a period of ninety (90) days after the Closing, take or require Huntington to take any action that would subject Huntington to application of the WARN Act or any State equivalent of the WARN Act. The Parties acknowledge and agree that after the Closing, Parent shall have the right to take action causing a change to the employer (without disrupting employment status at the time such change is made) of certain groups, classes or subsets of individuals (based on job function) who are employed by Huntington or a Huntington Subsidiary as of the Closing in order to develop a shared services organization benefitting all of the Affiliate Hospital Organizations; provided, however, if Parent makes such a change with respect to a distinct group, class or subset of employees of Huntington or a Huntington Subsidiary, such change shall be implemented uniformly with respect to all Affiliate Hospital Organizations, unless otherwise mutually agreed by Parent and Huntington. Notwithstanding the foregoing, Parent will not cause any such change prior to the fifth anniversary of the Closing Date without the prior written consent of Huntington. Additionally, the Parties agree that to the extent that any Huntington Employee Benefit Program is consolidated with any Parent Employee Benefit Program after the Closing Date, employees of Huntington will, to the extent permitted by applicable Law, receive full credit for their years of service to Huntington for purposes of eligibility and vesting upon entry as a participant under any Parent Employee Benefit Program.

13.10 Trust Distributions to Huntington.

(a) On the terms and subject to the conditions of this Section 13.10, the Trust will make distributions to Huntington during each calendar year of the Capital Plan Period to be used by Huntington solely to fund the general medical education program at Huntington Hospital (the "***GME Distributions***"). The total amount of GME Distributions for calendar year 2021 will equal Five Million Three Hundred Thousand Dollars ($5,300,000). The total amount of GME Distributions for each subsequent year during the Capital Plan Period will be increased each year by two and one-half percent (2.5%) over the prior year. GME Distributions will be prorated for any partial year during the Capital Plan Period. The Trust will determine the timing and amounts of GME Distributions to make throughout each year and may consider the timing of expenditures that Huntington will incur in the operations of its general medical education program. The Trust will be entitled to, and Huntington will promptly deliver to the Trust, such records as the Trust may reasonably request to substantiate the spending of GME Distributions in accordance with this Section 13.10(a).

(b) On the terms and subject to the conditions of this Section 13.10, the Trust will make distributions to Huntington during the Capital Plan Period to be used solely to fund one or more Huntington projects designated by the Trust and approved by the Board of Directors of Huntington (the "***Project Distributions***"), including projects in the Huntington Strategic Capital Plan. The total amount of the Project Distributions for each calendar year will equal the market value of the Trust Securities Portfolio as of December 31st of the preceding calendar year, multiplied by two and one-half percent (2.5%). The Trust will reasonably determine the annual

amount of each Project Distribution based on the records of the Trust relating to the Trust Securities Portfolio. The Trust will make payment of Project Distributions no more frequently than on a monthly basis. The Trust will be entitled to receive, and Huntington will promptly deliver to the Trust, such records as the Trust may reasonably request to substantiate the spending of Project Distributions in accordance with this Section 13.10(b). For purposes of this Agreement, "***Trust Securities Portfolio***" means the cash and marketable securities owned by the Trust that have a minimum hold or exit provision of less than six (6) months. The Trust Securities Portfolio specifically excludes real estate and securities related to the Trust's real estate holdings. The Trust Securities Portfolio excludes interests in real property.

(c) Notwithstanding anything to the contrary, the Trust's obligation to make any payment of a Trust Distribution is subject to satisfaction of each of the following conditions as of the date each Trust Distribution is to be made: (i) each Huntington Entity that is exempt from federal income tax under Section 501(c)(3) of the Code as of the Closing Date must continue to be exempt under such section of the Code; (ii) Huntington must continue to operate Huntington Hospital as a general acute care hospital; (iii) Parent must continue to be the sole member of Huntington; and (iv) Parent must continue to be in compliance in all material respects with its obligations under this Agreement, including those in Article XIV (Huntington Strategic Capital Plan and EHR Project).

13.11 Quality Risk Event Notifications and Response Plans. After the Closing, Huntington shall notify Parent within three (3) calendar days of discovery by Huntington of any of the following quality or safety risk events at Huntington Hospital or any other healthcare facility operated by Huntington or any of its Subsidiaries: (i) a potential sentinel event, (ii) a "Never 28" event, (iii) a quality or patient safety event reportable to a Governmental Entity or accreditation agency, (iv) any significant quality or safety issue pertaining to a member of the Huntington Hospital medical staff or an allied health professional that provides services at Huntington Hospital, including volatile behavior, potential criminal issues, or potential substance abuse or sexual harassment accusations, or (v) any quality or safety event or series of events that may pose a reputational or brand risk to Parent or any Affiliate Hospital Organization (each, a "***Quality Risk Event***"). Huntington shall confer with Parent regarding the development and implementation of a corrective action response plan ("***CARP***") for any Quality Risk Event and shall obtain the advance approval of Parent for each CARP (except in emergent situations where obtaining such advance approval is not feasible, in which case the CARP shall be presented to Parent as soon as reasonably practicable and notice thereof shall be provided immediately to Parent); provided, however, the foregoing shall not require, with respect to a Huntington Hospital medical staff peer review CARP pertaining to events described in subsection (iv) of the preceding sentence, the approval of Parent, but shall require prompt notice to Parent so long as such notice does not require Huntington to make any disclosure that would violate or waive the protection of California Evidence Code Section 1157. The CARP for a Quality Risk Event shall include the following elements, each with defined timeframes, as appropriate: (1) immediate risk mitigation for patient care, (2) patient and family disclosure, (3) external reporting details, (4) internal action plans to mitigate future risk, and (5) media relations. Huntington shall implement the elements of each approved CARP in accordance with its terms including within the stated timeframes. The implementation and completion of all elements of each CARP in response to a Quality Risk Event shall be reported to Parent. The Parties agree that as soon as reasonably practicable after the Closing Date the Parties shall use their best reasonable efforts to cause the

medical staffs of the hospitals operated by the Affiliate Hospital Organizations to enter into appropriate peer review sharing agreements in compliance with applicable law.

13.12 Administrative Support for Trust. After the Closing Date, the Parties acknowledge and agree that Huntington shall continue to provide meeting space and administrative support to the Trust that are reasonably necessary to support the operations of the Trust after the Closing Date, consistent with Huntington's past practices.

13.13 Access to Information. After the Closing Date:

(a) Parent and Huntington shall promptly deliver to the Trust copies of the duly executed form of this Agreement, the New Huntington Organizational Documents and the New Parent Organizational Documents;

(b) Huntington shall promptly deliver to Parent and the Trust a copy of the Attorney General's letter of consent (or conditional consent) relating to the Affiliation (the "***AG Consent***");

(c) Parent, Huntington and the Trust shall each promptly deliver to the other copies of all communications made or received to or by such party with the Attorney General relating to the Affiliation, this Agreement or the AG Consent after the Closing Date; and

(d) Upon the Trust's request from time to time, the Trust shall have reasonable access during normal business hours to records and information relating to the directors, officers, employees and operations of Huntington or the subject matter of any of the terms of this Agreement for the purpose of the Trust carrying out its duties as an organization existing to support Huntington; provided, however, such access to information be in a manner as to not unduly disrupt normal business activities of Parent or Huntington and shall be in compliance with Law and any contractual obligations relating to confidentiality.

13.14 Hospital Commitments. After the Closing, for the applicable periods of time set forth in the AG Consent, Parent will comply, and will cause Huntington to comply, with the conditions of the AG Consent, including each of the following to the extent required by the AG Consent:

(a) Huntington will operate and maintain Huntington Hospital as a licensed general acute care hospital, including to the extent that Huntington is able to meet the requirements of applicable accreditation agencies, maintaining each of the following with the same types and levels of services as currently provided:

Level II Trauma Center
Level III Neonatal Intensive Care Unit
Comprehensive Stroke Center
STEMI Receiving Center
Advanced Cardiology and Cardiovascular Surgery Programs
Advanced Robotic Surgery
Orthopedic Service Line
Oncology Service Line

Neurology Service Line
GME programs
Senior Care Network
Women's Health Services
End of Life Services

(b) Huntington will continue to participate in the Medi-Cal program at Huntington Hospital.

(c) Huntington will continue to participate in the Medicare program by maintaining a Medicare provider number.

(d) Neither Parent nor any of its Related Persons will (a) sell, lease, exchange, option, convey, manage, or otherwise dispose of Huntington Hospital or (b) transfer control, responsibility, management, or governance of Huntington Hospital, or in each case allow any such transaction to occur, without the prior approval of the Attorney General.

(e) Huntington will use commercially reasonable efforts to maintain Magnet Status with substantially the same types and levels of services as currently provided.

13.15 Charity Care and Community Benefit.

(a) Parent will ensure, and Huntington will cooperate with Parent in ensuring, that Huntington continues to provide charity care at such levels as required by the Attorney General.

(b) Parent will ensure, and Huntington will cooperate with Parent in ensuring, that Huntington continues to provide community benefit programs at such levels as required by the Attorney General.

13.16 Medical Staff. From and after the Closing, Parent will permit Huntington to retain a separate, independent medical staff accountable to Huntington's board of directors and to retain separate Medical Staff Bylaws of Huntington Hospital. Parent will not require or take any action as a condition of or in connection with the Closing that, effective as of the Closing, would change any of the following: (i) the positions of all elected and appointed leaders of the medical staff of Huntington Hospital (including officers, committee chairs and vice chairs, and department chairs and vice chairs), or (ii) the membership status or clinical privileges of members of the medical staff of Huntington Hospital. The Parties agree that such status or privileges may be changed only after the Closing Date and only in accordance with the provisions of the Medical Staff Bylaws of Huntington Hospital and applicable Laws.

Article XIV

HUNTINGTON STRATEGIC CAPITAL PLAN AND EHR PROJECT

14.1 Huntington Strategic Capital Plan and Funding Commitment**.**

(a) Huntington Strategic Capital Plan. Parent hereby approves Huntington's adoption of its strategic capital plan set forth on Exhibit C, attached hereto and incorporated herein by reference (the "***Huntington Strategic Capital Plan***"), in the total amount of Five Hundred Sixty Million Dollars ($560,000,000) (the "***Total Capital Plan Costs***") for the period (the "***Capital Plan Period***") commencing on the Closing Date and ending on December 31, 2029. The Parties acknowledge and agree that the line items in the Huntington Strategic Capital Plan, the amounts identified for each line item and the year in which they are to be spent are based on estimates and projections and are subject to decisions that Huntington will make over the course of the Capital Plan Period about the needs of the Huntington Entities and the communities they serve, taking into consideration circumstances that may change over the course of the Capital Plan Period. Subject to Section 14.4 and Parent's authority to approve the strategic plans and budgets of Huntington and the Huntington Subsidiaries as set forth in the New Huntington Organizational Documents, the Parties intend for Huntington to complete the Huntington Strategic Capital Plan during the Capital Plan Period. Huntington acknowledges and agrees that if the Huntington Strategic Capital Plan is accomplished within the Capital Plan Period for an amount less than the Total Capital Plan Costs, the amount of Total Capital Plan Costs shall be reduced accordingly. The Huntington Strategic Capital Plan will be binding for all purposes of this Agreement, the New Huntington Organizational Documents and the New Parent Organizational Documents.

(b) Funding Commitment. Parent hereby commits Three Hundred Million Dollars ($300,000,000) (the "***Funding Commitment***") to Huntington during the Capital Plan Period for use in the Huntington Strategic Capital Plan. The Funding Commitment will be reduced by each distribution from Parent to Huntington made in accordance with this Section 14.1 and will be increased (to an amount not to exceed Three Hundred Million Dollars ($300,000,000)) by the amount of any cash that any Huntington Entity or the Trust delivers to Parent. Parent will deliver amounts of such funds to Huntington pursuant to the terms and conditions set forth in this Section 14.1.

(c) Funding Timing. Notwithstanding anything in this Section 14.1 to the contrary, the Parties acknowledge and agree that at all times during the Capital Plan Period Huntington shall first use the cash on hand of the Huntington Entities in excess of Sixty Days Expenses to pay for capital expenditures under the Huntington Strategic Capital Plan. During each quarter of the Capital Plan Period, Huntington will prepare a projection of the anticipated Unrestricted Cash on Hand of the Huntington Entities during the subsequent quarter. In the event Huntington reasonably anticipates at any time during the Capital Plan Period that the use of cash on hand of the Huntington Entities to pay for capital expenditures under the Huntington Strategic Capital Plan will cause the Unrestricted Cash on Hand of the Huntington Entities during the subsequent quarter to be reduced to less than Sixty Days Expenses, Huntington shall notify Parent of the amount of the anticipated shortfall of Unrestricted Cash on Hand below Sixty Days Expenses, at which point Parent shall arrange, pursuant to Section 14.1(d), the additional funding source or sources as part of the Funding Commitment, and Parent will deliver such funding to Huntington in the amount of the anticipated shortfall by the end of the quarter in which the shortfall is anticipated to arise.

(d) Source of Funds for Funding Commitment. Subject to the other provisions of this Section 14.1, the Parties acknowledge and agree that Parent shall, in its sole

and absolute discretion, determine the source of funds for any portion of the Funding Commitment, which may include debt to be incurred by Parent, Huntington or another entity, Parent's cash, or intercompany loans made by Parent to Huntington.

(e) Annual Amounts and Types of Spending. The Parties acknowledge and agree that the annual amounts and types of spending by Huntington or a Huntington Subsidiary each year towards the Huntington Strategic Capital Plan shall be approved by Parent in accordance with Parent's right to approve the annual budgets of Huntington and the Huntington Subsidiaries as set forth in the New Huntington Organizational Documents and Section 14.4 of this Agreement.

14.2 EHR Project.

(a) Pursuant to the terms and conditions set forth in this Section 14.2, Parent shall complete the following (collectively, the "***EHR Project***"): (i) establish an integrated EHR system with Epic Systems Corporation ("***Epic***") for Huntington by extending to Huntington Parent's instance of the Epic modules set forth on Exhibit D, attached hereto and incorporated herein, and (ii) extend Parent's enterprise license to use Epic software to Huntington such that Huntington has a valid sublicense of the Epic system modules set forth on Exhibit E, attached hereto and incorporated herein. Parent will commence work on the EHR project as soon as reasonably practicable after the Closing Date and will complete the EHR Project, no later than the third (3rd) anniversary of the Closing Date unless otherwise mutually agreed by Parent and Huntington. Huntington agrees that Parent's obligation and ability to complete the EHR Project is subject to Huntington making available such Huntington staff as reasonably requested by Parent and otherwise cooperating with Parent in Parent completing the EHR Project.

(b) EHR Project Committee. The EHR Project shall be overseen and directed by an EHR governance and management structure and operating model as outlined in Exhibit F, attached hereto and incorporated herein (the "***EHR Project Committee***"). Parent shall lead and oversee the EHR Project Committee and shall commit the resources reasonably necessary to do so.

(c) EHR Project Timeline and Implementation Plan. Subject to the commitments in Section 14.2(a), the EHR Project Committee shall determine the timeline and implementation plan for the EHR Project, which may be updated or amended from time to time in the reasonable discretion of the EHR Project Committee.

(d) EHR Project Capital Costs; Annual Amounts and Types of Spending. Parent shall fund the capital costs necessary to complete the EHR Project (the "***EHR Project Capital Costs***"), subject to Parent's right to determine the source of funds for the EHR Project Capital Costs as contemplated in Section 14.2(e). The Parties acknowledge and agree that, subject to the commitments in Section 14.2, the annual amounts and types of spending each year on EHR Project Capital Costs shall be approved by Parent in accordance with Parent's right to approve the annual budgets of Huntington and the Huntington Subsidiaries as set forth in the New Huntington Organizational Documents. During the EHR Project period, Parent and Huntington shall consider from time to time, as reasonably requested by Parent, the extent to which the accumulated level of surplus Unrestricted Cash on Hand could reasonably be made

available for EHR Project Capital Costs without affecting the funds available to Huntington for the Huntington Strategic Capital Plan, the Total Capital Commitment and/or the Funding Commitment.

(e) Source of Funds for EHR Project Capital Costs. Subject to the other provisions of this Section 14.2, the Parties acknowledge and agree that Parent shall, in its sole and absolute discretion, determine the source of funds for any portion of the EHR Project Capital Costs, which may include debt to be incurred by Parent, Huntington or another entity, Parent's cash, or intercompany loans made by Parent to Huntington, but may not include Huntington's cash on hand. Parent acknowledges and agrees that the Funding Commitment described in Section 14.1 of this Agreement shall be used solely to support the Huntington Strategic Capital Plan and such obligation is separate and distinct from Parent's obligations under this Section 14.2 regarding the EHR Project Capital Costs.

14.3 In-Kind Advisory Support. During the Capital Plan Period, Parent shall provide at no cost to any of the Huntington Entities the expertise and advisory support of Parent's leadership and subject matter experts to assist the Huntington Entities in executing their strategic plans and initiatives, including physician network development, ambulatory network strategy and other projects where Parent has both the scale and expertise to support such plans and initiatives.

14.4 Approval of Strategic Plans and Budgets.

(a) Strategic Plans. Huntington management periodically will develop Huntington's strategic plans and present them to the Huntington board of directors. In developing such strategic plans, Huntington management may consult with management of Parent. The Huntington board of directors will have the authority to review the strategic plans and determine whether to approve and recommend them to Parent. Parent, in its capacity as sole member of Huntington, will have the final authority to approve the strategic plans as set forth in the New Huntington Organizational Documents; provided, however, that Parent will not use its approval authority over Huntington's strategic plans to create an annual "de novo" approval process for the Huntington Strategic Capital Plan and/or the EHR Project and will not, without good cause, withhold the completion of any portion of the Huntington Strategic Capital Plan and/or the EHR Project within the Capital Plan Period. Additionally, in no event shall Parent use its approval authority over Huntington's strategic capital plans to withhold approval of the completion within the Capital Plan Period of any projects that are part of the "FMP Non-Compliance & Major Capital Projects Budget" set forth on Exhibit C as long as the completion of all such projects do not exceed the total budget of Eighty-Five Million Dollars ($85,000,000) associated with such projects as set forth on Exhibit C.

(b) Budgets. Each year Huntington management will develop Huntington's annual operating and capital budgets and present them to the Huntington board of directors. In developing budgets, Huntington management may consult with management of Parent. The Huntington board of directors will have the authority to review the annual budgets and determine whether to approve and recommend them to Parent. Parent, in its capacity as sole member of Huntington, will have the final authority to approve the annual budgets; provided, however, that Parent will not use its approval authority over Huntington's annual budgets to create an annual "de novo" approval process for the Huntington Strategic Capital Plan and/or the EHR Project

and will not, without good cause, withhold the completion of any portion of the Huntington Strategic Capital Plan and/or the EHR Project within the Capital Plan Period. Additionally, in no event shall Parent use its approval authority over Huntington's annual budgets to withhold approval of the completion within the Capital Plan Period of any projects that are part of the "FMP Non-Compliance & Major Capital Projects Budget" set forth on Exhibit C as long as the completion of all such projects do not exceed the total budget of Eighty-Five Million Dollars ($85,000,000) associated with such projects as set forth on Exhibit C.

Article XV

REMEDIES

15.1 Remedies Prior to the Closing Date. The Parties acknowledge and agree that the sole and exclusive remedy of the Parties arising out of: (i) any breach of, or any inaccuracy in, any representation or warranty made by a Party in this Agreement that occurs prior to the Closing Date; or (ii) any breach of any covenant, obligation or agreement of a Party in this Agreement that occurs on or prior to the Closing Date, shall be Parent's or Huntington's right to terminate this Agreement pursuant to Section 9.1; provided, however, nothing contained in this Section 15.1 shall in any way limit or restrict the right of any Party to bring a cause of action based on actual common law fraud in the making of another Party's representations and warranties in Article IV, Article V or Article VI of this Agreement.

15.2 Remedies After the Closing Date. The Parties shall attempt to resolve any dispute, claim or controversy arising out of or relating to any breach of any covenant, obligation or agreement of a Party in this Agreement that occurs after the Closing Date through the meet and confer process set forth in Section 16.10; provided, however, that if the Parties are unable to resolve a dispute, claim or controversy through such meet and confer process, each Party shall have the right to seek any legal or equitable recourse or remedy available to such Party.

15.3 Damages Waiver. Notwithstanding anything to the contrary, the Parties acknowledge and agree that in no event shall a Party be liable to any other Party for any punitive, incidental, consequential, special or indirect damages in connection with any breach of any covenant, obligation or agreement of a Party in this Agreement that occurs after the Closing Date.

15.4 Non-Survival. The representations, warranties, covenants and agreements in this Agreement and any certificate delivered pursuant hereto by a Party, and all rights and remedies with respect thereto, will terminate at the Closing such that no claim for breach of any representation, warranty, covenant or agreement may be brought after the Closing with respect thereto and there will be no liability in respect thereof, except that this Section 15.4 will not limit responsibility for performance of covenants and agreements of the Parties which by their terms contemplate performance in whole or in part after the Closing ("***Post-Closing Responsibilities***").

15.5 Exclusive Remedies. Notwithstanding anything to the contrary:

(a) The exclusive remedies available to the Parties (or anyone claiming by, through or on behalf of a Party or any of their respective Related Persons) in connection with this Agreement or the Affiliation will be as set forth in Section 15.1 or Section 15.2.

(b) This Agreement may only be enforced against, and any claims or causes of action that may be based upon, arise out of or relate to this Agreement or the Affiliation, or the negotiation, execution or performance of this Agreement or the Affiliation, may only be made against, the Persons that are expressly identified as parties to this Agreement in their capacities as such. No former, current or future trustee, director, officer, employee, agent or representative of any Party, any Related Person of any of the foregoing or any successor or representatives of any of the foregoing (each, a "***Nonrecourse Person***") will have any liability for any obligations or liabilities of any party to this Agreement or for any Claims and Losses based on, in respect of, or by reason of, this Agreement or the Affiliation or in respect of any representations or warranties made or alleged to be made in connection with this Agreement or the Affiliation. In no event will any Party or any of its Related Persons seek to enforce this Agreement against, make any claim based upon, arising out of or relating to this Agreement or the Affiliation, or the negotiation, execution or performance of this Agreement or the Affiliation, against, or seek to recover monetary damages from, any Nonrecourse Person. Each party hereby absolves every Nonrecourse Person from any such liability.

(c) Each Party (each on behalf of itself and anyone claiming by, through or on behalf of such Party or any of its respective Related Persons) acknowledges and agrees that the remedies in this Article XV are reasonable and adequate and covenants and agrees not to assert or pursue any damages whatsoever not authorized in this Article XV. Effective as of the Effective Time, each Party (each on behalf of itself and anyone claiming by, through or on behalf of such Party or any of its Related Persons) and each of their respective successors and assigns (collectively, the "***Releasing Parties***"), irrevocably and unconditionally releases and forever discharges each of the Nonrecourse Persons from, and forever disclaims, waives and relinquishes and will be forever precluded from asserting, any and all Claims and Losses which the Releasing Parties may have against any of the Nonrecourse Persons, now or in the future, in each case in respect of any cause, matter or thing relating to any actions taken or failed to be taken by any of the Nonrecourse Persons in connection with this Agreement occurring or arising on or prior to the Effective Time.

(d) Effective as of the Effective Time, each of the Releasing Parties irrevocably and unconditionally releases and forever discharges each of the Parties from, and forever disclaims, waives and relinquishes and will be forever precluded from asserting, any and all Claims and Losses which the Releasing Parties may have against any of the Parties, now or in the future, in each case in respect of any cause, matter or thing relating to this Agreement, other than the Post-Closing Responsibilities.

(e) The releases set forth in Section 15.5(c) or Section 15.5(d) are general releases of the Claims and Losses which are described in Section 15.5(c) or Section 15.5(d) and are intended to encompass all known and unknown, foreseen and unforeseen claims described in under Section 15.5(c) or Section 15.5(d) as of the Effective Time arising out of or in any way related to this Agreement, other than—in the case of the Parties only—the Post-Closing Responsibilities. Accordingly, the Parties hereby waive and relinquish all rights and benefits

they may have under Section 1542 of the Civil Code of the State of California (as well as under any other statutes or common law principles of similar effect) with respect to the claims being released pursuant to Section 15.5(c) or Section 15.5(d). Section 1542 reads as follows:

> "Section 1542. A GENERAL RELEASE DOES NOT EXTEND TO CLAIMS THAT THE CREDITOR OR RELEASING PARTY DOES NOT KNOW OR SUSPECT TO EXIST IN HIS OR HER FAVOR AT THE TIME OF EXECUTING THE RELEASE AND THAT, IF KNOWN BY HIM OR HER, WOULD HAVE MATERIALLY AFFECTED HIS OR HER SETTLEMENT WITH THE DEBTOR OR RELEASED PARTY."

(f) The Parties acknowledge that they may discover facts after the Effective Time that are different from or in addition to those they know or believe to be true as of the Effective Time with respect to the Claims and Losses which are the subject of the releases set forth in Section 15.5(c) or Section 15.5(d), and the Parties expressly agree to assume the risk of the possible discovery of additional or different facts and agree that this Section 15.5 shall be and remain effective in all respects regardless of such additional or different facts.

Article XVI
MISCELLANEOUS

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

To Parent:	Cedars-Sinai Health System 8700 Beverly Boulevard Suite 2211 Los Angeles, California 90048 Attention: President and Chief Executive Officer
With a copy to:	McDermott Will & Emery LLP 2049 Century Park East Suite 3200 Los Angeles, California 90067 Attention: James F. Owens, Esq.
To Huntington or the Trust:	Pasadena Hospital Association, Ltd. 100 West California Boulevard Pasadena, CA 91105 Attn: Chief Executive Officer
With a copy to:	Davis Wright Tremaine LLP 920 Fifth Avenue, Suite 3300

Seattle, Washington 98104
Attention: Jason A. Farber, Esq.

and a copy to: Hahn & Hahn LLP
301 E. Colorado Blvd., 9th Floor
Pasadena, California 91101
Attention: Christianne F. Kerns, Esq.

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

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

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

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

16.6 Entire Agreement. This Agreement, including any certificate, attachment, schedule, exhibit or other document delivered pursuant to its terms, constitutes the entire agreement between the Parties, and supersedes all prior agreements and understandings between the Parties relating to the subject matter hereof. There are no verbal agreements, representations, warranties, or undertakings between the Parties other than as provided herein, and this Agreement may not be amended or modified in any respect, except by a written instrument signed by the Parties.

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

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

16.9 Expenses. Each Party shall be responsible for the payment of all attorney fees and costs incurred by such Party in connection with the negotiation, due diligence and completion of the final terms of this Agreement and the Affiliation.

16.10 Meet and Confer. Except as otherwise provided in this Agreement, a Party shall notify the other Parties of any dispute, claim or controversy arising out of or relating to this Agreement, or the breach, termination, enforcement, interpretation, or validity thereof (collectively, a "***Dispute***"). If, within fifteen (15) days after a Party receives written notice of a Dispute (the "***Dispute Notice***"), the Parties do not resolve such Dispute, then the Dispute shall be referred to the designated senior executives with authority to resolve the Dispute from each Party for further negotiation (the "***Meet and Confer***"). The obligation to conduct a Meet and Confer

pursuant to this Section 16.10 does not obligate any Party to agree to any compromise or resolution of the Dispute that such Party does not determine, in its sole and absolute discretion, to be a satisfactory resolution of the Dispute. The Meet and Confer shall be considered a settlement negotiation for the purpose of all applicable laws protecting statements, disclosures, or conduct in such context, and any offer in compromise or other statements or conduct made at or in connection with any Meet and Confer shall be protected under such laws, including California Evidence Code Section 1152. Additionally, nothing in this Agreement shall prevent a Party from seeking provisional measures from any court of competent jurisdiction, and any such request shall not be deemed incompatible with the agreement to Meet and Confer.

16.11 Attorneys' Fees and Costs. The prevailing Party of any Action arising out of or relating to this Agreement shall be entitled to its reasonable attorneys' fees and other costs for pertaining to such Action.

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

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

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

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

16.16 Attorney-Client Privilege and Waiver of Conflicts. Each of the Parties hereby agrees, on behalf of itself and its Affiliates, that Davis Wright Tremaine LLP, Hahn & Hahn LLP or any other internal or external legal counsel currently representing Huntington or the Trust (each, a "***Prior Counsel***") may serve as counsel to Huntington and the Trust in connection with the negotiation, preparation, execution and delivery of this Agreement and the consummation of the Affiliation. In addition, all communications between Huntington or the Trust, on the one hand, and Prior Counsel, on the other hand, related to this Agreement or the Affiliation will be deemed to be attorney-client confidences that belong solely to Huntington and the Trust (and not Parent) (the "***Pre-Closing Communications***"). Accordingly, Parent will not have access to any such Pre-Closing Communications or to the files of Prior Counsel relating to such engagement from and after the Closing, and all records and other materials of Huntington or the Trust in any medium (including electronic copies) containing or reflecting any of Pre-Closing Communications or the work product of legal counsel with respect thereto, including any related summaries, drafts or analyses, and all rights with respect to any of the foregoing, are hereby

assigned and transferred to the Trust effective as of the Closing. Such material and information will be excluded from any transfer contemplated by this Agreement and will be distributed to the Trust immediately prior to Closing with no copies thereof retained by Parent, Huntington or any of their respective representatives. From and after the Closing, Parent and the Huntington Entities will maintain the confidentiality of all such material and information. From and after the Closing, none of Parent, the Huntington Entities and their respective Related Persons and representatives will access or in any way, directly or indirectly, use or rely upon any such materials or information. To the extent that any such materials or information are not delivered to the Trust, they will be held for the benefit of the Trust, and Parent, the Huntington Entities and their respective Related Persons will deliver all such material and information to the Trust promptly upon discovery thereof, without retaining copies thereof. Without limiting the generality of the foregoing, from and after the Closing, (a) Huntington and the Trust will be the sole holders of the attorney-client privilege with respect to such Pre-Closing Communications, (b) to the extent that files of Prior Counsel contain Pre-Closing Communications, such files constitute property of the client, and only the Trust will hold such property rights and (c) Prior Counsel will have no duty whatsoever to reveal or disclose any Pre-Closing Communications to any Huntington Entity by reason of any attorney-client relationship between Prior Counsel and any Huntington Entity or otherwise. Each of Parent and Huntington hereby acknowledges and confirms that it has had the opportunity to review and obtain adequate information regarding the significance and risks of the waivers and other terms and conditions of this Section 16.16, including the opportunity to discuss with counsel such matters and reasonable alternatives to such terms. The covenants and obligations set forth in this Section 16.16 shall survive Closing, shall survive termination of this Agreement and the Trust Party End Date.

16.17 Trust Party End Date.

(a) The Parties acknowledge and agree that, notwithstanding anything in this Agreement that may be construed to the contrary, the Trust shall cease to be a party to this agreement as of the date (the "***Trust Party End Date***") that is the later of (i) the fifth (5^{th}) anniversary of the Closing Date and (ii) the date on which the projects that are part of the "FMP Non-Compliance & Major Capital Projects Budget" set forth on Exhibit C have been completed and (iii) the date on which the Trust is fully released from all of its obligations in connection with Huntington's bond indebtedness and related contractual obligations referenced in the Reimbursement Agreement. Notwithstanding anything to the contrary, any claim that is asserted by or on behalf of the Trust prior to the Trust Party End Date will survive until the resolution and satisfaction of such claim.

(b) In furtherance of the foregoing, the Parties expressly agree that as of the Trust Party End Date the Trust will have no further rights or obligations as against Parent or Huntington under this Agreement and Huntington and Parent will have no further rights or obligations as against the Trust under this Agreement; provided that the rights and obligations of the Parties pursuant to Section 1.2 (Rules of Interpretation), Article XII (Protective Provisions), Sections 13.10 (Trust Distributions), Article XV (Remedies), Article XVI (Miscellaneous) and all provisions of the NDA (collectively, the "***Surviving Trust Rights and Obligations***") will remain in full force and effect and survive the Trust Party End Date to the same extent otherwise set forth in this Agreement.

(c) Effective as of the Trust Party End Date:

(i) The Trust, on behalf of itself and its Releasing Parties, irrevocably and unconditionally releases and forever discharges each of Huntington and Parent and their respective Related Persons from, and forever disclaims, waives and relinquishes and will be forever precluded from asserting, any and all Claims and Losses which the Trust and its Releasing Parties may have against any of Huntington or Parent, now or in the future, in each case in respect of any cause, matter or thing relating to this Agreement, other than the Surviving Trust Rights and Obligations.

(ii) Each of Huntington and Parent (each on behalf of itself and their respective Releasing Parties), irrevocably and unconditionally releases and forever discharges the Trust and its Related Persons from, and forever disclaims, waives and relinquishes and will be forever precluded from asserting, any and all Claims and Losses which each of Huntington and Parent and their respective Releasing Parties may have against the Trust, now or in the future, in each case in respect of any cause, matter or thing relating to this Agreement, other than the Surviving Trust Rights and Obligations.

(d) The mutual release set forth in Section 16.17(c) is a general release of the Claims and Losses which are described in Section 16.17(c) and is intended to encompass all known and unknown, foreseen and unforeseen claims described in Section 16.17(c) as of the Trust Party End Date arising out of or in any way related to this Agreement, other than the Surviving Trust Rights and Obligations. Accordingly, the Parties hereby waive and relinquish all rights and benefits they may have under Section 1542 of the Civil Code of the State of California (as well as under any other statutes or common law principles of similar effect) with respect to the claims being released pursuant to Section 16.17(c). Section 1542 reads as follows:

> "Section 1542. A GENERAL RELEASE DOES NOT EXTEND TO CLAIMS THAT THE CREDITOR OR RELEASING PARTY DOES NOT KNOW OR SUSPECT TO EXIST IN HIS OR HER FAVOR AT THE TIME OF EXECUTING THE RELEASE AND THAT, IF KNOWN BY HIM OR HER, WOULD HAVE MATERIALLY AFFECTED HIS OR HER SETTLEMENT WITH THE DEBTOR OR RELEASED PARTY."

(e) The Parties acknowledge that they may discover facts after the Trust Party End Date that are different from or in addition to those they know or believe to be true as of the Trust Party End Date with respect to the Claims and Losses which are the subject of the release set forth in Section 16.17(c), and the Parties expressly agree to assume the risk of the possible discovery of additional or different facts and agree that this Section 16.17 shall be and remain effective in all respects regardless of such additional or different facts.

(f) This Section 16.17 shall survive the termination or expiration of this Agreement.

[Signature page follows]

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

PARENT:

CEDARS-SINAI HEALTH SYSTEM, a California nonprofit public benefit corporation

By: REDACTED

Name: Vera Guerin
Title: Chair of the Board

By: REDACTED

Name: Thomas M. Priselac
Title: President and Chief Executive Officer

HUNTINGTON:

PASADENA HOSPITAL ASSOCIATION LTD.,
a California nonprofit public benefit corporation
d/b/a Huntington Hospital

REDACTED

Name: Lori J. Morgan, M.D.
Title: President and Chief Executive Officer

TRUST:

REDACTED

By
Jaynie Studenmund, Trustee of the COLLIS P. AND HOWARD HUNTINGTON MEMORIAL HOSPITAL TRUST

REDACTED

By:
Armando L. Gonzalez, Trustee of the COLLIS P. AND HOWARD HUNTINGTON MEMORIAL HOSPITAL TRUST

REDACTED

By:
Michelle Quinones Chino, Trustee of the COLLIS P. AND HOWARD HUNTINGTON MEMORIAL HOSPITAL TRUST

REDACTED

By:
Paul Johnson, Trustee of the COLLIS P. AND HOWARD HUNTINGTON MEMORIAL HOSPITAL TRUST

REDACTED

By:
Wayne Brandt, Trustee of the COLLIS P. AND HOWARD HUNTINGTON MEMORIAL HOSPITAL TRUST

Exhibit A

Unwind Event

1. Huntington Unwind Event. If Parent causes a Huntington Unwind Event, Parent shall promptly notify Huntington in writing of the same (the "***Huntington Unwind Event Notice***"). Upon Huntington's receipt of the Huntington Unwind Event Notice, Huntington shall have the right, but not the obligation, to terminate Parent's membership in Huntington (the "***Huntington Unwind Right***") pursuant to the following terms:

(a) Huntington shall give Parent notice of Huntington's intent to exercise the Huntington Unwind Right within thirty (30) days of Huntington's receipt of the Huntington Unwind Event Notice from Parent ("***Exercise of Unwind Notice***"), which intent to exercise the Huntington Unwind Right shall have been approved by the Board of Directors of Huntington.

(b) As soon as practical thereafter, the Parties shall meet and confer in order to mutually agree to the actions necessary to effectuate the termination of Parent's membership in Huntington and an estimated date of termination for Parent's membership in Huntington (the "***Anticipated Termination Date***"). Thereafter, Parent and Huntington shall work together in good faith to modify their organizational documents, take all actions agreed to by the Parties, and take all other actions necessary and appropriate to terminate Parent's membership in Huntington, which shall result in Huntington assuming all assets and liabilities of Huntington and each Huntington Subsidiary.

(c) In connection with the termination of Parent's membership in Huntington, and in exchange for fair market value compensation, Huntington may require Parent to provide reasonable management or other administrative services to Huntington Entities on mutually agreed upon terms for a reasonable period of time after Parent's membership in Huntington is terminated to minimize any economic or operational injury to the Huntington Entities. Parent and Huntington agree to work together in good faith to agree upon such services if requested by Huntington.

(d) Within sixty (60) days of receiving the Exercise of Unwind Notice, Parent shall provide Huntington its accounting of and anticipated payment dates (all of which shall be prior to the Anticipated Termination Date) during the unwind period of the following amounts due from/due to each other as of the Anticipated Termination Date. In the event that Huntington disagrees with Parent's accounting or payment dates, the Parties shall work in good faith to resolve such dispute prior to the Anticipated Termination Date.

(i) The "***Owed Parent Expense Payments***" to be paid by Huntington to Parent, which shall be equal to: (a) the aggregate of all Parent Operating Expenses Payments owed to Parent by Huntington and unpaid as of the Anticipated Termination Date, plus (b) the aggregate of any Contribution Deferrals (as defined below) owed by Huntington pursuant to Exhibit B, and including all Interest (as defined below) on such amounts accrued until the date of payment;

(ii) The "***Aggregate Investment in Huntington***" to be paid by Huntington to Parent, which shall be equal to: (a) the aggregate capital invested or contributed by

Parent in or to Huntington or a Huntington Subsidiary after the Closing Date (the "***Investment in Huntington***"), which would include, without limitation, all portions of the Funding Commitment and EHR Project Capital Costs paid, incurred or loaned by Parent to Huntington or any other Person, plus (b) an amount equal to the Interest accrued on the Investment in Huntington until the date of payment;

(iii) The "***Owed Huntington Expense, Asset, and Capital Contribution Payments***" to be paid by Parent to Huntington, which shall be equal to: (a) the aggregate of all Huntington Capital Contributions pursuant to Exhibit B of this Agreement plus all Interest accrued on such contributions at the time each Huntington Capital Contribution was made, plus (b) the aggregate of all Parent Operating Expenses Payments pursuant to Section 13.4 of this Agreement plus all Interest accrued on all Parent Operating Expense Payments at the time each was made.

(iv) For purposes of this Exhibit A, "***Interest***" shall be defined as the payee's applicable annual rate of interest on its investment portfolio, at the time of payment and over the period paid to the other Party.

(v) Once all actions necessary and appropriate to terminate Parent's membership in Huntington have been completed and all payments due from/due to the Parties have been made or agreed to, the Parties shall execute a final notice indicating that all actions have been completed to effectuate the termination of Parent's membership in Huntington (the "***Final Notice***"). The execution date of the Final Notice shall be the date on which Parent's membership in Huntington shall be effectively terminated.

(e) Huntington acknowledges and agrees that if Parent's membership in Huntington has not been effectively terminated within thirty (30) months after Parent receives the Exercise of Unwind Notice, then unless the Parties otherwise agree in writing, the Huntington Unwind Right shall automatically expire and terminate as to that Exercise of Unwind Notice.

2. No Restrictions. In the event Parent's membership in Huntington is terminated pursuant to the terms set forth in this Exhibit A, the Parties acknowledge and agree that after the effective date of such membership termination there shall be no restrictions on the operations or actions of any Party or its affiliated entities. Without limiting the generality of the foregoing, in the event Parent's membership in Huntington is terminated pursuant to the terms set forth in this Exhibit A, the Parties: (i) shall not be restricted from competing with each other in any way, and (ii) shall not be restricted from soliciting or recruiting each other's employees or affiliated physicians in any way. The Parties further acknowledge and agree that in the event Parent's membership in Huntington is terminated pursuant to the terms set forth in this Exhibit A, any medical practitioner providing services on behalf of Parent, Huntington or any of their respective Related Persons may elect to either: (i) continue providing services on behalf of such entity, or (ii) provide services for any other entity. The Parties agree that Huntington and Parent may solicit physicians and other providers during any unwind period.

3. Termination of Agreement. Notwithstanding anything in this Agreement that may be construed to the contrary, the Parties acknowledge and agree that in the event Parent's

membership in Huntington is terminated pursuant to the terms set forth in this Exhibit A, this Agreement shall automatically terminate upon the effective date of the termination of Parent's membership interest in Huntington.

Exhibit B

Capital Contributions to Parent

1. Capital Contributions. If Parent determines at any time after the Capital Plan Period that additional capital or other funds are required for any investments, capital initiatives, transactions or growth of Parent, Huntington or a Huntington Subsidiary, CSMC, THA or any additional Affiliate Hospital Organization (a "***Capital Need***"), Huntington shall be obligated to contribute capital to Parent (or to an entity indicated by Parent) for the purpose of funding such Capital Need pursuant to this Exhibit B.

2. Capital Call Notice. If Parent determines that a capital contribution is necessary from Huntington to fund a Capital Need pursuant to this Exhibit B, then Parent shall deliver a written notice (the "***Capital Call Notice***") to Huntington stating:

(a) the aggregate amount of the Capital Need and the intended uses therefor;

(b) the amount of the Capital Need to be provided by Huntington, which shall be proportionate to the number of individuals that Huntington has the right to nominate to the Board of Directors of Parent pursuant to the bylaws of Parent then in effect (which calculation shall not take into account any ex-officio members of the Board of Directors of Parent) ("***Huntington Capital Contribution***");

(c) the amount of the Capital Need to be provided by each Affiliate Hospital Organization (including CSMC and THA);

(d) the due date for Huntington's payment of the Huntington Capital Contribution; provided, however, Huntington shall each have at least fifteen (15) days from the date of the Capital Call Notice to make the Huntington Capital Contribution or provide a Notice of Deferral (as defined in and pursuant to Section 3 of this Exhibit B);

(e) instructions for payment of the Huntington Capital Contribution; and

(f) any other information Parent reasonably determines should be included in the Capital Call Notice.

3. Timing of Capital Contribution. All Huntington Capital Contributions shall be made by Huntington pursuant to the payment instructions set forth in the Capital Call Notice on or prior to the due date set forth in the Capital Call Notice. Provided, however, if making a Huntington Capital Contribution pursuant to this Exhibit B would cause the Huntington Entities, on a consolidated basis, to have cash on hand in an amount that is less than Sixty Days Expenses, then Huntington shall have the right to defer making the Huntington Capital Contribution (a "***Contribution Deferral***") until such time as Huntington accumulates sufficient cash on hand to make the Huntington Capital Contribution. In the event that Huntington elects to defer making the Huntington Capital Contribution, Huntington shall provide notice to Parent of such deferral instead of the Huntington Capital Contribution (the "***Notice of Deferral***").

Exhibit C

Huntington Strategic Capital Plan

Huntington Strategic Capital Plan

	2021 - 2023	Total *(rounded)*
FMP Non-Compliance & Major Capital Projects Budget	85,000	**85,000**

	2021	2022	2023	2024	2025	2026	2027	2028	2029	Total *(rounded)*
Routine Capital Budget	30,500	30,500	30,500	30,500	30,500	30,500	30,500	30,500	30,500	**275,000**

	2021 - 2025	2026 - 2029	Total *(rounded)*
Strategic Capital Budget	100,000	100,000	**200,000**

Total Proposed Capital *(rounded)*	**560,000**

($ in 000's)

Detailed FMP Non-Compliance Projects and Major Capital Projects Budget

	2021	2022	2023	2024	2025	Total
FMP Non-Compliance	**31,352**	**7,000**	**-**	**-**	**-**	**38,352**
Operating Room Build Out and Renovation	*31,352*	*7,000*	-	-	-	*38,352*
Major Capital	**23,882**	**15,594**	**6,594**	**594**	**594**	**47,258**
COU Relocation	*500*	-	-	-	-	*500*
CSPD Masterplan	*12,879*	*3,000*	-	-	-	*15,879*
Unit 35 Relocation	*4,534*	-	-	-	-	*4,534*
IT Relocation	*900*	-	-	-	-	*900*
Clinical Lab HVAC Upgrade (Regulatory)	*875*	-	-	-	-	*875*
CT Scan Upgrade	*800*	-	-	-	-	*800*
Rad Fluoroscopy 7&8	*500*	-	-	-	-	*500*
Pathology Lab Upgrade	*300*	-	-	-	-	*300*
Surgery Department Associated Services Upgrade	*2,000*	*12000*	*6000*	-	-	*20,000*
Intuitive Robotics	*594*	*594*	*594*	*594*	*594*	*2,970*
Total	**55,234**	**22,594**	**6,594**	**594**	**594**	**85,610**

($ in 000's)

Exhibit D

EHR Project – Core Modules

Inpatient
Prelude Registration/ADT
Cadence Scheduling
Health Information Management (HIM)
EpicCare Clinical System
- EMR
- Clinical Order Entry
- Decision Support
- Results Review
- Clinical Documentation
- MAR
- Rover Barcoding
- Clinical Pathways
- Care Plans & Education
- Infection Control*
- Clinical Case Management
- ICU
- Willow Inpatient Pharmacy

Specialties
Optime (OR Management)
Anesthesia
ASAP (Emergency Department)
Beaker (Clinical Lab & Pathology)*
Radiant (Radiology)*
Beacon (Oncology)*
Cupid (Cardiology)*
Stork (OB Labor/Delivery)
Bones (Orthopaedics)
Behavioral Health*
Dialysis*
EpicCare Rehab

Access & Revenue Cycle
Resolute Hospital Billing
Resolute Professional Billing
Charge Router
Eligibility
Referrals
Financial Assistance
Transfer Center

Ambulatory
Prelude Registration
Cadence Scheduling
EpicCare EHR
- Charting
- Clinical Order Entry
- e-Prescribing
- Decision Support
- Results Review
- Coding & Benefits

Welcome Patient
Check-In

Population Health & Analytics
Healthy Planet (Population Health)
Cogito Analytics
- Dashboards
- Reporting
- Analytics
- Enterprise Data Warehouse

Patient Portal
MyChart (shared EMR for patients)
MyChart Bedside (for hospital patients)

Telemedicine
Video Visits
Specialty consults

Interoperability
Care Everywhere
Share Everywhere

Clinician Mobile
Haiku (for smartphone)
Canto (for tablet)
Limerick (for watch)

**Implementation of these modules as part of the completion of the EHR Project is subject to further discussion by and approval of the EHR Project Committee.*

Exhibit E

Modules To be Provided Under Parent's Epic Enterprise License

Inpatient
Prelude Registration/ADT
Cadence Scheduling
Health Information Management (HIM)
EpicCare Clinical System
- EMR
- Clinical Order Entry
- Decision Support
- Results Review
- Clinical Documentation
- MAR
- Rover Barcoding
- Clinical Pathways
- Care Plans & Education
- Infection Control
- Clinical Case Management
- ICU
- Willow Inpatient Pharmacy

Access & Revenue Cycle
Resolute Hospital Billing
Resolute Professional Billing
Charge Router
Eligibility
Referrals
Contract Modeling
Financial Assistance
Patient Estimates
Transfer Center

Specialties
Optime (OR Management)
Anesthesia
ASAP (Emergency Department)
Urgent Care
Beaker (Clinical Lab & Pathology)
Radiant (Radiology)
Beacon (Oncology)
Cupid (Cardiology)
Stork (OB Labor/Delivery)
Kaleidoscope (Ophthalmology)
Phoenix (Transplant)
Bones (Orthopaedics)
Wisdom (Dental)
Behavioral Health
Dialysis
EpicCare Fertility
Lumens (Endoscopy)
EpicCare Rehab

Managed Care (Tapestry)
Enrollment/Eligibility
Claims/Capitation
Utilization Management
Premium Billing
PlanLink

Ambulatory
Prelude Registration
Cadence Scheduling
Call Management/CRM
EpicCare EHR
- Charting
- Clinical Order Entry
- e-Prescribing
- Decision Support
- Results Review
- Coding & Benefits

Nurse Triage
Willow Ambulatory Pharmacy
Welcome Patient Check-In

Population Health & Analytics
Healthy Planet (Population Health)
Cogito Analytics
- Dashboards
- Reporting
- Analytics
- Enterprise Data Warehouse

Clinician Mobile
Haiku (for smartphone)
Canto (for tablet)
Limerick (for watch)

Patient Portal
MyChart (shared EMR for patients)
MyChart Bedside (for hospital patients)
MyChart Virtual Care (chronic disease management)
MyChart Health Coach (promotes wellness)
Lucy (free-standing PHR)

Telemedicine
Video Visits
Specialty consults
Remote interpreters
ICU / bed monitoring
Virtual Rounds

Interoperability
Community Connect
EpicCare Link
Care Everywhere
Share Everywhere

Research
Patient Enrollment
Research Analytics
Research Billing
CTMS Interface
Genomics

Exhibit F

EHR Project Committee

The EHR Project Committee will be the steering committee responsible for the EHR Project implementation and transformation efforts, timeline, resource allocation and commitments and budget management. The EHR Project Committee will set the overall EHR Project plan, provide day to day management of the EHR Project, make key decisions regarding the EHR Project and communicate all issues, risks and/or decisions with Huntington's executive leadership.

The following are assumptions and expectations regarding the composition of the EHR Project Committee and its scope:

- Chair: Cedars-Sinai shall assign a Chair for the EHR Project committee who is an expert in EHR implementation who can provide oversight and direction for the overall EHR Project. The Chair will have ultimate decision-making authority for the EHR Project in collaboration with the EHR Project Committee members.
- EHR Project Directors/Managers: Cedars-Sinai shall provide EHR Project Directors/Managers who will also be part of the EHR Project Committee; they will be full-time dedicated to the EHR Project and lead the EHR Project management and transformation office.
- Huntington Project Leadership: Huntington shall commit the necessary administrative and clinical leadership to the EHR Project Committee who have the authority to make critical decisions and prioritize key issues regarding the EHR Project. The Huntington EHR Committee members will also serve as the key communicators with the Huntington management team and EHR key stakeholders and users and will obtain input from key stakeholders to inform decisions and directions about EHR Project implementation.
- Sub-Committees and Workgroups: The EHR Project Committee will create sub-committees and workgroups, as needed, to focus on specific elements of implementation, training and/or development of the core modules for the EHR Project. These sub-committees and workgroups will report to the EHR Project Committee and will be led by a member of the EHR Project management and transformation office.
- Huntington shall identify and commit the necessary experts and resources from clinical areas, including but not limited to Medical Staff/physicians, nursing and pharmacy to support the EHR Project Committee, sub-committees and workgroups to ensure optimal and efficient workflow design and change management. In addition, other subject matter experts from Cedars-Sinai and Huntington will participate, as needed, on the EHR Project Committee, sub-committees and/or workgroups.

Exhibit G

Huntington Hospital Land – Legal Description[1]

PARCEL 1: 5719-027-042 also known as 624 South Pasadena Avenue

LOT 4 OF LEONARD'S SUBDIVISION OF PART OF DIVISION "F" OF THE LANDS OF THE SAN GABRIEL ORANGE GROVE ASSOCIATION, IN THE CITY OF PASADENA, COUNTY OF LOS ANGELES, STATE OF CALIFORNIA, AS PER MAP RECORDED IN BOOK 14, PAGE 11 OF MISCELLANEOUS RECORDS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY.

PARCEL 2: 5719-027-052 also known as 47 Congress Street

LOT 14 OF MARTIN'S SUBDIVISION OF PART OF THE FRANK GREEN TRACT, IN THE CITY OF PASADENA, AS PER MAP RECORDED IN BOOK 10, PAGE 46 OF MISCELLANEOUS RECORDS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY.

PARCEL 3: 5719-027-061 also known as 100 Congress Street

PARCEL 2, OF PARCEL MAP NO. 18337, IN THE CITY OF PASADENA, COUNTY OF LOS ANGELES, STATE OF CALIFORNIA, AS PER MAP RECORDED IN BOOK 246, PAGES 73-75 OF MAPS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY;

TOGETHER WITH A PORTION OF PARCEL 1, OF SAID PARCEL MAP NO. 18337, DESCRIBED AS FOLLOWS:

BEGINNING AT THE NORTHEASTERLY CORNER OF SAID PARCEL 1; THENCE ALONG THE NORTHERLY LINE OF SAID PARCEL 1, NORTH 89°58’04” WEST 147.58 FEET TO THE TRUE POINT OF BEGINNING; THENCE CONTINUING ALONG THE NORTHERLY LINE OF SAID PARCEL 1, NORTH 89°58’04” WEST 210.07 FEET TO THE NORTHWESTERLY CORNER OF SAID PARCEL 1; THENCE ALONG THE WESTERLY LINE OF SAID PARCEL 1, SOUTH 0°00’03” WEST 499.23 FEET TO THE SOUTHWESTERLY CORNER OF SAID PARCEL 1; THENCE ALONG THE SOUTHERLY LINE OF SAID PARCEL 1, SOUTH 89°49’41” EAST 211.07 FEET; THENCE PARALLEL WITH THE WESTERLY LINE OF SAID PARCEL 1, NORTH 0°00’03” EAST

[1] The legal description of Parcel 3 is subject to minor variations which become necessary as a result of the lot line adjustment approval process to the end that the legal description of Parcel 3 matches the parcel as so approved when the Huntington Hospital Land is transferred to Huntington.

174.05 FEET; THENCE NORTH 89°59’57”WEST 1.00 FEET; THENCE PARALLEL WITH THE WESTERLY LINE OF SAID PARCEL 1, NORTH 0°00’03” EAST 325.70 FEET TO THE TRUE POINT OF BEGINNING.

EXCEPT THAT PORTION OF SAID PARCEL 2, DESCRIBED AS FOLLOWS:

BEGINNING AT THE NORTHEAST CORNER OF SAID PARCEL 2; THENCE ALONG THE EASTERLY LINE OF SAID PARCEL 2, SOUTH 285.20 FEET TO THE EASTERLY PROLONGATION OF THAT CERTAIN COURSE ON THE EASTERLY LINE OF SAID PARCEL 2, SHOWN ON SAID PARCEL MAP NO. 18337 AS "NORTH 89°55'38" WEST 100.00 FEET", SAID INTERSECTION ALSO BEING THE NORTHWEST CORNER OF SAID LOT 7; THENCE WESTERLY ALONG SAID PROLONGED LINE NORTH 89°55'42" WEST 156.00 FEET; THENCE PARALLEL WITH THE EASTERLY LINE OF SAID PARCEL 2, NORTH 285.32 FEET TO THE NORTHERLY LINE OF SAID PARCEL 2; THENCE ALONG THE NORTHERLY LINE OF SAID PARCEL 2, SOUTH 89°52'55" EAST 156.00 FEET, TO THE POINT OF BEGINNING.

For conveyancing purposes only: APN 5719-027-042; 5719-027-052; 5719-027-061

Exhibit H

Huntington Hospital Land – Title Exceptions[2]

The following items shall be included as part of Permitted Liens:

1. Any defect, lien, encumbrance, adverse claim, or other matter that appears for the first time in the Public Records or is created, attaches, or is disclosed between the Commitment Date and the date on which all of the Schedule B, Part I-Requirements are met.

2. (a) Taxes or assessments that are not shown as existing liens by the records of any taxing authority that levies taxes or assessments on real property or by the Public Records; (b) proceedings by a public agency that may result in taxes or assessments, or notices of such proceedings, whether or not shown by the records of such agency or by the Public Records.

3. Any facts, rights, interests, or claims that are not shown by the Public Records but that could be ascertained by an inspection of the Land or that may be asserted by persons in possession of the Land.

4. Easements, liens or encumbrances, or claims thereof, not shown by the Public Records.

5. Any encroachment, encumbrance, violation, variation, or adverse circumstance affecting the Title that would be disclosed by an accurate and complete land survey of the Land and not shown by the Public Records.

6. (a) Unpatented mining claims; (b) reservations or exceptions in patents or in Acts authorizing the issuance thereof; (c) water rights, claims or title to water, whether or not the matters excepted under (a), (b), or (c) are shown by the Public Records.

7. General and special taxes and assessments for the fiscal year 2020-2021, a lien not yet due or payable.

8. The lien of supplemental taxes, if any, assessed pursuant to Chapter 3.5 commencing with Section 75 of the California Revenue and Taxation Code.

9. Water rights, claims or title to water, whether or not shown by the public records.

10. An easement for public street purposes for the widening of Fair Oaks Avenue, as shown on various maps of record.

[2] The parties agree to work together and with the Title Company and the surveyor preparing the Surveys after signing of this Agreement and prior to transferring title to the Huntington Hospital Land to Huntington to use commercially reasonable efforts to remove as exceptions from this Exhibit and the Title Commitment any items which do not affect the Huntington Hospital Land, and revise other general exceptions in this Exhibit and the Title Commitment to make them specific in light of specific facts pertaining to the Huntington Hospital Land at the time the Title Policy is issued.

11. An easement for conducting water and incidental purposes, recorded December 18, 1879 in Book 27 of Deeds, Page 229.

In Favor of:

Affects: John S. Griffin, P. Reynolds

12. Covenants, conditions, restrictions and easements in the document recorded in Book 2534 of Deeds, Page 15, which provide that a violation thereof shall not defeat or render invalid the lien of any first mortgage or deed of trust made in good faith and for value, but deleting any covenant, condition or restriction indicating a preference, limitation or discrimination based on race, color, religion, sex, handicap, familial status, national origin, sexual orientation, marital status, ancestry, source of income or disability, to the extent such covenants, conditions or restrictions violate Title 42, Section 3604(c), of the United States Codes or Section 12955 of the California Government Code. Lawful restrictions under state and federal law on the age of occupants in senior housing or housing for older persons shall not be construed as restrictions based on familial status.

13. Covenants, conditions, restrictions and easements in the document recorded in Book 2711 of Deeds, Page 46, which provide that a violation thereof shall not defeat or render invalid the lien of any first mortgage or deed of trust made in good faith and for value, but deleting any covenant, condition or restriction indicating a preference, limitation or discrimination based on race, color, religion, sex, handicap, familial status, national origin, sexual orientation, marital status, ancestry, source of income or disability, to the extent such covenants, conditions or restrictions violate Title 42, Section 3604(c), of the United States Codes or Section 12955 of the California Government Code. Lawful restrictions under state and federal law on the age of occupants in senior housing or housing for older persons shall not be construed as restrictions based on familial status.

14. Covenants, conditions, restrictions and easements in the document recorded in Book 2712 of Deeds, Page 272, which provide that a violation thereof shall not defeat or render invalid the lien of any first mortgage or deed of trust made in good faith and for value, but deleting any covenant, condition or restriction indicating a preference, limitation or discrimination based on race, color, religion, sex, handicap, familial status, national origin, sexual orientation, marital status, ancestry, source of income or disability, to the extent such covenants, conditions or restrictions violate Title 42, Section 3604(c), of the United States Codes or Section 12955 of the California Government Code. Lawful restrictions under state and federal law on the age of occupants in senior housing or housing for older persons shall not be construed as restrictions based on familial status.

15. Covenants, conditions, restrictions and easements in the document recorded in Book 4097 of Deeds, Page 90, which provide that a violation thereof shall not defeat or render invalid the lien of any first mortgage or deed of trust made in good faith and for value, but deleting any covenant, condition or restriction indicating a preference, limitation or discrimination based on race, color, religion, sex, handicap, familial status, national origin, sexual orientation, marital status, ancestry, source of income or disability, to the extent such covenants, conditions or restrictions violate Title 42, Section 3604(c), of the United States Codes or Section 12955 of the

California Government Code. Lawful restrictions under state and federal law on the age of occupants in senior housing or housing for older persons shall not be construed as restrictions based on familial status.

16. Covenants, conditions, restrictions and easements in the document recorded in Book 4339 of Deeds, Page 143, which provide that a violation thereof shall not defeat or render invalid the lien of any first mortgage or deed of trust made in good faith and for value, but deleting any covenant, condition or restriction indicating a preference, limitation or discrimination based on race, color, religion, sex, handicap, familial status, national origin, sexual orientation, marital status, ancestry, source of income or disability, to the extent such covenants, conditions or restrictions violate Title 42, Section 3604(c), of the United States Codes or Section 12955 of the California Government Code. Lawful restrictions under state and federal law on the age of occupants in senior housing or housing for older persons shall not be construed as restrictions based on familial status.

17. Covenants, conditions, restrictions and easements in the document recorded in Book 4370 of Deeds, Page 149, which provide that a violation thereof shall not defeat or render invalid the lien of any first mortgage or deed of trust made in good faith and for value, but deleting any covenant, condition or restriction indicating a preference, limitation or discrimination based on race, color, religion, sex, handicap, familial status, national origin, sexual orientation, marital status, ancestry, source of income or disability, to the extent such covenants, conditions or restrictions violate Title 42, Section 3604(c), of the United States Codes or Section 12955 of the California Government Code. Lawful restrictions under state and federal law on the age of occupants in senior housing or housing for older persons shall not be construed as restrictions based on familial status.

18. Covenants, conditions, restrictions and easements in the document recorded in Book 4428 of Deeds, Page 47, which provide that a violation thereof shall not defeat or render invalid the lien of any first mortgage or deed of trust made in good faith and for value, but deleting any covenant, condition or restriction indicating a preference, limitation or discrimination based on race, color, religion, sex, handicap, familial status, national origin, sexual orientation, marital status, ancestry, source of income or disability, to the extent such covenants, conditions or restrictions violate Title 42, Section 3604(c), of the United States Codes or Section 12955 of the California Government Code. Lawful restrictions under state and federal law on the age of occupants in senior housing or housing for older persons shall not be construed as restrictions based on familial status.

19. Covenants, conditions, restrictions and easements in the document recorded in Book 4680 of Deeds, Page 318, which provide that a violation thereof shall not defeat or render invalid the lien of any first mortgage or deed of trust made in good faith and for value, but deleting any covenant, condition or restriction indicating a preference, limitation or discrimination based on race, color, religion, sex, handicap, familial status, national origin, sexual orientation, marital status, ancestry, source of income or disability, to the extent such covenants, conditions or restrictions violate Title 42, Section 3604(c), of the United States Codes or Section 12955 of the California Government Code. Lawful restrictions under state and federal law on the age of occupants in senior housing or housing for older persons shall not be construed as restrictions based on familial status.

20. Covenants, conditions, restrictions and easements in the document recorded in Book 4494 of Deeds, Page 163, which provide that a violation thereof shall not defeat or render invalid the lien of any first mortgage or deed of trust made in good faith and for value, but deleting any covenant, condition or restriction indicating a preference, limitation or discrimination based on race, color, religion, sex, handicap, familial status, national origin, sexual orientation, marital status, ancestry, source of income or disability, to the extent such covenants, conditions or restrictions violate Title 42, Section 3604(c), of the United States Codes or Section 12955 of the California Government Code. Lawful restrictions under state and federal law on the age of occupants in senior housing or housing for older persons shall not be construed as restrictions based on familial status.

21. Covenants, conditions, restrictions and easements in the document recorded in Book 5212 of Deeds, Page 43, which provide that a violation thereof shall not defeat or render invalid the lien of any first mortgage or deed of trust made in good faith and for value, but deleting any covenant, condition or restriction indicating a preference, limitation or discrimination based on race, color, religion, sex, handicap, familial status, national origin, sexual orientation, marital status, ancestry, source of income or disability, to the extent such covenants, conditions or restrictions violate Title 42, Section 3604(c), of the United States Codes or Section 12955 of the California Government Code. Lawful restrictions under state and federal law on the age of occupants in senior housing or housing for older persons shall not be construed as restrictions based on familial status.

22. Covenants, conditions, restrictions and easements in the document recorded in Book 5655 of Deeds, Page 33, which provide that a violation thereof shall not defeat or render invalid the lien of any first mortgage or deed of trust made in good faith and for value, but deleting any covenant, condition or restriction indicating a preference, limitation or discrimination based on race, color, religion, sex, handicap, familial status, national origin, sexual orientation, marital status, ancestry, source of income or disability, to the extent such covenants, conditions or restrictions violate Title 42, Section 3604(c), of the United States Codes or Section 12955 of the California Government Code. Lawful restrictions under state and federal law on the age of occupants in senior housing or housing for older persons shall not be construed as restrictions based on familial status.

23. An easement for pole line and incidental purposes, recorded October 18, 1933 as Book 12466, Page 34 of Official Records.

In Favor of: Western Union Telegraph Co.

Affects: as described therein

24. The right of Southern California Edison Company, Ltd., to use an existing pole line under the terms and conditions of an unrecorded License Agreement between Los Angeles & Salt Lake Railroad Company, and the Western Union Telegraph Company, Licensors and Southern California Edison Company, Ltd., Licensee, as recited in the deed recorded October 18, 1933 in Book 12466, Page 34, Official Records.

25. Covenants, conditions, restrictions and easements in the document recorded March 10, 1937 as Instrument No. 361, in Book 14686 Page 348 of Official Records, which provide that a violation thereof shall not defeat or render invalid the lien of any first mortgage or deed of trust made in good faith and for value, but deleting any covenant, condition or restriction indicating a preference, limitation or discrimination based on race, color, religion, sex, handicap, familial status, national origin, sexual orientation, marital status, ancestry, source of income or disability, to the extent such covenants, conditions or restrictions violate Title 42, Section 3604(c), of the United States Codes or Section 12955 of the California Government Code. Lawful restrictions under state and federal law on the age of occupants in senior housing or housing for older persons shall not be construed as restrictions based on familial status.

26. Covenants, conditions, restrictions and easements in the document recorded as in Book 18405 Page 368 of Official Records, which provide that a violation thereof shall not defeat or render invalid the lien of any first mortgage or deed of trust made in good faith and for value, but deleting any covenant, condition or restriction indicating a preference, limitation or discrimination based on race, color, religion, sex, handicap, familial status, national origin, sexual orientation, marital status, ancestry, source of income or disability, to the extent such covenants, conditions or restrictions violate Title 42, Section 3604(c), of the United States Codes or Section 12955 of the California Government Code. Lawful restrictions under state and federal law on the age of occupants in senior housing or housing for older persons shall not be construed as restrictions based on familial status.

27. Intentionally Omitted.

28. Covenants, conditions, restrictions and easements in the document recorded as in Book 19570 Page 353 of Official Records, which provide that a violation thereof shall not defeat or render invalid the lien of any first mortgage or deed of trust made in good faith and for value, but deleting any covenant, condition or restriction indicating a preference, limitation or discrimination based on race, color, religion, sex, handicap, familial status, national origin, sexual orientation, marital status, ancestry, source of income or disability, to the extent such covenants, conditions or restrictions violate Title 42, Section 3604(c), of the United States Codes or Section 12955 of the California Government Code. Lawful restrictions under state and federal law on the age of occupants in senior housing or housing for older persons shall not be construed as restrictions based on familial status.

29. The right to explore for, remove and dispose of minerals by any suitable means or methods, without entering upon or using the surface of the land as reserved by Los Angeles & Salt Lake Railroad Company recorded in Book 24171 Page 421 and by Union Pacific Railroad Company in Book 24183 Page 434, both of Official Records.

30. An easement for telephone, telegraph and signal wires and incidental purposes, recorded February 10, 1948 as Instrument No. 950, in Book 26416 Page 372 of Official Records.

In Favor of:

Affects: as described therein

31. An easement for gas, sewers and water connection and incidental purposes, recorded March 23, 1950 as Instrument No. 415, in Book 32646, Page 294 of Official Records.

In Favor of:

Affects: as described therein

32. The terms, provisions and easement(s) contained in the document entitled "Grant of Easement" recorded February 15, 1961 as Instrument No. 4965 in Book D1124, Page 686 of Official Records.

33. The rights, if any, of a city, public utility or special district, pursuant to Section 8345 et seq. of the California Streets and Highways Code, to preserve a public easement in Fairmount Avenue and/or Congress Street as the same was vacated by the document recorded October 27, 1969 as Instrument No. 2122 of Official Records.

34. An easement for public utilities and incidental purposes, recorded May 12, 1972 as Instrument No. 3831 of Official Records.

In Favor of: The City of Pasadena, a municipal corporation

Affects: as described therein

35. Terms and provisions of an unrecorded lease dated February 12, 1972, by and between Alan E. Robbins as lessor and PMP, a limited partnership as lessee, as disclosed by a Memorandum of Lease recorded June 01, 1972 as Instrument No. 2430 of Official Records.

Defects, liens, encumbrances or other matters affecting the leasehold estate, whether or not shown by the public records are not shown herein.

36. The rights, if any, of a city, public utility or special district, pursuant to Section 8345 et seq. of the California Streets and Highways Code, to preserve a public easement in La Fuente Alley as the same was vacated by the document recorded December 31, 1979 as Instrument No. 79-1462774 of Official Records.

37. An easement for street or highway and incidental purposes, recorded July 08, 1982 as Instrument No. 82-688649 of Official Records.

In Favor of: The City of Pasadena, a municipal corporation

Affects: as described therein

38. Intentionally Omitted.

39. An easement for corner rounding and incidental purposes, recorded November 07, 1984 as Instrument No. 84-1328081 of Official Records.

In Favor of:

Affects: as described therein

Said property is more graphically described in City of Pasadena Public Works Department Drawing No. 3880, dated November 7, 1983, and attached thereto as Exhibit "A" and set forth in the deed Executed by: Richlin Company Pension Trust Recorded: May 10, 1985 as Instrument No. 85-531463, Official Records

40. The terms, provisions and easement(s) contained in the document entitled "Certificate of Correction" recorded November 09, 1984 as Instrument No. 84-1343089 of Official Records.

41. An easement for utilities and incidental purposes, recorded April 15, 1985 as Instrument No. 85- 420619 of Official Records.

In Favor of: Southern California Gas Company

Affects: as described therein

Said property is more graphically described in City of Pasadena Public Works Department Drawing No. 3880, dated November 7, 1983, and attached thereto as Exhibit "A" and set forth in the deed Executed by: Richlin Company Pension Trust Recorded: May 10, 1985 as Instrument No. 85-531463, Official Records

42. Covenants, conditions, restrictions and easements in the document recorded April 16, 1987 as Instrument No. 87-589690 of Official Records, which provide that a violation thereof shall not defeat or render invalid the lien of any first mortgage or deed of trust made in good faith and for value, but deleting any covenant, condition or restriction indicating a preference, limitation or discrimination based on race, color, religion, sex, handicap, familial status, national origin, sexual orientation, marital status, ancestry, source of income or disability, to the extent such covenants, conditions or restrictions violate Title 42, Section 3604(c), of the United States Codes or Section 12955 of the California Government Code. Lawful restrictions under state and federal law on the age of occupants in senior housing or housing for older persons shall not be construed as restrictions based on familial status.

43. The terms, provisions and easement(s) contained in the document entitled "License Agreement" recorded May 27, 1987 as Instrument No. 87-826037 of Official Records.

44. An easement for utilities, sanitary sewer, storm drain, ingress and egress and incidental purposes, recorded June 09, 1987 as Instrument No. 87-904741 of Official Records.

In Favor of: The City of Pasadena, a municipal corporation

Affects: as described therein

45. The terms, provisions and easement(s) contained in the document entitled "License Agreement No. 13,233" recorded September 23, 1987 as Instrument No. 87-1526087 of Official Records.

46. The rights, if any, of a city, public utility or special district, pursuant to Section 8345 et seq. of the California Streets and Highways Code, to preserve a public easement in Fairmount Avenue and/or Congress Street as the same was vacated by the document recorded May 24, 1989 as Instrument No. 89-843349 of Official Records.

47. Terms and provisions of an unrecorded lease dated September 08, 1989, by and between Collis P. and Howard Huntington Memorial Hospital Trust as lessor and Valacal Company, a California corporation as lessee, as disclosed by a Memorandum of Lease recorded September 12, 1989 as Instrument No. 89-1465512 of Official Records.

Defects, liens, encumbrances or other matters affecting the leasehold estate, whether or not shown by the public records are not shown herein.

48. An easement for utilities and incidental purposes, recorded October 30, 1989 as Instrument No. 89- 1747231 of Official Records.

In Favor of: Southern California Company, a corporation

Affects: as described therein

49. An easement shown or dedicated on the map filed or recorded Parcel Map No. 18337 as file in Book 246, Page 73 of Parcel Maps

For: Public utilities, ingress and egress, storm drain and appurtenant structures, sanitary sewer and incidental purposes and incidental purposes.

50. An easement shown or dedicated on the map filed or recorded Parcel Map No. 18337 as file in Book 246, Page 73 of Parcel Maps

For: Future Street and incidental purposes and incidental purposes.

51. The terms, provisions and easement(s) contained in the document entitled "Reciprocal Easement Agreement" recorded September 14, 1995 as Instrument No. 95-1501801 of Official Records.

52. An easement for traffic signal and incidental purposes, recorded October 07, 1997 as Instrument No. 97-1553800 of Official Records.

In Favor of: The City of Pasadena, a municipal corporation

Affects: as described therein

53. An easement for roadway and incidental purposes, recorded July 22, 2004 as Instrument No. 04- 1877736 of Official Records.

In Favor of:

Affects: as described therein

Defects, liens, encumbrances or other matters affecting the leasehold estate, whether or not shown by the public records are not shown herein.

54. Terms and provisions of an unrecorded lease dated July 12, 2005, by and between Pasadena Hospital Association LTD, a California non-profit organization dba Huntington Memorial Hospital as lessor and Sprint PCS Assets, L.L.C. a Delaware limited liability company as lessee, as disclosed by a Memorandum of Agreement recorded September 13, 2005 as Instrument No. 05-2200493 of Official Records.

Defects, liens, encumbrances or other matters affecting the leasehold estate, whether or not shown by the public records are not shown herein.

55. The effect of a document entitled "Affidavit of Successor Trustees", recorded October 02, 2007 as Instrument No. 20072258902 of Official Records.

56. The terms, provisions and easement(s) contained in the document entitled "Master Covenant and Agreement Regarding On-Site BMP Maintenance" recorded June 26, 2008 as Instrument No. 20081141925 of Official Records.

57. The rights, if any, of a city, public utility or special district, pursuant to Section 8345 et seq. of the California Streets and Highways Code, to preserve a public easement in Fairmount Avenue and/or Congress Street as the same was vacated by the document recorded March 27, 2012 as Instrument No. 20120462458 of Official Records.

58. An easement for public street and incidental purposes, recorded March 27, 2012 as Instrument No. 20120462458 of Official Records.

In Favor of: The City of Pasadena, a municipal corporation

Affects: as described therein

59. An easement for public street and incidental purposes, recorded March 27, 2012 as Instrument No. 20120462840 of Official Records.

In Favor of: The City of Pasadena, a municipal corporation

Affects: as described therein

60. The terms, provisions and easement(s) contained in the document entitled "License Agreement No. 23,190" recorded July 09, 2019 as Instrument No. 20190661971 of Official Records.

61. Prior to closing, the Company must confirm whether the county recording office in which the Land is located has changed its access policies due to the COVID-19 outbreak. If recording has been restricted, specific underwriting approval is required; and, additional requirement or exceptions may be made.

NOTE: As of the date hereof, recording in this county is restricted to electronic filings.

62. Any claim that the Title is subject to a trust or lien created under The Perishable Agricultural Commodities Act, 1930 (7 U.S.C. §§499a, et seq.) or the Packers and Stockyards Act (7 U.S.C. §§181 et seq.) or under similar state laws.

63. Rights of parties in possession.

64. The description shown in this report is not to be relied upon as a legal insurable parcel. This Company has provided said description only as an accommodation for the purpose of facilitating this report. A description approved by the appropriate governing agency pursuant to the Subdivision Map Act of the State of California must be submitted to this Company for review prior to closing.

65. Any facts, rights, interests or claims which would be disclosed by a correct ALTA/NSPS survey.

66. Any lien, or right to a lien, for services, labor or material hereafter furnished, imposed by law.

67. Oil, gas or other hydrocarbons or minerals reserved in deeds recorded May 06, 1944 in Book 20888, Page 256 and November 14, 1969 as Instrument No. 366, official records, and all minerals and all mineral rights of every kind and character now known to exist or hereafter discovered, including, without limiting the generality of the foregoing, oil and gas rights thereto, together with the sole, exclusive and perpetual right to explore for, remove and dispose of said minerals by any means or methods suitable to the grantor, its successors and assigns, but without entering upon or using the surface of the lands hereby conveyed and in such manner as not to damage the surface of said lands or to interfere with the use thereof by grantee recorded March 01, 1971 as Instrument No. 2403.

Exhibit I

Form of Quitclaim Deed

RECORDING REQUESTED BY:

COLLIS P. AND HOWARD HUNTINGTON
MEMORIAL HOSPITAL TRUST

WHEN RECORDED MAIL THIS
DEED AND TAX STATEMENTS TO:

Huntington Hospital
100 W. California Blvd.
Pasadena, CA 91105
Attention: Lori J. Morgan, M.D. MBA

(Above Space for Recorder's Use Only)

APN: _____

QUITCLAIM DEED

THE UNDERSIGNED GRANTOR DECLARES:

DOCUMENTARY TRANSFER TAX is $ - 0* - CITY TAX $ - 0* -
□ Computed on full value of property conveyed, or
□ computed on full value less value of liens or encumbrances remaining at time of sale,
□ Unincorporated area:
☒ City of Pasadena, and

*Conveyance is given for no value. This is a bona fide gift and the grantor received nothing in return. Revenue and Taxation Code section 11911.

FOR VALUABLE CONSIDERATION, receipt of which is hereby acknowledged, the undersigned, Jaynie Studenmund, Armando L. Gonzalez, Wayne Brandt, Michelle Quinones Chino and Paul Johnson, as Trustees of the COLLIS P. AND HOWARD HUNTINGTON MEMORIAL HOSPITAL TRUST, hereby remise, release and forever quitclaim to PASADENA HOSPITAL ASSOCIATION, LTD., a California nonprofit public benefit corporation, dba HUNTINGTON HOSPITAL, any and all right, title or interest in and to that certain real property in the County of Los Angeles, State of California described in Exhibit A attached hereto and incorporated herein, together with any and all right, title or interest in and to buildings and improvements located thereon (the "**Property**").

THIS DEED SERVES TO DISTRIBUTE TITLE TO THE PROPERTY FROM A TRUST TO THE SOLE BENEFICIARY OF THE TRUST.

[Signature(s) Appear on Following Page]

Dated: _____, 2020

GRANTOR:

_____
_____, Trustee of the
COLLIS P. AND HOWARD HUNTINGTON
MEMORIAL HOSPITAL TRUST

_____
_____, Trustee of the
COLLIS P. AND HOWARD HUNTINGTON
MEMORIAL HOSPITAL TRUST

_____
_____, Trustee of the
COLLIS P. AND HOWARD HUNTINGTON
MEMORIAL HOSPITAL TRUST

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California)
County of Los Angeles)

On _____, before me, _____, a Notary Public, personally appeared _____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California)
County of Los Angeles)

On _____, before me, _____, a Notary Public, personally appeared _____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California)
County of Los Angeles)

On _____, before me, _____, a Notary Public, personally appeared _____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____

Exhibit A to

Quitclaim Deed

That certain real property located in the City of Pasadena, County of Los Angeles, State of California, more particularly described as follows:

Exhibit J

Title Commitment

[Attached.]

First American	ALTA Commitment for Title Insurance
Commitment	ISSUED BY **First American Title Insurance Company** File No: NCS-1012328-MIA

COMMITMENT FOR TITLE INSURANCE

Issued By

FIRST AMERICAN TITLE INSURANCE COMPANY

NOTICE

IMPORTANT-READ CAREFULLY: THIS COMMITMENT IS AN OFFER TO ISSUE ONE OR MORE TITLE INSURANCE POLICIES. ALL CLAIMS OR REMEDIES SOUGHT AGAINST THE COMPANY INVOLVING THE CONTENT OF THIS COMMITMENT OR THE POLICY MUST BE BASED SOLELY IN CONTRACT.

THIS COMMITMENT IS NOT AN ABSTRACT OF TITLE, REPORT OF THE CONDITION OF TITLE, LEGAL OPINION, OPINION OF TITLE, OR OTHER REPRESENTATION OF THE STATUS OF TITLE. THE PROCEDURES USED BY THE COMPANY TO DETERMINE INSURABILITY OF THE TITLE, INCLUDING ANY SEARCH AND EXAMINATION, ARE PROPRIETARY TO THE COMPANY, WERE PERFORMED SOLELY FOR THE BENEFIT OF THE COMPANY, AND CREATE NO EXTRACONTRACTUAL LIABILITY TO ANY PERSON, INCLUDING A PROPOSED INSURED.

THE COMPANY'S OBLIGATION UNDER THIS COMMITMENT IS TO ISSUE A POLICY TO A PROPOSED INSURED IDENTIFIED IN SCHEDULE A IN ACCORDANCE WITH THE TERMS AND PROVISIONS OF THIS COMMITMENT. THE COMPANY HAS NO LIABILITY OR OBLIGATION INVOLVING THE CONTENT OF THIS COMMITMENT TO ANY OTHER PERSON.

COMMITMENT TO ISSUE POLICY

Subject to the Notice; Schedule B, Part I-Requirements; Schedule B, Part II-Exceptions; and the Commitment Conditions, ***First American Title Insurance Company***, a Nebraska Corporation (the "Company"), commits to issue the Policy according to the terms and provisions of this Commitment. This Commitment is effective as of the Commitment Date shown in Schedule A for each Policy described in Schedule A, only when the Company has entered in Schedule A both the specified dollar amount as the Proposed Policy Amount and the name of the Proposed Insured.

If all of the Schedule B, Part I-Requirements have not been met within six months after the Commitment Date, this Commitment terminates and the Company's liability and obligation end.

First American Title Insurance Company

Dennis J. Gilmore, President

Greg L. Smith, Secretary

If this jacket was created electronically, it constitutes an original document.

This page is only a part of a 2016 ALTA® Commitment for Title Insurance issued by First American Title Insurance Company. This Commitment is not valid without the Notice; the Commitment to Issue Policy; the Commitment Conditions; Schedule A; Schedule B, Part I-Requirements; Schedule B, Part II-Exceptions.

COMMITMENT CONDITIONS

1. DEFINITIONS

(a) "Knowledge" or "Known": Actual or imputed knowledge, but not constructive notice imparted by the Public Records.
(b) "Land": The land described in Schedule A and affixed improvements that by law constitute real property. The term "Land" does not include any property beyond the lines of the area described in Schedule A, nor any right, title, interest, estate, or easement in abutting streets, roads, avenues, alleys, lanes, ways, or waterways, but this does not modify or limit the extent that a right of access to and from the Land is to be insured by the Policy.
(c) "Mortgage": A mortgage, deed of trust, or other security instrument, including one evidenced by electronic means authorized by law.
(d) "Policy": Each contract of title insurance, in a form adopted by the American Land Title Association, issued or to be issued by the Company pursuant to this Commitment.
(e) "Proposed Insured": Each person identified in Schedule A as the Proposed Insured of each Policy to be issued pursuant to this Commitment.
(f) "Proposed Policy Amount": Each dollar amount specified in Schedule A as the Proposed Policy Amount of each Policy to be issued pursuant to this Commitment.
(g) "Public Records": Records established under state statutes at the Commitment Date for the purpose of imparting constructive notice of matters relating to real property to purchasers for value and without Knowledge.
(h) "Title": The estate or interest described in Schedule A.

2. If all of the Schedule B, Part I—Requirements have not been met within the time period specified in the Commitment to Issue Policy, this Commitment terminates and the Company's liability and obligation end.

3. The Company's liability and obligation is limited by and this Commitment is not valid without:
(a) the Notice;
(b) the Commitment to Issue Policy;
(c) the Commitment Conditions;
(d) Schedule A;
(e) Schedule B, Part I—Requirements; and
(f) Schedule B, Part II—Exceptions.

4. COMPANY'S RIGHT TO AMEND

The Company may amend this Commitment at any time. If the Company amends this Commitment to add a defect, lien, encumbrance, adverse claim, or other matter recorded in the Public Records prior to the Commitment Date, any liability of the Company is limited by Commitment Condition 5. The Company shall not be liable for any other amendment to this Commitment.

