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State of California
DEPARTMENT OF JUSTICE

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June 9, 2009

Jerry Peters, Esq.
Latham & Watkins LLP - San Francisco
505 Montgomery Street, Suite 2000
San Francisco, CA 94111-2562

RE: Proposed Sale of Anaheim Memorial Medical Center

Dear Mr. Peters:

The Attorney General hereby conditionally consents, pursuant to Corporations Code section 5914, to the sale of Anaheim Memorial Medical Center to AHMC Healthcare, Inc. and its affiliates, AHMC Anaheim Regional Medical Center LP and ARMC Calmed Investment LP, as set forth in the Notice filed on February 27, 2009. Corporations Code section 5917 and California Code of Regulations, title 11, section 999.5, subdivision (f) set forth factors that the Attorney General must consider in determining whether to consent to a proposed transaction between a nonprofit corporation and a for-profit 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.

Thank you for your cooperation and that of your client and the purchaser throughout the review process.

Sincerely,

/s/

WENDI A. HORWITZ
Deputy Attorney General

For EDMUND G. BROWN JR.
Attorney General

Attachment

cc: Maan-Huei Hung, Esq.

Conditions to Approval of Sale of Anaheim Memorial Medical Center

I.

For the purposes of these conditions, and unless the context indicates otherwise, the term "Buyer" shall mean AHMC Healthcare, Inc., a California for-profit corporation, AHMC Healthcare LP, AHMC, Inc., GEMW Healthcare LP, GEMW Healthcare Investment LP, AHMC Anaheim Regional Medical Center LP, ARMC Calmed Investment LP, the proposed acquirers of Anaheim Memorial Medical Center[1], any other subsidiary, parent, general partner, affiliate, successor, or assignee of AHMC Healthcare, Inc., a California for-profit corporation, AHMC Healthcare LP, AHMC, Inc., GEMW Healthcare LP, GEMW Healthcare Investment LP, AHMC Anaheim Regional Medical Center LP, ARMC Calmed Investment LP, any entity succeeding thereto by consolidation, merger or acquisition of all or substantially all of the assets of Anaheim Memorial Medical Center, any entity owned by the Buyer that subsequently becomes the owner or licensed operator of Anaheim Memorial Medical Center, any entity that owns the Buyer that subsequently becomes the owner or licensed operator of Anaheim Memorial Medical Center, any future entity that purchases Anaheim Memorial Medical Center from the Buyer, and any entity owned by a future purchaser that subsequently becomes the owner or licensed operator of Anaheim Memorial Medical Center. These conditions shall be legally binding on any and all future owners or operators of Anaheim Memorial Medical Center. The term "Seller" shall mean Anaheim Memorial Medical Center, a California nonprofit public benefit corporation, and Memorial Health Services, a California nonprofit public benefit corporation.

II.

The transaction approved by the Attorney General between the Buyer and Seller consists of the Asset Purchase Agreement dated February 13, 2009, Transition Services Agreement dated February 13, 2009, Escrow Agreement dated February 13, 2009, Payment Guaranty dated February 13, 2009, Confidentiality Agreement dated November 13, 2008, and Assignment and Assumption of Asset Purchase Agreement dated April 17, 2009. Buyer and Seller shall fulfill the terms and conditions of the transaction. Buyer and Seller shall notify the Attorney General in writing of any proposed modification of the transaction, including a proposed modification or rescission of any of the agreements. Such notification shall be provided at least thirty days prior to the effective date of such modification in order to allow the Attorney General to consider whether the proposed modification affects the factors set forth in Corporations Code section 5917.

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[1]Throughout this document, the term Anaheim Memorial Medical Center shall mean the general acute care hospital currently called Anaheim Memorial Medical Center and any other clinics, laboratories, units, services, or beds included on its license with the Department of Public Health, effective December 3, 2008, unless otherwise indicated.

III.

The Buyer and all future owners or operators of Anaheim Memorial Medical Center shall be required to provide written notice to the Attorney General sixty days prior to entering into any agreement or transaction to do either of the following:

(A) Sell, transfer, lease, exchange, option, convey, or otherwise dispose of Anaheim Memorial Medical Center.

(B) Transfer control, responsibility, or governance of Anaheim Memorial Medical Center. The substitution of a new corporate member of the Buyer or its members that transfers the control of, responsibility for, or governance of the Buyer shall be deemed a transfer for purposes of this condition. The substitution of one or more members of the governing body of the Buyer, or any arrangement, written or oral, that would transfer voting control of the members of the governing body of the Buyer, shall also be deemed a transfer for purposes of this condition.

IV.

For five years from the date of the transaction closing, the Buyer shall operate and maintain Anaheim Memorial Medical Center as a licensed general acute care hospital (as defined in California Health and Safety Code Section 1250) and shall maintain the following services, at current types and levels of services: 1) Obstetrics as currently[2] licensed (27 beds); 2) Adult intensive care as currently licensed (22 beds); 3) Coronary care unit as currently licensed (10 beds); 4) Neonatal Intensive Care Unit as currently licensed (11 beds); 5) Cardiac and medical cardiology programs, including cardiac rehabilitation; 6) Twenty-four hour emergency medical services as currently licensed (31 emergency stations/beds); 7) Cardiovascular receiving centers; 8) Cancer services with current certification (American College of Surgeons Accredited Program); and 9) Sexual Assault Response Center (The Safe Place). Buyer shall not place all or any portion of its above-listed licensed-bed capacity in voluntary suspension or surrender its license for any of these beds.

V.

For five years from the date of the transaction closing, the Buyer shall continue to operate the MemorialCare Breast Center at Anaheim Memorial Medical Center as currently licensed and at current types and levels of services. There shall be no closure, voluntary suspension, or change in the current license or types or levels of services at the Breast Center.

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[2]Throughout this document, the term "current" or "currently" means as of December 3, 2008.

VI.

The Buyer shall be certified to participate in the Medi-Cal program for as long as it operates Anaheim Memorial Medical Center as a general acute care hospital and provides emergency services. The Buyer shall accept assignment of Anaheim Memorial Medical Center's existing CalOptima contract at the time of the transaction closing date and shall not unilaterally cancel such contract without cause before the contract's termination date. After termination of Anaheim Memorial Medical Center's existing CalOptima contracts, Buyer shall enter into CalOptima contracts, on the same terms and conditions as other similarly-situated hospitals offering substantially the same services, for Medi-Cal, Healthy Families, Healthy Kids, and One Care, CalOptima's Medicare Advantage Special Needs Plan, at Anaheim Memorial Medical Center to provide the same types and levels of emergency and non-emergency services as required in these Conditions for at least five years from the date of the transaction closing. For five years from the date of the transaction closing, the Buyer shall have a Medicare Provider Number to provide the same types and levels of emergency and non-emergency services to Medicare beneficiaries (both Traditional Medicare and Medicare Managed Care) at Anaheim Memorial Medical Center as required in these Conditions.

VII.

The Buyer shall continue to provide services under the following contracts with the County of Orange, without interruption of service or quality, through the expiration period of each contract: Medical Services for the Indigent Program, Designated Emergency Services, Emergency Preparedness and Response to Disasters and Bioterrorism Services, and Provision of Tobacco Cessation Services.

VIII.

For five years from the date of the transaction closing, the Buyer shall maintain a Hospital Community Board, as set forth in Section 7.7 of the Asset Purchase Agreement. (Exhibit 1 hereto) In addition, Buyer shall consult with this Hospital Community Board prior to initiating any changes to medical services at Anaheim Memorial Medical Center, community benefit programs, or charity care services.

IX.

For five years from the date of the transaction closing, Buyer shall provide community benefit services at Anaheim Memorial Medical Center at an annual cost of $899,800. These community benefits shall include, but are not limited to, free health education classes in English and Spanish, professional nurse and pharmacy training programs, and senior services. Community benefit commitments shall be decided upon in conjunction with input from the Hospital Community Board, as described in Section 7.7 in the Asset Purchase Agreement. (Exhibit 1 hereto)

The minimum community benefit services amount shall be annually 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 All Urban Consumers in the Los Angeles-Riverside-Orange County Consolidated Metropolitan Statistical Area Base Period: 1982-84=100" (CPI-LA, as published by the U.S. Bureau of Labor Statistics).

If the actual amount of community benefit services provided by Buyer at Anaheim Memorial Medical Center for any year is less than the minimum community benefit services amount (as adjusted pursuant to the above-referenced Consumer Price Index) for such year, Buyer shall pay to the Irvine Health Foundation ("Foundation") an amount equal to the deficiency and such funds are to be used to provide community benefit services to residents in Anaheim Memorial Medical Center's service area (19 zip codes), as described on page 32 in the Healthcare Impact Report authored by Medical Development Specialists, dated April 7, 2009. (Exhibit 2 hereto) Buyer shall pay the deficiency described in the preceding sentence not more than nine (9) months following the end of such fiscal year.

X.