5. LIMITATIONS OF LIABILITY

(a) The Company's liability under Commitment Condition 4 is limited to the Proposed Insured's actual expense incurred in the interval between the Company's delivery to the Proposed Insured of the Commitment and the delivery of the amended Commitment, resulting from the Proposed Insured's good faith reliance to:
  (i) comply with the Schedule B, Part I—Requirements;
  (ii) eliminate, with the Company's written consent, any Schedule B, Part II—Exceptions; or
  (iii) acquire the Title or create the Mortgage covered by this Commitment.
(b) The Company shall not be liable under Commitment Condition 5(a) if the Proposed Insured requested the amendment or had Knowledge of the matter and did not notify the Company about it in writing.
(c) The Company will only have liability under Commitment Condition 4 if the Proposed Insured would not have incurred the expense had the Commitment included the added matter when the Commitment was first delivered to the Proposed Insured.
(d) The Company's liability shall not exceed the lesser of the Proposed Insured's actual expense incurred in good faith and described in Commitment Conditions 5(a)(i) through 5(a)(iii) or the Proposed Policy Amount.
(e) The Company shall not be liable for the content of the Transaction Identification Data, if any.
(f) In no event shall the Company be obligated to issue the Policy referred to in this Commitment unless all of the Schedule B, Part I—Requirements have been met to the satisfaction of the Company.
(g) In any event, the Company's liability is limited by the terms and provisions of the Policy.

6. LIABILITY OF THE COMPANY MUST BE BASED ON THIS COMMITMENT

(a) Only a Proposed Insured identified in Schedule A, and no other person, may make a claim under this Commitment.
(b) Any claim must be based in contract and must be restricted solely to the terms and provisions of this Commitment.
(c) Until the Policy is issued, this Commitment, as last revised, is the exclusive and entire agreement between the parties with respect to the subject matter of this Commitment and supersedes all prior commitment negotiations, representations, and proposals of any kind, whether written or oral, express or implied, relating to the subject matter of this Commitment.
(d) The deletion or modification of any Schedule B, Part II—Exception does not constitute an agreement or obligation to provide coverage beyond the terms and provisions of this Commitment or the Policy.
(e) Any amendment or endorsement to this Commitment must be in writing and authenticated by a person authorized by the Company.
(f) When the Policy is issued, all liability and obligation under this Commitment will end and the Company's only liability will be under the Policy.

7. IF THIS COMMITMENT HAS BEEN ISSUED BY AN ISSUING AGENT

The issuing agent is the Company's agent only for the limited purpose of issuing title insurance commitments and policies. The issuing agent is not the Company's agent for the purpose of providing closing or settlement services.

8. PRO-FORMA POLICY

The Company may provide, at the request of a Proposed Insured, a pro-forma policy illustrating the coverage that the Company may provide. A pro-forma policy neither reflects the status of Title at the time that the pro-forma policy is delivered to a Proposed Insured, nor is it a commitment to insure.

9. ARBITRATION

Arbitration provision intentionally removed.

Transaction Identification Data for reference only:

Issuing Agent: First American Title Insurance Company National Commercial Services
Commitment No.: NCS-1012328-MIA
Property Address: Huntington Memorial Hospital,, Pasadena, CA

Revision No.: 7/14/2020: Amended Legal Description (Parcel 3, Deleted Parcel 4); Added Schedule B-II, Items 66 and 67; Deleted Informational Note Item 4
7/13/2020: Delete Schedule B-I- Items H, I, J, L,M,N
7/10/2020: Revised Legal Description Parcel 3 (Less and Except) and Parcel 4 (Less and Except)

Issuing Office: Southeast Financial Center, 200 South Biscayne Blvd., Ste. 2930, Miami, FL 33131
Issuing Office File No.: NCS-1012328-MIA
Escrow Officer/Assistant: Vanessa Vazquez/Mariseli Gonzalez
Phone: /(305)908-6364

Email: vvazquez@firstam.com/magonzalez@firstam.com
Title Officer/Assistant: Vanessa Abreu/Mariseli Gonzalez
Phone: (305)908-6366/(305)908-6364
Email: vabreu@firstam.com/magonzalez@firstam.com

SCHEDULE A

1. Commitment Date: April 15, 2020 at 8:00 AM

2. Policy to be issued:

   (a) ☒ 2006 ALTA® ALTA Extended Owner Policy
   Proposed Insured: A natural person or legal entity to be determined
   Proposed Policy Amount: $ 1,000.00

   (b) ☐ 2006 ALTA® Policy
   Proposed Insured:
   Proposed Policy Amount: $ 0.00

   (c) ☐ 2006 ALTA® Policy
   Proposed Insured:
   Proposed Policy Amount: $

3. The estate or interest in the Land described or referred to in this Commitment is

   A Fee Simple

4. The Title is, at the Commitment Date, vested in:

   Jaynie Studenmund, Armando L. Gonzalez, Wayne Brandt, Michelle Quinones Chino and Paul Johnson (Collectively the current Successor Trustees, of the Collis P. and Howard Huntington Memorial Hospital Trust

5. The Land is described as follows:

   See Exhibit "A" attached hereto and made a part hereof

Commitment No.: NCS-1012328-MIA

SCHEDULE B, PART I

Requirements

All of the following Requirements must be met:

A. The Proposed Insured must notify the Company in writing of the name of any party not referred to in this Commitment who will obtain an interest in the Land or who will make a loan on the Land. The Company may then make additional Requirements or Exceptions.

B. Pay the agreed amount for the estate or interest to be insured.

C. Pay the premiums, fees, and charges for the Policy to the Company.

D. Documents satisfactory to the Company that convey the Title or create the Mortgage to be insured, or both, must be properly authorized, executed, delivered, and recorded in the Public Records.

E. Releases(s) or Reconveyance(s) of Item(s):

F. Other: Prior to closing, the Company must confirm whether the county recording office in which the Land is located has changed its access policies due to the COVID-19 outbreak. If recording has been restricted, specific underwriting approval is required; and, additional requirement or exceptions may be made.

NOTE: As of the date hereof, recording in this county is restricted to electronic filings.

G. You must give us the following information:
   a. Any off record leases, surveys, etc.
   b. Statement(s) of Identity, all parties.
   c. Other: WITH RESPECT TO A TRUST:

1. A certification pursuant to Section 18100.5 of the California Probate Code in a form satisfactory to the Company.

2. Copies of those excerpts from the original trust documents and amendments thereto which designate the trustee and confer upon the trustee the power to act in the pending transaction.

3. Other requirements which the Company may impose following its review of the material require herein and other information which the Company may require.

The following additional requirements, as indicated by "X", must be met:

[X] H. Provide information regarding any off-record matters, which may include, but are not limited to: leases, recent works of improvement, or commitment statements in effect under the Environmental Responsibility Acceptance Act, Civil Code Section 850, et seq.

The Company's Owner's Affidavit form (as provided by the company) must be completed and submitted prior to close in order to satisfy this requirement. This Commitment will then be subject to such further exceptions and/or requirements as may be deemed necessary.

[] I. An ALTA/NSPS survey of recent date, which complies with the current minimum standard detail requirements for ALTA/NSPS land title surveys, must be submitted to the Company for review. This Commitment will then be subject to such further exceptions and/or requirements as may be deemed necessary.

[] J. The following LLC documentation is required from:

(i) a copy of the Articles of Organization
(ii) a copy of the Operating Agreement, if applicable
(iii) a Certificate of Good Standing and/or other evidence of current Authority to Conduct Business within the State
(iv) express Company Consent to the current transaction

[] K. The following partnership documentation is required **:**

(i) a copy of the partnership agreement, including all applicable amendments thereto
(ii) a Certificate of Good Standing and/or other evidence of current Authority to Conduct Business within the State
(iii) express Partnership Consent to the current transaction

[] L. The following corporation documentation is required:

(i) a copy of the Articles of Incorporation
(ii) a copy of the Bylaws, including all applicable Amendments thereto
(iii) a Certificate of Good Standing and/or other evidence of current Authority to Conduct Business within the State
(iv) express Corporate Resolution consenting to the current transaction

[] M. Based upon the Company's review of that certain partnership/operating agreement dated **Not disclosed** for the proposed insured herein, the following requirements must be met:
Any further amendments to said agreement must be submitted to the Company, together with an affidavit from one of the general partners or members stating that it is a true copy, that said partnership or limited liability company is in full force and effect, and that there have been no further amendments to the agreement. This Commitment will then be subject to such further requirements as may be deemed necessary.

[] N. A copy of the complete lease, as referenced in Schedule A, #3 herein, together with any amendments and/or assignments thereto, must be submitted to the Company for review, along with an affidavit executed by the present lessee stating that it is a true copy, that the lease is in full force and effect, and that there have been no further amendments to the lease. This Commitment will then be subject to such further requirements as may be deemed necessary.

[X] O. Approval from the Company's Underwriting Department must be obtained for issuance of the policy contemplated herein and any endorsements requested thereunder. This Commitment will then be subject to such further requirements as may be required to obtain such approval.

[] P. Potential additional requirements, if ALTA Extended coverage is contemplated hereunder, and work on the land has commenced prior to close, some or all of the following requirements, and any other requirements which may be deemed necessary, may need to be met:

[] Q. The Company's "Indemnity Agreement I" must be executed by the appropriate parties.

[] R. Financial statements from the appropriate parties must be submitted to the Company for review.

[] S. A copy of the construction contract must be submitted to the Company for review.

[] T. An inspection of the Land must be performed by the Company for verification of the phase of construction.

[] U. The Company's "Mechanic's Lien Risk Addendum" form must be completed by a Company employee, based upon information furnished by the appropriate parties involved.

H. This item has been intentionally deleted.

I. This item has been intentionally deleted.

J. This item has been intentionally deleted.

K. A recorded satisfaction, release or termination of that claim of lien recorded August 20, 2019 as Instrument No. 20190836527 of Official Records.

Lien claimant:	RMG Building, Inc.
Amount:	$818,356.97

L. This item has been intentionally deleted.

M. This item has been intentionally deleted.

N. This item has been intentionally deleted.

Commitment No.: NCS-1012328-MIA

SCHEDULE B, PART II

Exceptions

THIS COMMITMENT DOES NOT REPUBLISH ANY COVENANT, CONDITION, RESTRICTION, OR LIMITATION CONTAINED IN ANY DOCUMENT REFERRED TO IN THIS COMMITMENT TO THE EXTENT THAT THE SPECIFIC COVENANT, CONDITION, RESTRICTION, OR LIMITATION VIOLATES STATE OR FEDERAL LAW BASED ON RACE, COLOR, RELIGION, SEX, SEXUAL ORIENTATION, GENDER IDENTITY, HANDICAP, FAMILIAL STATUS, OR NATIONAL ORIGIN.

The Policy will not insure against loss or damage resulting from the terms and provisions of any lease or easement identified in Schedule A, and will include the following Exceptions unless cleared to the satisfaction of the Company:

1. Any defect, lien, encumbrance, adverse claim, or other matter that appears for the first time in the Public Records or is created, attaches, or is disclosed between the Commitment Date and the date on which all of the Schedule B, Part I-Requirements are met.

2. (a) Taxes or assessments that are not shown as existing liens by the records of any taxing authority that levies taxes or assessments on real property or by the Public Records; (b) proceedings by a public agency that may result in taxes or assessments, or notices of such proceedings, whether or not shown by the records of such agency or by the Public Records.

3. Any facts, rights, interests, or claims that are not shown by the Public Records but that could be ascertained by an inspection of the Land or that may be asserted by persons in possession of the Land.

4. Easements, liens or encumbrances, or claims thereof, not shown by the Public Records.

5. Any encroachment, encumbrance, violation, variation, or adverse circumstance affecting the Title that would be disclosed by an accurate and complete land survey of the Land and not shown by the Public Records.

6. (a) Unpatented mining claims; (b) reservations or exceptions in patents or in Acts authorizing the issuance thereof; (c) water rights, claims or title to water, whether or not the matters excepted under (a), (b), or (c) are shown by the Public Records.

7. General and special taxes and assessments for the fiscal year 2020-2021, a lien not yet due or payable.

8. The lien of supplemental taxes, if any, assessed pursuant to Chapter 3.5 commencing with Section 75 of the California Revenue and Taxation Code.

9. Water rights, claims or title to water, whether or not shown by the public records.

10. An easement for public street purposes for the widening of Fair Oaks Avenue, as shown on various maps of record.

11. An easement for conducting water and incidental purposes, recorded December 18, 1879 in Book 27 of Deeds, Page 229.
In Favor of:
Affects: John S. Griffin, P. Reynolds

12. Covenants, conditions, restrictions and easements in the document recorded in Book 2534 of Deeds, Page 15, which provide that a violation thereof shall not defeat or render invalid the lien of any first mortgage or deed of trust made in good faith and for value, but deleting any covenant, condition or restriction indicating a preference, limitation or discrimination based on race, color, religion, sex, handicap, familial status, national origin, sexual orientation, marital status, ancestry, source of income or disability, to the extent such covenants, conditions or restrictions violate Title 42, Section 3604(c), of the United States Codes or Section 12955 of the California Government Code. Lawful restrictions under state and federal law on the age of occupants in senior housing or housing for older persons shall not be construed as restrictions based on familial status.

13. Covenants, conditions, restrictions and easements in the document recorded in Book 2711 of Deeds, Page 46, which provide that a violation thereof shall not defeat or render invalid the lien of any first mortgage or deed of trust made in good faith and for value, but deleting any covenant, condition or restriction indicating a preference, limitation or discrimination based on race, color, religion, sex, handicap, familial status, national origin, sexual orientation, marital status, ancestry, source of income or disability, to the extent such covenants, conditions or restrictions violate Title 42, Section 3604(c), of the United States Codes or Section 12955 of the California Government Code. Lawful restrictions under state and federal law on the age of occupants in senior housing or housing for older persons shall not be construed as restrictions based on familial status.

14. Covenants, conditions, restrictions and easements in the document recorded in Book 2712 of Deeds, Page 272, which provide that a violation thereof shall not defeat or render invalid the lien of any first mortgage or deed of trust made in good faith and for value, but deleting any covenant, condition or restriction indicating a preference, limitation or discrimination based on race, color, religion, sex, handicap, familial status, national origin, sexual orientation, marital status, ancestry, source of income or disability, to the extent such covenants, conditions or restrictions violate Title 42, Section 3604(c), of the United States Codes or Section 12955 of the California Government Code. Lawful restrictions under state and federal law on the age of occupants in senior housing or housing for older persons shall not be construed as restrictions based on familial status.

15. Covenants, conditions, restrictions and easements in the document recorded in Book 4097 of Deeds, Page 90, which provide that a violation thereof shall not defeat or render invalid the lien of any first mortgage or deed of trust made in good faith and for value, but deleting any covenant, condition or restriction indicating a preference, limitation or discrimination based on race, color, religion, sex, handicap, familial status, national origin, sexual orientation, marital status, ancestry, source of income or disability, to the extent such covenants, conditions or restrictions violate Title 42, Section 3604(c), of the United States Codes or Section 12955 of the California Government Code. Lawful restrictions under state and federal law on the age of occupants in senior housing or housing for older persons shall not be construed as restrictions based on familial status.

16. Covenants, conditions, restrictions and easements in the document recorded in Book 4339 of Deeds, Page 143, which provide that a violation thereof shall not defeat or render invalid the lien of any first mortgage or deed of trust made in good faith and for value, but deleting any covenant, condition or

restriction indicating a preference, limitation or discrimination based on race, color, religion, sex, handicap, familial status, national origin, sexual orientation, marital status, ancestry, source of income or disability, to the extent such covenants, conditions or restrictions violate Title 42, Section 3604(c), of the United States Codes or Section 12955 of the California Government Code. Lawful restrictions under state and federal law on the age of occupants in senior housing or housing for older persons shall not be construed as restrictions based on familial status.

17. Covenants, conditions, restrictions and easements in the document recorded in Book 4370 of Deeds, Page 149, which provide that a violation thereof shall not defeat or render invalid the lien of any first mortgage or deed of trust made in good faith and for value, but deleting any covenant, condition or restriction indicating a preference, limitation or discrimination based on race, color, religion, sex, handicap, familial status, national origin, sexual orientation, marital status, ancestry, source of income or disability, to the extent such covenants, conditions or restrictions violate Title 42, Section 3604(c), of the United States Codes or Section 12955 of the California Government Code. Lawful restrictions under state and federal law on the age of occupants in senior housing or housing for older persons shall not be construed as restrictions based on familial status.

18. Covenants, conditions, restrictions and easements in the document recorded in Book 4428 of Deeds, Page 47, which provide that a violation thereof shall not defeat or render invalid the lien of any first mortgage or deed of trust made in good faith and for value, but deleting any covenant, condition or restriction indicating a preference, limitation or discrimination based on race, color, religion, sex, handicap, familial status, national origin, sexual orientation, marital status, ancestry, source of income or disability, to the extent such covenants, conditions or restrictions violate Title 42, Section 3604(c), of the United States Codes or Section 12955 of the California Government Code. Lawful restrictions under state and federal law on the age of occupants in senior housing or housing for older persons shall not be construed as restrictions based on familial status.

19. Covenants, conditions, restrictions and easements in the document recorded in Book 4680 of Deeds, Page 318, which provide that a violation thereof shall not defeat or render invalid the lien of any first mortgage or deed of trust made in good faith and for value, but deleting any covenant, condition or restriction indicating a preference, limitation or discrimination based on race, color, religion, sex, handicap, familial status, national origin, sexual orientation, marital status, ancestry, source of income or disability, to the extent such covenants, conditions or restrictions violate Title 42, Section 3604(c), of the United States Codes or Section 12955 of the California Government Code. Lawful restrictions under state and federal law on the age of occupants in senior housing or housing for older persons shall not be construed as restrictions based on familial status.

20. Covenants, conditions, restrictions and easements in the document recorded in Book 4494 of Deeds, Page 163, which provide that a violation thereof shall not defeat or render invalid the lien of any first mortgage or deed of trust made in good faith and for value, but deleting any covenant, condition or restriction indicating a preference, limitation or discrimination based on race, color, religion, sex, handicap, familial status, national origin, sexual orientation, marital status, ancestry, source of income or disability, to the extent such covenants, conditions or restrictions violate Title 42, Section 3604(c), of the United States Codes or Section 12955 of the California Government Code. Lawful restrictions under state and federal law on the age of occupants in senior housing or housing for older persons shall not be construed as restrictions based on familial status.

21. Covenants, conditions, restrictions and easements in the document recorded in Book 5212 of Deeds, Page 43, which provide that a violation thereof shall not defeat or render invalid the lien of any first mortgage or deed of trust made in good faith and for value, but deleting any covenant, condition or restriction indicating a preference, limitation or discrimination based on race, color, religion, sex, handicap, familial status, national origin, sexual orientation, marital status, ancestry, source of income or disability, to the extent such covenants, conditions or restrictions violate Title 42, Section 3604(c), of the United States Codes or Section 12955 of the California Government Code. Lawful

restrictions under state and federal law on the age of occupants in senior housing or housing for older persons shall not be construed as restrictions based on familial status.

22. Covenants, conditions, restrictions and easements in the document recorded in Book 5655 of Deeds, Page 33, which provide that a violation thereof shall not defeat or render invalid the lien of any first mortgage or deed of trust made in good faith and for value, but deleting any covenant, condition or restriction indicating a preference, limitation or discrimination based on race, color, religion, sex, handicap, familial status, national origin, sexual orientation, marital status, ancestry, source of income or disability, to the extent such covenants, conditions or restrictions violate Title 42, Section 3604(c), of the United States Codes or Section 12955 of the California Government Code. Lawful restrictions under state and federal law on the age of occupants in senior housing or housing for older persons shall not be construed as restrictions based on familial status.

23. An easement for pole line and incidental purposes, recorded October 18, 1933 as Book 12466, Page 34 of Official Records.

In Favor of:	Western Union Telegraph Co.
Affects:	as described therein

24. The right of Southern California Edison Company, Ltd., to use an existing pole line under the terms and conditions of an unrecorded License Agreement between Los Angeles & Salt Lake Railroad Company, and the Western Union Telegraph Company, Licensors and Southern California Edison Company, Ltd., Licensee, as recited in the deed recorded October 18, 1933 in Book 12466, Page 34, Official Records.

25. Covenants, conditions, restrictions and easements in the document recorded March 10, 1937 as Instrument No. 361, in Book 14686 Page 348 of Official Records, which provide that a violation thereof shall not defeat or render invalid the lien of any first mortgage or deed of trust made in good faith and for value, but deleting any covenant, condition or restriction indicating a preference, limitation or discrimination based on race, color, religion, sex, handicap, familial status, national origin, sexual orientation, marital status, ancestry, source of income or disability, to the extent such covenants, conditions or restrictions violate Title 42, Section 3604(c), of the United States Codes or Section 12955 of the California Government Code. Lawful restrictions under state and federal law on the age of occupants in senior housing or housing for older persons shall not be construed as restrictions based on familial status.

26. Covenants, conditions, restrictions and easements in the document recorded as in Book 18405 Page 368 of Official Records, which provide that a violation thereof shall not defeat or render invalid the lien of any first mortgage or deed of trust made in good faith and for value, but deleting any covenant, condition or restriction indicating a preference, limitation or discrimination based on race, color, religion, sex, handicap, familial status, national origin, sexual orientation, marital status, ancestry, source of income or disability, to the extent such covenants, conditions or restrictions violate Title 42, Section 3604(c), of the United States Codes or Section 12955 of the California Government Code. Lawful restrictions under state and federal law on the age of occupants in senior housing or housing for older persons shall not be construed as restrictions based on familial status.

27. A lease dated April 13, 1942, executed by The Trustees of the Collis P. and Howard Huntington Memorial Hospital as lessor and Pasadena Hospital Association, Ltd., a corporation as lessee, recorded May 05, 1942 as Instrument No. 1111 in Book 19264, Page 336 of Official Records.

Defects, liens, encumbrances or other matters affecting the leasehold estate, whether or not shown by the public records are not shown herein.

28. Covenants, conditions, restrictions and easements in the document recorded as in Book 19570 Page 353 of Official Records, which provide that a violation thereof shall not defeat or render invalid the lien of any first mortgage or deed of trust made in good faith and for value, but deleting any covenant, condition or restriction indicating a preference, limitation or discrimination based on race, color, religion, sex, handicap, familial status, national origin, sexual orientation, marital status, ancestry, source of income or disability, to the extent such covenants, conditions or restrictions violate Title 42, Section 3604(c), of the United States Codes or Section 12955 of the California Government Code. Lawful restrictions under state and federal law on the age of occupants in senior housing or housing for older persons shall not be construed as restrictions based on familial status.

29. The right to explore for, remove and dispose of minerals by any suitable means or methods, without entering upon or using the surface of the land as reserved by Los Angeles & Salt Lake Railroad Company recorded in Book 24171 Page 421 and by Union Pacific Railroad Company in Book 24183 Page 434, both of Official Records.

30. An easement for telephone, telegraph and signal wires and incidental purposes, recorded February 10, 1948 as Instrument No. 950, in Book 26416 Page 372 of Official Records.
In Favor of:
Affects: as described therein

31. An easement for gas, sewers and water connection and incidental purposes, recorded March 23, 1950 as Instrument No. 415, in Book 32646, Page 294 of Official Records.
In Favor of:
Affects: as described therein

32. The terms, provisions and easement(s) contained in the document entitled "Grant of Easement" recorded February 15, 1961 as Instrument No. 4965 in Book D1124, Page 686 of Official Records.

33. The rights, if any, of a city, public utility or special district, pursuant to Section 8345 et seq. of the California Streets and Highways Code, to preserve a public easement in Fairmount Avenue and/or Congress Street as the same was vacated by the document recorded October 27, 1969 as Instrument No. 2122 of Official Records.

34. An easement for public utilities and incidental purposes, recorded May 12, 1972 as Instrument No. 3831 of Official Records.
In Favor of: The City of Pasadena, a municipal corporation
Affects: as described therein

35. Terms and provisions of an unrecorded lease dated February 12, 1972, by and between Alan E. Robbins as lessor and PMP, a limited partnership as lessee, as disclosed by a Memorandum of Lease recorded June 01, 1972 as Instrument No. 2430 of Official Records.

    Defects, liens, encumbrances or other matters affecting the leasehold estate, whether or not shown by the public records are not shown herein.

36. The rights, if any, of a city, public utility or special district, pursuant to Section 8345 et seq. of the California Streets and Highways Code, to preserve a public easement in La Fuente Alley as the same was vacated by the document recorded December 31, 1979 as Instrument No. 79-1462774 of Official Records.

37. An easement for street or highway and incidental purposes, recorded July 08, 1982 as Instrument No. 82-688649 of Official Records.
In Favor of: The City of Pasadena, a municipal corporation
Affects: as described therein

38. Terms and provisions of an unrecorded lease dated March 16, 1984, by and between Collis P. and Howard Huntington Memorial Hospital Trust, a Trust created by the Will of Henry Huntington as lessor and Huntington Medical Plaza, LTD, a California limited partnership as lessee, as disclosed by a Short Form of Ground Lease and Purchase Option recorded March 16, 1984 as Instrument No. 84-322947 of Official Records.

Document(s) declaring modifications thereof recorded November 13, 1987 as Instrument No. 87-1819247 of Official Records.

Document(s) declaring modifications thereof recorded April 04, 1990 as Instrument No. 90-648091 of Official Records.

Document(s) declaring modifications thereof recorded April 04, 1990 as Instrument No. 90-648092 of Official Records.

Document(s) declaring modifications thereof recorded July 07, 2010 as Instrument No. 2010-925345 of Official Records.

Document(s) declaring modifications thereof recorded June 15, 2012 as Instrument No. 20120896123 of Official Records.

The lessor's interest under the lease has been assigned to Trustees of the Collis P. and Howard Huntington Memorial Hospital Trust, a testamentary charitable trust by assignment recorded September 27, 2012 as September 27, 2012 of Official Records.

Instrument No. 2012-1452712

Defects, liens, encumbrances or other matters affecting the leasehold estate, whether or not shown by the public records are not shown herein.

39. An easement for corner rounding and incidental purposes, recorded November 07, 1984 as Instrument No. 84-1328081 of Official Records.
In Favor of:
Affects: as described therein

Said property is more graphically described in City of Pasadena Public Works Department Drawing No. 3880, dated November 7, 1983, and attached thereto as Exhibit "A" and set forth in the deed Executed by: Richlin Company Pension Trust Recorded: May 10, 1985 as Instrument No. 85-531463, Official Records

40. The terms, provisions and easement(s) contained in the document entitled "Certificate of Correction" recorded November 09, 1984 as Instrument No. 84-1343089 of Official Records.

41. An easement for utilities and incidental purposes, recorded April 15, 1985 as Instrument No. 85-420619 of Official Records.
In Favor of: Southern California Gas Company
Affects: as described therein

Said property is more graphically described in City of Pasadena Public Works Department Drawing No. 3880, dated November 7, 1983, and attached thereto as Exhibit "A" and set forth in the deed Executed by: Richlin Company Pension Trust Recorded: May 10, 1985 as Instrument No. 85-531463, Official Records

42. Covenants, conditions, restrictions and easements in the document recorded April 16, 1987 as Instrument No. 87-589690 of Official Records, which provide that a violation thereof shall not defeat or render invalid the lien of any first mortgage or deed of trust made in good faith and for value, but deleting any covenant, condition or restriction indicating a preference, limitation or discrimination based on race, color, religion, sex, handicap, familial status, national origin, sexual orientation, marital status, ancestry, source of income or disability, to the extent such covenants, conditions or restrictions violate Title 42, Section 3604(c), of the United States Codes or Section 12955 of the California Government Code. Lawful restrictions under state and federal law on the age of occupants in senior housing or housing for older persons shall not be construed as restrictions based on familial status.

43. The terms, provisions and easement(s) contained in the document entitled "License Agreement" recorded May 27, 1987 as Instrument No. 87-826037 of Official Records.

44. An easement for utilities, sanitary sewer, storm drain, ingress and egress and incidental purposes, recorded June 09, 1987 as Instrument No. 87-904741 of Official Records.
In Favor of: The City of Pasadena, a municipal corporation
Affects: as described therein

45. The terms, provisions and easement(s) contained in the document entitled "License Agreement No. 13,233" recorded September 23, 1987 as Instrument No. 87-1526087 of Official Records.

46. The rights, if any, of a city, public utility or special district, pursuant to Section 8345 et seq. of the California Streets and Highways Code, to preserve a public easement in Fairmount Avenue and/or Congress Street as the same was vacated by the document recorded May 24, 1989 as Instrument No. 89-843349 of Official Records.

47. Terms and provisions of an unrecorded lease dated September 08, 1989, by and between Collis P. and Howard Huntington Memorial Hospital Trust as lessor and Valacal Company, a California corporation as lessee, as disclosed by a Memorandum of Lease recorded September 12, 1989 as Instrument No. 89-1465512 of Official Records.

Defects, liens, encumbrances or other matters affecting the leasehold estate, whether or not shown by the public records are not shown herein.

48. An easement for utilities and incidental purposes, recorded October 30, 1989 as Instrument No. 89-1747231 of Official Records.
In Favor of: Southern California Company, a corporation
Affects: as described therein

49. An easement shown or dedicated on the map filed or recorded Parcel Map No. 18337 as file in Book 246, Page 73 of Parcel Maps
For: Public utilities, ingress and egress, storm drain and appurtenant structures, sanitary sewer and incidental purposes and incidental purposes.

50. An easement shown or dedicated on the map filed or recorded Parcel Map No. 18337 as file in Book 246, Page 73 of Parcel Maps
For: Future Street and incidental purposes and incidental purposes.

51. The terms, provisions and easement(s) contained in the document entitled "Reciprocal Easement Agreement" recorded September 14, 1995 as Instrument No. 95-1501801 of Official Records.

52. An easement for traffic signal and incidental purposes, recorded October 07, 1997 as Instrument No. 97-1553800 of Official Records.
In Favor of: The City of Pasadena, a municipal corporation
Affects: as described therein

53. An easement for roadway and incidental purposes, recorded July 22, 2004 as Instrument No. 04-1877736 of Official Records.
In Favor of:
Affects: as described therein

Defects, liens, encumbrances or other matters affecting the leasehold estate, whether or not shown by the public records are not shown herein.

54. Terms and provisions of an unrecorded lease dated July 12, 2005, by and between Pasadena Hospital Association LTD, a California non-profit organization dba Huntington Memorial Hospital as lessor and Sprint PCS Assets, L.L.C. a Delaware limited liability company as lessee, as disclosed by a Memorandum of Agreement recorded September 13, 2005 as Instrument No. 05-2200493 of Official Records.

Defects, liens, encumbrances or other matters affecting the leasehold estate, whether or not shown by the public records are not shown herein.

55. The effect of a document entitled "Affidavit of Successor Trustees", recorded October 02, 2007 as Instrument No. 20072258902 of Official Records.

56. The terms, provisions and easement(s) contained in the document entitled "Master Covenant and Agreement Regarding On-Site BMP Maintenance" recorded June 26, 2008 as Instrument No. 20081141925 of Official Records.

57. The rights, if any, of a city, public utility or special district, pursuant to Section 8345 et seq. of the California Streets and Highways Code, to preserve a public easement in Fairmount Avenue and/or Congress Street as the same was vacated by the document recorded March 27, 2012 as Instrument No. 20120462458 of Official Records.

58. An easement for public street and incidental purposes, recorded March 27, 2012 as Instrument No. 20120462458 of Official Records.
In Favor of: The City of Pasadena, a municipal corporation
Affects: as described therein

59. An easement for public street and incidental purposes, recorded March 27, 2012 as Instrument No. 20120462840 of Official Records.
In Favor of: The City of Pasadena, a municipal corporation
Affects: as described therein

60. The terms, provisions and easement(s) contained in the document entitled "License Agreement No. 23,190" recorded July 09, 2019 as Instrument No. 20190661971 of Official Records.

61. Prior to closing, the Company must confirm whether the county recording office in which the Land is located has changed its access policies due to the COVID-19 outbreak. If recording has been restricted, specific underwriting approval is required; and, additional requirement or exceptions may be made.

NOTE: As of the date hereof, recording in this county is restricted to electronic filings.

62. Any claim that the Title is subject to a trust or lien created under The Perishable Agricultural Commodities Act, 1930 (7 U.S.C. §§499a, et seq.) or the Packers and Stockyards Act (7 U.S.C. §§181 et seq.) or under similar state laws.

63. Rights of parties in possession.

64. The description shown in this report is not to be relied upon as a legal insurable parcel. This Company has provided said description only as an accommodation for the purpose of facilitating this report. A description approved by the appropriate governing agency pursuant to the Subdivision Map Act of the State of California must be submitted to this Company for review prior to closing.

65. Any facts, rights, interests or claims which would be disclosed by a correct ALTA/NSPS survey.

66. Any lien, or right to a lien, for services, labor or material hereafter furnished, imposed by law.

67. Oil, gas or other hydrocarbons or minerals reserved in deeds recorded May 06, 1944 in Book 20888, Page 256 and November 14, 1969 as Instrument No. 366, official records, and all minerals and all mineral rights of every kind and character now known to exist or hereafter discovered, including, without limiting the generality of the foregoing, oil and gas rights thereto, together with the sole, exclusive and perpetual right to explore for, remove and dispose of said minerals by any means or methods suitable to the grantor, its successors and assigns, but without entering upon or using the surface of the lands hereby conveyed and in such manner as not to damage the surface of said lands or to interfere with the use thereof by grantee recorded March 01, 1971 as Instrument No. 2403.

ALERT - CA Senate Bill 2 imposes an additional fee of $75 up to $225 at the time of recording on certain transactions effective January 1, 2018. Please contact your First American Title representative for more information on how this may affect your closing.

1. Taxes for proration purposes only for the fiscal year 2019-2020.
   First Installment: $18,483.58, PAID
   Second Installment: $18,483.56, PAID
   Tax Rate Area: 07500
   APN: 5719-027-042

   (Affects Parcel 1)

2. Taxes for proration purposes only for the fiscal year 2019-2020.
   First Installment: $7,092.56, PAID
   Second Installment: $7,092.55, PAID
   Tax Rate Area: 07500
   APN: 5719-027-052

   (Affects Parcel 2)

3. Taxes for proration purposes only for the fiscal year 2019-2020.
   First Installment: $53,703.80, PAID
   Second Installment: $53,703.80, PAID
   Tax Rate Area: 07500
   APN: 5719-027-061

   (Affects Parcel 3)

4. This item has been intentionally deleted.

5. According to the latest available equalized assessment roll in the office of the county tax assessor, there is located on the land a(n) Health Care Facility known as Huntington Memorial Hospital,, Pasadena, California.

6. According to the public records, there has been no conveyance of the land within a period of twenty-four months prior to the date of this report, except as follows:

   None

7. If this preliminary report/commitment was prepared based upon an application for a policy of title insurance that identified land by street address or assessor's parcel number only, it is the responsibility of the applicant to determine whether the land referred to herein is in fact the land that is to be described in the policy or policies to be issued.

The map attached, if any, may or may not be a survey of the land depicted thereon. First American Title Insurance Company expressly disclaims any liability for loss or damage which may result from reliance on

this map except to the extent coverage for such loss or damage is expressly provided by the terms and provisions of this Commitment or the Policy, if any, to which the map is attached.

Exhibit A

File No.: NCS-1012328-MIA

The Land referred to herein below is situated in the City of Pasadena, County of Los Angeles, State of California, and is described as follows:

PARCEL 1: 5719-027-042 also known as 624 South Pasadena Avenue

LOT 4 OF LEONARD'S SUBDIVISION OF PART OF DIVISION "F" OF THE LANDS OF THE SAN GABRIEL ORANGE GROVE ASSOCIATION, IN THE CITY OF PASADENA, COUNTY OF LOS ANGELES, STATE OF CALIFORNIA, AS PER MAP RECORDED IN BOOK 14, PAGE 11 OF MISCELLANEOUS RECORDS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY.

PARCEL 2: 5719-027-052 also known as 47 Congress Street

LOT 14 OF MARTIN'S SUBDIVISION OF PART OF THE FRANK GREEN TRACT, IN THE CITY OF PASADENA, AS PER MAP RECORDED IN BOOK 10, PAGE 46 OF MISCELLANEOUS RECORDS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY.

PARCEL 3: 5719-027-061 also known as 100 Congress Street

PARCEL 2, OF PARCEL MAP NO. 18337, IN THE CITY OF PASADENA, COUNTY OF LOS ANGELES, STATE OF CALIFORNIA, AS PER MAP RECORDED IN BOOK 246, PAGES 73-75 OF MAPS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY;

TOGETHER WITH A PORTION OF PARCEL 1, OF SAID PARCEL MAP NO. 18337, DESCRIBED AS FOLLOWS:

BEGINNING AT THE NORTHEASTERLY CORNER OF SAID PARCEL 1; THENCE ALONG THE NORTHERLY LINE OF SAID PARCEL 1, NORTH 89°58’04” WEST 147.58 FEET TO THE TRUE POINT OF BEGINNING; THENCE CONTINUING ALONG THE NORTHERLY LINE OF SAID PARCEL 1, NORTH 89°58’04” WEST 210.07 FEET TO THE NORTHWESTERLY CORNER OF SAID PARCEL 1; THENCE ALONG THE WESTERLY LINE OF SAID PARCEL 1, SOUTH 0°00’03” WEST 499.23 FEET TO THE SOUTHWESTERLY CORNER OF SAID PARCEL 1; THENCE ALONG THE SOUTHERLY LINE OF SAID PARCEL 1, SOUTH 89°49’41” EAST 211.07 FEET; THENCE PARALLEL WITH THE WESTERLY LINE OF SAID PARCEL 1, NORTH 0°00’03” EAST 174.05 FEET; THENCE NORTH 89°59’57”WEST 1.00 FEET; THENCE PARALLEL WITH THE WESTERLY LINE OF SAID PARCEL 1, NORTH 0°00’03” EAST 325.70 FEET TO THE TRUE POINT OF BEGINNING.

EXCEPT THAT PORTION OF SAID PARCEL 2, DESCRIBED AS FOLLOWS:

BEGINNING AT THE NORTHEAST CORNER OF SAID PARCEL 2; THENCE ALONG THE EASTERLY LINE OF SAID PARCEL 2, SOUTH 285.20 FEET TO THE EASTERLY PROLONGATION OF THAT CERTAIN COURSE ON THE EASTERLY LINE OF SAID PARCEL 2, SHOWN ON SAID PARCEL MAP NO. 18337 AS "NORTH 89°55'38" WEST 100.00 FEET", SAID INTERSECTION ALSO BEING THE NORTHWEST CORNER OF SAID LOT 7; THENCE WESTERLY ALONG SAID PROLONGED LINE NORTH 89°55'42" WEST 156.00 FEET; THENCE PARALLEL WITH THE EASTERLY LINE OF SAID PARCEL 2, NORTH 285.32 FEET TO THE NORTHERLY LINE OF SAID PARCEL 2; THENCE ALONG THE NORTHERLY LINE OF SAID PARCEL 2, SOUTH 89°52'55" EAST 156.00 FEET, TO THE POINT OF BEGINNING.

For conveyancing purposes only: APN 5719-027-042; 5719-027-052; 5719-027-061

Exhibit K

Form of Termination of Master Lease

RECORDING REQUESTED BY:

COLLIS P. AND HOWARD HUNTINGTON
MEMORIAL HOSPITAL TRUST

WHEN RECORDED MAIL THIS DOCUMENT TO:

Huntington Hospital
100 W. California Blvd.
Pasadena, CA 91105
Attention: Lori J. Morgan, M.D. MBA

═══

(Above Space for Recorder's Use Only)

APN: _____

LEASE TERMINATION AGREEMENT

This Lease Termination Agreement (this "Agreement") is made and entered into as of _____, 2020, by and between Jaynie Studenmund, Armando L. Gonzalez, Wayne Brandt, Michelle Quinones Chino and Paul Johnson, as Trustees of the COLLIS P. AND HOWARD HUNTINGTON MEMORIAL HOSPITAL TRUST, a Testamentary Charitable Trust ("Lessor"), and PASADENA HOSPITAL ASSOCIATION, LTD., a California non-profit public benefit corporation, d/b/a Huntington Hospital ("Lessee"), as follows:

A. Lessor and Lessee entered into that certain Lease dated as of April 13, 1942, a copy of which was recorded on May 5, 1942, as Instrument No. 1111 in Book 19264, Page 336 of the Official Records of Los Angeles County, California, which has been amended by amendments dated June 23, 1942, February 23, 1945, June 18, 1946, December 1, 1952, January 5, 1959, September 6, 1968, December 28, 1972, July 22, 1982, November 5, 1985, September 27, 1990, November 19, 1992, August 12, 1996, September 18, 1997, April 28, 2005, May 1, 2014 and April 1 2018 (collectively, the "Lease"). Pursuant to the Lease, Lessor leased real property described in Exhibit A hereto and certain improvements thereon (the "Premises") to Lessee for the operation of the Collis P. and Howard Huntington Memorial Hospital, now known as Huntington Hospital.

B. Lessor is a charitable trust which exists for the sole benefit and support of the healthcare operations of Lessee.

C. Substantially concurrently herewith, Lessor is recording a quitclaim deed (the "Quitclaim Deed") in the Official Records of Los Angeles County, California, transferring and distributing all of its right, title and interest in and to the Premises to Lessee as a gift, for no value. The date on which such quitclaim deed is recorded shall be the "Effective Date" herein.

D. As of the Effective Date, the Lessee's interest in the fee and leasehold interests in the Premises will merge, and the Lease will terminate, on the terms and conditions set forth herein.

NOW, THEREFORE, for good and valuable consideration, the receipt and sufficiency of which are hereby expressly acknowledged, the parties hereto agree as follows:

1. Termination of the Lease. Subject to the terms hereof, as of the Effective Date, the Lease is canceled and terminated in its entirety, and the leasehold estate created by, and all rights, privileges, benefits, obligations, duties and liabilities of Lessee and Lessor, respectively, under the Lease, shall be terminated in their entirety, the Lease shall be of no further force or effect, and Lessor and Lessee each does hereby release the other from any and all obligations and liabilities under the Lease, except for obligations that expressly survive the termination of the Lease and as specifically set forth in this Agreement. Without limiting the generality of the foregoing, (a) Lessee's payment obligations under the Lease continue through the Effective Date, pro-rated as of the Effective Date if and as applicable, and any previously unpaid obligations shall be due and payable in full on the Effective Date, and (b) any indemnification obligations under the Lease shall survive termination of the Lease with respect to claims that are based on facts or conditions that first arose prior to the Effective Date.

2. Representations and Warranties. Lessee represents and warrants to Lessor that (i) Lessee is the sole owner of the leasehold interest in the Premises, and (ii) Lessee has not assigned its interests under the Lease. Lessor represents and warrants to Lessee that Lessor has not assigned its interests under the Lease. Additionally, Lessor and Lessee each warrant and represent (i) that the person executing this Agreement on its behalf is authorized to execute this Agreement, (ii) that this Agreement is a valid, binding, and enforceable against such party, except as may be limited by applicable bankruptcy, reorganization, insolvency, moratorium or other laws affecting the enforcement of creditors' rights generally and by general principles of equity regardless of whether such enforceability is considered in a proceeding at law or in equity, and (iii) that it has the authority to enter into this Agreement without the joinder of any other party.

3. Counterparts. This Agreement may be executed in counterparts, including by facsimile or electronic copies, each of which shall be an original, but all of which together shall constitute one agreement binding on all of the parties notwithstanding that all of the parties are not signatories to the same counterpart or page.

4. Governing Law; Venue. This Agreement shall be construed and interpreted in accordance with the laws of the State of California. In the event of a dispute arising under or related to this Agreement, the parties submit to the sole and exclusive jurisdiction and venue of the courts of the County of Los Angeles, State of California.

5. Miscellaneous. Except for the Quitclaim Deed, this Agreement contains the entire understanding of the parties with respect to the transactions contemplated, and any prior agreements or understandings with respect to the subject matter hereof, whether oral or written, are entirely superseded hereby. This Agreement shall extend to, shall inure to the benefit of, and shall be binding upon all of the parties and upon all of their respective successors, predecessors and assigns. Nothing contained in this Agreement is intended to confer upon any person, other than the parties and their respective heirs, successors and permitted assigns, any rights, remedies or obligations under, or by reason of, this Agreement. If any provision of this Agreement is declared invalid by a court of competent jurisdiction, the parties intend that all other provisions of this Agreement shall be valid and binding as if the invalid provision had not been included herein. Time is of the essence of this Agreement. The headings of paragraphs of this Agreement are for the convenience of the parties only and shall not be used in any way to govern, limit, modify, construe or otherwise affect the interpretation or intent of this Agreement.

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

LESSOR:

_____

_____, Trustee of the

COLLIS P. and HOWARD HUNTINGTON MEMORIAL HOSPITAL TRUST

_____

_____, Trustee of the

COLLIS P. and HOWARD HUNTINGTON MEMORIAL HOSPITAL TRUST

_____

_____, Trustee of the

COLLIS P. and HOWARD HUNTINGTON MEMORIAL HOSPITAL TRUST

LESSEE:

PASADENA HOSPITAL ASSOCIATION LTD., a California nonprofit public benefit corporation d/b/a Huntington Hospital

By: _____

Lori J. Morgan, M.D.,
President and Chief Executive Officer

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California)
County of Los Angeles)

On _____, before me, _____, a Notary Public, personally appeared _____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California)
County of Los Angeles)

On _____, before me, _____, a Notary Public, personally appeared _____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California)
County of Los Angeles)

On _____, before me, _____, a Notary Public, personally appeared _____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California)
County of Los Angeles)

On _____, before me, _____, a Notary Public, personally appeared _____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____

Exhibit A to

Termination of Master Lease

LEGAL DESCRIPTION

That certain real property located in the City of Pasadena, County of Los Angeles, State of California, more particularly described as follows:

Exhibit L

ASSIGNMENT OF LEASE

THIS ASSIGNMENT OF LEASE (this "Assignment") is dated as of _____, 2020, by Jaynie Studenmund, Armando L. Gonzalez, Wayne Brandt, Michelle Quinones Chino and Paul Johnson, as the Trustees of the COLLIS P. AND HOWARD HUNTINGTON MEMORIAL HOSPITAL TRUST, a testamentary charitable trust ("Assignor"), and PASADENA HOSPITAL ASSOCIATION LTD., a California nonprofit public benefit corporation d/b/a Huntington Hospital ("Assignee").

B. Assignor is the lessor under that certain Standard Industrial/Commercial Single-Tenant Lease – Net (including an addendum thereto), dated July 1, 2012, as amended by amendments dated June 30, 2015, [March 15, 2017, and _____, 2020] (as amended, the "Lease"), by and between Assignor, as lessor, and Huntington Medical Research Institutes, a California non-profit corporation, as lessee, for the premises located at 734 South Fairmount Ave., Pasadena, CA 91105 (the "Premises").

C. Assignor is a charitable trust which exists for the sole benefit and support of the healthcare operations of Assignee.

D. Substantially concurrently herewith, Assignor is recording a quitclaim deed in the Official Records of Los Angeles County, California, transferring and distributing, among other property, all of its right, title and interest in and to the Premises to Assignee as a gift, for no value. The date on which such quitclaim deed is recorded shall be the "Effective Date" herein.

E. As of the Effective Date, Assignor desires to assign and quitclaim to Assignee, and Assignee desires to accept from Assignor, all of Assignor's right, title and interest as lessor in and to the Lease.

NOW, THEREFORE, for good and valuable consideration, the receipt and sufficiency of which are hereby expressly acknowledged, the parties hereto agree as follows:

1. Assignment of Lease. Effective as of the Effective Date, Assignor hereby assigns and quitclaims to Assignee, except as specifically set forth in this Assignment, without representation or warranty, express or implied, all of Assignor's right, title and interest as lessor in, to and under the Lease together with any and all rights of Assignor in and to such security deposits (collectively, the "Deposits") and prepaid rents (collectively, the "Prepaid Rents"), if any, as have been paid to Assignor pursuant to the Lease and not previously applied to the lessee's obligations under the Lease.

Assignor represents to Assignee that, as of the Effective Date: (i) the amount of the Deposits held by Assignor is $_____, (ii) the amount of the Prepaid Rents held by Assignor is $_____, representing rent due under the Lease for the period of _____, (iii) rents in the amount of $_____ due under the Lease have been paid to Assignor through and including _____, 2020, and (iv) to Assignor's actual knowledge, there are no defaults by either party under the Lease.

2. Acceptance. Assignee accepts the foregoing assignment and assumes and shall perform and discharge, as and when due, all of the agreements and obligations of Assignor under the Lease first accruing or arising on or after the Effective Date and agrees to be bound by all of the terms and conditions of the lessor under the Lease first arising on or after the Effective Date.

3. Further Assurances. Assignor hereby covenants that Assignor will, at any time and from time to time upon written request by Assignee therefor, execute and deliver to Assignee such documents as Assignee may reasonably request in order to fully assign and transfer to and vest in Assignee the Lease and the Deposits.

4. Successors and Assigns. The provisions of this Assignment shall be binding upon, and shall inure to the benefit of, the successors and assigns of Assignor and Assignee, respectively.

5. Governing Law; Venue. This Assignment shall be governed by and construed in accordance with the laws of the state of California. In the event of a dispute arising under or related to this Assignment, the parties submit to the sole and exclusive jurisdiction and venue of the courts of the County of Los Angeles, State of California.

6. Costs and Expenses. In the event of any action or suit between the parties hereto for or in connection with claims arising out of this Assignment, the prevailing party shall be entitled to have and recover of and from the other party all reasonable costs and expenses of the action or suit, including reasonable attorneys' fees and costs incurred at all trial and appellate levels.

7. Representations and Warranties. Assignor and Assignee each warrant and represent (i) that the person executing this Assignment on its behalf is authorized to execute this Assignment, (ii) that this Assignment is a valid, binding, and enforceable against such party, except as may be limited by applicable bankruptcy, reorganization, insolvency, moratorium or other laws affecting the enforcement of creditors' rights generally and by general principles of equity regardless of whether such enforceability is considered in a proceeding at law or in equity, and (iii) that it has the authority to enter into this Assignment without the joinder of any other party. Additionally, Assignor represents and warrants to Assignee that Assignor is the sole owner of the lessor's interests under the Lease and that Assignor has not previously assigned its interests under the Lease, the rent thereunder, the Deposits or the Prepaid Rents.

8. Counterparts. This Assignment may be executed in counterparts, including by facsimile or electronic copies, each of which shall be an original, but all of which together shall constitute one agreement binding on all of the parties notwithstanding that all of the parties are not signatories to the same counterpart or page.

[Signatures follow on next page]

IN WITNESS WHEREOF, Assignor and Assignee have caused their duly authorized representatives to execute this Assignment as of the date first above written.

ASSIGNOR:

_____
_____, Trustee of the COLLIS P. AND HOWARD HUNTINGTON MEMORIAL HOSPITAL TRUST

_____
_____, Trustee of the COLLIS P. AND HOWARD HUNTINGTON MEMORIAL HOSPITAL TRUST

_____
_____, Trustee of the COLLIS P. AND HOWARD HUNTINGTON MEMORIAL HOSPITAL TRUST

ASSIGNEE:

PASADENA HOSPITAL ASSOCIATION LTD., a California nonprofit public benefit corporation d/b/a Huntington Hospital

By: _____
Lori J. Morgan, M.D.,
President and Chief Executive Officer

Exhibit 2

JD Healthcare

Effect of the Affiliation Agreement between Huntington Hospital and Cedars-Sinai Health System on the Availability and Accessibility of Healthcare Services to the Communities Served by Huntington Hospital

Prepared for the Office of the California Attorney General

September 28, 2020

Table of Contents

Introduction & Purpose

JD Healthcare, Inc. was retained by the Office of the California Attorney General to assess the potential impact of the proposed Affiliation Agreement by and between Cedars-Sinai Health System, a California nonprofit public benefit corporation ("Cedars-Sinai"), and Pasadena Hospital Association Ltd., a California nonprofit public benefit corporation ("PHA") d/b/a Huntington Hospital, and the Trustees of the Collis P. and Howard Huntington Memorial Hospital Trust (the "Trust"), on the availability and accessibility of healthcare services to the communities served by Huntington Hospital ("Hospital").[1]

PHA has requested the California Attorney General's consent to the affiliation which contemplates that the Hospital will become a part of the Cedars-Sinai's integrated healthcare delivery system, and Cedars-Sinai will become the Hospital's sole member.

This healthcare impact statement analyzes the possible effects that the proposed transaction may have on the availability and accessibility of healthcare services to the residents served by the Hospital.

In its preparation of this report, JD Healthcare, Inc. performed the following:

- A review of the written notice submitted to the California Attorney General on July 22, 2020, and supplemental information subsequently provided by the Hospital;
- A review of press releases and news articles related to the proposed Affiliation Agreement and other hospital transactions;
- Interviews with community representatives, representatives of the Hospital's medical staff, management, and employees, members of the Hospital's Board of Directors, Cedars-Sinai representatives, and others as listed in the Appendix;
- An analysis of financial, utilization, and service information provided by the Hospital and the California Office of Statewide Health Planning and Development (OSHPD[2]); and
- An analysis of publicly available data and reports regarding the Hospital, Cedars-Sinai, and the service area, including demographic characteristics and trends, payer mix, hospital utilization rates and trends, health status indicators, and hospital market share.

[1] We understand the Attorney General's Office is conducting a competitive impact review of this transaction. Nothing in this report is intended to express an opinion one way or the other on that review or its outcome.
[2] California's Office of Statewide Health Planning and Development (OSHPD) collects data and disseminates information about California's healthcare infrastructure. It also monitors the construction, renovation, and seismic safety of hospitals and skilled nursing facilities and provides loan insurance to assist the capital needs of California's not-for-profit healthcare facilities.

Background Description of the Transaction

The Hospital

Founded in 1892, the Hospital operates as a 619 licensed-bed general acute care hospital located at 100 W. California Blvd., in the City of Pasadena within the San Gabriel Valley,[3] in Los Angeles County. The Hospital also provides outpatient services through its California Health & Safety Code Section 1206(l) medical foundation clinics and conducts the management and business affairs of various joint venture entities.

The Hospital is currently governed by a twenty-four (24) member Board of Directors with responsibility for overseeing the management and financial needs of the Hospital. The Hospital has other entities and joint ventures as described below.

Congress Services Corporation

Incorporated in 1985 as a for-profit corporation, Congress Services Corporation is a wholly owned subsidiary of Huntington Hospital and is a partial owner of two imaging joint ventures.

Huntington Ambulatory Surgery Center

Started in 2010, the Huntington Ambulatory Surgery Center is a limited liability company that is owned 99.8% by the Hospital with the remaining balance owned by a physician group. It is located adjacent to the campus at 625 S. Fair Oaks Avenue, Suite 380 in Pasadena.

The Huntington Medical Foundation

Organized in 1993 as a California non-profit public benefit corporation and a 1206(l) medical foundation[4], the Huntington Medical Foundation (also known as Huntington Health Physicians) conducts medical research and health education and provides health care to its patients in settings or place(s) of service including private practice offices, outpatient imaging centers, and the Hospital. Health care services are provided by the Huntington Foundation Medical Group, the Hill Medical Group for Radiology Services, and the Huntington Aligned Medical Group under three (3) separate professional services agreements. The foundation has over 78 providers, including advanced practice providers. Sixty-five (65) of the providers are on a full-time basis.

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[3] The San Gabriel Valley is located in the eastern region of Los Angeles County and includes 31 cities covering an area of 400 square miles with over 1.8 million residents (source LA Economic Development Corporation).

[4] The Medical Foundation operates under California Health and Safety Code section 1206(l). Under section 1206(l), a clinic operated by a nonprofit corporation that conducts medical research and health education and provides healthcare to its patients through a group of 40 or more physicians and surgeons, who are independent contractors representing not less than ten board-certified specialties, and not less than two-thirds of whom practice on a full-time basis at the clinic, is not required to be licensed.

The Huntington Medical Foundation is contracted with Davita Healthcare Partners, which was recently acquired by Optum in May 2020, as the exclusive primary care provider for approximately 23,800 commercial enrollees. In 2018, the Huntington Medical Foundation accounted for 156,000 outpatient visits/encounters. The Hospital is the sole corporate member of the Foundation.

Huntington Hill Imaging

Huntington Hill Imaging is a limited liability company formed in 2019 as a joint venture owned 50% by Congress Services Corporation and 50% by Hill Radiology. It provides outpatient imaging services to patients at several locations including the Jim & Eleanor Randall Breast Center on the Hospital campus.

Huntington Outpatient Imaging Centers

A limited liability company formed in 1997, Huntington Outpatient Imaging Centers is owned by four entities: Hill Medical Corporation (42%), which is a radiology medical group; Huntington Medical Research Institute (28%), which is an independent, tax-exempt research organization; Congress Services Corporation (29%) and the Hospital (1%). Since, 1985, Huntington Outpatient Imaging Centers has an affiliation agreement with the Hospital focused on sharing resources, including recruiting physicians to enhance research activities and the Hospital's patient care activities, conferring general medical education opportunities, and a commitment to use the same Institutional Review Board.

Huntington Care Network Accountable Care Organization (ACO)

Formed in 2013 as a limited liability company, the Huntington Care Network ACO participated in the federal Medicare Share Savings Program[5] as an enrolled ACO[6] but has since terminated the contract in January 2019. At that time, there were 110 participating providers in the ACO, of which 90 were primary care physicians. The Huntington Medical Foundation is the sole member of the ACO. The Hospital provides certain administrative services to the ACO via an administrative services agreement.

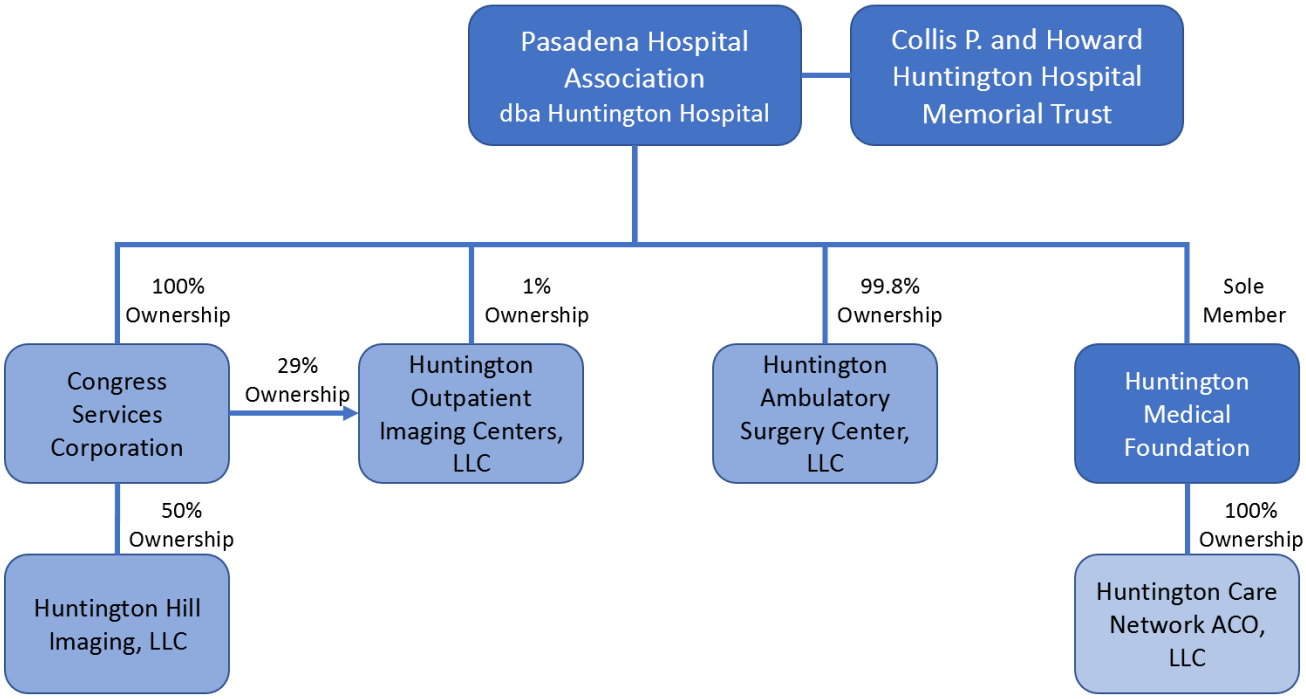
[5] According to the Centers for Medicare & Medicaid Services, the Shared Savings Program offers providers and suppliers an opportunity to create an accountable care organization that agrees to be held accountable for the quality, cost, and experience of care of an assigned Medicare fee-for-service beneficiary population.
[6] ACOs are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high-quality care to their Medicare patients (CMS.gov)

The Trust

The Trust was created in 1932 by court order pursuant to the will of Henry E. Huntington. It exists for the benefit and support of the Hospital, its sole beneficiary, and manages an endowment that funds specific maintenance and operational programs at the Hospital. The Trust has five (5) Trustees, who are appointed for life and serve as ex-officio Directors on the Board of Directors of the Hospital. The affirmative vote of a majority of the five trustees is necessary for the transaction of certain business of the Hospital and can block but not compel action.

The Trust assets include an investment portfolio of $240 million. It owns the land on which the Hospital is located and other adjacent real estate and leases the hospital land to the Hospital. The Trust is also a co-obligor of Hospital debt (approximately $195 million are callable in 2024 and $100 million callable in 2028).

Below is an organizational chart depicting the relationship of the various entities.



Note: dark blue shaded boxes are non-profit and lighter blue shaded boxes are for-profit organizations

History of Huntington Hospital

The Hospital was founded in 1892 as a 16-bed hospital that was originally known as Pasadena Hospital. In 1932 the Hospital was re-named Huntington Memorial Hospital after Henry E. Huntington endowed the hospital with a $2 million gift and established the Collis P. and Howard Huntington Memorial Hospital Trust. In 1975 the Neonatal Intensive Care Unit (NICU) opened at the Hospital and is currently a level III NICU, the highest level available in the San Gabriel Valley. In 1983 the Hospital became a Level II trauma center and the only one in the San Gabriel Valley. The five story Carmen and Charles Hale East Hospital Tower opened in 1998. In 2007 the Hospital continued to expand, when the West Hospital Tower opened. In 2011 the Hospital received Magnet designation[7], which is a prestigious distinction awarded to certain hospitals for nursing excellence and quality patient outcomes. The emergency department was expanded in 2014 doubling the Hospital's ability to treat emergency patients. In 2020 the Hospital was ranked the 12th best hospital in Los Angeles and 20th best in California according to U.S. News & World Report Hospital Rankings.

Reasons for the Transaction[8]

The Hospital plans to affiliate with Cedars-Sinai in order to join its integrated healthcare delivery system, which together intend to maintain and improve healthcare quality and access throughout the communities of Los Angeles and the San Gabriel Valley.

The affiliation includes commitments for continued investment in the Hospital, including its identified needs for information technology, ambulatory services and physician development.

The Hospital's Board of Directors states the following goals for the affiliation:

- Enhance the Hospital's ability to fulfill its mission and vision;
- Develop a compatible culture with Cedars-Sinai, with a focus on collaboration and a commitment to quality and community;
- Recognize the Hospital's commitment to and relationship with its community as key foundational assets to be maintained and built upon;
- Develop the leading clinically integrated healthcare delivery platform in the Hospital's service area;

[7] The designation of "Magnet Hospital" is awarded by the American Nurses Credentialing Center (ANCC). Before achieving Magnet status, a hospital must demonstrate excellence in nursing and patient care as well as innovation in professional nursing practice. This coveted honor helps hospitals attract patients, nurses, and other medical staff.
[8] The Board of Director's goals as stated in the written notice submitted to the California Attorney General.

- Enhance the relationship with the Hospital's medical provider community;
- Commit to the wellness of the Hospital's service area;
- Balance the current economic realities of the greater Los Angeles area;
- Enable the Hospital to continue and enhance its ambulatory growth strategy;
- Support investment in the ambulatory resources necessary to provide value-based care;
- Position the Hospital to be a leader in a value-based care environment with specific competencies, including the ability to enter into risk-based payment arrangements, coordinate care effectively, perform sophisticated data analytics and provide broad access to care;
- Implement an enterprise-wide information technology strategy, including electronic health records, ambulatory population health management and wellness, and revenue cycle management;
- Provide the resources necessary to support the development of a full-service management services organization and offer competitive employment and quasi-employment options to the medical community;
- Consider strategic and economic realities, balancing the possible effects on the Hospital's current partnerships and relationships;
- Support the full spectrum of the clinical services the Hospital offers to the community, particularly in areas of cardiology and oncology;
- Commit to clinical quality;
- Demonstrate alignment with the Hospital's focus upon excellence in nursing and its medical staff;
- Continue the Hospital's existing commitment to research and education;
- Provide financial strength and stability to support the combined capital needs of the Hospital and Cedars-Sinai;
- Ensure ongoing commitment to the Hospital's relationship with the community as well as its existing mission, including a meaningful role in governance for the Hospital's Board and the Trust;
- Demonstrate that the affiliation with the Hospital is a strategic priority for Cedars-Sinai; and

- Successfully execute an affiliation strategy.

Timeline of the Transaction

The events leading up to this transaction are chronologically ordered as follows:

- Late 2018 - The Hospital's Board began evaluating a variety of potential transactions intended to preserve and strengthen the quality and scope of healthcare services that the Hospital and its affiliates provide to their communities, including its charity care and community benefit services, as well as to provide the Hospital with access to additional resources to support its current and anticipated capital needs into the future;

- The Hospital's Board authorized the formation of a committee (the "Rose Committee") to explore alternatives for the Hospital to consider and evaluate options. The Rose Committee consisted of trustees, Hospital board and management team members, and advisors;

- February 5, 2019 – The Rose Committee identified and refined the Hospital's priorities, which it determined included mission, culture, clinical programs and services, physician alignment, ambulatory strategies, value-based care capabilities, IT resources, financial resources, and strategic alignment, as well as effects on the community governance of the Hospital and its relationship with the Trust;

- February 26, 2019 – The Rose Committee presented to the Board a summary of possible strategic partnerships, along with a review of the first draft of potential partnership goals;

- April 25, 2019 - A follow-up presentation and discussion of healthcare trends was held by the Rose Committee;

- May 29, 2019 – The Hospital's Board determined that it would be in the best interests of the Hospital and its charitable purposes to pursue a process designed to generate interest in an affiliation transaction in which the Hospital could join a health system that best met the Hospital's priorities. The Board authorized the reconstitution of the Rose Committee as the "Partnership Committee," adjusted the membership of the Partnership Committee to consist solely of volunteer directors, including directors who are also trustees of the Trust, and granted broad authority to the Partnership Committee to explore strategic alternatives for the Hospital;

- July 8, 2019 - The Partnership Committee explored strategic alternatives for the Hospital, including identifying health systems whose missions, values and operations provided a reasonable basis to believe that an affiliation with one of the systems could help the

Hospital meet its objectives. The Partnership Committee sent a request for proposals to Cedars-Sinai and other health care organizations on a potential partnership;

- September 12, 2019 – The Partnership Committee received and reviewed RFP responses;
- October 1, 2019 - Follow up questions were submitted to potential partners to clarify elements indicated in the response to the Hospital's proposal;
- November 7, 2019 – Responses were presented, and the Hospital's Board voted to continue discussions with three organizations and discontinue discussions with one organization;
- November 2019 – December 2019 – A series of internal due diligence processes occurred at the Hospital;
- January 23rd - The Partnership Committee distributed draft Letters of Intent (LOIs) to potential partners;
- February 10, 2020 – The Partnership Committee reviewed the final LOIs received from potential partners;
- March 6, 2020 - The Hospital Board voted to enter into a LOI with Cedars-Sinai;
- March 2020 - The Hospital and Cedars-Sinai entered into due diligence discussions and began the development of affiliation documents;
- July 2, 2020 – The Hospital Board held a meeting to review and discuss the terms of the affiliation;
- July 13, 2020 – Cedars-Sinai approved the affiliation documents; and
- July 14, 2020 – The Hospital Board approved the affiliation with Cedars-Sinai.

Summary of the Affiliation Agreement

The Affiliation Agreement was made and entered into as of July 15, 2020, by and between the Cedars-Sinai and the Hospital.

The Affiliation Agreement includes commitments for continued investment in the Hospital—including its identified needs in information technology, ambulatory services and physician development.

The Affiliation Agreement provides for an ongoing commitment to advancing the Hospital's mission and culture as a community institution governed by its local community board.
The major provisions of the Affiliation Agreement include the following.

Change in Control and Governance

- Cedars-Sinai will become the sole member of the Hospital and will designate the Hospital as one of the supported organizations of Cedars-Sinai. Cedars-Sinai will have certain reserved powers, as specified in the bullets below, over the governance and operations of the Hospital and its affiliates.

- Hospital Board Representation:

    - The number of Directors on the Hospital Board is not less than thirteen (13) and not more than twenty-eight (28);

        - Cedars-Sinai will add two (2) Directors to the the Hospital Board;

        - The Trust will have five (5) Directors on the Board;

        - There will be three (3) physician Directors on the Board;

        - The remaining eighteen (18) individuals will be Community Directors, including the Chief Executive Officer (CEO) of the Hospital; and

        - The ten (10) person Hospital Executive Committee will include one (1) person from Cedars-Sinai.

- Cedars-Sinai Health System Board Representation

    - At all times, at least one (1) member of Cedars-Sinai's Board of Directors shall be a Hospital representative;

    - The Hospital will nominate three (3) individuals constituting a mimimun of ten (10) percent of the total number of directors to serve on Cedars-Sinai's Board of Directors; and

    - Cedars-Sinai will elect the Hospital's nominated directors to serve on the Board of Directors.

Hospital and Cedars-Sinai Member Powers

- The Hospital Board will continue to be a fiduciary board of the Hospital and shall have reserve powers for the business affairs of the Hospital except as noted below, and subject to the provisions of the Affiliation Agreement and Bylaws.

- The Hospital Board and Cedars-Sinai Board shall have joint approval powers for the following:

    - Unbudgeted expenditures over $5 million;

    - Loans in excess of 2% of net assets (except for intercompany transfers); and

    - Community benefit plan.

- The Hospital Board, with at least three (3) of five (5) Trust directors approval, and the Cedars-Sinai Board shall have joint approval powers for the following:
    - Change in the mission, vision, or values;
    - Change in the Hospital name;
    - Change to legal form of the Hospital (except as part of a Change in Control);
    - Dissolution (except as part of a Change in Control);
    - Any action that jeopardizes the tax-exempt status of the Trust;
    - Sale of the Hospital physician network assests (except an internal reorganization); and
    - Sale of assets with value exceeding 2% of net revenue (except as part of a Change in Control),
- The Hospital Board, with at least three (3) of five (5) Trust directors approval, and the Cedars-Sinai Board shall have joint approval powers for the first five (5) years after Closing[9] for the following:
    - Approval of successor to the person serving as the CEO as of Closing;
    - Ammendment of Articles or Bylaws; and
    - Any action or decision that would change the size or composition of the Hospital Board.
- The Board, with at least three (3) of five (5) Trust directors approval, and the Cedars-Sinai Board shall have joint approval powers for the first ten (10) years after Closing for the following:
    - Sale of Hospital real property (except as part of a Change in Control).
- The Cedars-Sinai Board shall have, subject to the Hospital Board's reserved powers, exclusive power over the following:
    - Periodic strategic plans (other than the capital plan);
    - Annual operating and capital budgets;
    - Appointment and removal of the CEO other than the approval of successor to the incumbent CEO during the first five (5) years after Closing;
    - Borrowed indebtedness (except leases under $5 million);
    - Including the Hospital in an obligated group;

[9] Closing means completion of the Affiliation and shall take place remotely via exchange of documents and signature pages.

- Settlement or consent decree (except for non-governmental settlements; no reputational impact on Cedars-Sinai);
- Change in the legal form of the Hospital;
- Change in Control of the Hospital;
- Closure, sale, lease, transfer, exchange, disposition, or change in use of the Hospital;
- Dissolution of the Hospital;
- Election of individuals to serve as Community Directors on the Hospital Board;
- Removal of Community Directors from the Hospital Board;
- Sale of the Hospital's real property after ten (10) years from Closing;
- Internal reorganization of physician network assets;
- Sale of assets with value exceeding 2% of net revenue (except as part of a Change in Control); and
- Selection of an independent auditor.

Capital and Operating Expenses

- Cedars-Sinai approves the Hospital's long-range $560 million strategic capital plan through December 31, 2029. If the Hospital's days cash on hand falls below 60 days, then Cedars-Sinai will fund up to $300 million of the strategic capital plan from sources other than operating cash of the Hospital (e.g., borrowings or intercompany loans);
- Annual capital spending is subject to a budget approval processes, except that a current three-year $85 million strategic capital plan (a portion of the $560 million) is pre-approved for major capital projects for existing commitments;
- The Hospital is responsible for a proportional share of Cedars-Sinai "system-level" operating expenses; and
- The Hospital is responsible for a proportional share of Cedars-Sinai "system-level" capital expenses.

Electronic Health Records

- Cedars-Sinai agrees, within three years after Closing, to install Epic software for an enterprise integrated electronic health records system at the Hospital. Cedars-Sinai agrees to fund the capital costs of this project from sources other than operating cash of the Hospital.

Employees

- Employees of the Hospital and its affiliates will remain employed at Closing. For 90 days after Closing Cedars-Sinai will not trigger obligations under federal or state Worker Adjustment and Retraining Notification **(**WARN) laws. For five years after Closing Cedars-Sinai will not reassign employees to other affiliates of Cedars-Sinai without the prior consent of the Hospital. If such reassignment ever occurs, employees will receive full credit for their years of service to the Hospital for purposes of eligibility and vesting, to the extent applicable.

Medical Staff

- The Hospital will retain a separate, independent medical staff and separate medical staff bylaws for the Hospital. At Closing, its elected and appointed medical staff leadership will remain the same and membership status and clinical privileges will remain the same.

Charity Care and Community Benefit

- Cedars-Sinai commits to the Hospital providing charity care and community benefit programs at levels required by the California Attorney General.

Healthcare Service Commitments

Cedars-Sinai commits to the Hospital continuing important aspects of its healthcare operations and for the periods determined by the California Attorney General, including the following:

- The Hospital will continue as a licensed general acute care hospital, including to the extent that the Hospital is able to meet the requirements of applicable accreditation agencies, maintaining each of the following with the same types and levels of services as currently provided:
    - Level II Trauma Center;
    - Level III Neonatal Intensive Care Unit;
    - Comprehensive Stroke Center;
    - STEMI Receiving Center;
    - Advanced Cardiology and Cardiovascular Surgery Programs;
    - Advanced Robotic Surgery;
    - Orthopedic Service Line;
    - Oncology Service Line;
    - Neurology Service Line;
    - Graduate Medical Education Programs;
    - Senior Care Network;
    - Women's Health Services; and
    - End of Life Services.
- The Hospital will continue to participate in the Medi-Cal and Medicare programs;
- Any future sale or change in control of the Hospital will require the prior approval of the California Attorney General; and

- The Hospital will use commercially reasonable efforts to maintain Magnet Status with substantially the same types and levels of services as currently provided.

Trust-Related Terms

- The Trust will gift to the Hospital the legal title to the Hospital land (the Hospital already holds the beneficial and lessee interests). As a result, the ground lease for the Hospital land will be terminated;

- The Trust commits to make the two types of annual distributions to the Hospital through the year 2029, so long as the Hospital and its tax-exempt affiliates continue to be tax-exempt, the Hospital continues as a general acute care hospital, Cedars-Sinai continues to be the sole member of the Hospital, and Cedars-Sinai complies with its obligations under the Affiliation Agreement:

    - The Trust will make annual distributions to fund the general medical education program at The Hospital. In 2021, the amount of this annual distribution is $5,300,000. The amount of this distribution will increase in subsequent years by 2.5% per year; and

    - The Trust will make annual distributions to fund the Hospital projects selected by the Trust and approved by the the Hospital Board. The annual amount of this distribution will be 2.5% of the market value of certain cash and marketable securities owned by the Trust (that have a minimum hold or exit provision of less than six (6) months).

Conditions to Closing

Conditions to the Closing of the Affiliation include the following, among other standard closing conditions:

- The 30-day period under the Hart-Scott-Rodino Act will have expired or been terminated;
- The California Attorney General will have issued its approval of the Affiliation with terms of approval comparable to other recent nonprofit hospital acquisitions;
- The Trust will have received court approval of the actions to be taken by the Trust in connection with the Affiliation;
- At Closing, certain conditions stated in the Reimbursement Agreement dated as of July 15, 2020, among Cedars-Sinai, CSMC and the Trust will continue to be in full force and effect:
    - The Trust will remain as co-obligor of existing Hospital debt for the $85 million strategic capital plan through 2024;
    - By July 1, 2024, the Trust will be released from its obligations related to the Series 2014A and 2014B bonds;
    - By July 1, 2028, the Trust will be released of any and all other obligations under the master indenture of trust and related agreements involving the bond indebtedness of the Hospital; and
    - All parties will be released from all claims and liabilities, other than surviving Trust rights and obligations.

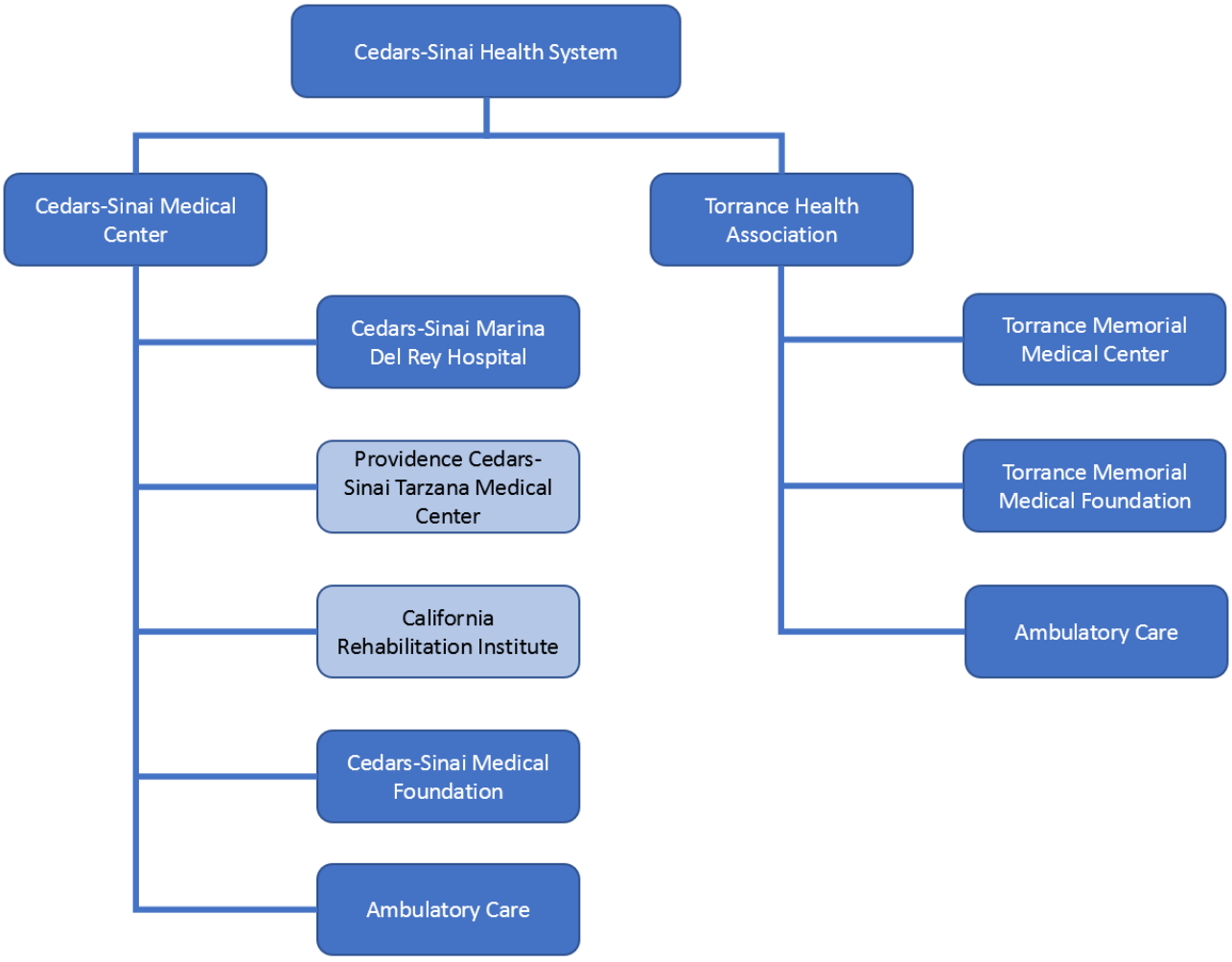
Use of Net Sale Proceeds

The Affiliation will result in Cedars-Sinai becoming the sole member of the Hospital and does not involve the sale, transfer, merger or other disposition of any assets of the Hospital. Immediately after Closing, the Hospital will retain its assets and liabilities and continue to own and operate the Hospital. There will be no net proceeds as a result of the proposed transaction.

Profile of Purchaser

Overview

Cedars-Sinai is a nonprofit, public benefit corporation and the sole corporate member of Cedars-Sinai Medical Center, CFHS Holdings Inc., a California nonprofit public benefit corporation, doing business as Cedars-Sinai Marina Del Rey Hospital, and Torrance Health Association, Inc. – the sole corporate member of Torrance Memorial Medical Center and Torrance Memorial Medical Center Health Care Foundation. The health system was formed on May 1, 2017 to facilitate the affiliation between Cedars-Sinai Medical Center and Torrance Health Association, Inc., and functions as an integrated parent organization of nonprofit healthcare organizations that establishes maintains, sponsors, and promotes activities relating to the improvement of health and wellbeing.



Note: Light blue shaded boxes are joint ventures where Cedars Sinai has a minority ownership

Cedars-Sinai Medical Center (CSMC) is a California nonprofit, public benefit corporation that owns and operates a general acute care hospital with 886 licensed beds located at 8700 Beverly Boulevard, Los Angeles, California. The hospital provides patient care, medical education and research, health education, and community service. CSMC is also the sole corporate member of Cedars-Sinai Medical Care Foundation and Cedars-Sinai Marina Del Rey Hospital.

Cedars-Sinai Medical Care Foundation (CSMCF) is a California nonprofit, public benefit corporation that operates, manages, and maintains multi-specialty clinics, holds payer contracts and the assets of acquired physician and physician group practices and independent practice associations; and contracts for physician services pursuant to professional services agreements.

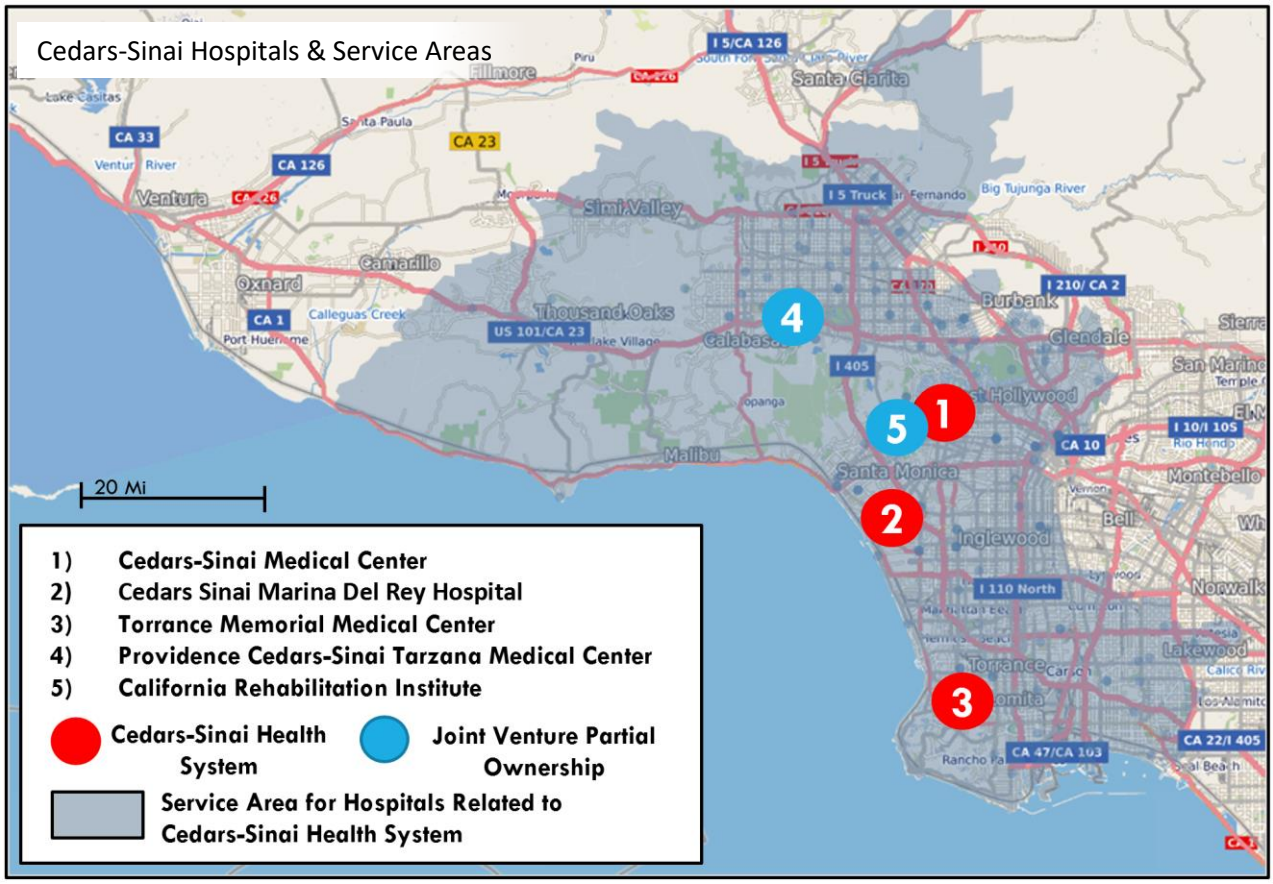
Cedars-Sinai Marina Del Rey Hospital was acquired in 2015, by the Cedars-Sinai and operates as a general acute care hospital licensed for 133 beds located at 4650 Lincoln Boulevard in Marina Del Rey. The hospital provides general acute care medical services, emergency services, and surgical services.