With respect to each of Buyer's five fiscal years following the closing of the transaction, Buyer shall provide an annual amount of Charity Care (as defined below) at Anaheim Memorial Medical Center equal to or greater than $1,600,000 (the "Minimum Charity Care Amount"). For purposes hereof, the term "Charity Care" shall mean the amount of charity care costs (not charges) incurred by Buyer in connection with the operations and provision of services at Anaheim Memorial Medical Center. The definition and methodology for calculating "charity care" and the methodology for calculating "cost" shall be the same as that used by the California Office of Statewide Health Planning and Development (OSHPD) for annual hospital reporting purposes.[3] The Buyer shall use substantially the same charity care policies that are in effect at Anaheim Memorial Medical Center, effective January 1, 2009, which shall include procedures to advise patients of the availability of charity care services and to qualify them to receive such services. (Exhibit 3 hereto) Buyer's obligation under this condition for the period from the transaction closing date through the end of Buyer's first fiscal year following the transaction closing date shall be prorated on a daily basis if the transaction closing date is a date other than the first day of Buyer's fiscal year.

As of the end of Buyer's first fiscal year following the transaction closing date and the end of each of Buyer's fiscal years thereafter, 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 All Urban Consumers in the Los Angeles-

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[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."

Riverside-Orange County Consolidated Metropolitan Statistical Area Base Period: 1982-84=100" (CPI-LA, as published by the U.S. Bureau of Labor Statistics).

If the actual amount of Charity Care provided by Buyer at Anaheim Memorial Medical Center for any fiscal year is less than the Minimum Charity Care Amount (as adjusted pursuant to the above-referenced Consumer Price Index) for such fiscal year, Buyer shall pay to the Foundation an amount equal to the deficiency and such funds are to be used to provide health care services to residents in Anaheim Memorial Medical Center's service area (19 zip codes), as described on page 32 in the Healthcare Impact Report authored by Medical Development Specialists, dated April 7, 2009. (Exhibit 2 hereto) Buyer shall pay the deficiency described in the preceding sentence not more than nine (9) months following the end of such fiscal year.

XI.

For the years 2009 through and including 2013, Buyer shall hold an annual community health forum to discuss the capital needs of the Hospital, the healthcare needs of the residents of Anaheim, especially those who are economically disadvantaged and under-served, and how Anaheim Memorial Medical Center can better meet those needs, taking into consideration the cultural, demographic, and socio-economic factors specific to the Anaheim area. Buyer shall invite to the annual community health forum, and consult with representatives from any Federal Health Qualified Clinics and other nonprofit healthcare clinics treating residents of the service area, Orange County's Emergency Medical Services Agency and other health officials, members of the medical staff and employees, community leaders, local elected officials, local school district members, community-based healthcare organizations, and the public.

XII.

Buyer agrees to upgrade emergency services at Anaheim Memorial Medical Center to become a base station, in conjunction with and subject to the approval by the County of Orange, and to consider the addition of radio and nurse response capabilities.

XIII.

Buyer shall satisfy the "Capital Expenditures" requirement set forth in Section 7.1 of the Asset Purchase Agreement. (Exhibit 4 hereto)

XIV.

On or before December 31, 2009, Seller shall transfer all remaining funds in the Marshall Stonestreet M.D. Endowment Fund (approximately $171,000) to the Irvine Health Foundation to be used as designated in the "Guidelines and Policy" attached hereto. (Exhibit 5 hereto)

XV.

For the years 2010 through and including 2014, Buyer shall submit to the Attorney General, no later than December 31st of each year, a report describing in detail its compliance with each condition set forth herein including, but not limited to, an itemization of the costs and description for the Capital Expenditures. The chief executive officer of Buyer shall certify that the report is true and correct.

XVI.

At the request of the Attorney General, Buyer and Seller shall provide such information as is reasonably necessary for the Attorney General to monitor compliance with the terms and conditions 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 public interest in maintaining confidentiality clearly outweighs the public interest in disclosure.

XVII.

The Attorney General reserves the right to enforce each and every condition set forth herein to the fullest extent provided by law. Pursuant to Government Code section 12598, the Attorney General shall also be entitled to recover its attorney fees and costs incurred in remedying each and every violation.

EXHIBIT 1

shall, within five (5) Business Days after the Closing Date, (a) remove such logos and marks from all of the Purchased Assets, including, without limitation, signage at the Hospital, stationery, marketing materials and patient brochures, and provide written verification thereof to Seller promptly after completing such removal and (b) return or destroy (with proof of destruction) all stationery and other materials that contain such logos or marks. Purchaser will not send, or cause to be sent, any correspondence or other materials to any Person on any stationery that contains any such logos or marks. Notwithstanding the above, Purchaser shall have the right to use the terms "Anaheim" and "Medical Center" in the name.