California Rehabilitation Institute, LLC, a joint venture created in December 2013, with Select Hospital Investors, Inc. and UCLA Health, is a 145-bed acute rehabilitation hospital. It is located in Century City, where Cedars-Sinai owns 38.1% of the venture.

Torrance Memorial Medical Center entered into an affiliation agreement with Cedars-Sinai and established joint system-level governance over their operations in 2017. It is a general acute care hospital licensed for 596 beds located at 3330 Lomita Boulevard in Torrance, California. The hospital offers medical services including emergency, neonatal intensive, cardiovascular, oncology, pediatric, and maternal and child health services.

On March 12, 2019, Providence St. Joseph Health (Providence) and CSMC formed a joint venture agreement for Providence Cedars-Sinai Tarzana Medical Center (PCSTMC). Providence is the majority owner and will operate PCSTMC with CSMC as a minority interest owner. Providence and CSMC will jointly continue the build-out and redevelopment of the PCSTMC campus. The joint venture expands primary and specialty care services on or near the PCSTMC campus, and enhances other programs, including heart, cancer and women's services.

A map with the service area and locations of hospitals related to Cedars-Sinai is shown below.



Statement of Operations

The following table below shows Cedars-Sinai's FY 2019 and FY 2018 Consolidated Statements of Operations which include the accounts of CSMC and its affiliates.

Cedars-Sinai Health System Consolidated Statements of Operations and Changes in Net Assets FY 2018 - FY 2019 (In Thousands)		
REVENUES, GAINS AND OTHER SUPPORT	**FY 2018**	**FY 2019**
Patient service revenue (net of contractual allowances and discounts)	$ 3,739,817	
Provision for bad debts	(37,352)	
Net patient service revenue before Medi-Cal Fee Program	3,702,465	$ 4,354,791
Medi-Cal Fee Program revenue	183,228	132,625
Net patient service revenue	3,885,693	4,487,416
Premium revenue	168,236	263,941
Other operating revenues	113,499	134,295
Net assets released from restrictions	198,434	225,407
Total revenues, gains, and other support	**4,365,862**	**5,111,059**
EXPENSES		
Salaries and related costs	2,073,133	2,359,996
Professional fees	286,387	349,357
Materials, supplies, and other	1,333,224	1,583,067
Medi-Cal Fee Program expense	191,273	129,849
Interest	40,643	45,165
Depreciation and amortization	212,064	239,881
Total expenses	**4,136,724**	**4,707,315**
Income from operations	**229,138**	**403,744**
NONOPERATING INCOME		
Investment income	110,620	144,973
Gain on equity method investments	8,001	5,264
Excess of revenues over expenses before inherent contribution from affiliation	347,759	553,981
Inherent contribution from affiliation	508,088	–
Excess of revenues over expenses	855,847	553,981
Deficit (excess) of revenues over expenses attributable to non-controlling interests	(2,938)	2,687
Excess of revenues over expenses attributable to the Health System	**$852,909**	**$556,668**

Source: Cedars-Sinai Health System Audited Financial Statements Years Ended June 30, 2019 and 2018

Key Statistics

A detailed profile of the hospitals that are part of the Cedars-Sinai Health System is provided in the table below.

CEDARS-SINAI HEALTH SYSTEM HOSPITALS						
	Cedars-Sinai Medical Center		Cedars-Sinai Marina Del Rey Hospital		Torrance Memorial Medical Center	
	FY 2017	FY 2018	FY 2017	FY 2018	FY 2017	FY 2018*
City/Area	Los Angeles		Marina Del Rey		Torrance	
Licensed Beds	886	886	133	133	596	596
Patient Days	260,550	263,201	12,417	13,822	111,032	58,013
Discharges	49,901	50,136	3,886	4,299	26,701	13,658
ALOS	5.2	5.2	3.2	3.2	4.2	4.2
Average Daily Census	714	721	34	38	304	159
Occupancy	81%	81%	26%	28%	51%	54%
ED Visits	92,111	91,064	36,008	32,564	85,461	43,125
Inpatient Surgeries	16,657	15,970	3,760	3,657	6,663	3,385
Outpatient Surgeries	15,141	14,705	1,918	4,306	9,064	4,614
Births	6,664	6,440	-	-	2,790	1,245
Payer Mix (Based on Discharges):						
Medicare Traditional	41.6%	40.8%	37.3%	42.2%	24.8%	24.9%
Medicare Managed Care	4.0%	4.3%	11.8%	12.5%	26.1%	27.8%
Medi - Cal Traditional	6.1%	5.6%	5.3%	4.0%	3.3%	3.0%
Medi - Cal Managed Care	6.0%	6.3%	5.6%	6.2%	4.8%	5.2%
Third - Party Traditional	2.1%	1.9%	1.2%	6.2%	0.9%	0.9%
Third - Party Managed Care	38.9%	39.6%	28.8%	27.4%	38.0%	36.4%
Other Payers	1.3%	1.4%	9.8%	1.4%	2.1%	1.8%
Other Indigent	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
County Indigent	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Income Statement:						
Net Patient Revenue	$2,947,129,071	$3,092,144,785	$93,101,164	$106,396,752	$626,896,694	$323,946,960
Other Operating Revenue	$323,726,613	$341,194,334	$2,118,588	$2,829,658	$21,913,614	$12,992,265
Total Operating Revenue	$3,270,855,684	$3,433,339,119	$95,219,752	$109,226,410	$648,810,308	$336,939,225
Total Operating Expense	$2,966,031,795	$3,149,102,784	$106,631,934	$111,323,933	$640,280,825	$331,269,589
Net From Operations	$304,823,889	$284,236,335	($11,412,182)	($2,097,523)	$8,529,483	$5,669,636
Non-operating Revenue	($23,540,726)	$25,367,418	$81,532	$99,506	$39,085,851	$5,089,987
Non-operating Expense	$5,547,027	$6,054,556	$0	$0	$12,759,894	$6,073,236
Net Income	**$275,736,136**	**$303,549,197**	**($11,330,650)**	**($1,998,017)**	**$34,855,440**	**$4,686,387**
Other Financial:						
Charity Care Charges	$30,502,264	$31,091,400	$2,127,920	$273,265	$19,347,611	$13,375,434
Bad Debt Charges	$24,983,772	$2,311,284	$7,952,413	$9,092,318	$11,727,755	$2,939,330
Total Uncompensated Care	**$55,486,036**	**$33,402,684**	**$10,080,333**	**$9,365,583**	**$31,075,366**	**$16,314,764**
Cost to Charge Ratio	16.9%	16.9%	24.1%	20.6%	17.3%	16.3%
Cost of Charity	$5,154,949	$5,241,781	$512,648	$56,283	$3,350,516	$2,184,194
Uncompensated Care as % of Chgs.	0.4%	0.2%	2.3%	1.8%	0.9%	0.8%
Disproportionate Share Hospital	NON-DSH		NON-DSH		NON-DSH	

Source: OSHPD Pivot Profile, FY 2017 & 2018

Note: Excludes Normal Newborns.

* Torrance Memorial Medical Center switched financial reporting procedures from calander year to fiscal year midway through 2018, and therefore only reported half a year's volume.

A detailed profile of hospitals that are joint ventures with Cedars-Sinai Medical Center is provided in the table below.

JOINT VENTURE HOSPITALS WITH CEDARS-SINAI HEALTH SYSTEM				
	Providence Cedars-Sinai Tarzana Medical Center		California Rehabilitaton Institute	
	FY 2017	FY 2018	FY 2017	FY 2018
City/Area	Tarzana		Los Angeles	
Licensed Beds	249	249	138	138
Patient Days	52,145	47,432	24,390	37,693
Discharges	13,249	12,822	1,888	2,715
ALOS	3.9	3.7	12.9	13.9
Average Daily Census	143	130	67	103
Occupancy	57%	52%	48%	75%
ED Visits	52,433	51,829	-	-
Inpatient Surgeries	3,137	2,881	-	-
Outpatient Surgeries	7,112	6,581	-	-
Births	2,612	2,541	-	-
Payer Mix (Based on Discharges):				
Medicare Traditional	36.3%	33.9%	62.9%	69.6%
Medicare Managed Care	6.5%	8.6%	3.5%	4.3%
Medi - Cal Traditional	7.7%	6.8%	0.1%	0.1%
Medi - Cal Managed Care	14.8%	14.8%	0.1%	0.1%
Third - Party Traditional	0.7%	0.6%	29.4%	25.5%
Third - Party Managed Care	32.9%	34.0%	0.0%	0.0%
Other Payers	0.1%	0.7%	0.7%	0.4%
Other Indigent	0.9%	0.5%	3.2%	0.0%
County Indigent	0.0%	0.0%	0.0%	0.0%
Total	**100%**	**100%**	**100%**	**100%**
Income Statement:				
Net Patient Revenue	$260,098,362	$264,059,033	$70,756,894	$96,124,998
Other Operating Revenue	$1,773,409	$1,789,106	$85,778	$104,006
Total Operating Revenue	$261,871,771	$265,848,139	$70,842,672	$96,229,004
Total Operating Expense	$272,547,934	$283,902,012	$68,372,813	$84,920,675
Net From Operations	($10,676,163)	($18,053,873)	$2,469,859	$11,308,329
Non-operating Revenue	$1,607,934	($28,865)	$0	$0
Non-operating Expense	$915,342	$437,650	$0	$0
Net Income	**($9,983,571)**	**($18,520,388)**	**$2,469,859**	**$11,308,329**
Other Financial:				
Charity Care Charges	$17,743,161	$13,511,713	$3,276,005	$0
Bad Debt Charges	$1,613,470	$2,780,727	$1,478,912	$1,949,000
Total Uncompensated Care	**$19,356,631**	**$16,292,440**	**$4,754,917**	**$1,949,000**
Cost to Charge Ratio	19.2%	21.8%	51.0%	37.9%
Cost of Charity	$3,405,327	$2,949,024	$1,669,470	$0
Uncompensated Care as % of Chgs.	1.4%	1.3%	3.5%	0.9%
Disproportionate Share Hospital	NON-DSH		NON-DSH	

Source: OSHPD Pivot Profile, FY 2017 & 2018
Note: Excludes Normal Newborns.

Hospital Compare

The Centers for Medicare & Medicaid Services' (CMS) Hospital Compare website is a hospital rating system that summarizes 57 quality measures into a single quality Star Rating in order to rank and provide information about the quality of care at over 4,000 Medicare-certified hospitals, including over 130 Veterans Administration (VA) medical centers, across the country. The information assists the public in making decisions about where to get health care services and encourages hospitals to improve the quality of care they provide.

The 57 quality measures are summarized into seven categories. These include:

- **General information:** Name, address, telephone number, type of hospital, and other general information about the hospital;

- **Survey of patients' experiences:** How patients recently discharged from the hospital responded to a survey about their hospital experience. The survey asks questions such as how well a hospital's doctors and nurses communicated with the patient;

- **Timely and effective care:** How often or how quickly hospitals give recommended treatments known to get the best results for people with certain common conditions;

- **Complications and deaths:** How likely patients will have complications while in the hospital or after certain inpatient surgical procedures, and how often patients died within 30 days of being in the hospital for a specific condition;

- **Unplanned hospital visits:** Whether patients return to a hospital after an initial hospital stay or outpatient procedure, and how much time they spend back in the hospital;

- **Use of medical imaging:** How a hospital uses outpatient medical imaging tests (like CT scans and MRIs); and

- **Payment and value of care:** How payments made by patients treated at individual hospitals compare to hospitals nationally.

CMS updated its overall hospital Quality Star Ratings in February 2020, recognizing 407 hospitals country-wide with 5-Star Ratings. Below is a breakdown of the Star Ratings:

- **1-Star:** 228 hospitals
- **2-Stars:** 710 hospitals
- **3-Stars:** 1,450 hospitals
- **4-Stars**: 1,138 hospitals
- **5-Stars:** 407 hospitals

CSMC achieved the top five-star rating, while the Hospital achieved a four-star rating as shown below:

Hospital Compare Star Ratings		
	Hospital	**Star Rating**
Cedars-Sinai Health System	Cedars-Sinai Medical Center	★★★★★
	Cedars-Sinai Marina Del Rey Hospital	★★★
	Torrance Memorial Hospital	★★★★
	Huntington Hospital	★★★★

Source: Medicare.gov, July, 2020

Leapfrog Hospital Safety Grade

Leapfrog Hospital Safety Grade is a composite score made up of up to 28 national performance measures of patient safety measures that indicate how well hospitals protect patients from preventable errors, injuries and infections. Submission of a Leapfrog Hospital Survey from general acute-care hospitals in the U.S. is encouraged though not required for hospitals to receive a grade. The composite score is based on data compiled by CMS and measures from Leapfrog Group's own customized survey developed by a panel of patient safety experts. The patient safety criteria used to determine the score include outcome and process measures.

Outcome measures include, among other measures:

- Infections, including: central line-associated bloodstream infections, catheter-associated urinary tract infections, surgical site infections for colon surgery, MRSA and C. diff;
- Falls and trauma, very severe pressure ulcers; and
- Preventable complications from surgery such as foreign objects retained in the body and accidental punctures or lacerations.

Process/structural measures include, among other measures:

- Strong nursing leadership and engagement;
- Computerized physician order entry systems to prevent medication errors;
- Safe medication administration;
- Hand hygiene policies; and
- The right staffing for the Intensive Care Unit (ICU).

The Leapfrog Hospital Safety Grade does not measure:

- Issues commonly considered quality measures, such as death rates for certain procedures;
- Measures of hospital quality, such as ratings by specialty or procedure; and
- Readmission rates.

Hospitals are then assigned a grade twice annually, using a scoring algorithm to determine each hospital's score as an A, B, C, D, or F letter grade.

Below are Leapfrog's Safety Grades for the hospitals.

Leapfrog Hospital Safety Grade				
	Hospital	Safety Letter Grade	Hospital	Safety Letter Grade
Cedars-Sinai Health System	Cedars-Sinai Medical Center	C SPRING 2020	Torrance Memorial Medical Center	B SPRING 2020
	Huntington Hospital	A SPRING 2020		

Source: Leapfrog Hospital Safety Grade
Note: Cedars-Sinai Marina Del Rey Hospital not reported.

Profile of Huntington Hospital

Overview of the Hospital

The Hospital is a 619-bed general acute care facility located at 100 W. California Boulevard in Pasadena, California that primarily serves the San Gabriel Valley area.

The table below shows the Hospital's licensed beds by type for 2020. A copy of the license can be found in the appendix.

BED DISTRIBUTION 2020	
Bed Type	**Number of Beds**
General Acute Care	372
Chemical Dependancy Recovery	12
Intensive Care	38
Neonatal Intensive Care	51
Pediatric	25
Perinatal	56
Rehabilitation	24
Total General Acute Care Beds	**578**
Acute Psychiatric (D/P)*	41
Total Licensed Beds	**619**

Source: Hospital License 2020

*"Distinct part" refers to a portion of an institution or institutional complex (e.g., a nursing home, psychiatric unit or a hospital) that is certified to provide the distinct services. A distinct part must be physically distinguishable from the larger institution and fiscally separate for cost reporting purposes.

A number of beds are "suspended" on the license, meaning that these are not being operated or used as licensed. These include 12 Chemical Dependency Recovery beds, 7 Pediatric beds, and 34 Unspecified General Acute Care beds.

The Hospital has a "basic" emergency department[10] with 50 licensed emergency treatment stations and is designated a Level II Trauma Center[11]. It also has 15 surgical operating rooms and three cardiac catheterization labs for inpatient and outpatient cardiac catheterization services.

[10] A "basic" emergency department provides emergency medical care in a specifically designated part of a hospital that is staffed and equipped at all times to provide prompt care for any patient presenting urgent medical problems.

[11] A Level II Trauma Center is able to initiate definitive care for all injured patients. Level II Trauma requirements include 24-hour immediate coverage by general surgeons, as well as coverage by the specialties of orthopedic surgery, neurosurgery, anesthesiology, emergency medicine, radiology and critical care.

Key Statistics

For FY 2018, the Hospital had a total of 28,635 inpatient discharges, 121,897 patient days, and an average daily census of 334 patients per day (approximately 72% occupancy on 578 total licensed beds).

HUNTINGTON HOSPITAL KEY STATISTICS FY 2016 - FY 2018			
	FY 2016	FY 2017	FY 2018
Inpatient Discharges	29,561	29,712	28,635
Licensed Beds	578	578	578
Patient Days	130,259	126,305	121,897
Average Daily Census	357	346	334
Occupancy	61.6%	59.9%	57.8%
Average Length of Stay	4.4	4.3	4.3
Cardiac Catheterization Procedures[1]	934	1,140	1,323
Emergency Service Visits[1]	70,779	75,338	75,802
Coronary Artery Bypass Graft (CABG)[1]	97	82	100
Total Live Births	3,518	3,675	3,558

Sources: OSHPD Disclosure Reports, FY 2016 - FY 2018

[1] OSHPD Alirts Annual Utilization Reports

- Since FY 2016, inpatient discharges have decreased by 3%, from 29,561 discharges to 28,635 discharges in FY 2018;
- Between FY 2016 and FY 2018, the average daily census decreased by 6.4% from 357 to 334 patients;
- Between FY 2016 and FY 2018, patient days visits decreased by 6.4% to 121,897 visits in FY 2018;
- Between FY 2016 and FY 2018, total live births remained relatively stable from 3,518 in FY 2016 to 3,558 in FY 2018; and
- Cardiac catheterization procedures increased by 42% from 934 in FY 2016 to 1,323 in FY 2018.

Programs and Services

The Hospital offers a comprehensive range of services, including emergency and trauma care, internal medicine, neonatal intensive care, cardiovascular, oncology, pediatric, behavioral health, rehabilitation, psychiatric and maternity and children's services. A more thorough description of services is provided below:

- Behavioral health services include a licensed 41-bed acute psychiatric unit that provides inpatient services and outpatient treatments. The Hospital has a Psychiatric Evaluation Team that has 5150[12] authority and conducts mobile crisis evaluation services for patients who are experiencing, or are at risk of experiencing, a psychotic episode;

- Brain and Spine services include neuroradiology, movement disorders treatment, neurosurgery, epilepsy and brain mapping, and a spine program;

- Cancer services include treatment for breast cancer, colorectal cancer, gynecological cancer, lung cancer, and prostate cancer that includes the use of radiation oncology and radiology;

- Cardiac services include a non-invasive vascular lab, cardiothoracic surgery, cardiac rehabilitation, cardiac electrophysiology, cardiac catheterization, cardiac screening and diagnostics. The Hospital is also a designated STEMI Receiving Center;

- Emergency and trauma services include an emergency department with 50 treatment stations and a Level II Trauma Center along with the following designations:

    - Emergency Department Approved for Pediatrics (EDAP);
    - Certified Advanced Comprehensive Stroke Center; and
    - Designated Paramedic Base Station.

- Designated Level II Trauma Center that meets the essential criteria by providing the necessary resources and scope of specialty physician services in order to provide comprehensive trauma coverage, as verified by the American College of Surgeons;

- Digestive system services include gastroenterology, nutrition counseling, and weight loss surgery;

[12] Welfare and Institutions Code, Section 5150: When a person, as a result of a mental health disorder, is a danger to oneself or others, a peace officer, professional person, or member of the staff at a designated 5150 Receiving Center may, upon probable cause, hold the person at the 5150 facility for evaluation and treatment over a 72-hour period.

- Lung & Kidney services include lung cancer program, bronchoscopy, urology and super dimension urology;
- Imaging services include mammography, CT, PET, MRI, ultrasound, X-ray, nuclear medicine, and radiation therapy;
- Intensive care/critical care services include a nursing unit that is a combined intensive medical, surgical, and cardiac care unit;
- Men's health services include prostate health, gastroenterology health, and urological health;
- Obstetric services include labor & delivery, high risk pregnancy, childbirth classes, Level III NICU, maternal wellness program, breast feeding center and gestational diabetes program;
- Pathology services include tissue registry;
- Inpatient pediatric services;
- Rehabilitation services include physical therapy, occupational therapy, and speech therapy;
- Respiratory care services include respiratory therapy and pulmonary rehab;
- Senior care services include injury prevention and a senior care network;
- Surgical services include general, trauma, cardiac, thoracic, neurological, orthopedic, ophthalmologic, otolaryngologic, laparoscopic, plastics, urology, total joint replacement, gastrointestinal, and vascular surgical services;
- Wellness & community services include blood donation, community outreach, disaster preparedness and asthma education & management; and
- Women's health services include obstetrics and maternity, Level III neonatal intensive care unit services, imaging and oncology.

Accreditation, Certifications and Awards

The Hospital is accredited for three years by The Joint Commission, effective September 2017. Over the years, the Hospital received several awards and accolades including the following:

- Certified by The Joint Commission as an Advanced Comprehensive Stroke Center effective May 2019 through May 2022;
- Certified by The Joint Commission as an Advanced Total Hip and Total Knee Replacement effective January 2020 through January 2022;
- In February 2020, Blue Shield of California selected the Hospital as a Blue Distinction Center for Knee and Hip Replacement, part of the Blue Distinction Specialty Care program. Blue Distinction Centers are nationally designated health care facilities that show a commitment to delivering high-quality patient safety and better health outcomes, based on objective measures that were developed with input from the medical community and leading accreditation and quality organizations;
- In 2020, the Hospital received America's 100 Best Hospital awards for cardiac care, coronary intervention and general surgery;
- In 2019, the Hospital received an Outstanding Patient Experience Award. This award recognizes organizations that are the top in the nation for overall patient experience based on nine measures related to doctor and nurse communication, hospital cleanliness and noise levels, and medication and post-discharge care instructions;
- In 2019, the Hospital also received America's 100 Best Hospital awards for gastrointestinal care excellence and general surgery;
- In 2018, the Hospital also received America's 100 Best Hospital awards for spine surgery, general surgery and orthopedic surgery excellence; and
- According to the U.S News and World Report, the Hospital ranked 12th best in Los Angeles and 20th best in California in 2020.

Quality Measures

The Value-Based Purchasing Program, established by the Federal Patient Protection and Affordable Care Act (ACA[13]) in 2012, encourages hospitals to improve the quality and safety of care. The Centers for Medicare & Medicaid Services rewards and penalizes hospitals through payment increases and reductions by determining hospital performance on four domains that reflect hospital quality: the clinical process of care and outcomes domain, the patient and caregiver centered experience of care/care coordination domain, the safety domain, and the efficiency and cost reduction domain. In FY 2019, the Centers for Medicare & Medicaid Services increased Medicare payments to the Hospital by 0.34%. For FY 2020, the Centers for Medicare & Medicaid Services increased payments to the Hospital by 0.35%.

The following table reports the Hospital's performance compared to all hospitals across the nation for the seven categories that comprise Hospital Compare's overall quality rating:

QUALITY MEASURES	
Condition/Procedure	**National Average**
Mortality	Above the national average
Safety of Care	Same as the national average
Readmission	Below the national average
Patient Experience	Same as the national average
Effectiveness of Care	Below the national average
Timeliness of Care	Below the national average
Efficient Use of Medical Imaging	Above the national average

Source: Data.medicare.gov Hospital Compare, June 2020

[13] The Affordable Care Act (ACA) is a comprehensive health care reform law enacted in March 2010. Its goals are to make affordable health insurance available to more people, provide consumers with subsidies ("premium tax credits") that lower costs for households with incomes between 100% and 400% of the federal poverty level and expand to cover all adults with income below 138% of the federal poverty level.

The Federal Hospital Readmissions Reduction Program[14], implemented in 2012, penalizes hospitals for excess patient readmissions within 30 days of discharge for the following six applicable conditions: chronic obstructive pulmonary disease, heart attack, heart failure, pneumonia, stroke and hospital-wide readmissions. The penalty is administered by reducing all of a hospital's reimbursement payments under the Medicare program by a certain percentage for the entire year.

In FY 2019, the Hospital was penalized with a 0.26% reduction in reimbursement. For FY 2020, the Hospital is penalized with a 0.15% reduction in reimbursement. The following table shows the Hospital's 30-day readmission rates for chronic obstructive pulmonary disease, heart attack, heart failure, pneumonia, and all causes hospital-wide. The Hospital's 30-day readmission rate is higher than the national average for chronic obstructive pulmonary disease, heart failure, pneumonia and hospital-wide conditions.

30-DAY READMISSION RATES		
Condition/Procedure	**Huntington Hospital**	**National Average**
Chronic Obstructive Pulmonary Disease	21.2%	19.5%
Heart Attack	15.2%	15.7%
Heart Failure	21.7%	21.6%
Pneumonia	17.5%	16.6%
Hospital-Wide	15.4%	15.3%

Source: Data.medicare.gov Hospital Compare, August 2020

[14] The formula for determining hospital reimbursement payments under the Hospital Readmissions Reduction Program varies by hospital and geographic location and may not correspond directly to state and national hospital averages.

Seismic Issues

Using the HAZUS seismic criteria[15], the Hospital's structures that are subject to seismic compliance have been classified according to the California Senate Bill 1953 Seismic Safety Act for the Structural Performance Category (SPC) and the Non-Structural Performance Category (NPC), as shown in the table below.

HUNTINGTON HOSPTIAL		
Building Name	**SPC Compliance Status**	**NPC Compliance Status**
East Tower (3 Story)	3	2
West Tower	5	4
La Vina Building	3	2
Daily Martin Center - Psychiatric B	N/A	N/A
Emergency Plant	5	4
Chiller Building	4	4
Cooling Towers	N/A	N/A
Wingate/Hanh Building	1	3
Service Building	1	2
1938 Building	1	2
1921 Building	1	2
Electrical Switchgate Vault	4	4
East Tower (7 Story)	5	2
East Tower Lobby	3	2
New Boiler Building	5	4
ED Addition	5	4
Ambulance Canopy	5	4
West Tower Tunnel	N/A	2
South Campus Utility Tunnel	N/A	4
East Tower Utility Tunnel	N/A	4
ED Utility Tunnel	N/A	4
East Tower Pedestrian Tunnel	4	4
Bulk Oxygen Storage	N/A	4
Bulk Oxygen	N/A	4

Source: OSHPD

[15]OSHPD uses HAZARDS U.S. (HAZUS), a methodology used to assess the seismic risk of hospital buildings.

Structural Performance Category (SPC) Rating of Hospital Buildings

- The Hospital has six buildings rated as SPC-5. Buildings in this category will have been constructed or reconstructed under a building permit obtained through OSHPD. These buildings may be used without restriction to January 1, 2030, and beyond;
- The Hospital has three buildings rated SPC-4. These buildings are in compliance with the structural provisions of the Alquist Hospital Facilities Seismic Safety Act (SBC 1953). Buildings in this category will have been constructed, or reconstructed, under a building permit obtained through OSHPD and may be used for inpatient services through to January 1, 2030, and beyond;
- The Hospital has three buildings rated as SPC-3. Buildings with this rating may experience structural damage which does not significantly jeopardize life but may not be repairable or functional following strong ground motion. Buildings in this category will have been constructed or reconstructed under a building permit obtained through OSHPD. These buildings may be used to January 1, 2030, and beyond; and
- Four of the Hospital's buildings are rated as SPC-1. These structures pose a risk of collapse and danger to the public. The structures require seismically compliant upgrades if they were to be made operational for patient services. Services in these buildings include a morgue, kitchen, and the supply, processing and distribution department. There are plans to move these departments as the buildings will not be seismically retrofitted.

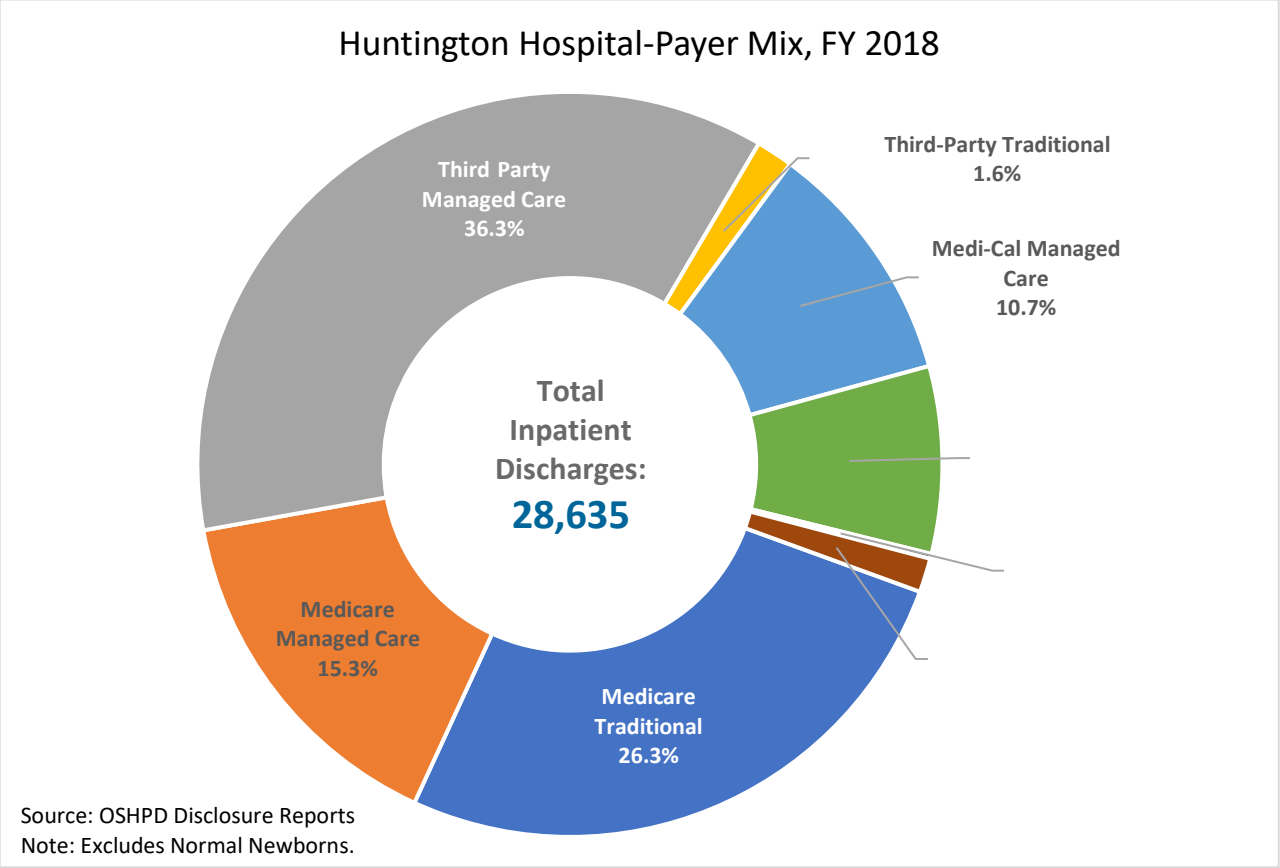
Non-Structural Performance Category (NPC) Rating of Hospital Buildings

- The Hospital has 13 buildings rated as NPC-4. These buildings meet the criteria for NPC-3 and all architectural, mechanical, electrical systems, components and equipment meet the bracing and anchorage requirements of Part 2, Title 24 of the California Building Code. This classification category is used for the purposes of the Office of Emergency Services. The deadline to meet the requirement was either January 1, 2020 or 2030 depending on the Seismic Design Category and extension request requirements;
- The Hospital has one building rated as NPC-3. This building meets the criteria for NPC-2 and in critical care areas, clinical laboratory services spaces, pharmaceutical service spaces, radiological service spaces, and central and sterile supply areas, the following components for this building meet the bracing and anchorage requirements of Part 2, Title 24; and
- The Hospital has eight buildings rated as NPC-2. For these buildings, the communication systems, emergency power supply, bulk medical gas systems, fire alarm systems and emergency lighting equipment for the building are either anchored in accordance with the

Part 2, Title 24 of the California Building Code or approved by the Department of General Services, Office of Architecture and Construction, Structural Safety Section.

Payer Mix

The Hospital's payer mix for FY 2018 consisted of a large proportion of Medicare (Traditional and Managed Care) patients that accounted for 41.6% of all inpatient hospital discharges. Third-Party Managed Care patients accounted for 36.3% of all inpatient discharges, with Medi-Cal Managed Care at 10.7% and Medi-Cal Traditional at 8.1%.



The following table provides the Hospital's FY 2018 inpatient discharge payer mix compared to Los Angeles County and the State of California for CY 2018. The comparison shows that the Hospital has much lower percentages of Medi-Cal Managed Care patients (10.7%) and Medi-Cal Traditional Patients (8.1%) relative to Los Angeles County and California overall. The table also shows that the Hospital has a higher percentage of Third Party Traditional and Managed Care patients (37.9%) relative to Los Angeles County (25.5%) and California overall (27.7%).

PAYER MIX COMPARISON						
	Hospital[1] (FY 2018)		Los Angeles County (CY 2018)		California (CY 2018)	
Payer Type	Discharges	% of Total	Discharges	% of Total	Discharges	% of Total
Medi-Cal Managed Care	3,056	10.7%	189,247	19.4%	673,236	19.0%
Medi-Cal Traditional Coverage	2,325	8.1%	144,413	14.8%	399,695	11.3%
Medi-Cal Total	**5,381**	**18.8%**	**333,660**	**34.3%**	**1,072,931**	**30.3%**
Medicare Traditional Coverage	7,531	26.3%	228,313	23.4%	866,924	24.5%
Medicare Managed Care	4,384	15.3%	125,080	12.8%	445,211	12.6%
Medicare Total	**11,915**	**41.6%**	**353,393**	**36.3%**	**1,312,135**	**37.1%**
Third-Party Managed Care	10,396	36.3%	224,421	23.0%	884,468	25.0%
Third-Party Traditional Coverage	459	1.6%	24,403	2.5%	96,701	2.7%
Third-Party Total	**10,855**	**37.9%**	**248,824**	**25.5%**	**981,169**	**27.7%**
Other Traditional Coverage	62	0.2%	35,847	3.7%	155,937	4.4%
Other Managed Care	422	1.5%	2,265	0.2%	16,709	0.5%
Other Total	**484**	**1.7%**	**38,112**	**3.9%**	**172,646**	**4.9%**
Grand Total	**28,635**	**100%**	**973,989**	**100%**	**3,538,881**	**100%**

Source: OSHPD Discharge Database, CY 2018, Excludes Normal Newborns

[1] FY 2018 OSHPD Disclosure Report

Medi-Cal Managed Care

The Medi-Cal Managed Care Program contracts for healthcare services through established networks of organized systems of care. Over 12 million Medi-Cal beneficiaries in all 58 counties in California receive their healthcare through six models of managed care, including: County Organized Health Systems, the Two-Plan Model, Geographic Managed Care, the Regional Model, the Imperial Model, and the San Benito Model.

Los Angeles County has a Two-Plan Model that offers a local initiative plan and a commercial plan. The Two-Plan Model is provided by L.A. Care Health Plan and Health Net Community Solutions, Inc. The local initiative and commercial plans contract with the Medi-Cal Managed Care program. The percentage of Los Angeles County residents with Medi-Cal Managed Care coverage has fluctuated as a result of the ACA and California initiatives to expand managed care. Since 2014, the number of Medi-Cal eligible people in Los Angeles County has increased from 3,622,367 in 2014 to 3,895,310 in 2018 and decreased to 3,690,133 people in 2020.

Medical Staff

According to OSPHD, the Hospital has 739 physicians on its active medical staff. The five largest active specialties, comprising 51% of the medical staff, include: internal medicine, pediatric medicine, obstetrics/gynecology, anesthesiology, and general surgery. The table below lists the active medical staff at the Hospital.

ACTIVE MEDICAL STAFF PROFILE 2018		
Specialty	**Count**	**% of Total**
Internal Medicine	117	15.8%
Pediatric Medicine	94	12.7%
Obstetrics and Gynecology	70	9.5%
Anesthesiology	52	7.0%
General Surgery	47	6.4%
Cardiovascular Diseases	37	5.0%
Oncology	33	4.5%
Orthopedic Surgery	30	4.1%
Plastic and Reconstructive Surgery	27	3.7%
Urology	25	3.4%
Ophthalmology	23	3.1%
Pulmonary Disease	23	3.1%
Radiology	23	0.3%
Neurology	19	2.6%
Gastroenterology	14	1.9%
Thoracic Surgery	14	1.9%
Otolaryngology	11	1.5%
Neurological Surgery	10	1.4%
Psychiatry	10	1.4%
Vascular Surgery	10	1.4%
General/Family Practice	9	1.2%
Pediatric-Cardiology	9	1.2%
Pediatric-Surgery	6	0.8%
Dermatology	5	0.7%
Physical Medicine/Rehabilitation	5	0.7%
Podiatry	5	0.7%
Pathology	4	0.5%
Colon and Rectal Surgery	3	0.4%
Allergy and Immunology	2	0.3%
Oral Surgery (Dentists Only)	2	0.3%
TOTAL	**739**	**97%**

Source: OSHPD

Note: Not all specialties were listed in OSHPD as some specialties may be rolled up into another category

Patient Utilization Trends

The table below shows volume trends at the Hospital from FY 2014 through FY 2018:

HUNTINGTON HOSPITAL SERVICE VOLUMES FY 2014- FY 2018					
PATIENT DAYS	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**	**FY 2018**
Medical/Surgical[1]	69,871	76,110	84,535	81,839	79,471
Intensive Care	7,304	7,217	8,388	7,305	7,207
Neonatal Intensive Care	6,807	7,372	8,244	8,007	8,143
Obstetrics	10,796	10,589	10,825	11,544	11,500
Pediatric Intensive Care[3]	415	513	590	478	372
Pediatric Acute	2,745	2,693	2,824	2,728	2,511
Physical Rehabilitation Care	4,586	4,155	4,780	4,913	4,797
Psychiatric Care	7,079	7,080	6,748	6,052	6,111
Chemical Dependency Services[4]	3,585	3,510	3,325	3,439	1,785
Total	**113,188**	**119,239**	**130,259**	**126,305**	**121,897**
DISCHARGES					
Medical/Surgical[1]	18,093	19,490	21,956	22,018	21,189
Intensive Care	373	369	386	339	398
Neonatal Intensive Care	390	445	445	493	476
Obstetrics	3,482	3,479	3,704	3,854	3,790
Pediatric Intensive Care[3]	97	85	93	100	82
Pediatric Acute	2,512	2,530	1,232	1,142	1,147
Physical Rehabilitation Care	337	295	323	358	357
Psychiatric Care	966	885	911	864	847
Chemical Dependency Services[4]	497	466	511	544	349
Total	**26,747**	**28,044**	**29,561**	**29,712**	**28,635**
AVERAGE LENGTH OF STAY					
Medical/Surgical[1]	3.9	3.9	3.9	3.7	3.8
Intensive Care	19.6	19.6	21.7	21.5	18.1
Neonatal Intensive Care	17.5	16.6	18.5	16.2	17.1
Obstetrics	3.1	3.0	2.9	3.0	3.0
Pediatric Intensive Care[3]	4.3	6.0	6.3	4.8	4.5
Pediatric Acute	1.1	1.1	2.3	2.4	2.2
Physical Rehabilitation Care	13.6	14.1	14.8	13.7	13.4
Psychiatric Care	7.3	8.0	7.4	7.0	7.2
Chemical Dependency Services[4]	7.2	7.5	6.5	6.3	5.1
Total	**4.2**	**4.3**	**4.4**	**4.3**	**4.3**
AVERAGE DAILY CENSUS					
Medical/Surgical[1]	191	209	232	224	218
Intensive Care	20	20	23	20	20
Neonatal Intensive Care	19	20	23	22	22
Obstetrics	30	29	30	32	32
Pediatric Intensive Care[3]	1	1	2	1	1
Pediatric Acute	8	7	8	7	7
Physical Rehabilitation Care	13	11	13	13	13
Psychiatric Care	19	19	18	17	17
Chemical Dependency Services[4]	10	10	9	9	5
Total	**310**	**327**	**357**	**346**	**334**
OTHER SERVICES					
Inpatient Surgeries	7,264	7,646	8,539	7,897	7,548
Outpatient Surgeries	4,331	4,285	4,470	4,791	5,459
Emergency Service Visits[2]	60,721	65,756	70,779	75,338	75,802
Total Live Births	3,474	3,428	3,518	3,675	3,558

Sources: OSHPD Disclosure Reports, FY 2014 - FY 2018

Note: Excludes Normal Newborns.

[1] Includes Definitive Observation Beds

[2] OSHPD Alirts Annual Utilization Reports

[3] The Hospital closed the Pediatric Intensive Care Unit in 2019.

[4] The Hospital closed the Chemical Dependency Unit in 2018.

A review of the Hospital's historical utilization trends, between FY 2014 and FY 2018, supports the following conclusions:

- Over the last five fiscal years, patient days increased by 15.1% the first three years from 113,188 in FY 2014 to 130,259 in FY 2016, then decreased by 6.4% the last two fiscal years from 126,305 in FY 2017 to 121,897 in FY 2018;

- Between FY 2014 to FY 2017, total discharges increased by 10.5% before decreasing by 3.6% in FY 2018 to 28,635 discharges;

- Outpatient surgeries increased by 26% over five years to 5,459 cases in FY 2018;

- Neonatal intensive care days increased 20% over five years resulting in an average daily census of 17 patients in FY 2018;

- Pediatric intensive care discharges decreased over the last five years with an average daily census of only one patient in FY 2018. (The unit was closed in 2019);

- The chemical dependency unit was closed in 2018;

- Psychiatric care discharges decreased over five years by 12.3%; and

- Total live births increased by 2% over five years to 3,474 births in FY 2018.

Financial Profile

Over the last five fiscal years, the Hospital's net income has varied, ranging from approximately $15.2 million profit to -$17.4 million loss. However, the Hospital's operating income has consistently been negative over the past five years ranging from a -$9.2 million to -$23.7 million loss.

HUNTINGTON HOSPITAL FINANCIAL AND RATIO ANALYSIS FY 2014 - FY 2018						
Volumes	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**	**FY 2018**	
Patient Days	113,188	119,239	130,259	126,305	121,897	
Discharges	26,491	26,779	29,561	29,712	28,635	
ALOS	4.4	4.5	4.4	4.3	4.3	
Financials (In Thousands)						
Net Patient Revenue	$513,846	$552,371	$646,922	$654,876	$646,767	
Other Operating Revenue	$24,576	$23,632	$23,896	$17,701	$13,790	
Total Operating Revenue	$538,423	$576,002	$670,819	$672,577	$660,557	
Operating Expenses	$547,676	$591,567	$685,362	$696,320	$674,473	
Net from Operations	($9,253)	($15,565)	($14,544)	($23,744)	($13,917)	
Net Non-Operating Revenues/Expenses	$14,558	$19,399	$20,658	$38,970	($3,529)	
Net Income	**$5,305**	**$3,834**	**$6,114**	**$15,226**	**($17,445)**	
Ratios						**2018 California Data**
Current Ratio	4.54	4.45	4.15	4.15	3.75	1.74
Days in A/R	66	66	51	52	58	56
Bad Debt Rate	0.19%	0.86%	0.54%	0.53%	0.41%	0.70%
Operating Margin	-1.72%	-2.70%	-2.17%	-3.53%	-2.11%	4.45%

Source: OSHPD Disclosure Reports, FY 2014 - FY 2018

The Hospital's current ratio[16] has decreased over the last five years from 4.54 in FY 2014 to 3.75 in FY 2018 (the California average in FY 2018 was 1.74). The Hospital's percentage of bad debt in FY 2018 is 0.41% and lower than the statewide average of 0.7%.

[16]The current ratio compares a company's current assets to its current liabilities to measure its ability to pay short-term and long-term debt obligations. A low current ratio of less than 1.0 could indicate that a company may have difficulty meeting its current obligations. The higher the current ratio, the more capable the company is of paying its obligations as it has a larger proportion of assets relative to its liabilities.

Cost of Hospital Services

The Hospital's cost of services includes both inpatient and outpatient care. In FY 2018, 47% of total costs were associated with Medicare, followed by 33% with Third-Party, and 17% with Medi-Cal.

HUNTINGTON HOSPITAL OPERATING EXPENSES BY PAYER CATEGORY FY 2014 - FY 2018					
	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018
(In Thousands)					
Operating Expenses	**$547,676**	**$591,567**	**$685,362**	**$696,320**	**$674,473**
Cost of Services By Payer:					
Medicare	$256,312	$278,205	$316,332	$325,286	$318,858
Medi-Cal	$78,426	$90,224	$107,728	$112,211	$117,013
County Indigent	$204	$673	$1,000	$306	$263
Third-Party	$198,519	$212,380	$246,795	$245,563	$225,689
Other Indigent	$7,078	$2,084	$1,188	$1,602	$1,515
All Other Payers	$7,137	$8,001	$12,320	$11,353	$11,136

Source: OSHPD Disclosure Reports, FY 2014 - FY 2018

Charity Care

The following table shows the charity care and bad debt of the Hospital compared to the averages of all general acute care hospitals in the State of California. The Hospital's five-year (FY 2014 – FY 2018) average of charity care and bad debt, as a percentage of gross patient revenue, was 1.13% and lower than the four-year statewide average of 1.86%. According to OSHPD, "…the determination of what is classified as charity care can be made by establishing whether or not the patient has the ability to pay. The patient's accounts receivable must be written off as bad debt if the patient has the ability but is unwilling to pay off the account." The Hospital's Charity Care and Discount Policy states that persons with family income at or below 350% of the federal policy level, and without other sources to pay for care received, qualify for the financial assistance program[17].

HUNTINGTON HOSPITAL CHARITY CARE COMPARISON FY 2014 - FY 2018 (In Thousands)										
	FY 2014		FY 2015		FY 2016		FY 2017		FY 2018	
	Hospital	Avg. of California Hospitals	Hospital	Avg. of California Hospitals	Hospital	Avg. of California Hospitals	Hospital	Avg. of California Hospitals	Hospital	Avg. of California Hospitals
Gross Patient Revenue (Charges)	$2,223,040	$1,084,367	$2,580,466	$1,171,479	$2,952,885	$1,270,602	$3,039,739	$1,308,295	$3,239,299	$1,396,645
Charity	$38,941	$16,391	$13,035	$11,030	$7,404	$11,083	$9,751	$9,181	$10,076	$12,710
Bad Debt	$4,220	$13,993	$22,163	$10,457	$16,039	$9,965	$16,036	$8,855	$13,242	$9,867
Total Charity & Bad Debt Gross Rev.	**$43,160**	**$30,384**	**$35,198**	**$21,487**	**$23,443**	**$21,048**	**$25,787**	**$18,036**	**$23,319**	**$22,577**
Charity Care as a % of Gross Patient Rev.	1.75%	1.51%	0.51%	0.94%	0.25%	0.87%	0.32%	0.70%	0.31%	0.91%
Bad Debt as a % of Gross Patient Rev.	0.19%	1.29%	0.86%	0.89%	0.54%	0.78%	0.53%	0.68%	0.41%	0.71%
Total as a % of Gross Patient Rev.	1.94%	2.80%	1.36%	1.80%	0.79%	1.70%	0.85%	1.40%	0.72%	1.62%
Uncompensated Care										
Cost to Charge Ratio	23.5%	23.6%	22.0%	24.1%	22.4%	23.8%	22.3%	23.0%	20.4%	23.0%
Charity	$9,163	$3,868	$2,869	$2,658	$1,659	$2,638	$2,176	$2,112	$2,056	$2,922
Bad Debt	$993	$3,302	$4,878	$2,520	$3,593	$2,372	$3,579	$2,037	$2,701	$2,269
Total Cost of Charity Care & Bad Debt	**$10,156**	**$7,177**	**$7,747**	**$5,174**	**$5,251**	**$5,007**	**$5,756**	**$4,149**	**$4,757**	**$5,190**

Source: OSHPD Disclosure Reports FY 2014 - FY 2018

[17] The Hospital's financial assistance program helps low-income, uninsured or underinsured patients who need help paying for all or part of their medical care. The specific discount amount is determined based on a sliding scale, with patients whose income and monetary assets are below 200% of the federal poverty level receiving a 100% discount (one end of the scale) and those whose income is between 300% and 350% of the federal poverty level receiving a 25% discount (the other end of the scale), with gradations in between. In no event are patients who are eligible for financial assistance charged more than amounts generally billed for comparable care to patients with insurance. A copy of the Hospital's charity care policy is provided in the Appendix.

In the written notice on July 22, 2020 to the California Attorney General, the Hospital mistakenly reported charity care gross charges and not charity care costs. The following revised table, provided by the Hospital, shows the distribution of charity care costs by inpatient, outpatient, and emergency room visits. Note that some of the totals are also different than what the Hospital previously reported to OSHPD.

COST OF CHARITY CARE BY SERVICE FY 2014 - FY 2019					
		Emergency	Inpatient	Outpatient	Total Costs
FY 2019:					
	Cost of Charity	$2,470,330	$2,184,937	$145,399	$4,800,666
	Visits/Discharges	2,283	47	312	2,642
FY 2018:					
	Cost of Charity	$2,399,631	$2,280,034	$93,734	$4,773,399
	Visits/Discharges	3,413	47	366	3,826
FY 2017:					
	Cost of Charity	$4,232,940	$3,199,605	$92,857	$7,525,402
	Visits/Discharges	5,285	48	390	5,723
FY 2016:					
	Cost of Charity	$601,963	$1,007,915	$48,764	$1,658,642
	Visits/Discharges	946	12	82	1,040
FY 2015:					
	Cost of Charity	$693,162	$2,073,048	$102,726	$2,868,936
	Visits/Discharges	1,123	37	77	1,237
FY 2014:					
	Cost of Charity	$2,624,963	$5,084,861	$88,445	$7,798,269
	Visits/Discharges	N/A	N/A	N/A	N/A

Source: Huntington Hospital

The table below shows the Hospital's historical costs for charity care as was reported to OSHPD and the recent update provided to JD Healthcare Inc. by the Hospital. The average cost of charity care as reported by the Hospital for the last five-year period was $4,924,930 while the three-year average cost of charity care was $4,652,481. In FY 2017 and FY 2018, the Hospital used a presumptive charity care definition in their audited financial statements and community benefit reporting, recording higher amounts than reported to OSHPD.

HUNTINGTON HOSPITAL
COST OF CHARITY CARE FY 2014 - FY 2018

Year	Charity Care Charges	Cost to Charge Ratio	Cost of Charity Care As Reported By OSHPD	Cost of Charity Care As Reported from the Hospital
FY 2018	$10,076,314	20.40%	$2,055,568	$4,773,399
FY 2017	$9,750,809	22.32%	$2,176,381	$7,525,402
FY 2016	$7,404,390	22.40%	$1,658,583	$1,658,642
FY 2015	$13,035,263	22.01%	$2,869,061	$2,868,936
FY 2014	$38,940,643	23.53%	$9,162,733	$7,798,269*
FY 2016 - FY 2018 Average			**$1,963,511**	**$4,652,481**
FY 2014 - FY 2018 Average			**$3,584,465**	**$4,924,930**

Source: OSHPD Disclosure Reports FY 2014 - FY 2018

*The $38,940,643 reported charges in 2014 mistakenly included $5.8 million of self-pay revenue.

Community Benefit Services

The Hospital has a history of providing several community benefit [18] services. As shown in the table below, the average annual cost of community benefit services over the five years was $34.7 million.

COST OF COMMUNITY BENEFIT SERVICES FY 2015 - FY 2019							
Community Benefit Programs	**FY 2015**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**5-Year Average**	**Total**
Benefits for Vulnerable Populations	$4,625,012	$6,453,295	$6,377,757	$5,147,890	$4,103,228	$5,341,436	$26,707,182
Benefits for Broader Community	$6,159,484	$5,296,374	$8,282,312	$7,705,398	$8,422,644	$7,173,242	$35,866,212
Health Research Education and Training	$17,739,808	$20,777,023	$22,319,864	$25,347,622	$24,550,843	$22,147,032	$110,735,160
Total	**$28,524,304**	**$32,526,692**	**$36,979,933**	**$38,200,910**	**$37,076,715**	**$34,661,711**	**$173,308,554**

Source: Huntington Hospital

Note: Grant donations, restricted donations or fees collected not included.

The following table lists the Hospital's community benefit services over the past five fiscal years that cost over $10,000, followed by descriptions of these community benefit services:

COST OF COMMUNITY BENEFIT SERVICES FY 2015 - FY 2019					
Programs and Services over $10,000 in cost:	**FY 2015**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**
Blair Health Careers Academy Partnership	$77,326	$94,530	$105,485	$71,536	$79,149
Cancer RN Navigators/Dietitian/Social Worker	$1,446,965	$1,157,895	$1,705,621	$1,773,844	$1,905,714
Cash Donations to Organizations for HRET	$260,635	$254,078	$265,214	$265,149	$262,806
Cash Donations to Organizations for OBBC	$82,330	$54,021	$41,576	$46,205	$41,000
Cash Donations to Organizations for OBVP	$33,750	$57,075	$66,775	$59,675	$68,050
Clinical Nurse Navigators	$0	$0	$1,473,431	$1,504,636	$1,441,138
Clinical Research	$979,488	$1,198,674	$1,165,475	$1,339,118	$1,129,837
Clothing for Patients	$27,402	$23,846	$18,041	$30,608	$67,087
Community Benefit Operations and Health Needs Assessment	$94,227	$156,986	$157,950	$153,784	$156,171
Community Education and Support Groups (Various Conditions)	$1,597,871	$1,281,743	$1,242,944	$818,016	$1,190,469
Community Organization Support - General and In-Kind	$36,658	$223,834	$336,195	$286,338	$333,116
Community Outreach Services	$819,999	$807,290	$851,478	$781,794	$759,058
Constance G. Zahorik Appearance Center	$68,094	$87,218	$92,825	$99,691	$117,563
Discounted Equipment/Supplies for Patients	$7,037	$114,478	$19,348	$50,523	$102,281
Discounted or Free Prescription Drugs	$38,505	$73,272	$44,523	$70,746	$57,373
Education Nursing/Nursing Students	$8,366,106	$9,265,977	$12,068,744	$12,109,267	$13,205,552
Education Other Health Professions	$2,131,603	$3,382,529	$2,708,008	$4,309,826	$4,593,385
Graduate Medical Education Program	$5,415,091	$5,923,028	$5,578,674	$6,552,132	$4,557,759
Hospital Website and Calendar of Events	$127,430	$196,628	$408,841	$656,445	$1,151,444
Huntington Ambulatory Care Center	$1,209,900	$1,991,300	$2,201,300	$1,678,100	$910,700
Huntington Health eConnect	$1,907,066	$1,308,618	$1,590,315	$1,081,297	$1,084,116
Huntington Health Services Library	$509,559	$658,207	$428,264	$700,594	$722,355
Integrative Oncology	$161,270	$184,498	$250,081	$192,056	$214,630
Interpreter Services	$68,200	$183,012	$249,960	$249,451	$237,299
Palliative Care (Special care, beyond routine)	$511,956	$523,253	$702,751	$773,024	$506,038
Physician Referral Services	$151,644	$95,654	$187,772	$224,395	$200,117
Senior Care Programs	$1,849,267	$2,766,809	$2,700,068	$1,846,750	$1,574,446
Shelter and Conservatorships for Patients	$271,827	$223,039	$88,750	$150,237	$96,138
Transportation Assistance (Various Programs)	$264,895	$230,619	$220,402	$317,553	$302,617

Source: Huntington Hospital

Note: Grant donations, restricted donations or fees collected not included.

[18] Community benefit means a hospital's activities that are intended to address community needs and priorities primarily through disease prevention and improvement of health status.

The Hospital's community benefit services have supported many important programs for the community as described below:

- Blair Health Careers Academy Partnership: Through partnerships with Blair Health Careers Academy and Pasadena Unified School District Center for Independent Study - Medical Arts Program, the Hospital provided various health-related internships for high school students;

- Cancer RN Navigators/Dietitian/Social Worker: The program provides nurse navigators to cancer patients to assist with decision making, treatment organization and emotional support;

- Cash Donations to Organizations for Health Research Education and Training (HRET): The Hospital provides cash donations to local organizations that conduct health research, education and training. The Hospital has also provided cash donations to Huntington Medical Research Institute;

- Cash Donations to Organizations for Other Benefit for Broader Community (OBBC): The Hospital provides cash donations to local organizations serving the broader community;

- Cash Donations to Organizations for Other Benefit for Vulnerable Population (OBVP): Local organizations serving the poor and low-income populations received cash donations from the Hospital;

- Clinical Nurse Navigators: The program provided a group of nurse navigators and a community navigator to assist patients in improving their hospital experience and ensuring a safe and successful transition to their home following hospitalization. Navigators collaborated with other health care personnel to:
    - Provide patients with information about medical conditions, treatments and services
    - Explore patients' goals, barriers to treatment, and needs in self-management and
    - Assist with setting appointments, obtaining transportation and medications, and connecting patients to community resources

- Clinical Research: The Hospital worked with Cedars-Sinai Medical Center, UCLA Ronald Reagan Medical Center and Torrance Memorial Medical Center to subsidize clinical research on improving care for elderly patients;

- Clothing for Patients: This service provided clothing for patients at the Hospital;

- Community Benefit Operations and Health Needs Assessment: Consulting assistance for triannual Community Health Needs Assessments (e.g., 2016, 2019), Community Benefits Plan meetings and reporting, and maintaining the Healthy Pasadena website;

- Community Education and Support Groups (Various Conditions): This program supports health education and support groups, including topics such as CPR, disaster preparedness, fitness/exercise, heart disease, cancer, blood pressure, and stress management. The support groups are regularly offered for NICU, stroke, diabetes, cancer, and bereavement grief;

- Community Organization Support - General and In-Kind: The Hospital organizes various activities, including sponsorship of community organizations, advocacy, coalition building, and use of hospital meeting rooms/equipment;

- Community Outreach Services: Registered nurses conduct free health screenings and counseling (e.g., BMI measurements, blood pressure, and blood glucose), and provide health education classes and information to underserved populations in community settings;

- Constance G. Zahorik Appearance Center: The Hospital provides services of licensed cosmetologist to cancer patients, including hair/wigs, makeup and use of scarves and hats;

- Discounted Equipment/Supplies for Patients: Home health care visits, IV antibiotics or medications, durable medical equipment and nonmedical supplies for uninsured or underinsured persons;

- Discounted or Free Prescription Drugs: This program supplies medication for uninsured and/or indigent patients who have no other means to obtain medications;

- Education for Nursing/Nursing Students: The education program provides training for nurses;

- Education for Other Health Professions: This funds education and training of health care professionals: such as interns in pharmacy, physical therapy and speech language pathology, radiology technology, social work, occupational therapy, dietetic, surgical technologists, cardiovascular and echocardiography technologists and clinical lab scientists;

- Graduate Medical Education Program: The Hospital supports a training program for Graduate Medical Education with approximately 50 residents in general surgery and internal medicine;

- Hospital Website and Calendar of Events: The Hospital provides funds to support a website with community health information, calendar of events, and general health education;

- Huntington Ambulatory Care Center (HACC): HACC provides primary and specialty care for uninsured and underinsured residents. HACC is a full-service medical clinic staffed by the Hospital's internal medicine and surgical residents;

- Huntington Health eConnect: Health information exchange for use by all providers in the community to improve the quality of healthcare through access to data needed for optimal patient care;

- Huntington Health Services Library: The library serves as an information resource center for medical, nursing, and allied health staff; residents and students, employees, volunteers, health professional from the community, and the community at large. Services provided include: retrieval of health care information, assistance/training to access information from the library's medical databases, reference services to health information and document delivery services to the Hospital's healthcare professionals and employees;

- Integrative Oncology: This integrative medicine service is offered at no charge to cancer patients by a licensed and certified Ph.D. nurse practitioner. Services include acupuncture, meditation, yoga, and nutritional counseling;

- Interpreter Services: The Hospital offers various interpreter services (Stratus Video Interpreter, Language Line, and Life Signs) to assist non-English speaking patients and visitors and those using American Sign Language in their communications with Hospital staff;

- Palliative Care (Special care, beyond routine): This program is a palliative care program offered to patients, in addition to standard care;

- Physician Referral Services: This service supplies free physician referrals for those who call a dedicated number or use web services. This program assists Medi-Cal beneficiaries to locate providers and offers information on health education classes and support groups;

- Senior Care Programs: These dedicated programs for seniors and family members include Care Coordination programs, dedicated Resource Center services, hospital liaisons, Health Connection membership, and noon hour lecture for seniors on topics of interest;

- Shelter and Conservatorships for Patients: This service provides shelter and conservatorships for patients; and

- Transportation Assistance (Various Programs): The programs provide transportation assistance - cab fare, bus tokens, ambulance, and ride sharing services - to those without funds or transportation access.

Analysis of the Hospital's Service Area

Service Area Definition

Based on the Hospital's CY 2018 inpatient discharges, the Hospital's service area is comprised of 36 ZIP Codes from which 76% of the Hospital's inpatient discharges emanate. Approximately 44% of the Hospital's discharges originated from the top eight ZIP Codes, located in Pasadena, Altadena and Los Angeles. In CY 2018, the Hospital's market share was approximately 20% based on total service area discharges.

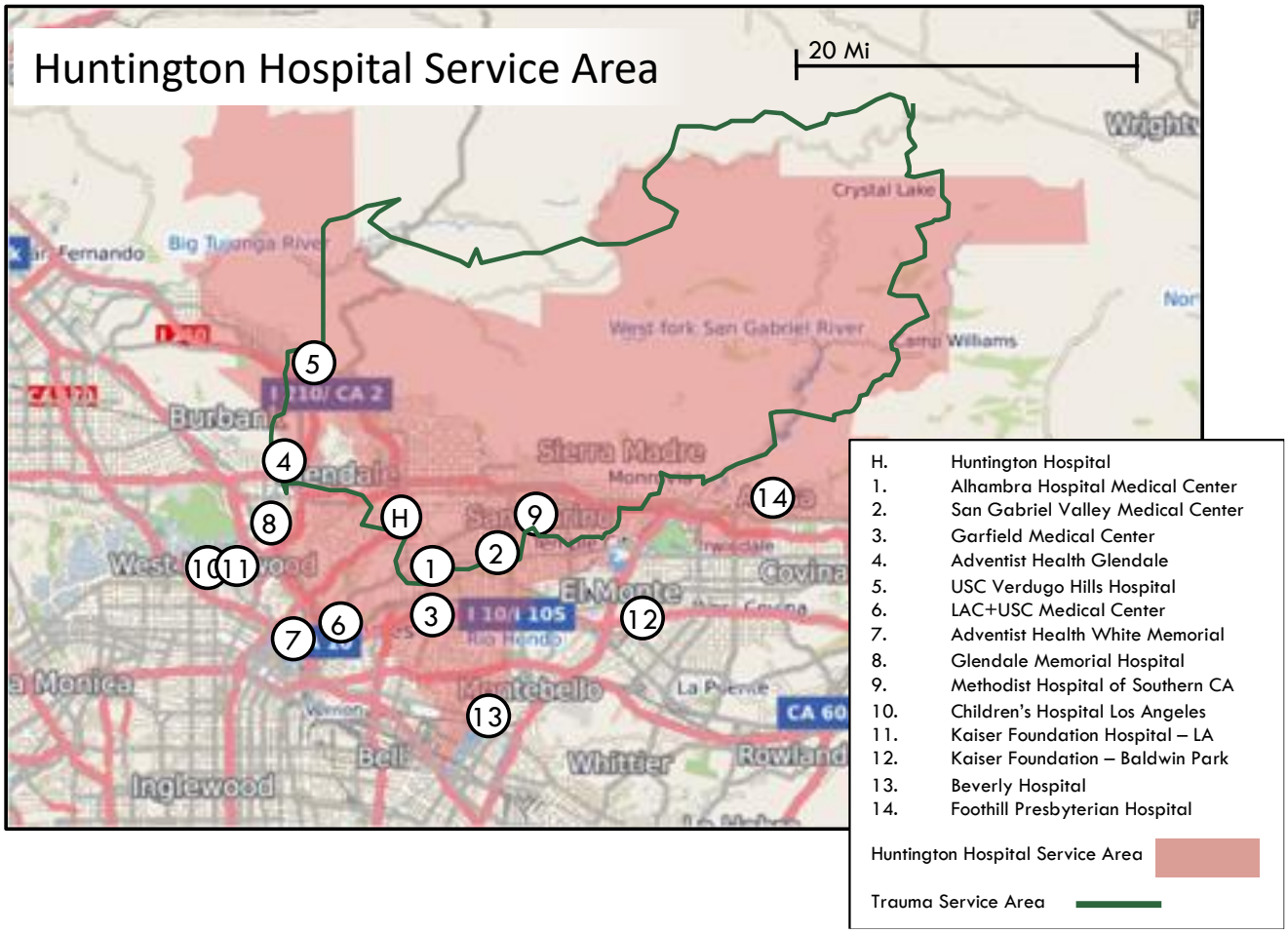
Patient Origin, CY 2018						
Patient ZIP	Patient City	Hospital Discharges	Percentage of Discharges	Cumulative Percentage	Market Share	Total Discharges
91105	Pasadena	2,068	7.0%	7.0%	75.9%	2,723
91104	Pasadena	2,036	6.9%	13.8%	53.2%	3,825
91103	Pasadena	2,009	6.8%	20.6%	49.2%	4,084
91001	Altadena	1,957	6.6%	27.2%	51.1%	3,828
91107	Pasadena	1,468	4.9%	32.1%	44.5%	3,302
90042	Los Angeles	1,212	4.1%	36.2%	23.9%	5,064
91101	Pasadena	1,205	4.1%	40.3%	61.4%	1,961
91106	Pasadena	1,152	3.9%	44.2%	58.6%	1,967
91030	South Pasadena	966	3.3%	47.4%	51.0%	1,895
91801	Alhambra	820	2.8%	50.2%	18.1%	4,536
91016	Monrovia	681	2.3%	52.5%	16.8%	4,042
90032	Los Angeles	625	2.1%	54.6%	14.5%	4,323
91775	San Gabriel	419	1.4%	56.0%	20.6%	2,037
91011	La Canada Flintridge	404	1.4%	57.3%	26.9%	1,504
91803	Alhambra	387	1.3%	58.7%	15.3%	2,526
91108	San Marino	369	1.2%	59.9%	47.2%	782
90065	Los Angeles	347	1.2%	61.1%	8.6%	4,050
90041	Los Angeles	342	1.2%	62.2%	12.8%	2,671
91770	Rosemead	327	1.1%	63.3%	4.8%	6,881
91007	Arcadia	323	1.1%	64.4%	10.4%	3,096
91214	La Crescenta	315	1.1%	65.5%	12.3%	2,552
91006	Arcadia	301	1.0%	66.5%	12.6%	2,394
91024	Sierra Madre	300	1.0%	67.5%	30.3%	989
91754	Monterey Park	285	1.0%	68.5%	8.0%	3,564
91010	Duarte	285	1.0%	69.4%	9.9%	2,890
91780	Temple City	277	0.9%	70.3%	8.2%	3,384
91702	Azusa	273	0.9%	71.3%	5.2%	5,285
91776	San Gabriel	265	0.9%	72.2%	8.1%	3,279
90031	Los Angeles	184	0.6%	72.8%	5.8%	3,186
90640	Montebello	175	0.6%	73.4%	2.6%	6,830
91755	Monterey Park	160	0.5%	73.9%	7.1%	2,265
91208	Glendale	160	0.5%	74.4%	10.9%	1,462
91042	Tujunga	160	0.5%	75.0%	4.9%	3,239
91741	Glendora	159	0.5%	75.5%	6.2%	2,577
91020	Montrose	66	0.2%	75.7%	6.8%	965
91008	San Marino	7	0.0%	75.8%	10.0%	70
Sub-Total		**22,489**	**75.8%**	**75.8%**	**20.4%**	**110,028**
All Other		7,193	24.2%	100%		
Grand Total		**29,682**	**100.0%**			

Source: OSHPD Discharge Database, CY 2018, Excludes Normal Newborns

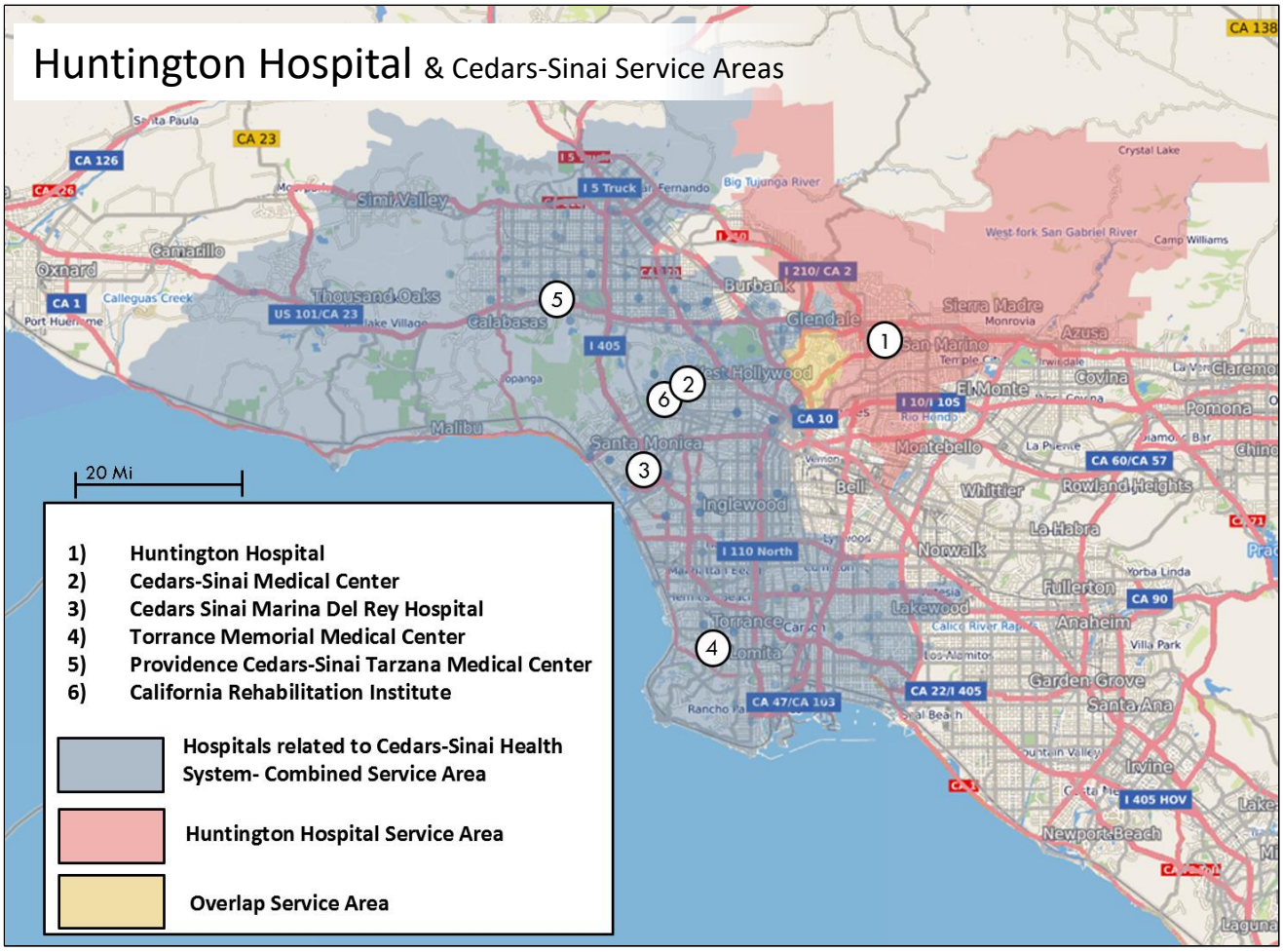
Service Area Map

The Hospital's service area, with approximately 1.2 million residents, includes the communities of Pasadena, Los Angeles, South Pasadena, Monrovia, Alhambra, San Gabriel, La Canada Flintridge, San Marino, Rosemead, La Crescenta, Sierra Madre, Monterey Park, Temple City, Duarte, Azusa, Montebello, Montrose, Glendale and Tujunga.

There are nine other hospitals located within the Hospital's service area, including Alhambra Hospital Medical Center, San Gabriel Valley Medical Center, Garfield Medical Center, USC Verdugo Hills Hospital, LAC+USC Medical Center, Adventist Health White Memorial, Methodist Hospital of Southern California, Beverly Hospital and Foothill Presbyterian Hospital-Johnston Memorial. Adventist Health Glendale, Glendale Memorial Hospital and Health Center, Children's Hospital of Los Angeles, Kaiser Foundation Hospital-Los Angeles, and Kaiser Foundation Hospital-Baldwin Park are located just outside of the service area but provide healthcare services to service area residents. The Hospital is the inpatient market share leader in the service area.



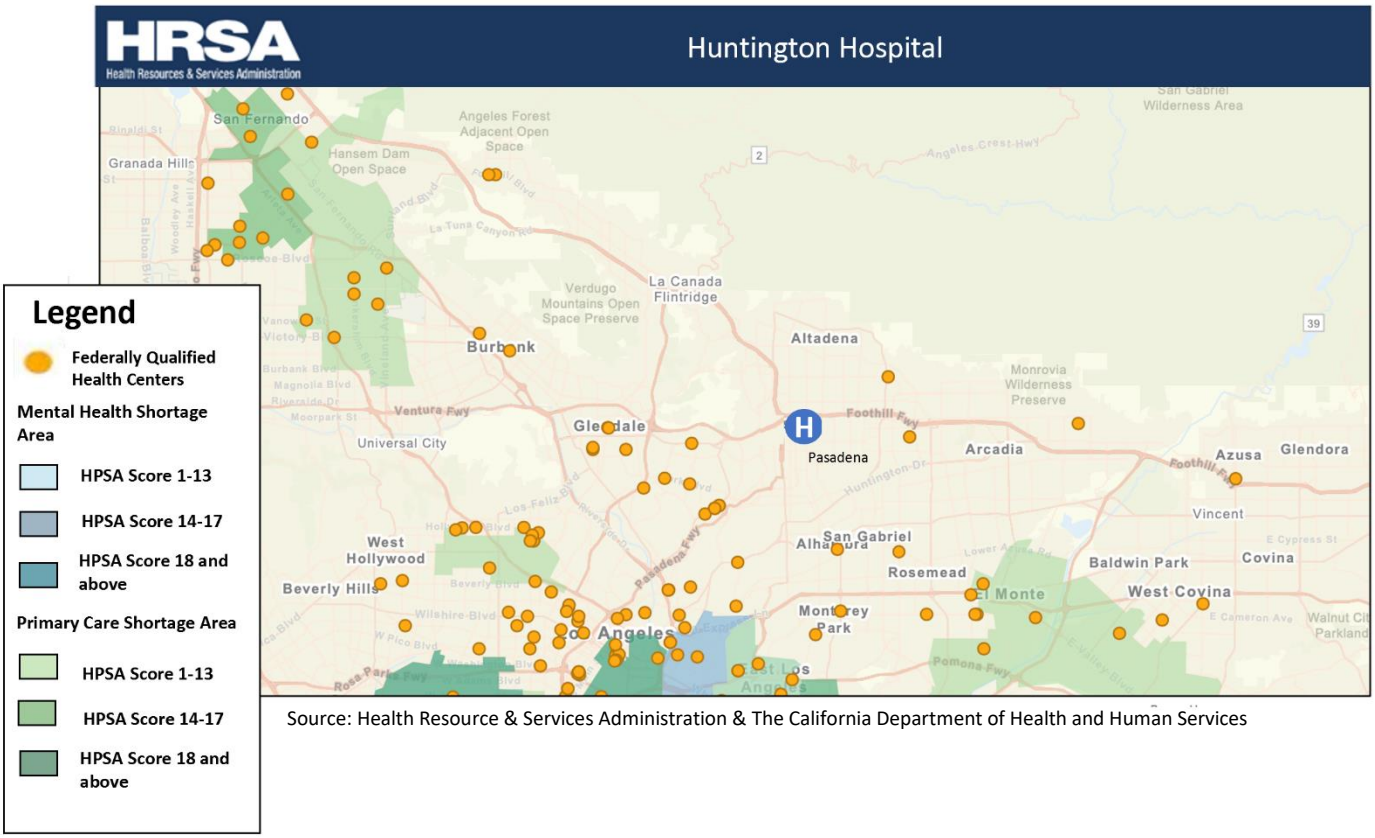
The following map shows the Hospital's service area relative to Cedar-Sinai's service area.



Health Professional Shortage Areas (HPSA)

The Federal Health Resources and Services Administration (HRSA) designates Health Professional Shortage Areas (HPSA) as areas with a shortage of primary medical care, dental care, or mental health providers. They are designated according to geography (i.e., service area), demographics (i.e., low-income population), or institutions (i.e., comprehensive health centers). The Hospital and the majority of its service area are not in a designated Health Professional Shortage Area. The map below depicts primary health shortage and mental health shortage areas relative to the Hospital's location.

HPSA scores are calculated based on three scoring criteria including population to provider ratio, percentage of the population below 100% of the Federal Poverty Level and travel time to the nearest source of care outside the HPSA designation area. Once designated, HRSA scores HPSAs on a scale of 0-25 for primary care and mental health, with higher scores indicating greater need.

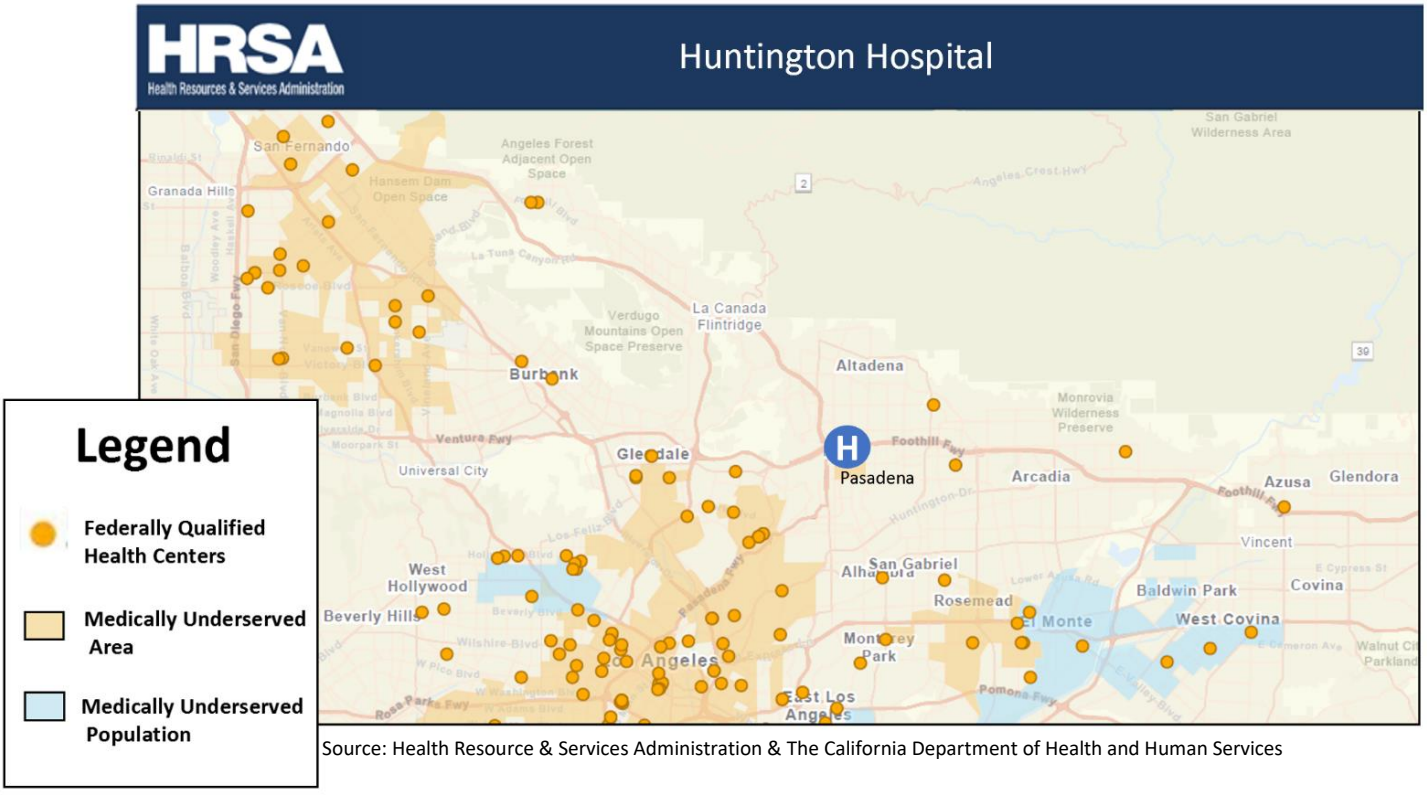


Source: Health Resource & Services Administration & The California Department of Health and Human Services

Medically Underserved Areas & Medically Underserved Populations

Medically Underserved Areas and Medically Underserved Populations are defined by the Federal Government to include areas or population groups that demonstrate a shortage of healthcare services. This designation process was originally established to assist the government in allocating community health center grant funds to the areas of greatest need. Medically Underserved Areas are identified by calculating a composite index of need indicators compiled and compared with national averages to determine an area's level of medical "under service." Medically Underserved Populations are identified based on documentation of unusual local conditions that result in access barriers to medical services. The map below depicts the Medically Underserved Areas /Medically Underserved Populations relative to the Hospital's location.