7.7 Hospital Community Board. Following the Closing, Purchaser shall appoint a Hospital community board for the Hospital composed of the Hospital's chief executive officer and physicians on the Hospital's medical staff and community representatives, all in accordance with Purchaser's standard policy. Subject to applicable Legal Requirements, the community board will be responsible for medical staff credentialing, quality assurance and accreditation of the Hospital, in accordance with Purchaser's model community board bylaws.

7.8 Charity Care; Other Related Matters.

(a) Charity and Indigent Care. Purchaser accepts the responsibility to treat indigent patients and to provide charity care in the service area of the Hospital and will comply with all applicable Legal Requirements governing such matters. To this end, for a period of five (5) years following the Closing Date, Purchaser shall maintain policies for the treatment of indigent patients at the Hospital similar to those currently in effect as set forth in **Schedule 7.8** (or new policies that are intended to provide a similar or greater benefit to the community), subject to changes in governmental policy, such as implementation of universal healthcare; *provided*, that the amount of charity and indigent care to be provided at the Hospital after the Closing Date will in no event be less than the average aggregate amount of charity and indigent care provided at the Hospital during each of the three (3) fiscal years immediately preceding the Closing Date, increased by the rate of inflation as measured by the Consumer Price Index for Orange County.

(b) Other Related Matters. To insure adequate access to Medicare and Medi-Cal patients, for a period of not less than five (5) years after the Closing Date, Purchaser will continue to operate the Hospital as a general acute care hospital under California Health and Safety Code Section 1250 and shall continue to offer an open emergency room, subject to the availability of physicians on the Hospital's medical staff qualified to support such services and subject further to such changes as may be necessary or appropriate based on community needs, market demand and the financial viability of such services. Purchaser shall adopt a policy to provide for an appropriate medical screening examination to any patient presented to the emergency room who has a medical emergency, or who, in the judgment of the staff physician, has an immediate emergency need. No such patient shall be turned away because of age, race, religion, gender, payment source or inability to pay.

7.9 Intentionally Omitted.

7.10 Memorial Data Center Assets Access. Following the Closing Date, Purchaser shall provide Memorial access to the MOB so that Memorial may utilize and remove those assets

EXHIBIT 2

Anaheim Memorial Medical Center Service Area Definition

Approximately 72% of AMMC's discharges come from a combination of 19 area ZIP Codes and 44% of AMMC's discharges emanate from the top five ZIP Codes in the service area.

SERVICE AREA PATIENT ORIGIN MARKET SHARE BY ZIP Code - 2007						
ZIPs	Community	AMMC Discharges	% OF DISCHARGES	CUMM % OF DISCHARGES	TOTAL DISCHARGES	MARKET SHARE
92801	Anaheim	2,206	14.5%	14.5%	6,778	32.5%
92804	Anaheim	1,479	9.7%	24.2%	9,833	15.0%
92805	Anaheim	1,398	9.2%	33.4%	6,343	22.0%
90620	Buena Park	813	5.3%	38.7%	5,165	15.7%
92833	Fulerton	794	5.2%	43.9%	4,169	19.0%
92806	Anaheim	673	4.4%	48.3%	3,427	19.6%
92802	Anaheim	647	4.2%	52.6%	3,831	16.9%
90621	Buena Park	420	2.8%	55.3%	2,886	14.6%
92832	Fulerton	403	2.6%	58.0%	2,327	17.3%
92870	Placentia	320	2.1%	60.1%	4,632	6.9%
92840	Garden Grove	317	2.1%	62.1%	5,081	6.2%
90680	Stanton	268	1.8%	63.9%	3,214	8.3%
92807	Anaheim	267	1.8%	65.6%	3,178	8.4%
92831	Fulerton	237	1.6%	67.2%	2,710	8.7%
90630	Cypress	234	1.5%	68.7%	4,301	5.4%
92841	Garden Grove	193	1.3%	70.0%	3,033	6.4%
92835	Fulerton	117	0.8%	70.8%	2,504	4.7%
90623	La Palma	105	0.7%	71.5%	1,380	7.6%
92808	Anaheim	103	0.7%	72.1%	1,358	7.6%
Sub Total		**10,994**	**72.1%**		**76,150**	**14.4%**
Other ZIPs		4,247	27.9%	100.0%		
Total		**15,241**	**100.0%**			

Source: OSHPD Patient Database 2007

EXHIBIT 3

Memorial Health Services **Policies and Procedures**	**Effective Date: December 20, 2007** **Note: For origination date see History at end of Policy.**
Subject: Financial Assistance	**Approval Signature:** **[Barry Arbuckle]** **Barry Arbuckle** **President & CEO**
Manual: Finance/Purchasing **Policy/Procedure # 236** **Section:**	**Sponsor Signature:** **[Christopher H. Finch]** **Christopher H. Finch** **Executive Director** **Revenue Cycle Management**

PURPOSE: Memorial Health Services (MHS) is a non-profit organization which provides hospital services in five distinct Southern California communities. Memorial Health Services and its member hospitals are committed to meeting the health care needs of patients who may be uninsured or underinsured. As part of fulfilling this commitment, MHS provides medically necessary services, without cost or at a reduced cost, to patients who qualify in accordance with the requirements of this Financial Assistance Policy.

The Financial Assistance Policy establishes the guidelines, policies and procedures for use by hospital personnel in evaluating and determining patient qualification for financial assistance. This policy also specifies the appropriate methods for the accounting and reporting of Financial Assistance provided to patients at hospitals within Memorial Health Services.

POLICY

Financial Assistance Defined

Financial assistance, also known as Charity Care, is defined as any necessary[1] inpatient or outpatient hospital service that must be provided at an MHS facility to a patient who is unable to pay for care. Patients unable to pay for their care must establish eligibility in accordance with requirements contained in the Memorial Health Services Financial Assistance Policy.

Depending upon individual patient eligibility, financial assistance may be granted on a full or partial aid basis. Financial assistance may be denied when the patient or other responsible guarantor does not meet the MHS Financial Assistance Policy requirements.

Financial Assistance Reporting

All Memorial Health System hospitals will report the amounts of financial assistance, full or partial, provided to patients as required for Charity Care. Charity Care reporting will be in accordance with the regulatory requirements issued by the Office of Statewide Health Planning and Development(OSHPD) as contained in the Accounting and Reporting Manual for Hospitals,

[1] Necessary services are defined as any hospital inpatient or outpatient service, or emergency care that is not entirely elective for patient comfort and/or convenience.

Second Edition and any other subsequent clarification or advisement issued by OSHPD. To comply with these regulations, each hospital will maintain this policy as written documentation regarding its Charity Care criteria, and for individual patients, each hospital will maintain written documentation regarding all financial assistance determinations. As required by OSHPD, Charity Care provided to patients will be recorded on the basis of actual charges for services rendered.

Charity Care will be reported as an element of each hospital's annual Community Benefit Report submitted to OSHPD and any other appropriate state agencies.

General Process and Responsibilities

Access to emergency medical care shall in no way be affected by whether financial assistance eligibility under this policy exists; emergency medical care will always be provided to the extent the facility can reasonably do so.

All patients who do not indicate coverage by a third party payer will be provided a Medi-Cal application prior to discharge

The Memorial Health Services Financial Assistance Policy relies upon the cooperation of individual applicants for accurate and timely submission of financial screening information. To facilitate receipt of such information, MHS hospitals will use a Financial Assistance application to collect information from patients who:

- Are unable to demonstrate financial coverage by a third party insurer and requests financial assistance;
- Insured patients who indicate that they are unable to pay patient liabilities; and
- Any other patient who requests financial assistance

The financial assistance application should be completed as soon as there is an indication the patient may be in need of financial assistance. The form may be completed prior to service, during a patient stay, or after services are completed and the patient has been discharged. Accordingly, eligibility for the MHS Financial Assistance Program may be determined at any time the hospital has sufficient information to determine qualification.

Completion of a financial assistance application provides:

1. Information necessary for the hospital to determine if the patient has income and/or assets sufficient to pay for services;

2. Authorization for the hospital to obtain a credit report for the patient or responsible party;

3. Documentation useful in determining eligibility for financial assistance; and

4. An audit trail documenting the hospital's commitment to providing financial assistance.

Eligibility

Eligibility for financial assistance shall be determined solely by the patient's and/or patient guarantor's ability to pay. Eligibility for financial assistance shall not be based in any way on age, gender, sexual orientation, ethnicity, national origin, veteran status, disability or religion.

The patient/guarantor bears the burden of establishing eligibility for qualification under any financial assistance program. Patients/guarantors are required to provide timely, honest and complete disclosure in order to obtain financial assistance. Each hospital will provide guidance and/or direct assistance to patients or their guarantors as necessary to facilitate completion of government low-income program applications when the patient may be eligible. Assistance should also be provided for completion of an application for the MHS Financial Assistance Program.

Completion of the Financial Assistance application and submission of any or all required supplemental information may be required for establishing eligibility with the Financial Assistance Program.