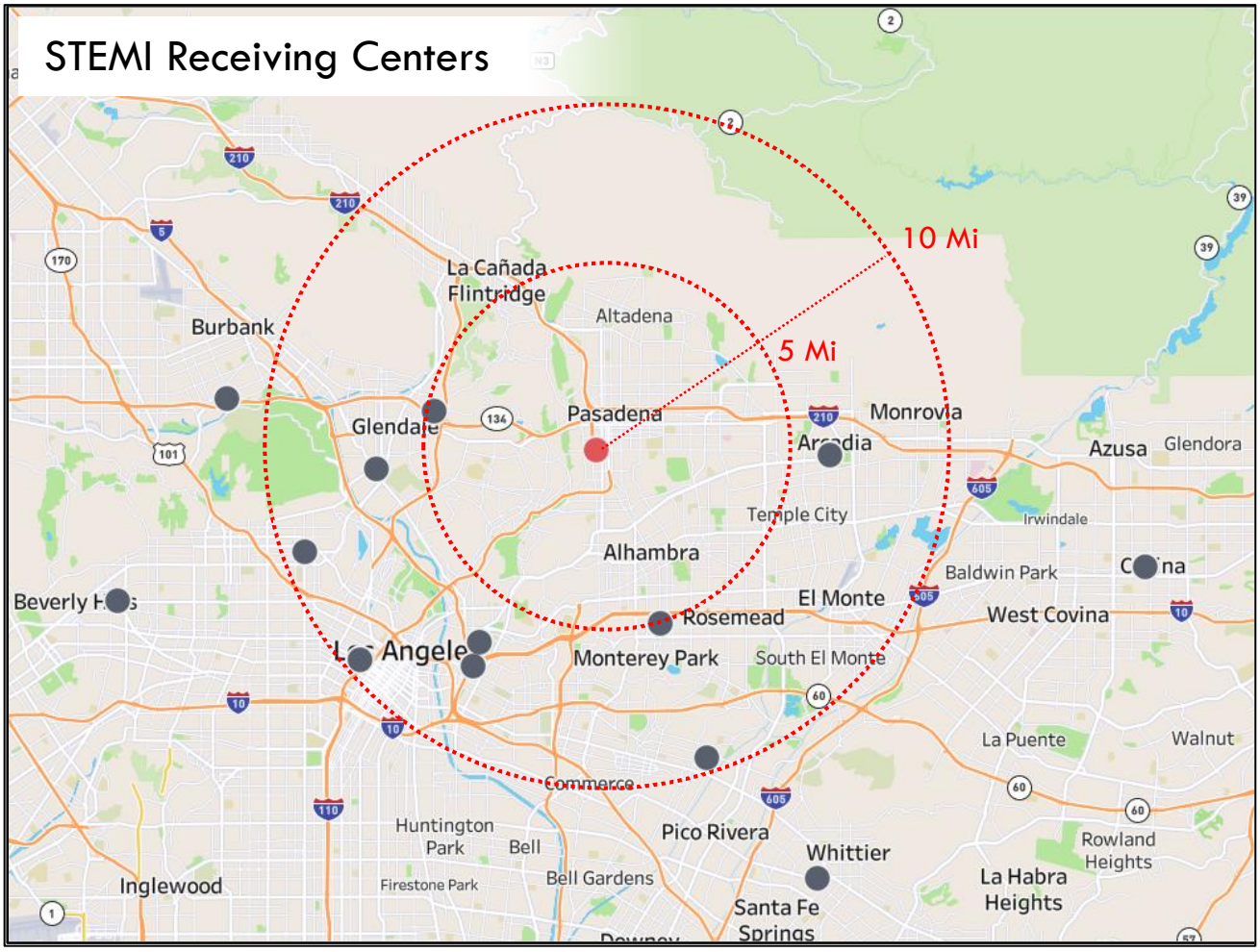
The Hospital location and the surrounding five-mile radius is not located in a designated Medically Underserved Areas/Medically Underserved Populations area.



Source: Health Resource & Services Administration & The California Department of Health and Human Services

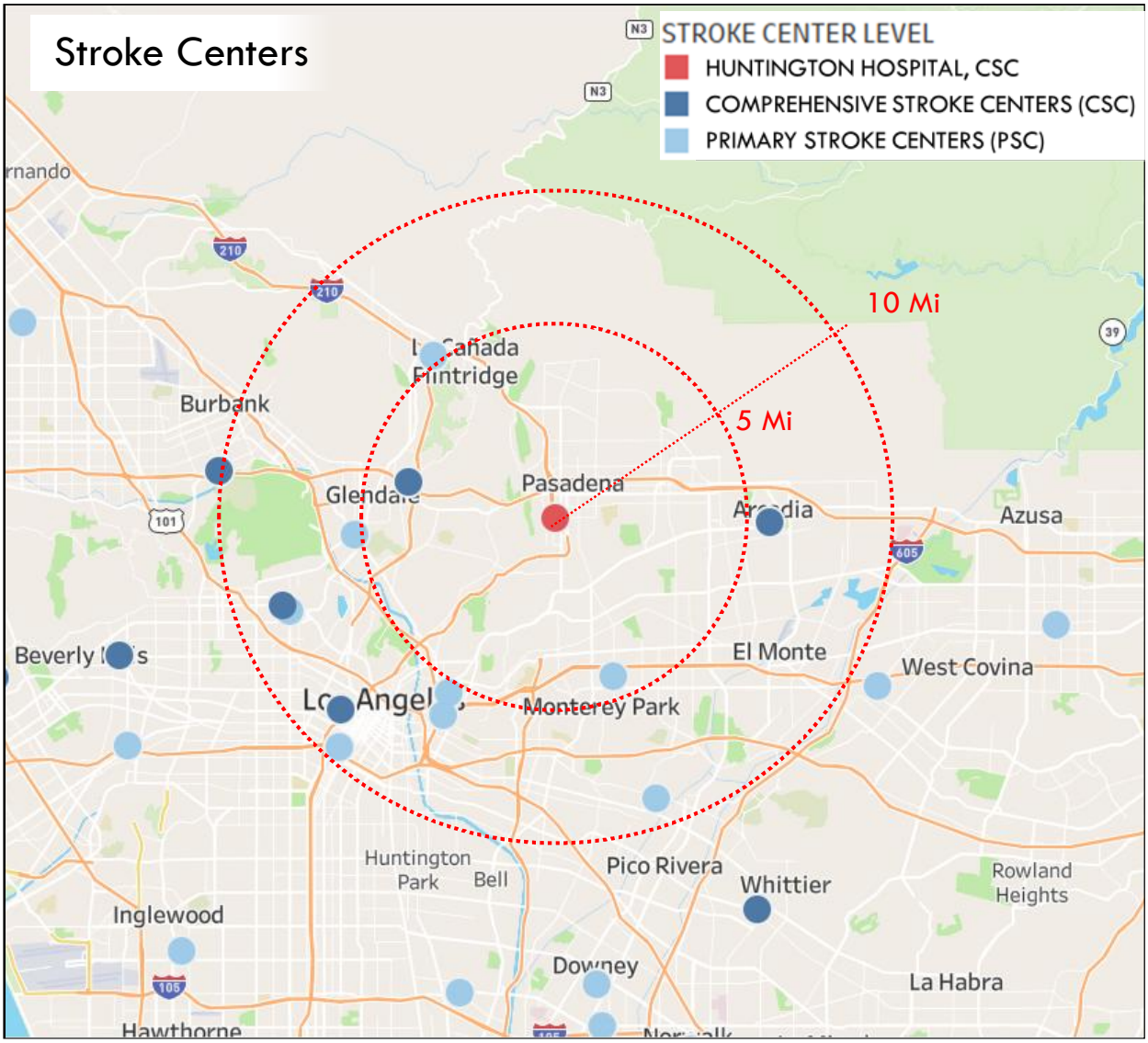
ST Elevation Myocardial Infarction (STEMI) Receiving Centers in Los Angeles County

Within Los Angeles County, there over 30 STEMI Receiving Centers that are specialized to administer percutaneous coronary intervention for patients experiencing an acute heart attack. The Hospital is one of the ten STEMI Receiving Center within a 10-mile radius and is an important provider of percutaneous coronary intervention treatment services for service area residents.



Certified Stroke Centers in Los Angeles County

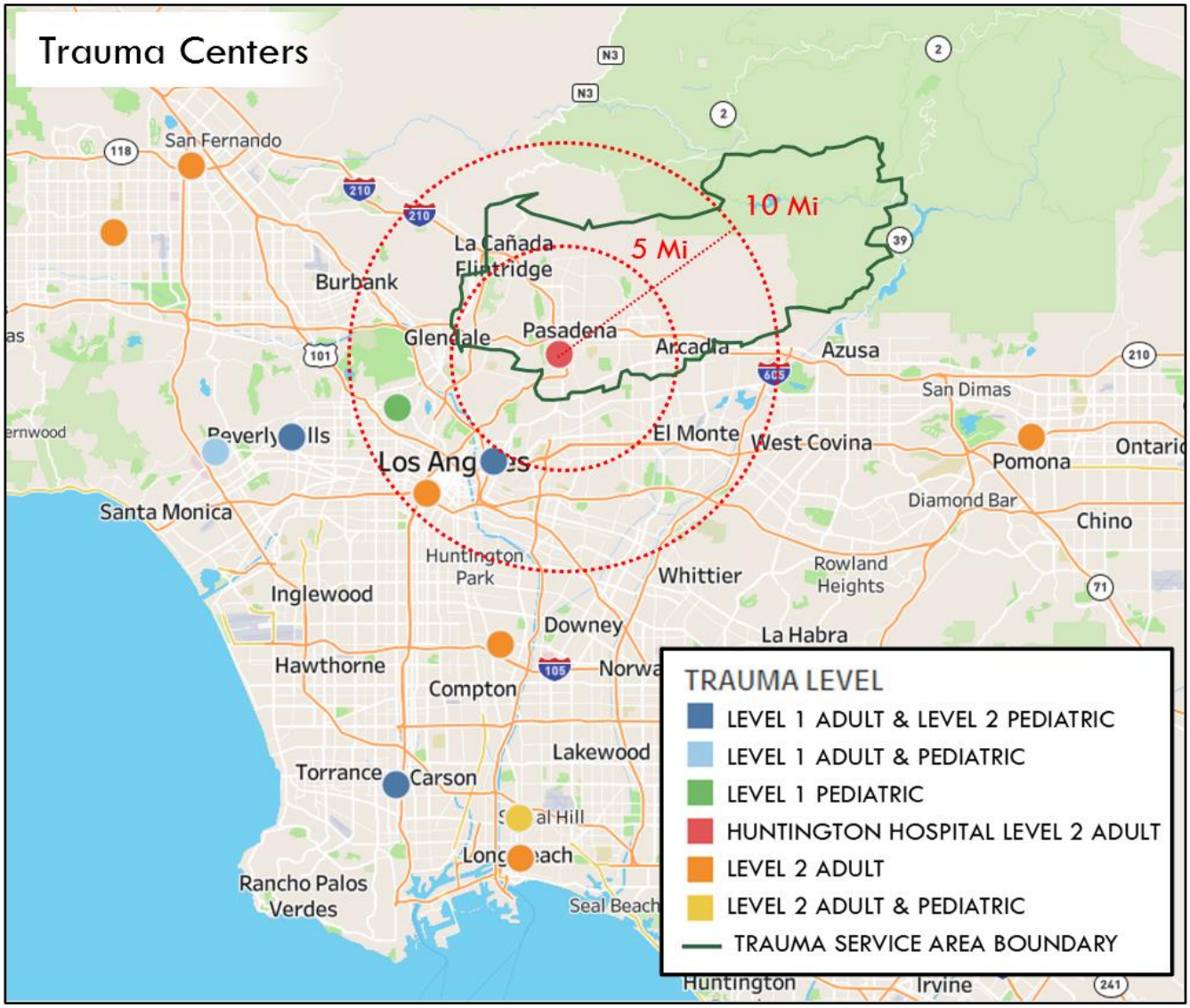
As of June 2020, there are 52 stroke centers with additional resources and processes that are certified through the Joint Commission within Los Angeles County. This includes the Hospital which is one of the 15 that are designated as Comprehensive Stroke Centers.



Service Area Trauma Services

The American College of Surgeons' Committee on Trauma classifies trauma centers as Level I through Level IV. Level I Trauma Centers provide the highest level of trauma care, while those designated as Level IV provide initial trauma care and transfer trauma patients to a higher-level trauma center if necessary.

The map below illustrates the Hospital's trauma service area boundary, as defined by the Emergency Medical Services Agency – Los Angeles County, relative to other trauma centers within Los Angeles.



The Hospital is a Level II Trauma Center and is thus required to have emergency and surgical services with immediate 24-hour coverage by general surgeons, as well as coverage by the specialties of orthopedic surgery, neurosurgery, anesthesiology, emergency medicine, radiology and critical care. A Level II Trauma Center must also have an in-house lab and be able to provide immediate advanced life support for air and ambulance transport, as well as have the necessary equipment and staff available in the intensive care unit, emergency department, and operating rooms.

- The Hospital is the only Level II Trauma Center in the service area; and

- There are three other trauma centers located within 10 miles of the Hospital: LAC+USC Medical Center, California Hospital Medical Center, and Children's Hospital Los Angeles (for pediatrics only).

Demographic Profile

The Hospital's service area population is projected to increase by 0.8% over the next five years. This is lower than the expected growth rate for Los Angeles County (1.4%) and lower than the State of California (3.4%).

SERVICE AREA POPULATION STATISTICS						
	2020 Estimate			2025 Projection		
	Service Area	Los Angeles County	California	Service Area	Los Angeles County	California
Population	1,179,766	10,173,432	39,648,525	1,189,537	10,311,054	40,742,448
Households	394,149	3,338,199	13,300,367	395,814	3,377,828	13,638,985
Percentage Female	51.3%	49.4%	50.3%	51.2%	49.5%	49.7%

Source: Esri Demographics

The ethnicity with the largest population in the Hospital's service area is White (44%) followed by Asian (31%) and Some Other Race (16 %). Approximately 41% of the service area population is of Hispanic origin. This is lower than Los Angeles County (49.0%) and California (39.7%).

SERVICE AREA POPULATION RACE /ETHNICITY						
	2020 Estimate			2025 Projection		
	Service Area	Los Angeles County	California	Service Area	Los Angeles County	California
White Alone	44.3%	48.5%	54.6%	43.6%	48.0%	53.1%
Black Alone	3.5%	8.2%	5.9%	3.4%	7.9%	5.7%
American Indian Alone	0.7%	0.7%	0.9%	0.6%	0.7%	0.9%
Asian Alone	30.8%	15.0%	14.9%	31.6%	15.8%	16.0%
Pacific Islander Alone	0.1%	0.3%	0.4%	0.1%	30.0%	0.4%
Some Other Race Alone	16.2%	22.4%	17.9%	16.2%	22.4%	18.2%
Two or More Races	4.4%	4.9%	5.4%	4.5%	5.0%	5.6%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Hispanic Origin (Any Race)	40.6%	49.0%	39.7%	41.1%	49.7%	41.0%
Non Hispanic Origin	59.4%	51.0%	60.3%	58.9%	50.3%	59.0%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Source: Esri Demographics

The median age of the population in the Hospital's service area is 39.6 years, older than the statewide median age of 36.3 years and Los Angeles County's median age of 36.0 years. The percentage of adults over the age of 65 is the fastest growing age cohort, predicted to increase by approximately 12.4% between 2020 and 2025.

SERVICE AREA POPULATION AGE DISTRIBUTION						
	2020 Estimate			2025 Projection		
	Service Area	Los Angeles County	California	Service Area	Los Angeles County	California
0-14	16.6%	18.5%	19.1%	16.0%	17.8%	18.7%
15-44	40.2%	43.6%	42.1%	39.8%	43.3%	41.9%
45-64	26.4%	32.3%	24.2%	25.4%	32.3%	23.1%
65+	16.8%	5.6%	14.6%	18.7%	6.6%	16.4%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Female 15-44	20.0%	21.5%	20.5%	19.6%	21.2%	20.5%
Median Age	39.6	36.0	36.3	40.8	37.3	37.2

Source: Esri Demographics

Households in the Hospital's service area have an average median household income of $77,896. This is 11.6% higher than the Los Angeles County average of $69,795 and 4.5% higher than the State of California average of $74,520. The percentage of higher-income households ($150,000+) in the Hospital's service area is projected to grow at the same rate (3.1%) as Los Angeles County rate of (3%) and slower than the State of California rate of approximately (4%).

SERVICE AREA HOUSEHOLD INCOME DISTRIBUTION						
	2020 Estimate			2025 Projection		
	Service Area	Los Angeles County	California	Service Area	Los Angeles County	California
<$15,000	9%	10%	9%	8%	9%	7%
$15,000 - $24,999	7%	8%	8%	6%	7%	6%
$25,000 - $34,999	7%	8%	7%	6%	7%	6%
$35,000 - $49,999	10%	11%	11%	9%	10%	9%
$50,000 - $74,999	16%	16%	16%	15%	16%	15%
$75,000 - $99,999	12%	12%	12%	12%	13%	13%
$100,000 - $149,999	18%	16%	17%	19%	17%	19%
$150,000 - $199,999	9%	8%	9%	10%	9%	11%
$200,000+	13%	11%	12%	15%	13%	14%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Median Household Income	$77,896	$69,795	$74,520	$85,752	$77,588	$86,333

Source: Esri Demographics

Medi-Cal Eligibility

With the implementation of the ACA and the statewide expansion of Medi-Cal, 13.2 million of the State of California's population are eligible for Medi-Cal (33% of California's population). In Los Angeles County, the California Department of Health Care Services estimated 3,895,310 people were eligible for Medi-Cal in September 2018 (37% of Los Angeles County's population). Out of the total estimated population in Los Angeles County, 29% of the population was enrolled for Medi-Cal Managed Care. Since the population in the Hospital's service area has a higher median household income than Los Angeles County, it is expected that the percent eligible for Medi-Cal would not exceed 29%. In the future, Medi-Cal eligibility could be significantly impacted by political changes (e.g., potential repeal of the ACA and/or economic changes such as a viral pandemic).

Selected Health Indicators

A review of health indicators that are available for Los Angeles County (deaths, diseases, and births) is shown on the following tables. Los Angeles County is generally better in natality statistics than the National Goal and better than the State of California except for a higher percentage of low birth weight infants.

NATALITY STATISTICS: 2019			
Health Status Indicator	Los Angeles County	California	National Goal
Low Birth Weight Infants	7.2%	6.8%	7.8%
First Trimester Prenatal Care	84.8%	83.6%	77.9%
Adequate/Adequate Plus Care	80.7%	79.2%	77.6%

Source: California Department of Public Health

Los Angeles County had higher morbidity rates than the State of California for six of the eight health status indicators;

MORBIDITY STATISTICS: 2019 RATE PER 100,000 POPULATION			
Health Status Indicator	Los Angeles County	California	National Goal[2]
HIV/AIDS Incidence (Age 13 and Over)[1]	595.9	397.7	N/A
Chlamydia Incidence	589.4	514.6	N/A
Gonorrhea Incidence Female Age 15-44	277.3	252.4	251.9
Gonorrhea Incidence Male Age 15-44	616.7	444.8	194.8
Tuberculosis Incidence	5.8	5.3	1.0
Congenital Syphilis	29.4	44.4	9.6
Primary Secondary Syphilis Female	2.4	3.5	1.3
Primary Secondary Syphilis Male	33.4	26.2	6.7

Source: California Department of Public Health. Note: Crude death rates, crude case rates, and age-adjusted death rates are per 100,000 population.

[1] California Department of Public Health, Office of AIDS, Surveillance Section reporting periods are: Current Period 2014-2016, Previous Period 2011-

[2] Health People 2020 Goals have not been established for the measures of HIV/AIDS Incidence and Chlamydia Incidence

The overall age-adjusted mortality rate for Los Angeles County is lower than that of the State of California. Los Angeles County reported higher age-adjusted mortality rates on six of the 18 causes compared to the state of California's age adjusted rates.

MORTALITY STATISTICS: 2019 RATE PER 100,000 POPULATION			
Selected Cause	Los Angeles County Age Adjusted Death Rate	California Age Adjusted Death Rate	HP 2020 National Objective
All Causes	574.1	641.1	a
- All Cancers	132.8	151.0	161.4
- Colorectal Cancer	13.1	13.9	14.5
- Lung Cancer	24.8	33.6	45.5
- Female Breast Cancer	18.5	20.7	20.7
- Prostate Cancer	19.2	20.2	21.8
- Diabetes	22.9	20.8	N/A
- Alzheimer's Disease	35.6	30.8	N/A
- Coronary Heart Disease	101.7	103.8	103.4
- Cerebrovascular Disease (Stroke)	34.0	35.9	34.8
- Influenza/Pneumonia	18.7	16.3	N/A
- Chronic Lower Respiratory Disease	28.2	35.9	N/A
- Chronic Liver Disease And Cirrhosis	13.2	11.7	8.2
- Accidents (Unintentional Injuries)	23.7	27.9	36.4
- Motor Vehicle Traffic Crashes	7.9	7.6	12.4
- Suicide	8.0	10.2	10.2
- Homicide	6.1	5.1	5.5
- Firearm-Related Deaths	7.4	7.8	9.3
- Drug-Induced Deaths	8.5	11.1	11.3

Source: California Department of Public Health

Healthy People 2020 is the federal government's prevention agenda for building a healthier nation. It is a statement of national health objectives designed to identify the most significant preventable threats to health and to establish national goals to reduce these threats. The vision of Healthy People 2020 is to have a society in which all people live long, healthy lives. The overarching goals of Healthy People 2020 are to: attain high-quality, longer lives free of preventable disease, disability, injury, and premature death; achieve health equity, eliminate disparities, and improve the health of all groups; create social and physical environments that promote good health for all; and promote quality of life, healthy development, and healthy

a: Healthy People (HP) 2020 National Objective has not been established.

2019 Community Health Needs Assessment

In an effort to understand the communities served by the Hospital, their most critical healthcare needs, and the resources available to meet those needs, the Hospital conducts a Community Health Needs Assessment[19] (CHNA) every three years. The Hospital's most recent 2019 assessment incorporated primary data collected through interviews, focus groups and surveys. Secondary data was gathered from a variety of studies and reports compiled by numerous organizations at the local, state, and national levels. The region of focus for the CHNA is defined by four geographic regions that include: Altadena, Pasadena, San Marino and South Pasadena. The top three areas of community needs were identified as the following:

- Housing Insecurity and Homelessness: There are approximately 58,936 people experiencing homelessness in Los Angeles County. As of January 2019, there were 677 homeless individuals living in the city of Pasadena, about a quarter of whom are chronically homeless and forty percent of whom are over the age of 50. In Pasadena, there was an approximately 27% increase in the number of homeless people in Pasadena since 2016 (from 530 people to 677 people). Although the service area is a rather affluent area in the Pasadena area, community members and key stakeholders voiced concerns that the current economic trends, including the increasing cost of rental housing combined with comparatively stagnant wages, have put more residents in a position where they have little expendable income, and therefore less money to spend on nutritious food, transportation, childcare and other basic necessities. Another theme heard from the community was that a growing number of residents are at risk of missing rent payments and/ or are facing eviction;

- Mental Health: There was a concern about anxiety and depression becoming more widespread. Those interviewed have observed an increase in people reporting symptoms of trauma- and stress related disorders, particularly among veterans and people experiencing homelessness. Many agreed there is a need for more funding and services for children for mental health support, prevention, and early intervention. There is also a need for psychiatrists to serve the youth and homeless populations; and

- Access to Care: Despite an increase of insured people in Pasadena, many residents still struggle to connect with and pay for health care. Some residents with health insurance said they do not seek care because they will not be able to cover the additional co-pays and other costs associated with treatment. Many residents have an income just over the threshold to qualify for Medi-Cal. Part-time workers who do not qualify for employer-based health insurance can find themselves in a situation where they are required to purchase their own insurance, but their income does not allow them to afford Covered California[20]

[19] The IRS per Section 501(r)(3)(A) of the Internal Revenue Code requires a non-profit hospital organization to conduct a community health needs assessment (CHNA) every three years and to adopt an implementation strategy to meet the community health needs identified through the CHNA. (IRS.gov)

[20] Covered California is the health insurance marketplace in the U.S. state of California established under the ACA. The exchange enables eligible individuals and small businesses to purchase private health insurance coverage at federally subsidized rates. It is administered by an independent agency of the government of California.

plans. Residents also reported struggling with navigating health care systems due to the complexity of the system, and confusion in the community over what health services would be considered "public charge" (and therefore count against an undocumented immigrant's appeals in the immigration process). Stakeholders explained that the lack of access to linguistically, culturally, and socioeconomically responsive services, including health care navigation services, acts as a barrier to health care access.

Service Area Market Share by Individual Hospital

The table below shows inpatient service area market share by hospital from CY 2016 to CY 2018.

SERVICE AREA MARKET SHARE TREND, CY 2016-2018- INDIVIDUAL HOSPITAL				
Facility Name	2016	2017	2018	Trend
HUNTINGTON HOSPITAL	**19.9%**	**20.3%**	**20.4%**	↗
METHODIST HOSPITAL OF SOUTHERN CALIFORNIA	10.5%	10.1%	10.0%	↘
GARFIELD MEDICAL CENTER	6.6%	5.8%	5.5%	↘
SAN GABRIEL VALLEY MEDICAL CENTER	5.9%	5.7%	5.6%	↘
ADVENTIST HEALTH GLENDALE	6.2%	5.8%	5.4%	↘
KAISER FOUNDATION HOSPITAL - LOS ANGELES	4.4%	4.7%	4.9%	↗
ALHAMBRA HOSPITAL MEDICAL CENTER	3.3%	3.3%	3.3%	→
LAC+USC MEDICAL CENTER	3.2%	3.2%	3.2%	→
USC VERDUGO HILLS HOSPITAL	3.2%	3.4%	3.4%	↗
KAISER FOUNDATION HOSPITAL - BALDWIN PARK	2.9%	2.8%	2.7%	↘
BEVERLY HOSPITAL	2.5%	2.8%	2.9%	↗
FOOTHILL PRESBYTERIAN HOSPITAL-JOHNSTON MEMORIAL	2.1%	2.2%	2.2%	→
ADVENTIST HEALTH WHITE MEMORIAL	2.1%	2.1%	2.1%	→
GLENDALE MEMORIAL HOSPITAL AND HEALTH CENTER	1.8%	1.8%	1.8%	→
CHILDREN'S HOSPITAL OF LOS ANGELES	1.5%	1.6%	1.6%	→
CEDARS-SINAI MEDICAL CENTER	1.3%	1.2%	1.2%	→
All Other	**22.6%**	**23.3%**	**23.8%**	
Grand Total	**111,983**	**111,768**	**110,028**	↘

Source: OSHPD Discharge Database, CY 2018, Excludes Normal Newborns

- From CY 2016 to CY 2018, the Hospital has ranked first in overall service area market share based on discharges. The Hospital increased its market share in the service area from 19.9% in CY 2016 to 20.4% in CY 2018 by increasing service area discharges 0.9% while total inpatient discharges emanating from the service area decreased by 1.7%;

- Methodist Hospital of Southern California located 10 miles away, is second in market share with 10% market share; and

- Cedars-Sinai Medical Center has 1.2% market share in the service area.

Service Area Market Share by Health System

The table below shows inpatient service area market share by health system from CY 2016 to CY 2018. A list of hospital facilities that were part of the system at that time is included in the appendix.

SERVICE AREA MARKET SHARE TREND, CY 2016-2018 - HEALTH SYSTEM				
Facility/Health System	2016	2017	2018	Trend
HUNTINGTON HOSPITAL	**19.9%**	**20.3%**	**20.4%**	↗
AHMC HEALTHCARE	17.4%	16.3%	15.8%	↘
METHODIST HOSPITAL OF SO CAL	10.5%	10.1%	10.0%	↘
KAISER FOUNDATION HOSPITALS	8.4%	8.5%	8.7%	↗
ADVENTIST HEALTH	8.3%	7.9%	7.5%	↘
KECK MEDICINE OF USC	4.8%	5.0%	5.1%	↗
EMANATE HEALTH	4.2%	4.3%	4.3%	→
LAC+USC MEDICAL CENTER	3.2%	3.2%	3.2%	→
BEVERLY HOSPITAL	2.5%	2.8%	2.9%	↗
DIGNITY HEALTH	2.4%	2.4%	2.4%	→
BHC ALHAMBRA HOSPITAL	1.0%	1.2%	1.6%	↗
CHILDREN'S HOSPITAL OF LOS ANGELES	1.5%	1.7%	1.6%	→
PIH HEALTH HOSPITALS	1.5%	1.4%	1.5%	→
CEDARS-SINAI	1.4%	1.3%	1.4%	→
UCLA HEALTH	1.2%	1.0%	1.1%	→
SOUTHERN CALIFORNIA HOSPITAL	0.7%	0.8%	1.0%	↗
PROVIDENCE & ST. JOSEPH HOSPITALS	1.0%	1.0%	1.0%	→
All Other	10.1%	10.9%	10.5%	↗
Service Area Total	**100.0%**	**100.0%**	**100.0%**	
Total Discharges	**111,983**	**111,768**	**110,028**	↘

Source: OSHPD Discharge Database, CY 2018, Excludes Normal Newborns

Note: Each entity includes several facilities operated by the health system or just an independent hospital where the patients in the Hospital's market share received care.

- Among health systems, AHMC Healthcare reported the most inpatient discharges (15.8%) in the service area; and

- Over the past three years, Kaiser Foundation Hospitals as a system reported the highest increase in market share (212 discharges) in the service area over the past three years.

Market Share by Payer Type-Individual Hospital

The following table shows the CY 2018 service area inpatient market share by payer type for each individual hospital listed below:

SERVICE AREA MARKET SHARE BY PAYER TYPE, CY 2018 - INDIVIDUAL FACILITY						
Payer	Medicare	Private Coverage	Medi-Cal	All Other Payers	Total Market Share	Discharges
HUNTINGTON HOSPITAL	**18.3%**	**27.8%**	**15.4%**	**20.3%**	**20.4%**	**22,489**
METHODIST HOSPITAL OF SOUTHERN CALIFORNIA	13.9%	11.7%	2.4%	6.4%	**10.0%**	**11,012**
SAN GABRIEL VALLEY MEDICAL CENTER	6.3%	2.6%	7.8%	5.5%	**5.6%**	**6,116**
GARFIELD MEDICAL CENTER	6.4%	2.3%	6.6%	10.9%	**5.5%**	**5,999**
ADVENTIST HEALTH GLENDALE	6.3%	4.1%	5.8%	4.1%	**5.4%**	**5,973**
KAISER FOUNDATION HOSPITAL - LOS ANGELES	4.6%	9.4%	1.0%	0.7%	**4.9%**	**5,395**
USC VERDUGO HILLS HOSPITAL	5.3%	2.8%	1.5%	1.1%	**3.4%**	**3,747**
ALHAMBRA HOSPITAL MEDICAL CENTER	4.4%	0.8%	4.7%	0.4%	**3.3%**	**3,591**
LAC+USC MEDICAL CENTER	1.5%	0.6%	8.8%	4.2%	**3.2%**	**3,525**
BEVERLY HOSPITAL	3.1%	0.9%	5.4%	0.9%	**2.9%**	**3,209**
KAISER FOUNDATION HOSPITAL - BALDWIN PARK	2.7%	5.0%	0.6%	0.3%	**2.7%**	**3,018**
FOOTHILL PRESBYTERIAN HOSPITAL-JOHNSTON MEMORIAL	2.6%	1.5%	2.4%	1.3%	**2.2%**	**2,378**
ADVENTIST HEALTH WHITE MEMORIAL	1.6%	0.8%	4.0%	3.7%	**2.1%**	**2,277**
GLENDALE MEMORIAL HOSPITAL AND HEALTH CENTER	1.6%	0.8%	3.7%	0.5%	**1.8%**	**2,034**
CHILDREN'S HOSPITAL OF LOS ANGELES	0.0%	2.0%	3.9%	0.1%	**1.6%**	**1,725**
BHC ALHAMBRA HOSPITAL	0.3%	4.2%	0.7%	0.2%	**1.6%**	**1,725**
KECK HOSPITAL OF USC	1.8%	1.5%	0.4%	4.9%	**1.5%**	**1,654**
CEDARS SINAI MEDICAL CENTER	0.9%	2.5%	0.4%	0.5%	**1.2%**	**1,356**
CITRUS VALLEY MEDICAL CENTER - QV CAMPUS	0.6%	0.6%	2.9%	1.1%	**1.2%**	**1,286**
MONTEREY PARK HOSPITAL	0.9%	0.3%	1.7%	2.8%	**1.0%**	**1,114**
CITRUS VALLEY MEDICAL CENTER - IC CAMPUS	1.2%	0.4%	1.3%	0.7%	**1.0%**	**1,085**
All Other	17.8%	18.3%	**21.5%**	**33.1%**	**17.6%**	**19,320**
PAYER MIX	**41.0%**	**29.2%**	**25.3%**	**4.4%**	**100.0%**	
TOTAL	**100%**	**100%**	**100%**	**100%**		
TOTAL DISCHARGES	**45,111**	**32,155**	**27,873**	**4,889**		**110,028**

Source: OSHPD Discharge Database, CY 2018, Excludes Normal Newborns

Note: Each entity includes several facilities operated by the health system or just an independent hospital where the patients in the Hospital's market share received care.

- The largest payer category of service area inpatient discharges is Medicare with 45,111 inpatient discharges (41%), followed by Private Coverage with 32,155 inpatient discharges (29.2%), and Medi-Cal with 27,873 inpatient discharges (25.3%); and

- The Hospital is the market share leader for Private Coverage (27.8%) and All Other (20.3%) which includes self-pay, workers' compensation, other government, and other payers.

Market Share by Payer Type-Health System

The following tables show the CY 2018 service area inpatient market share by payer type for each health system listed below:

SERVICE AREA MARKET SHARE BY PAYER TYPE, CY 2018 - HEALTH SYSTEM						
	Medicare	Private Coverage	Medi-Cal	All Other Payers	Total Percentage	Discharges
HUNTINGTON HOSPITAL	**18.3%**	**27.8%**	**15.4%**	**20.3%**	**20.4%**	**22,489**
AHMC HEALTHCARE	**18.4%**	6.2%	**21.9%**	19.9%	**15.8%**	**17,363**
METHODIST HOSPITAL OF SO CAL	13.9%	11.7%	2.4%	6.4%	**10.0%**	**11,012**
KAISER FOUNDATION HOSPITALS	8.2%	16.4%	1.9%	1.3%	**8.7%**	**9,563**
ADVENTIST HEALTH	7.9%	4.9%	9.9%	7.8%	**7.5%**	**8,262**
KECK MEDICINE OF USC	7.3%	4.5%	2.0%	7.2%	**5.1%**	**5,633**
EMANATE HEALTH	4.4%	2.5%	6.5%	3.1%	**4.3%**	**4,749**
LAC+USC MEDICAL CENTER	1.5%	0.6%	8.8%	4.2%	**3.2%**	**3,525**
BEVERLY HOSPITAL	3.1%	0.9%	5.4%	0.9%	**2.9%**	**3,209**
DIGNITY HEALTH	1.8%	1.3%	5.0%	0.9%	**2.4%**	**2,660**
BHC ALHAMBRA HOSPITAL	0.3%	4.2%	0.7%	0.2%	**1.6%**	**1,725**
CHILDRENS HOSPITAL OF LOS ANGELES	0.0%	2.0%	3.9%	0.1%	**1.6%**	**1,725**
CEDARS- SINAI	1.1%	2.8%	0.4%	0.5%	**1.4%**	**1,525**
All Other	13.8%	14.5%	15.7%	27.2%	**15.1%**	**16,588**
PAYER MIX	**41.0%**	**29.2%**	**25.3%**	**4.4%**	**100.0%**	
TOTAL	**100%**	**100%**	**100%**	**100%**		
TOTAL DISCHARGES	**45,111**	**32,155**	**27,873**	**4,889**		**110,028**

Source: OSHPD Discharge Database, CY 2018, Excludes Normal Newborns

Note: Each entity includes several facilities operated by the health system or just an independent hospital where the patients in the Hospital's market share received care.

- The Hospital is the market share leader for Private Coverage (27.8%) and All Other (20.3%);
- AHMC Healthcare is the market share leader for Medicare (18.4%) and Medi-Cal (21.9%) and; and
- Cedars-Sinai's total market share in the Hospital's service area is 1.4%.

Market Share by Service Line-Individual Facility

The following two tables show the CY 2018 service area inpatient market share by service line for each individual hospital listed below:

SERVICE AREA MARKET SHARE BY SERVICE LINE, CY 2018 - INDIVIDUAL FACILITY													
	General Medicine	Obstetrics	Cardiac Services	Behavioral Health	General Surgery	Orthopedics	Neurology	Neonatology	Oncology/Hematology (Medical)	Urology	Gynecology	Total Percentage	Total Discharges
HUNTINGTON MEMORIAL HOSPITAL	**20%**	**22%**	**18%**	11%	**22%**	**25%**	**19%**	**28%**	**19%**	**24%**	**20%**	**20%**	**22,489**
METHODIST HOSPITAL OF SOUTHERN CALIFORNIA	11%	8%	13%	1%	11%	14%	14%	7%	10%	7%	12%	**10%**	**11,012**
SAN GABRIEL VALLEY MEDICAL CENTER	6%	10%	5%	3%	4%	4%	4%	6%	5%	4%	12%	**6%**	**6,116**
GARFIELD MEDICAL CENTER	5%	7%	8%	0%	5%	3%	8%	6%	6%	8%	11%	**5%**	**5,999**
ADVENTIST HEALTH GLENDALE	5%	5%	7%	6%	5%	5%	7%	5%	4%	4%	4%	**5%**	**5,973**
KAISER FOUNDATION HOSPITAL - LOS ANGELES	4%	8%	6%	3%	4%	4%	4%	11%	5%	5%	4%	**5%**	**5,395**
USC VERDUGO HILLS HOSPITAL	5%	1%	3%	1%	3%	5%	4%	1%	2%	6%	1%	**3%**	**3,747**
ALHAMBRA HOSPITAL MEDICAL CENTER	5%	0%	4%	1%	3%	2%	4%	0%	5%	4%	2%	**3%**	**3,591**
LAC+USC MEDICAL CENTER	3%	1%	4%	1%	5%	3%	3%	3%	5%	5%	5%	**3%**	**3,525**
BEVERLY HOSPITAL	4%	1%	4%	0%	3%	2%	3%	1%	3%	4%	3%	**3%**	**3,209**
KAISER FOUNDATION HOSPITAL - BALDWIN PARK	2%	7%	2%	0%	3%	5%	2%	5%	2%	2%	2%	**3%**	**3,018**
FOOTHILL PRESBYTERIAN HOSPITAL-JOHNSTON MEM	3%	2%	3%	0%	3%	2%	2%	1%	2%	3%	1%	**2%**	**2,378**
ADVENTIST HEALTH WHITE MEMORIAL	2%	3%	2%	1%	2%	2%	2%	2%	2%	1%	2%	**2%**	**2,277**
GLENDALE MEMORIAL HOSPITAL AND HEALTH CENTE	1%	4%	2%	1%	1%	1%	2%	4%	1%	1%	1%	**2%**	**2,034**
BHC ALHAMBRA HOSPITAL	0%	0%	0%	**18%**	0%	0%	0%	0%	0%	0%	0%	**2%**	**1,725**
CHILDREN'S HOSPITAL OF LOS ANGELES	2%	0%	1%	0%	2%	2%	3%	1%	4%	2%	1%	**2%**	**1,725**
KECK HOSPITAL OF USC	1%	0%	2%	0%	4%	3%	2%	0%	1%	4%	1%	**2%**	**1,654**
CEDARS-SINAI MEDICAL CENTER	1%	2%	1%	0%	2%	2%	1%	3%	1%	2%	1%	**1%**	**1,356**
ALL OTHER FACILITIES	18%	18%	15%	50%	20%	18%	19%	16%	23%	15%	16%	**21%**	**22,805**
Total Percentage	**32%**	**12%**	**11%**	**9%**	**7%**	**6%**	**5%**	**4%**	**4%**	**2%**	**1%**	**100%**	
Total Discharges	**35,007**	**12,715**	**12,248**	**9,822**	**8,200**	**7,056**	**5,797**	**4,231**	**3,920**	**1,701**	**1,582**		**110,028**

Source: OSHPD Discharge Database, CY 2018, Excludes Normal Newborns

SERVICE AREA MARKET SHARE BY SERVICE LINE, CY 2018 - INDIVIDUAL FACILITY												
	ENT	Spine	Vascular Services	Trauma	Spine Surgery	Neurosurgery	Thoracic Surgery	Ophthalmology	Rehabilitation	Ungroupable	Total Percentage	Total Discharges
HUNTINGTON MEMORIAL HOSPITAL	**23%**	**37%**	**18%**	**29%**	**28%**	**22%**	**19%**	**20%**	12%	0%	**20%**	**22,489**
METHODIST HOSPITAL OF SOUTHERN CALIFORNIA	6%	12%	11%	9%	13%	7%	5%	8%	2%	0%	**10%**	**11,012**
SAN GABRIEL VALLEY MEDICAL CENTER	3%	4%	7%	4%	4%	2%	5%	5%	0%	17%	**6%**	**6,116**
GARFIELD MEDICAL CENTER	4%	1%	6%	5%	7%	7%	8%	3%	0%	0%	**5%**	**5,999**
ADVENTIST HEALTH GLENDALE	6%	3%	7%	3%	4%	6%	6%	3%	0%	0%	**5%**	**5,973**
KAISER FOUNDATION HOSPITAL - LOS ANGELES	4%	5%	3%	5%	3%	7%	7%	4%	0%	**50%**	**5%**	**5,395**
USC VERDUGO HILLS HOSPITAL	2%	0%	1%	4%	6%	1%	2%	3%	0%	0%	**3%**	**3,747**
ALHAMBRA HOSPITAL MEDICAL CENTER	4%	0%	3%	3%	3%	1%	3%	4%	**63%**	0%	**3%**	**3,591**
LAC+USC MEDICAL CENTER	5%	1%	2%	10%	2%	6%	3%	19%	0%	0%	**3%**	**3,525**
BEVERLY HOSPITAL	4%	1%	5%	3%	3%	1%	0%	2%	0%	0%	**3%**	**3,209**
KAISER FOUNDATION HOSPITAL - BALDWIN PARK	1%	0%	4%	1%	0%	0%	0%	0%	0%	0%	**3%**	**3,018**
FOOTHILL PRESBYTERIAN HOSPITAL-JOHNSTON MEMORIAL	1%	0%	2%	1%	2%	1%	1%	1%	0%	0%	**2%**	**2,378**
ADVENTIST HEALTH WHITE MEMORIAL	3%	3%	3%	1%	1%	1%	1%	2%	0%	0%	**2%**	**2,277**
GLENDALE MEMORIAL HOSPITAL AND HEALTH CENTER	0%	1%	3%	1%	2%	0%	2%	0%	0%	0%	**2%**	**2,034**
BHC ALHAMBRA HOSPITAL	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	**2%**	**1,725**
CHILDREN'S HOSPITAL OF LOS ANGELES	12%	2%	1%	2%	0%	3%	2%	11%	0%	0%	**2%**	**1,725**
KECK HOSPITAL OF USC	4%	7%	4%	2%	2%	10%	8%	2%	0%	0%	**2%**	**1,654**
CEDARS-SINAI MEDICAL CENTER	1%	3%	1%	1%	2%	2%	2%	0%	0%	0%	**1%**	**1,356**
ALL OTHER FACILITIES	17%	19%	18%	18%	17%	24%	25%	14%	23%	33%	**21%**	**22,805**
Total Percentage	**1%**	**1%**	**1%**	**1%**	**1%**	**1%**	**1%**	**0%**	**0%**	**0%**	**100%**	
Total Discharges	**1,341**	**1,204**	**1,197**	**1,150**	**1,012**	**964**	**557**	**192**	**126**	**6**		**110,028**

Source: OSHPD Discharge Database, CY 2018, Excludes Normal Newborns

- The Hospital is a service line leader in 18 of 20 service lines including: general medicine (20%), obstetrics (22%), cardiac services (18%), general surgery (22%), orthopedics (25%), neurology (19%), neonatology (28%), oncology/hematology medical (19%), urology (24%), gynecology (20%), ENT (23%), spine (37%), vascular services (18%), trauma (29%), spine surgery (28%), neurosurgery (22%), thoracic surgery (19%), and ophthalmology (20%); and

- The Hospital also reported the second most behavioral health inpatient discharges behind BHC Alhambra, which is a specialty behavioral health hospital.

Market Share by Service Line-Health System

The following two tables shows the CY 2018 service area inpatient market share by service line for each health system listed below:

SERVICE AREA MARKET SHARE BY SERVICE LINE, CY 2018 - HEALTH SYSTEM													
	General Medicine	Obstetrics	Cardiac Services	Behavioral Health	General Surgery	Orthopedics	Neurology	Neonatology	Oncology/Hematology (Medical)	Urology	Gynecology	Total Percentage	Total Discharges
HUNTINGTON MEMORIAL HOSPITAL	**20%**	**22%**	18%	**11%**	**22%**	**25%**	**19%**	**28%**	**19%**	**24%**	20%	**20%**	**22,489**
AHMC HEALTHCARE	19%	19%	**19%**	4%	13%	9%	17%	12%	17%	17%	**27%**	**16%**	**17,363**
METHODIST HOSPITAL OF SOUTHERN CALIFORNIA	11%	8%	13%	1%	11%	14%	14%	7%	10%	7%	12%	**10%**	**11,012**
KAISER FOUNDATION HOSPITALS	7%	17%	8%	3%	9%	10%	7%	18%	8%	8%	8%	**9%**	**9,563**
ADVENTIST HEALTH	7%	8%	9%	8%	7%	7%	8%	8%	6%	5%	6%	**8%**	**8,262**
KECK MEDICINE OF USC	6%	1%	5%	1%	7%	8%	6%	1%	6%	11%	2%	**5%**	**5,633**
EMANATE HEALTH	5%	6%	6%	2%	5%	4%	4%	5%	3%	5%	3%	**4%**	**4,749**
LAC+USC MEDICAL CENTER	3%	1%	4%	1%	5%	3%	3%	3%	5%	5%	5%	**3%**	**3,525**
BEVERLY HOSPITAL	4%	1%	4%	0%	3%	2%	3%	1%	3%	4%	3%	**3%**	**3,209**
DIGNITY HEALTH	2%	5%	3%	2%	2%	2%	2%	4%	2%	1%	3%	**2%**	**2,660**
CHILDREN'S HOSPITAL OF LOS ANGELES	2%	0%	1%	0%	2%	2%	3%	1%	4%	2%	1%	**2%**	**1,725**
BHC ALHAMBRA HOSPITAL	0%	0%	0%	18%	0%	0%	0%	0%	0%	0%	0%	**2%**	**1,725**
PIH HEALTH HOSPITALS	1%	2%	2%	0%	1%	2%	2%	2%	1%	1%	2%	**1%**	**1,626**
CEDARS-SINAI	1%	2%	1%	0%	2%	2%	1%	3%	1%	2%	1%	**1%**	**1,525**
UCLA HEALTH	1%	1%	1%	0%	2%	1%	1%	1%	2%	1%	1%	**1%**	**1,173**
SOUTHERN CALIFORNIA HOSPITAL	1%	0%	0%	4%	0%	0%	1%	0%	0%	0%	0%	**1%**	**1,106**
PROVIDENCE & ST. JOSEPH HOSPITALS	1%	2%	1%	0%	1%	2%	1%	2%	1%	2%	2%	**1%**	**1,051**
ALL OTHER FACILITIES	9%	5%	5%	43%	8%	7%	8%	5%	11%	6%	5%	**11%**	**11,632**
Total	**32%**	**12%**	**11%**	**9%**	**7%**	**6%**	**5%**	**4%**	**4%**	**2%**	**1%**	**100%**	
Total Discharges	**35,007**	**12,715**	**12,248**	**9,822**	**8,200**	**7,056**	**5,797**	**4,231**	**3,920**	**1,701**	**1,582**		**110,028**

Source: OSHPD Discharge Database, CY 2018, Excludes Normal Newborns

Note: Each entity includes several facilities operated by the health system or just an independent hospital where the patients in the Hospital's market share received care.

SERVICE AREA MARKET SHARE BY SERVICE LINE, CY 2018 - HEALTH SYSTEM												
	ENT	Spine	Vascular Services	Trauma	Spine Surgery	Neurosurgery	Thoracic Surgery	Ophthalmology	Rehabilitation	Ungroupable	Total Percentage	Total Discharges
HUNTINGTON MEMORIAL HOSPITAL	**23%**	**37%**	**18%**	**29%**	**28%**	**22%**	**19%**	**20%**	12%	0%	**20%**	**22,489**
AHMC HEALTHCARE	13%	6%	17%	12%	15%	9%	18%	14%	**63%**	17%	**16%**	**17,363**
METHODIST HOSPITAL OF SOUTHERN CALIFORNIA	6%	12%	11%	9%	13%	7%	5%	8%	2%	0%	**10%**	**11,012**
KAISER FOUNDATION HOSPITALS	6%	7%	8%	8%	4%	11%	9%	4%	0%	**50%**	**9%**	**9,563**
ADVENTIST HEALTH	8%	7%	10%	3%	5%	7%	7%	5%	0%	0%	**8%**	**8,262**
KECK MEDICINE OF USC	6%	8%	5%	5%	8%	11%	10%	5%	0%	0%	**5%**	**5,633**
EMANATE HEALTH	2%	1%	5%	1%	4%	2%	1%	1%	0%	0%	**4%**	**4,749**
LAC+USC MEDICAL CENTER	5%	1%	2%	10%	2%	6%	3%	19%	0%	0%	**3%**	**3,525**
BEVERLY HOSPITAL	4%	1%	5%	3%	3%	1%	0%	2%	0%	0%	**3%**	**3,209**
DIGNITY HEALTH	2%	1%	3%	2%	3%	1%	2%	1%	0%	17%	**2%**	**2,660**
CHILDREN'S HOSPITAL OF LOS ANGELES	12%	2%	1%	2%	0%	3%	2%	11%	0%	0%	**2%**	**1,725**
BHC ALHAMBRA HOSPITAL	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	**2%**	**1,725**
PIH HEALTH HOSPITALS	1%	2%	2%	1%	2%	3%	2%	0%	0%	0%	**1%**	**1,626**
CEDARS-SINAI	1%	4%	1%	1%	2%	2%	3%	0%	0%	0%	**1%**	**1,525**
UCLA HEALTH	2%	1%	2%	1%	1%	4%	3%	5%	0%	0%	**1%**	**1,173**
SOUTHERN CALIFORNIA HOSPITAL	1%	1%	0%	1%	1%	0%	0%	1%	2%	17%	**1%**	**1,106**
PROVIDENCE & ST. JOSEPH HOSPITALS	1%	2%	1%	1%	1%	2%	3%	0%	3%	0%	**1%**	**1,051**
ALL OTHER FACILITIES	8%	9%	8%	9%	8%	11%	14%	5%	18%	0%	**11%**	**11,632**
Total	**1%**	**1%**	**1%**	**1%**	**1%**	**1%**	**1%**	**0%**	**0%**	**0%**	**100%**	
Total Discharges	**1,341**	**1,204**	**1,197**	**1,150**	**1,012**	**964**	**557**	**192**	**126**	**6**		**110,028**

Source: OSHPD Discharge Database, CY 2018, Excludes Normal Newborns

Note: Each entity includes several facilities operated by the health system or just an independent hospital where the patients in the Hospital's market share received care.

- AHMC Healthcare, which represents 16% of the service area discharges, is a service line leader in two of the 20 service lines including: cardiac services (19%), and gynecology (27%).

Huntington Hospital Analysis by Bed Type

The tables on the following pages show existing hospital bed capacity, occupancy, and bed availability for medical/surgical, intensive/coronary care, obstetrics, pediatrics, pediatric intensive care, neonatal intensive care, acute psychiatric care, physical rehabilitation, chemical dependency, and emergency services using FY 2018 and FY 2019 data.

Hospital Supply and Demand

There are nine other general acute care hospitals within the Hospital's service area that, together with the Hospital, have a combined total of 3,017 licensed beds and an aggregate occupancy rate of approximately 66%. Hospitals in the service area run at occupancy rates that range between 53% at Beverly Hospital and approximately 80%, at LAC+USC Medical Center.

The hospitals listed in the table below were analyzed to determine available bed capacity in the area.

AREA HOSPITAL DATA 2018								
Hospital	City	Within Service Area	Licensed Beds	Discharges	Patient Days	Average Daily Census	Percent Occupied	Miles from Hospital
Huntington Hospital	**Pasadena**	**X**	**578**	**28,635**	**121,897**	**334**	**57.8%**	
Alhambra Hospital Medical Center*	Alhambra	x	144	5,027	32,938	90	62.7%	3.5
San Gabriel Valley Medical Center*	San Gabriel	x	273	9,220	65,228	179	65.5%	4.5
Garfield Medical Center*	Monterey Park	x	210	10,215	54,126	148	70.6%	5.6
USC Verdugo Hills Hospital*	Glendale	x	158	6,873	32,401	89	56.2%	7.9
LAC+USC Medical Center*	Los Angeles	x	670	30,175	195,296	535	79.9%	8.5
Adventist Health White Memorial	Los Angeles	x	353	19,171	85,045	233	66.0%	8.8
Methodist Hospital of Southern California	Arcadia	x	324	15,478	74,602	204	63.1%	10.0
Beverly Hospital	Montebello	x	202	9,915	38,893	107	52.8%	18.6
Foothill Presbyterian Hospital - Johnston Memorial	Glendora	x	105	5,690	23,030	63	60.1%	19.3
SUB-TOTAL			**3,017**	**140,399**	**723,456**	**1,982**	**65.7%**	
Adventist Health Glendale	Glendale		515	19,879	100,611	276	53.5%	6.3
Glendale Memorial Hospital and Health Center*	Glendale		334	9,758	42,582	117	34.9%	9.5
Children's Hospital of Los Angeles*	Los Angeles		495	17,677	118,243	324	65.4%	11.7
Kaiser Foundation Hospital- Los Angeles	Los Angeles		528	27,468	138,036	378	71.6%	12.5
Kaiser Foundation Hospital- Baldwin Park	Baldwin Park		257	10,797	36,108	99	38.5%	14.4
TOTAL			**5,146**	**225,978**	**1,159,036**	**3,175**	**61.7%**	

Source: OSHPD Disclosure Reports

* 2019 Data

- The Hospital's 578 licensed beds represent approximately 19% of the service area's beds, and inpatient volume accounts for approximately 20% of discharges and 17% of patient days among hospitals that are located in the service area.

Medical/Surgical Capacity Analysis

The Hospital has 372 medical/surgical beds representing 22% of all licensed medical surgical beds available in the service area and 20% of the medical/surgical inpatient discharges among hospitals that are located in the service area.

AREA HOSPITAL DATA : MEDICAL/SURGICAL, FY 2018							
Hospital	Miles from Hospital	Within Service Area	Licensed Beds	Discharges	Patient Days	Average Daily Census	Percent Occupied
Huntington Hospital	**-**	**X**	**372**	**21,189**	**79,471**	**218**	**58.5%**
Alhambra Hospital Medical Center*	3.5	x	88	4,168	17,452	48	54.3%
San Gabriel Valley Medical Center*	4.5	x	127	5,981	26,352	72	56.8%
Garfield Medical Center*	5.6	x	106	6,866	34,244	94	88.5%
USC Verdugo Hills Hospital*	7.9	x	86	5,006	14,309	39	45.6%
LAC+USC Medical Center*	8.5	x	329	22,492	119,139	326	99.2%
Adventist Health White Memorial	8.8	x	158	11,019	47,136	129	81.7%
Methodist Hospital of Southern California	10.0	x	204	12,717	53,472	146	71.8%
Beverly Hospital	18.6	x	134	8,235	31,176	85	63.7%
Foothill Presbyterian Hospital - Johnston Memorial	19.3	x	74	4,436	17,100	47	63.3%
SUB-TOTAL			**1,678**	**102,109**	**439,851**	**1,205**	**71.8%**
Adventist Health Glendale	6.3		291	14,669	61,329	168	57.7%
Glendale Memorial Hospital and Health Center*	9.5		180	5,887	21,952	60	33.4%
Children's Hospital of Los Angeles*	11.7		-	-	-	-	-
Kaiser Foundation Hospital- Los Angeles	12.5		256	15,581	72,681	199	77.8%
Kaiser Foundation Hospital- Baldwin Park	14.4		172	7,084	24,667	68	39.3%
TOTAL			**2,577**	**145,330**	**620,480**	**1,700**	**65.8%**

Source: OSHPD Disclosure Reports

Includes Definitive Observation

* 2019 Data

- In FY 2019, LAC+USC Medical Center, ran at the highest medical/surgical bed occupancy rate of 99% among hospitals in the service area; and

- The Hospital reported 21,189 inpatient hospital discharges for its medical/surgical beds with 79,471 patient days resulting in an occupancy rate of 59% and an average daily census of 218 patients.

Intensive Care Capacity Analysis

The Hospital has 30 adult intensive care beds, which represent 8.8% of all adult intensive care beds and 6.8% of the critical care discharges among hospitals that are located in the service area.

AREA HOSPITAL DATA : INTENSIVE CARE, FY 2018							
Hospital	Miles from Hospital	Within Service Area	Licensed Beds	Discharges	Patient Days	Average Daily Census	Percent Occupied
Huntington Hospital	**-**	**X**	**30**	**398**	**7,207**	**20**	**65.8%**
Alhambra Hospital Medical Center*	3.5	x	13	624	2,609	7	55.0%
San Gabriel Valley Medical Center*	4.5	x	19	267	4,091	11	59.0%
Garfield Medical Center*	5.6	x	22	341	5,743	16	71.5%
USC Verdugo Hills Hospital*	7.9	x	12	276	2,667	7	60.9%
LAC+USC Medical Center*	8.5	x	120	2,246	31,050	85	70.9%
Adventist Health White Memorial	8.8	x	34	243	4,455	12	35.9%
Methodist Hospital of Southern California	10.0	x	49	492	8,119	22	45.4%
Beverly Hospital	18.6	x	25	501	4,984	14	54.6%
Foothill Presbyterian Hospital - Johnston Memorial	19.3	x	18	406	4,220	12	64.2%
SUB-TOTAL			**342**	**5,794**	**75,145**	**206**	**60.2%**
Adventist Health Glendale	6.3		32	507	6,992	19	59.9%
Glendale Memorial Hospital and Health Center*	9.5		24	264	3,883	11	44.3%
Children's Hospital of Los Angeles*	11.7		-	-	-	-	-
Kaiser Foundation Hospital- Los Angeles	12.5		96	2,690	25,609	70	73.1%
Kaiser Foundation Hospital- Baldwin Park	14.4		12	174	2,960	8	67.6%
TOTAL			**506**	**9,429**	**114,589**	**314**	**61.9%**

Source: OSHPD Disclosure Reports

* 2019 Data

- In FY 2018, the Hospital's adult intensive care beds had an occupancy rate of 66% and an average daily census of 19 patients;
- The Hospital's adult intensive care beds are an important resource for supporting the Hospital's designation as a Level II trauma center; and
- During 2020, the Hospital has been an important provider of care to patients infected with COVID-19 that require intensive care.

Obstetrics Capacity Analysis

There are 242 obstetrics beds located in the service area with an aggregate occupancy rate of 48%. The Hospital reported 56 licensed obstetric beds with an occupancy rate of 56%.

AREA HOSPITAL DATA : OBSTETRICS, FY 2018							
Hospital	Miles from Hospital	Within Service Area	Licensed Beds	Discharges	Patient Days	Average Daily Census	Percent Occupied
Huntington Hospital	**-**	**X**	**56**	**3,790**	**11,500**	**32**	**56.3%**
Alhambra Hospital Medical Center*	3.5	x	-	-	-	-	-
San Gabriel Valley Medical Center*	4.5	x	29	2,033	5,702	16	53.9%
Garfield Medical Center*	5.6	x	34	2,454	6,267	17	50.5%
USC Verdugo Hills Hospital*	7.9	x	12	427	1,034	3	23.5%
LAC+USC Medical Center*	8.5	x	32	1,044	3,518	10	30.0%
Adventist Health White Memorial	8.8	x	24	3,445	7,132	20	81.2%
Methodist Hospital of Southern California	10.0	x	24	1,491	4,014	11	45.7%
Beverly Hospital	18.6	x	18	653	1,366	4	20.8%
Foothill Presbyterian Hospital - Johnston Memorial	19.3	x	13	848	1,710	5	36.0%
SUB-TOTAL			**242**	**16,185**	**42,243**	**116**	**47.8%**
Adventist Health Glendale	6.3		30	1,842	5,026	14	45.9%
Glendale Memorial Hospital and Health Center*	9.5		24	1,650	4,664	13	53.2%
Children's Hospital of Los Angeles*	11.7		-	-	-	-	-
Kaiser Foundation Hospital- Los Angeles	12.5		27	3,085	4,522	12	45.9%
Kaiser Foundation Hospital- Baldwin Park	14.4		53	3,259	5,315	15	27.5%
TOTAL			**376**	**26,021**	**61,770**	**169**	**45.0%**

Source: OSHPD Disclosure Reports

Includes Alternate Birthing Centers

* 2019 Data

- Within the service area, the Hospital provided 23% of licensed obstetrics beds and reported approximately 23% of the 16,185 discharges among hospitals that are located in the service area; and

- Adventist Health White Memorial had the second most discharges among hospitals located in the service area with 3,445.

Neonatal Intensive Care Capacity Analysis

As shown below, the occupancy rate for neonatal intensive care services among the service area hospitals is approximately 40% based on 184 licensed beds.

AREA HOSPITAL DATA : NEONATAL INTENSIVE CARE, FY 2018								
Hospital	Miles from Hospital	Within Service Area	Designation	Licensed Beds	Discharges	Patient Days	Average Daily Census	Percent Occupied
Huntington Hospital	**-**	**X**	**Level III**	**51**	**476**	**8,143**	**22**	**43.7%**
Alhambra Hospital Medical Center*	3.5	x	-	-	-	-	-	-
San Gabriel Valley Medical Center*	4.5	x	Level II	12	130	1,761	5	40.2%
Garfield Medical Center*	5.6	x	Level II	20	172	2,400	7	32.9%
USC Verdugo Hills Hospital*	7.9	x	Level II	6	40	331	1	15.1%
LAC+USC Medical Center*	8.5	x	Level III	40	351	5,977	16	40.9%
Adventist Health White Memorial	8.8	x	Level III	28	479	6,617	18	64.7%
Methodist Hospital of Southern California	10.0	x	Level II	17	134	1,097	3	17.7%
Beverly Hospital	18.6	x	Level II	10	40	196	1	5.4%
Foothill Presbyterian Hospital - Johnston Memorial	19.3	x	-	-	-	-	-	-
SUB-TOTAL				**184**	**1,822**	**26,522**	**73**	**39.5%**
Adventist Health Glendale	6.3		Level III	14	153	2,989	8	58.5%
Glendale Memorial Hospital and Health Center*	9.5		Level III	13	322	2,211	6	46.6%
Children's Hospital of Los Angeles*	11.7		Level IV	98	708	27,585	76	77.1%
Kaiser Foundation Hospital- Los Angeles	12.5		Level III	33	400	7,588	21	63.0%
Kaiser Foundation Hospital- Baldwin Park	14.4		Level III	20	280	3,166	9	43.4%
TOTAL				**362**	**3,685**	**70,061**	**192**	**53.0%**

Source: OSHPD Disclosure Reports

* 2019 Data

- The Hospital operates 51 licensed neonatal intensive care beds, making up approximately 28% of the service area's neonatal intensive care beds and recorded an occupancy rate of approximately 44%;

- The Hospital reported 476 inpatient hospital discharges and 8,143 patient days in FY 2018, resulting in an average daily census of approximately 22 patients; and

- The Hospital operates a Level III neonatal intensive care unit that cares for newborn infants with extreme prematurity who are critically ill or require surgical intervention.

Pediatrics Capacity Analysis

In FY 2018, there were 93 pediatric beds located within the service area with an aggregate occupancy rate of approximately 27%. The Hospital reported 25 licensed pediatric beds with an average daily census of seven patients and occupancy rate of 27%. However, because of a lack of fire safety sprinklers and to be in compliance with a CMS survey, the Hospital requested seven of the 25 beds be placed in suspense.

AREA HOSPITAL DATA: PEDIATRIC ACUTE, FY 2018							
Hospital	Miles from Hospital	Within Service Area	Licensed Beds	Discharges	Patient Days	Average Daily Census	Percent Occupied
Huntington Hospital	**-**	**X**	**25**	**1,147**	**2,511**	**6.9**	**27.4%**
Alhambra Hospital Medical Center*	3.5	x	-	-	-	-	-
San Gabriel Valley Medical Center*	4.5	x	-	-	-	-	-
Garfield Medical Center*	5.6	x	-	-	-	-	-
USC Verdugo Hills Hospital*	7.9	x	-	-	-	-	-
LAC+USC Medical Center*	8.5	x	25	1,057	3,024	8.3	33.0%
Adventist Health White Memorial	8.8	x	28	1,095	2,302	6.3	22.5%
Methodist Hospital of Southern California	10.0	x	-	-	-	-	-
Beverly Hospital	18.6	x	15	486	1,171	3.2	21.3%
Foothill Presbyterian Hospital - Johnston Memorial	19.3	x	-	-	-	-	-
SUB-TOTAL			**93**	**3,785**	**9,008**	**24.6**	**26.5%**
Adventist Health Glendale	6.3		-	-	-	-	-
Glendale Memorial Hospital and Health Center*	9.5		-	-	-	-	-
Children's Hospital of Los Angeles*	11.7		324	14,248	72,239	197.9	60.9%
Kaiser Foundation Hospital- Los Angeles	12.5		32	1,782	5,905	16.2	50.4%
Kaiser Foundation Hospital- Baldwin Park	14.4		-	-	-	-	-
TOTAL			**449**	**19,815**	**87,152**	**238.8**	**53.0%**

Source: OSHPD Disclosure Reports

* 2019 Data

- Just outside the service area, Children's Hospital of Los Angeles, located 12 miles from the Hospital, is licensed for 324 pediatric beds and has an occupancy rate of 61%; and
- The Hospital is also an EDAP (Emergency Department Approved for Pediatrics) with specially designed equipment for children and staff trained in pediatric emergency medicine and advanced life support.

Pediatric Intensive Care Capacity Analysis

In FY 2018, there were 23 pediatric intensive care beds located within the service area with an aggregate occupancy rate of approximately 28%. The Hospital reported 8 licensed pediatric intensive care beds with an average daily census of only one patient and an occupancy rate of 13%. Because of a continuing low census, the Hospital closed the unit in 2019.

AREA HOSPITAL DATA: PEDIATRIC INTENSIVE CARE FY 2018							
Hospital	Miles from Hospital	Within Service Area	Licensed Beds	Discharges	Patient Days	Average Daily Census	Percent Occupied
Huntington Hospital	**-**	**X**	**8**	**82**	**372**	**1**	**12.7%**
Alhambra Hospital Medical Center*	3.5	x	-	-	-	-	-
San Gabriel Valley Medical Center*	4.5	x	-	-	-	-	-
Garfield Medical Center*	5.6	x	-	-	-	-	-
USC Verdugo Hills Hospital*	7.9	x	-	-	-	-	-
LAC+USC Medical Center*	8.5	x	10	213	1,578	4	43.1%
Adventist Health White Memorial	8.8	x	5	126	425	1	23.2%
Methodist Hospital of Southern California	10.0	x	-	-	-	-	-
Beverly Hospital	18.6	x	-	-	-	-	-
Foothill Presbyterian Hospital - Johnston Memorial	19.3	x	-	-	-	-	-
SUB-TOTAL			**23**	**421**	**2,375**	**6**	**28.2%**
Adventist Health Glendale	6.3		-	-	-	-	-
Glendale Memorial Hospital and Health Center*	9.5		-	-	-	-	-
Children's Hospital of Los Angeles*	11.7		73	2,721	18,419	50	68.9%
Kaiser Foundation Hospital- Los Angeles	12.5		16	250	2,860	8	48.8%
Kaiser Foundation Hospital- Baldwin Park	14.4		-	-	-	-	-
TOTAL			**112**	**3,392**	**23,654**	**65**	**57.7%**

Source: OSHPD Disclosure Reports

* 2019 Data

- Children's Hospital of Los Angeles, 12 miles away has a licensed pediatric intensive care bed capacity of 73 beds that are about 69% occupied.

Psychiatric Care Capacity Analysis

There are 223 licensed psychiatric care beds located in the service area with an aggregate occupancy rate of 77%. The Hospital has 41 licensed psychiatric beds consisting of 26 general adult psychiatric beds, 12 psychiatric intensive care beds and 3 seclusion rooms. All the psychiatric care beds are in locked units.

The Hospital is the only provider of psychiatric intensive (isolation) care beds in the service area. Psychiatric intensive (isolation) care is inpatient mental health care, assessment and comprehensive treatment for individuals experiencing the most acutely disturbed phase of a serious mental disorder. The next closest hospital that offers psychiatric intensive (isolation) care services is Adventist Health Glendale located 6.3 miles away.

AREA HOSPITAL DATA: PSYCHIATRIC CARE BEDS, FY 2018							
Hospital	Miles from Hospital	Within Service Area	Licensed Beds	Discharges	Patient Days	Average Daily Census	Percent Occupied
Huntington Hospital[1]	**-**	**X**	**41**	**847**	**6,116**	**17**	**40.8%**
Alhambra Hospital Medical Center*	3.5	x	-	-	-	-	-
San Gabriel Valley Medical Center*	4.5	x	42	779	12,602	35	82.0%
Garfield Medical Center*	5.6	x	-	-	-	-	-
USC Verdugo Hills Hospital*	7.9	x	24	551	8,543	23	97.3%
LAC+USC Medical Center*	8.5	x	59	651	17,312	47	80.2%
Adventist Health White Memorial	8.8	x	33	2,185	9,555	26	79.1%
Methodist Hospital of Southern California	10.0	x	-	-	-	-	-
Beverly Hospital	18.6	x	24	551	8,543	23	97.3%
Foothill Presbyterian Hospital - Johnston Memorial	19.3	x	-	-	-	-	-
SUB-TOTAL			**223**	**5,564**	**62,671**	**171**	**76.8%**
Adventist Health Glendale[1]	6.3		80	2,107	17,109	47	58.4%
Glendale Memorial Hospital and Health Center*	9.5		49	1,309	6,413	18	35.8%
Children's Hospital of Los Angeles*	11.7		-	-	-	-	-
Kaiser Foundation Hospital- Los Angeles	12.5		68	3,680	18,871	52	75.8%
Kaiser Foundation Hospital- Baldwin Park	14.4		-	-	-	-	-
TOTAL			**420**	**12,660**	**105,064**	**288**	**68.3%**

Source: OSHPD Disclosure Reports

* 2019 Data

[1] Hospitals with Psychiatric Intensive (Isolation) Care Beds

- In the service area service area, the Hospital reported 847 psychiatric discharges which represented 15% of the total discharges in the service area; and

- Adventist Health White Memorial had the most discharges with 2,185.

Physical Rehabilitation Capacity Analysis

The Hospital is licensed to operate 24 physical rehabilitation beds. The Hospital is one of five general acute care hospitals in the service area that are licensed to operate physical rehabilitation beds. It reported an occupancy rate of nearly 55% and an average daily census of 13 patients.

AREA HOSPITAL DATA: PHYSICAL REHABILITATION CARE, FY 2018							
Hospital	Miles from Hospital	Within Service Area	Licensed Beds	Discharges	Patient Days	Average Daily Census	Percent Occupied
Huntington Hospital	**-**	**X**	**24**	**357**	**4,797**	**13**	**54.6%**
Alhambra Hospital Medical Center*	3.5	x	17	230	3,389	9	54.5%
San Gabriel Valley Medical Center*	4.5	x	-	-	-	-	-
Garfield Medical Center*	5.6	x	28	382	5,472	15	53.4%
USC Verdugo Hills Hospital*	7.9	x	-	-	-	-	-
LAC+USC Medical Center*	8.5	x	-	-	-	-	-
Adventist Health White Memorial	8.8	x	16	233	2,973	8	50.8%
Methodist Hospital of Southern California	10.0	x	30	644	7,900	22	71.9%
Beverly Hospital	18.6	x	-	-	-	-	-
Foothill Presbyterian Hospital - Johnston Memorial	19.3	x	-	-	-	-	-
SUB-TOTAL			**115**	**1,846**	**24,531**	**67**	**58.3%**
Adventist Health Glendale	6.3		28	601	7,166	20	69.9%
Glendale Memorial Hospital and Health Center*	9.5		14	326	3,459	9	67.5%
Children's Hospital of Los Angeles*	11.7		16	233	2,973	8	50.8%
Kaiser Foundation Hospital- Los Angeles	12.5		-	-	-	-	-
Kaiser Foundation Hospital- Baldwin Park	14.4		-	-	-	-	-
TOTAL			**173**	**3,006**	**38,129**	**104**	**60.2%**

Source: OSHPD Disclosure Reports

* 2019 Data

- Methodist Hospital of Southern California operated at the highest occupancy of 72% on 30 beds and an average daily census of 22 patients on 30 beds.

Emergency Services Analysis

In CY 2019, the Hospital reported 50 emergency treatment stations and nearly 78,000 total emergency department visits. The table below shows the visits by severity category for area emergency departments as reported by OSHPD's Automated Licensing Information and Report Tracking System.

EMERGENCY DEPARTMENT VISITS BY CATEGORY 2019

Hospital	Miles from Hospital	Within Service Area	ER Level/Trauma Level	Stations	Total Visits	Percentage Admitted	Minor	Low/ Moderate	Moderate	Severe w/o Threat	Severe w/ Threat
Huntington Hospital	**-**	**X**	**Basic/Level II**	**50**	**77,899**	**26.7%**	**4.8%**	**7.2%**	**27.5%**	**27.4%**	**33.1%**
Alhambra Hospital Medical Center	3.5	X	Basic	8	19,891	16.9%	4.1%	16.0%	39.4%	24.1%	16.3%
San Gabriel Valley Medical Center	4.5	X	Basic	12	26,882	15.6%	1.5%	19.0%	44.4%	23.9%	11.3%
Garfield Medical Center	5.6	X	Basic	21	24,782	25.7%	0.2%	11.2%	27.1%	30.0%	31.5%
USC Verdugo Hills Hospital	7.9	X	Basic	13	31,099	13.2%	17.8%	13.1%	24.1%	27.8%	17.2%
LAC+USC Medical Center	8.5	X	Comprehensive/Level I	106	156,368	13.8%	4.4%	21.8%	54.6%	17.8%	1.4%
Adventist Health White Memorial	8.8	X	Basic	28	66,539	16.2%	1.0%	16.5%	30.7%	28.7%	23.0%
Methodist Hospital of Southern California	10.0	X	Basic	26	48,368	15.2%	2.8%	13.0%	19.3%	59.8%	5.0%
Beverly Hospital	18.6	X	Basic	32	37,543	22.1%	8.5%	2.1%	23.8%	40.3%	25.3%
Foothill Presbyterian - Johnston Memorial	19.3	X	Basic	22	41,346	10.9%	0.0%	6.9%	44.4%	17.4%	31.3%
SUB-TOTAL				**318**	**530,717**	**17.2%**	**4.3%**	**14.3%**	**37.3%**	**27.7%**	**16.5%**
Adventist Health Glendale	6.3		Basic	39	52,730	24.1%	0.5%	6.4%	21.7%	32.9%	38.5%
Glendale Memorial Hospital and Health Center	9.5		Basic	16	37,193	15.5%	7.2%	22.8%	37.3%	21.6%	11.1%
Children's Hospital of Los Angeles	11.7		Basic/Level I Peds	39	104,656	8.4%	0.5%	18.1%	29.0%	28.3%	24.1%
Kaiser Foundation Hospital- Los Angeles	12.5		Basic	57	73,606	11.2%	6.3%	7.3%	30.0%	42.0%	14.3%
Kaiser Foundation Hospital- Baldwin Park	14.4		Basic	30	86,509	6.1%	5.5%	11.2%	30.2%	41.2%	12.0%
TOTAL				**499**	**885,411**	**13.8%**	**4.0%**	**13.7%**	**34.1%**	**30.3%**	**17.9%**

Source: OSHPD Alirts Annual Utilization Reports, 2019

- The Hospital admitted 27% of the patients seen at the emergency room. This is higher than the service area average of 17% of emergency department visits that resulted in an admission.

Emergency Services Capacity Analysis

Industry sources, including the American College of Emergency Physicians (ACEP), have used a benchmark of 2,000 visits per emergency station/bed to estimate the capacity of an emergency department. In 2018, the median number of visits per emergency station/bed for all hospitals in California was 1,765. Based upon the ACEP benchmark, in CY 2019, the Hospital's emergency department was operating at 78% of its 50–bed capacity.

EMERGENCY DEPARTMENT CAPACITY 2019								
Hospital	Miles from Hospital	Within Service Area	ER Level/Trauma Level	Stations	Total Visits	Capacity	Remaining Capacity	Ambulance Diversion Hours
Huntington Hospital	**-**	**X**	**Basic/Level II**	**50**	**77,899**	**100,000**	**22,101**	**1,419**
Alhambra Hospital Medical Center	**3.5**	X	Basic	8	19,891	16,000	(3,891)	556
San Gabriel Valley Medical Center	4.5	X	Basic	12	26,882	24,000	(2,882)	103
Garfield Medical Center	5.6	X	Basic	21	24,782	42,000	17,218	456
USC Verdugo Hills Hospital	7.9	X	Basic	13	31,099	26,000	(5,099)	1,126
LAC+USC Medical Center	8.5	X	Comprehensive/Level I	106	156,368	212,000	55,632	2,254
Adventist Health White Memorial	8.8	X	Basic	28	66,539	56,000	(10,539)	29
Methodist Hospital of Southern California	10.0	X	Basic	26	48,368	52,000	3,632	1,186
Beverly Hospital	18.6	X	Basic	32	37,543	64,000	26,457	164
Foothill Presbyterian - Johnston Memorial	19.3	X	Basic	22	41,346	44,000	2,654	67
SUB-TOTAL				**318**	**530,717**	**636,000**	**105,283**	**7,360**
Adventist Health Glendale	6.3		Basic	39	52,730	78,000	25,270	13
Glendale Memorial Hospital and Health Center	9.5		Basic	16	37,193	32,000	(5,193)	16
Children's Hospital of Los Angeles	11.7		Basic/Level I Peds	39	104,656	78,000	(26,656)	240
Kaiser Foundation Hospital- Los Angeles	12.5		Basic	57	73,606	114,000	40,394	2,121
Kaiser Foundation Hospital- Baldwin Park	14.4		Basic	30	86,509	60,000	(26,509)	4,156
TOTAL				**499**	**885,411**	**998,000**	**112,589**	**13,906**

Source: OSHPD Alirts Annual Utilization Reports, 2019

- Alhambra Hospital Medical Center, the closest hospital to the Hospital, operated at 124% of capacity. Three others of the ten hospitals in the service area operated over capacity including San Gabriel Valley Medical Center (112% of capacity), USC Verdugo Hills Hospital (120% of capacity), and Adventist Health White Memorial (119% of capacity); and

- Service area hospitals reported over 7,300 hours of diversion in CY 2019. When a hospital goes on diversion, incoming ambulances are diverted to other hospital emergency department departments. Hospitals may go on diversion for a variety of reasons including high volume, insufficient staffing or physician availability, unavailable intensive care beds or operating rooms etc.

Summary of Interviews

In August and September of 2020, interviews were conducted by telephone and video conference with representatives of the Hospital and Cedars-Sinai, as well as physicians and other community representatives. The purpose of the interviews was to gather information from area healthcare professionals and community members regarding any potential impact on healthcare availability and accessibility as a result of the proposed transaction. The list of individuals who were interviewed is located in the Appendix of this report. The major findings of these interviews are summarized below.

Reasons for the Proposed Transaction

Those interviewed cited multiple reasons for the transaction, including the following:

- The Hospital has been losing money on operations over recent years and has only had a positive net income in the recent past because of the contributions of non-operating income. However, the Hospital also had a negative net income in 2018, and is continuing to experience financial challenges that have been further aggravated by the COVID-19 pandemic. As a result of financial pressures, the Hospital is concerned that it may not be able to fund long term capital needs for information technology, seismic related building improvements, ambulatory service expansion, physician recruitment to its medical foundation, and population health programs. A projection of 10-year cash flows revealed that while the Hospital may be able to fund many of its planned capital requirements, any unexpected shifts in the market, increased competition, COVID-19 or other pandemics, major earthquakes, or other significant events could jeopardize those plans.;

- Healthcare providers in the Los Angeles area are increasingly consolidated and represented by larger and more integrated healthcare systems including Kaiser Permanente, Providence, Adventist Health, Dignity, PIH Health, and UCLA Health. The Hospital Board and management believe these health systems have competitive advantages including size, geographic coverage, expanded ambulatory services, ability to access capital, and more developed physician alignment models. The Hospital would be at a competitive disadvantage if it were to remain an independent, standalone hospital provider;[21]

- The Hospital lacks the ability to attract new physicians to the community without a stronger physician alignment structure that offers a competitive alternative to Kaiser Permanente, larger medical groups, competitor medical foundations and faculty practice plans;

[21] This report does not express an opinion one way or the other as to whether this reason given by interviewees is in fact true or how it might affect healthcare consumers.

- The Hospital lacks the size and scale to fund investment in new technologies, population health programs and clinical initiatives to most effectively and efficiently benefit the community;

- An affiliation with Cedars-Sinai will help assure the financial viability of the Hospital and can provide patients access to increased clinical expertise, sub-specialty care and innovations in care; and

- The Board members interviewed believed that it was better to seek an affiliation partner while the Hospital was still in a position of organizational strength. The Board was also concerned that there may be fewer opportunities in the future to become affiliated with a health system of their preference.

Importance of the Hospital to the Community

According to all who were interviewed, the Hospital is a critically important provider of healthcare services to the local community. In its service area, the Hospital holds the largest market share and is the market leader in the majority of clinical service lines. Some of the programs and services that were mentioned in the interviews as especially important include the following:

- Emergency and Level II trauma services;
- Obstetric and Level III neonatal intensive care services;
- Cardiovascular services, including designation as a STEMI Receiving Center;
- Behavioral health and psychiatric services;
- Intensive care services;
- Neurology and neurosurgical services, including certification as a Comprehensive Stroke Center;
- Oncology services;
- Orthopedic services;
- Graduate Medical Education;
- Senior Care Network;
- Women's health services;
- Pediatric services, including designation as an Emergency Department Approved for Pediatrics;
- Planning and care for COVID-19 patients;
- Provision of inpatient services for Shriners for Children Medical Center – Pasadena;
- Community benefit services for the community; and
- Public health relationship with the City of Pasadena for COVID-19, pulmonary clinic, emergency preparedness, and maternal and child health services.

If the Hospital does not maintain its current level of healthcare services, significant availability and accessibility issues would be created for residents of the communities served by the Hospital.

Selection of Cedars-Sinai Health System for the Proposed Transaction

The Board of Directors concluded that as a result of the growing needs of the community and the changing healthcare market, the Hospital needed to become formally affiliated with a health system that has the size, financial capability, clinical expertise and support infrastructure necessary to continue and enhance the services it provides to the local community and remain competitive in the long-term. The members of the Hospital's management team and Board who were interviewed indicated that a number of factors were considered in selecting Cedars-Sinai for the transaction, including the following:

- Compatibility of mission, vision, and culture;
- Vision as an integrated delivery system;
- Financial strength and access to capital;
- Cedars-Sinai support for the Hospital's long-range capital plan;
- Ability to support the development of an electronic health record using the EPIC electronic health record system and Cedars-Sinai IT personnel;
- Academic status and strength of clinical programs;
- The Cedars-Sinai model of governance encourages the continuation of local governance and decision-making;
- Expectation of continuing a local hospital fiduciary decision-making Board that would also have participation and influence in a new larger health system;
- Enhanced access to tertiary and quaternary level services;
- Support for women's reproductive health service;
- Access to research and clinical trials;
- Collaboration among physicians and sharing of clinical best practices;
- Expectation of service expansion and increased innovation;
- Economies of scale and the ability of attain efficiencies due to scale and size;
- Improved purchasing and negotiating positions;
- Population health and care management initiatives;
- Strong brand and reputation;
- Ability to recruit and retain physicians and employees; and
- A record of a successful transaction experience with Torrance Memorial Medical Center.

Representatives from Cedars-Sinai explained that affiliating with the Hospital will provide the opportunity to become part of a larger integrated delivery system that will be better equipped to meet their respective missions and improve the health of the population of the greater Los Angeles area through strengthened clinical capabilities, access to capital, efficiencies, research, manpower, resources, and scale.

All of those interviewed expressed support for the selection of Cedars-Sinai and were not aware of any opposition from physicians, employees or the community. While still being supportive, some physicians did express concern that the physicians on medical staff who also have relationships with other health systems may be displaced by physicians affiliated with Cedars-Sinai.

Impact on the Availability & Accessibility of Healthcare Services

All interviewed believed that the affiliation would not have a negative impact on the availability or accessibility of healthcare services. In fact, it was believed that the affiliation with Cedars-Sinai would enhance the expansion of facilities, information technology, ambulatory services, physician recruitment, specialty services and operations and therefore, enhance access. Furthermore, Cedars-Sinai is committed to preserve existing services at the Hospital and sharing clinical best practices among the physicians at both institutions.

Assessment of Potential Issues Associated with the Availability or Accessibility of Healthcare Services

Importance of the Hospital to the Community

The Hospital is a critically important provider of healthcare services to the residents of the surrounding communities. The Hospital is essential for its provision of emergency, trauma, obstetrics, and mental health services to residents within the service area, as well as for the broader community. In addition, the Hospital provides specialized and tertiary services that are not available at many community hospitals, such as cardiothoracic surgery, neurology, neurosurgery, bariatric surgery, cancer care, mental health services, rehabilitation services, STEMI, comprehensive stroke, cancer, and level III neonatal intensive care. As the only Level II Trauma Center in the San Gabriel Valley, the Hospital treats over 1,400 patients each year for traumatic injuries. The Hospital has also been an important resource during the pandemic treating patients infected with COVID-19. Over the last year the Hospital has had varying numbers of COVID-19 patients reaching a census of almost 80 patients a day, and at times having the fourth highest volume in California.

Continuation as a General Acute Care Hospital

None of the parties to the transaction anticipate that there will be any reductions in the availability or accessibility of healthcare services as a result of the transaction. Furthermore, Cedars-Sinai has agreed to comply with the conditions set forth by the Attorney General. The Health System will also operate the Hospital as a general acute care hospital maintaining each of the following with the same types and levels of services as currently provided: level II trauma center, level III neonatal intensive care unit, comprehensive stroke center, STEMI receiving center, advanced cardiology and cardiovascular surgery programs, advanced robotic surgery, orthopedic services, oncology services, neurology services, GME programs, senior care network, women's health services, and end of life services.

Emergency Services

The Hospital is an important provider of emergency services to the residents of its surrounding communities. In FY 2019, the Hospital's 50 emergency treatment stations reported 77,899 emergency service visits, operating at 78% of capacity. Additionally, the Hospital's Level II Trauma Center is the largest in the region and the only Level II Trauma Center in the San Gabriel Valley.

Almost half of the emergency departments within the service area are operating close to or over 100% capacity. Some emergency departments in the area are overburdened and functioning beyond desirable capacity, including Alhambra Hospital Medical Center (124%), San Gabriel Valley Medical Center (112%), USC Verdugo Hills Hospital (120%), and Adventist Health White Memorial (119%). Collectively, service area emergency departments are

operating at 83% of total capacity. In addition, the Hospital's emergency department sees a greater percentage of high severity patients (56% of all emergency department visits are classified "Severe with Threat") when compared to service area hospitals overall. A higher percentage of patients are admitted through the Hospital's emergency department (27%) when compared to the service area hospitals overall (17%).

As a result of the uncertainties of the future of the ACA and healthcare reform, a widespread and potentially prolonged COVID pandemic, and aging demographics, utilization of the emergency department may increase.

Keeping the Hospital's Emergency Department open, and maintaining its Level II Trauma Center designation, is critical to providing emergency services within the Hospital's service area.

Medical/Surgical Services

The Hospital reported an occupancy rate of 59%, on its 372 licensed medical/surgical beds in FY 2018. LAC+USC Medical Center with 329 licensed medical/surgical beds is nine miles away and is operating at 99% capacity. Within the service area, the Hospital is the largest provider of medical/surgical services. Keeping the Hospital's medical/surgical beds available for use is important to meeting the needs in the Hospital's service area.

Intensive Care Services

The Hospital's 30 adult intensive care beds had an occupancy rate of about 66% in FY 2018. Intensive care services are important for supporting the emergency department, trauma center, and other surgical and medical services at the Hospital. The Hospital reported the second highest occupancy in the service area. Area hospitals are running at a combined occupancy rate of approximately 60% on 342 total intensive care beds. Maintaining intensive care services at the Hospital is important to ensure the accessibility and availability of intensive care beds in the service area. The importance of having ICU bed availability at the Hospital was highlighted by the needs in the community that were created by the COVID-19 pandemic.

Obstetrics/Perinatal Services

The Hospital has an occupancy rate of 56% on its 56 beds used for obstetrics services based on an average daily census of approximately 31 patients. With 3,558 reported deliveries in FY 2019, the Hospital held the largest market share in the service area in CY 2018, with approximately 23% of inpatient obstetrics discharges. The Hospital is a very important provider of obstetrics services to the local community.

Neonatal Intensive Care Services

In FY 2018, the Hospital operated 51 neonatal intensive care beds, had 476 discharges, and an average daily census of 22 patients. The Hospital maintains a Level III NICU with an occupancy rate of nearly 44%. Because the Hospital has nearly 3,600 deliveries and receives neonatal referrals from other hospitals due to its higher acuity Level III NICU, it is important to continue operating the NICU.

Pediatric Care Services

In FY 2018, the Hospital reported 25 pediatric beds with 1,147 discharges and an average daily census of only 6.9 patients resulting in an occupancy rate of 27%. The Hospital is one of four hospitals in the service area operating licensed inpatient pediatric beds and reported the second highest occupancy in its service area. However, due to facility safety issues, the Hospital placed seven of the 25 beds in suspense. Children's Hospital of Los Angeles with 325 pediatric beds and a 61% occupancy in CY 2018, is 12 miles away also has capabilities to meet the community needs for pediatric patients.

Rehabilitation Services

The Hospital reported an occupancy rate of 55%, on its 24 licensed physical rehabilitation beds in FY 2018. Within the service area, the Hospital is the third largest hospital provider of physical rehabilitation services. Keeping the Hospital's physical rehabilitation beds available is important to meeting the needs in the Hospital's service area.

Psychiatric Care Services

In FY 2018, the Hospital operated 41 adult psychiatric care beds where 26 are general psychiatric care beds, 12 are psychiatric intensive care beds, and 3 are seclusion rooms. Although the occupancy rate of the Hospital's psychiatric beds was only 40.8%, all of the other hospitals in the service area are operating above 79%. Due to the shortage of available psychiatric beds in the service area and in Los Angeles County overall, maintaining the current number of psychiatric beds at the Hospital at current licensure with the same type and/or level of services is critical to ensuring continued access for community residents. Furthermore, because the Hospital is only one of two area hospitals offering psychiatric intensive (isolation) care services, it is important that the Hospital continue operating these services to meet the needs of the community residents.

Reproductive Health Services

The Hospital is an important provider of a range of healthcare services for women. Neither the Hospital nor Cedars-Sinai have restrictions on the provision of any reproductive healthcare services. No changes on the availability or accessibility of these services are expected as a result of the transaction. It is therefore expected that the Hospital will continue to provide reproductive services including tubal ligations and sterilizations.

HUNTINGTON HOSPITAL CY 2018 REPRODUCTIVE SERVICE BY DIAGNOSTIC RELATED GROUP		
MS DRG	**MS-DRG Title**	**CY 2018**
767	Vaginal Delivery with Sterilization and/or D&C	50
768	Vaginal Delivery with O.R. Proc Except Steril &/or D&C	43
776	Postpartum & Post Abortion Diagnoses without O.R. Procedure	39
778	Threatened Abortion	33
777	Ectopic Pregnancy	33
770	Abortion with D&C, Aspiration Curettage or Hysterotomy	33
779	Abortion without D&C	17
769	Postpartum & Post Abortion Diagnoses with O.R. Procedure	4
Total Discharges		**252**

Source: OSHPD Discharge Database, CY 2018, Excludes Normal Newborns
D&C is an abbreviation for Dilation and Currettage

Out of the eight diagnostic related groups for reproductive healthcare services, MS-DRG 767-Vaginal Delivery with Sterilization and/or D&C had the highest number of inpatient reproductive health discharges at the Hospital in CY 2018.

Effects on Services to Medi-Cal & Other Classes of Patients

Approximately 60.4% of the Hospital's inpatients are reimbursed through Medicare (41.6%) and Medi-Cal (18.8%). The Hospital currently participates in the Medicare and Medi-Cal program, and contracts with both of the County's Medi-Cal managed care plans (L.A. Care Health Plan and Health Net Community Solutions, Inc.) Cedars-Sinai has committed to maintaining the Hospital's Medicare and Medi-Cal managed care contracts outlined in the Affiliation Agreement. If the Hospital did not participate in the Medicare and Medi-Cal programs, eligible patients could be denied access to certain non-emergency healthcare services, thus creating a negative impact on the availability or accessibility for these patient populations.

Effects on the Level & Type of Charity Care Historically Provided

Many uninsured and under-insured individuals in the community rely on the Hospital for healthcare services. Between FY 2014 and FY 2018, the Hospital provided an average of $4,924,930 in charity care costs per year over the five-year period. Medicaid expansion and the ACA increased access to healthcare insurance coverage and therefore reduced the amount of charity care provided to uninsured patients at the Hospital. Charity care costs at the Hospital decreased from $7.8 million in FY 2014 to $4.8 million in FY 2018. In its application to the Office of the California Attorney General, Cedars-Sinai has agreed to provide an annual amount of charity care set forth by the California Attorney General.

Effects on Community Benefit

The Hospital has historically provided a significant amount of community benefit services, averaging approximately $34,661,711 per year over the last five years. Furthermore, in its application to the Office of the California Attorney General, Cedars-Sinai committed to providing an annual amount of community benefit services at such levels as required by the California Attorney General.

Effects on Staffing & Employee Rights

In the Affiliation Agreement, employees of the Hospital and its affiliates will remain employed at Closing. For 90 days after Closing Cedars-Sinai will not trigger obligations under federal or state WARN laws. For five years after Closing Cedars-Sinai will not reassign employees to other affiliates of Cedars-Sinai without the prior consent of the Hospital. If such reassignment ever occurs, employees will receive full credit for their years of service to the Hospital for purposes of eligibility and vesting, to the extent applicable. Neither the Hospital's employees nor Cedars-Sinai employees are represented by unions.

Effects on Medical Staff

As a result of the affiliation, no changes to the Hospital's medical staff are expected. If services are expanded at the Hospital, physicians from Cedars-Sinai may be added to the Hospital's medical staff.

Alternatives

If the proposed Affiliation Agreement is not approved, it is expected that the Hospital would evaluate alternative proposals from other health systems for a transaction.

Conclusions

Based on Cedars-Sinai's commitments outlined in the Affiliation Agreement and subsequent correspondence regarding the Hospital, the proposed transaction is likely to continue the availability and accessibility of healthcare services provided by the Hospital in the communities served. It is anticipated that access for Medi-Cal, Medicare, uninsured and other types of insured patients will remain unchanged. All persons interviewed expressed that because of the benefits of joining Cedars-Sinai, the Hospital would expand access to services with additional physicians, outpatient services and inpatient capabilities.

Potential Conditions for Transaction Approval by the California Attorney General

If the California Attorney General approves the proposed transaction, JD Healthcare, Inc. recommends that the following conditions be required in order to minimize any potential negative healthcare impact[22] that might result from the transaction:

1. For at least ten years from the Closing Date, the Hospital shall continue to operate as a general acute care hospital;

2. For at least ten years from the Closing Date, the Hospital shall maintain 24-hour emergency and trauma medical services at no less than current licensure and designation with the same types and/or levels of services, including the following:

    a. At a minimum, 50 emergency treatment stations;
    b. Designation as a Level II Trauma Center;
    c. Designation as a 5150 Receiving Facility, as defined by the Welfare and Institutions Code, Section 5150, for behavioral health patients under involuntary evaluation;
    d. Designation as an Emergency Department Approved for Pediatrics (EDAP);
    e. Designation as a Paramedic Base Station; and
    f. Certification as an Advanced Comprehensive Stroke Center.

3. For at least ten years from the Closing Date, the Hospital shall maintain the following inpatient and outpatient services at current licensure, types, and/or levels of services:

    a. Cardiac services, including three cardiac catheterization labs and the designation as a STEMI Receiving Center;
    b. Critical care services, including a minimum of 30 intensive care unit beds;
    c. Neonatal intensive care services, maintaining a Level III NICU including a minimum of 51 neonatal intensive care beds;

[22] These conditions do not address any conditions imposed, or any decision made as a result of, the competitive impact review of the Attorney General's Office.

d. Neurology and neurosurgery services;
e. Women's health services, including reproductive health and women's imaging services;
f. Pediatric services, including a designated area with at least 18 general acute care beds for pediatric patients;
g. Oncology services;
h. Behavioral health and psychiatric acute care services, including a minimum of 41 psychiatric acute care beds including 12 psychiatric intensive care beds and 3 seclusion rooms all with locked capabilities;
i. Orthopedic surgical services;
j. Advanced robotic surgical services; and
k. Perinatal services, including a minimum of 56 perinatal beds.

4. For at least ten years from the Closing Date, the Hospital shall maintain the same types and/or levels of women's healthcare services and mammography services, currently provided at the location below or an equivalent location:

    a. Jim and Eleanor Randall Breast Center, located at 625 S. Fair Oaks Blvd., Pasadena, California;

5. For at least five years from the Closing Date, the Hospital shall maintain the outpatient healthcare services provided at the locations below or a similar location with equivalent services:

    a. Admitting/Reg/Pre-Op Testing services, located at 625 S. Fair Oaks Blvd., Suite #355, Pasadena, California;
    b. Cancer services/Radiation therapy/CT services, located at 625 S. Fair Oaks Blvd., Suite #100, Pasadena, California;
    c. Heart & Vascular Lab, located at 625 S. Fair Oaks Blvd., Suite #345, Pasadena, California;
    d. Neurosciences/Sleep Center, located at 625 S. Fair Oaks Blvd., Suite #325, Pasadena, California;
    e. Rehabilitation-Physical, Occupational or Speech Therapy, located at 630 South Raymond Ave., Suite 340 and Suite 120, Pasadena, California; and
    f. Senior Care Network services, located at 837 S. Fair Oaks Ave., Pasadena, California.

6. For at least five years from the Closing Date, the Hospital shall maintain a charity care policy that is no less favorable than its current charity care policy (see Appendix for detail) and in compliance with California and Federal law and shall provide an annual amount of charity care equal to or greater than $4,924,930, (the "Minimum Charity Care Amount"). Alternatively, because of uncertainty concerning the impact of the COVID-19 pandemic and the future of the ACA on the need for charity care, the

California Attorney General could consider adjusting the required commitment to charity care based on available data from more recent time periods. An example would be to require a commitment based on a five-year rolling average of the most recent available data. For purposes herein, the term "Charity Care" shall mean the amount of charity care costs (not charges) incurred by the Hospital in connection with the operations and provision of services at the Hospital. The definition and methodology for calculating "Charity Care" and the methodology for calculating "cost" shall be the same as that used by OSHPD for annual hospital reporting purposes. The Minimum Charity Care Amount will be increased on an annual basis by the rate of inflation as measured by the Consumer Price Index for Los Angeles-Long Beach-Anaheim Average Base Period: 1982-84=100 (as published by the U.S. Bureau of Labor Statistics). Additionally, the Hospital Fair Pricing Policies, Health and Safety Code section 127405 gives the Hospital the flexibility to adjust eligibility for its discount payment and charity care policies. The Attorney General may consider imposing other charity care protections such as improving the charity care policy and disclosure requirements as was done for the Dignity Health (now Common Spirit Health) transaction issued on November 21, 2018;

7. For at least ten years from the Closing Date, the Hospital shall continue to expend no less than $34,661,711 annually in community benefit services (Minimum Community Benefits Amount). If the Hospital receives any grant funds for community benefit services, those grant funds may not be applied to the Minimum Community Benefits Amount. The Minimum Community Benefits Amount will be increased on an annual basis by the rate of inflation as measured by the Consumer Price Index for Los Angeles-Long Beach-Anaheim Average Base Period: 1982-84=100 (as published by the U.S. Bureau of Labor Statistics). In addition, the following community benefit programs shall continue to be offered and/or supported for at least five years from the Closing Date:

    a. Community Education and Support Groups;
    b. Community Organization Support;
    c. Community Outreach Services;
    d. Graduate Medical Education Program;
    e. Education for Nursing/ Nursing Students Program;
    f. Education for Other Health Professions;
    g. Huntington Ambulatory Care Center;
    h. Huntington Health eConnect; and
    i. Huntington Health Services Library.

8. For at least ten years from the Closing Date, the Hospital shall maintain its participation in the Medicare program, by maintaining a Medicare Provider Number and providing the same types and/or levels of emergency and non-emergency

services to Medicare beneficiaries, on the same terms and conditions as other similarly situated hospitals;

9. For at least ten years from the Closing Date, the Hospital shall be certified to participate in the Traditional Medi-Cal program, providing the same type, and/or levels of emergency and non-emergency services to Medi-Cal beneficiaries;

10. For at least ten years from the Closing Date, the Hospital shall maintain its participation in the Medi-Cal Managed Care program, providing the same types and/or levels of emergency and non-emergency services to Medi-Cal Managed Care beneficiaries, on the same terms and conditions as other similarly situated hospitals offering substantially the same services, without any loss, interruption of service, or decrease of quality, or gap in contracted hospital coverage, including continuation of the following contracts:

    a. Local Initiative Plan: L.A. Care Health Plan; and
    b. Commercial Plan: Health Net Community Solutions, Inc., or its successor.

11. For at least five years from the Closing Date, the Hospital shall maintain its current city/county contracts for the programs listed below subject to the request and agreement of the appropriate city/county:

    a. Trauma Center Service Agreement between the County of Los Angeles and the Hospital, for the provision of trauma center designation services;
    b. Master Agreement and all its components between the County of Los Angeles and the Hospital for Specialty Care Center Designations;
    c. Mental Health Services Agreement, Contract Allowable Rate - Fee For Service, Medi-Cal Acute Psychiatric Inpatient Hospital Services between the County of Los Angeles and the Hospital for reimbursement of Psychiatric Inpatient Hospital Services for Medi-Cal beneficiaries;
    d. Master Agreement between the County of Los Angeles and the Hospital for designation as a Comprehensive Stroke System;
    e. Master Agreement No. H-708207 between the County of Los Angeles and the Hospital for Specialty Care Center Designations as amended by Amendment No. 1; and
    f. Social Program Agreement (Contract # CP-05-377) dated March 5, 2020, between the County of Los Angeles and the Hospital, regarding a $5,000 grant for health and social service initiatives and programs.

12. For at least five years from the Closing Date, the Hospital shall maintain the Hospital services agreement (including Amendment I through Amendment VI) between Shriners Hospitals for Children on the same terms and conditions as indicated in the agreement and related amendments;

13. Cedars-Sinai and the Hospital shall commit the necessary investments required to maintain OSHPD seismic compliance requirements at the Hospital through 2030 under the Alfred Alquist Hospital Facilities Seismic Safety Act of 1983, as amended by the California Hospital Facilities Seismic Safety Act, (Health & Safety. Code, § 129675-130070);

14. Cedars-Sinai and the Hospital, within three years after Closing, will install Epic software for an enterprise integrated electronic health records system at the Hospital. Cedars-Sinai will fund the capital costs of this project from sources other than operating cash of the Hospital;

15. Cedars-Sinai and the Hospital will fund the $560 million long-range strategic capital plan through December 31, 2029. If the Hospital's days cash on hand falls below 60 days, then Cedars-Sinai will fund up to $300 million of the strategic capital plan from sources other than operating cash of the Hospital (e.g., borrowings or intercompany loans);

16. The Collis P. and Howard Huntington Memorial Hospital Trust will gift to the Hospital the legal title to the Hospital land;

17. The Trust will contribute two types of annual distributions to the Hospital through the year 2029, so long as the Hospital and its tax-exempt affiliates continue to be tax-exempt, the Hospital continues operating as a general acute care hospital, Cedars-Sinai continues to be the sole member of the Hospital, and Cedars-Sinai complies with its obligations under the Affiliation Agreement:

    a. First, the Trust will make annual distributions to fund the general medical education program at the Hospital. In 2021, the amount of this annual distribution is $5,300,000. The amount of this distribution will increase in subsequent years by 2.5% per year; and

    b. Second, the Trust will make annual distributions to fund the Hospital projects selected by the Trust and approved by the Hospital Board. The annual amount of this distribution will be 2.5% of the market value of certain cash and marketable securities owned by the Trust (that have a minimum hold or exit provision of less than six (6) months).

18. The Hospital Center shall maintain written policies that prohibit discrimination against lesbian, gay, bisexual, or transgender individuals and reproductive rights care.

Appendix

List of Interviewees

Last Name	First Name	Position	Organization
Albert, MD	Tim	Physician- Medical Foundation	Huntington Hospital
Battaglia	Steven	MD Chair of Credentials Committee	Huntington Hospital
Birnie	Allison	Emergency Department and Behavioral Health Director	Huntington Hospital
Bowles, MD	Harry	Chief of Staff	Huntington Hospital
Bruno	Diana	Interim Director of Obstetrics & Women's Health	Huntington Hospital
Chidester	Cathy	Director	Los Angeles County Emergency Medical Services
Cinexi	Gail	Vice President of Procedural & Support Services/Cardiac	Huntington Hospital
Cohen, MD	Robbin G.	Professor of Cardiothoracic Surgery Keck/USC	Huntington Hospital
Dikranian, MD	Armen	Chair of Surgery	Huntington Hospital
Dougherty	Christopher	Administrator	Shriners for Children Medical Center
Frieders	Bryan	Fire Chief/EMS	Pasadena Fire Department
Goh, MD	Ying-Ying	Director and Health Officer	City of Pasadena Public Health
Haderlein	Jane	Senior Vice President of Philanthropy, Public Relations & Community Benefits	Huntington Hospital
Havner	Ron	Board Member/Partnership Committee	Huntington Hospital
Jacobs	Richard	Executive Vice President & Chief Strategy Officer	Cedars-Sinai Health System
Kirchheimer	David	Board Member/Partnership Committee	Huntington Hospital
Laster, MD	Daniel	MD Chair of Medical Quality	Huntington Hospital
Lew, DO	Brandon	Emergency Department Medical Director/ Chief of Staff Elect	Huntington Hospital
Margaret	Martinez	Chief Executive Officer	ChapCare
Mathies, MD	Allen	Board Member	Huntington Hospital
Matsuda, MD	George	OB/GYN Physician	Huntington Hospital
Mohr	Steve	Chief Financial Officer	Huntington Hospital
Morgan, MD	Lori J.	Chief Executive Officer	Huntington Hospital
Obaid-Schmidt, MD	Amal	Trauma Physician	Huntington Hospital
Olson	Liz	Board Member	Huntington Hospital
Powers, MD	Jamie	Pediatrics Physician	Huntington Hospital
Priselac	Thomas	President and Chief Executive Officer	Cedars-Sinai Health System
Quinones Chino	Michelle	Board, Trustee, & Chair-Quality Comm.	Huntington Hospital
Rosenberg, MD	Peter	Secretary/Treasurer, Medical Executive	Huntington Hospital
Rudie	Sheryl	Executive Director of Ambulatory & Oncology	Huntington Hospital
Sanchez-Rico	Gloria	Chief Nursing Officer	Huntington Hospital
Shindy, MD	Waleed	Physician - Medicine Chair	Huntington Hospital
Studenmund	Jaynie	Board Chair, Trustee, Partnership Committee	Huntington Hospital
Takhar	Raj	Senior Vice President of Strategy	Huntington Hospital
Verrette, MD	Paula	Chief Medical Officer	Huntington Hospital
Yang, MD	Roger	Medical Director	Huntington Hospital

Health Systems and Hospitals

HEALTH SYSTEMS WITH MULTIPLE HOSPITALS THAT PROVIDED INPATIENT CARE FOR SERVICE AREA RESIDENTS	
Health System	**Hospitals**
Adventist Health Locations	Adventist Health Bakersfield, Adventist Health Feather River, Adventist Health Glendale, Adventist Health Hanford, Adventist Health Lodi Memorial, Adventist Health Simi Valley, Adventist Health St. Helena, Adventist Health Ukiah Valley, Adventist Health Vallejo, and Adventist Health White Memorial
AHMC	Alhambra Hospital Medical Center, Garfield Medical Center, Greater El Monte Community Hospital, Monterey Park Hospital, San Gabriel Valley Medical Center, and Whittier Hospital Medical Center
Cedars-Sinai	Cedars-Sinai Medical Center, California Rehabilitation Hospital, Cedars-Sinai Marina Del Rey Hospital and Torrance Memorial Medical Center
Dignity Health	California Hospital Medical Center - Los Angeles, Community Hospital of San Bernardino, Glendale Memorial Hospital and Health Center, Northridge Hospital Medical Center, St. Bernardine Medical Center, and St. Mary Medical Center - Long Beach
Emanate Health	Citrus Valley Medical Center-Inter Community Campus, Foothill Presbyterian Hospital-Johnston Memorial, and Citrus Valley Medical Center-Queen of the Valley Campus
Kaiser Foundation Hospital Locations	Baldwin Park, Downey, Fontana, Fremont, Fresno, Los Angeles, Manteca, Moreno Valley, Oakland/Richmond, Orange County - Anaheim, Panorama City, Redwood City, Riverside, Roseville, Sacramento, San Diego – Zion, San Francisco, San Jose, San Leandro, San Rafael ,Santa Clara, Santa Rosa, South Bay, South Sacramento, South San Francisco, Walnut Creek, West Los Angeles, and Woodland Hills
Keck Medicine of USC	Keck Hospital of USC, USC Kenneth Norris, Jr. Cancer Hospital, and USC Verdugo Hills Hospital
PIH Health	PIH Downey and PIH Whittier
Providence & St. Joseph Hospitals	Providence Holy Cross Medical Center, Providence Little Company of Mary Medical Center - San Pedro, Providence Little Company of Mary Medical Center Torrance, Providence Saint John's Health Center, Providence Saint Joseph Medical Center, Providence Cedars-Sinai Tarzana Medical Center, St. Joseph Hospital – Orange, and St. Mary Medical Center - Apple Valley
Southern California Hospital	Southern California Hosptial at Culver City and Southern California Hopsital at Hollywood
UCLA Health	UCLA Ronald Reagan UCLA Medical Center, and Santa Monica - UCLA Medical Center and Orthopedic Hospital

Source: OSHPD Discharge Database

Huntington Hospital Charity Care Policy

HUNTINGTON HOSPITAL
ADMINISTRATIVE POLICY & PROCEDURE

SUBJECT: FINANCIAL ASSISTANCE, PREVIOUSLY REFERRED TO AS "CHARITY CARE"	POLICY NO: 329	PAGE 1 of 14
AUTHORIZED APPROVAL:	EFFECTIVE DATE: 01/01/2019	SUPERCEDES/REPLACES 01/01/2016

PURPOSE

The purpose of this policy is to establish the criteria by which patients can apply for financial assistance and the process and guidelines used in that process in compliance with applicable financial assistance regulations.

POLICY

Huntington Hospital provides a reasonable amount of its services without charge to financially eligible patients who cannot afford to pay for care. All emergency and medically necessary services as defined by Medicare as services or items reasonable and necessary for the diagnosis or treatment of illness or injury, except for elective cosmetic procedures, can be considered for financial assistance. Financial assistance discounts will be written off based on a determination under this policy that the patient/other responsible party has demonstrated an inability to pay. However, in cases where it is determined that the account has not been paid and no demonstrated hardship under this policy has been provided, such accounts will be characterized as "bad debts" and collection of such accounts will be pursued, including referrals of such accounts to a collection agency.

DEFINITIONS

I. FINANCIAL ASSISTANCE previously referred to as CHARITY CARE, IS DEFINED AS FOLLOWS:

Financial Assistance is financial aid to a patient or responsible party and does not include discounts normally given to insurance policy holders, contract prices that are negotiated with insurance companies or other adjustments once the final bill has been created. When the patient is able to pay part of their bill, consideration will be given to writing off a portion of that account as partial financial assistance. Financial Assistance may also include assistance to patients who have incurred high medical costs as defined as yearly healthcare costs greater than 10% of household income.

Financial Assistance is not to be considered a substitute for personal responsibility and patients are expected to cooperate with Huntington Hospital's procedure for applying for Financial Assistance, and to contribute to the cost of their care based on their individual ability to pay.

REASONSABLE PAYMENT PLAN: means monthly payments that are not more than 10 percent of the patient's family income for a month, excluding deductions for essential living expenses. "Essential living expenses" means expenses of any of the following: rent or house payment and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child or spousal support, transportation and auto expenses, including insurance, gas, and repairs, installment payments, laundry and cleaning, and other extraordinary expenses.

If after a payment plan is established and there is a period of 90 days of no payment, the payment plan will be deemed to be no longer operative.

II. FINANCIAL ASSISTANCE PATIENTS ARE DEFINED AS FOLLOWS:

A. Uninsured patients (those without third party insurance, Medicare, Medicaid, or with injuries or conditions qualifying for coverage worker's compensation or automobile insurance for injuries) who do not have the ability to pay based on criteria described in the Eligibility section below.
B. Insured patients whose insurance coverage and ability to pay are inadequate to cover their out of pocket expenses.
C. Insured patient unable to pay for portion of the bill due to uncollected co-payments, deductibles and non-covered services. .
D. An insured or uninsured patient with high medical costs, whose household income does not exceed 350% of the federal poverty level, but whose out-of-pocket medical costs or expenses exceed 10% of their income for the prior year.
E. Any patient who demonstrates an inability to pay, versus bad debt, which is the unwillingness of the patient to pay.

III. AMOUNTS GENERALLY BILLED

The AGB, (Amounts Generally Billed) is defined as the maximum amount a patient who qualifies under the financial assistance policy for a discount which is equal to the average amounts historically allowed as a percentage of billed charges for all services provided under the Medicare program for a 12-month look back period calculated in accordance with IRC 501(r). Please see appendix A for the AGB calculation.

IV. COVERED ENTITIES

Only Huntington Hospital, which includes all services and areas listed on our license from the state of California including but not limited to inpatient and outpatient services, medication management clinic, Huntington Ambulatory Care Clinic, and the Senior Care Network, is covered under this financial assistance policy. Any ancillary physician billing that may be generated during a patient's stay, i.e. pathology, radiology, anesthesia services are not covered under this policy.

Emergency Room physicians are not covered under this financial assistance policy but have their own financial assistance policy per Health and Safety Code Sections 127450-127462. Please see appendix B for a list of providers that provide emergency and medically necessary services at Huntington Hospital.

PROCEDURES

I. NOTICE TO PATIENTS

A. Communication and notification of the availability of the financial assistance policy within the community of each hospital shall be in accordance with AB774, SB350, SB1276 and the federal PPACA.
B. The hospital will post notices informing patients of the hospital's financial assistance program. The notice will be posted in inpatient and outpatient areas of the hospital, including the

emergency department, billing office, patient admissions and registration offices and outpatient settings. The notice will include contact information on how a patient may obtain more information on the financial assistance program.

C. All patients will be informed of the hospital's financial assistance program at the time of admission or registration and will be offered a copy of the plain language version of the policy as well as an application for assistance.
D. The hospital will provide the financial assistance policy and application translated into the language spoken by the patient consistent with section 12693.30 of the Insurance Code and Health and Safety Code Section 127410(a).
E. All printed statements of accounts to the patient will include a summary of the financial assistance policy with contact information on how to obtain an application for assistance and the copy of the complete policy. A summary of the FAP, the application for assistance with instructions will be sent out with the first two statements of account to the guarantor.
F. The financial assistance policy and the plain language summary are available on the hospital's web site and/or the on-line patient portal.

II. ELIGIBILITY DETERMINATION:

A. Gross income should fall within established standards for determination of the federal poverty level, considering family or household size, geographic area and other pertinent factors. (See grid in Section IV).
B. The term "income" shall mean the annual family or household earnings and cash benefits from all sources before taxes, less payment made for alimony and child support. Proof of earnings may be determined by annualizing year-to-date family or household income. (see II E below for definition of Family or household)
C. Financial assets will be considered to the extent allowed by financial assistance regulations.
D. Employment status will be considered along with the projected availability of future earnings sufficient to meet the obligation within a reasonable period of time.
E. Family or household size will be considered. For this purpose, "Family or Household" for an adult patient is defined as spouse, domestic partner, dependent children under the age of 21, whether living at home or not and anyone else claimed as a dependent on the patient's federal tax return. For patients under the age of 18, "Family or household" is defined as the patient's parent(s) and/or caretaker relatives, other children under 21 years of age of the parent or caretaker relative and anyone else claimed as a dependent on the patient's federal tax return.
F. Other financial obligations, including living expenses and other items of a reasonable and necessary nature will be analyzed.
G. Patients whose out-of-pocket medical expenses exceed 10% of their prior year income and whose household income is 350% or below of the federal poverty level are eligible for financial assistance.
H. For financial assistance consideration, (charity care policy), monetary assets are included in determining eligibility. The first ten thousand dollars ($10,000) of a patient's monetary assets shall not be counted in determining eligibility, nor shall 50 percent of a patient's monetary assets over the first ten thousand dollars ($10,000) be counted in determining eligibility. Discounts under other financial discount policies do not count monetary assets in determining eligibility.
I. A letter is requested to be submitted, along with the other documentation, detailing the patient's need for financial assistance and stating a request for aid.
J. The amount(s) and frequency of the hospital bill(s) in relation to all of the factors outlined above will be considered.

K. There will be a credit report run to verify financial and related information that will assist in making a determination about the patient's eligibility for financial assistance.
L. Before making any determination of whether all or part of an account qualifies for financial assistance treatment and the amount of any write-off that should be applied, the patient shall be required to assist the Hospital in obtaining payment from and helping to assure that all other resources will be first applied, including Medi-Cal, welfare and other third-party sources.
M. Patients that are eligible for Government sponsored low–income assistance programs (e.g. Medi-Cal /Medicaid, Healthy Families, California Children's Services and any other applicable state or local low-income programs) to be automatically eligible for full financial assistance when payment is not made by the governmental program. For example, patients who qualify for Medi-Cal/Medicaid as well as other programs serving the needs of low-income patients (e.g. CHDP, Healthy Families, and some CCS) where the program does not make payment for all services or days during a hospital stay are eligible for Financial Assistance coverage. Under Huntington Hospital's financial assistance policy, these types of non-reimbursed patient account balances are eligible for full write-off as financial assistance. Specifically, included as financial assistance are charges related to denied stays or denied days of care. All Treatment Authorization Request (TAR) denials provided to Medi-Cal/Medicaid and other patients covered by qualifying low-income programs, and other denials (e.g. restricted coverage) are to be classified as Financial Assistance.
N. In cases where the patient is non-responsive and/or other sources of information are readily available to perform an individual assessment of financial need, i.e., existing eligibility for Medicaid or PARO score, these sources of information can be used to support and/or validate the decision for qualifying a patient for full financial assistance.
Unless a patient is informed otherwise, Financial Assistance provided under this Policy shall be valid for one full year beginning on the first day of the month of the screening. However, Huntington Hospital reserves the right to reevaluate a patient's eligibility for Financial Assistance during that one year time period if there is any change in the patient's financial status. Additionally, financial assistance provided to non-responsive patients based on other sources of information will not be valid for the full year, and will only be applicable for the eligible retroactive dates of service.

O. Patients will be notified in writing of the financial assistance approval amount. If a full discount was not approved the notification will indicate why and what additional steps if any that could be taken to obtain additional coverage.
P. The business office has the final authority to determine if reasonable efforts have been made to determine FAP eligibility.
Q. Patients completing Financial Assistance Applications are responsible for making reasonable effort to supply the information needed to make a determination. Failure to provide that information may result in a denial of the Financial Assistance Application.
R. To the extent the patient is determined to not be FAP eligible or at least not determined to be eligible at the time of the charge, (i.e. billing was issued prior to submitting a completed application), the patient may be charged in excess of the AGB.
S. Under no circumstances will a FAP application be considered in excess of 240 days from the date of first billing.

Financial Assistance status will be determined after the time of discharge by the Business Office after all required documentation is submitted by the patient or responsible party (see Section III.B.). There may be some instances where, because of complications unforeseen at the time of admission, the hospital charges turn out to be considerably greater than anticipated or estimated, and the patient is unable to pay the full amount. A patient may request a financial assistance

application form from a financial counselor at any time. If the patient is unable to complete the form, the patient's surrogate decision maker may assist in completing the form, or the patient may ask for assistance from the financial counselor.

Once the account is settled, the information used for determination will be kept on file in the Business Office.

Patients who are not eligible for financial assistance or are eligible to receive partial assistance which leaves them owing a balance due to the Hospital may request a payment plan from the Business Office.

In the event of non-payment of a discounted amount due under this financial assistance policy the hospital may engage in further collection activity. The details of the further collection actions can be found in the Billing and Collection policy. A copy of this policy can be obtained by contacting the business office.

III. FINANCIAL ASSISTANCE AND OTHER DISCOUNTS:

A. General Relief

General Relief patients usually do not qualify for Medi-Cal, because they are normally single, have no children, are unemployed and homeless. General Relief patients are considered financial assistance eligible patients.

B. Financial Assistance (full and partial)

To be eligible for financial assistance, a patient's or responsible family member's income must be at or below 350% of the federal poverty level. The patient or responsible family member must complete the financial assistance form and include the documentation as stated in Section IV.

- Patients whose income and monetary assets are below 200% of the federal poverty level will receive financial assistance equal to 100% of the Amounts Generally Billed as defined in Section III above.
- Patients whose income is between 200% and 250% of the federal poverty level will receive a financial assistance discount equal to 75% of the Amounts Generally Billed as defined in Section III above.
- Patients whose income is between 250% and 300% of the federal poverty level will receive a financial assistance discount equal to 50% of the Amounts Generally Billed as defined in Section III above.
- Patients whose income is between 300% and 350% of the federal poverty level will receive a financial assistance discount equal to 25% of the Amounts Generally Billed as defined in Section III above.

The remaining balance, for patients qualifying for partial financial assistance, may be paid in interest-free installments as mutually agreed upon between the patient and Huntington Hospital. If a payment plan cannot be agreed upon mutually, the "Reasonable Payment Plan" as defined will be applied. Payment will not be considered delinquent, nor will further collection activity occur, as long as any payments made pursuant to a payment plan are not more than 90 days delinquent under the terms of that plan. If an outside collection agency is utilized to

collect the unpaid debt, the agency agrees to abide by the requirements of this policy and will not garnish wages or place a lien on a principal residence.

C. Presumptive Eligibility for Financial Assistance

Huntington Hospital understands that certain patients may be non-responsive to the financial assistance application process. Under these circumstances, Huntington Hospital may utilize other sources of information to make an individual assessment of financial need. This information will enable Huntington Hospital to make an informed decision on the financial need of non- responsive patients utilizing the best estimates available in the absence of information provided directly by the patient.

Huntington Hospital will utilize a third-party (PARO) to conduct an electronic review of patient information to assess financial need. This review utilizes a healthcare industry-recognized model that is based on public record databases. This predictive model incorporates public record data to calculate a socio-economic and financial capacity score that includes estimates for income, assets and liquidity. The model is designed to assess each patient to the same standards and is calibrated against historical approvals for Huntington Hospital's financial assistance under the traditional application process.

The electronic technology will be deployed prior to bad debt assignment after in-house collection efforts and all other eligibility and payment sources have been exhausted. This allows Huntington Hospital to screen all patients for financial assistance prior to pursuing any extraordinary collection actions. The data returned from this electronic eligibility review will constitute adequate documentation of financial need under this policy and will include:

- PARO Financial Assistance Score – Score rank from 0 to 999. A lower score indicates a lower socioeconomic status, suggesting that the guarantor is more likely to require financial assistance. A higher score indicates a higher socioeconomic status suggesting that the guarantor is less likely to require financial assistance. The score is calculated from a series of index values used to define factors relating to liquidity, asset level, socio-economic standing and poverty. Based on historical approvals this score will be less than or equal to 554, as calculated by PARO.
- Federal Poverty Level (FPL) – The estimated income to household ratio compared to income thresholds determined by the US Department of Health and Human Services. This is used as a measure to determine if a person or family is eligible for assistance through hospital financial assistance programs, as well as various federal programs. This estimate is used as the secondary rule for qualification as it adds another level of likely liquidity. Based on historical approvals, this score will be less than or equal to 200% FPL, as reported by PARO.
- Residence Status – An indication of the guarantor's property ownership status. This estimate is used as the secondary rule for qualification as it adds another level of likely liquidity.

When electronic enrollment is used as the basis for presumptive eligibility, the highest discount levels will be granted for eligible services for retrospective dates of service only. If a patient does not qualify under the electronic enrollment process, the patient may still be considered under the traditional financial assistance application process.

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

D. Self-Pay/Uninsured Patient Discount

Huntington Hospital provides discount options for our self-pay/uninsured patient financial needs.

Uninsured patients will automatically be given a self-pay discount on charges for hospital based medical services. The amount of the discount is similar to Medicare rates. This discount is applied automatically at the time of billing.

- This discount is not available on elective pre-paid procedures which must be paid in full prior to the time of service (i.e. cosmetic procedures, bariatric procedures).
- This discount is not available if some form of insurance or third-party payer may be responsible for paying for the care provided (i.e. worker's compensation, third party liability company). The difference between amount received and total charges for patients with coverage from entities that have no contractual relationship with the hospital (out of network) and qualify for financial assistance under this policy shall be considered as uncompensated care. In addition, non-covered or denied services to insured patients who otherwise would qualify for financial assistance shall be considered as uncompensated care.

E. Prompt Pay Discount

Huntington Hospital also offers patients a 10% prompt pay discount, upon request, when the patient is willing to pay the entire outstanding balance of their bill. Prompt pay discounts are not applied to accounts which have a payment plan set-up. Prompt payment must be made within 30 days of the bill date.

IV. ELIGIBILITY STANDARDS:

A. Eligibility is based on the current years' Federal Poverty Guidelines which are issued annually by the Federal Register by the Department of Health and Human Services (HHS) https://aspe.hhs.gov/poverty-guidelines

V. OTHER FUNDING

A. Patient Services Assistance (Huntington Hospital Ambulatory Care Clinic (HACC) only)

When a patient receiving services from HACC cannot pay the bill, they may qualify for patient services funding. To qualify, the patient must:

- Live in the immediate area (i.e., Alhambra, Altadena, Arcadia, Duarte, Eagle Rock, Glendale, Monrovia, Pasadena, South Pasadena, Temple City)
- Apply for financial assistance as stated in Part II of this policy.

Funds donated to the hospital and restricted for financial assistance care purposes will be used to cover all or part of the self-pay obligation of patients who meet the donated fund qualifications.

B. Trauma Patients

To obtain trauma funds, Patient Financial Services must have the following:

- The Trauma Service County Eligibility (TSCE) form must be filled out and signed by the patient or responsible relative/party.
- If the patient is medically unable to sign and there is no family member available, the "Certificate when Patient Unable to Cooperate" form will be filled out by a financial counselor. The reason why the TSCE form could not be signed will be recorded. The preparer must sign their name on the line for Hospital Reviewer.

C. Victims of Crime (VOC)

Patients who are a victim of a crime could be eligible for State of California funding from the VOC program. The patient can apply at the District Attorney's office at the courthouse in Pasadena. The patient will not qualify if:

- There is insurance involved
- He/she initiated the crime
- He/she expires

VI. ITEMIZED BILLS

The final bill will be produced within ten days after discharge. The Business Office will automatically send the itemized bill. If a bill is not received, one can be obtained by calling the Business Office at (626) 397-5324.

If the patient wishes to request an itemized bill while still a patient in the hospital, they may do so by calling (626) 397-5324 or by asking a financial counselor. The patient should keep in mind that an itemized bill requested during their stay will be incomplete and only list charges that have been put in the system through midnight of the previous day.

VII. FINANCIAL ASSISTANCE FORM

The financial assistance form is located at the end of this policy.

Instructions:

Please print and complete the form. Attach your most recent paycheck stub or your previous year's tax form. In addition, please write a letter stating your circumstances and request for financial assistance. Then, mail the form, letter, and supporting documents to:

Huntington Hospital
Attn: Patient Financial Services, Customer Service
100 W. California Boulevard
P.O. Box 7013
Pasadena, CA 91109-7013

For questions regarding this form, please call: (626) 397-5324 from 8:00am-4:00pm M-F. Assistance completing the application, obtaining copies of this policy, or answering any related financial assistance questions can be obtained at the Help Hub in the lobby of the main hospital 8:00am-4:00pm M-F.

The approved application and any discounts can be applied to any subsequent hospital visits in the same calendar year the application was first approved.

The application and accompanying documents must be returned to business office within 10 days. If an additional time is needed to complete the application please call the business office.

Copies of all the financial assistance policies and the application can be found on our website www.huntingtonhospital.com

The polices are also available translated into the following languages: Spanish, Chinese, Armenian, Korean, Arabic, Vietnamese, Russian, Czech, and Farsi.

VIII. FINANCIAL ASSISTANCE APPLICATION REVIEW/APPROVAL PROCESS

a. A Financial Assistance Application will be reviewed by a business office financial counselor. If gross income is at or below 250% of FPG, the counselor may approve the financial assistance application, based on the information submitted with the application (proof of income required). If the gross income is more than 250% but less than 350% of FPG, an assessment for qualification of partial financial assistance based on income, assets, and medical debt load will be made by the financial counselor.
b. Financial Assistance Applications will be reviewed and approved, denied or returned to the patient with a request for additional information within ten (10) business days of receipt.
c. Collection agency requests for financial assistance or Financial Assistance Applications received from a collections agency shall be reviewed by a RBO Financial Counselor. The counselor shall follow the review process described in (b) above in determining ability to pay and approving partial, total or no financial assistance. Standard transaction approval levels will apply.
d. An approved financial assistance determination is applicable to all services referenced in the application AND services provided up to the end of the calendar year within which the

services were rendered, provided there is no change in the applications financial status that would warrant a reevaluation.

e. If financial assistance is approved at 100%, any patient deposits paid toward accounts approved for financial assistance must be refunded to the account guarantor. This does NOT apply to any third-party payments, including casualty insurance payments or settlements paid from attorney trust accounts. Those payments will be retained and financial assistance will be granted for the difference between gross charges and the sum of those excluded payments. Refunds under this provision will include interest at the rate prescribed in Section 685.010 of the Code of Civil Procedure. In the event the refund is $5 or less, no monies will be refunded.

VIII. DISPUTE RESOLUTION

In the event of a dispute, a patient may seek review from the Business Office Manager by calling (626) 397-5324.

SOURCES

Patient Financial Services
Compliance & Internal Audit Services

Financial Assistance Policy Summary

Huntington Hospital is dedicated to making healthcare services accessible to our patients and acknowledges the financial needs of our community who are unable to afford the charges associated with the cost of their medical care. Huntington Hospital provides Financial Assistance for qualifying patients who receive emergency or medically necessary care. Patients must complete an application, submit verification documents and meet the eligibility requirements listed below. This policy does not cover any other providers of service except Huntington Hospital.

Who is eligible for financial assistance?

Our program helps low-income, uninsured or underinsured patients who need help paying for all or part of their medical care. Patients are eligible for Financial Assistance when their family income is at or below 350% of the Federal Poverty Guidelines (FPG). Additional information may be requested and ultimately may affect the hospital's decision.

Patients who are eligible for Financial Assistance will not be charged more than amounts generally billed (AGB) for emergency or other medically necessary care to patients with insurance. (AGB as defined by IRS Section 501(r)). See appendix A in Financial Assistance Policy.

What does the program cover?

The Financial Assistance program covers medically necessary care provided at Huntington Hospital. Elective cosmetic services are not covered under this policy.

What will I need to provide to submit an application?

1) Previous year's income tax return
2) Current paycheck stubs for the last 2 months (Self/Spouse if applicable)
3) Letter of hardship (Description supporting your financial needs)

You must provide information about your family's income. Income verification is required to determine financial assistance. All family members 18 years or older in the household must provide their income. **There are detailed explanations on the financial assistance application.**

Who can I contact if I have questions filling out the application?

For Assistance on completing the application or to request a copy of the policy you may receive help at any of the following sources:

- At any inpatient, outpatient or emergency department patient intake areas.
- Call the business office at (626) 397-5324 between the hours 8:00am to 4:00PM M-F, (leave a message after hours). Live translation services are available
- The Help Hub in the main lobby of the hospital, M-F 8:00am – 4:00pm
- By mail at the address shown below
- Or you can download an application and copy of polices at www.huntingtonhospital.com

Is there language assistance available?

The policy and application forms are available in most languages spoken in our community and are available at the above mentioned locations. Interpreter services are also available.

Huntington Hospital
100 W. California Blvd.
PO Box 7013 Pasadena, Ca 91109-7013
Attention: Business Office

Reviewed and Updated Quarterly

APPENDIX A
CALCULATION OF AMOUNT GENERALLY OWED BY INDIVIDUALS
ELIGIBLE FOR FINANCIAL ASSISTANCE

The hospital limits the amount owed by individuals eligible under this Financial Assistance Policy who received services except for cosmetic and elective procedures to an Amount Generally Billed (AGB) to patients covered by Medicare. In addition, the hospital also limits the eligible patient's financial responsibility to less than total charges. The hospital shall periodically, at least once a year, update the AGB calculation and re-evaluate the method used. The AGB shall be based on all services provided to Medicare patients fully adjudicated as of the end of a recent 12-month look back period ending no more than 120 days prior to the effective date of the policy or every January 1st thereafter. The calculation of the current AGB is as follows:

Total Medicare Expected Reimbursement / Total Medicare Gross Charges = AGB Percentage
(current AGB is 15% effective January 1, 2019)

The eligible individual's financial responsibility is calculated as follows and applied to the patient liability only (excluding any portion assumed or paid by insurance or other entities on behalf of the patient):

Total Gross Charges for the Services Rendered X AGB Percentage = Patient Financial Responsibility

FAP Eligibility Percentage and the latest published Federal Poverty Level (FPL) Guideline

Annual Income is	FAP Eligibility %
Below 200% of FPL	100% or FREE
200% to less than 250% of FPL	75%
250% to less than 300% of FPL	50%
300% to 350%	25%
Greater than 350%	0%

Persons in Family or Household	100% Poverty Level Annual Income	200% Poverty Level Annual Income	250% Poverty Level Annual Income	300% Poverty Level Annual Income	350% Poverty Level Annual Income
1	$12,140	$24280	$30,350	$36,420	$42,490
2	$16,460	$32,920	$41,150	$49,380	$57,610
3	$20,780	$41,560	$51,950	$62,340	$72,730
4	$25,100	$50,200	$62,750	$75,300	$87,850
5	$29,420	$58,840	$73,550	$88,260	$102,970
6	$33,740	$67,480	$84,350	$101,220	$118,090
7	$38,060	$76,120	$95,150	$114,180	$133,210
8	$42,380	$84,760	$105,950	$127,140	$148,330
For families with more than 8 persons, add for each additional person	$4,320	$8,640	$10,800	$12,960	$15,120

SOURCE: Federal Register, Vol. 83, No. 12, pp. 2642-2644

The AGB will apply to services received from the hospital inpatient and outpatient departments.

Appendix B

Dear Patients:

Huntington Hospital is very pleased that you and your primary care physician have shown such confidence in us as evidenced by this admission to the hospital. We realized that there are many options open to you in a free society and we are especially gratified that you considered us your care provider of choice.

In that spirit and to avoid possible future confusion we would like to advise you that although Huntington and your primary care physician may be contracted with your insurance carrier, there may be other "hospital-based" physicians (Anesthesiologist, Emergency, Hospitalists, Intensivists, Lab/Pathologist, Pediatrics, Radiologist) who may not be contracted with your carrier and from whom you may receive balance due statements separate from the hospital's statements to you.

If you should receive billing from the Anesthesiology, Emergency, Hospitalists, Intensivists, Pathology, Pediatrics, and/or Radiology groups and if you have any questions regarding their billings, we encourage you to contact them directly at the telephone numbers listed below. They will be able to explain all of the aspects of their billing methods and contractual relations (if any) with your carrier.

Anesthesiology

ABC Billing
8905 SW Nimbus Ave Ste 300
Beaverton, OR 97008
(800) 275 2152

Emergency Physicians

HMH Emergency Med Grp
PO BOX 60259
Los Angeles, CA 90060
(877) 346 2455

Hospitalists

Academic Hospitalists Med Grp
50 Bellefontaine St Ste 307
Pasadena, CA 91105
(626) 352 1444

Intensivists

Huntington Pulmonary MG
39 Congress St
Pasadena, CA 91105
(626) 486 0181

Lab/Pathology

Huntington Pathology Med Grp
5700 Southwyck Blvd
Toledo, OH 43614-1509
(800) 536 1197

OB Hospitalists

OBHG California PC
PO Box 6127
Greenville, SC 29606
(800) 967 2289

Pediatrics

CA Med Business Serv
PO Box 60049
Arcadia, CA 91066
(626) 821 1411

Radiation Oncology

Huntington Rad Onc Med Grp
PO Box 67808
Los Angeles, CA 90067
(310) 273 7365

Radiology

CA Med Business Serv
PO Box 60049
Arcadia, CA 91066
(626) 821 1411

Reviewed and Updated Quarterly

Huntington Hospital License

License: 930000372
Effective: 03/01/2020
Expires: 02/28/2021
Licensed Capacity: 619

State of California
Department of Public Health

In accordance with applicable provisions of the Health and Safety Code of California and its rules and regulations, the Department of Public Health hereby issues

this **License** *to*

Pasadena Hospital Association, Ltd

to operate and maintain the following **General Acute Ca e Hospital**

Huntington Memorial Hospital
100 W California Blvd
Pasadena, CA 91105-3010

Bed Classifications/Services
578 General Acute Care
56 Perinatal
51 Intensive Care Newborn Nursery
38 Intensive Care
25 Pediatric
24 Rehabilitation
12 Chemical Dependency Recovery
372 Unspecified General Acute Care
41 Acute Psychiatric (D/P)

Other Approved Services
Basic Emergency Medical
Cardiovascular Surgery
Nuclear Medicine
Occupational Therapy
Outpatient Services - Admitting/Reg./Pre-Op Testing at 625 S. FAIR OAKS AVE., SUITE #355, PASADENA
Outpatient Services - Cancer Center/Rad. Therapy/CT at 625 S. FAIR OAKS AVE., SUITE #100, PASADENA
Outpatient Services - Heart & Vascular Lab at 625 S. FAIR OAKS AVE., SUITE #345, PASADENA
Outpatient Services - Neurosciences/Sleep Center at 625 S. FAIR OAKS AVE., SUITE # 325, PASADENA
Outpatient Services - Rehabilitation – Physical, Occupational, or Speech Therapy at 630 South Raymond Ave. Suite 340, Suite 120, Pasadena
Outpatient Services - Senior Care Network at 837 S. FAIR OAKS AVE., PASADENA
Physical Therapy
Radiation Therapy
Respiratory Care Services
Social Services
Speech Pathology

(Additional Information Listed on License Addendum)

Refer Complaints regarding these facilities to: The California Department of Public Health, Licensing and Certification, L.A. Acute/Ancillary Unit, 3400 Aerojet Ave., Suite 323, El Monte, CA 91731, (626)312-1104

POST IN A PROMINENT PLACE

State of California
Department of Public Health
License Addendum

License: 930000372
Effective: 03/01/2020
Expires: 02/28/2021
Licensed Capacity: 619

Huntington Memorial Hospital (Continued)
100 W.California Blvd
Pasadena, CA 91105-3010

This **LICENSE** is not transferable and is granted solely upon the following conditions, limitations and comments:
12 Chemical Dependency Recovery beds suspended from 03/01/2020 to 02/28/2021.
7 Pediatric beds suspended from 03/22/2019 to 03/21/2020.
34 Unspecified General Acute Care beds suspended from 09/28/2019 to 09/27/2020.

Sonia Y. Angell, MD, MPH
State Public Health Officer & Director

Rose McDowall, Staff Service Manager I

Refer Complaints regarding these facilities to: The California Department of Public Health, Licensing and Certification, L.A. Acute/Ancillary Unit, 3400 Aerojet Ave., Suite 323, El Monte, CA 91731, (626)312-1104

POST IN A PROMINENT PLACE

Exhibit 3

Competitive Impact Conditions

Definitions

1. "And" means "and/or."
2. "Attorney General's Office" means the California Attorney General's Office, California Department of Justice, Public Rights Division, Healthcare Rights and Access Section.
3. "Cedar-Sinai" includes all persons or entities that deliver any healthcare services (e.g., hospitals, physicians, ambulatory surgery centers, urgent care centers, imaging centers, laboratories, hospice, etc.) and on whose behalf Cedars-Sinai Health System may, does, or will negotiate Managed Care Contracts with Payors or with Future Payors. Cedars-Sinai Health System refers to any California nonprofit corporation, its successors, domestic or foreign parents, divisions, joint ventures, affiliates, subsidiaries, and other organizational units of any kind that serves communities in the state of California in providing health care services by managing any network of hospitals, clinics, and physicians that specifically includes Cedars-Sinai Medical Center, located at 8700 Beverly Boulevard, Los Angeles, California 90048.
4. "Contract Administration" means the act or acts associated with compliance and implementation of final contract terms, such as payment monitoring, communication of Payor medical and administrative policies, utilization management, liaison to the business office, annual updates, and organizing Managed Care Contract-related budget information.
5. "Final Offer Arbitration" means a manner of arbitration whereby each party in a disputed matter submits its best and final offer to an arbitrator who is then required to choose what they believe is the best offer (sometimes referred to as "baseball arbitration").
6. "Huntington Hospital" includes all persons or entities that deliver any healthcare services (e.g., hospitals, physicians, ambulatory surgery centers, urgent care centers, imaging centers, laboratories, hospice, etc.) and on whose behalf Huntington Hospital does or will negotiate Managed Care Contracts with Payors or with Future Payors. Huntington Hospital refers to any California nonprofit corporation, its successors, domestic or foreign parents, divisions, joint ventures, affiliates, subsidiaries, and other organizational units of any kind that serves communities in the state of California in providing health care services by managing any network of hospitals, clinics, and physicians that specifically includes Pasadena Hospital (d/b/a Huntington Memorial Hospital), located at 100 W. California Blvd., Pasadena California 91105.
7. "Managed Care Contract Year" means a 12-month period in which a Managed Care Contract between Huntington Hospital and that Payor, or between Cedars-Sinai and that Payor where that contract covers Huntington Hospital, is in effect. The first Managed Care Contract Year shall begin the day that the contract's reimbursement rates or prices go into effect; subsequent Managed Care Contract Years shall begin 12 months after the previous Managed Care Contract Year began.
8. "Managed Care Contracts" means contracts and agreements for all healthcare services (e.g., inpatient, outpatient, physician, and laboratory services, etc.) provided by any or all

individual components of Huntington Hospital to any Payor, including but not limited to rates, definitions, terms, conditions, policies, and pricing methodologies (e.g., per diem, discount rate, or case rate, etc.) who sell any commercial, Medicare, and Medi-Cal healthcare plans of any kind or make any networks available to self-insured employers, union trusts, and/or state and local government entities. This term includes contracts and agreements negotiated with any independent physician associations (e.g., Heritage Provider Network ("Heritage") or HealthCare Partners, now known as Optum ("HealthCare Partners")), who in turn provide capitated services, under a limited or restricted Knox-Keane license from the Department of Managed Health Care, to any Payor who sells any commercial, Medicare, and Medi-Cal healthcare plans of any kind or make any networks available to self-insured employers, union trusts, and/or state and local government entities.

9. "Managed Care Contracting Information" means information concerning the negotiation, execution, provisions, and enforcement of Managed Care Contracts, or negotiations with a specific Payor or Future Payor for healthcare services of any kind and in any form, including but not limited to documents, materials, data, and knowledge of such; provided, however, that "Managed Care Contracting Information" shall not include (i) information that is in the public domain or falls in the public domain through no violation of these conditions or breach any confidentiality or non-disclosure agreement or provision with respect to such information by Cedars-Sinai or Huntington Hospital; (ii) information that becomes known to Cedars-Sinai or Huntington Hospital through a third party that discloses this information legitimately; (iii) information that is required by law to be publicly disclosed; or (iv) aggregated information concerning the financial condition of Huntington Hospital.
10. "Payor" shall include any company that provides healthcare insurance policies, capitated networks for inclusion in healthcare insurance policies, or makes networks accessible for L.A. residents with whom Cedar-Sinai and Huntington Hospital negotiate Managed Care Contracts, specifically including, but not limited to, Aetna Health of California, Aetna Health Management, Aetna Life Insurance Co., Anthem Blue Cross Inc./Blue Cross of California, California Physician Services (d/b/a Blue Shield of California), Cigna HealthCare of California, Inc., Cigna Health and Life Insurance Co., Heritage, HealthCare Partners, Health Net of California, Inc., The Local Initiative Health Authority for Los Angeles County (d/b/a L.A. Care Health Plan), United Healthcare of California, and their subdivisions, subsidiaries, successors, assigns, and affiliates.
    a. For purposes of these conditions, the term "Payor" does not include individually or collectively Kaiser Foundation Health Plan Inc., Kaiser Foundation Hospitals, The Permanente Medical Groups, and Kaiser Permanente Insurance Corporation.
    b. For purposes of these conditions, the term "Payor" shall exclude any commercial healthcare plans or networks co-branded with any healthcare provider aside from Huntington Hospital, which shall be administered by a Payor.
11. "Future Payor" shall include any new company that provides or intends to provide healthcare insurance policies, capitated networks for inclusion in healthcare insurance

policies, or makes networks accessible for L.A. residents and wishes to negotiate a Managed Care Contract directly with Huntington Hospital.

a. If a Future Payor does not have, and has an insubstantial likelihood of obtaining, a significant market presence for any commercial plan, or any Medicare or Medi-Cal Managed Care Plan, and if Cedars-Sinai is not also negotiating, or has not entered into, a Managed Care Contract with that Future Payor, Huntington Hospital shall notify the Attorney General's Office, and provide details, as to how that Future Payor meets those conditions. Upon notification, the Attorney General may release Huntington Hospital from the requirements of independently and separately negotiating a Managed Care Contract with the Future Payor contained in these provisions.
b. For purposes of these conditions, the term "Future Payor" does not include individually or collectively Kaiser Foundation Health Plan Inc., Kaiser Foundation Hospitals, The Permanente Medical Groups, and Kaiser Permanente Insurance Corporation.
c. For purposes of these conditions, the term "Future Payor" shall exclude any commercial healthcare plans or networks co-branded with any healthcare provider with the exception of Huntington Hospital, which shall be administered by a Future Payor.
d. Once a Future Payor enters into a Managed Care Contract with Huntington Hospital, that Future Payor shall become a Payor for purposes of these conditions.

12. "Reimbursement" means any payment to Huntington Hospital by a Payor, or by a self-insured or self-funded entity (e.g., employer, union trust, or government entity) through a Payor acting in an Administrative Service Organization (ASO) or a Third-Party Administrator (TPA) capacity, or by a member of a plan provided by that Payor or provided by a self-insured or self-funded entity with that Payor acting in an ASO or TPA capacity, for any healthcare service it provides under its Managed Care Contract for that Payor in any given Managed Care Contract Year under that contract.

Terms

Separate Negotiations and Firewalls for Huntington Hospital

1. Huntington Hospital and Cedars-Sinai shall negotiate all commercial, Medicare, and Medi-Cal Managed Care Contracts, including contracts for Covered California, with any Payor or Future Payor, separately and independently from each other.
    a. If a Payor or Future Payor voluntarily elects to negotiate jointly with Huntington Hospital and Cedars-Sinai for those services and then so notifies the Attorney General's Office separately in writing for each and every applicable joint negotiation, nothing in this set of conditions on separate negotiations and firewalls for Huntington Hospital shall prevent Huntington Hospital from negotiating a

Managed Care Contract for any or all healthcare services to be provided jointly by Huntington Hospital and Cedars-Sinai to a Payor or Future Payor.

2. Huntington Hospital shall not make any Managed Care Contract contingent on entering into any Managed Care Contract for Cedars-Sinai, and Cedars-Sinai shall not make any Managed Care Contract contingent on entering into any Managed Care Contract for Huntington Hospital.
3. Huntington Hospital shall not make any price, rate, or term of any Managed Care Contract contingent on agreeing to any price, rate, or term of any Managed Care Contract for Cedars-Sinai and Cedars-Sinai shall not make any price, rate, or term of any Managed Care Contract contingent on agreeing to any price, rate, or term of any Managed Care Contract for Huntington Hospital.
4. Huntington Hospital may not terminate any Managed Care Contract so as to re-set the length of that contract to match that of any Managed Care Contract of Cedars-Sinai and Cedars-Sinai may not terminate any Managed Care Contract so as to re-set the length of that contract to match that of any Managed Care Contract of Huntington Hospital.
5. Huntington Hospital shall continue to maintain a team of negotiators of Managed Care Contracts for Payors and Future Payors that will not overlap with, and otherwise shall be kept separate both from Cedar-Sinai's team of negotiators of Managed Care Contracts for Payors and Future Payors, and from any joint team of negotiators of Managed Care Contracts for both Huntington Hospital and for Cedars-Sinai for Payors and Future Payors who voluntarily elect such joint negotiations.
6. Cedars-Sinai shall continue to maintain a team of negotiators of Managed Care Contracts for Payors and Future Payors that will not overlap with, and otherwise shall be kept separate both from Huntington Hospital's team of negotiators of Managed Care Contracts for Payors and Future Payors, and from any joint team of negotiators of Managed Care Contracts for both Huntington Hospital and for Cedars-Sinai for Payors and Future Payors who voluntarily elect such joint negotiations.
7. Huntington Hospital's team of negotiators shall be known as the Huntington Hospital Negotiating Team for purposes of the conditions governing separate negotiations and firewalls for Huntington Hospital.
8. Cedars-Sinai's team of negotiators of Managed Care Contracts for Payors and Future Payors shall be known as the Cedars-Sinai Negotiating Team for purposes of the conditions governing separate negotiations and firewalls for Huntington Hospital.
9. Any joint negotiating team of negotiators of Managed Care Contracts for both Huntington Hospital and for Cedars-Sinai for Payors and Future Payors who voluntarily elect such joint negotiations shall be known as the Joint Negotiating Team.
10. The Huntington Hospital Negotiating Team shall be exclusively responsible for negotiating Managed Care Contracts for Huntington Hospital except when joint negotiations for Huntington Hospital and Cedars-Sinai are authorized pursuant to these conditions.
11. The Cedars-Sinai Negotiating Team shall be exclusively responsible for negotiating Managed Care Contracts for Cedars-Sinai except when joint negotiations for Huntington Hospital and Cedars-Sinai are authorized pursuant to these conditions.

12. The Joint Negotiating Team shall be exclusively responsible for negotiating Managed Care Contracts for Cedars-Sinai and for Huntington Hospital only when joint negotiations for Huntington Hospital and Cedars-Sinai are authorized pursuant to these conditions.
13. Huntington Hospital shall segregate and keep confidential, any and all of the Managed Care Contracting Information of Managed Care Contracts for Huntington Hospital from any and all of the Managed Care Contracting Information of Managed Care Contracts for Cedars-Sinai.
    a. However, the provision of this paragraph shall not be construed to require Huntington Hospital to have a separate and independent electronic system of any kind for storing and accessing information from Cedars-Sinai.
14. Cedars-Sinai shall segregate and keep confidential, any and all of the Managed Care Contracting Information of Managed Care Contracts for Cedars-Sinai from any and all of the Managed Care Contracting Information of Managed Care Contracts for Huntington Hospital.
    a. However, this provision of this paragraph shall not be construed to require Cedars-Sinai to have a separate and independent electronic system of any kind for storing and accessing information from Huntington Hospital.
15. Cedars-Sinai and Huntington Hospital shall segregate and keep confidential, any and all of the Managed Care Contracting Information of Managed Care Contracts that they are negotiating on a joint basis as authorized by these conditions, separate and confidential from any and all of the Managed Care Contracting Information of Managed Care Contracts for Huntington Hospital only, or any and all of the Managed Care Contracting Information of Managed Care Contracts for Cedars-Sinai only.
    a. However, the provision of this paragraph shall not be construed to require Cedars-Sinai or Huntington Hospital to have separate and independent electronic systems of any kind for storing and accessing information.
16. Any Managed Care Contracting Information related to Managed Care Contracts involving Huntington Hospital shall not be transmitted directly or indirectly to, or received by, the Cedars-Sinai Negotiating Team or the Joint Negotiating Team.
    a. However, the provision of this paragraph shall not operate to prevent the sharing of information involving costs, quality, patient mix, service utilization, experience data, budgets, capital needs, expenses, and overhead for Huntington Hospital with Cedars-Sinai itself.
17. Any Managed Care Contracting Information related to Managed Care Contracts involving Cedars-Sinai shall not be transmitted directly or indirectly to, or received by, the Huntington Hospital Negotiating Team or the Joint Negotiating Team.
    a. However, the provision of this paragraph shall not operate to prevent the sharing of information involving costs, quality, patient mix, service utilization, experience data, budgets, capital needs, expenses, and overhead for Cedars-Sinai with Huntington Hospital itself.
18. Any Managed Care Contracting Information related to Managed Care Contracts involving the Joint Negotiating Team shall not be transmitted directly or indirectly to, or

received by, the Huntington Hospital Negotiating Team or the Cedars-Sinai Negotiating Team.

a. However, the provision of this paragraph shall not operate to prevent the sharing of information involving costs, quality, patient mix, service utilization, experience data, budgets, capital needs, expenses, and overhead for Cedars-Sinai with Huntington Hospital or to prevent the sharing of information involving costs, quality, patient mix, service utilization, experience data, budgets, capital needs, expenses and overhead for Huntington Hospital with Cedars-Sinai.

19. Managed Care Contracts negotiated by the Huntington Negotiating Team shall only be administered by Huntington Hospital and any information involved in Contract Administration shall not be shared with Cedars-Sinai except insofar as such information involves costs, quality, patient mix, service utilization, experience data, budgets, capital needs, expenses, and overhead.
20. Managed Care Contracts negotiated by the Cedars-Sinai Negotiating Team shall only be administered by Cedars-Sinai and any information involved in Contract Administration shall not be shared with Huntington Hospital except insofar as such information involves costs, quality, patient mix, service utilization, experience data, budgets, capital needs, expenses, and overhead.
21. Managed Care Contracts negotiated by the Joint Negotiating Team shall be administered by Cedars-Sinai and Cedars-Sinai may request from any such joint negotiating team Managed Care Contracting Information as needed to administer these contracts.
    a. Provided that, however, Cedars-Sinai may not share any Managed Care Contracting Information involving any such Joint Negotiating Team with either the Huntington Negotiating Team or the Cedars-Sinai Negotiating Team, and provided that any personnel involved in such Contract Administration will not overlap with, and will kept separate from, any personnel involved in Contract Administration for Managed Care Contracts negotiated by the Huntington Negotiating Team or Managed Care Contracts negotiated by the Cedars-Sinai Negotiating Team.
22. Not later than ninety (90) days after the Closing Date of the Affiliation Agreement, Huntington Hospital and Cedars-Sinai shall implement procedures and protections to ensure that Managed Care Contracting Information for Huntington Hospital on the one hand, and Managed Care Contracting Information for Cedars-Sinai on the other hand, is maintained separate and confidential, including but not limited to:
    a. Establishing a firewall-type mechanism that prevents the Huntington Hospital Negotiating Team from requesting, receiving, sharing, or otherwise obtaining any Managed Care Contracting Information with respect to Cedars-Sinai and prevents the Cedars-Sinai Negotiating Team from requesting, receiving, sharing, or otherwise obtaining any Managed Care Contracting Information with respect to Huntington Hospital, including but not limited to the following provisions:
        i. Any firewall-type mechanism shall include confidentiality protections, internal practices, training, segregation of personnel, communication restrictions, data storage restrictions, protocols, and other system and

network controls and restrictions, all as reasonably necessary to make that firewall-type mechanism effective; and

ii. Any firewall-type mechanism shall also include measures by which Cedars-Sinai and Huntington Hospital shall (1) investigate any suspected material violation of any established policies and procedures; (2) develop and implement appropriate remedial training and/or disciplinary action for any substantiated violation; (3) adopt disclosure mitigation measures in the event of a breach; and (4) document and maintain records of reported firewall policy violations to be turned over to the Attorney General's Office upon demand.

b. Establishing and/or Maintaining a Contract Management System for the Huntington Hospital Negotiating Team that is segregated or clearly partitioned from the Contract Management System for the Cedar-Sinai Negotiating Team to ensure the confidentiality of Managed Care Contracting Information;

c. Establishing and/or Maintaining a Contract Management System for the Cedars-Sinai Negotiating Team that is segregated or clearly partitioned from the Contract Management System for the Huntington Negotiating Team to ensure the confidentiality of Managed Care Contracting Information;

d. Establishing and/or Maintaining a Contract Management System for the Joint Negotiating Team that is segregated or clearly partitioned from the Contract Management Systems for the Cedars-Sinai Negotiating Team and the Huntington Negotiating Team to ensure the confidentiality of Managed Care Contracting Information; and

e. Causing each of Huntington Hospital and Cedars-Sinai's employees with access to Managed Care Contracting Information to maintain the confidentiality required by these conditions, including but not limited to:

i. Requiring each employee to sign a statement that the employee will keep Managed Care Contracting Information confidential and not disclose it except as authorized by these conditions;

ii. Maintaining complete records of all such statements at Cedars-Sinai and at Huntington Hospital; and

iii. Providing statements annually from an authorized officer at Cedars-Sinai and an authorized officer at Huntington Hospital to the Attorney General's Office stating that the statements required by paragraph 22.e.i. have been signed and are being complied with by all relevant employees.

23. Nothing in this set of conditions on separate negotiations and firewalls for Huntington Hospital shall prevent the Huntington Negotiating Team from requesting, receiving, sharing, using, or otherwise obtaining Managed Care Contracting Information, or information regarding costs, quality, patient mix, service utilization, experience data, budgets, capital needs, expenses, and overhead as to Huntington Hospital.

a. Provided that while information regarding costs, quality, patient mix, service utilization, experience data, budgets, capital needs, expenses, and overhead as to

Cedars-Sinai may be shared with Huntington officers and directors on its board, such information shall not be shared with the Huntington Negotiating Team.

24. Nothing in this set of conditions on separate negotiations and firewalls for Huntington Hospital shall prevent the Cedars-Sinai Negotiating Team from requesting, receiving, sharing, using, or otherwise obtaining Managed Care Contracting Information, or information regarding costs, quality, patient mix, service utilization, experience data, budgets, capital needs, expenses, and overhead as to Cedars-Sinai.
    a. Provided that while information regarding costs, quality, patient mix, service utilization, experience data, budgets, capital needs, expenses, and overhead as to Huntington Hospital may be shared with Cedars-Sinai officers and directors on its board, such information shall not be shared with the Cedars-Sinai Negotiating Team.
25. Nothing in this set of conditions shall prevent the Joint Negotiating Team from requesting, receiving, sharing, using, or otherwise obtaining Managed Care Contracting Information as to those contracts that they negotiate, or information regarding costs, quality, patient mix, service utilization, experience data, budgets, capital needs, expenses, and overhead as to Cedars-Sinai and Huntington Hospital.
    a. Provided that, however, any member of the Joint Negotiating Team may not share any Managed Care Contracting Information with either the Cedars-Sinai Negotiating Team or Huntington Negotiating Team, or any information regarding costs, quality, patient mix, service utilization, experience data, budgets, capital needs, expenses, and overhead as to Cedars-Sinai with the Huntington Negotiating Team, or any information regarding costs, quality, patient mix, service utilization, experience data, budgets, capital needs, expenses, and overhead as to Huntington Hospital with the Cedars-Sinai Negotiating Team.
26. Within ninety (90) days of the Closing Date of the Affiliation Agreement, Huntington Hospital and Cedars-Sinai shall affirm to the Attorney General's Office that they will continue to maintain, as separate, non-overlapping negotiating teams, the Huntington Hospital Negotiating Team, the Cedars-Sinai Negotiating Team, and the Joint Negotiating Team, respectively, and identify the members of each negotiating team. Huntington Hospital and Cedars-Sinai shall provide annually, starting January 15, 2022, an update as to the identity of the members of each negotiating team and continue to affirm that they are maintaining these separate, non-overlapping negotiating teams.

Price Cap

1. For each Managed Care Contract that Huntington Hospital enters into or renews after December 4, 2020, the increase in Huntington Hospital's total reimbursement, as determined below, for each current Managed Care Contract Year as compared to the previous Managed Care Contract Year shall not exceed the increase in the permitted total reimbursement, as defined below, for each Managed Care Contract Year, minus any allowed savings permitted by Paragraph 5 of these conditions.

2. The increase in the permitted total reimbursement ("Allowed Increase") is defined as the maximum of the percentage change in the Index, as defined below, and as calculated over a 12-month period beginning 18 months before the current Managed Care Contract Year and ending six (6) months before the current Managed Care Contract Year ("Current Managed Care Contract Year") between the Current Managed Care Contract Year and the immediately preceding Managed Care Contract Year ("Previous Managed Care Contract Year") (e.g., if the Managed Care Contract for a Payor is entered into on January 1, 2024, the Allowed Increase for 2025 versus 2024 cannot be more than the 12-month percentage change in the Index) or four percent (4%), except for the first Managed Care Contract Year after execution of the Managed Care Contract in which event the Allowed Increase is defined as the percentage change in the Index, as defined below, and as calculated over a 12-month period beginning 18 months before the current Managed Care Contract Year and ending six (6) months before the Current Managed Care Contract Year between the Current Managed Care Contract Year and the Previous Managed Care Contract Year.
    a. The Index is defined for purposes of these conditions as the seasonally adjusted Consumer Price Index for Hospital Services in U.S. Cities as reported by the United States Bureau of Labor Statistics.
3. Huntington's total reimbursement shall be calculated by comparing the Current Managed Care Contract Year with the Previous Managed Care Contract Year ("Calculated Total Reimbursement") as follows:
    a. First, the volume and utilization of all healthcare services for both the Current Managed Care Contract Year and the Previous Managed Care Contract Year shall be calculated by determining volume and utilization of all healthcare services in the Baseline Managed Care Contract Year as defined below.
        i. The Baseline Managed Care Contract Year for all Managed Care Contracts that are renewed or entered into after 2022 shall be the immediately Previous Managed Care Contract Year prior to that year in which the Managed Care Contract is entered or renewed.
        ii. The Baseline Managed Care Contract Year for all Managed Care Contracts that are renewed or entered into in 2020, 2021, or 2022 shall be the Managed Care Contract Year ending in 2019.
    b. Second, the volume and utilization of all healthcare services for the Baseline Managed Care Contract Year shall be applied to all of the prices, pricing formulas, rates, and other price terms ("Price Schedule") for all healthcare services provided in the Current Managed Care Contract Year to determine the Calculated Total Reimbursement for the Current Managed Care Contract Year.
    c. Third, the volume and utilization of all healthcare services for the Baseline Managed Care Contract Year shall also be applied to the Price Schedule for all healthcare services provided in the Previous Managed Care Contract Year to determine the Calculated Total Reimbursement for the Previous Managed Care Contract Year.

d. The difference between the Calculated Total Reimbursement for the Current Managed Care Contract Year as calculated in Paragraph 3(b) of the this set of conditions under the Price Cap section ("Price Cap Conditions") and the Calculated Total Reimbursement for the Preceding Managed Care Contract Year as calculated in Paragraph 3(c) of the Price Cap Conditions, using the Price Schedule for the Current Managed Care Contract Year and the Price Schedule for the Previous Managed Care Contract Year ("Calculated Total Reimbursement Increase") cannot exceed the Allowed Increase as defined and calculated in Paragraphs 2 and 2(a) of the Price Cap Conditions.
e. Provided that, however, nothing in these conditions prevents a Payor or Future Payor from negotiating any provision in a Managed Care Contract that is more stringent that the Allowed Increase, or to the extent that Medicare Managed Care Plans or Medi-Cal Managed Care Plans require a price or cost cap more stringent than the Allowed Increase, from applying that more stringent price or cost cap here.
f. Examples of how these Price Cap Conditions, including the determination of the Calculated Total Reimbursement for the Current Managed Care Contract Year, the Calculated Total Reimbursement for the Previous Managed Care Contract Year, the Calculated Total Reimbursement Increase, and the Allowed Increase, are all provided in the Expert Report of Greg Vistnes, attached as Exhibit 4.

4. To the extent that the Allowed Increase is exceeded by the Calculated Total Reimbursement Increase for any Managed Care Contract Year, in comparing the Calculated Total Reimbursement for a Current Managed Care Contract Year with the Calculated Total Reimbursement for the Previous Managed Care Contract Year, Cedars-Sinai and Huntington Hospital shall reimburse that Payor or Future Payor for that excess in the Calculated Total Reimbursement Increase above the Allowed Increase within 60 (sixty) days after the close of any Managed Care Contract Year.
5. To the extent that the Calculated Total Reimbursement Increase for any Managed Care Contract Year, in comparing the Calculated Total Reimbursement for a Current Managed Care Contract Year with the Calculated Total Reimbursement for the Previous Managed Care Contract Year is less than the Allowed Increase for that Managed Care Contract Year, Huntington Hospital may apply the difference as an offset against any excess increase by a Calculated Total Reimbursement Increase over the Allowed Increase in any future Managed Care Contract Year for the duration of these Price Cap Conditions.
6. Huntington Hospital, a Payor, or Future Payor may resort to conditions one through three in the Arbitration of Disputes Under These Conditions section ("Arbitration Conditions") in the event of a dispute over whether the Allowed Increase was exceeded pursuant to these Price Cap Conditions.
7. Huntington Hospital may also resort to conditions one through three of the Arbitration Conditions in the event of a dispute over whether the Allowed Increase was exceeded pursuant to these Price Cap Conditions because the use of volume and utilization of services in the Baseline Managed Care Contract Year, as applied to the Price Schedules for the Managed Care Contract Year, would result in the Calculated Total

Reimbursement exceeding the Allowed Increase for that Managed Care Contract Year, because Huntington Hospital would be credited with payments for the execution of value-based designs, capitated arrangements, or other accountable-care like arrangements for some or all healthcare services pursuant to the Price Schedule for that Managed Care Contract Year.

8. Huntington Hospital shall notify the Attorney General's Office, and provide details if there will be a significant change in market conditions that will have a quantifiable and material adverse impact on Huntington Hospital's revenues such that a change to these Price Cap Conditions is required to enable Huntington Hospital to address those market conditions. Upon notification, the Attorney General's Office may alter or eliminate these Price Cap Conditions to address that quantifiable and material adverse impact on Huntington Hospital's revenues.
    a. A significant change in market conditions may include, for example, changes in law or new law that requires Huntington Hospital to increase its rates for all of its healthcare services immediately in all current Managed Care Contracts beyond the Allowed Increase.
    b. A significant change in market conditions may also include, for example, Huntington Hospital's plan to sign a Managed Care Contract with a Payor or Future Payor in which Huntington Hospital may exceed the Allowed Increase because the nature of that Managed Care Contract as an exclusive capitated contract, a value-base design, accountable care organization-type of arrangement, or similar design, may envision such a sharing of risk that capping the Calculated Total Reimbursement Increase with an Allowed Increase would serve as a material disincentive to entering into that contract.
9. The basis of any calculations applicable to any of these Price Cap Conditions shall be made available upon request to the Attorney General's Office to verify all amounts so calculated.

Arbitration of Disputes Under These Conditions

1. Any Payor or Future Payor may submit any disputes as to prices and terms of a Managed Care Contract with Huntington Hospital, Cedars-Sinai, or Huntington Hospital and Cedars-Sinai jointly in which that Payor or Future Payor claims that any proposed price or term of a Managed Care Contract is one that arises from the affiliation of Cedars-Sinai with Huntington and would not have been proposed but for that affiliation, or as to the refund owed by Huntington Hospital to a Payor under the Price Cap, as follows:
    a. First to mediation under the Commercial Mediation Rules of JAMS with a mediator experienced in managed care contracting negotiating who has not exclusively worked for healthcare payors or for healthcare providers, or if not available at JAMS, then to mediation under the Commercial Mediation Rules of the American Arbitration Association (AAA) with a mediator experienced in managed care contracting negotiating who has not exclusively worked for healthcare payors or for healthcare providers.

b. If the dispute cannot be reasonably settled by mediation, at the request of the Payor to a single arbitrator at JAMS, experienced in managed care contracting negotiating, who shall conduct binding arbitration in accordance with the commercial arbitration rules of JAMS, or if not available at JAMS, at AAA in accordance with the commercial arbitration rules of AAA, who shall conduct the arbitration in Los Angeles County at a location mutually agreed to by the Payor/Future Payor and Huntington Hospital or virtually as may either by agreed to by the Payor/Future Payor and Huntington Hospital, or as may be required by federal, state, or L.A. County executive orders, federal, state, or L.A. County laws, or federal, state, or L.A. County regulations or orders of any kind, in order to determine fair and reasonable prices and terms that would exist for Huntington Hospital, or for Cedars-Sinai, but for the affiliation of Huntington Hospital with Cedars-Sinai, or in order to resolve a disputed issue over whether the Price Cap was exceeded such that Huntington Hospital owes the Payor a refund of the reimbursement paid to it.
    i. The arbitrator shall be mutually agreed on by the Payor and Huntington Hospital or by the Payor and Cedars-Sinai if Cedars-Sinai is involved. In the event of a dispute over the arbitrator that cannot be reasonably resolved, the Attorney General's Office shall select the arbitrator from a list of two arbitrators each provided separately by the Payor and by Huntington Hospital or by Cedars-Sinai.
c. The arbitration shall be conducted as Final Offer Arbitration, unless the Payor/Future Payor and Huntington Hospital, or the Payor/Future Payor and Cedars-Sinai if Cedars-Sinai is involved, agree to an alternate manner of arbitration.
d. The costs of the arbitration (other than attorneys' fees, which shall be borne by the party that incurs them) shall be borne by the loser of Final Offer Arbitration. If the parties settle the matter prior to the issuance of the final decision by the arbitrator, the arbitrator shall assess costs, unless the parties agree as to the allocation of costs.
e. The existing Managed Care Contract between a Payor and Huntington Hospital, or between a Payor and Cedars-Sinai if Cedars-Sinai is involved, shall continue past the termination date in all respects, including as to those prices and terms in arbitration, until the arbitration concludes with a decision as to those prices and terms.
    i. Other prices and terms already negotiated between the parties with a resolution shall not be reopened after the arbitration has concluded as to those prices and terms submitted to the arbitrator.
f. The Price Cap conditions shall continue in effect regardless of whether any disputed issue over whether the Allowed Increase was exceeded is being arbitrated in accordance with these conditions.
g. The Attorney General's Office shall have a right in its discretion to provide a submission to the arbitrator stating its views as to the matter under arbitration.

h. Provided that, however, that neither the mediator nor the arbitrator shall have any responsibility or authority to resolve issues concerning any violation or possible violation of these conditions as the Attorney General's Office retains jurisdiction over those issues.