Financial Assistance Program qualification is determined after the patient and/or patient guarantor establishes eligibility according to criteria contained in this policy. While financial assistance shall not be provided on a discriminatory or arbitrary basis, the hospital retains full discretion to establish eligibility criteria and determine when a patient has provided sufficient evidence of qualification for financial assistance.

Once determined, Financial Assistance Program eligibility will remain in effect for a period of six (6) months and then may be renewed by the hospital upon submission of required information by the patient. Patient financial services will develop methods for accurate tracking and verification of financial assistance program eligibility.

Any eligible patient account balance created by a visit that resulted in the request for Financial Assistance Program coverage and those occurring for a period of six (6) months following eligibility determination will be considered for full or partial write-off as Charity Care. Other pre-existing patient account balances outstanding at the time of eligibility determination by the hospital may be included as eligible for write-off at the sole discretion of management.

Patient obligations for Medi-Cal Share of Cost (SOC) payments will not be waived under any circumstance. However, after collection of the patient share of cost portion, any other unpaid balance relating to a Medi-Cal SOC patient may be considered for Charity Care.

Factors considered when determining whether an individual is qualified for financial assistance pursuant to this policy may include, but shall not be limited to the following:

- No insurance coverage under any government or other third party program
- Household[2] income
- Household net worth including all assets, both liquid and non-liquid
- Employment status
- Unusual expenses
- Family size as defined by Federal Poverty Level (FPL) Guidelines
- Credit history

Eligibility criteria are used in making each individual case determination for coverage under the MHS Financial Assistance Program. Financial assistance will be granted based upon each individual determination of financial need. To assure appropriate allocation of assistance, financial need may be determined based upon consideration of both income and available patient family assets.

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[2] "Household" includes the patient, the patient's spouse, any individual to whom the patient is a dependent and any other individual legally responsible to provide for the patient's health care needs.

Covered services include necessary inpatient and outpatient hospital care provided the services are not covered or reimbursed by Medi-Cal, county indigent programs or any other third party payer. All patients not covered by third-party insurance and those insured patients who indicate that they are unable to pay patient obligations such as co-payments and deductibles, may be considered for eligibility under the Financial Assistance Program.

For the purpose of determining eligibility for discounted payment, documentation of income shall be limited to recent pay stubs or income tax returns.

INCOME QUALIFICATION LEVELS

Full Charity

If the patient's household income is two hundred percent (200%) or less of the established poverty income level, based upon current FPL Guidelines and the patient meets all other Financial Assistance Program qualification requirements, one hundred percent (100%) of the patient liability portion of the bill for services will be written off.

Low Income Financial Assistance (LIFA)

If the patient's household income is between two hundred one percent (201%) and three hundred fifty percent (350%) of the established poverty income level, based upon current FPL Guidelines, and the patient meets all other Financial Assistance Program qualification requirements, the following will apply:

a. Patient's care is not covered by a payer If the services are not covered by any third party payer so that the patient ordinarily would be responsible for the full billed charges, the patient's payment obligation will be one hundred percent (100%) of the total expected payment, including co-payment and deductible amounts, that the Medicare program would have paid for the service if the patient was a Medicare beneficiary. If the service provided is not covered under the Medicare program then the patient will be responsible for forty (40%) of billed charges.

b. Patient's care is covered by a payer If the services are covered by a third party payer so that the patient is responsible for only a portion of the billed charges (i.e., a deductible or co-payment), the patient's payment obligation will be one-hundred percent (100%) of the patient liability portion of total payment up to the point where total payments (patient + insurance) equal one-hundred percent (100%) of the total expected payment, including co-payment and deductible amounts, that the Medicare program would have paid for the service if the patient was a Medicare beneficiary.

ASSET QUALIFICATION

Patient owned assets may be evaluated to determine if sufficient patient household resources exist to satisfy the hospital's bill for services rendered. Evaluation of patient assets will consider both the asset value and amounts owed against the asset to determine if potential net worth is available to satisfy the patient payment obligation.

Recognizing the need to protect basic household assets, each patient family unit evaluated will be allowed the following asset exemptions:

- Primary residence
- One vehicle per patient or two vehicles per family unit
- Tax-exempt retirement program funds
- Ten Thousand Dollars ($10,000) and fifty percent (50%) greater than Ten Thousand Dollars ($10,000) in other total assets
- Deferred Compensation Plans

Patients who have assets beyond those specifically exempted will be expected to leverage the assets through independent financing in order to satisfy the patient account. Accordingly, patients with sufficient assets available are not qualified for the MHS Financial Assistance Program. Patients with sufficient assets will be denied eligibility even when they meet basic income qualification requirements.