2. Huntington Hospital shall notify the Attorney General's Office of all requests for mediation or arbitration, within thirty (30) days of said request, and shall provide a full description of any mediation or arbitration within thirty (30) days of the conclusion of said arbitration or mediation, including the resolution of said mediation or arbitration, with any such notification or description being kept confidential by the Attorney General's Office to the fullest extent permitted by law.
3. Any agreement reached pursuant to mediation under these conditions or any arbitral award reached under these conditions shall be binding on Huntington Hospital and on Cedars-Sinai.

Notification of Payors

1. Not later than sixty (60) days the Closing Date of the Affiliation Agreement, Huntington Hospital shall notify all Payors with which it has a Managed Care Contract of these conditions.
2. Huntington Hospital shall send notification of the requirement set out in paragraph 1 of this section, and a copy of these conditions, to the Chief Executive Officer, the General Counsel, and the network manager of each such Payor by first-class mail or by email, with return receipt or confirmation of receipt requested, and keep a file of such receipt for three (3) years after these conditions become final.
    a. Complete records of these notifications shall be maintained at Huntington Hospital; and
    b. Huntington Hospital shall provide an officer's certification to the Attorney General's Office that these notification conditions have been implemented and complied with upon demand.

Annual Reports and Powers to Enforce Compliance

1. Starting January 15, 2022, and continuing every year thereafter, as well as other times as the Attorney General's Office may require, Huntington Hospital shall submit a verified written report to the Attorney General's Office setting forth in detail the manner and form with which it has complied and is complying with all of the conditions set out herein.
2. For the purpose of determining or securing compliance with these conditions, Huntington Hospital and Cedars-Sinai shall, upon five (5) days written notice to their headquarters address and subject to any claim of privilege, permit the Attorney General's Office to do the following:
    a. Access, during business office hours of Huntington Hospital and Cedars-Sinai and in the presence of counsel, to all facilities and access to inspect and copy all books, ledgers, accounts, correspondence, memoranda, calendars, and all other records and documents in its possession, or under its control, relating to any

matter contained in this Order, which copying services shall be provided by Huntington Hospital and Cedars-Sinai at the request of the Attorney General's Office and at their expense;

b. Interview current or former officers, directors, or employees of Huntington Hospital and Cedars-Sinai, or interview third parties, who may have counsel present, regarding matters directly or indirectly covered by these conditions; and
c. Obtain production of documents and information from Huntington Hospital and Cedars-Sinai relating to any matter contained in this Order.

General Provisions and Term of Conditions

1. These conditions shall be binding on Cedars-Sinai and Huntington Hospital and their successors, agents, employees, servants, trustees, and assigns.
2. These conditions shall not relieve Cedars-Sinai and Huntington Hospital of any obligation to comply with all federal, state, and local laws and regulations.
3. All notices and reports required to be sent to the Attorney General's Office under these conditions shall be sent via email and U.S. Mail to:

   Emilio Varanini
   Supervising Deputy Attorney General
   Healthcare Rights and Access Section, Public Rights Division
   Office of the California Attorney General
   455 Golden Gate Avenue, Suite 11000
   San Francisco, Ca. 94102
   Phone #: 415-510-3541
   E-mail: Emilio.Varanini@doj.ca.gov

4. These conditions shall terminate ten (10) years after January 15, 2021 unless the Attorney General in his, her, or their own discretion extend these conditions for another five (5) years.

Exhibit 4

Competitive Effects Analysis of the Proposed Cedars-Sinai Health System / Huntington Memorial Hospital Affiliation

Gregory S. Vistnes, Ph.D.
Charles River Associates

December 4, 2020

Competitive Effects Analysis of the Proposed Cedars-Sinai/Huntington Memorial Affiliation

I. QUALIFICATIONS AND SCOPE OF REPORT

A. Scope of report

I have been retained by the Office of the California Attorney General (OCAG) to provide an economic analysis of the competitive effects of the proposed affiliation between Cedars-Sinai Health System ("Cedars-Sinai" or "CSHS") and Huntington Memorial Hospital ("HM") in Los Angeles County,[1] and to assess the Conditions proposed by the OCAG.[2]

My economic analyses involves two significant aspects.[3] First, I have been asked to assess whether the proposed affiliation creates a risk of higher inpatient hospital prices, either due to a significant reduction in "direct competition" "between the affiliating hospitals *or* because of what are sometimes referred to as "cross-market effects." Second, I have been asked to assess the Conditions that the OCAG has proposed as a means of addressing concerns that the affiliation could cause prices to increase higher than would otherwise be the case.

This report sets forth my conclusions and the basis for those conclusions.

B. Qualifications

I am an economist with specialties in the fields of industrial organization and the economics of competition. I hold a Ph.D. in economics from Stanford University and a B.A. in economics from the University of California at Berkeley. I have published, made professional presentations, testified, and consulted in the areas of industrial organization, competition, and antitrust economics for over 30 years. A copy of my current curriculum vitae is provided in Appendix 1.

I am a Vice President in the Oakland, CA office of Charles River Associates ("CRA"), an economics and business consulting firm. At CRA, my work has focused almost exclusively on issues relating to competition and how different types of conduct (e.g., mergers, exclusive contracts, possible foreclosure) can affect competition. While at CRA, I have been retained by private parties, as well as by government competition authorities in the United States and Canada, to serve as their expert witness on antitrust and competition-related matters. I have also provided economic assistance to parties involved in private litigation regarding antitrust and competition-related matters.

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[1] More formally, HM is the Pasadena Hospital Association Ltd., a California nonprofit public benefit corporation d/b/a Huntington Hospital, and the Trustees of the Collis P. and Howard Huntington Memorial Hospital Trust.

[2] As part of my retention by the OCAG, I have also provided advice regarding those Conditions.

[3] This report focuses on likely price effects. Although the affiliation could also result in important benefits such as lower costs, access to care (other than how that might be affected by price), higher quality of care, or improved integration of services, this report does not address the existence, likelihood or magnitude of any such benefits or the extent to which the Conditions might affect those benefits. I am not aware, however, of any evidence from the parties demonstrating or quantifying how or why the Conditions would likely adversely affect any claimed benefits.

Prior to joining CRA, I held several senior positions in the government related to antitrust and competition policy. Immediately before joining CRA, I served as Deputy Director for Antitrust in the U.S. Federal Trade Commission's ("FTC's") Bureau of Economics. In that position, I was responsible for directing the economic analysis of all antitrust matters before the FTC and overseeing its staff of approximately 40 Ph.D. economists. Before that, I held several positions in the Economic Analysis Group of the U.S. Department of Justice's ("DOJ's") Antitrust Division, including Assistant Chief of the Economic Regulatory Section.

Throughout my career, I have been actively involved in analyzing competition in the healthcare industry, including serving as one of the principal authors of the DOJ/FTC *Statements of Enforcement Policy in Health Care*. My work in the healthcare field has also included providing economic analyses and advice regarding regulatory relief to address competitive concerns associated with hospital mergers, including the review of both proposed relief and reviews of the effectiveness of historically imposed relief.

I have also been active with respect to healthcare policy, including providing testimony at the FTC/DOJ *Joint Hearings on Health Care and Competition Law and Policy*, and speaking at numerous conferences regarding health care and healthcare policy. My work also includes publishing several articles in peer-reviewed journals regarding competition in the healthcare industry, including two widely cited articles describing the manner in which hospital mergers or affiliations should be analyzed to assess the likelihood of a direct reduction in competition,[4] and a third article that was one of the first to discuss how cross-market hospital mergers could affect price.[5]

II. SUMMARY OF OPINIONS

Based on my review and analysis of the available evidence, I reach the following conclusions:[6]

- Cedars-Sinai, either as a system or with respect to any of its individual hospitals, is not a significant direct competitor to Huntington Memorial. Thus, the proposed affiliation is unlikely to significantly reduce direct competition or raise what are often referred to as "horizontal" competitive concerns.

[4] Vistnes, G., "Hospitals, Mergers, and Two-Stage Competition," *The Antitrust Law Journal*, January 2000 (hereafter "Vistnes (2000)"); and Town. R. and Vistnes, G., "Hospital Competition in HMO Networks: An Empirical Analysis of Hospital Pricing Behavior," *The Journal of Health Economics*, September 2001 (hereafter "Town and Vistnes (2001)").

[5] Vistnes, G. and Sarafidis, Y., "Cross-Market Hospital Mergers: A Holistic Approach," *Antitrust Law Journal*, 2013 (hereafter "Vistnes and Sarafidis (2013)").

[6] This evidence includes my analysis of hospital and patient data provided by California's Office of Statewide Health Planning and Development (OSHPD), interviews of and data provided by several health plans and other parties operating in the Los Angeles region, my review of the relevant economic literature, a review of data and arguments presented by the affiliating parties, discussions with lawyers and economists at the U.S. Federal Trade Commission and the OCAG, and analyses of various public data sources. My conclusions, however, are subject to change in light of any additional evidence that I may review.

- The proposed affiliation between Cedars-Sinai and Huntington Memorial creates a risk of "cross-market" effects: that post-affiliation, prices will increase at one or more of the affiliating hospitals even though few patients would likely consider the affiliating hospitals to be "good substitutes" to each other.

The conclusion that the affiliation is unlikely to significantly reduce direct competition is unlikely to be controversial. The conclusion that there is a risk of cross-market effects, however, is more likely to be controversial and thus constitutes the principal focus of this report.

With respect to cross-market effects, this report reaches the following conclusions:

- The economic literature shows that cross-market effects are a legitimate economic concern with respect to hospital mergers and affiliations, with recent (albeit limited) economic research finding cross-market price effects as high as 17 percent.

- The economic literature identifies three principal theories of harm (i.e., mechanisms) by which the proposed affiliation might cause cross-market effects:
  - Traditional Tying ("TT") theories;
  - A Common Customer ("CC") theory;
  - A Change in Control ("CiC") theory.

- While posing a real *risk* of cross-market effects, the *likelihood*, and likely *magnitude*, of cross-market effects is unclear. Several "plus-factors" associated with the proposed affiliation, however, increase that risk. This report identifies the following plus-factors:
  - Both Cedars-Sinai Medical Center ("CSMC"), Cedars-Sinai's flagship hospital in downtown Los Angeles, and Huntington Memorial ("HM") likely have substantial market power;
  - There are likely many "common customers," defined as employers with employees that use both CSHS and HM;
  - Some (albeit not all) payers have expressed concerns consistent with one or more cross-market theories of harm;
  - Relative prices at CSMC and at HM are consistent with cross-market concerns;
  - Predictions about the future are not inconsistent with the past: there have been no previous affiliations involving CSHS in which cross-market effects would have been predicted, yet failed to materialize.

To address cross-market concerns that the affiliation will result in higher prices, the OCAG has set forth certain Conditions that include two key regulatory restrictions. These two restrictions will significantly reduce the risk that cross-market effects will result in higher prices:[7]

- The "Unbundling Requirement" generally prevents implicit or explicit linking of contract negotiations between CSHS hospitals and HM unless such linkages are requested by a payer. These restrictions significantly reduce concerns associated with the TT and CC theories, and provide an important secondary safeguard under the CiC theory.

- The "Price Cap" restriction limits the amount by which HM's prices can increase each year, significantly reducing concerns associated with the CiC theory, and providing important secondary safeguards under the TT and CC theories.[8]

III. OVERVIEW OF THE MARKET AND THE PROPOSED AFFILIATION

A. Overview of the parties

Table 1 provides an overview of characteristics of CSHS, HM, and other general acute care ("GAC") hospitals in the four-county Los Angeles region,[9] with the locations of those GAC hospitals shown in Figure 1.[10]

As shown, CSHS is a four-hospital system consisting of CSMC in Los Angeles, and affiliates Cedar-Sinai Marina del Rey ("Marina Del Rey"), Torrance Memorial Medical Center ("Torrance"), and Providence Cedars-Sinai Tarzana Medical Center ("Tarzana").[11] Of these, CSMC is CSHS's flagship hospital: an 889-bed teaching hospital offering some of the most

[7] The Conditions also include other provisions, including an Arbitration provision, Term provision, and Notification and Reporting provisions. The Arbitration provision sets forth the conditions and protocol under which disputes will be addressed, while the Term provision defines the period of time (10 years) that the Conditions will be in force and the conditions under which that term can be extended (a 5-year extension at the sole discretion of the OCAG). The Notification and Reporting provisions specify the types of information that CSHS is obligated to provide to the OCAG during the term of the Conditions. Based on my experience, these types of terms, and the overall duration of the Conditions, is typical.

[8] I understand that this Price Cap is similar to the price restrictions imposed on hospitals by the Massachusetts Attorney General with respect to hospital mergers in the Boston area) where the government was concerned that a merger would result in higher prices.

[9] This four-county region consists of Los Angeles, Orange, San Bernardino, and Riverside counties.

[10] Non-GAC hospitals include psychiatric hospitals, substance abuse hospitals, long-term care hospitals, and rehabilitation hospitals. Those non-GAC hospitals, as well as Kaiser's hospitals that do not contract with independent health plans such as Blue Cross or United Healthcare, play little or no role in assessing likely cross-market effects from the proposed affiliation.

[11] CSHS acquired Marina Del Rey Hospital in 2015, entered into an affiliation agreement with Torrance in 2018, and formed a joint venture with Tarzana in 2019. For more details, see the report prepared by JD Healthcare, Inc. on behalf of the Office of the California Attorney General, "Effect of the Affiliation Agreement between Huntington Hospital and Cedars-Sinai Health System on the Availability and Accessibility of Healthcare Services to the Communities Served by Huntington Hospital," September 28, 2020 (hereafter "2020 Health Impact Report").

complex and sophisticated medical services available. CSMC also offers a strong maternity services program (with over 6,000 births in 2019)[12] and has a patient mix that is generally attractive to commercial health plans and their members.[13]

HM is a 378-bed hospital located in Pasadena. HM offers a wide range of services including maternity services (with 3,375 births in 2019). While smaller than CSMC, HM is larger than many other nearby hospitals. Similarly, while not offering the full range of the most complex services (often referred to as "tertiary" and "quaternary" care), HM offers a limited range of those complex services. Thus, HM is typically viewed as larger, and offering more sophisticated services, than other nearby community hospitals.

CSMC and HM draw most of their patients from Los Angeles County: Figures 2 and 3 show the primary and secondary service areas ("PSA" and "SSA," respectively) for those two hospitals.[14] As shown, the service area for CSMC (particularly its SSA) is broader than the service area for HM, likely reflecting that CSMC has greater recognition among more distant patients than HM and offers more complex services that tend to attract more distant patients.

As shown in Figure 4, there is very limited overlap between the two hospitals' primary (or even secondary) service areas. In fact, neither of the two hospitals' PSAs even extend into the zip code in which the other hospital is located (although CSMC's PSA comes very close to including HM). This lack of overlap emphasizes that the two hospitals largely draw from different patient bases.

B. The proposed affiliation

CSHS and HM entered into an affiliation agreement in July 2020. Under this affiliation, HM anticipates joining CSHS's healthcare delivery system, with the parties claiming that the affiliation will improve healthcare quality and access throughout the communities of Los Angeles and the San Gabriel Valley.[15]

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[12] I highlight a hospital's provision of maternity services because of the importance of maternity services to many potential health plan enrollees, especially the younger population that can be among the most profitable to health plans. Maternity services also account for a very high percentage of commercial health plans' total member visits, further emphasizing the importance of those services as a differentiating factor when considering hospitals' relative importance to health plans and members, and thus to hospital competition.

[13] In 2019, approximately 44% of CSMC's patients were commercially insured, approximately 44% of patients were covered under the Medicare and less than 10% of patients were covered under the state's MediCal program.

[14] A hospital's PSA is the region accounting for 75% of the hospital's total discharges, while its SSA encompasses 90% of discharges. The service areas shown in Figures 2 and 3 are limited to commercial patients.

[15] I understand that CSHS was formed in part to add new members, that CSHS was contemplating expansion into additional geographic areas in Los Angeles County (including the Pasadena region in which HM competes) through membership partnerships, system patient locations, and access points. I also understand that one of the goals from that expansion would relate to "price" considerations. (See CSHS's Health System Strategic Plan, one of the affiliation-related filings made to the OCAG, pp. 518, 534 (available at: https://www.huntingtonhospital.org/wp-content/uploads/2020/07/California-Attorney-General-Submission-Final-7-22-2020_60mb.pdf) and the 2020 Health Impact Report.) I do not address, or offer an opinion regarding, whether the affiliation's claimed benefits are in fact

Under the proposed affiliation agreement, I understand that price and related contract negotiations at CSHS and HM will occur on a unified basis that simultaneously takes into account both hospital systems' interests. Thus, for the purposes of analyzing the possible effects on competition and prices, the affiliation can be treated as a merger.[16]

C. Overview of the hospital marketplace

As shown in Figure 1 and Table 1, there are many hospitals in the Los Angeles area. The large number of hospitals in this region (and dots on the map in Figure 1) can be quite misleading, however, when assessing the competitiveness of the hospital market.

In part, hospital competition is less than Figure 1 might first suggest because many of the hospitals identified in Figure 1 and Table 1 are co-owned and thus do not compete with each other. For example, five of the hospitals shown in Figure 1 are part of the Providence St. Joseph system and thus do not compete with each other.[17] Similarly, the University of California includes three hospitals in the region (Ronald Reagan UCLA Medical Center; UC Irvine Medical Center; and Santa Monica UCLA Medical Center), the University of Southern California includes three hospitals (Keck Hospital of USC; USC Verdugo Hills; and USC Cancer Hospital), and Memorial Health Services includes four hospitals (Children's and Women's Hospital in Long Beach; Long Beach Medical Center; Saddleback Medical Center; and Orange Coast Medical Center).

Competition among many of the hospitals identified in Figure 1 is also limited because of important differentiation between hospitals. Some of this differentiation pertains to differences in hospital characteristics that can limit competition. For example, CSMC, an 889-bed teaching hospital offering some of the most sophisticated medical services available as well as a large maternity program, likely faces very limited competition from nearby Olympia Medical Center, a 67-bed non-teaching hospital with a limited range of services (including no maternity services). Similarly, HM, a 378-bed teaching hospital offering a broad range of services including maternity services likely faces limited competition from nearby Alhambra Hospital, a 98-bed non-teaching hospital with limited services (including no maternity services).

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benefits for healthcare consumers, the likelihood that any or all of those claimed benefits will actually result, or whether the claimed benefits can only reasonably be realized through the proposed affiliation. Thus, I neither accept nor reject any CSHS's claimed affiliation motives. I note, however, that to the extent any of claimed benefits could be achieved absent the affiliation, they would not be deemed "merger-specific" and would thus not be credited as an offset to anticompetitive effects. (See, for example, the U.S. Department of Justice/Federal Trade Commission's 2010 *Horizontal Merger Guidelines* (hereafter "2010 Horizontal Merger Guidelines") stating, "The Agencies [the DOJ and FTC] credit only those efficiencies … unlikely to be accomplished in the absence of either the proposed merger …. These are termed merger-specific efficiencies.")

[16] For this reason, I will often use the terms "affiliation," "merger," "transaction," and "acquisition" synonymously. Similarly, I will sometimes refer to CSMC (or CSHS) as the "acquiring" hospital (or hospital system) and HM as the "acquired" hospital.

[17] This count excludes Tarzana which is part of the joint venture between Providence St. Joseph and Cedars-Sinai.

Geographic differentiation among hospitals also limits competition. Because traffic congestion can mean long travel times even between geographically proximate hospitals, and because commercial health plans recognize that enrollees typically do not to travel long distances for hospital care, many of the hospitals identified in Figure 1 likely provide little competition to each other.[18] For example, while CSMC may be similar in many respects to UC Irvine Medical Center, a large teaching hospital that offers a broad range of services (including a strong maternity program), UC Irvine is located almost 40 miles away, and more than a 45 minute drive time,[19] from CSMC. This distance between CSMC and UC Irvine likely makes them poor competitive alternatives to each other. The same is true of HM. Many of the nearby hospitals are differentiated in significant ways from HM, while hospitals that are more similar to HM are not particularly close.

IV. HORIZONTAL CONCERNS REGARDING DIRECT COMPETITION ARE LIMITED

Hospital merger analysis typically focuses on whether the merging hospitals are "direct competitors" engaged in what economists often refer to as "horizontal competition." Direct competition is said to exist when the merging hospitals compete in the same market with health plans and individual patients viewing the merging hospitals as potential substitutes to each other.[20]

As discussed below, the evidence indicates that the proposed affiliation between CSHS and HM are not likely significant direct competitors to each other, with HM likely not even competing in the same markets as CSMC.[21] Accordingly, the proposed affiliation is unlikely to reduce direct competition and have significant horizontal effects.

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[18] The finding that distance significantly affects competition among hospitals has been confirmed in numerous economic studies including Town and Vistnes (2001); Ho, K., "The Welfare Effects of Restricted Hospital Choice in the US Medical Care Market," *Journal of Applied Econometrics*, November 2006; Gowrisankaran, G., et al., "Mergers When Prices Are Negotiated: Evidence from the Hospital Industry," *The American Economic Review*, January 2015.

[19] All drive times are based on Google Maps and reflect the route calculated at the specific time the search was conducted. I rely on drive times calculated on Friday, November 20th, 2020 at approximately 8pm PST These reported drive times may substantially understate normal drive times, especially during rush hour traffic. These drive times may also be less than normal due to Covid-related reductions in traffic congestion.

[20] See Vistnes, G., "Hospitals, Mergers, and Two-Stage Competition," *Antitrust Law Journal*, 2000 (hereafter "Vistnes (2000)") for a more detailed discussion of how hospitals compete, and the importance of distinguishing between "first-stage competition" in which hospitals directly compete for inclusion in a health plan's provider network and "second-stage competition" in which hospitals compete for individual patients. That article discusses how patient preferences affect health plan preferences, and thus how first- and second-stage competition are related but not the same.

[21] I focus primarily on assessing direct competition between CSMC and HM because of the belief that, if direct competition between CSHS hospitals and HM exists, it is likely to be greatest between those two hospitals. More generally, however, other analyses not presented in this report confirm that there is not likely to be any significant direct competition between CSHS's other hospital affiliates and HM.

A. Payers generally do not view CSHS and HM as good alternatives

The extent to which HM and CSMC (or other CSHS hospitals) are direct competitors depends in significant part on patients' willingness to substitute between those hospitals. Interviews with payers consistently indicate that such substitution between CSHS and HM hospitals is unlikely: they view HM and each one of the CSHS hospitals as simply too far away from each other to be considered useful alternatives.[22]

This testimony – generally consistent across payers – provides important evidence CSMC and HM likely do not compete in the same market, and are not likely significant direct competitors to each other. Thus, evidence from payers indicates that the proposed affiliation is unlikely to pose significant horizontal concerns.

B. CSMC and HM are geographically distant and have limited patient overlap

Payers' view that HM and CSMC likely compete in distinct markets and provide minimal direct competition to each other is consistent with the evidence in Figures 2, 3 and 4 showing the general lack of service area overlap between CSMC and HM. [23]

Payers' view that HM and CSMC are not significant direct competitors is also consistent with analyses showing that the patients using CSMC have many closer alternatives than HM, and vice-versa.

To assess patients' alternatives to CSMC, I looked at each zip code in CSMC's primary and secondary service areas. In each of those zip codes, I then calculated the drive time and distance to each hospital in the Los Angeles area, and then calculated the average of those drive times and distances across all of those zip codes.[24] Those average drive times and distances are shown in Table 4. Not surprisingly, the closest hospital (on average) for CSMC patients is CSMC itself: on average, CSMC is 12.5 miles away and a 25-minute drive. Those CSMC patients would travel longer distances were they to switch to other hospitals, and Table 4 shows that there are many other hospitals that are much closer to CSMC's patients than HM. On average, HM is 22 miles and 29 minutes away from CSMC's patients, while there are 35 other hospitals that are closer to those patients than HM.

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[22] As shown in Tables 2 and 3, CSMC and HM are an approximately 20-mile drive distance and 31-minute drive time from each other. (Note that the driving distance from HM to CSMC in Table 2 (20.6 miles) is slightly different than the driving distance from CSMC to HM in Table 3 (19.7 miles) because Google Maps assigns travelers different routes depending on the direction they are traveling.)

[23] Although a service area overlap does not necessarily mean that two hospitals *are* significant competitors to each other, a lack of overlap is generally viewed as important evidence that the hospitals are *not* significant competitors. This asymmetry stems from the general recognition that hospital service areas generally overstate the area in which hospitals compete.

[24] This average was weighted by the number of CSMC commercial discharges from each zip code.

Table 5 similarly shows there are many other hospitals closer to HM's patients than CSMC. While Table 5 shows that HM is (on average) the closest hospital to HM's patients (10 miles and 17 minutes), CSMC is much further away (25 miles and 39 minutes) with 43 other hospitals closer to those HM patients than CSMC. Thus, this analysis of travel times and distances confirms that CSMC and HM are likely poor substitutes from the perspective of their respective patient bases, and thus not likely significant direct competitors to each other.

C. Diversion analyses indicate limited direct competition

Diversion analyses are a technique that economists commonly rely upon to assess the extent to which firms compete. In the context of hospital mergers, diversion analysis involves estimating a patient choice model that identifies individual patients' preferred ranking of hospitals (based on both patient and hospital characteristics), and then calculating where patients would go (i.e., where they would "divert to") if their first-choice hospital was unavailable to them.[25, 26] The greater the likely diversion between two merging hospitals, the stronger the evidence that the two merging hospitals are close substitutes to each other, and thus the greater the likely direct competition.

The diversion analyses I conducted confirm that HM and the CSHS hospitals are not significant direct competitors: diversion between HM and the CSHS hospitals is generally quite low, with diversion to other hospitals typically much higher.[27] Those low estimated diversions indicate that the hospitals are likely poor substitutes to each other, and thus provide only limited direct competition to each other.

- Table 6 shows that diversion from CSMC to HM is only 5.4 percent, with three other hospitals with significantly higher diversion estimates. The low diversion from CSMC to HM indicates that HM provides very limited direct competition to CSMC, while the higher

[25] These patient choice models estimate how a patient's choice of hospital depends on factors such as hospital characteristics (e.g., size and teaching status), the patient's zip code (which determines travel time from the patient's home to the hospital), the patient's age and sex, and the patient's medical condition. This model can be used to predict both a patient's "first choice" of hospital as well as their "second choice" if that first choice hospital is unavailable.

[26] To estimate the patient choice model, I use the approach described in Raval, D., et al., "A Semiparametric Discrete Choice Model: An Application to Hospital Mergers," *Economic Inquiry*, 2017. This approach allows for a more efficient estimation process than the standard logit approach that was first used to estimate patient choice models.

[27] The patient choice model and diversion estimates are based on OSHPD data for commercially insured patients (excluding Medicare Advantage and MediCal) in the Los Angeles area covering October 2018 through 2019. These data identify each patient discharged from a California hospital and include patient-specific information such as the admitting hospital, treatment, total charges, patient characteristics (e.g., age, race, sex, and 5-digit zip code where the patient lives), and patients' source of coverage (e.g., Traditional Medicare and Private Coverage.) These discharge data can be paired with other data from OSHPD and the American Hospital Association regarding characteristics of each hospital (e.g., location, staffed beds, teaching status, and number of admissions).

diversion to other several hospitals indicates that those other hospitals provide greater direct competition to CSMC.[28]

- Tables 7 through 9 show that diversion from other individual CSHS hospitals to HM is also low (under 4 percent). In aggregate, Table 10 shows diversion across the entire CSHS system to HM is just 4.1 percent. In contrast, there are five other hospitals with higher diversion estimates from the CSHS system, thus providing further evidence that HM provides very limited competition to the CSHS system, and much less than several other hospitals.
- Table 11 shows that diversion from HM to CSMC is only 8.4 percent, with diversion to the entire CSHS system just 9.8 percent.[29] Although diversion from HM is only higher at two other hospitals (Methodist with 12.2 percent and USC with 8.8 percent), the fact that the CSHS system only accounts for 9.8 percent of HM diversion means that HM faces a broad set of competitors and that, while individual competitors may only offer limited competition, they collectively offer substantial competition.

V. THE ECONOMIC LITERATURE SHOWS THAT CROSS-MARKET MERGERS CAN INCREASE PRICES

Having concluded that direct horizontal effects are unlikely, the remainder of the report focuses on assessing whether the proposed affiliation creates a risk of (non-horizontal) *cross-market* effects. Unlike direct effects analyses that consider how a merger of hospitals in the same market can affect price, cross-market effects analyses consider how a merger of hospitals in distinct markets across which there is little or no patient substitution can affect price.

Traditional economic analyses regarding cross-market mergers encompasses a large body of literature and typically focus on how a firm with market power in one market can employ tying, bundling, or other strategies to reduce competition in a second more competitive market.

More recently, economists have analyzed whether there are additional means by which a multi-market firm can reduce competition.[30] In this report, I focus on two specific theories that are most

[28] In general, the diversion statistic between the two merging hospitals is more informative about likely competitive effects than is the ranking of those diversions. Generally, diversion estimates of less than 10% are unlikely to raise significant horizontal concerns with respect to inpatient hospital services.

[29] 9.8% is the sum of reported diversion to CSMC (8.4%), Tarzana (0.7%), Torrance (0.4%), and Marina del Rey (0.3%).

[30] Different theories of harm differ in their assumptions about the market structure, market power, and conduct that would give rise to cross-market effects. In the 1960s, these concerns were sometimes characterized as "conglomerate effects" concerns, and distinguished from more traditional theories of harm because they either considered situations where a multi-market firm had a broad footprint (i.e., participated in many related markets) but had limited market power in all of its markets, or where the multi-market firm had significant market power in each of its markets. Such concerns arose with respect to the conglomerate merger between Clorox and Proctor & Gamble, both of which were alleged to have substantial market power in the distinct markets for bleach and detergent, respectively. More recently in Europe, these concerns have been characterized as "portfolio power" concerns, as exemplified in the conglomerate

likely to apply to the proposed affiliation. One of these theories (the "Common Customer") is directly motivated by observations of how competition in the hospital industry occurs, while a second theory ("Change in Control") potentially applies to a variety of different industries. This recent economic research not only demonstrates how and why cross-market effects in the hospital industry may arise, it also shows that the magnitude of any such cross-market effects can be significant.

The remainder of this section describes in greater detail the economic literature identifying the *mechanisms* by which cross-market hospital mergers can lead to higher prices, and the research regarding historic *effects* of such mergers.[31]

A. The theoretical literature identifies at least three possible mechanisms of harm

The economic literature identifies three mechanisms (or theories) under which the proposed affiliation might result in higher prices because of cross-market effects. [32]

1. Traditional Tying theories (TT)

There is a long history of economists (and the courts) relying on Traditional Tying (TT) theories to assess cross-market mergers and conduct involving a firm that competes in distinct antitrust

merger involving Guinness and Grand Metropolitan in 1997, and General Electric and Honeywell in 2002. Cross-market concerns have also been discussed in the context of effects due to "multi-market contact" (see, for example, Bernheim, D. and Whinston, M., "Multimarket Contact and Collusive Behavior," *The Rand Journal of Economics*, 1990 (hereafter Bernheim and Whinston (1990)")).

[31] This report does not address legal issues associated with cross-market mergers, including the extent or the reach of existing laws or regulations with respect to possible cross-market theories or effects. For a discussion of these legal issues, including the burdens under federal law and relevant federal case law and federal statutes, see Varanini, E., "Addressing the Red Queen Problem: A Proposal for Pursuing Antitrust Challenges to Cross-Market Mergers in Health Care Systems," *Antitrust Law Journal*, forthcoming, 2020.

[32] These theories of harm are also discussed and summarized in Brand, K. and Rosenbaum, T., "A Review of the Economic Literature on Cross-Market Healthcare Mergers," *Antitrust Law Journal*, 2019 (hereafter "Brand and Rosenbaum (2019)"). There are additional mechanisms through which cross-market mergers can lead to competitive harm that I do not discuss because I do not believe they are applicable to the proposed affiliation (e.g., the Bernheim and Whinston (1990) theory relating to multi-market contact between competitors.) Huntington Memorial, however, is present in just a single market, thus rendering theories of multi-market contact largely irrelevant. In a second mechanism, cross-market mergers can increase price when there are opportunities for business recapture typically associated with horizontal mergers, even though the firms aren't direct competitors. For example, consider a merger between a hospital and a physician group that are located in the same geographic market. If the physician group (or hospital) threatens to not be part of a payer's network and the payer loses members, the hospital (or physician group) will recapture some of these lost members when they enroll with other payers. After merging, the parties will internalize this recapture and potentially negotiate higher prices even though they supply services in different product markets. This mechanism was introduced by Peters, C., "Bargaining Power and the Effects of Joint Negotiation: The Recapture Effect," Economic Analysis Group Discussion Paper, EAG 14-3, September 2014 (available at: https://www.justice.gov/sites/default/files/atr/legacy/2014/09/26/308877.pdf). This mechanism, however, is not applicable to the proposed affiliation since HM and CSMC are in separate geographic markets, thus making patient recapture unlikely.

markets. In general, these TT theories consider how a firm with market power in one "primary" market can tie, bundle, or somehow link sales in that market with the firm's sales in a "secondary" market, thus "leveraging" market power from the primary market into the secondary market.

TT theories are well accepted by economists as posing a real potential threat of harm.[33] The economic literature regarding TT theories considers a variety of specific means by which tying or bundling can cause harm, with the necessary conditions for harm often dependent upon the specific fact pattern of the markets and conduct at issue. TT theories have also been accepted by the government and the courts as providing a legitimate basis for competitive concerns.[34]

In most cases, TT theories focus on how a firm can use its market power in the primary market to disadvantage its rivals in other more competitive secondary markets.[35] By reducing those rivals' competitive significance (and perhaps even foreclosing those rivals entirely from the market), the firm with market power can then raise price in the secondary market and, in some circumstances, within the primary (tying) market.

In one variant of these TT theories (often referred to as "regulatory evasion"), a firm has market power in the primary market but is unable to fully exercise that market power and thus cannot raise price as high as it would like. Thus, the firm could and would profitably increase price, but for some exogenous restraint.[36] By merging with a firm in a second competitive market, the firm may be able to "shift" its desired price increase from the primary market to the secondary market, thus "evading" the regulation (or other price constraint) that kept prices low in the primary market. In other variants, economists have examined how bundling across markets can affect firms' relative bargaining strength[37] or ability to extract surplus from consumers,[38] thus leading to higher prices without necessarily disadvantaging rivals.

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[33] See, for example, Riordan, M. and Salop, S., "Evaluating Vertical Mergers: A Post-Chicago Approach," *Antitrust Law Journal*, Winter 1995; and Krattenmaker, T. and Salop, S., "Anticompetitive Exclusion: Raising Rivals' Costs to Achieve Power over Price," *The Yale Law Journal*, 1986.

[34] *Jefferson Parish Hosp. Dist. v. Hyde*, 466 U.S. 2, (1984) is a well-known tying case involving hospitals and anesthesiologists. One of the best known recent cases outside of healthcare involves the United States' concerns in the early 2000s about Microsoft bundling its Internet Explorer product with its (allegedly dominant) Windows operating system.

[35] See, for example, Whinston, M., "Tying, Foreclosure, and Exclusion," *The American Economic Review*, 1990.

[36] This variant is often referred to as "regulatory evasion" with the exogenous price constraint being imposed by a regulator that caps the firm's prices. See, for example, Brennan, T., "Cross-Subsidization and Cost Misallocation by Regulated Monopolists," *Journal of Regulatory Economics*, 1990. More generally, however, the price constraint could be less explicit, for example community pressure to avoid excessive (and observable) prices. This potential for cross-market effects in the context of hospital mergers has been noted by Vistnes and Sarafidis (2013) at note 60; Brand and Rosenbaum (2019) at note 46; and Dafny, L., et al., "The price effects of cross-market mergers: theory and evidence from the hospital industry." *RAND Journal of Economics, 2019* (hereafter "Dafny, L., et al. (2019)") at note 22.

[37] See, for example, Nalebuff, B., "Bundling as a Way to Leverage Monopoly," Working Paper, September 2004 (available at SSRN: https://ssrn.com/abstract=586648).

[38] See, for example, Schmalensee, R., "Monopolistic Two-Part Pricing Arrangements," *The Bell Journal of Economics*, Autumn 1981.

In the context of the proposed affiliation, TT concerns might arise if CSHS or HM are found to have substantial market power. CSHS might then condition its willingness to contract at CSMC (either its full set of services or its tertiary/quaternary services) or at HM on a payer's willingness to contract with the entire CSHS system "bundle" (with that bundle also potentially including CSHS physicians or other non-inpatient care providers).

2. The "Common Customer" (CC) theory

TT theories typically assume that a firm has substantial market power in one, but not both, markets at issue. The CC theory, however, can apply when the firm has market power in *both* markets.

Although cross-market effects may occur for a variety of reasons, economic research has recently identified one particular way in which effects in healthcare markets may occur: when health plans market their health plans to employers that have employees in both markets.[39] This is often referred to as the "common customer" theory of cross-market effects, in recognition of a key assumption that, even though the hospitals at issue may serve distinct *patient* pools, there are employers that provide insurance coverage to diverse sets of employees, some of which use one hospital and some of which use the other. Thus, through its employees, the employer is said to be a "common customer" of both hospitals.[40]

This theory, which I refer to as the Common Customer theory, is driven by the following intuition. Consider a large employer with employees in multiple distinct markets, where employees living in one market are unwilling to use a hospital located in a different market. Assume this employer offers a limited number of health plans to its employees, but that the employer offers the same health plans to all employees, irrespective of the market in which the employee lives.[41, 42]

Assume the employer has two objectives when choosing the set of health plans that it offers. First, the employer wants to offer health plans that offer employees the best overall combination of quality and price, where quality might reflect the health plans' provider networks, reputations, claims administrative process, etc. Second, the employer wants to offer a set of health plans that allow each employee to have attractive alternatives to choose from: employers will prefer offering

[39] See note 32 for additional reasons that cross-market effects can occur.

[40] See, for example, Vistnes and Sarafidis (2013); and Dafny, L., et al. (2019).

[41] Many employers today offer little plan choice to employees. In 2019, 75% of all employers and 39% of all large employers offered employees only one plan type. See, for example, the Kaiser Employer Health Benefits 2019 Annual Survey at p. 76 (available at: http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2019).

[42] The employer might choose to offer its employees a limited number of plans offered by an MCO if there are fixed costs from each plan offered or if MCOs face competition from other health plans. See, for example, Dafny, et al. (2019).

plans that appeal to most of their employees rather than offer plans that only appeal to a limited set of employees.[43]

If employers prefers offering health plans that appeal to most employees, then a health plan with important "holes" in its provider network (i.e., inadequate access to providers in important geographies) will not be an attractive choice for employers that have employees living in the region with the network hole: while employees outside that region may not care about the hole, employees living in that region will find the plan unattractive. Thus, network holes reduce the attractiveness, and thus profitability of, the products that health plans market to employers. As a result, hospitals that can threaten to create important holes in a health plan's provider network will have greater bargaining power, and can thus negotiate higher prices from the health plan.[44]

Cross-market effects under the CC theory can emerge if a multi-market hospital can threaten to create multiple holes in a health plan's provider network, and if that threat of creating multiple holes significantly increases the hospital's market power. Intuitively, this could occur because the more holes a health plan has in its provider network, the more likely the employer will begin viewing the health plan as offering a "niche appeal" product that is only attractive to a limited number of its employees (i.e., the ones living outside the areas with a hole). At some point, a health plan's product may have so many holes (and thus become such a niche appeal product) that employers will decide to instead offer their employees a product without holes that appeals to most employees.

Thus, the more holes that a hospital system can threaten to impose on a health plan, the greater the likelihood that the health plan will become unattractive to employers. This ability to harm the health plan by creating multiple holes in its network if it fails to agree on a contract can increase the health system's bargaining power and lead to higher prices when the harm from additional holes is "super-additive:" the harm (i.e., the health plan's loss in profits) from two holes must not just be greater than the harm from either individual hole, but actually greater than the sum of the harm from each hole.[45] This condition is also referred to as the "concavity" condition.[46] Concavity

[43] In particular, the employer wants to avoid offering plans that only appeal to certain employees, with the result that even though an employee can arguably choose from several plans, there is really only one plan (or a limited number of plans) that the employee views as an attractive choice. It follows that, in order to maximize employees choice, the employer will want the different plans it offers to generally cover the same geographic regions (i.e., that all plans will have adequate geographic coverage for all employees).

[44] This concept is also fundamental to theories of how mergers within a market can reduce direct competition: if a merger significantly reduces a health plan's options for providing coverage within a market, the merged hospitals can threaten to create a hole in a health plan's network in that particular market, thus enabling the hospital to negotiate higher prices.

[45] Thus, concavity corresponds to the situation where the whole is greater than the sum of the parts.

[46] See Vistnes and Sarafidis (2013) and Dafny, et al. (2019). For example, assume that a health plan is negotiating with two hospitals A and B and the health plan's profits would fall by $50 if it excluded just Hospital A, or if it instead excluded just Hospital B. The health plan's profits are said to be "concave" if the loss of *both* of those hospitals would cause the health plan's profits to fall by more than $100.

can equivalently be thought of as the situation in which the health plan's valuation of including one of the hospitals increases if the health plan cannot contract with the other hospital.[47]

To further illustrate, consider the following example. Suppose a hypothetical employer's employees live in three distinct geographic markets A, B, and C, each with one hospital. If a health plan competing to win the employer's business excludes only one hospital (say, hospital A) the employer might continue to offer the health plan to employees because the plan will be adequate for its employees in markets B and C. But if the health plan loses a second hospital from its network (say, hospital B), the health plan becomes unattractive to employees in both markets A and B. If the employer is willing to tolerate and offer its employees a health plan that has only one hole (e.g., in market A) but unwilling to offer its employees a health plan that has two holes (e.g., in markets A and B), then a network with two holes would be much less marketable than a network with a single hole. Thus, while neither hospital A nor hospital B individually have much bargaining leverage against a health plan (since the health plan is willing to exclude either one of those hospitals), a merger between hospitals A and B could significantly increase the two-hospital system's bargaining power (since the health plan would be very reluctant to exclude both hospitals). Under these circumstances, the cross-market merger could increase prices, despite the merging hospitals competing in distinct markets.[48]

The CC model is formally considered in Vistnes and Sarafidis (2013). Their model suggests the most attractive health plans may be the most vulnerable to hospitals' expanded bargaining power following a cross-market merger.[49] More recently, Dafny et al. (2019) use a Nash bargaining model, in which MCOs and hospitals simultaneously negotiate prices across markets, to study these effects. Those authors describe large employers with employees spread across multiple markets as "common customers" to the MCOs operating in each of these markets. As in Vistnes and Sarafidis (2013), these "common customers" can make MCOs' profits concave with respect

[47] This concavity condition typically holds when considering within-market mergers, but may, or may not, hold in any particular cross-market merger.

[48] This argument is valid only if there are also insurers common to markets A, B, and C. For example, if the markets are only served by regional insurers, then hospitals A and B can't jointly threaten to remove themselves from an insurer's network. See, for example, Dafny et al. (2019) at p. 295.

[49] Intuitively, the most attractive health plans may be the most vulnerable to cross-market effects because their profits are likely concave with respect to losing hospitals from their networks: although the plan can "afford" one or two holes and remain more attractive than rival plans, once the plan incurs multiple holes, it may be at much greater risk of being dropped by an employer.

to cross-market hospitals' status in their networks.[50, 51] The authors predict that cross-market price effects will occur more frequently across markets that share common customers.[52]

In the context of the proposed affiliation, interviews with payers indicate that there are likely to be many "common customers" at both CSMC and HM: employers whose employees are dispersed across the Los Angeles region where some employees live or work near CSMC while other employees live or work near HM.[53] Thus, the proposed affiliation raises cross-market concerns that health plans will be much more averse to excluding both CSMC and HM (thus marketing a product with two holes in their provider network) than to excluding either CSMC or HM (and thus marketing a product with a single hole in their network).[54]

3. Harm from a Change in Control (CiC)

Changes in control at a hospital (or other firm) can change the objectives, information, or bargaining skills and sophistication of the parties' negotiating price. Those changes can result in post-merger price increases regardless of whether the merging parties operate in the same, or distinct, markets. Thus, changes in control can result in cross-market price effects.[55] I refer to this as the Change in Control ("CiC") theory.

Cross-market hospital mergers can enhance hospitals' bargaining sophistication if sophistication is increasing in hospital size. For example, if a less sophisticated standalone hospital is acquired by a more sophisticated hospital system, the standalone hospital may adopt the system's approach to negotiations in order to negotiate higher prices.

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[50] Dafny et al. (2019) at note 18 suggest a second reason an MCO's profits might be concave with respect to cross-market hospitals when facing common customers that is grounded in agency theory. They hypothesize that the employer hires a single negotiator who bargains with MCOs on the employer's behalf. If the negotiator fears his job will be in jeopardy if negotiations with two hospital systems fall apart but not one, then the MCO's profits will become concave across markets.

[51] Dafny et al. (2019) at p. 296. "The price effect of a cross-market merger should be larger the more prevalent are common customers for the merging hospitals. We posit that mergers combining hospitals across different states or with greater distances between one another likely have fewer common customers."

[52] In some cases, health plans' profits may be convex, rather than concave, in the number of holes in its provider network. In that case, cross-market mergers can result in price decreases. We have seen no evidence that such is the case here.

[53] Examples of common customers might include local governments, or regional employers. Even single-site employers, if large enough, are likely to draw employees from across the region, thus increasing the likelihood that the employer will be a common customer to both CSMC and HM.

[54] While difficult to assess, there is some indication that the concavity condition may also be met.

[55] I do not opine here on the legality of such price increases if the pre-existing market power supporting that price increase was legitimately obtained. From an economic perspective, however, that price increase – whether or not it is deemed legal – nevertheless harms consumers.

Economists have proposed several reasons why a large hospital system may have more bargaining sophistication that enables them to negotiate higher prices.[56] Large systems may be able to improve their bargaining power by pooling information on MCOs and sharing the costs of creating a larger and more skilled team of negotiators. Alternatively, large hospital systems may be less risk averse than smaller systems. If hospital systems' negotiators are less risk-averse than smaller systems' negotiators, increasing system size will enable hospitals to negotiate higher prices from MCOs. Finally, large hospital systems serving multiple communities may feel less loyalty to any particular community than a stand-alone hospital.[57]

In other contexts, a merger may change a hospital's willingness to use its existing market power. For example, consider a hospital with substantial market power that has set price below the profit-maximizing price: perhaps because of community pressure, or because the hospital's not-for-profit status has led the hospital to set price below the profit-maximizing level.[58] A new owner of that hospital may, however, be more willing to take advantage of that previously unused market power in order to increase price. This may be particularly likely in instances where the new owner has weaker community ties (and is thus less susceptible to community pressure to keep prices low), faces stronger pressures to increase short-term profits, or has exhibited a greater willingness to fully exercise market power at other hospitals it operates.

In the context of the proposed affiliation, CiC concerns are consistent with several payers' statements that CSMC is much more expensive than HM and that they are concerned the affiliation will lead CSHS to increase its price at HM to more closely approximate its price at CSMC.[59]

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[56] Lewis, M. and Pflum, K., "Diagnosing Hospital System Bargaining Power in Managed Care Networks," *American Economic Journal: Economic Policy*, 2015.

[57] Understanding how the mechanism through which system size enhances bargaining sophistication is secondary. If health plans *believe* large hospital systems are more sophisticated, or more likely to walk away from negotiations, than smaller hospital systems, then large hospital systems will be able to extract higher prices even if the health plans' beliefs are misinformed.

[58] There is a long-standing debate as to whether certain hospitals' not-for-profit status reduces merger-related antitrust concerns. Economists (and the courts) generally accept that, even if a not-for-profit hospital does not want to set a profit-maximizing price, a merger that increases the hospital's market power is nevertheless likely to result in higher prices (particularly to the commercial customers that hospitals often rely upon to support allegedly more altruistic goals) even if the resulting post-merger price remains below the profit-maximizing price. For a discussion of this debate and the empirical literature regarding merger-related price effects at not-for-profit hospitals mergers, see, for example, Gaynor, M. and Town, R., "Competition in Health Care Markets," NBER Working Paper No. 17208, July 2011 (available at: https://www.nber.org/papers/w17208; hereafter "Gaynor and Town (2011)").

[59] One might ask, under this theory, if HM's price is more likely to gravitate to CSMC's price or instead to prices at one of CSHS's other affiliate hospitals. Although HM's range of services may more closely approximate the range at CSMC than CSHS's other "community" hospitals, HM does not offer the full range of tertiary and quaternary services offered at CSMC. Thus, if comparing range of services, one might anticipate an increase in HM's price, but not to the same level as CSMC's price. Alternatively, as discussed in more detail in Section VI.A below, CSMC and HM appear to have comparable levels of market power that might allow CSHS to set comparable prices at HM and CSMC.

B. The empirical literature provides evidence of cross-market effects

In addition to assessing the theoretical basis for cross-market concerns, economists have recently investigated the extent to which there is empirical evidence of cross-market effects: are prices in fact higher at hospitals that compete in multiple, but distinct, markets?

In conducting this empirical inquiry, economists generally compare prices across different hospitals, controlling for how factors such as hospital size or teaching status likely affect price. One then asks whether, even after controlling for other factors likely to affect price, hospital prices are higher when those hospitals are part of a cross-market system.[60]

Two recent papers find evidence that hospital prices are higher for hospitals that are part of (or, though a merger, became part of) a cross-market system.[61] This research also suggests that the magnitude of these cross-market effects may be substantial: one paper finds effects on the order of 7 – 10 percent, while the other paper finds effects as high as 17 percent. Thus, while this research has not sought to carefully distinguish between the most likely mechanisms driving those cross-market price effects, it provides important confirmation that cross-market hospital mergers pose a real risk of higher prices.

1. Dafny, Ho and Lee (2019)

Using multiple data sources, Dafny et al. (2019)[62] identify 144 hospitals acquired by an out-of-market system between 1996 and 2011, and another 159 hospitals acquired by an out-of-market system between 2002 and 2012.[63, 64] DHL describe the vast majority[65] of the acquired hospitals as located in the same state as their out-of-market acquirer.

To test for cross-market price effects, DHL use regression analysis to compare the price changes at hospitals that became part of a cross-market system with price changes at other "control"

[60] Similarly, the research also considers whether a merger that creates a cross-market hospital system (e.g., a merger between hospitals in distinct markets) results in higher prices.

[61] See also Brand and Rosenbaum (2019) who assess the economic literature on cross-market hospital effects and conclude that the evidence of higher prices from cross-market effects is credible: "[T]he empirical analysis in this literature provide credible evidence that prices have increased following [cross-market hospital] mergers" (p. 533).

[62] In only Section V.B, I use "DHL" to abbreviate Dafny et al. (2019).

[63] DHL assume a hospital merger spans multiple markets if the acquired hospital is not within a 30 minute drive of its merging partner's hospitals.

[64] DHL take several steps in creating the sample of hospitals they study as having been involved in a cross-market merger. First, they limit their sample to what they refer to as "bystander" hospitals: hospitals whose prices were not expected to increase for reasons other than the cross-market mechanisms they emphasized. For example, DHL exclude the "crown jewel" of each hospital merger (e.g., the largest hospital acquired) since there is good reason to expect the prices at hospitals that drive mergers to change for reasons unrelated to cross-market effects. DHL also exclude from their sample of cross-market mergers any hospitals within a 30 minute drive of one of their acquirer's hospitals in case there was within-market overlap between these hospitals and their acquirers.

[65] 116 and 104 of the two groups of 144 and 159 hospitals, are acquired by systems with hospitals in the same state.

hospitals.[66] DHL then ask whether price increases were higher at hospitals involved in a cross-market merger relative to the control hospitals that were not involved in a cross-market merger.[67]

DHL find evidence of cross-market effects: their research shows a price effect from cross-market mergers of 7 to 10 percent relative to control group hospitals that were not involved in a cross-market merger.[68] Thus, DHL find that cross-market effects are not only real, but that they can be substantial in magnitude.

DHL are largely agnostic as to why cross-market mergers cause elevated prices but they suggest the evidence is consistent with the CC theory. In particular, DHL note that the CC theory assumes that individual employers have employees using both hospitals, even though the hospitals are in distinct markets. Thus, a merger involving hospitals in very different areas (e.g., two distant states) is less likely to satisfy this assumption of a common customer, thus making the CC theory less applicable to mergers between distant hospitals. DHL test for cross-market effects from mergers of very geographically distanced hospitals, and find no evidence of effects. Rather, they find cross-merger effects are most likely, and the greatest, when the merging hospitals are nearby (while still unlikely to be direct competitors themselves).[69] As DHL explain, "[t]hese are precisely the sort of cross-market hospital mergers where common customers are likeliest to be present" and their results "are consistent with the presence of a common customer effect that is driving post-merger price increases."[70]

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[66] DHL do not directly observe hospitals' prices. Instead, DHL observe the total net payments hospitals receive from payers for inpatient and outpatient care. To estimate inpatient payments, DHL multiply this total by the fraction of hospitals' gross revenues earned on inpatient services. Their measure of price is then estimated inpatient payments per commercial inpatient admission.

[67] DHL include numerous controls in their regression to control for differences between the hospitals acquired by out-of-market systems and the control hospitals, including hospital and year fixed effects, controls for hospitals' case-mix, beds, ownership status, and Medicaid admissions. These controls ensure DHL are, in effect, comparing "similar" hospitals as described above.

[68]For the FTC sample of hospitals exposed to cross-market mergers, DHL found price effects of approximately 7%, with those effects significant at the 1 percent level. Within the Broad sample of hospitals, DHL found a price effect of 9 – 10%, with those effects significant at the 5 percent level. (See DHL at Tables 4 and 5.)

[69] Specifically, DHL find no evidence that cross-market mergers elevate prices if the acquired hospital is in a different state. They also find that price effects are greatest if the acquired hospital is less than 90 minute drive from its acquirer.

[70] DHL at p. 315. DHL also note that they estimate larger price effects when there are many common insurers in the acquired hospital and acquiring hospitals' local markets using CPT-level insurer market shares. The more overlap between insurers there is, the larger the price effect they find. This result is also consistent with the Common Customer theory since without common insurers, there cannot be common customers.

2. *Lewis and Pflum (2017)*

Lewis and Pflum (2017)[71] use American Hospital Association hospital surveys to identify 81 stand-alone hospitals acquired by an out-of-market system between 2000 and 2010.[72] Like DHL, LP use regression analysis[73] and measure the price effects after these cross-market mergers by comparing the acquired hospitals' prices[74] to prices set by standalone hospitals that were not acquired or exposed to any merger.[75]

LP find support for cross-market concerns: their research shows that after a stand-alone hospital is acquired by an out-of-market system, prices at the stand-alone hospital increase as much as 17 percent relative to control group hospitals after the acquisition.[76, 77]

LP attribute their observed price effects to one variant of the CiC theory: that cross-market hospital mergers can increase the bargaining sophistication of smaller acquired hospitals. This view is based in part on those authors' other research[78] showing that cross-market price effects are larger when the acquiring out-of-market hospital system is larger, and effects are smaller when the standalone hospital has fewer beds. These findings are consistent with the view that the acquiring hospital is more sophisticated and can extend its bargaining skills to benefit the smaller acquired hospital.[79, 80]

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[71] Lewis, M. and Pflum, K., "Hospital Systems and Bargaining Power: Evidence from Out-Of-Market Acquisitions." *RAND Journal of Economics*, 2017 (abbreviated "LP").

[72] LP use American Hospital Association Annual Hospital Surveys to distinguish between standalone hospitals acquired between 2000 and 2010 from standalone hospitals that were not acquired. The 81 hospitals under consideration by LP were are in the former category and further, were acquired by systems without locations within 45 miles of the standalone hospital. So, LP would not have categorized this affiliation as a cross-market merger.

[73] LP also include controls in their regression to account for differences between the standalone hospitals that were acquired and the standalone hospitals that were not, including hospital and year fixed effects, controls for hospitals' costs per discharge, capacity, and hospitals' sources of revenue.

[74] LP measure prices using a methodology very similar to that of DHL.

[75] LP's control group is comprised of hospitals that remained standalone hospitals between 1998 and 2010 (i.e., they were not involved in any merger).

[76] LP, Table 2. LP estimate 17% price effects using a specification that allows the year fixed effects to differ between standalone hospitals that were and weren't acquired. Absent these fixed-year effects, LP find that out-of-market acquisitions increase prices by 10% relative to prices at standalone hospitals. These findings are statistically significant at the 1 and 5 percent levels, respectively.

[77] LP also estimate the effect of within-market hospital acquisitions. When a standalone hospital is acquired by a system hospital with locations within 45 miles of the acquired hospital, prices increase by 9 to 10% relative to control groups' hospitals. LP attribute these smaller effects to antitrust enforcement that limits price effects from within-market mergers.

[78] See note 56.

[79] LP, Table 9. Price effects after a cross-market merger involving a system with more than 26 members are more than 70% larger than one involving a system member with 4 members or fewer. Similarly, price effects after a cross-market merger involving a standalone hospital with fewer than 58 beds are more than 50% larger than price effects if the standalone hospital had more than 184 beds.

[80] LP, pp. 38-39.

VI. PLUS-FACTORS INDICATE AN INCREASED RISK OF CROSS-MARKET EFFECTS

The proposed affiliation can be distinguished from a typical cross-market affiliation in several ways, each of which increase competitive concerns with the proposed affiliation. These distinguishing factors can be viewed as "plus-factors" that increase the risk of harm from cross-market effects, similar to how plus-factors have been identified as factors that increase the risk that a merger will result in collusion or other types of coordinated effects.[81, 82]

I discuss the following plus-factors with respect to the risk of cross-market effects from the proposed affiliation.

- CSMC and HM likely have substantial market power;
- Several important payers have expressed concerns consistent with cross-market concerns;
- There is evidence that CSMC prices are higher than comparable hospitals' prices;
- There have been no previous affiliations involving CSHS in which cross-market effects would have been predicted, yet failed to materialize: predictions about the future are not inconsistent with what the theories would predict about the past.

These plus-factors provide a basis for distinguishing the CSHS/HM affiliation from other affiliations, and thus a rationale for intervening here but not in every cross-market merger or affiliation.

A. Market power

Economists recognize that in cases where competitors are highly differentiated from each other, defining a relevant market and then calculating market concentration measures can be misleading: those market concentration measures can either substantially understate *or* overstate the actual extent of competition among market participants. [83, 84] This important caveat about the usefulness

[81] See, for example, Baker, J., "Two Sherman Act Section 1 Dilemmas: Parallel Pricing the Oligopoly Problem, and Contemporary Economic Theory," *Antitrust Bulletin*, Spring 1993.

[82] Of note, the parallel between economic analyses of collusion and cross-market effects extends beyond the relevance of plus-factors. In particular, while the CC and CiC cross-market theories are limited with respect to their ability to identify which *particular* cross-market mergers are likely to cause harm, the same is also largely true of economic theories regarding collusion and coordination: while certain plus-factors have been identified, economists' theories regarding collusion and coordination have limited predictive power. That lack of predictive power, however, has not prevented economists (as well as the courts) from recognizing that coordination and collusion are very real problems that often cause substantial competitive harm.

[83] See 2010 Horizontal Merger Guidelines.

[84] Using what economists sometimes refer to as "the smallest market" principle in which the market is defined to include the minimal number of competitors while still passing the SSNIP test, hospitals with some (albeit limited) competitive significance would likely be excluded from the market. In that case, market shares and HHIs would likely *understate* the actual level of competition. Alternatively, if markets are instead broadened beyond the smallest market

of defining relevant antitrust markets and calculating market shares, HHIs,[85] or other measures of market concentration is particularly relevant here given the significant differentiation among the hospitals in the Los Angeles region.[86] Economists also recognize that market shares and market concentration often provide only an initial estimate of market power, and that more detailed analyses are necessary to more reliably assess market power.[87]

For these reasons, rather than define the specific relevant antirust markets in which CSMC and HM compete, and then calculate market concentration in those markets, I move immediately to the next step that would have followed that market definition/market concentration exercise: assessing other evidence to determine the extent to which CSMC and HM likely have substantial market power.[88]

1. Health Plan interviews

In the course of my inquiry, I interviewed the significant health plans in the Los Angeles region.[89] In several instances, these health plans indicated that both CSMC and HM were very important providers in their hospital network, and that excluding either hospital from their provider network would significantly disadvantage the plan's ability to market their product to employers, with some

(as envisioned under the 2010 Horizontal Merger Guidelines) to encompass even weaker competitors, market concentration would likely overstate the actual level of competition. Given the sensitivity of market concentration measures to the precise metes and bounds of the defined market, in cases where there is significant differentiation among competitors (as is the case here), economists often assess market power using techniques that do not depend on market definition.

[85] The HHI (or more formally the Herfindahl-Hirschman Index) is a commonly used measure of market concentration based on competing firms' market shares. The HHI is calculated by summing up the square of each firm's market share. For example, in a market with four firms with market shares of 40%, 30%, 20% and 10%, the HHI = $40^2 + 30^2 + 20^2 + 10^2 = 3{,}000$.) The HHI ranges from 0 (an extremely unconcentrated, very competitive market) to 10,000 (a monopoly market with a single competitor).

[86] Hospitals in this region are significantly differentiated in several different dimensions (many of which are identified in Table 1), including location, size, patient mix, range of services, and teaching status.

[87] See, for example, the 2010 Horizontal Merger Guidelines at Section 4 ("The measurement of market shares and market concentration is not an end in itself …." and "[s]ome of the analytical tools … to assess competitive effects do not rely on market definition ….").

[88] Notably, however, I have seen no evidence suggesting that I would reach any different conclusions were I to formally define relevant antitrust markets and then estimate market shares and market concentration measures. In particular, I anticipate that any properly defined geographic markets would be relatively small and that both CSMC and HM would have significant shares in those markets. Moreover, for reasons discussed below, those market shares would likely understate CSMC's and HM's market power within those markets.

[89] In this report, I generally use the terms "health plans" and "payers" interchangeably. [redacted]

of those plans suggesting that the loss of one of those hospitals would make it even more costly to lose the other.[90, 91]

Health plans typically identified CSMC as one of the few providers of high-end ("tertiary" or "quaternary") services in the Los Angeles area, and as a hospital with an excellent reputation for care. As a result, health plans felt it would be difficult to leave CSMC out of their provider network.

Payers similarly identified HM as a hospital that they could not easily exclude from their provider networks. Health plans consistently identified HM as the most important, and best-regarded, hospital in the Pasadena area: an area in which many health plans had an important enrollee population for which they need to provide local hospital care. And while there are other hospitals in the general Pasadena area, payers indicated that those other hospitals are smaller, do not offer the same range of services, and do not enjoy the same reputation for high quality care as HM.

Although health plans typically include HM in their provider networks, some health plans acknowledged that they offer certain products that at least partially exclude CSMC from their provider network. This exclusion of CSMC from a limited number of networks, however, is not inconsistent with CSMC having substantial market power. In particular, hospitals can have substantial market power without having "monopoly power" in which customers have no alternative but to contract with the hospital. In particular, all that is required for market power is that the hospital be sufficiently important, and differentiated from, other options so that the hospital can raise price above competitive levels.[92] Thus, there is no inconsistency with a firm having substantial market power and seeing that some customers choose the competing product.[93]

Although these health plans' views on the importance of CSMC and HM to their network is not dispositive in isolation, their views are consistent with, and supportive of, other evidence that CSMC and HM have substantial market power.

2. Market shares by zip code

Although I do not calculate market shares in a regions corresponding to a relevant antitrust market, I do calculate hospitals' shares of patients drawn from individual zip codes. This allows me to

[90] These suggestions imply plans' profits are concave with respect to CSMC and HM. See note 46 regarding the significance of concavity with respect to the CC theory of harm.

[91] Health plans also indicated that it would be difficult to shift patients away from CSMC and HM using techniques other than network exclusion, with such techniques likely to significantly reduce the marketability of their product to the health plans' customers.

[92] Similarly, the term "must have" hospital (a hospital that health plans feel they need in order to have a marketable health plan) is often used when assessing hospital market power. Yet while "must have" status may be a *sufficient* condition to have substantial market power, it is not a *necessary* condition: a hospital simply needs to be an "important to have" hospital in order to have market power.

[93] Analogously, one might think that both Coca-Cola and Pepsi-Cola have market power with respect to soda, and the fact that some consumers opt for Coca-Cola over Pepsi does not mean that Pepsi has no market power.

identify whether, and where, CSMC and HM are particularly important to residents in that area. This information can be used to assess the likely importance of CSMC, and of HM, to a health plan's provider network, and thus to assess each hospital's likely market power.[94]

Figures 5 and 6 confirm that CSMC and HM draw a high share of patients in certain areas: as shown, there are regions in Los Angeles in which CSMC or HM account for more than 30 percent, and sometimes more than 50 percent, of patient discharges from a zip code.

CSHS documents confirm that CSHS and HM draw a high share of patients from different regions of Los Angeles. Focusing on regions rather than zip codes, one analysis by CSHS identifies CSHS as having the highest market share among all hospitals in the West Los Angeles region: CSHS's share is estimated at 47.1 percent, compared to the next highest hospital (UCLA) with a share of just 14.5 percent.[95] That CSHS analysis also identifies HM as having the highest market share (21.5%) in the Pasadena/West San Gabriel Valley region, almost double the share of the next highest hospital (Methodist Hospital with a 11.2% share).

Those high market shares speak to the importance of those two hospitals to individuals residing in those areas, and thus to the health plans that seek to market their plans to those individuals and any employers or other entities that offer health insurance to those individuals.

3. Willingness to pay ("WTP") estimates

Economists commonly calculate a statistic known as the "willingness to pay" (or WTP) when assessing hospital market power.[96] Very generally, WTP measures the incremental attractiveness of a hospital to individuals in an area, and thus the importance of the hospital to a health plan

[94] As noted earlier, however, given the significant differentiation between hospitals, market shares can be misleading. Looking at hospitals' shares of patients living within narrowly drawn geographic regions, however, can reduce some of those potential problems; in particular, a narrow geographic focus helps address concerns that hospital patient draw patterns, and competitive interactions, may differ significantly across regions, thus leading to distorted views of competition if market shares are calculated across a broadly defined geographic region.

[95] These market shares refer to 2017 inpatient market shares. CSHS's estimated shares are also high in several other regions: the South Bay region (26.1%, compared to the next highest hospital with share of 15.4%); the North Los Angeles region (9.6% share, compared to the next highest hospital with share of 9.5%); and the South Coastal region (23.1% share, compared to the hospital with highest share of 24.4%). See the CSHS' Health System Strategic Plan at p. 532.

[96] The concept underlying WTP was introduced in Town and Vistnes (2001) and then more formally defined in Capps, C., et al., "Competition and market power in option demand markets," *RAND Journal of Economics*, 2003 (hereafter "Capps, et al. (2003)"). Very generally, a hospital's WTP is estimated as follows. Economists first estimate a patient choice model (as discussed in notes 25, 26, and 27 above) that probabilistically identifies patients' first and second choice hospitals, and then estimates how much 'worse off' patients would be if forced to switch from their first-choice to their second-choice hospital. That difference, aggregated across all patients, determines the incremental value of the hospital to a health plan and its provider network, and thus determines the hospital's WTP.

seeking to market their product to those individuals.[97] Thus, the larger the hospital's WTP, the greater the hospital's likely market power.[98]

Looking at the WTP statistic as an indicator of hospital market power has at least two important benefits. First, the WTP statistic can be calculated without having to define a particular geographic market. Thus, while traditional measures of market power such as market shares can be very sensitive to the precise bounds of the defined market in which they are calculated, the WTP statistic is agnostic with respect to market definition. Second, while traditional measures of market power and market concentration can fail to take into account important dimensions by which hospitals are differentiated (e.g., bed size, teaching status, reputation, specific geographic location), the WTP statistic implicitly takes those factors into account: to the extent certain dimensions of differentiation (e.g., teaching status) are important, more patients will choose that hospital over the available alternatives, and thus the higher will be the WTP.

I calculate the WTP for each GAC hospital in the Los Angeles area. Table 12 and Figure 7 show that, when looking across hospitals in the four-county Los Angeles area, HM and CSMC have the highest, and third-highest, WTP, respectively, with those WTPs dramatically higher than almost every other hospital in the area.[99] These high relative WTPs for CSMC and HM provide strong evidence that both those hospitals have substantial market power.[100]

The finding that CSMC and HM have much higher WTPs that almost all other hospitals in the Los Angeles region is robust to alternative methods for estimating the WTP. For example, Table 12 show that when WTP is calculated without adjusting for hospitals' case-mix index, the WTP statistics for CSMC and HM remain much higher than for other hospitals.[101]

The WTP calculations I report exclude emergency admissions. Patients admitted through the emergency room or for life-threatening medical issues are often excluded from WTP analyses

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[97] More specifically, WTP measures the attractiveness (estimated across all individuals) of a hospital network that does, versus does not, include the particular hospital at issue. To the extent that there are good substitutes to the hospital at issue, a hospital's WTP will be low: ease of substitution means that excluding that particular hospital from a health plan's provider network will not significantly reduce the value of the plan's provider network. In contrast, a hospital for which there are few good alternatives will have a high WTP, reflecting that the plan's provider network would be significantly less attractive to many members if that hospital were excluded, thus leaving those members with significantly less attractive alternatives.

[98] The WTP statistic is measured in something that economist refer to as "utils." The WTP measure is best interpreted as a relative measure (i.e., that one hospital's WTP is 25% higher than the average hospital's WTP) rather than as an absolute measure (i.e., that a hospital has a WTP of 10,000 utils). Thus, a hospital with a much higher WTP than other hospitals is likely to have much more market power.

[99] Figure 7 provides a visual summary of the WTPs reported in Table 12.

[100] I estimate WTP based on (traditional) commercially insured individuals, excluding Medicare Advantage and MediCal members, since these plans sometimes restrict members' hospital choices. I also calculated WTPs by instead looking at enrollees in Traditional Medicare, whose hospital choices are not restricted, and again found that CSMC and HM have very high WTPs.

[101] Adjusting the WTP for hospitals' case-mix index ("CMI"), the approach used in Town and Vistnes (2001), recognizes that hospitals providing more complex care may have increased importance to a provider in constructing its network. Other economists (e.g., Capps, et al. (2003)) estimate WTP without that case-mix adjustment.

because their choice of hospital is typically driven principally by proximity to the hospital rather than factors that might affect individuals' ex-ante preferences for the hospitals in a non-emergency setting. Nevertheless, because patients are sometimes admitted to a hospital through the emergency room even in non-emergency settings, economists sometimes include those emergency-room admissions when estimating the patient choice models that are then used to estimate WTP. To test for sensitivity of my findings to the inclusion of emergency admissions, I also conducted an alternative set of analyses including emergency admissions, and found that CSMC and HM continue to have among the very highest WTPs of all Los Angeles region hospitals, consistent with the conclusion that CSMC and HM have substantial market power.

Table 13 provides additional evidence regarding HM and CSHS market power. While Table 12 shows the incremental value of an *individual hospital* (e.g., CSMC) to a health plan and its provider network, Table 13 shows the estimated incremental value of an entire hospital *system* (e.g., the 4-hospital CSHS system) to the health plan. Once again, regardless of which specific methodology is used to estimate the system-level WTP, Table 13 shows that the WTPs for the CSHS system and the Huntington Memorial system (composed of just HM) are dramatically higher than almost every other system in the Los Angeles region.[102] Thus, the evidence again indicates that CSHS and HM have substantial market power.

4. Relative prices

Market power is traditionally defined as the ability to raise price above competitive levels. Thus, evidence that CSMC and HM have high prices can be suggestive of market power.[103]

Although I do not have access to detailed claims data that can be used to estimate hospitals' relative prices, payers consistently indicate that CSMC has much higher prices than most other hospitals in the Los Angeles area, and that those higher prices are not fully justified on the basis of CSMC's more acute patient mix. Thus, payers believe that CSMC prices exceed competitive prices.[104]

In contrast to CSMC, HM appears to set prices that payers deem to be at (or much closer to) competitive levels: payers generally characterize HM's prices as somewhat high relative to comparable hospitals, but not dramatically so. Competitive prices at HM would be consistent

[102] Table 13 shows that the Providence St. Joseph system has the highest case mix adjusted and unadjusted WTP. This high system-level WTP reflects both the fact that Providence includes Hoag Memorial (which has a very high hospital-level WTP) and the fact that Providence includes several other hospitals that, while each may only have a relatively small hospital-level WTP, collectively add to Providence's system-level WTP.

[103] Because a hospital's competitive price depends on the hospital's cost, a high-price does not necessarily imply market power if the hospital is also high-cost. A hospital's higher costs could, however, reflect market power since market power can insulate a hospital from the need to lower costs in order to better compete. See, for example, Gaynor and Town (2011).

[104] Payers' are unlikely to have good insight into CSMC's costs, however. Thus, payers' beliefs that CSMC prices exceed "competitive levels" must be interpreted with some caution.

either with HM not having market power (a conclusion in tension with other evidence) *or* that HM has market power that it does not fully exercise in the form of higher prices.[105]

5. Geography and hospital attributes

Table 1 and Figure 1 show that both CSMC and HM are differentiated in several ways from other nearby hospitals.[106]

- With 889 staffed beds, CSMC is much larger than many nearby hospitals. For example, nearby Olympia Medical Center (2 miles away) has only 67 staffed beds, while Southern California Hospital at Hollywood (4.5 miles away) has only 54 staffed beds. Even Ronald Reagan UCLA Medical Center (5 miles away) is significantly smaller than CSMC (445 staffed beds).
- CSMC is known for offering more complex, sophisticated care than most other hospitals in the area. This limits the extent to which other nearby hospitals compete with CSMC for those services. CSMC's ability to provide the most sophisticated medical care also enhances CSMC's reputation among patients, increasing payers' perceived importance of including CSMC in their provider networks.
- CSMC's role as a teaching hospital enhances its reputation, thus, increasing payers' perceived importance of including CSMC in their provider networks.
- The patient mix at CSMC is likely more attractive to commercial insurers and their members than several other large teaching hospitals in the area. While Los Angeles County/USC Medical Center is large (546 staffed beds), almost 73 percent of its patients are MediCal patients. In contrast, only 10 percent of CSMC's patients are MediCal patients. This much higher concentration of MediCal patients likely makes LAC/USC a less attractive network provider for commercial health plans. Similarly, the high share of MediCal members at Hollywood Presbyterian (59 percent) and Good Samaritan (40 percent) likely leave them less significant competitors to CSMC.
- HM faces a limited number of significant competitors in the Pasadena area. Nearby hospitals are frequently differentiated with respect to size, teaching status, presence or size of maternity services, and ability to offer more sophisticated tertiary services.
- Several of HM's nearby competitors have a high share of MediCal patients that can limit those hospitals' competitive significance with respect to commercial health plans. In contrast to an 18 percent MediCal share at HM, MediCal shares are higher at nearby San

[105] The possibility that HM possesses unexercised market power is important: if true, that market power potentially could be exercised in the future, thus increases concerns related to the CiC theory whereby a new owner (e.g. CSHS) will impose price increases that the current owner has opted not to impose.

[106] The point of this discussion is not to suggest that CSMC or HM are unique, or that they are "must have" hospitals for a health plan: hospitals (or any other firm) can have substantial market power even when they face competition with a limited number of competitors.

Gabriel Valley Medical Center (39 percent), Garfield Medical Center (36 percent), LAC/USC (73 percent), and Adventist White Memorial (59 percent).

Differentiation in these different dimensions reduces the competition that both CSMC and HM face, thus increasing those hospitals' market power.

B. Common customers

As discussed above, cross-market concerns increase when there are "common customers:" employers with employees that use both CSMC and HM, and who thus may feel the absence of both hospitals from a health plan's provider network renders the health plan an unattractive product to offer its employees.

Regions such as Los Angeles in which employers' employees tend to be geographically dispersed means that individual employers are likely to have some employees that live near, and prefer using, CSMC while other employees live near, and prefer using, HM. This is particularly true for larger employers such as local governments or regional retailers.

Payers confirm that many of the employers to which they sell and market their plans use both CSMC and HM to serve their employees. Data provided by payers provides further evidence of common customers, with [redacted], for example, providing employer-specific data showing that several of its largest employer customers had employees using both CSMC and HM in significant numbers. Data from [redacted] similarly shows that several of its largest employer customers rely on both CSMC and HM, with those two hospitals sometimes the two most heavily used hospitals by their employees. Thus, the evidence confirms that the presence of common customers across CSHS and HM, thus increasing cross-market concerns.

C. Payer concerns

Several payers have expressed concerns consistent with one or more cross-market theories of harm. In particular, some payers have expressed concerns that the proposed affiliation may make it easier for CSHS to leverage its own importance to force payers to continue contracting with HM even if HM were to impose higher post-affiliation prices. Other payers have indicated that losing both CSMC and HM, thus incurring two significant "holes" in their provider network, would cause significant problems and could ultimately allow CSHS to impose higher post-affiliation prices. Still other payers also expressed concerns that, as a result of the affiliation, CSHS's negotiating team would seek to raise HM's prices to more closely match those at CSMC.[107]

Payers' concerns should not be taken at face value and are not dispositive about likely outcomes, nor should their concerns about likely competitive harm be relied upon as an alternative to a more

[107] In some cases, the same payer expressed two or more of these concerns.

thorough competitive effects analysis. However, a well-articulated expression of concern consistent with a competitive theory of harm can be important in assessing likely harm.[108] Here, the concerns expressed by payers are consistent with, and add weight to, the concern that the proposed affiliation creates a risk of cross-market effects.[109]

D. High CSMC prices

As discussed above, there is some evidence that CSMC rates are higher than those at comparable hospitals (and for comparable services). Evidence of high CSMC prices increase cross-market concerns for several reasons:

- As discussed above, high prices are consistent with the presence of substantial market power, a necessary condition for each of the three cross-market theories of harm.[110]
- High prices at CSMC, together with lower prices at HM, increase concerns with respect to the CiC theory. In particular, higher CSMC prices raise concerns that the owner/operator of CSMC has chosen to exercise its market power by setting a high price, and thus similarly seeks to exercise any HM market power by raising price. Similarly, the lower HM price (in conjunction with evidence that HM has market power) means that a new owner could profitably impose an HM price increase.
- In an analysis conducted for [redacted],[111] RAND estimated that CSMC's price for inpatient services was approximately 32 percent higher than the HM's prices.[112] Thus, if CSMC were to increase HM's prices post-affiliation, as predicted under the CiC theory, the potential price increase at HM could be substantial: if the price gap between CSMC and

[108] See, for example, Vistnes, G., "The Role of Third Party Views in Antitrust Analysis: Trust But Verify," *Government Antitrust Litigation Advisory*, American Bar Association, July 1998; and Tucker, D., et al., "The Customer is Sometimes Right: The role of Customer Views in Merger Investigations," *Journal of Competition Law & Economics*, December 2007.

[109] In contrast, had there been consistent evidence that payers were *not* concerned with cross-market effects, even when carefully asked about the likely basis for such concerns, would have provided important evidence that cross-market concerns are *less* likely. Few of the payers I interviewed, however, had no such concerns about the proposed affiliation.

[110] As discussed further below, market power at both the acquired and acquiring hospital are required under the CC theory. In contrast, the TT theory requires market power at just one of the hospitals (either the acquiring or the acquired hospital), while the CiC theory only requires market power at the acquired hospital.

[111] [redacted]

[112] In making these price comparisons, RAND accounts for differences in patient mix across hospitals by estimating hospitals' prices relative to what Medicare pays for those services. RAND also compared system-level prices across hospitals and found that in 2018, CSHS' prices (relative to Medicare) were 23% higher than HM's prices. These findings from RAND's Nationwide Evaluation of Health Care Prices Paid by Private Health Plans are available at https://www.rand.org/pubs/research_reports/RR4394.html.

HM were completely eliminated, HM's price would increase by 32 percent, and even if CSMC only reduced that price gap by half, HM's prices would still increase by 16 percent.

E. CSHS's history with respect to previous affiliations does not mitigate concerns

CSHS has been involved in three previous affiliations with Los Angeles area hospitals: it acquired Marina Del Rey in 2015; it entered into an affiliation agreement with Torrance in 2018; and it formed a joint venture with Tarzana in 2019.[113] In each case, these affiliated hospitals were likely competing in a different market than CSMC, and thus the affiliations could be considered cross-market mergers. Accordingly, one can ask whether the same theories suggesting possible competitive harm from the future CSHS/HM affiliation would have predicted harm from those historic cross-market affiliations, and if so, whether that harm occurred. Thus, one can ask whether the cross-market theories used to predict the future were able to accurately predict the past.[114]

Based on interviews of payers, there is little evidence of cross-market effects with respect to CSHS's past affiliations. This finding, however, comes with two important qualifications First, the evidence about price effects is based on payer interviews rather than a more careful analysis of actual price data. Second, and perhaps more important, Marina Del Rey, Torrance, and Tarzana have had few opportunities since affiliating with CSHS to re-negotiate contracts with payers. Thus, with only a limited number of observations to draw upon, the extent to which the past is prologue, and thus the likelihood of effects from the CSHS/HM affiliation, is unclear.

Yet, even more important than the limited number of post-affiliation contract negotiations is fact that those past affiliations were unlikely candidates for cross-market effects. In particular, none of the affiliated hospitals likely had significant market power as proxied by the WTP estimates shown in Table 12.[115] Yet both the CC and CiC theories of cross-market harm depend on the acquired hospital having significant market power. Thus, while a lack of historic effects is relevant to assessing the likelihood of cross-market effects under the TT theory (which only requires market power for the acquiring hospital but not the acquired hospital), a lack of historic effects at those affiliates is largely *irrelevant* when assessing the likelihood of cross-market effects from the CSHS/HM affiliation in which both CSMC and HM likely have substantial market power.

VII. THE PROPOSED CONDITIONS

The OCAG has set forth certain conditions ("Conditions") to address competitive concerns regarding possible cross-market effects from the proposed affiliation. From an economic

[113] See 2020 Health Impact Report.

[114] Obviously a finding that the theories would have incorrectly predicted harm that never emerged would raise doubts about the reliability of the theories to predict the future.

[115] Payer interviews similarly provided no basis to believe that any of those CSHS affiliates has significant market power.

perspective, the Conditions define two principal restrictions: what I refer to as the "Unbundling Requirement" and the "Price Cap" restriction.[116]

In my opinion, the Conditions provide less protection to consumers than would be the case if the proposed affiliation were prohibited. Prohibiting the affiliation, however, would put at risk any benefits that might otherwise flow from the affiliation.[117] I also understand that prohibiting the affiliation is not currently an option under consideration. Accordingly, one can ask whether some form of regulatory intervention short of outright prohibition is likely to benefit consumers relative to a but-for world in which the affiliation proceeds without intervention.[118]

As discussed below, the Unbundling Requirements and the Price Cap restrictions work together to significantly reduce the risk that cross-market effects will result in higher prices.

A. The Condition's restrictions

1. The "Unbundling" Requirement

Very generally, the "Unbundling Requirement" requires that, unless otherwise requested by the payers, CSHS negotiate post-affiliation contracts separately for HM and for the remainder of the CSHS affiliates.[119] Moreover, not only must those negotiations be done separately, they must be done by distinct contracting personnel at CSHS and HM, with no unnecessary communication between those contracting teams.

2. The Price Cap

Very generally, the Price Cap restrictions in the Conditions impose a limit on the amount by which HM's prices (on a payer-specific basis) can increase each year.[120] This involves two basic steps. First, the Price Cap specifies a methodology defining (in percentage terms) the amount by which prices are *allowed* to increase. Second, the Price Cap specifies a methodology for calculating the

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[116] As noted in note 7, the Conditions also include other provisions, including an Arbitration provision that in turn relates to the Unbundling provision, the Price Cap provision, the Term provision, and the Notification and Reporting provision.

[117] As previously noted, I offer no opinion on the existence, likelihood, or expected magnitude of any such benefits, or whether any claimed benefits are the motive CSHS' proposed affiliation with HM.

[118] In assessing the merits of intervention, economists recognize that virtually any form of regulatory intervention is both imperfect and has its own costs. Thus, when assessing the merits of any proposed regulatory intervention, one should assess both costs and benefits to determine the *net* costs or benefits of intervention. I do not understand the parties to have presented specific evidence regarding any such costs although I understand they were given an opportunity to do after having been informed about the proposed Conditions.

[119] I refer to the Unbundling Requirements as the conditions set forth in the section "Separate Negotiations and Firewalls for Huntington Hospital."

[120] The Price Cap is applicable to all HM prices (including both inpatient and outpatient services).

amount by which HM's prices *actually* increase. That actual price increase is then compared to the allowed increase.

The Price Cap is designed in a way that takes into account the complex nature of the services that HM provides, the fact that the number of patients receiving different services can change over time, and the fact that payers may wish to change how those services are reimbursed (e.g., changing from a DRG-based contract to a per-diem or capitation contract).[121] The remainder of this section elaborates on the Price Cap methodology for calculating the actual, and allowed, price increases, with illustrative examples provided in Appendix 2.

a) Determining HM's Allowed Price Increase

In defining an Allowed Price Increase, the Price Cap tries to allow HM to increase its price by the same amount that other hospitals in competitive markets increase their price.[122] To determine this "competitive hospital price increase," the Price Cap looks to the U.S. Bureau of Labor Statistics' seasonally adjusted *CPI for Hospital Services in U.S. Cities* ("the Index").[123] The Price Cap then defines the Allowed Price Increase as the amount by which the Index changes from year to year.

The Price Cap includes two provisions with respect to how the Allowed Price Increase is calculated to give HM greater certainty about how large a price increase it will be allowed in the future. First, the Allowed Amount focuses on lagged Index values so that the calculated change in the Index will be known at the time the contract is being negotiated. Second, the Allowed Amount includes a provision for a "4% floor price increase": a minimum price increase that HM can set when negotiating multi-year contracts where the changes in the Index cannot be predicted with certainty.

(1) The lagged Index

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[121] The Price Cap also includes several provisions, including provisions related to the parties seeking to offer risk-based contracts or contracts that provide incentives for the more efficient provision of care, for the contract terms to be reviewed under the Arbitration provisions of the Conditions or for said contracts to be reviewed by the OCAG. These provisions provide important additional safeguards to help ensure against overly restrictive price regulation that might otherwise prevent beneficial contracts (e.g., capitated or global risk contracts) from being entered into. These provisions mean that the specific terms of the Price Cap do not need to be unnecessarily complicated in an effort to specify precisely how such contracts, should they be proposed, would be evaluated.

[122] Estimating the competitive price increase at HM by looking at other hospitals' price increases is admittedly imperfect. In particular, HM is not the same as all other hospitals that make up the inpatient hospital price index, and the factors affecting the extent to which HM would change price in a competitive market are not necessarily the same as those affecting other competitive hospitals. Thus, changes in the competitive price at HM could differ from the average competitive price change across all other hospitals. I also note that, even among hospitals making up the price index, there can be significant variation in prices and price changes over time, thus illustrating that there is no single "competitively determined" price change in a particular year: competitively-determined price changes can differ among hospitals for a variety of reasons that the price index does not capture. Nevertheless, absent the ability to establish a complex regulatory regime in which cost-based prices specific to HM can be estimated, the BLS's hospital price index likely provides the best available proxy for what a competitively determined inpatient hospital price increase would be, and one that appears to be generally consistent with estimates of HM's historic price changes.

[123] This statistic is available from the BLS at https://beta.bls.gov/dataViewer/view/timeseries/CUSR0000SEMD01.

The Allowed Price Increase is calculated over a 12-month period beginning 18 months before the Current Year and ending 6 months before the Current Year.[124] This six-month lag takes into account that contracts are typically negotiated in advance of the date at which they take effect, and helps to ensure that negotiators, even 6-months before the contract takes effect, can determine the magnitude of the Allowed Price Increase.

(2) The 4 Percent Floor Price Increase

While the use of a lagged Index means that HM can determine the Allowed Price Increase governing price increases in the first year of its contract, HM can only predict changes in the Index for future years. Thus, if entering into a multi-year contract, HM would not be able to set prices for year 2 and beyond without running a risk that its Actual Price Increase will end up exceeding its Allowed Price Increase. For this reason, the Price Cap also specifies what can be viewed as a "floor price increase" This floor price increase specifies a minimum Allowed Price Increase for years 2 and beyond in a multi-year contract.

The Price Cap sets a 4 percent floor price increase. Thus, if the Change in the Index for year 2 ends up as 3 percent, the Allowed Price Increase is equal to the 4 percent floor. If, however, the Change in the Index is 5 percent, the Allowed Price Increase is equal to that higher 5 percent amount. This 4 percent floor reflects observed changes in the Index over time, with that change in the Index ranging from approximately 2.3 percent to 7.1 percent over the last 10 years, and an average annual change of approximately 4.8 percent over that time period.

b) Determining HM's Actual Price Increase

The Actual Price Increase is calculated as the amount by which a health plan's total payments, for a *fixed set of inpatient hospital services,* would increase from year to year solely because of any price changes. Thus, if the payer would have paid exactly the same amount over time for the same "baseline" basket of services, the Actual Price Increase is zero. If, however, that same baseline basket of services would have been more expensive under the new contract than was the case under the old contract, prices are said to have increased.

The definition and calculation of the Actual Price Increase (expressed in percentage terms between years *t-1* and *t*) can be concisely summarized as:

$$Actual\ Price\ Increase = \frac{Q_0 * P_t - Q_0 * P_{t-1}}{Q_0 * P_{t-1}}$$

[124] The Price Cap refers to the Current Year as the "Current Managed Care Contract Year."

where:[125]

$$Q_0 = Baseline\ Year\ Basket;$$

$$P_t = Current\ Year\ Price\ Schedule;$$

$$P_{t-1} = Previous\ Year\ Price\ Schedule;$$

Alternatively, the Price Cap can be expressed without the use of formulas. As set forth by the Price Cap, a payer's Actual Price Increase[126] is calculated as the percentage change in a payer's Current Year Payments relative to its Previous Year Payments, *where*:

Current Year Payment (CYP):[127] The CYP is calculated as the payments the payer would make to the hospital to provide the services defined by the Baseline Service Basket,[128] based on the Current Price Schedule.[129]

Previous Year Payment (PYP):[130] The PYP is calculated as the payments the payer would make to the hospital to provide the services defined by the Baseline Service Basket, based on the Previous Year Price Schedule.[131]

where:

Baseline Year: The Baseline Year is defined as the most recent 12-month period covered by a payer's previous contract.[132]

[125] Each of the terms below (Q_0, P_t, and P_{t-1}) refer to a *set* (i.e., a "vector") of quantities and prices associated with each one of the individual services that HM offers, e.g., $Q_0 = \{Q_0^1, Q_0^2, Q_0^3, \ldots. Q_0^n\}$ in the case where there are *n* individual services.

[126] The Price Cap refers to the Actual Price Increase as the difference between the "Calculated Total Reimbursement" for the "Current Managed Care Contract Year" and the "Calculated Total Reimbursement" for the "Previous Managed Care Contract Year."

[127] The Price Cap refers to the CYP as the "Calculated Total Reimbursement" for the "Current Managed Care Contract Year."

[128] The Price Cap refers to the Baseline Service Basket as the "volume and utilization of all healthcare services for the Baseline Managed Care Contract Year."

[129] The Price Cap refers to the Current Price Schedule as the "Price Schedule for all healthcare services provided in the Current Managed Care Contract Year."

[130] The Price Cap refers to the PYP as the "Calculated Total Reimbursement" for the "Previous Managed Care Contract Year."

[131] The Price Cap refers to the Current Price Schedule as the "Price Schedule for all healthcare services provided in the Previous Managed Care Contract Year."

[132] See note 133 below for certain conditions under which 2019 will be used as the Baseline Year.

Baseline Service Basket: The Baseline Service Basket consists of the set of all hospital services provided by HM to that payer in the Baseline Year.[133]

Current Year Price Schedule: The Current Year Price Schedule consists of the price schedule applicable in the Current Contracting Year.[134]

Previous Year Price Schedule: The Previous Year Price Schedule consists of the price schedule applicable in the Previous Contracting Year.

It follows that the Current Year Payment can be thought of as what it would have cost to treat the payer's Baseline Year patients had the Current Year price schedule been in effect, and the Actual Price Increase is calculated as the different between what the payer would have paid to treat those same patients based on the previous year price schedule versus the current year price schedule. [135]

The intuition for basing HM's year-to-year price increase on the fixed baseline set of services can be explained as follows. For simplicity, assume that the Allowed Price Increase is 0 percent. HM could then satisfy the Price Cap, regardless of any year-to-year changes in the number or distribution of patients it treats, by simply keeping every price the same over time: by keeping the same prices, the payer's total cost of the baseline set of services is unchanged when evaluated at the prices in effect during the Current Year versus the Previous Year.

The Price Cap allows HM greater pricing flexibility, however. Continuing to assume an Allowed Price Increase of 0 percent, the Price Cap does not require that the price of every single service stay the same. Rather, the Price Cap allows individual prices to change as long as those individual changes are offsetting: if the price of one service goes up, the price of other services must go down by enough that the overall cost of that fixed set of services does not change.[136]

The Price Cap's use of a baseline set of services also means that changes in a hospital's patient volume do not affect the price cap: since the Price Cap always looks at the cost of purchasing the

[133] In choosing the fixed basket of services over which the Price Cap is applied, the Price Cap specifies that basket as the set of services the health plan purchased from HM in the last year of its previous contract. Thus, if the health plan seeks to renegotiate a contract with HM with a new start-date of 2024, the fixed basket of services corresponds to what the health plan purchased in 2023. There is an exception to this, however, if the new contract begins prior to January 2023, in which case the fixed basket will be what the payer purchased in 2019. This caveat addresses concerns that the basket of services purchased during the Covid pandemic period may not be representative.

[134] More generally, the Current Year Price Schedule refers to the price formulas, price schedules or other price terms defining the total reimbursement a hospital will receive for treating a payer's patients.

[135] Thus, the Current Year Payment can, in principle, be calculated by running the payer's claims data from the Baseline Year through whatever reimbursement algorithm the payer uses in the Current Year. The Previous Year Payment can be similarly calculated, but using the reimbursement algorithm that was used in the Previous Year.

[136] The simple analogy is to a shopping basket of goods at a grocery store: the Price Cap does not impose any conditions on the prices of individual items (i.e., the price of milk vs. tuna fish vs. ground beef), but it does require that the cost of a fixed shopping basket (e.g., 2 gallons of milk, 3 cans of tuna fish, and 2 pounds of ground beef) stays the same over time.

baseline set of services, the Price Cap is unaffected by whether the hospital increases or decreases patient volume over time, or changes the mix of services that it provides.[137]

The Price Cap's use of a baseline set of services also allows HM to change *how* it prices its services, e.g. moving from discounted charges to DRG prices, or per-diem prices to capitated prices. To calculate the price change, the fixed set of services is simply "re-priced" in the current year (with the new price schedule) to see if the overall cost to the payer has increased relative to what the payer would have paid for those same services at last year's prices (with the old price schedule).[138]

c) When the Actual Price Increase differs from the Allowed Price Increase

In the event that HM's Actual Price Increase is less than the Allowed Price Increase, the Price Cap makes provisions for the hospital to "bank" that difference so that HM can use it to offset future excess price increases. In the event that HM's actual price increase exceeds the allowed price increase, the Price Cap requires HM to reimburse the payer.

(1) When the Actual Price Increase is less than the Allowed Price Increase

In the event that HM's Actual Price Increase is less than its Allowed Price Increase, the Price Cap allows HM to "bank" the difference to offset future instances in which HM's Actual Price Increase may exceed its Allowed Price Increase.[139]

To illustrate, assume that HM's Allowed Price Increase for a particular payer is 7 percent, but HM only increases price by 4 percent. In that scenario, HM can bank the 3 percent difference. If the Allowed Price Increase for the following year is 5 percent, HM can then use its banked allowance of 3 percent to increase price by as much as 8 percent (and thus depleting its banked allowance). Alternatively, if HM only increased price by 6 percent in that second year, HM would only use 1 percent of its banked allowance, thus keeping 2 percent in banked allowances to be used at some future date.[140]

The Price Cap's provision for banked allowances serves two important purposes. First, allowing HM to bank an allowance avoids creating an undesirable "use or lose" incentive in which HM has incentives to set price as high as allowed because (absent the banked allowance provision), if the

[137] Those changes only matter in the event that a new contract requires that a new baseline set of services be defined. See Example 3 in Appendix 2 for details.

[138] See Example 4 in Appendix 2.

[139] That "banked difference" is specific to a particular payer. The Price Cap does not allow HM to use banked savings from one payer to offset excessive prices to another payer.

[140] There is no provision for "loans" in which HM's banked allowance becomes negative.

fully allowed price increase is not imposed today, the opportunity to impose that price increase is lost forever.

The second purpose of the provision for banked allowances stems from the recognition that the Index governing HM's allowed price increase is likely to be an imperfect means of estimating HM's but-for competitive price in any particular year. Specifically, while the Index provides a reasonable estimate of the *average* price increases across competitive hospitals, in any particular year that Index-based price increase may be higher or lower than what any *particular* competitive hospital sets. Thus, in any given year, the Index may not provide an accurate estimate of the price increase that HM would have set absent the affiliation. Absent the banked allowance provision, the Price Cap would then set an Allowed Price Increase that is "too small" in some years, but leave HM unable to make up for that overly restrictive cap in other years.[141] The banking provision allows HM to deviate on a year-by-year basis from the Index while still requiring it to limit its *average price increase over time* to the price increase set forth by the Index.[142]

(2) When the Actual Price Increase exceeds the Allowed Price Increase

In the event that HM's Actual Price Increase to a payer exceeds the Allowed Price Increase, and if HM has no (or insufficient) banked allowances, the Price Cap requires HM to refund the difference to the payer, with that refund sufficient to fully offset the calculated difference between the actual and allowed amount.[143]

B. The Unbundling and Price Cap restrictions are designed to address cross-market concerns

Both the Unbundling and Price Cap restrictions are designed to address the cross-market concerns identified in Section V.A.[144]

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[141] To illustrate this point, assume that HM's actual but-for price increase over time would have been 3%, 1%, and 5% over a three year period. Further assume that the Allowed Amount is 3% in each year. Thus, *on average*, the Allowed Amount provides an accurate proxy for HM's but-for price increases but that Allowed Amount is off in two of the three years. If HM chooses to only impose its desired but-for price increase of 1% in Year 2, but is then limited in Year 3 to only imposing a 3% price increase when the but-for price increase would have been 5%, HM's price increase over the 3-year period is only 7% instead of the 9% that other competitive hospitals would have set. Absent the banking provision, this creates incentives for HM to impose the maximum allowed price increase of 3% in Year 2 rather than the price increase of just 1% that it prefers. In contrast, the banking provision means that HM could increase price by just 1% in Year 2, bank the 2% savings, and use those savings in Year 3 to raise price by 5% instead of just 3%.

[142] While the Conditions allows HM to bank allowances for use in future years, it makes no provision for "loans:" HM cannot increase price by more than the allowed amount by going into deficit with respect to its banked allowances.

[143] Specifically, using the terminology introduced above, the required refund is equal to $Q_0*P_t - Q_0*P_{t-1}$.

[144] As discussed in note 8, I understand that similar restrictions have been imposed in other situations where there was a fear of post-merger hospital price effects. Yet, even though the reason why a hospital's incentive to raise price may differ across situations (i.e., because of reductions in *direct* competition versus *cross-market* effects), the regulatory means used to prevent that price increase can be the same.

1. The Unbundling Requirement

The Unbundling Requirement directly addresses concerns relating to the TT and CC theories of harm. In particular, both theories assume the hospital can link contract negotiations between the CSHS hospitals and HM following the affiliation. Absent the ability to link those negotiations, those two theories predict no competitive harm. Thus, the Unbundling Requirement is a targeted, and potentially very powerful means, of reducing competitive concerns associated with the TT and CC theories.

The Unbundling Requirement also plays an important role in addressing competitive concerns stemming from the CiC theory in which CSHS is assumed to take advantage of HM's pre-existing, but unexercised, market power to raise price at HM. As discussed below, the most direct means of preventing a post-affiliation price increase at HM is through the Price Cap. But because the Price Cap only limits HM's prices, CSHS could engage in "regulatory evasion" in which it imposes the price increase at another one of CSHS's facilities rather than at HM itself. This form of regulatory evasion, however, assumes that CSHS can require payers to contract with those other (now higher priced facilities) as a pre-condition for contracting with HM. The Unbundling Requirement prevents that bundling, and therefore reduces CSHS's ability to engage in this form of regulatory evasion. Thus, the Unbundling Requirement is an important means of ensuring that the Price Cap effectively addresses CiC concerns.

2. The Price Cap

As discussed above, the Unbundling Requirement largely eliminates TT and CC concerns *if* it is totally effective at preventing tying or bundling. To the extent that the Unbundling Requirement is imperfect, the Price Cap provides secondary price protection under the TT and CC theories.[145]

The Price Cap plays a much more important role in preventing harm under the CiC theory: it constitutes the principal means of protecting against a post-affiliation price increase. The Price Cap focuses on limiting price increases at just HM (and not the other CSHS facilities) because it is directly tied to the concern that, under the CiC theory, the price increases will be at HM rather than other CSHS facilities.[146]

This discussion of how the Price Cap protects against possible cross-market price increases is not meant to downplay the potential problems associated with using any form of price cap as a means of regulating prices. Economists have long recognized the difficulty of effectively regulating price,

[145] Because the Price Cap only governs price increases at HM, the Price Cap only provides this secondary protection at HM and not at other CSHS facilities. In my opinion, limiting the scope of the Price Cap to just HM appropriately recognizes that its role with respect to the TT and CC theories is only secondary. Thus, given the likely burden that extending the Price Cap to the rest of the CSHS facilities would impose, on balance it is likely appropriate to limit the Price Cap to HM.

[146] As discussed, absent the Unbundling Requirement, CSHS might try to raise price at other facilities if the Price Cap prevented it from doing so at HM. But as long as the Unbundling Requirement prevents that regulatory evasion, the principal risk of price increase under the CiC theory is at HM.

whether in the healthcare industry or any other industry in which firms are believed to have substantial market power that will allow them to set higher-than-desired prices. Thus, economists recognize that there can be both costs and benefits of imposing price regulation. With respect to the CSHS/HM affiliation, extensive cost-based price regulation that would allow a more hospital-specific estimate of the competitive but-for price is not a realistic option. As a result, the most feasible means of regulating price is through the use of a price index based estimated prices (and price increases) at other hospitals. This imperfect means of deriving a proxy for the competitive but-for price at HM affects the relative costs and benefits of price regulation. Nevertheless, this imperfect price regulation is likely the best available means by which to prevent a post-affiliation price increase at HM driven by cross-market effects, while still allowing for price increases due to marketwide cost changes.

Table 1
Southern California Hospitals
General Acute Care and Specialty Hospitals (2018-2019)

			Hospital Type				Patient Mix (Share of Total Discharges)			Discharges		Average Daily Census
Map ID	Hospital Name	City	Staffed Beds	Teaching or Rural	Trauma Desig.	Births	MediCal	Medicare	Comm.	Total Acute	Comm. Acute	Comm.
	General Acute Care Hospitals											
1	Cedars-Sinai Medical Center	Los Angeles	889	Teaching	Yes	6,285	9.5%	44.4%	43.7%	55,629	24,291	315
2	Docs Surgical Hospital	Los Angeles	2		No		0.4%	29.7%	37.8%	283	107	0
3	Olympia Medical Center	Los Angeles	67		No		30.6%	57.9%	4.2%	4,442	185	3
4	Kaiser Foundation Hospital - West LA	Los Angeles	85		No	1,908	11.6%	32.2%	54.5%	10,723	5,842	42
5	Southern California Hospital At Hollywood	Hollywood	54		No		53.3%	45.6%	1.0%	4,046	41	3
6	Southern California Hospital At Culver City	Culver City			No	4	27.6%	27.1%	44.1%	7,558	3,331	
7	Ronald Reagan UCLA Medical Center	Los Angeles	445	Teaching	Yes	1,695	20.6%	31.0%	42.7%	24,349	10,409	194
8	Hollywood Presbyterian Medical Center	Los Angeles	243		No	2,757	58.7%	26.5%	10.5%	14,954	1,578	23
9	Kaiser Foundation Hospital - Los Angeles	Los Angeles	363	Teaching	No	2,772	7.8%	34.7%	56.1%	26,611	14,941	212
10	L.A. Downtown Medical Center	Los Angeles	79		No		37.0%	60.4%	0.4%	2,015	9	1
11	Providence Saint Joseph Medical Center	Burbank	197		No	2,164	25.1%	43.1%	28.8%	17,479	5,035	57
12	Providence Saint John's Health Center	Santa Monica	149		No	2,017	7.6%	45.8%	44.3%	14,798	6,558	65
13	Glendale Memorial Hospital and Health Center	Glendale	135		No	1,473	49.5%	36.5%	12.0%	9,521	1,146	15
14	Santa Monica - UCLA Medical Center and Orthopaedic Hospital	Santa Monica	227		No	1,623	12.0%	39.3%	45.1%	16,320	7,358	94
15	California Hospital Medical Center - Los Angeles	Los Angeles	207		Yes	3,113	78.0%	14.7%	4.3%	21,054	902	9
16	Good Samaritan Hospital-Los Angeles	Los Angeles	230		No	2,614	39.7%	25.8%	31.7%	14,975	4,745	55
17	Cedars-Sinai Marina Del Rey Hospital	Marina Del Rey	97		No		10.9%	51.7%	30.3%	4,738	1,434	11
18	Encino Hospital Medical Center	Encino	82		No		18.9%	68.5%	11.0%	1,742	192	7
19	Sherman Oaks Hospital	Sherman Oaks	94		No		27.7%	61.8%	8.1%	4,798	387	7
20	Adventist Health White Memorial	Los Angeles	242	Teaching	No	3,500	58.8%	25.0%	8.1%	19,912	1,610	19
21	LAC+USC Medical Center	Los Angeles	546	Teaching	Yes	1,169	72.9%	13.0%	3.3%	30,906	1,029	17
22	Los Angeles Community Hospital	Los Angeles	109		No		66.8%	31.3%	1.8%	5,350	97	3
23	Keck Hospital of USC	Los Angeles	294	Teaching	No		9.4%	43.3%	28.5%	11,983	3,417	67
24	Community Hospital of Huntington Park	Huntington Park	41		No		58.9%	34.8%	4.8%	3,577	172	2
25	Centinela Hospital Medical Center	Inglewood	198		No	596	48.0%	44.8%	4.8%	16,097	772	9
26	Kaiser Foundation Hospital - Panorama City	Panorama City	88		No	2,526	8.8%	29.5%	60.9%	10,696	6,515	48

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Map ID	Hospital Name	City	Staffed Beds	Teaching or Rural	Trauma Desig.	Births	MediCal	Medicare	Comm.	Total Acute	Comm. Acute	Comm.
27	Valley Presbyterian Hospital	Van Nuys	199		No	2,735	70.8%	19.8%	7.0%	15,892	1,111	13
28	East Los Angeles Doctors Hospital	Los Angeles	60		No	809	77.1%	16.9%	4.8%	4,013	191	3
29	Pacifica Hospital of The Valley	Sun Valley	138		No		75.4%	17.9%	4.6%	2,603	119	6
30	Providence Cedars-Sinai Tarzana Medical Center	Tarzana	136		No	2,500	22.8%	35.4%	38.4%	14,631	5,619	50
31	Mission Community Hospital - Panorama Campus	Panorama City	133		No		34.7%	33.9%	28.8%	4,937	1,421	35
32	Monterey Park Hospital	Monterey Park	55		No	1,173	58.1%	23.1%	6.3%	6,031	381	3
33	Martin Luther King, Jr. Community Hospital	Los Angeles	92	Teaching	No	679	69.4%	22.9%	2.7%	10,345	280	2
34	Adventist Health Glendale	Glendale	325		No	1,658	28.8%	48.1%	19.5%	19,415	3,778	54
35	Memorial Hospital of Gardena	Gardena	134		No	474	60.9%	32.1%	5.1%	6,532	335	7
36	Garfield Medical Center	Monterey Park	152		No	2,438	35.7%	33.7%	14.9%	12,148	1,815	22
37	Kaiser Foundation Hospital - Woodland Hills	Woodland Hills	88		No	1,733	5.5%	43.4%	50.3%	9,414	4,735	41
38	Northridge Hospital Medical Center	Northridge	176		Yes	670	27.2%	44.4%	23.7%	13,418	3,177	43
39	Alhambra Hospital Medical Center	Alhambra	98		No		37.7%	52.7%	8.4%	4,566	382	8
40	Huntington Memorial Hospital	Pasadena	378	Teaching	Yes	3,375	18.1%	32.4%	44.2%	29,428	13,006	148
41	Beverly Hospital	Montebello	133		No	740	52.2%	34.8%	10.0%	11,560	1,152	11
42	Providence Holy Cross Medical Center	Mission Hills	262		Yes	3,091	34.9%	35.8%	25.8%	21,095	5,441	67
43	Providence Little Company of Mary Medical Center Torrance	Torrance	192		No	2,711	21.8%	42.4%	31.6%	19,293	6,092	82
44	St. Francis Medical Center	Lynwood	291		Yes	3,809	66.6%	22.8%	8.2%	20,249	1,653	24
45	PIH Health Hospital - Downey	Downey	110		No	973	31.6%	45.8%	20.3%	10,656	2,158	16
46	San Gabriel Valley Medical Center	San Gabriel	174		No	1,854	39.4%	38.6%	16.8%	10,047	1,690	29
47	USC Verdugo Hills Hospital	Glendale	106		No	408	9.7%	58.3%	30.2%	5,540	1,674	26
48	Greater El Monte Community Hospital	South El Monte	55		No	130	60.5%	31.8%	4.1%	3,034	125	2
49	Torrance Memorial Medical Center	Torrance	484		No	2,537	9.6%	49.4%	38.4%	27,854	10,695	123
50	LAC/Harbor-UCLA Medical Center	Torrance	314	Teaching	Yes	924	69.9%	16.3%	5.6%	17,312	965	16
51	West Hills Hospital and Medical Center	West Hills	115		No	508	14.2%	53.3%	23.9%	9,169	2,192	27
52	Los Angeles County Olive View-UCLA Medical Center	Sylmar	235	Teaching	No	748	74.5%	12.2%	1.4%	10,953	156	3
53	Coast Plaza Hospital	Norwalk	32		No		42.9%	46.7%	6.9%	2,455	170	2
54	Kaiser Foundation Hospital - Downey	Downey	191		No	4,239	10.9%	28.4%	59.7%	19,814	11,832	103
55	Norwalk Community Hospital	Norwalk			No		51.5%	42.6%	3.3%	2,839	94	
56	Kaiser Foundation Hospital - South Bay	Harbor City	134		No	2,538	9.8%	30.6%	58.7%	12,631	7,419	152

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57	PIH Health Hospital - Whittier	Whittier	251		No	1,667	18.7%	54.4%	24.7%	20,594	5,080	56
58	Kaiser Foundation Hospital - Baldwin Park	Baldwin Park	115		No	3,130	9.6%	29.9%	59.4%	13,188	7,839	59
59	Whittier Hospital Medical Center	Whittier	97		No	1,914	43.4%	21.8%	16.9%	9,027	1,525	16
60	College Medical Center	Long Beach	98		No		77.0%	19.1%	2.3%	3,533	81	4
61	Lakewood Regional Medical Center	Lakewood	114		No		24.0%	50.6%	23.3%	8,691	2,022	26
62	Memorialcare Long Beach Medical Center	Long Beach	310	Teaching	Yes		25.7%	49.6%	21.9%	21,076	4,616	62
63	West Covina Medical Center	West Covina	36		No		10.2%	83.3%	2.1%	575	12	1
64	Providence Little Company of Mary Mc - San Pedro	San Pedro	157		No	146	31.2%	46.0%	17.5%	4,111	720	36
65	Emanate Health Queen of The Valley Hospital	West Covina	198		No	3,876	49.5%	25.2%	16.6%	18,580	3,085	48
66	La Palma Intercommunity Hospital	La Palma	40		No		20.9%	63.7%	9.7%	2,833	275	4
67	Methodist Hospital of Southern California	Arcadia	298		No	1,541	6.5%	48.9%	38.4%	16,159	6,210	79
68	Henry Mayo Newhall Hospital	Valencia	244		Yes	1,386	17.5%	38.5%	38.9%	12,069	4,689	61
69	St. Mary Medical Center - Long Beach	Long Beach	197		Yes	1,945	58.1%	28.7%	10.2%	13,369	1,361	15
70	West Anaheim Medical Center	Anaheim	110		No		31.9%	53.9%	8.0%	6,313	505	9
71	Los Alamitos Medical Center	Los Alamitos	117		No	242	9.4%	60.1%	26.5%	8,378	2,216	29
72	Emanate Health Inter-Community Hospital	Covina			No		31.5%	52.5%	12.4%	7,111	883	
73	Ahmc Anaheim Regional Medical Center	Anaheim	131		No	874	39.3%	33.7%	20.9%	10,262	2,140	26
74	Anaheim Global Medical Center	Anaheim	132		No	871	60.9%	20.1%	6.5%	3,716	240	8
75	St. Jude Medical Center	Fullerton	204		No	2,350	15.6%	47.0%	36.0%	16,104	5,795	67
76	San Dimas Community Hospital	San Dimas	37		No	521	24.6%	42.8%	30.2%	3,915	1,184	10
77	Emanate Health Foothill Presbyterian Hospital	Glendora	69		No	485	26.3%	46.2%	21.9%	5,900	1,290	14
78	University of California Irvine Medical Center	Orange	402	Teaching	Yes	1,546	40.4%	31.1%	22.2%	22,056	4,889	76
79	Kaiser Foundation Hospital - Orange County - Anaheim	Anaheim	140		No	6,643	7.9%	27.3%	64.1%	30,316	19,429	151
80	St. Joseph Hospital - Orange	Orange	259		No	4,862	32.0%	31.9%	33.3%	23,838	7,928	73
81	Garden Grove Hospital and Medical Center	Garden Grove	50		No	901	39.5%	35.8%	6.1%	5,457	334	3
82	Pomona Valley Hospital Medical Center	Pomona	254		Yes	5,579	48.4%	27.0%	17.2%	25,034	4,297	42
83	Placentia Linda Hospital	Placentia	52		No		21.3%	45.8%	28.3%	3,054	864	7

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Map ID	Hospital Name	City	Staffed Beds	Teaching or Rural	Trauma Desig.	Births	MediCal	Medicare	Comm.	Total Acute	Comm. Acute	Comm.
84	Orange County Global Medical Center	Santa Ana	155		Yes	1,282	53.0%	28.8%	13.7%	8,877	1,220	16
85	Chapman Global Medical Center	Orange	59		No		16.9%	43.4%	31.4%	1,905	598	17
86	Foothill Regional Medical Center	Tustin	61		No		30.9%	60.5%	7.7%	2,926	226	5
87	South Coast Global Medical Center	Santa Ana	94		No	1,915	32.5%	15.8%	4.1%	5,738	237	4
88	Montclair Hospital Medical Center	Montclair	31		No	181	57.2%	31.8%	6.9%	2,963	205	2
89	Chino Valley Medical Center	Chino	80		No		44.7%	37.6%	14.6%	4,710	688	6
90	Memorialcare Orange Coast Medical Center	Fountain Valley	122		No	1,645	13.0%	44.6%	39.1%	13,898	5,429	43
91	Huntington Beach Hospital	Huntington Beach	61		No		28.6%	55.5%	8.2%	3,050	250	5
92	Fountain Valley Regional Hospital & Medical Center - Euclid	Fountain Valley	199		No	2,836	43.5%	31.5%	14.1%	21,497	3,037	33
93	San Antonio Regional Hospital	Upland	231		No	2,280	24.2%	40.2%	31.1%	19,958	6,210	57
94	Hoag Memorial Hospital Presbyterian	Newport Beach	306		No	6,848	10.4%	36.3%	45.9%	37,642	17,268	152
95	Memorialcare Saddleback Medical Center	Laguna Hills	127		No	2,233	6.1%	46.8%	43.9%	14,112	6,202	52
96	Corona Regional Medical Center-Main	Corona	98		No	927	38.9%	37.4%	19.9%	8,739	1,735	29
97	Mission Hospital Regional Medical Center	Mission Viejo	206		Yes	2,386	19.0%	43.8%	33.8%	16,968	5,735	74
98	Kaiser Foundation Hospital - Fontana	Fontana	275		No	7,100	13.3%	27.2%	57.6%	37,432	21,561	200
99	Palmdale Regional Medical Center	Palmdale	104		No		30.7%	49.6%	14.0%	8,165	1,139	15
100	Kaiser Foundation Hospital - Riverside	Riverside	119		No	3,267	11.9%	25.5%	61.7%	13,011	8,032	66
101	Mission Hospital LAguna Beach	Laguna Beach			No		20.2%	32.2%	43.9%	1,795	789	
102	Arrowhead Regional Medical Center	Colton	312	Teaching	Yes	2,549	58.6%	19.9%	4.8%	19,467	944	15
103	Doctors Hospital of Riverside	Riverside	83		No	1,572	42.6%	29.3%	20.5%	8,683	1,779	16
104	Riverside Community Hospital	Riverside	319		Yes	3,711	41.7%	28.9%	18.5%	27,358	5,069	57
105	Antelope Valley Hospital	Lancaster	262		Yes	4,379	46.8%	25.6%	23.7%	22,609	5,355	54
106	Community Hospital of San Bernardino	San Bernardino	225		No	2,251	76.3%	16.1%	5.4%	9,536	513	11
107	Loma Linda University Medical Center	Loma Linda	242	Teaching	Yes		35.2%	39.8%	16.6%	23,511	3,911	58
108	St. Bernardine Medical Center	San Bernardino	203		No	1,143	45.2%	39.5%	12.6%	16,324	2,060	23
109	Redlands Community Hospital	Redlands	159		No	1,973	25.4%	41.0%	31.1%	13,694	4,260	42
110	Riverside University Health System - Medical Center	Moreno Valley	266	Teaching	Yes	1,618	58.9%	22.4%	5.9%	17,146	1,016	17

Table 1
Southern California Hospitals
General Acute Care and Specialty Hospitals (2018-2019)

			Hospital Type				Patient Mix (Share of Total Discharges)			Discharges		Average Daily Census
Map ID	Hospital Name	City	Staffed Beds	Teaching or Rural	Trauma Desig.	Births	MediCal	Medicare	Comm.	Total Acute	Comm. Acute	Comm.
111	Kaiser Foundation Hospital - Moreno Valley	Moreno Valley	37		No	1,416	13.8%	29.8%	54.7%	5,832	3,193	18
112	Menifee Global Medical Center	Sun City	38		No		48.8%	44.3%	6.2%	3,810	236	2
113	Southwest Healthcare System-Murrieta	Murrieta	75		Yes	3,113	32.5%	33.3%	28.2%	19,560	5,518	42
114	San Gorgonio Memorial Hospital	Banning	62	Rural	No	253	35.2%	40.5%	20.0%	3,134	627	6
115	Loma Linda University Medical Center-Murrieta	Murrieta	90		No	1,012	20.7%	49.6%	22.1%	10,478	2,314	19
116	Desert Valley Hospital	Victorville	119		No	639	37.1%	43.8%	14.3%	10,635	1,521	15
117	Mountains Community Hospital	Lake Arrowhead	23	Rural	No		38.8%	42.9%	13.9%	289	40	3
118	Victor Valley Global Medical Center	Victorville	60	Rural	No	1,276	56.6%	25.2%	15.1%	6,809	1,027	8
119	Hemet Global Medical Center	Hemet	182		No	697	34.5%	54.1%	10.0%	9,396	942	17
120	St. Mary Medical Center - Apple Valley	Apple Valley	196	Rural	No	1,789	43.4%	39.1%	14.8%	15,503	2,291	27
121	Temecula Valley Hospital	Temecula	100		No		17.3%	59.1%	18.8%	9,421	1,767	19
122	Bear Valley Community Hospital	Big Bear LAke	26	Rural	No		19.1%	64.9%	15.3%	102	16	3
123	Desert Regional Medical Center	Palm Springs	272		Yes	2,896	34.5%	37.3%	24.1%	21,257	5,121	62
124	Barstow Community Hospital	Barstow	21		No	325	48.2%	33.2%	14.9%	2,202	327	3
125	Eisenhower Medical Center	Rancho Mirage	242		No		16.4%	60.7%	19.8%	19,892	3,935	42
126	John F. Kennedy Memorial Hospital	Indio	54		No	1,929	57.9%	16.9%	22.6%	8,896	2,011	11
127	Hi-Desert Medical Center	Joshua Tree	142	Rural	No	344	43.7%	24.9%	28.1%	2,469	694	27
128	Palo Verde Hospital	Blythe	20	Rural	No	106	45.1%	28.5%	24.4%	652	159	2
129	Colorado River Medical Center	Needles	6	Rural	No		40.6%	50.9%	6.4%	468	30	0
	Specialty Hospitals											
130	Children's Hospital of Los Angeles	Los Angeles	420	Teaching	Yes	16	73.9%	0.2%	23.7%	18,051	4,287	75
131	USC Kenneth Norris, Jr. Cancer Hospital	Los Angeles	35		No		16.6%	26.8%	25.1%	1,583	398	9
132	Memorialcare Miller Children's & Women's Hospital Long Beach	Long Beach	210		No	5,768	62.9%	0.1%	34.7%	19,535	6,783	67
133	City of Hope Helford Clinical Research Hospital	Duarte	200		No		12.5%	35.3%	48.6%	6,575	3,196	97
134	Children's Hospital of Orange County	Orange	187		Yes		60.6%	0.1%	37.5%	13,109	4,921	67
135	Hoag Orthopedic Institute	Irvine	25		No		0.1%	55.6%	40.0%	4,742	1,896	9
136	Children's Hospital At Mission	Mission Viejo	20		No	2	42.7%		52.7%	2,049	1,079	10
137	Loma Linda University Children's Hospital	Loma Linda	230		No	3,331	64.2%	0.2%	26.3%	18,012	4,732	60

Table 1
Southern California Hospitals
General Acute Care and Specialty Hospitals (2018-2019)

Map ID	Hospital Name	City	Hospital Type				Patient Mix (Share of Total Discharges)			Discharges		Average Daily Census
			Staffed Beds	Teaching or Rural	Trauma Desig.	Births	MediCal	Medicare	Comm.	Total Acute	Comm. Acute	Comm.

Notes:

[1] Commercial Acute Discharges ("Comm. Acute") is equal to the product of the number of acute discharges and the commercial share of total discharges reported in 2019 OSHPD data.
[2] Average Daily Census ("ADC") is equal to the number of patient days divided by the number of reporting days in the 2018 OSHPD data.
[3] Commercial Average Daily Census ("Comm.") is equal to the product of the average daily census from 2018 and the commercial share of total discharges from 2019.
[4] Service type is determined according to the categories in 2017 American Hospital Association data, and where not available, through online research. Only service types 10, 41, 47, and 50 are included.
[5] Catalina Island Medical Center is not included in this list.
[6] Number of births come from 2019 OSHPD data; all other information come from the 2020 OSHPD list.
[7] Number of staffed beds is calculated as the product of total number of beds from 2019 OSHPD data and the share of staffed beds out of all available beds according to 2018 OSHPD data.

Sources:

[1] 2018 OSHPD Pivot Profile
[2] 2019 OSHPD Pivot Profile
[3] 2017 American Hospital Association Data
[4] 2020 OHSPD List of Current Facilities

Table 2
Cedars-Sinai Medical Center: Nearby Hospitals
General Acute Care and Specialty Hospitals (2018-2019)

Hospital Name	City	Driving Distance (miles)	Drive Time (minutes)	Hospital Type				Patient Mix (Share of Total Discharges)			Discharges		Average Daily Census
				Staffed Beds	Teaching or Rural	Trauma Desig.	Births	MediCal	Medicare	Comm.	Total Acute	Comm. Acute	Comm.
General Acute Care Hospitals													
Cedars-Sinai Medical Center	Los Angeles	0.0	0.0	889	Teaching	Yes	6,285	9.5%	44.4%	43.7%	55,629	24,291	315
Docs Surgical Hospital	Los Angeles	1.8	7.6	2		No		0.4%	29.7%	37.8%	283	107	0
Olympia Medical Center	Los Angeles	1.9	8.2	67		No		30.6%	57.9%	4.2%	4,442	185	3
Kaiser Foundation Hospital - West LA	Los Angeles	3.0	10.0	85		No	1,908	11.6%	32.2%	54.5%	10,723	5,842	42
Southern California Hospital At Hollywood	Hollywood	4.5	15.1	54		No		53.3%	45.6%	1.0%	4,046	41	3
Southern California Hospital At Culver City	Culver City	4.7	16.6			No	4	27.6%	27.1%	44.1%	7,558	3,331	
Ronald Reagan UCLA Medical Center	Los Angeles	4.8	15.9	445	Teaching	Yes	1,695	20.6%	31.0%	42.7%	24,349	10,409	194
Hollywood Presbyterian Medical Center	Los Angeles	6.4	21.6	243		No	2,757	58.7%	26.5%	10.5%	14,954	1,578	23
Kaiser Foundation Hospital - Los Angeles	Los Angeles	6.5	22.6	363	Teaching	No	2,772	7.8%	34.7%	56.1%	26,611	14,941	212
L.A. Downtown Medical Center	Los Angeles	7.5	20.1	79		No		37.0%	60.4%	0.4%	2,015	9	1
Providence Saint Joseph Medical Center	Burbank	8.9	26.4	197		No	2,164	25.1%	43.1%	28.8%	17,479	5,035	57
Providence Saint John's Health Center	Santa Monica	9.2	18.9	149		No	2,017	7.6%	45.8%	44.3%	14,798	6,558	65
Glendale Memorial Hospital and Health Center	Glendale	9.8	30.8	135		No	1,473	49.5%	36.5%	12.0%	9,521	1,146	15
Santa Monica - UCLA Medical Center and Orthopaedic Hospital	Santa Monica	9.8	21.2	227		No	1,623	12.0%	39.3%	45.1%	16,320	7,358	94
California Hospital Medical Center - Los Angeles	Los Angeles	10.0	19.1	207		Yes	3,113	78.0%	14.7%	4.3%	21,054	902	9
Good Samaritan Hospital-Los Angeles	Los Angeles	10.9	21.3	230		No	2,614	39.7%	25.8%	31.7%	14,975	4,745	55
Cedars-Sinai Marina Del Rey Hospital	Marina Del Rey	12.2	20.6	97		No		10.9%	51.7%	30.3%	4,738	1,434	11
Encino Hospital Medical Center	Encino	13.3	25.8	82		No		18.9%	68.5%	11.0%	1,742	192	7
Sherman Oaks Hospital	Sherman Oaks	13.8	24.1	94		No		27.7%	61.8%	8.1%	4,798	387	7
Adventist Health White Memorial	Los Angeles	14.2	22.9	242	Teaching	No	3,500	58.8%	25.0%	8.1%	19,912	1,610	19
LAC+USC Medical Center	Los Angeles	14.3	24.3	546	Teaching	Yes	1,169	72.9%	13.0%	3.3%	30,906	1,029	17
Los Angeles Community Hospital	Los Angeles	14.7	22.6	109		No		66.8%	31.3%	1.8%	5,350	97	3
Keck Hospital of USC	Los Angeles	14.9	26.8	294	Teaching	No		9.4%	43.3%	28.5%	11,983	3,417	67
Community Hospital of Huntington Park	Huntington Park	15.1	29.1	41		No		58.9%	34.8%	4.8%	3,577	172	2
Centinela Hospital Medical Center	Inglewood	15.2	25.8	198		No	596	48.0%	44.8%	4.8%	16,097	772	9
Kaiser Foundation Hospital - Panorama City	Panorama City	15.4	28.7	88		No	2,526	8.8%	29.5%	60.9%	10,696	6,515	48
Valley Presbyterian Hospital	Van Nuys	15.7	26.6	199		No	2,735	70.8%	19.8%	7.0%	15,892	1,111	13
East Los Angeles Doctors Hospital	Los Angeles	15.8	25.0	60		No	809	77.1%	16.9%	4.8%	4,013	191	3
Pacifica Hospital of The Valley	Sun Valley	15.8	29.2	138		No		75.4%	17.9%	4.6%	2,603	119	6

Table 2
Cedars-Sinai Medical Center: Nearby Hospitals
General Acute Care and Specialty Hospitals (2018-2019)

Hospital Name	City	Driving Distance (miles)	Drive Time (minutes)	Hospital Type				Patient Mix (Share of Total Discharges)			Discharges		Average Daily Census
				Staffed Beds	Teaching or Rural	Trauma Desig.	Births	MediCal	Medicare	Comm.	Total Acute	Comm. Acute	Comm.
Providence Cedars-Sinai Tarzana Medical Center	Tarzana	17.1	28.2	136		No	2,500	22.8%	35.4%	38.4%	14,631	5,619	50
Mission Community Hospital - Panorama Campus	Panorama City	17.8	28.9	133		No		34.7%	33.9%	28.8%	4,937	1,421	35
Monterey Park Hospital	Monterey Park	18.4	28.7	55		No	1,173	58.1%	23.1%	6.3%	6,031	381	3
Martin Luther King, Jr. Community Hospital	Los Angeles	19.2	28.3	92	Teaching	No	679	69.4%	22.9%	2.7%	10,345	280	2
Adventist Health Glendale	Glendale	19.8	28.7	325		No	1,658	28.8%	48.1%	19.5%	19,415	3,778	54
Memorial Hospital of Gardena	Gardena	19.8	28.5	134		No	474	60.9%	32.1%	5.1%	6,532	335	7
Garfield Medical Center	Monterey Park	20.0	27.9	152		No	2,438	35.7%	33.7%	14.9%	12,148	1,815	22
Kaiser Foundation Hospital - Woodland Hills	Woodland Hills	20.0	29.0	88		No	1,733	5.5%	43.4%	50.3%	9,414	4,735	41
Northridge Hospital Medical Center	Northridge	20.2	33.1	176		Yes	670	27.2%	44.4%	23.7%	13,418	3,177	43
Alhambra Hospital Medical Center	Alhambra	20.3	30.9	98		No	0	37.7%	52.7%	8.4%	4,566	382	8
Huntington Memorial Hospital	Pasadena	20.6	31.5	378	Teaching	Yes	3,375	18.1%	32.4%	44.2%	29,428	13,006	148
Specialty Hospitals													
Children's Hospital of Los Angeles	Los Angeles	6.6	22.6	420	Teaching	Yes	16	73.9%	0.2%	23.7%	18,051	4,287	75
USC Kenneth Norris, Jr. Cancer Hospital	Los Angeles	14.7	26.2	35		No	0	16.6%	26.8%	25.1%	1,583	398	9

Notes:

[1] Commercial Acute Discharges ("Comm. Acute") is equal to the product of the number of acute discharges and the commercial share of total discharges reported in 2019 OSHPD data.
[2] Average Daily Census ("ADC") is equal to the number of patient days divided by the number of reporting days in the 2018 OSHPD data.
[3] Commercial Average Daily Census ("Comm.") is equal to the product of the average daily census from 2018 and the commercial share of total discharges from 2019.
[4] Service type is determined according to the categories in 2017 American Hospital Association data, and where not available, through online research. Only service types 10, 41, 47, and 50 are included.
[5] Catalina Island Medical Center is not included in this list.
[6] Number of births come from 2019 OSHPD data; all other information come from the 2020 OSHPD list.
[7] Number of staffed beds is calculated as the product of total number of beds from 2019 OSHPD data and the share of staffed beds out of all available beds according to 2018 OSHPD data.
[8] Drive times between hospitals' addresses are determined by the Google Maps API.

Sources:

[1] 2018 OSHPD Pivot Profile
[2] 2019 OSHPD Pivot Profile
[3] 2017 American Hospital Association Data
[4] 2020 OHSPD List of Current Facilities

Table 3
Huntington Memorial: Nearby Hospitals
General Acute Care and Specialty Hospitals (2018-2019)

Hospital Name	City	Driving Distance (miles)	Drive Time (minutes)	Hospital Type				Patient Mix (Share of Total Discharges)			Discharges		Average Daily Census
				Staffed Beds	Teaching or Rural	Trauma Desig.	Births	MediCal	Medicare	Comm.	Total Acute	Comm. Acute	Comm.
General Acute Care Hospitals													
Huntington Memorial Hospital	Pasadena			378	Teaching	Yes	3,375	18.1%	32.4%	44.2%	29,428	13,006	147.6
Alhambra Hospital Medical Center	Alhambra	3.5	11.0	98		No		37.7%	52.7%	8.4%	4,566	382	7.9
San Gabriel Valley Medical Center	San Gabriel	4.9	13.8	174		No	1,854	39.4%	38.6%	16.8%	10,047	1,690	28.7
Garfield Medical Center	Monterey Park	5.6	17.3	152		No	2,438	35.7%	33.7%	14.9%	12,148	1,815	21.9
Adventist Health Glendale	Glendale	5.8	8.1	325		No	1,658	28.8%	48.1%	19.5%	19,415	3,778	53.6
Monterey Park Hospital	Monterey Park	6.5	19.1	55		No	1,173	58.1%	23.1%	6.3%	6,031	381	3.4
USC Verdugo Hills Hospital	Glendale	7.4	10.8	106		No	408	9.7%	58.3%	30.2%	5,540	1,674	26.1
LAC+USC Medical Center	Los Angeles	8.8	14.1	546	Teaching	Yes	1,169	72.9%	13.0%	3.3%	30,906	1,029	17.4
Methodist Hospital of Southern California	Arcadia	9.0	11.8	298		No	1,541	6.5%	48.9%	38.4%	16,159	6,210	78.6
Adventist Health White Memorial	Los Angeles	9.0	13.3	242	Teaching	No	3,500	58.8%	25.0%	8.1%	19,912	1,610	18.8
Keck Hospital of USC	Los Angeles	9.2	14.9	294	Teaching	No		9.4%	43.3%	28.5%	11,983	3,417	66.9
Glendale Memorial Hospital and Health Center	Glendale	9.5	13.6	135		No	1,473	49.5%	36.5%	12.0%	9,521	1,146	14.9
L.A. Downtown Medical Center	Los Angeles	9.7	14.5	79		No		37.0%	60.4%	0.4%	2,015	9	0.7
Good Samaritan Hospital-Los Angeles	Los Angeles	9.9	14.3	230		No	2,614	39.7%	25.8%	31.7%	14,975	4,745	55.1
Providence Saint Joseph Medical Center	Burbank	11.5	13.1	197		No	2,164	25.1%	43.1%	28.8%	17,479	5,035	56.8
Greater El Monte Community Hospital	South El Monte	12.1	24.9	55		No	130	60.5%	31.8%	4.1%	3,034	125	2.2
California Hospital Medical Center - Los Angeles	Los Angeles	12.1	17.2	207		Yes	3,113	78.0%	14.7%	4.3%	21,054	902	8.6
Hollywood Presbyterian Medical Center	Los Angeles	12.4	18.9	243		No	2,757	58.7%	26.5%	10.5%	14,954	1,578	23.4
Los Angeles Community Hospital	Los Angeles	12.4	16.0	109		No		66.8%	31.3%	1.8%	5,350	97	3.2
Kaiser Foundation Hospital - Los Angeles	Los Angeles	12.9	20.5	363	Teaching	No	2,772	7.8%	34.7%	56.1%	26,611	14,941	212.3
East Los Angeles Doctors Hospital	Los Angeles	13.5	18.3	60		No	809	77.1%	16.9%	4.8%	4,013	191	2.7
Community Hospital of Huntington Park	Huntington Park	13.5	23.6	41		No		58.9%	34.8%	4.8%	3,577	172	1.8
Southern California Hospital At Hollywood	Hollywood	14.0	20.0	54		No		53.3%	45.6%	1.0%	4,046	41	3.2
Kaiser Foundation Hospital - West LA	Los Angeles	16.7	20.3	85		No	1,908	11.6%	32.2%	54.5%	10,723	5,842	42.1
Olympia Medical Center	Los Angeles	17.4	26.2	67		No		30.6%	57.9%	4.2%	4,442	185	2.7
Docs Surgical Hospital	Los Angeles	18.0	25.7	2		No		0.4%	29.7%	37.8%	283	107	0.4
Pacifica Hospital of The Valley	Sun Valley	18.3	21.0	138		No		75.4%	17.9%	4.6%	2,603	119	5.7
Beverly Hospital	Montebello	18.4	25.7	133		No	740	52.2%	34.8%	10.0%	11,560	1,152	10.6
Sherman Oaks Hospital	Sherman Oaks	18.8	20.4	94		No		27.7%	61.8%	8.1%	4,798	387	7.4
Southern California Hospital At Culver City	Culver City	18.8	26.2			No	4	27.6%	27.1%	44.1%	7,558	3,331	
Emanate Health Foothill Presbyterian Hospital	Glendora	19.1	21.0	69		No	485	26.3%	46.2%	21.9%	5,900	1,290	13.8

Table 3
Huntington Memorial: Nearby Hospitals
General Acute Care and Specialty Hospitals (2018-2019)

Hospital Name	City	Driving Distance (miles)	Drive Time (minutes)	Hospital Type				Patient Mix (Share of Total Discharges)			Discharges		Average Daily Census	
				Staffed Beds	Teaching or Rural	Trauma Desig.	Births	MediCal	Medicare	Comm.	Total Acute	Comm. Acute		Comm.
Emanate Health Inter-Community Hospital	Covina	19.2	23.0			No		31.5%	52.5%	12.4%	7,111	883		
Kaiser Foundation Hospital - Baldwin Park	Baldwin Park	19.7	20.9	115		No	3,130	9.6%	29.9%	59.4%	13,188	7,839	#	58.8
Cedars-Sinai Medical Center	Los Angeles	19.7	30.3	889	Teaching	Yes	6,285	9.5%	44.4%	43.7%	55,629	24,291	#	314.9
Specialty Hospitals														
USC Kenneth Norris, Jr. Cancer Hospital	Los Angeles	9.0	14.3	35		No	0	16.6%	26.8%	25.1%	1,583	398	#	8.8
City of Hope Helford Clinical Research Hospital	Duarte	12.0	13.7	200		No	0	12.5%	35.3%	48.6%	6,575	3,196	#	97.3
Children's Hospital of Los Angeles	Los Angeles	12.6	19.8	420	Teaching	Yes	16	73.9%	0.2%	23.7%	18,051	4,287	#	74.9

Notes:

[1] Commercial Acute Discharges ("Comm. Acute") is equal to the product of the number of acute discharges and the commercial share of total discharges reported in 2019 OSHPD data.
[2] Average Daily Census ("ADC") is equal to the number of patient days divided by the number of reporting days in the 2018 OSHPD data.
[3] Commercial Average Daily Census ("Comm.") is equal to the product of the average daily census from 2018 and the commercial share of total discharges from 2019.
[4] Service type is determined according to the categories in 2017 American Hospital Association data, and where not available, through online research. Only service types 10, 41, 47, and 50 are included.
[5] Catalina Island Medical Center is not included in this list.
[6] Number of births come from 2019 OSHPD data; all other information come from the 2020 OSHPD list.
[7] Number of staffed beds is calculated as the product of total number of beds from 2019 OSHPD data and the share of staffed beds out of all available beds according to 2018 OSHPD data.
[8] Drive times between hospitals' addresses are determined by the Google Maps API.

Sources:

[1] 2018 OSHPD Pivot Profile
[2] 2019 OSHPD Pivot Profile
[3] 2017 American Hospital Association Data
[4] 2020 OHSPD List of Current Facilities

Table 4
Average Drive Distance and Times
For Patients in Cedars-Sinai Medical Center PSA and SSA

Rank	Distance/Time to:	Avg. Driving Distance (miles)	Avg. Drive Time (minutes)
1	Cedars-Sinai Medical Center	12.5	25.0
2	Olympia Medical Center	12.6	23.4
3	Docs Surgical Hospital	12.8	23.2
4	Kaiser Foundation Hospital - West LA	13.2	20.3
5	Southern California Hospital At Culver City	13.5	23.3
6	Southern California Hospital At Hollywood	13.5	24.2
7	Ronald Reagan UCLA Medical Center	14.6	25.4
8	L.A. Downtown Medical Center	14.7	22.4
9	Hollywood Presbyterian Medical Center	15.1	25.3
10	Children's Hospital of Los Angeles	15.2	26.2
11	Good Samaritan Hospital-Los Angeles	15.2	23.1
12	Kaiser Foundation Hospital - Los Angeles	15.3	26.4
13	Santa Monica - UCLA Medical Center and Orthopaedic Hospital	15.4	26.4
14	Providence Saint John's Health Center	15.5	24.2
15	California Hospital Medical Center - Los Angeles	15.7	23.3
16	Sherman Oaks Hospital	15.8	23.1
17	Encino Hospital Medical Center	17.0	25.3
18	Providence Saint Joseph Medical Center	17.0	24.9
19	LAC+USC Medical Center	17.2	25.6
20	Cedars-Sinai Marina Del Rey Hospital	17.3	24.4
21	Adventist Health White Memorial	17.3	24.2
22	Glendale Memorial Hospital and Health Center	17.6	26.8
23	USC Kenneth Norris, Jr. Cancer Hospital	17.7	26.8
24	Keck Hospital of USC	18.0	27.4
25	Centinela Hospital Medical Center	18.0	27.6
26	Valley Presbyterian Hospital	18.5	26.3
27	Los Angeles Community Hospital	18.6	24.8
28	Community Hospital of Huntington Park	18.8	31.5
29	Adventist Health Glendale	19.0	26.2
30	Kaiser Foundation Hospital - Panorama City	19.3	29.6
31	East Los Angeles Doctors Hospital	19.7	27.0
32	Mission Community Hospital - Panorama Campus	19.7	28.4
33	Providence Cedars-Sinai Tarzana Medical Center	19.8	27.5
34	Martin Luther King, Jr. Community Hospital	21.4	28.2
35	Memorial Hospital of Gardena	21.4	28.3
36	Huntington Memorial Hospital	21.6	29.3
37	Monterey Park Hospital	21.9	30.2
38	Pacifica Hospital of The Valley	22.0	30.0
39	Garfield Medical Center	22.3	28.8
40	Providence Holy Cross Medical Center	22.3	28.4
41	Northridge Hospital Medical Center	22.4	32.1
42	Alhambra Hospital Medical Center	22.4	31.7
43	Kaiser Foundation Hospital - Woodland Hills	22.4	28.2
44	USC Verdugo Hills Hospital	22.4	29.0
45	St. Francis Medical Center	23.3	30.8
46	Providence Little Company of Mary Medical Center Torrance	23.4	35.2
47	Beverly Hospital	24.3	34.0

Table 4
Average Drive Distance and Times
For Patients in Cedars-Sinai Medical Center PSA and SSA

Rank	Distance/Time to:	Avg. Driving Distance (miles)	Avg. Drive Time (minutes)
48	LAC/Harbor-UCLA Medical Center	24.4	30.1
49	San Gabriel Valley Medical Center	24.7	35.4
50	PIH Health Hospital - Downey	24.8	33.7
51	Torrance Memorial Medical Center	25.3	38.7

Notes:

[1] Exhibit reports average drive times from the ZIP codes in the Cedars-Sinai Medical Center Secondary Service Area (SSA) to Los Angeles area hospitals. Drive times between ZIP code centroids to hospitals' addresses are determined by the Google Maps API and are weighted by the number of admissions at Cedars-Sinai Medical Center from the ZIP code.

[2] Hospitals in the exhibit are sorted by driving distance.

[3] The above table only shows Cedars-Sinai System hospitals, Huntington Memorial, and hospitals within 25 miles driving distance of Cedars-Sinai Medical Center.

Sources:

[1] 2019 OSHPD Pivot Profile

[2] 2019 OSHPD Discharge Data

Table 5
Average Drive Distance and Times
For Patients in Huntington Memorial PSA and SSA

Rank	Distance/Time to:	Avg. Driving Distance (miles)	Avg. Drive Time (minutes)
1	Huntington Memorial Hospital	9.8	16.6
2	San Gabriel Valley Medical Center	9.9	20.2
3	Alhambra Hospital Medical Center	10.7	20.8
4	Methodist Hospital of Southern California	11.0	19.1
5	Garfield Medical Center	11.7	21.0
6	Monterey Park Hospital	12.6	23.2
7	Adventist Health Glendale	12.7	18.3
8	City of Hope Helford Clinical Research Hospital	13.9	20.2
9	LAC+USC Medical Center	14.1	21.5
10	USC Kenneth Norris, Jr. Cancer Hospital	14.1	21.6
11	Keck Hospital of USC	14.2	22.2
12	Adventist Health White Memorial	14.4	21.0
13	Glendale Memorial Hospital and Health Center	14.9	22.1
14	USC Verdugo Hills Hospital	15.2	20.6
15	L.A. Downtown Medical Center	15.3	22.3
16	Beverly Hospital	15.6	28.0
17	Good Samaritan Hospital-Los Angeles	16.0	22.8
18	Greater El Monte Community Hospital	16.2	24.3
19	Los Angeles Community Hospital	16.4	23.0
20	Hollywood Presbyterian Medical Center	16.6	26.6
21	East Los Angeles Doctors Hospital	16.7	23.9
22	Kaiser Foundation Hospital - Baldwin Park	16.8	22.9
23	Children's Hospital of Los Angeles	17.2	27.0
24	Providence Saint Joseph Medical Center	17.2	22.4
25	Kaiser Foundation Hospital - Los Angeles	17.4	27.9
26	California Hospital Medical Center - Los Angeles	17.8	25.2
27	Emanate Health Inter-Community Hospital	18.3	26.5
28	West Covina Medical Center	18.5	23.7
29	Community Hospital of Huntington Park	18.9	31.0
30	Southern California Hospital At Hollywood	19.0	28.5
31	Emanate Health Queen of The Valley Hospital	19.1	25.5
32	Emanate Health Foothill Presbyterian Hospital	19.1	25.6
33	San Dimas Community Hospital	20.6	27.6
34	PIH Health Hospital - Downey	22.5	31.6
35	Kaiser Foundation Hospital - West LA	22.7	28.6
36	PIH Health Hospital - Whittier	23.0	35.0
37	Pacifica Hospital of The Valley	23.2	29.6
38	Olympia Medical Center	23.2	34.6
39	Docs Surgical Hospital	23.9	34.1
40	Sherman Oaks Hospital	24.0	30.1
41	St. Francis Medical Center	24.2	32.3
42	Kaiser Foundation Hospital - Downey	24.8	31.4
43	Coast Plaza Hospital	24.9	32.1
44	Cedars-Sinai Medical Center	25.0	38.7
:			
:			
60	Providence Cedars-Sinai Tarzana Medical Center	29.5	36.2

Table 5
Average Drive Distance and Times
For Patients in Huntington Memorial PSA and SSA

Rank	Distance/Time to:	Avg. Driving Distance (miles)	Avg. Drive Time (minutes)
:			
:			
69	Cedars-Sinai Marina Del Rey Hospital	31.9	38.5
:			
:			
85	Torrance Memorial Medical Center	37.0	49.2

Notes:

[1] Exhibit reports average drive times from the ZIP codes in the Huntington Memorial Secondary Service Area (SSA) to Los Angeles area hospitals. Drive times between ZIP code centroids to hospitals' addresses are determined by the Google Maps API and are weighted by the number of admissions at Huntington Memorial from the ZIP code.

[2] Hospitals in the exhibit are sorted by driving distance.

[3] The above table only shows Cedars-Sinai System hospitals, Huntington Memorial, and hospitals within 25 miles driving distance of Huntington Memorial.

[4] One ZIP code in the Huntington Memorial SSA (91024 Sierra Madre, Los Angeles) has a centroid in the mountains. For this ZIP code, drive times are based on distances from the approximate centroid of the Sierra Madre town area.

Sources:

[1] 2019 OSHPD Pivot Profile

[2] 2019 OSHPD Discharge Data

Table 6
Diversion Estimates
Cedars-Sinai Medical Center to Los Angeles Area Hospitals
General Acute Care Commercial Admissions (Oct 2018 - Dec 2019)

Rank	Hospital Name	City	Diversion from CS Medical Center
1	PROVIDENCE SAINT JOHN'S HEALTH CENTER	SANTA MONICA	16.2%
2	RONALD REAGAN UCLA MEDICAL CENTER	LOS ANGELES	12.3%
3	SANTA MONICA - UCLA MEDICAL CENTER AND ORTHOPAEDIC HOSPITAL	SANTA MONICA	10.8%
4	HUNTINGTON MEMORIAL HOSPITAL	PASADENA	5.4%
5	GOOD SAMARITAN HOSPITAL-LOS ANGELES	LOS ANGELES	5.2%
6	PROVIDENCE LITTLE COMPANY OF MARY MEDICAL CENTER TORRANCE	TORRANCE	4.4%
7	PROVIDENCE SAINT JOSEPH MEDICAL CENTER	BURBANK	4.3%
8	HOLLYWOOD PRESBYTERIAN MEDICAL CENTER	LOS ANGELES	4.1%
9	SOUTHERN CALIFORNIA HOSPITAL AT CULVER CITY	CULVER CITY	3.0%
10	ADVENTIST HEALTH GLENDALE	GLENDALE	2.5%
11	KECK HOSPITAL OF USC	LOS ANGELES	2.0%
12	NORTHRIDGE HOSPITAL MEDICAL CENTER	NORTHRIDGE	1.7%
13	CALIFORNIA REHABILITATION INSTITUTE, LLC	LOS ANGELES	1.7%
14	MISSION COMMUNITY HOSPITAL - PANORAMA CAMPUS	PANORAMA CITY	1.5%
15	MEMORIALCARE MILLER CHILDREN'S & WOMEN'S HOSPITAL LONG BEACH	LONG BEACH	1.4%
16	HOAG MEMORIAL HOSPITAL PRESBYTERIAN	NEWPORT BEACH	1.4%
17	CHILDREN'S HOSPITAL OF LOS ANGELES	LOS ANGELES	1.3%
18	CITY OF HOPE HELFORD CLINICAL RESEARCH HOSPITAL	DUARTE	1.2%
19	HENRY MAYO NEWHALL HOSPITAL	VALENCIA	1.2%
20	PROVIDENCE HOLY CROSS MEDICAL CENTER	MISSION HILLS	1.0%
	OTHER HOSPITALS		17.5%

Notes:

[1] Analysis limited to patients with commercial insurance residing in Los Angeles, Orange, Riverside and San Bernardino Counties and excludes non-general acute care (GAC) services (i.e., excludes newborns and services related to behavioral health, substance abuse, and rehabilitation). Analysis also excludes admissions to Kaiser hospitals and admissions with invalid patient ZIP codes, services with invalid or ungroupable DRGs, and emergency admissions.

[2] Each diversion represents the fraction of patients admitted to a given hospital that would switch to an alternative hospital if the selected hospital, and all co-owned hospitals, were no longer available.

[3] Each diversion ratio is calculated using a semiparametric hospital choice model. Hospital preferences are assumed to vary by patient group, where admissions are grouped using the following characteristics: patient location (county, zip code), admission type (major diagnostic category, medical-surgical indicator, DRG weight quartile, DRG), and patient demographics (age, sex). An iterative procedure is used to allocate patients into groups subject to a minimum group size of 25 admissions.

[4] The table reports diversions from Cedars-Sinai Medical Center to Huntington Memorial Hospital and all diversions that are greater or equal to 1 percent. The first column reports hospitals' ranking in terms of diversion from the specified hospital. Diversions to all other hospitals are reported in the row labeled Other Hospitals at the bottom of the table.

Sources:

[1] OSHPD 2018-2019 Discharge Data

[2] 2017 American Hospital Association Data

[3] CMS DRG Data

Table 7
Diversion Estimates
Cedars-Sinai Marina Del Rey Hospital to Los Angeles Area Hospitals
General Acute Care Commercial Admissions (Oct 2018 - Dec 2019)

Rank	Hospital Name	City	Diversion from CS Marina Del Rey
1	PROVIDENCE SAINT JOHN'S HEALTH CENTER	LOS ANGELES	11.2%
2	RONALD REAGAN UCLA MEDICAL CENTER	LOS ANGELES	6.4%
3	SOUTHERN CALIFORNIA HOSPITAL AT CULVER CITY	LOS ANGELES	5.0%
4	SANTA MONICA - UCLA MEDICAL CENTER AND ORTHOPAEDIC HOSPITAL	LOS ANGELES	4.8%
5	HUNTINGTON MEMORIAL HOSPITAL	LOS ANGELES	3.6%
6	PROVIDENCE LITTLE COMPANY OF MARY MEDICAL CENTER TORRANCE	LOS ANGELES	3.6%
7	KECK HOSPITAL OF USC	LOS ANGELES	3.2%
8	HOAG ORTHOPEDIC INSTITUTE	ORANGE	2.8%
9	GOOD SAMARITAN HOSPITAL-LOS ANGELES	LOS ANGELES	2.5%
10	NORTHRIDGE HOSPITAL MEDICAL CENTER	LOS ANGELES	2.3%
11	CITY OF HOPE HELFORD CLINICAL RESEARCH HOSPITAL	LOS ANGELES	2.3%
12	MISSION COMMUNITY HOSPITAL - PANORAMA CAMPUS	LOS ANGELES	2.2%
13	MEMORIALCARE LONG BEACH MEDICAL CENTER	LOS ANGELES	2.2%
14	HENRY MAYO NEWHALL HOSPITAL	LOS ANGELES	2.1%
15	LOMA LINDA UNIVERSITY MEDICAL CENTER	SAN BERNARDINO	2.1%
16	PIH HEALTH HOSPITAL - WHITTIER	LOS ANGELES	1.8%
17	CALIFORNIA REHABILITATION INSTITUTE, LLC	LOS ANGELES	1.8%
18	SAN ANTONIO REGIONAL HOSPITAL	SAN BERNARDINO	1.7%
19	HOAG MEMORIAL HOSPITAL PRESBYTERIAN	ORANGE	1.6%
20	CHILDREN'S HOSPITAL OF LOS ANGELES	LOS ANGELES	1.6%
21	PROVIDENCE SAINT JOSEPH MEDICAL CENTER	LOS ANGELES	1.5%
22	MEMORIALCARE MILLER CHILDREN'S & WOMEN'S HOSPITAL LONG BEACH	LOS ANGELES	1.4%
23	CHILDREN'S HOSPITAL OF ORANGE COUNTY	ORANGE	1.4%
24	UNIVERSITY OF CALIFORNIA IRVINE MEDICAL CENTER	ORANGE	1.3%
25	ADVENTIST HEALTH GLENDALE	LOS ANGELES	1.2%
26	CASA COLINA HOSPITAL	LOS ANGELES	1.2%
27	HOLLYWOOD PRESBYTERIAN MEDICAL CENTER	LOS ANGELES	1.1%
	OTHER HOSPITALS		26.3%

Notes:

[1] Analysis limited to patients with commercial insurance residing in Los Angeles, Orange, Riverside and San Bernardino Counties and excludes non-general acute care (GAC) services (i.e., excludes newborns and services related to behavioral health, substance abuse, and rehabilitation). Analysis also excludes admissions to Kaiser hospitals and admissions with invalid patient ZIP codes, services with invalid or ungroupable DRGs, and emergency admissions.

[2] Each diversion represents the fraction of patients admitted to a given hospital that would switch to an alternative hospital if the selected hospital, and all co-owned hospitals, were no longer available.

[3] Each diversion ratio is calculated using a semiparametric hospital choice model. Hospital preferences are assumed to vary by patient group, where admissions are grouped using the following characteristics: patient location (county, zip code), admission type (major diagnostic category, medical-surgical indicator, DRG weight quartile, DRG), and patient demographics (age, sex). An iterative procedure is used to allocate patients into groups subject to a minimum group size of 25 admissions.

[4] The table reports diversions from Cedars-Sinai Marina del Rey to Huntington Memorial Hospital and all diversions that are greater or equal to 1 percent. The first column reports hospitals' ranking in terms of diversion from the specified hospital. Diversions to all other hospitals are reported in the row labeled Other Hospitals at the bottom of the table.

Sources:

[1] OSHPD 2018-2019 Discharge Data

[2] 2017 American Hospital Association Data

[3] CMS DRG Data

Table 8
Diversion Estimates
Providence Cedars-Sinai Tarzana Medical Center to Los Angeles Area Hospitals
General Acute Care Commercial Admissions (Oct 2018 - Dec 2019)

Rank	Hospital Name	City	Diversion from Prov. CS Tarzana
1	NORTHRIDGE HOSPITAL MEDICAL CENTER	NORTHRIDGE	13.3%
2	PROVIDENCE SAINT JOSEPH MEDICAL CENTER	BURBANK	11.1%
3	RONALD REAGAN UCLA MEDICAL CENTER	LOS ANGELES	11.0%
4	PROVIDENCE SAINT JOHN'S HEALTH CENTER	SANTA MONICA	8.8%
5	SANTA MONICA - UCLA MEDICAL CENTER AND ORTHOPAEDIC HOSPITAL	SANTA MONICA	8.1%
6	PROVIDENCE HOLY CROSS MEDICAL CENTER	MISSION HILLS	7.8%
7	WEST HILLS HOSPITAL AND MEDICAL CENTER	WEST HILLS	7.3%
8	HENRY MAYO NEWHALL HOSPITAL	VALENCIA	5.0%
9	MISSION COMMUNITY HOSPITAL - PANORAMA CAMPUS	PANORAMA CITY	4.7%
10	ADVENTIST HEALTH GLENDALE	GLENDALE	3.2%
11	HUNTINGTON MEMORIAL HOSPITAL	PASADENA	3.1%
12	GOOD SAMARITAN HOSPITAL-LOS ANGELES	LOS ANGELES	1.6%
13	HOLLYWOOD PRESBYTERIAN MEDICAL CENTER	LOS ANGELES	1.5%
14	SHERMAN OAKS HOSPITAL	SHERMAN OAKS	1.3%
15	KECK HOSPITAL OF USC	LOS ANGELES	1.2%
16	CHILDREN'S HOSPITAL OF LOS ANGELES	LOS ANGELES	1.1%
	OTHER HOSPITALS		10.1%

Notes:

[1] Analysis limited to patients with commercial insurance residing in Los Angeles, Orange, Riverside and San Bernardino Counties and excludes non-general acute care (GAC) services (i.e., excludes newborns and services related to behavioral health, substance abuse, and rehabilitation). Analysis also excludes admissions to Kaiser hospitals and admissions with invalid patient ZIP codes, services with invalid or ungroupable DRGs, and emergency admissions.

[2] Each diversion represents the fraction of patients admitted to a given hospital that would switch to an alternative hospital if the selected hospital, and all co-owned hospitals, were no longer available.

[3] Each diversion ratio is calculated using a semiparametric hospital choice model. Hospital preferences are assumed to vary by patient group, where admissions are grouped using the following characteristics: patient location (county, zip code), admission type (major diagnostic category, medical-surgical indicator, DRG weight quartile, DRG), and patient demographics (age, sex). An iterative procedure is used to allocate patients into groups subject to a minimum group size of 25 admissions.

[4] The table reports diversions from Providence Cedars-Sinai Tarzana Medical Center to Huntington Memorial Hospital and all diversions that are greater or equal to 1 percent. The first column reports hospitals' ranking in terms of diversion from the specified hospital. Diversions to all other hospitals are reported in the row labeled Other Hospitals at the bottom of the table.

Sources:

[1] OSHPD 2018-2019 Discharge Data

[2] 2017 American Hospital Association Data

[3] CMS DRG Data

Table 9
Diversion Estimates
CS - Torrance Memorial Medical Center to Los Angeles Area Hospitals
General Acute Care Commercial Admissions (Oct 2018 - Dec 2019)

Rank	Hospital Name	City	Diversion from CS Torrance
1	PROVIDENCE LITTLE COMPANY OF MARY MEDICAL CENTER TORRANCE	TORRANCE	38.2%
2	MEMORIALCARE MILLER CHILDREN'S & WOMEN'S HOSPITAL LONG BEACH	LONG BEACH	11.0%
3	PROVIDENCE SAINT JOHN'S HEALTH CENTER	SANTA MONICA	6.6%
4	RONALD REAGAN UCLA MEDICAL CENTER	LOS ANGELES	5.9%
5	SANTA MONICA - UCLA MEDICAL CENTER AND ORTHOPAEDIC HOSPITAL	SANTA MONICA	4.3%
6	MEMORIALCARE LONG BEACH MEDICAL CENTER	LONG BEACH	2.9%
7	KECK HOSPITAL OF USC	LOS ANGELES	2.7%
8	SOUTHERN CALIFORNIA HOSPITAL AT CULVER CITY	CULVER CITY	2.3%
9	LAC/HARBOR-UCLA MEDICAL CENTER	TORRANCE	2.0%
10	PROVIDENCE LITTLE COMPANY OF MARY MC - SAN PEDRO	SAN PEDRO	1.9%
11	GOOD SAMARITAN HOSPITAL-LOS ANGELES	LOS ANGELES	1.6%
12	ST. MARY MEDICAL CENTER - LONG BEACH	LONG BEACH	1.4%
13	CITY OF HOPE HELFORD CLINICAL RESEARCH HOSPITAL	DUARTE	1.4%
14	CHILDREN'S HOSPITAL OF LOS ANGELES	LOS ANGELES	1.3%
15	HOAG MEMORIAL HOSPITAL PRESBYTERIAN	NEWPORT BEACH	1.2%
16	HUNTINGTON MEMORIAL HOSPITAL	PASADENA	1.2%
	OTHER HOSPITALS		14.2%

Notes:

[1] Analysis limited to patients with commercial insurance residing in Los Angeles, Orange, Riverside and San Bernardino Counties and excludes non-general acute care (GAC) services (i.e., excludes newborns and services related to behavioral health, substance abuse, and rehabilitation). Analysis also excludes admissions to Kaiser hospitals and admissions with invalid patient ZIP codes, services with invalid or ungroupable DRGs, and emergency admissions.

[2] Each diversion represents the fraction of patients admitted to a given hospital that would switch to an alternative hospital if the selected hospital, and all co-owned hospitals, were no longer available.

[3] Each diversion ratio is calculated using a semiparametric hospital choice model. Hospital preferences are assumed to vary by patient group, where admissions are grouped using the following characteristics: patient location (county, zip code), admission type (major diagnostic category, medical-surgical indicator, DRG weight quartile, DRG), and patient demographics (age, sex). An iterative procedure is used to allocate patients into groups subject to a minimum group size of 25 admissions.

[4] The table reports diversions from Torrance Memorial Medical Center to Huntington Memorial and all diversions that are greater or equal to 1 percent. The first column reports hospitals' ranking in terms of diversion from the specified hospital. Diversions to all other hospitals are reported in the row labeled Other Hospitals at the bottom of the table.

Sources:

[1] OSHPD 2018-2019 Discharge Data

[2] 2017 American Hospital Association Data

[3] CMS DRG Data

Table 10
Diversion Estimates
Cedars-Sinai System to Los Angeles Area Hospitals
General Acute Care Commercial Admissions (Oct 2018 - Dec 2019)

Rank	Hospital Name	City	Diversion from CS System
1	PROVIDENCE SAINT JOHN'S HEALTH CENTER	SANTA MONICA	12.8%
2	PROVIDENCE LITTLE COMPANY OF MARY MEDICAL CENTER TORRANCE	TORRANCE	11.1%
3	RONALD REAGAN UCLA MEDICAL CENTER	LOS ANGELES	10.5%
4	SANTA MONICA - UCLA MEDICAL CENTER AND ORTHOPAEDIC HOSPITAL	SANTA MONICA	8.7%
5	PROVIDENCE SAINT JOSEPH MEDICAL CENTER	BURBANK	4.3%
6	HUNTINGTON MEMORIAL HOSPITAL	PASADENA	4.1%
7	GOOD SAMARITAN HOSPITAL-LOS ANGELES	LOS ANGELES	3.8%
8	MEMORIALCARE MILLER CHILDREN'S & WOMEN'S HOSPITAL LONG BEACH	LONG BEACH	3.3%
9	NORTHRIDGE HOSPITAL MEDICAL CENTER	NORTHRIDGE	3.1%
10	HOLLYWOOD PRESBYTERIAN MEDICAL CENTER	LOS ANGELES	2.8%
11	SOUTHERN CALIFORNIA HOSPITAL AT CULVER CITY	CULVER CITY	2.6%
12	KECK HOSPITAL OF USC	LOS ANGELES	2.1%
13	ADVENTIST HEALTH GLENDALE	GLENDALE	2.0%
14	PROVIDENCE HOLY CROSS MEDICAL CENTER	MISSION HILLS	1.8%
15	MISSION COMMUNITY HOSPITAL - PANORAMA CAMPUS	PANORAMA CITY	1.7%
16	WEST HILLS HOSPITAL AND MEDICAL CENTER	WEST HILLS	1.6%
17	HENRY MAYO NEWHALL HOSPITAL	VALENCIA	1.6%
18	CHILDREN'S HOSPITAL OF LOS ANGELES	LOS ANGELES	1.3%
19	CITY OF HOPE HELFORD CLINICAL RESEARCH HOSPITAL	DUARTE	1.3%
20	CALIFORNIA REHABILITATION INSTITUTE, LLC	LOS ANGELES	1.2%
21	HOAG MEMORIAL HOSPITAL PRESBYTERIAN	NEWPORT BEACH	1.2%
22	MEMORIALCARE LONG BEACH MEDICAL CENTER	LONG BEACH	1.1%
	OTHER HOSPITALS		16.0%

Notes:

[1] Analysis limited to patients with commercial insurance residing in Los Angeles, Orange, Riverside and San Bernardino Counties and excludes non-general acute care (GAC) services (i.e., excludes newborns and services related to behavioral health, substance abuse, and rehabilitation). Analysis also excludes admissions to Kaiser hospitals and admissions with invalid patient ZIP codes, services with invalid or ungroupable DRGs, and emergency admissions.

[2] Each diversion represents the fraction of patients admitted to a given hospital that would switch to an alternative hospital if the selected hospital, and all co-owned hospitals, were no longer available.

[3] Each diversion ratio is calculated using a semiparametric hospital choice model. Hospital preferences are assumed to vary by patient group, where admissions are grouped using the following characteristics: patient location (county, zip code), admission type (major diagnostic category, medical-surgical indicator, DRG weight quartile, DRG), and patient demographics (age, sex). An iterative procedure is used to allocate patients into groups subject to a minimum group size of 25 admissions.

[4] The table reports diversions from the Cedars-Sinai Medical Center, Marina del Rey, Tarzania facilities and Torrance Memorial to Huntington Memorial and all diversions that are greater or equal to 1 percent. The first column reports hospitals' ranking in terms of diversion from the specified hospital. Diversions to all other hospitals are reported in the row labeled Other Hospitals at the bottom of the table.

Sources:

[1] OSHPD 2018-2019 Discharge Data

[2] 2017 American Hospital Association Data

[3] CMS DRG Data

Table 11
Diversion Estimates
Huntington Memorial to Los Angeles Area Hospitals
General Acute Care Commercial Admissions (Oct 2018 - Dec 2019)

Rank	Hospital Name	City	Diversion from Huntington
1	METHODIST HOSPITAL OF SOUTHERN CALIFORNIA	ARCADIA	12.2%
2	KECK HOSPITAL OF USC	LOS ANGELES	8.8%
3	CEDARS-SINAI MEDICAL CENTER	LOS ANGELES	8.4%
4	ADVENTIST HEALTH GLENDALE	GLENDALE	8.1%
5	CITY OF HOPE HELFORD CLINICAL RESEARCH HOSPITAL	DUARTE	6.3%
6	GOOD SAMARITAN HOSPITAL-LOS ANGELES	LOS ANGELES	4.3%
7	CHILDREN'S HOSPITAL OF LOS ANGELES	LOS ANGELES	3.7%
8	RONALD REAGAN UCLA MEDICAL CENTER	LOS ANGELES	3.6%
9	PROVIDENCE SAINT JOSEPH MEDICAL CENTER	BURBANK	3.1%
10	USC VERDUGO HILLS HOSPITAL	GLENDALE	3.0%
11	EMANATE HEALTH QUEEN OF THE VALLEY HOSPITAL	WEST COVINA	2.1%
12	SANTA MONICA - UCLA MEDICAL CENTER AND ORTHOPAEDIC HOSPITAL	SANTA MONICA	2.0%
13	ADVENTIST HEALTH WHITE MEMORIAL	LOS ANGELES	1.9%
14	GARFIELD MEDICAL CENTER	MONTEREY PARK	1.8%
15	EMANATE HEALTH FOOTHILL PRESBYTERIAN HOSPITAL	GLENDORA	1.5%
16	PROVIDENCE SAINT JOHN'S HEALTH CENTER	SANTA MONICA	1.4%
17	HOLLYWOOD PRESBYTERIAN MEDICAL CENTER	LOS ANGELES	1.4%
18	POMONA VALLEY HOSPITAL MEDICAL CENTER	POMONA	1.3%
19	PIH HEALTH HOSPITAL - WHITTIER	WHITTIER	1.2%
20	SOUTHERN CALIFORNIA HOSPITAL AT CULVER CITY	CULVER CITY	1.2%
21	SAN ANTONIO REGIONAL HOSPITAL	UPLAND	1.2%
28	PROVIDENCE CEDARS-SINAI TARZANA MEDICAL CENTER	TARZANA	0.7%
44	TORRANCE MEMORIAL MEDICAL CENTER	TORRANCE	0.4%
46	CEDARS-SINAI MARINA DEL REY HOSPITAL	MARINA DEL REY	0.3%
	OTHER HOSPITALS		19.9%

Notes:

[1] Analysis limited to patients with commercial insurance residing in Los Angeles, Orange, Riverside and San Bernardino Counties and excludes non-general acute care (GAC) services (i.e., excludes newborns and services related to behavioral health, substance abuse, and rehabilitation). Analysis also excludes admissions to Kaiser hospitals and admissions with invalid patient ZIP codes, services with invalid or ungroupable DRGs, and emergency admissions.