For the purpose of determining eligibility for discounted payment, documentation of income shall be limited to recent pay stubs or income tax returns.

SPECIAL CIRCUMSTANCES:

Any evaluation for financial assistance relating to patients covered by the Medicare Program must include a reasonable analysis of all patient asset net worth, income and expenses, prior to eligibility qualification for the Financial Assistance Program. Such financial assistance evaluations must be made prior to service completion by the MHS hospital.

- If the patient is determined to be homeless he/she will be deemed eligible for the Financial Assistance Program.
- If the patient/guarantor has recently been declared bankrupt by a Federal Bankruptcy Court.

Patients seen in the emergency department, for whom the hospital is unable to issue a billing statement, may have the account charges written off as Charity Care. All such circumstances shall be identified on the patient's Financial Assistance Application as an essential part of the documentation process.

OTHER ELIGIBLE CIRCUMSTANCES:

Memorial Health Services deems those patients that are eligible for any or all government sponsored low-income assistance programs to be indigent. Therefore, such patients are automatically eligible for Charity Care under the MHS Financial Assistance Policy and account balances classified as Charity Care if the government program does not make payment for all services provided, or days during a hospital stay.

For example, patients who qualify for Medi-Cal, CCS, CHDP, Healthy Families, MSI, CMSP or other similar low-income government programs are included as eligible for the MHS Financial Assistance Program.

Any or all non-reimbursed patient account balances are eligible for full write-off as Charity Care. Specifically included as Charity Care are charges related to denied stays, denied days of care, and non-covered services. All Treatment Authorization Request (TAR) denials and any other failure to pay for covered or non-covered services provided to Medi-Cal and/or other government low-income qualified patients are covered.

Patients with restricted coverage, and/or other forms of limitation shall have non-covered amounts classified as Charity Care when payment is not made by the low-income government program.

The portion of Medicare patient accounts (a) for which the patient is financially responsible (coinsurance and deductible amounts), (b) which is not covered by insurance or any other payer including Medi-Cal, and (c) which is not reimbursed by Medicare as a bad debt, may be classified as Charity Care if:

1. The patient is a beneficiary under Medi-Cal or another program serving the health care needs of low-income patients; or
2. The patient otherwise qualifies for financial assistance under this policy and then only to the extent of the write-off provided for under this policy.

Any patient who experiences a catastrophic medical event may be deemed eligible for financial assistance. The determination of a catastrophic medical event shall be based upon the amount of the patient liability at billed charges, and consideration of the individual's income and assets as reported at the time of occurrence. Management shall use reasonable discretion in making a determination based upon a catastrophic medical event. As a general guideline, any account with a patient liability for services rendered that exceeds $100,000 may be considered for eligibility as a catastrophic medical event.

Any account returned to the hospital from a collection agency that has determined the patient or guarantor does not have the resources to pay his or her bill, may be deemed eligible for Charity Care. Documentation of the patient or guarantor's inability to pay for services will be maintained in the Charity Care documentation file.

Criteria for Re-Assignment from Bad Debt to Charity Care

All outside collection agencies contracted with MHS to perform account follow-up and/or bad debt collection will utilize the following criteria to identify a status change from bad debt to Charity Care:

1. Patient accounts must have no applicable insurance coverage including governmental or other third party payers); and
2. The patient or guarantor must have an Experian credit score rating of less than or equal to 500. If the collection agency is using a credit scoring tool other than Experian, the patient and or guarantor must fall into 20th percentile of credit scores for the method used; and
3. The patient or guarantor has not made a payment within one hundred eighty (180) days of assignment to the collection agency; and
4. The collection agency has determined that the patient/guarantor is unable to pay; and/or
5. The patient does not have a valid Social Security Number and/or an accurately stated residence address in order to determine a credit score.

Public Notice

Each MHS hospital shall post notices informing the public of the Financial Assistance Program. Such notices shall be posting in high volume inpatient, outpatient and emergency service areas of the hospital. Notices shall also be posted in the patient financial services and collection departments. Notices will include contact information on how a patient may obtain more information on financial assistance as well as where to apply for such assistance. These notices shall be posted in English and Spanish and any other languages that are representative of five

percent (5%), or more, of the patients in the hospital's service area according to the Federal Title VI guidelines.

Data mailers sent to patients as part of the routine billing process will contain information about the MHS Financial Assistance Program. These notices shall be available in English and Spanish and any other languages that are representative of five percent (5%), or more, of the patients in the hospital's service area according to the Federal Title VI guidelines.