[2] Each diversion represents the fraction of patients admitted to a given hospital that would switch to an alternative hospital if the selected hospital, and all co-owned hospitals, were no longer available.

[3] Each diversion ratio is calculated using a semiparametric hospital choice model. Hospital preferences are assumed to vary by patient group, where admissions are grouped using the following characteristics: patient location (county, zip code), admission type (major diagnostic category, medical-surgical indicator, DRG weight quartile, DRG), and patient demographics (age, sex). An iterative procedure is used to allocate patients into groups subject to a minimum group size of 25 admissions.

[4] The table reports diversions from Huntington Memorial Hospital to Cedars-Sinai hospitals and all diversions that are greater or equal to 1 percent. The first column reports hospitals' ranking in terms of diversion from the specified hospital. Diversions to all other hospitals are reported in the row labeled Other Hospitals at the bottom of the table.

Sources:

[1] OSHPD 2018-2019 Discharge Data

[2] 2017 American Hospital Association Data

[3] CMS DRG Data

Table 12
Hospital-Level Willingness to Pay
General Acute Care Commercial Admissions (Oct 2018 - Dec 2019)

	Hospital Name	Willingness to Pay (Case Mix Adjusted)	Willingness to Pay (Unadjusted)
1	HUNTINGTON MEMORIAL HOSPITAL	18,102	12,235
2	HOAG MEMORIAL HOSPITAL PRESBYTERIAN	17,069	12,970
3	CEDARS-SINAI MEDICAL CENTER	14,042	10,860
4	RONALD REAGAN UCLA MEDICAL CENTER	7,310	4,330
5	HOAG ORTHOPEDIC INSTITUTE	6,449	2,700
6	CHILDREN'S HOSPITAL OF ORANGE COUNTY	6,274	3,586
7	EISENHOWER MEDICAL CENTER	6,219	3,299
8	TORRANCE MEMORIAL MEDICAL CENTER	5,755	3,894
9	PROVIDENCE SAINT JOHN'S HEALTH CENTER	5,624	4,091
10	PIH HEALTH HOSPITAL - WHITTIER	5,262	3,610
11	KECK HOSPITAL OF USC	5,190	2,690
12	MEMORIALCARE MILLER CHILDREN'S & WOMEN'S LONG BEACH	4,670	4,125
13	CITY OF HOPE HELFORD CLINICAL RESEARCH HOSPITAL	4,447	2,387
14	UNIVERSITY OF CALIFORNIA IRVINE MEDICAL CENTER	4,409	2,486
15	HENRY MAYO NEWHALL HOSPITAL	4,277	3,193
16	SANTA MONICA - UCLA MED CENTER & ORTHOPAEDIC HOSPITAL	4,153	2,887
17	LOMA LINDA UNIVERSITY MEDICAL CENTER	4,094	2,096
18	SAN ANTONIO REGIONAL HOSPITAL	3,720	2,702
19	MEMORIALCARE LONG BEACH MEDICAL CENTER	3,584	1,768
20	MEMORIALCARE SADDLEBACK MEDICAL CENTER	3,543	3,148
21	GOOD SAMARITAN HOSPITAL-LOS ANGELES	3,519	2,149
22	DESERT REGIONAL MEDICAL CENTER	3,481	2,623
23	SOUTHERN CALIFORNIA HOSPITAL AT CULVER CITY	3,455	1,824
24	ST. JOSEPH HOSPITAL - ORANGE	3,362	2,339
25	ADVENTIST HEALTH GLENDALE	3,182	2,255
26	MISSION HOSPITAL REGIONAL MEDICAL CENTER	3,111	2,085
27	MISSION COMMUNITY HOSPITAL - PANORAMA CAMPUS	2,997	1,671
28	PROVIDENCE LITTLE COMPANY OF MARY MED CENTER TORRANCE	2,968	2,489
29	PROVIDENCE CEDARS-SINAI TARZANA MEDICAL CENTER	2,868	2,624
30	LOMA LINDA UNIVERSITY CHILDREN'S HOSPITAL	2,705	2,467
31	PROVIDENCE SAINT JOSEPH MEDICAL CENTER	2,697	1,968
32	NORTHRIDGE HOSPITAL MEDICAL CENTER	2,655	1,542
33	FOUNTAIN VALLEY REGIONAL HOSPITAL & MEDICAL CENTER - EUCL	2,447	1,470
34	MEMORIALCARE ORANGE COAST MEDICAL CENTER	2,429	1,760
35	ANTELOPE VALLEY HOSPITAL	2,428	1,732
36	ST. JUDE MEDICAL CENTER	2,425	1,932
37	LOS ALAMITOS MEDICAL CENTER	2,309	1,405
38	METHODIST HOSPITAL OF SOUTHERN CALIFORNIA	2,178	1,626
39	CHILDREN'S HOSPITAL OF LOS ANGELES	2,154	1,130
40	EMANATE HEALTH QUEEN OF THE VALLEY HOSPITAL	2,019	1,427
41	POMONA VALLEY HOSPITAL MEDICAL CENTER	1,916	1,584
42	RIVERSIDE COMMUNITY HOSPITAL	1,819	1,123
43	CASA COLINA HOSPITAL	1,635	854
44	SOUTHWEST HEALTHCARE SYSTEM-MURRIETA	1,596	968
45	PROVIDENCE HOLY CROSS MEDICAL CENTER	1,433	1,122
46	HOLLYWOOD PRESBYTERIAN MEDICAL CENTER	1,329	937
47	LAKEWOOD REGIONAL MEDICAL CENTER	1,312	715
48	PIH HEALTH HOSPITAL - DOWNEY	1,310	892
49	CALIFORNIA REHABILITATION INSTITUTE, LLC	1,226	649
50	CEDARS-SINAI MARINA DEL REY HOSPITAL	1,185	561
51	CORONA REGIONAL MEDICAL CENTER-MAIN	1,169	749
52	REDLANDS COMMUNITY HOSPITAL	1,129	872

53	EMANATE HEALTH INTER-COMMUNITY HOSPITAL	1,085	603
54	ADVENTIST HEALTH WHITE MEMORIAL	1,060	664
55	ST. MARY MEDICAL CENTER - LONG BEACH	1,046	630

Notes:

[1] Analysis limited to patients with commercial insurance residing in Los Angeles, Orange, Riverside and San Bernardino Counties and excludes non-general acute care (GAC) services (i.e., excludes newborns and services related to behavioral health, substance abuse, and rehabilitation). Analysis also excludes admissions to Kaiser hospitals, admissions with invalid patient ZIP codes, services with invalid or ungroupable DRGs, and emergency admissions.

[2] Willingness to Pay (WTP) for hospitals is calculated using a semiparametric hospital choice model. Hospital preferences are assumed to vary by patient group, where admissions are grouped using the following characteristics: patient location (county, zip code), admission type (major diagnostic category, medical-surgical indicator, DRG weight quartile, DRG), and patient demographics (age, sex). An iterative procedure is used to allocate patients into groups subject to a minimum group size of 25 admissions. The case mix adjusted WTPs weight groups of patients by the mean DRG resource intensity weight within the group.

[3] Hospitals in the exhibit are sorted according to the case mix adjusted WTP. The exhibit is restricted to hospitals whose case mix adjusted WTP is 1,000 or greater.

Sources:

[1] OSHPD 2018-2019 Discharge Data

[2] 2017 American Hospital Association Data

[3] CMS DRG Data

Table 13
System-Level Willingness to Pay
General Acute Care Commercial Admissions (Oct 2018 - Dec 2019)

	Hospital or System Name	Willingness to Pay (Case Mix Adjusted)	Willingness to Pay (Not Adjusted)
1	PROVIDENCE ST. JOSEPH HEALTH	53,445	37,093
2	CEDARS-SINAI HEALTH SYSTEM	25,480	19,289
3	HUNTINGTON MEMORIAL HOSPITAL	18,102	12,235
4	UNIVERSITY OF CALIFORNIA SYSTEMWIDE ADMINISTRATION	16,458	10,094
5	MEMORIALCARE	14,976	11,367
6	TENET HEALTHCARE CORPORATION	12,218	8,219
7	LOMA LINDA UNIVERSITY ADVENTIST HEALTH SCIENCES CENTER	7,904	5,350
8	PIH HEALTH	6,797	4,662
9	KECK MEDICINE OF USC	6,354	3,421
10	CHILDREN'S HOSPITAL OF ORANGE COUNTY	6,274	3,586
11	EISENHOWER MEDICAL CENTER	6,219	3,299
12	DIGNITY HEALTH	5,530	3,438
13	UNIVERSAL HEALTH SERVICES, INC.	4,634	2,748
14	EMANATE HEALTH	4,467	2,879
15	CITY OF HOPE HELFORD CLINICAL RESEARCH HOSPITAL	4,447	2,387
16	HENRY MAYO NEWHALL HOSPITAL	4,277	3,193
17	ADVENTIST HEALTH	4,276	2,941
18	PROSPECT MEDICAL HOLDINGS	3,823	2,008
19	SAN ANTONIO REGIONAL HOSPITAL	3,720	2,702
20	GOOD SAMARITAN HOSPITAL-LOS ANGELES	3,519	2,149
21	MISSION COMMUNITY HOSPITAL - PANORAMA CAMPUS	2,997	1,671
22	PRIME HEALTHCARE SERVICES	2,716	1,662
23	KINDRED HEALTHCARE	2,569	1,402
24	HCA HEALTHCARE	2,505	1,618
25	ANTELOPE VALLEY HOSPITAL	2,428	1,732
26	METHODIST HOSPITAL OF SOUTHERN CALIFORNIA	2,178	1,626
27	CHILDREN'S HOSPITAL OF LOS ANGELES	2,154	1,130
28	KPC HEALTHCARE, INC.	1,983	1,103
29	POMONA VALLEY HOSPITAL MEDICAL CENTER	1,916	1,584
30	AHMC & HEALTHCARE, INC.	1,680	1,061
31	CASA COLINA HOSPITAL	1,635	854
32	HOLLYWOOD PRESBYTERIAN MEDICAL CENTER	1,329	937
33	LOS ANGELES COUNTY-DEPARTMENT OF HEALTH SERVICES	1,233	709
34	CALIFORNIA REHABILITATION INSTITUTE, LLC	1,226	649
35	REDLANDS COMMUNITY HOSPITAL	1,129	872

Notes:

[1] Analysis limited to patients with commercial insurance residing in Los Angeles, Orange, Riverside and San Bernardino Counties and excludes non-general acute care (GAC) services (i.e., excludes newborns and services related to behavioral health, substance abuse, and rehabilitation). Analysis also excludes admissions to Kaiser hospitals and admissions with invalid patient ZIP codes, services with invalid or ungroupable DRGs, and emergency admissions.

[2] Willingness to Pay (WTP) for systems is calculated using a semiparametric hospital choice model. Hospital preferences are assumed to vary by patient group, where admissions are grouped using the following characteristics: patient location (county, zip code), admission type (major diagnostic category, medical-surgical indicator, DRG weight quartile, DRG), and patient demographics (age, sex). An iterative procedure is used to allocate patients into groups subject to a minimum group size of 25 admissions. The case mix adjusted WTPs weight groups of patients by the mean DRG resource intensity weight within the group.

[3] Systems in the exhibit are sorted according to the case mix adjusted WTP. The exhibit is restricted to systems whose case mix adjusted WTP is

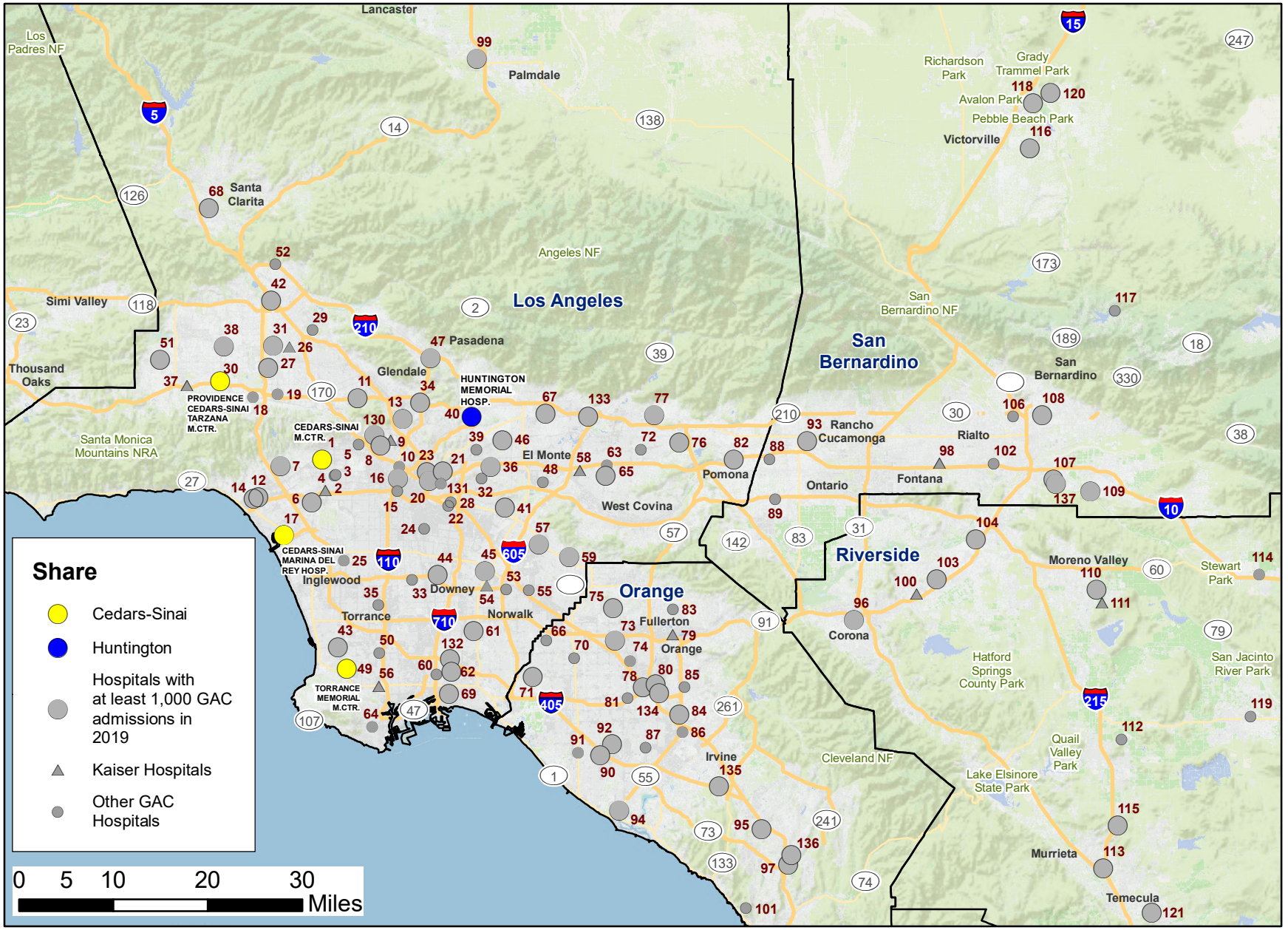
[4] Not all hospitals belong to a system.

Sources:

[1] OSHPD 2018-2019 Discharge Data

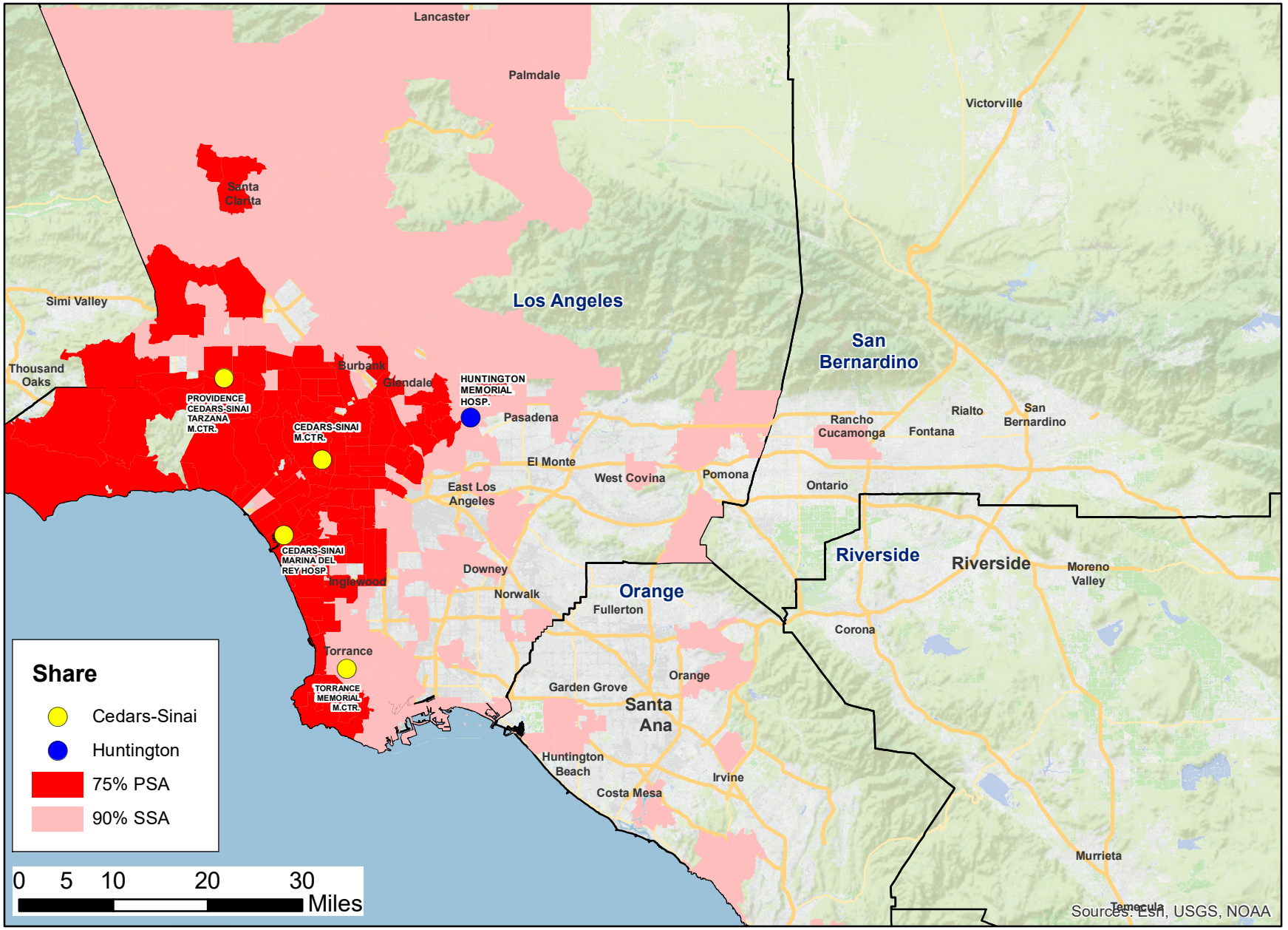
[2] 2017 American Hospital Association Data

Figure 1
General Acute Care Hospitals
Los Angeles, Orange, Riverside, and San Bernardino Counties



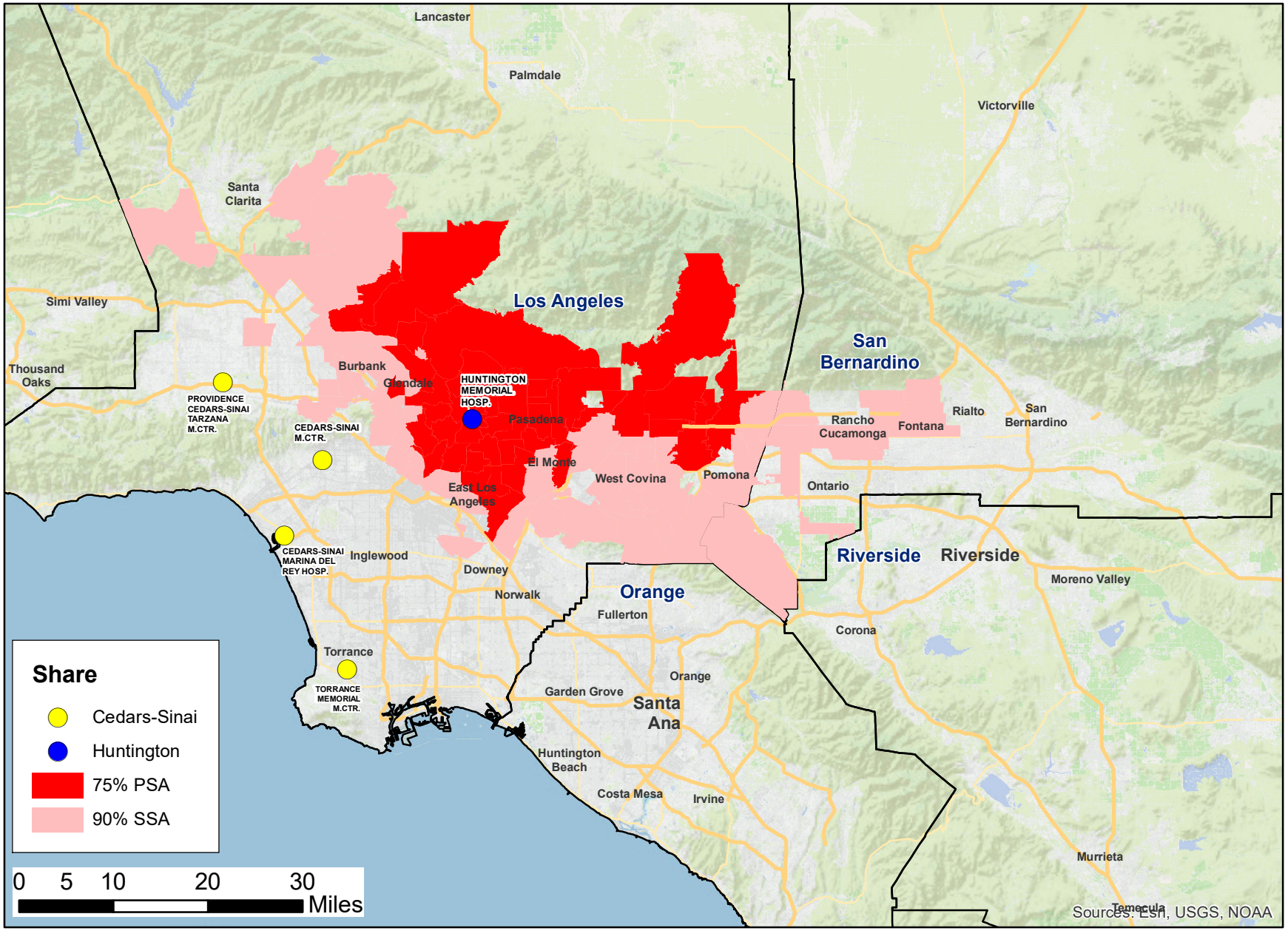
Notes: [1] The map displays 137 general acute care (GAC) hospitals located in Los Angeles, Orange, Riverside, and San Bernardino counties. [2] The displayed hospitals include hospitals from the 2019 OSHPD Pivot Profile with general acute care licensing, excluding those whose main service type in the 2017 AHA Data is acute long-term care, adult or children's rehabilitation, or psychiatric services. Hospitals with general acute care licensing whose service types are children's general medical and surgical, cancer, or orthopedics are displayed on the map. [3] The map does not display Catalina Island Medical Center [4] Some hospital locations are slightly adjusted in order to display their markers
Sources: [1] 2019 OSHPD Pivot Profile; [2] 2017 American Hospital Association Data

Figure 2
Primary and Secondary Service Areas
Cedars-Sinai Medical Center



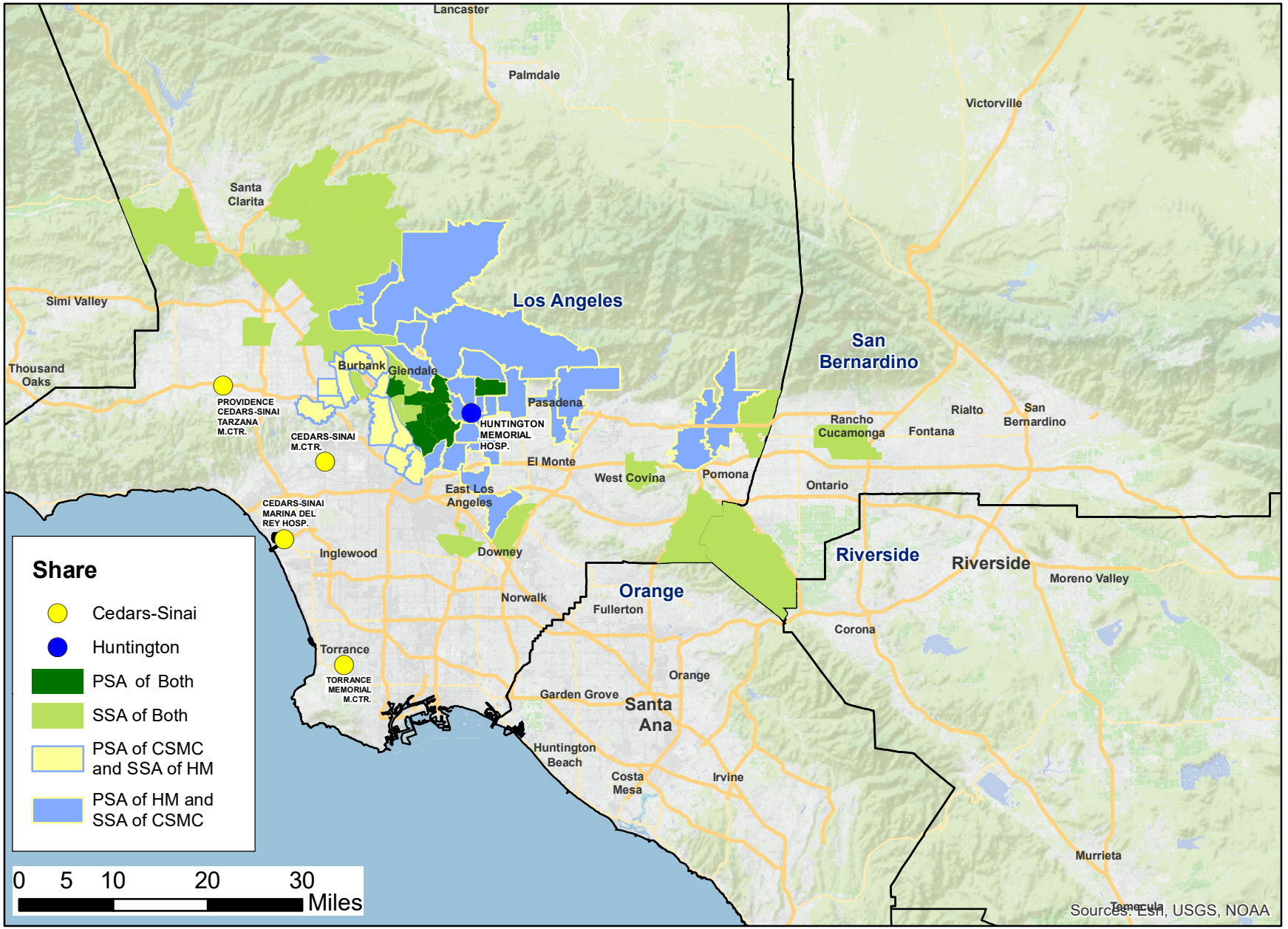
Notes: [1] Service areas are calculated using the discharges from the 2018 – 2019 OSHPD Discharge Data used to calculate WTP in Tables 12 and 13. See the notes to these tables for details about the sources and methodology used to process the discharge data. [2] Huntington Memorial's and Cedar-Sinai Medical Center's Primary Service Areas (PSA) and Secondary Service Areas (SSA) are comprised of the ZIP codes with the most discharges at the hospitals that represent 75 percent and 90 percent of the hospitals' total discharges, respectively. [3] When ZIP codes have the same number of discharges, ties are broken based on straight-line distances between the hospital and ZIP codes' centroids.
Sources: [1] 2019 OSHPD Pivot Profile; [2] 2017 American Hospital Association Data; [3] OSHPD 2018-2019 Discharge Data; [4] CMS DRG Data

Figure 3
Primary and Secondary Service Areas
Huntington Memorial



Notes: [1] Service areas are calculated using the discharges from the 2018 – 2019 OSHPD Discharge Data used to calculate WTP in Tables 12 and 13. See the notes to these tables for details about the sources and methodology used to process the discharge data. [2] Huntington Memorial's and Cedar-Sinai Medical Center's Primary Service Areas (PSA) and Secondary Service Areas (SSA) are comprised of the ZIP codes with the most discharges at the hospitals that represent 75 percent and 90 percent of the hospitals' total discharges, respectively. [3] When ZIP codes have the same number of discharges, ties are broken based on straight-line distances between the hospital and ZIP codes' centroids.
Sources: [1] 2019 OSHPD Pivot Profile; [2] 2017 American Hospital Association Data; [3] OSHPD 2018-2019 Discharge Data; [4] CMS DRG Data

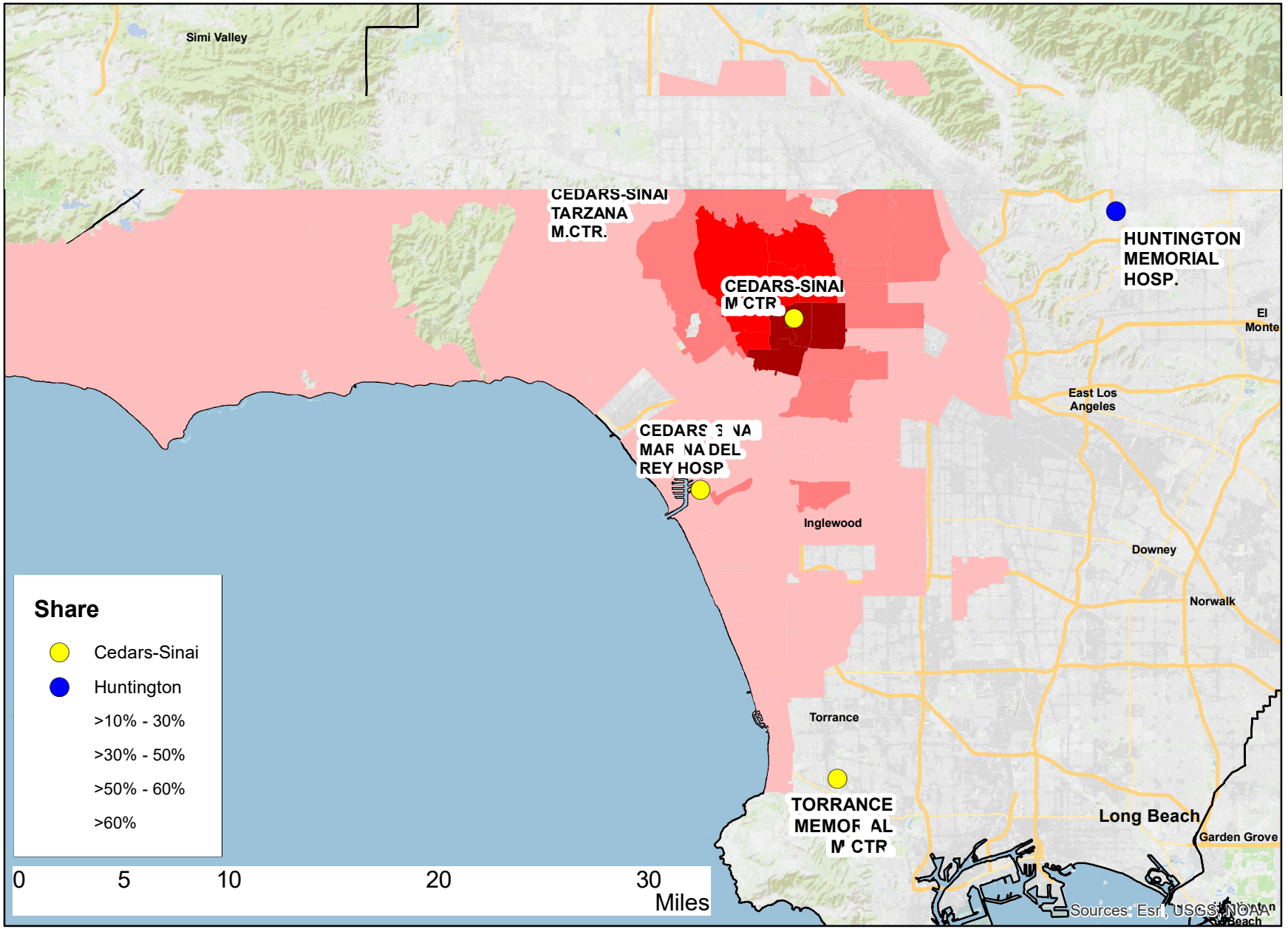
Figure 4
Primary and Secondary Service Areas
Overlap Areas Between CSMC and HM



Notes: [1] See the notes to Figures 2 and 3 for details about the methodology and sources used to identify each hospital's Primary Service Area (PSA) and Secondary Service Area (SSA).

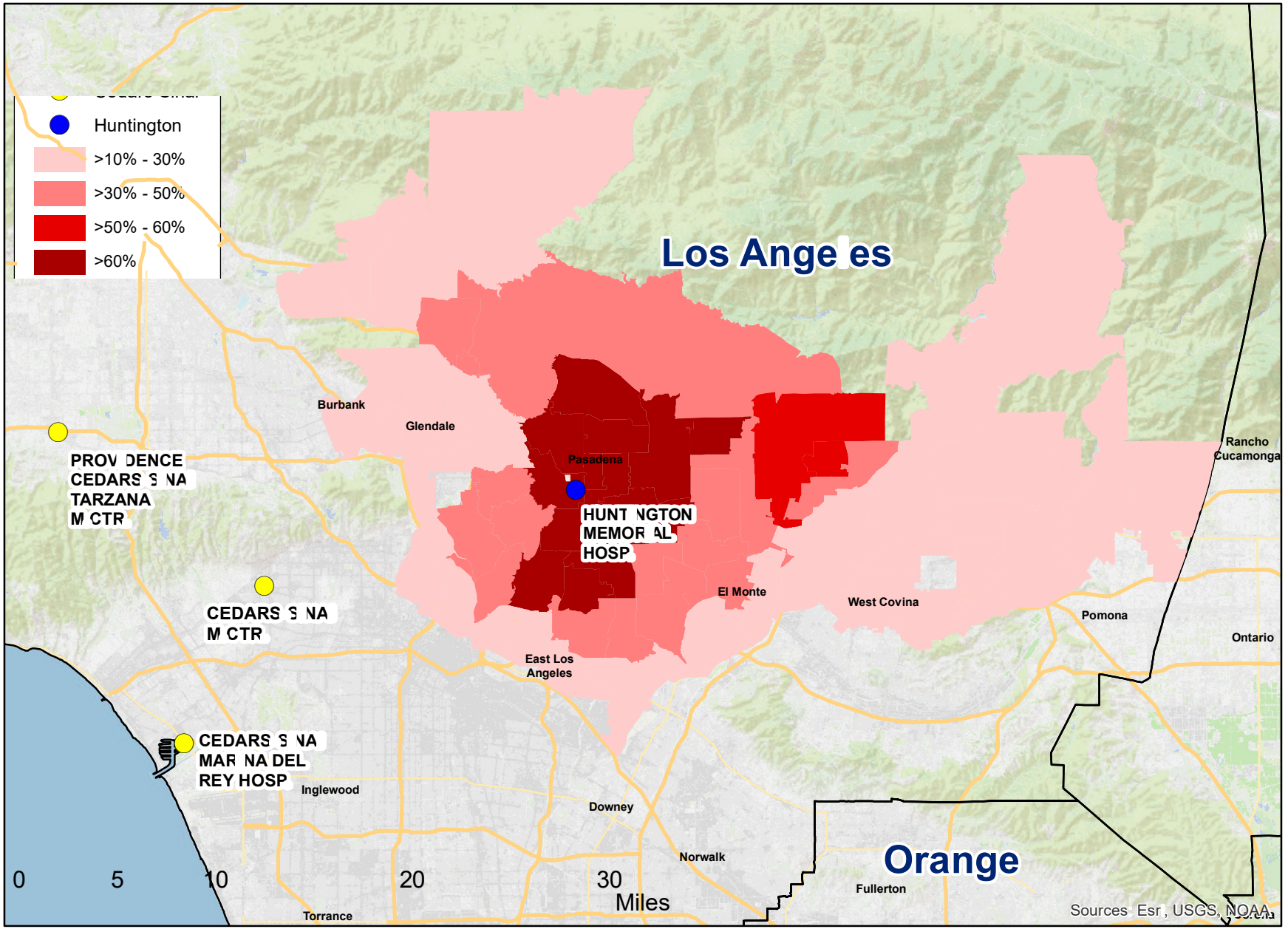
Sources: [1] 2019 OSHPD Pivot Profile; [2] 2017 American Hospital Association Data; [3] OSHPD 2018-2019 Discharge Data; [4] CMS DRG Data

Figure 5
Share of Commercial Discharges
Cedars-Sinai Medical Center



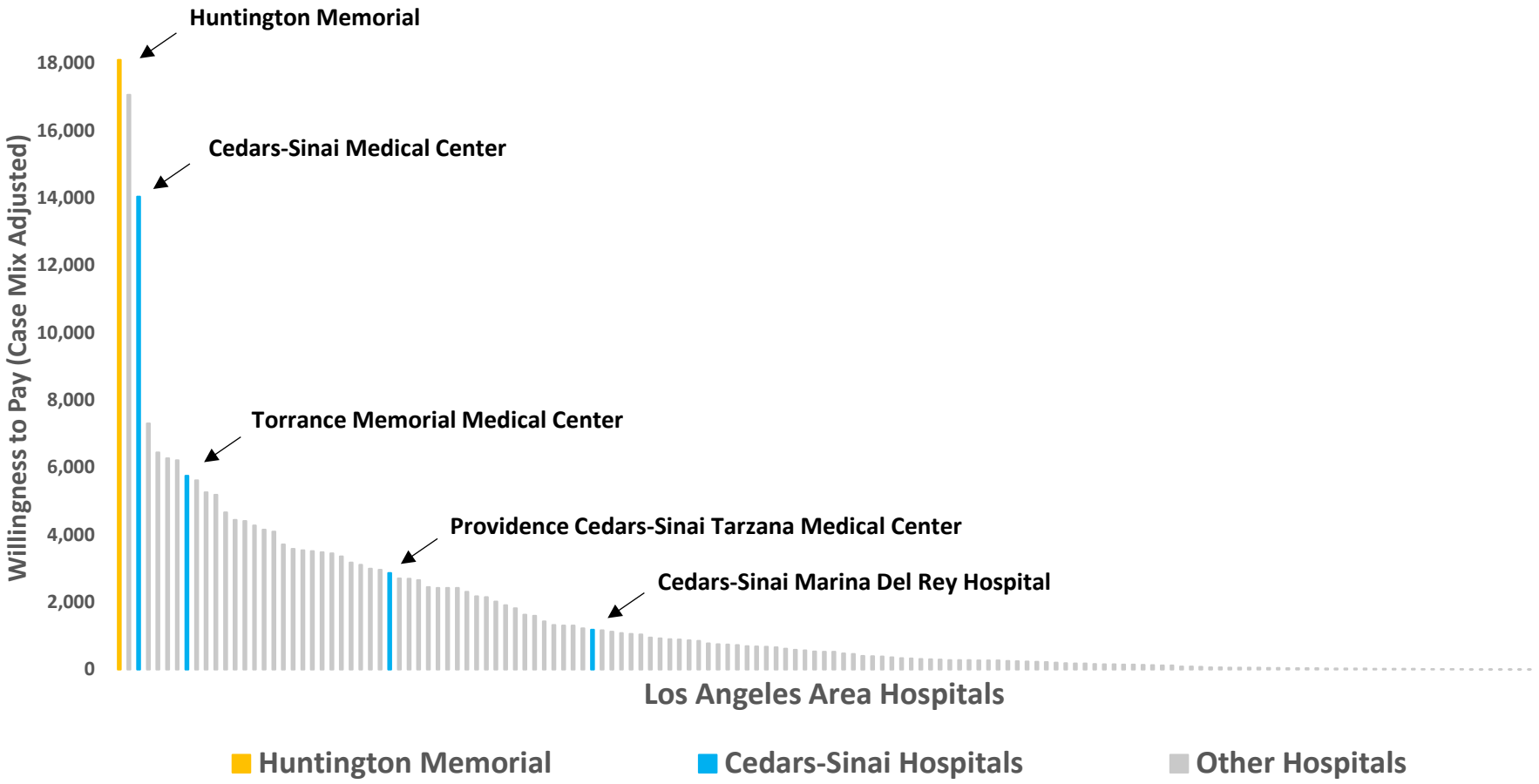
Notes: [1] Share of commercial discharges by ZIP code are calculated using the discharges from the 2018 – 2019 OSHPD Discharge Data used to calculate WTP in Tables 12 and 13. See the notes to these tables for details about the sources and methodology used to process the discharge data.
Sources: [1] 2019 OSHPD Pivot Profile; [2] 2017 American Hospital Association Data; [3] OSHPD 2018-2019 Discharge Data; [4] CMS DRG Data

Figure 6
Share of Commercial Discharges
Huntington Memorial



Notes: [1] Share of commercial discharges by ZIP code are calculated using the discharges from the 2018 – 2019 OSHPD Discharge Data used to calculate WTP in Tables 12 and 13. See the notes to these tables for details about the sources and methodology used to process the discharge data.
Sources: [1] 2019 OSHPD Pivot Profile; [2] 2017 American Hospital Association Data; [3] OSHPD 2018-2019 Discharge Data; [4] CMS DRG Data

Figure 7
Hospital-Level Case Mix Adjusted Willingness to Pay
General Acute Care Commercial Admissions (Oct 2018 - Dec 2019)



Notes: [1] Analysis limited to patients with commercial insurance residing in Los Angeles, Orange, Riverside and San Bernardino Counties and excludes non-general acute care (GAC) services (i.e., excludes newborns and services related to behavioral health, substance abuse, and rehabilitation). Analysis also excludes admissions to Kaiser hospitals, admissions with invalid patient ZIP codes, services with invalid or ungroupable DRGs, and emergency admissions. [2] Willingness to Pay (WTP) for hospitals is calculated using a semiparametric hospital choice model. Hospital preferences are assumed to vary by patient group, where admissions are grouped using the following characteristics: patient location (county, zip code), admission type (major diagnostic category, medical-surgical indicator, DRG weight quartile, DRG), and patient demographics (age, sex). An iterative procedure is used to allocate patients into groups subject to a minimum group size of 25 admissions. The case mix adjusted WTPs weight groups of patients by the mean DRG resource intensity weight within the group.

Sources: [1] OSHPD 2018-2019 discharge data, [2] 2017 American Hospital Association data, [3] CMS DRG data

Appendix 1

GREGORY S. VISTNES

Vice President

Ph.D. Economics,
Stanford University

B.A. Economics,
University of California at
Berkeley (with High Honors)

Dr. Vistnes is an antitrust and industrial organization economist who works in a broad array of industries, including financial services, insurance, defense and aerospace, medical equipment, chemicals, software, energy, pharmaceuticals, steel, and various retail and industrial products. Dr. Vistnes is also an expert in the healthcare industry where he has frequently testified, published, and spoken at professional conferences.

In the course of his work, Dr. Vistnes regularly presents his analyses to the U.S. Department of Justice (DOJ) and the U.S. Federal Trade Commission (FTC). He also provides economic analyses for clients involved in private antitrust litigation, for clients involved in matters before state attorney generals, and for firms interested in anticipating the competitive implications of alternative strategies. Dr. Vistnes has been retained to provide expert testimony in a variety of antitrust matters, both on behalf of private sector firms and on behalf of various state and federal antitrust agencies.

Prior to joining CRA, Dr. Vistnes was the Deputy Director for Antitrust in the Federal Trade Commission's Bureau of Economics. In that position, he supervised the FTC's staff of approximately 40 Ph.D.-level antitrust economists and directed the economic analysis of all antitrust matters before the FTC. Before that, he served as an Assistant Chief in the Antitrust Division of the U.S. Department of Justice. At both the FTC and DOJ, Dr. Vistnes headed analytical teams responsible for investigating pending mergers and acquisitions or alleged anticompetitive behavior. As part of his duties, he regularly advised key agency decision makers, including FTC commissioners and the Assistant Attorney General for Antitrust.

REPRESENTATIVE PROJECTS AND INDUSTRY EXPERTISE

- *Healthcare and Medical Products.* Dr. Vistnes has provided court testimony and economic analyses relating to hospital mergers, hospital certificate of need applications, health plan mergers, and physician conduct. He has also provided analyses and testimony related to mergers and conduct issues relating to medical technology providers, medical products and equipment, and medical technology.
- *Pharmaceutical Markets*. Dr. Vistnes has provided economic analyses relating to both mergers and litigation matters involving a variety of pharmaceutical products and conduct. Dr. Vistnes' work in this area includes analyses of branded/generic mergers, conduct relating to bundling, Hatch-Waxman related work, analyses of biosimilar products and innovation, and pricing behavior.

- *Consumer Products*. Dr. Vistnes has provided merger analysis of a variety of retail products, including frozen desserts, processed meats, condiments, and hardware products. Dr. Vistnes' analyses include demand estimation based on detailed scanner data, product market analyses, product market definition and assessment of product differentiation.

- *Retail Service Providers*. Dr. Vistnes has provided competitive analyses of retail provider markets including supermarkets, pharmacies, department stores, and bookstores. Dr. Vistnes' work includes analyses relating to geographic and product markets, empirically-driven consumer choice models, and quantification of differentiation between providers.

- *Real Estate*. Dr. Vistnes served as the testifying expert for the DOJ in their multi-year litigation *U.S. v. National Association of Realtors* (NAR) regarding NAR's rules on how real estate brokers could use the Internet to compete as well as the testifying expert for the Canadian Competition Bureau in the *Commissioner v. Toronto Real Estate Board (TREB)* litigation regarding brokers' use of Internet-enabled technologies. Dr. Vistnes has also testified before several states regarding competition in the title insurance industry, and worked on several mergers (e.g., *Fidelity/LandAmerica*) involving title insurance providers.

- *Chemicals and Chemical Processes.* Dr. Vistnes has provided antitrust analyses in a variety of different chemicals industries and at different stages of the chemical manufacturing process. His work in this area has included price fixing cases relating to rubber chemicals and hydrogen peroxide, mergers involving polyvinyls and other plastic products, and conduct-related cases associated with industrial manufacturing processes.

- *Energy and Natural Resources*. Dr. Vistnes has provided economic analyses of several antitrust matters in different sectors of the energy industry, including the oil, electricity, gas pipelines and gas storage sectors. Dr. Vistnes has worked in a wide variety of industries relating to natural resources, including aggregates, cement, copper, and other semi-precious minerals.

- *Aftermarkets*. Dr. Vistnes testified before a jury in the *Static Control Components v. Lexmark International* litigation relating to replacement toner cartridges for laser printers. The jury agreed with Dr. Vistnes' opinion that the evidence showed that the aftermarket of replacement toner cartridges was the appropriate relevant market.

- *Insurance and Financial Services.* Dr. Vistnes has testified and provided analyses to both state and federal competition authorities regarding mergers of both insurance carriers (e.g., *MetLife/Travelers*) and insurance brokers (e.g., *Aon/Benfield*). Dr. Vistnes has also analyzed price fixing claims regarding initial public offerings (IPOs) and private equity firms.

- *Computer Software and Technology.* Dr. Vistnes has provided economic analyses in several software mergers that helped the merging parties avoid a second request by the government. Examples include matters involving software that provides security for internet websites; billing software used by large health plans; and the provision of electronic business-to-business services between trading partners.

PROFESSIONAL EXPERIENCE

2000–Present *Vice President*, Charles River Associates, Washington, D.C.

Dr. Vistnes' work focuses on analyzing antitrust and competition issues including:

- Horizontal and vertical mergers;
- Contractual provisions such as exclusivity provisions, most favored customer clauses, bundling provisions, and price discount schedules;
- Intellectual property and antitrust;
- Price fixing and conspiracy allegations;
- Class action litigation.

2015–Present *Research Fellow*, William Davidson Institute at the University of Michigan.

Dr. Vistnes' work at the William Davidson Institute focuses on analyzing competition and market dynamics in international healthcare markets with an emphasis on how microeconomic tools can be used to increase individuals' access to medicine in low- and middle-income countries.

1997–2000 *Deputy Director for Antitrust*, Bureau of Economics, U.S. Federal Trade Commission, Washington, D.C.

- Directed the economic analyses of all antitrust matters before the Commission.
- Briefed Commissioners and the Director of the Bureau of Economics regarding all antitrust matters before the Commission, including mergers, vertical restraints, and joint ventures.
- Advised the Commission on whether to challenge mergers or other anticompetitive activities.
- Developed strategies for the investigation and litigation of antitrust matters before the Commission.
- Directed the FTC's antitrust staff of 55 Ph.D. economists, managers, and support staff.

1996–1997 *Assistant Chief*, Economic Regulatory Section, Antitrust Division, U.S. Department of Justice, Washington, DC.

- Directed economic analyses at the Antitrust Division in the health care and telecommunications industries;
- Briefed the Assistant Attorney General and Deputies on the economic aspects of health care and telecommunications matters;
- Played a key role in writing the 1996 Department of Justice/Federal Trade Commission's Statements of Antitrust Enforcement Policy in the Health Care Area;
- Led the Antitrust Division's economic analyses of hospital and HMO mergers and/or joint ventures in the health care industry;

- Directed the economic analyses of Bell Operating Company mergers;
- Headed DOJ's economic assessment of the conditions under which Bell Operating Companies should be allowed to enter into long-distance markets;
- Directed the economic analyses of the wave of radio station mergers following passage of the 1996 Telecommunications Act.

1995–1996 *Manager*, Health Care Issues Antitrust Division, U.S. Department of Justice, Washington, DC.

- Directed the economic analyses of all health care matters at the Division.

1990–1995 *Staff Economist*, Antitrust Division, U.S. Department of Justice, Washington, DC.

- Analyzed antitrust and competition-related matters in the health care, entertainment, natural resources, and industrial machinery industries;
- Designated as the Antitrust Division's economic testifying expert in numerous hospital mergers;
- Analyzed hospital and HMO mergers, physician joint ventures, healthcare information exchanges, and physician/hospital affiliations and mergers;
- Played a key role in writing the 1993 and 1994 Department of Justice/Federal Trade Commission's *Statements of Antitrust Enforcement Policy in the Health Care Area*;
- Designated as DOJ's Economic Representative to President Clinton's 1993 White House Task Force on Health Care Reform.

1988–1990 *Economic Consultant*, Putnam, Hayes and Bartlett, Washington, DC.

- Analyzed health care matters;
- Wrote strategy reports for clients interested in directing the course of health care reform at the local and federal levels;
- Developed pricing methodologies to promote competition in the electric utility industry.

1987–1988 *Visiting Professor*, Department of Economics, University of Washington, Seattle.

- Taught graduate and undergraduate health care economics, industrial organization & strategic firm behavior, and intermediate price theory.

SELECTED INDUSTRY EXPERTISE

- Healthcare
- Pharmaceuticals
- Supermarkets and Other Retail Providers
- Consumer Products
- Real Estate
- Chemicals
- Insurance
- Software
- Financial Markets
- Aerospace and Defense
- Medical Equipment and Services
- Energy

ORAL TESTIMONY

UCFW and Employers Benefit Trust vs. Sutter Health; and People of the State of California vs. Sutter Health, Superior Court of the State of California, County of San Francisco. [Deposition testimony on behalf of UCFW and State of California, November 2018 and February 2019]

United Healthcare Acquisition of Rocky Mountain Health Plan, Testimony before the Colorado Division of Insurance, January 10, 2017. [Oral hearing testimony on behalf of United Healthcare]

Kissing Camels Surgery Center, et al. v. Centura Health Corp, et al. U.S. District Court, District of Colorado (Civil Action No. 1:12-cv-03012-WJM-NYM). [Deposition testimony on behalf of Aetna, October 2016]

The Commissioner of Competition (Canada) v. Toronto Real Estate Board (TREB). [Trial testimony on behalf of the Canadian Competition Bureau, September 2012 and October 2015]

Deborah Heart and Lung Center v. Presbyterian Medical Center of the University of Pennsylvania Health System d/b/a/ Penn Presbyterian Medical Center, et al., U.S. District Court, District of New Jersey (Civil Action No. 1:11-cv-01290-RMB-KMW). [Deposition testimony on behalf of Virtua Health, March 2014]

Wendy Fleischman, et al. v. Albany Medical Center, et al., U.S. District Court, Northern District of New York (Case No. 06-CV-0765/TJM/DRH). [Deposition testimony on behalf of plaintiff class, July 2009 and January 2010]

Pat Cason-Merenda et al. v. Detroit Medical Center, et al., Eastern District of Michigan, Southern Division (Case No. 06-15601). [Deposition testimony on behalf of plaintiff class, April 2009]

Munich Reinsurance Group Application for the Acquisition of Control of Hartford Steam Boiler. Testimony before the Commissioner of Insurance of the State of Connecticut. [Oral hearing testimony on behalf of Munich Reinsurance Group, March 2009]

United States of America v. National Association of Realtors. U.S. District Court (Northern District of Illinois – Eastern Division). [Deposition testimony on behalf of the U.S. Department of Justice, July 2007 and December 2007]

Funeral Consumers Alliance, Inc., et al. v. Service Corporation International, et al., U.S. District Court, Southern District of Texas (Civil Action 3H-05-3394). [Deposition testimony on behalf of Funeral Consumers Alliance, Inc. July 2007]

Static Control Components v. Lexmark International. U.S. District Court (Eastern District of Kentucky at Lexington). [Trial and deposition testimony on behalf of Static Control Components, Wazana Brothers International and Pendl Companies, June 2007]

Saint Alphonsus Diversified Care, Inc. v. MRI Associates, LLP; and MRI Associates, LLP v. Saint Alphonsus Diversified Care, Inc. and Saint Alphonsus Regional Medical Center. District Court for the Fourth Judicial District of the State of Idaho. [Deposition testimony on behalf of Saint Alphonsus Regional Medical Center, May 2007]

Louisiana Municipal Police Employees' Retirement System, et al., v. Crawford, et al., and *Express Scripts, Inc. v. Crawford, et al.* (Del. Ch., C.A., No. 2635-N and 2663-N). [Deposition testimony on behalf of Caremark Rx, Inc., February 2007]

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SELECTED EXPERT REPORTS AND WRITTEN TESTIMONY

Economic Analysis of the Proposed Acquisition of Stewart Information Services Corp. by Fidelity National Financial: Competitive Effects Analysis in Selected States. State-specific expert reports submitted to insurance commissions in multiple states (2018 and 2019).

Yakima Valley Memorial Hospital v. Washington State Department of Health, U.S. District Court, Eastern District of Washington (Case CV-09-3032-EFS). Expert reports submitted on behalf of Yakima Valley Memorial Hospital, April 2010, December 2011, and January 2012.

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"Welfare Effects and Policy Implications of Recent COPA Studies," Federal Trade Commission Workshop on Certificate of Public Advantage Legislation, Washington, DC, June 18, 2019.

"Rethinking Settlement in Mergers Cases," GCR Annual Antitrust Law Leaders Forum, Miami, February 2018.

"Cross-Market Hospital Mergers: The Next Frontier in Antitrust Enforcement," AHLA/Antitrust Practice Group Webinar, November 30, 2017.

"Cross-Market Provider Mergers," FTC Microeconomics Conference, Washington, DC, November 2, 2017.

"The best use of evidence: The economist perspective," Global Competition Review Conference, New York, NY, November, 2016.

"Critical Issues in Health Plan Payer Litigation," ABA/AHLA Antitrust in Healthcare Conference, Arlington, VA, May 2014.

"Competition Concerns in Innovation and Technology Markets," GCR Annual Antitrust Law Leaders Forum, Miami, February 2014.

"An Economist's View of the New Merger Guidelines: From Betty Crocker to Julia Child," Stafford Webinar, October 14, 2010.

"Healthcare Provider Market Power," ABA/AHLA Antitrust in Healthcare Conference, Arlington, VA, May 2010.

"Interpreting Evidence Regarding Price Effects in Consummated Mergers," ABA Spring Meetings, Washington, DC, April 2010.

"Are There Different Rule of Reason Tests for Vertical and Horizontal Conduct?" ABA Joint Conduct Committee, teleconference presentation, June 2009.

"The Economics of Information Sharing and Competition," ABA Section on Business Law, Vancouver, BC, April 2009.

"United States versus the National Association of Realtors: The Economic Arguments and Implications for Trade Associations," ABA Spring Meetings, Washington, DC, March 2009.

"The Use of Price Effects Evidence in Consummated Merger Analysis," ABA Section of Antitrust Law, teleconference presentation, February 2009.

"Competition in the Title Insurance Industry – An Economic Analysis." National Association of Insurance Commissioners, Washington, DC, June 2006.

"Antitrust Issues in the BioTech Industry." Biotech Industry Organization BIO 2005 International Meetings, Philadelphia, June 2005.

"Cartels and Price Fixing – Ensuring Consistency Between Theory and the Facts." The Use of Economics in Competition Law, Brussels, January 2005.

"Intellectual Property and Antitrust in High-Tech Industries." ABA Section on Business Law, Atlanta, August 2004.

"Antitrust, Intellectual Property and Innovation." Biotech Industry Organization BIO 2004 International Meetings, San Francisco, June 2004.

"Quality, Healthcare and Antitrust." Petris Center/UC Berkeley Conference on Antitrust and Healthcare, University of California at Berkeley, April 2004.

"Unilateral Effects - Be Careful What You Wish For." Second Annual Merger Control Conference, the British Institute of International and Comparative Law, London, December 2003.

"Geographic Market Definition in Hospital Antitrust Analysis – Theory and Empirical Evidence." Federal Trade Commission/Department of Justice Joint Hearings on Health Care and Competition Law and Policy, Washington, DC, March 2003.

"Trade Barriers and Antitrust: Foreign Firms – Down but Not Out." Antitrust Issues in Today's Economy, The Conference Board, New York City, March 2003.

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"Practical Issues in Intellectual Property Investigations: Balancing Rules versus Discretion." Department of Justice/Federal Trade Commission Joint Hearings on Intellectual Property and Antitrust, Washington, DC, May 2002.

"Bundling and Tying: Recent Theories and Applications." Antitrust Section of the American Bar Association Meeting, Washington, DC, April 2002.

"Antitrust Issues in the Pharmaceutical Industry: The Hatch-Waxman Cases." ABA Healthcare and Intellectual Property Sections Brownbag, Washington, DC, February 2002.

"The GE/Honeywell Deal: Is Europe Raising the Yellow Flag on Efficiencies?" CRA Conference on Current Topics in Merger and Antitrust Enforcement, Washington, DC, October 2001.

"Marching to the Sounds of the Cannon: Antitrust Battlegrounds of the Future." National Association of Attorneys General Conference, San Diego, October 2000.

"The Joint Venture Guidelines: Navigating Outside the Safety Zones." The 8th Annual Golden State Antitrust and Unfair Competition Law Institute, Los Angeles, October 2000.

"Strategic Behavior in the Pharmaceutical Industry: The Hatch-Waxman Act and Blockading Entry." Antitrust Section of the American Bar Association Meeting, Washington, DC, April 2000.

"Working With Economic Experts." Antitrust Common Ground Conference, Chicago, IL, December 1999.

"Merger Enforcement Trends." CRA Conference on Current Topics in Merger and Antitrust Enforcement, Washington, DC, December 1998.

"Hot Topics in Health Care Antitrust." Antitrust Fundamentals for the Health Care Provider, Sponsored by the Wisconsin Field Office of the Federal Trade Commission, the US Department of Justice, and Marquette University Law School, Milwaukee, WI, December 1998.

"Federal Antitrust Enforcement in the Health Care Industry: New Directions." Fourth Annual Health Care Antitrust Forum, Northwestern University, September 1998.

"Hospital Competition in HMO Networks." American Economic Association Meetings, San Francisco (1996) and Chicago (1998).

"Creating Competitive Markets amidst Barriers to Entry." Weeklong Presentation to the Russian State Committee of Antimonopoly Policy, Volgograd, Russia, January 1997.

"The Economics of Antitrust Law." Maine Bar Association, January 1995.

"The Competitive Impact of Differentiation Across Hospitals." Fourth Annual Health Economics Conference, Chicago, 1993.

"Multi-Firm Systems, Strategic Alliances, and Provider Integration." Pennsylvania State University, the University of California at Santa Barbara, and the Johns Hopkins School of Public Health, 1992 and 1993.

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"A Competitive Analysis of Malaria Markets," With Paul Clyde. *working paper*, May 2016.

"Cross-Market Hospital Mergers: A Holistic Approach." With Yianis Sarafidis. *The Antitrust Law Journal*, 2013.

"The Seven Potential Sins of Most Favored Nation (MFN) Clauses: Risk Factors and the USDOJ's Michigan MFN Litigation." *Working paper*, April 2013.

"The Interplay Between Competition and Clinical Integration: Why the Antitrust Agencies Care About Medical Delivery Styles," *CPI Antitrust Journal*, Competition Policy International, October 2010.

"Presumptions, Assumptions and the Evolution of U.S. Antitrust Policy." With Andrew Dick. *Trade Practices Law Journal*, December 2005.

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"Employer Contribution Methods and Health Insurance Premiums: Does Managed Competition Work?" With Jessica Vistnes and Phillip Cooper. *The International Journal of Health Care Finance and Economics*, 2001.

"Hospital Competition in HMO Networks: An Empirical Analysis of Hospital Pricing Behavior." With Robert Town. *The Journal of Health Economics*, September 2001.

"Hospitals, Mergers, and Two-Stage Competition." *The Antitrust Law Journal*, January 2000.

"Defining Geographic Markets for Hospital Mergers." *Antitrust*, Spring 1999.

"The Role of Third Party Views in Antitrust Analysis: Trust But Verify." *Government Antitrust Litigation Advisory*, American Bar Association, July 1998.

"Hospital Mergers and Antitrust Enforcement." *The Journal of Health Politics, Policy and Law*, spring 1995.

"An Empirical Investigation of Procurement Contract Structures." *The Rand Journal of Economics*, Summer 1994.

PROFESSIONAL ACTIVITIES

Referee for:

- *The American Economic Review*
- *The Antitrust Law Journal*

- *Health Services Research*
- *Inquiry*
- *The Journal of Industrial Economics*
- *The Rand Journal of Economics*
- *The Review of Industrial Organization*

Grant Reviewer for:

- Robert Wood Johnson Foundation/Academy Health
- The Alpha Center
- Agency for Health Care Policy and Research

HONORS AND AWARDS

- Named one of *Global Competition Review's* 2006 "Top Young Economists" (identifying the top 22 antitrust economists in the U.S. and Europe under the age of 45)
- Assistant Attorney General's Merit Award (1994), Antitrust Division, U.S. Department of Justice
- Distinguished Teaching Fellowship (1986), Department of Economics, Stanford University
- Academic Fellowship (1983–1984), Department of Economics, Stanford University

Appendix 2

ILLUSTRATING THE PRICE CAP CALCULATIONS

The following examples illustrate how price changes are calculated under the Price Cap, for a particular payer in highly stylized world in which the hospital provides just seven different services (DRGs A through G).[147]

1. A simple example with a one-year contract

Example 1 provides the simplest illustration of how the Price Cap works by focusing on a case where a payer enters into a new one-year contract beginning January 1, 2022.[148] This example illustrates how HM can determine whether the 2022 prices it is negotiating will satisfy the Price Cap.

In this example, the Baseline Year Service Basket corresponds to the services that HM provided to the payer in 2019, the Current Year Price Schedule corresponds to the 2022 contract prices that will go into effect under the new contract, and the Previous Year Price Schedule corresponds to the contract prices that were in effect in 2021.

As shown in Table A1, the cost of the Baseline Year Service Basket (consisting of 10 patients in each of 7 different DRGs) evaluated at 2021 contract prices is $13,550. The cost of that same basket of services, evaluated at the 2022 contract prices, is $14,000.[149] Thus, moving from 2021 prices to 2022 prices increases the cost of the Baseline Service Basket by 3.3 percent. That 3.3 percent represents the Actual Price Increase as calculated under the Price Cap.[150]

To calculate the Allowed Price Increase, one looks at the Index values over 12-month period from July 2020 – July 2021. The July 2020 Index value equals 354.0, and for purposes of this illustration, assume the July 2021 Index value equals 368.2.[151] Thus, the change in the Index, and thus the Allowed Price Increase, is 4.0 percent.[152]

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[147] Although these examples focus on inpatient services, the same approach is followed when including outpatient or other services provided by HM.

[148] The numbers (and magnitudes of numbers) used in these examples were chosen to simplify the discussion of how the Price Cap methodology works. For these purposes, no effort was made to choose those assumed numbers to approximate actual prices or likely price increases.

[149] As shown, this example assumes that some individual service prices increase from 2021 to 2022, while other prices fall or stay the same.

[150] Note that the Actual Price Increase does not depend in any way on what services HM provides in 2022. Thus, the calculated Actual Price Increase of 3.3% holds regardless of whether the mix of services that HM provides to the payer might be changing over time.

[151] The July 2021 Index value was not yet known at the time this report was written, but would be known to HM in late 2021 when it would presumably be negotiating 2022 prices.

[152] In the case of one-year contracts, the Price Cap does not make provision for a 4% floor price increase.

It follows that in this example, the Actual Price Increase (3.3 percent) is slightly below the Allowed Price Increase (4.0 percent), thus HM is permitted to bank that difference (0.7 percent) as an allowance against future years in which its Actual Price Increase exceeds the Allowed Price Increase.

2. Applying the Price Cap with a multi-year contract

Payers often enter into multi-year contracts in which they specify prices that will apply for several years in the future. The example illustrated in Table A2 shows how the Price Cap calculates the Allowed Price Increase in that more complicated situation.

As in the previous example, assume the new contract begins on January 1, 2022, and thus the Baseline Year is again 2019. Table A2 shows that HM is again assumed to have treated 10 patients in each of the 7 DRGs in that Baseline Year. The Table also shows the assumed negotiated contract prices in each year of the assumed 3-year contract, with individual service prices sometimes increasing over time and sometimes decreasing or staying the same.[153]

The example illustrates how the payer's overall cost of the Baseline Year Service Basket changes over time when evaluated at the different prices in effect each year. In particular, while the Baseline Year Service Basket would cost (in total) $13,550 when evaluated at 2021 prices, that same basket of services would cost $14,000 when evaluated at 2022 prices, a 3.3 percent increase. That actual price increase is compared to the change in the Index which, for the period in question, is 4 percent.

The same basic methodology is used to calculate the Actual Price Increase in other years covered by the contract.[154] That same 2019 basket of services, when evaluated at the assumed 2023 prices, would only cost $13,900, thus the cost of the basket falls by 0.7 percent relative to its 2022 cost.[155] Similarly, the cost of that 2019 basket of services is $13,900 when evaluated at the assumed 2024 contract prices, thus the Actual Price Increase from 2023 to 2024 is 0.0 percent.

3. Applying the Price Cap in the case of a contract renewal

Table A3 shows how the Price Cap is applied in the situation where a payer renews a multi-year contract and thus changes the Baseline Year and Baseline Year Service Basket.

This example builds on the example shown in Table A2, but assumes the payer enters into a new multi-year contract in 2024 after the multi-year contract in Table A2 expires. In Table A3, Actual

[153] The assumption of falling prices may be unrealistic, but is shown to demonstrate the flexibility of the Price Cap methodology.

[154] In those subsequent years, the Actual Price Increase is compared to the maximum of the Change in the Index and the 4% floor price increase.

[155] Although HM can calculate the change in the Actual Price Increase from 2022 to 2023 in advance (i.e., during its contract negotiations in 2021), HM will not be able to calculate the Allowed Price Increase for 2022 to 2023 until the relevant data are available sometime after the contract is negotiated.

Price Increases in 2024 through 2026 are calculated in the same way as the Actual Price Increase for 2022 (3.3 percent) and 2023 (-0.7 percent) calculated in Table A2, where 2019 is the relevant Baseline Year.

A new contract, however, means that a new Baseline Year is defined for that new contract. With a new contract being entered into in January 2024, the new Baseline Year becomes 2023 (the "immediately preceding Managed Care Contract Year prior to that year in which the Managed Care Contract is entered or renewed.") Thus, when evaluating the *new* contract, the Price Cap will look at an updated basket of services, i.e., the set of services the payer purchased in 2023.

Table A3 shows how Actual Price Increases are calculated using this updated 2023 basket of services. When evaluating the cost of that 2023 basket of services using 2024 prices, the cost of those services would be $19,875. Based on prices from the previous year (2023), that same basket of services would have cost $19,450. Thus, the price increase from 2023 to 2024 is 2.2 percent. Similarly, the cost of that 2023 basket of services increases by 0.4 percent from 2024 to 2025, and falls by 2.5 percent from 2025 to 2026.

4. Applying the Price Cap to mixed pricing methodologies

In many cases, payers enter into contracts that use a variety of different pricing methodologies. For example, a payer may specify a single per-diem rate that applies to most med/surg cases, but then carve out other types of care for different per-diem rates or different pricing methodologies. Table A4 illustrates how the Price Cap applies in such cases.

The example in Table A4 assumes a single per-diem rate that applies to most med/surg cases, but carve-out rates for maternity cases (with different case rates applicable to different types of cases, e.g., vaginal deliveries vs. caesarean sections), a higher per-diem rate for babies in the neonatal intensive care unit (NICU), and special prices for three different types of cardiac care (a case rate; a case rate with additional per-diem rates for long lengths of stay; and percent of charges).

That example then show the payer's total cost of treating its 2019 baseline set of patients using both the 2021 price schedule ($15,900) and the 2022 price schedule ($16,615).[156] This results in an Actual Price Increase of 4.5%.

[156] For the Cardiac 3 services in which payments are based on discounted charges, the Table does not show the price. For those services, the Previous Year and Current Year Payments depend both on the level of charges (as defined by that year's chargemaster) and the negotiated discount off chargers for that year.

5. Applying the Price Cap when pricing methodologies change

The Price Cap is sufficiently flexible to allow HM to change how it prices its services, e.g., changing from DRG-based contracts to per-diem contracts, or changing from discounted-charges to a mix of DRG-based, per-diem, and discounted charges.[157]

Table A5 illustrates how the Price Cap methodology is applied in several scenarios in which HM changes pricing methodologies. It assumes that the initial contract is DRG-based, with HM then moving to a (one-year) contract in 2022 that is either based on per diem prices (Variant 1), capitated prices (Variant 2), or discounted charges (Variant 3).[158]

In each variant of this example, the Baseline Year is 2019. Under the 2021 (Previous Year) DRG-based price schedule, the 2019 basket of services would have cost the payer $13,550.

In Variant 1, HM is assumed to move to a per-diem contract in 2022.[159] Based on that new 2022 per-diem contract, that same 2019 basket of services would cost $13,950, a 3.0 percent increase in cost relative to what the payer would have paid in 2021 (based on the 2021 DRG-contract).[160]

In Variant 2, HM is instead assumed to move to a capitated contract in 2022 in which it receives a lump-sum payment for each patient it treats.[161] In this example, I assume two different capitated rates ($130 and $375) that can be viewed as corresponding to high-cost and low-cost patients. The cost of the 2019 baseline services is unchanged at $13,550. However, when that 2019 basket of services is repriced using 2022 capitated prices, the cost of that basket increases to $14,000 (a 3.3 percent increase).

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[157] This discussion does not directly apply to a scenario in which the hospital accepts risk by accepting a capitated rate that applies to a covered patient population pool and is thus more akin to a type of insurance premium that is paid to the hospital regardless of whether the patient is hospitalized. The Price Cap (at paragraph 7) recognizes that such risk-arrangements may instead need to be assessed as part of the Arbitration provisions of the Conditions.

[158] To simplify, this example focuses on the case where HM only uses a single type of price, e.g., *all* services are priced using DRG-prices, or all services are priced using discounted charges. The methodology, however, easily extends to situations where different services are priced using different approaches (e.g., maternity-related services under capitation prices, tertiary services under discounted-charges, and other services under either DRG-based or per-diem prices). It is also easy to see how this methodology would be applied in cases with outlier provisions, e.g., where capitated or DRG rates apply unless the patient stay exceed some threshold level at which point prices are based on a discounted charges.

[159] In this example, HM is assumed to set different per-diem rates for different services, but the methodology is unchanged if there is a single per-diem across all services, or a different per-diem for each service.

[160] Note that this calculation of the 2022 cost requires information about the number of patient days associated with the 2019 baseline basket of services. As will be seen, whatever metric the new pricing schedule relies upon (e.g., charges, days, or number of patients) is information that needs to be known for the baseline basket of services.

[161] Note that capitated rates are a special case of DRG-rates, i.e., where the capitated rate is the same across multiple DRGs. In this example, I assume two tiers of capitated prices, thus significant aggregation of price across individual DRGs.

In Variant 3, HM is instead assumed to move to a discounted-charge contract in 2022.[162] In this example, I assume that HM is paid 60 percent of charges for all services.[163] Because the cost of the 2019 baseline services does not depend on the 2022 price schedule, that cost of that baseline set of services is again $13,550. When repriced using the 2022 discounted charge price schedule, however, the cost of that basket increases to $14,010 (a 3.4 percent increase).

[162] To simplify, the examples assumes that HM's chargemaster is the same in 2019 and 2022. More generally, the Current Year Payment is based on total charges for 2019 assuming both a 2022 chargemaster and the 2022 discount off charges.

[163] The example could readily be changed to allow for different discounts for different types of services.

Table A1
Illustrating the Price Cap Calculations (Example 1)
A Simple One-Year Contract

		Assessing the Price Cap in 2021			
DRG	**Baseline Year Service Basket (Discharges)**	**Previous Year Price Schedule**	**Previous Year Payment (PYP)**	**Current Year Price Schedule**	**Current Year Payment (CYP)**
	[Q_{2019}]	**[P_{2021}]**	**[$Q_{2019}*P_{2021}$]**	**[P_{2022}]**	**[$Q_{2019}*P_{2022}$]**
A	10	$200	$2,000	$220	$2,200
B	10	$80	$800	$90	$900
C	10	$75	$750	$50	$500
D	10	$50	$500	$40	$400
E	10	$150	$1,500	$150	$1,500
F	10	$300	$3,000	$325	$3,250
G	10	$500	$5,000	$525	$5,250
Calculated Total Reimbursement:			**$13,550**		**$14,000**
Actual Price Increase:					**3.3%**

Notes:

[1] This table reports the calculations in Appendix 2, Example 1.

Table A2
Illustrating the Price Cap Calculations (Example 2)
Applying the Price Cap with a Multi-Year Contract

DRG	Baseline Year Service Basket (Discharges)	Assessing the Price Cap in Year 2021 (Year 1)				Assessing the Price Cap in Year 2022 (Year 2)			Assessing the Price Cap in Year 2023 (Year 3)		
		Previous Year Price Schedule	Previous Year Payment (PYP)	Current Year Price Schedule	Current Year Payment (CYP)	Previous Year Payment (PYP)	Current Year Price Schedule	Current Year Payment (CYP)	Previous Year Payment (PYP)	Current Year Price Schedule	Current Year Payment (CYP)
	[Q_{2019}]	[P_{2021}]	[$Q_{2019}*P_{2021}$]	[P_{2022}]	[$Q_{2019}*P_{2022}$]	[$Q_{2019}*P_{2022}$]	[P_{2023}]	[$Q_{2019}*P_{2023}$]	[$Q_{2019}*P_{2023}$]	[P_{2024}]	[$Q_{2019}*P_{2024}$]
A	10	$200	$2,000	$220	$2,200	$2,200	$200	$2,000	$2,000	$220	$2,200
B	10	$80	$800	$90	$900	$900	$100	$1,000	$1,000	$95	$950
C	10	$75	$750	$50	$500	$500	$60	$600	$600	$60	$600
D	10	$50	$500	$40	$400	$400	$50	$500	$500	$55	$550
E	10	$150	$1,500	$150	$1,500	$1,500	$130	$1,300	$1,300	$140	$1,400
F	10	$300	$3,000	$325	$3,250	$3,250	$300	$3,000	$3,000	$250	$2,500
G	10	$500	$5,000	$525	$5,250	$5,250	$550	$5,500	$5,500	$570	$5,700
Calculated Total Reimbursement:			**$13,550**		**$14,000**	**$14,000**		**$13,900**	**$13,900**		**$13,900**
Actual Price Increase:					**3.3%**			**-0.7%**			**0.0%**

Notes:

[1] This table reports the calculations in Appendix 2, Example 2.

[2] In Year 1, the Price Cap is assessed like in Example 1. In Years 2 and 3, the Price Cap continues to be assessed using the Baseline Year Service Basket from 2019.

Table A3
Illustrating the Price Cap Calculations (Example 3)
Applying the Price Cap in the Case of a Contract Renewal in 2024

DRG	Baseline Year Service Basket (Discharges)	Assessing the Price Cap in Year 2024 (Year 1)				Assessing the Price Cap in Year 2025 (Year 2)			Assessing the Price Cap in Year 2026 (Year 3)		
		Previous Year Price Schedule	Previous Year Payment (PYP)	Current Year Price Schedule	Current Year Payment (CYP)	Previous Year Payment (PYP)	Current Year Price Schedule	Current Year Payment (CYP)	Previous Year Payment (PYP)	Current Year Price Schedule	Current Year Payment (CYP)
	[Q_{2023}]	[P_{2023}]	[$Q_{2023}*P_{2023}$]	[P_{2024}]	[$Q_{2023}*P_{2024}$]	[$Q_{2023}*P_{2024}$]	[P_{2025}]	[$Q_{2023}*P_{2025}$]	[$Q_{2023}*P_{2025}$]	[P_{2026}]	[$Q_{2023}*P_{2026}$]
A	10	$200	$2,000	$220	$2,200	$2,200	$250	$2,500	$2,500	$200	$2,000
B	15	$100	$1,500	$95	$1,425	$1,425	$100	$1,500	$1,500	$100	$1,500
C	25	$60	$1,500	$60	$1,500	$1,500	$60	$1,500	$1,500	$60	$1,500
D	30	$50	$1,500	$55	$1,650	$1,650	$50	$1,500	$1,500	$50	$1,500
E	20	$130	$2,600	$140	$2,800	$2,800	$130	$2,600	$2,600	$130	$2,600
F	7	$300	$2,100	$250	$1,750	$1,750	$300	$2,100	$2,100	$300	$2,100
G	15	$550	$8,250	$570	$8,550	$8,550	$550	$8,250	$8,250	$550	$8,250
Calculated Total Reimbursement:			**$19,450**		**$19,875**	**$19,875**		**$19,950**	**$19,950**		**$19,450**
Actual Price Increase:					**2.2%**			**0.4%**			**-2.5%**

Notes:

[1] This table reports the calculations in Appendix 2, Example 3.

[2] In 2024 the contract from Example 2 is renewed. Therefore, 2023 is the Baseline Year when assessing the Price Cap.

Table A4
Illustrating the Price Cap Calculations (Example 4)
Applying the Price Cap to Mixed Pricing Methodolgies

			Assessing the Price Cap in 2021			
Case Type	**Pricing Methodology**	**Baseline Year Service Basket (Discharges)**	**Previous Year Price Schedule**	**Previous Year Payment (PYP)**	**Current Year Price Schedule**	**Current Year Payment (CYP)**
		[Q_{2019}]	**[P_{2021}]**	**[$Q_{2019}*P_{2021}$]**	**[P_{2022}]**	**[$Q_{2019}*P_{2022}$]**
Med/Surg	Per Diem	100	$20	$2,000	$21	$2,100
Maternity 1	Case Rate	20	$50	$1,000	$52	$1,040
Maternity 2	Case Rate	10	$75	$750	$80	$800
NICU	Per DIem	25	$40	$1,000	$43	$1,075
Cardiac 1	Case Rate	5	$100	$500	$100	$500
Cardiac 2	Case Rate + Per Diem			$650		$700
Cardiac 3	% Charges			$10,000		$10,400
Calculated Total Reimbursement:				**$15,900**		**$16,615**
Actual Price Increase:						**4.5%**

Notes:

[1] This table reports the calculations in Appendix 2, Example 4.

[2] The table omits calculations for the Previous Year Payment (PYP) and Current Year Payment (CYP) for DRGs F and G. The notes below describe these calculations.

[3] For DRG F, the hospital receives a Case Rate for each admission and a Per Diem for each excess admission day. Thus, the Baseline Year Service Basket contains the number of admissions and excess days in 2019 and the Current and Previous Year Price Schedules contain case rates and per diem prices. The PYP and CYPs are calculated from these updated inputs.

[4] For DRG G, the hospital receives a percentage of their listed charges. Thus, the Baseline Year Service Basket contains the total charges on DRG G in 2019 and the Current and Previous Year Price Schedules contain discounts off listed charges. The PYP and CYPs are calculated from these updated inputs. These calculations are made explicit in Table A5, Variant 3.

Table A5
Illustrating the Price Cap Calculations (Example 5)
Applying the Price Cap When Pricing Methodologies Change

DRG	Baseline Year Service Basket (Discharges)	Previous Year Price Schedule (Price per Discharge)	Previous Year Payment (PYP)	Variant 1: Assessing the Price Cap in 2022 Under Per-Diem Pricing			Variant 2: Assessing the Price Cap in 2022 Under Capitated Payments			Variant 3: Assessing the Price Cap in 2022 Under Discounted Charges		
				Baseline Year Service Basket (Patient Days)	Current Year Price Schedule (Price per Diem)	Current Year Payment (CYP)	Baseline Year Service Basket (Discharges)	Current Year Price Schedule (Capitation per Discharge)	Current Year Payment (CYP)	Baseline Year Service Basket (Total Charges)	Current Year Price Schedule (as % of Charges)	Current Year Payment (CYP)
	[Q_{2019}]	[P_{2023}]	[$Q_{2023}*P_{2023}$]	[Q_{2023}]	[P_{2025}]	[$Q_{2023}*P_{2025}$]	[Q_{2023}]	[P_{2025}]	[$Q_{2023}*P_{2025}$]	[Q_{2023}]	[P_{2026}]	[$Q_{2023}*P_{2026}$]
A	10	$200	$2,000	50	$30	$1,500	10	$130	$1,300	$1,500	60%	$900
B	10	$80	$800	40	$30	$1,200	10	$130	$1,300	$2,000	60%	$1,200
C	10	$75	$750	60	$30	$1,800	10	$130	$1,300	$8,000	60%	$4,800
D	10	$50	$500	20	$20	$400	10	$130	$1,300	$750	60%	$450
E	10	$150	$1,500	70	$20	$1,400	10	$130	$1,300	$5,000	60%	$3,000
F	10	$300	$3,000	50	$75	$3,750	10	$375	$3,750	$3,000	60%	$1,800
G	10	$500	$5,000	30	$130	$3,900	10	$375	$3,750	$3,100	60%	$1,860
Calculated Total Reimbursement:			**$13,550**			**$13,950**			**$14,000**			**$14,010**
Actual Price Increase:						**3.0%**			**3.3%**			**3.4%**

Notes:
[1] This table reports the calculations in Appendix 2, Example 5.