A patient information brochure that describes the features of the MHS Financial Assistance Program will be made available to patients and members of the general public. These notices shall be posted in English and Spanish and any other languages that are representative of five percent (5%), or more, of the patients in the hospital's service area according to the Federal Title VI guidelines.

Billing and Collection Practices

Patients in the process of qualifying for government or hospital low-income financial assistance programs will not be assigned to collections prior to 120 days from the date of initial billing.

If a patient is attempting to qualify for eligibility under the hospital's charity care or discount payment policy and is attempting in good faith to settle an outstanding bill with the hospital by negotiating a reasonable payment plan or by making regular partial payments of a reasonable amount, the hospital shall not send the unpaid bill to any collection agency or other assignee, unless that entity has agreed to comply with guidelines outlined in California Health and Safety Code 127400 et seq.Low-income patients, who at the sole discretion of the hospital are reasonably cooperating to settle an outstanding hospital bill by making regular and reasonable payments towards their outstanding hospital bill, will not be sent to an outside collection agency if doing so would negatively impact the patient's credit. The hospital extended payment plan may be declared no longer operative after the patient's failure to make all consecutive payments due during a 90-day period. Before declaring the hospital extended payment plan no longer operative the hospital shall make a reasonable attempt to contact the patient by phone and, to give notice in writing, that the extended payment plan may become inoperative, and of the opportunity to renegotiate the extended payment plan. Prior to the hospital extended payment plan being declared inoperative, the hospital shall attempt to renegotiate the terms of the defaulted extended payment plan, if requested by the patient. The hospital shall not report adverse information to a consumer credit reporting agency or commence a civil action against the patient or responsible party for nonpayment prior to the time the extended payment plan is declared to be no longer operative. For purposes of this section, the notice and phone call to the patient may be made to the last known phone number and address of the patient.

Patients who communicate that they have an appeal for coverage of services pending will not be forwarded to collections until the final determination of that appeal is made. Examples of appeals are; Health Plan Appeals, Independent Medical Review, Medi-Cal and Medicare coverage appeals.

The hospital shall reimburse the patient or patients any amount actually paid in excess of the amount due under this article, including interest. Interest owed by the hospital to the patient shall accrue at the rate (10% per annum) set forth in Section 685.010 of the Code of Civil Procedure, beginning on the date payment by the patient is received by the hospital. However, a hospital is not required to reimburse the patient or pay interest if the amount due is less than five dollars ($5.00). The hospital shall give the patient a credit for the amount due for at least 60 days from the date the amount is due.

All extended payment plans will be interest free.

Confidentiality

It is recognized that the need for financial assistance is a sensitive and deeply personal issue for recipients. Confidentiality of requests, information and funding will be maintained for all that seek or receive financial assistance. The orientation of staff and selection of personnel who will implement this policy shall be guided by these standards.

Good Faith Requirements

Every MHS hospital makes arrangements for financial assistance with medical care for qualified patients in good faith and relies on the fact that information presented by the patient is complete and accurate.

Provision of financial assistance does not eliminate the right to bill, either retrospectively or at the time of service, for all services when fraudulent, inaccurate or incomplete information has been given. In addition, the MHS hospital reserves the right to seek all remedies, including but not limited to civil and criminal damages from those who have provided false, inaccurate or incomplete information in order qualify for the MHS Financial Assistance Program.

In the event that a patient qualifies for partial financial assistance under the LIFA component of this Policy and then fails to make payment in full on their remaining patient liability balance, the hospital, at its sole and exclusive discretion, may use any or all appropriate means to collect the outstanding balance while in compliance with California Health and Safety Code 127400 et seq.

History:

Origination: May 22, 2006 (Replaces Policies #230 Low Income Financial Assistance (LIFA), Qualifications For: and #231 Charity Care, Qualification and Process for Assignment)
Reviewed/Revised: January 1, 2007
Reviewed/Revised: December 20, 2007

EXHIBIT 4

6.15 Completion of Certain Projects. Seller shall make commercially reasonable efforts to complete before Closing (or shall make commercially reasonable arrangements for the completion of), and shall bear the cost of the completion of, the projects at the Hospital described in **Schedule 6.15**.

ARTICLE VII

COVENANTS OF PURCHASER

7.1 Capital Expenditures. Following the Closing, Purchaser shall (a) be solely responsible for all capital costs of the Hospital and (b) without limiting the foregoing, on a timely basis, provide all funds necessary for the operation of the Hospital, if then operated by Purchaser and functioning as a general acute care hospital. Without limiting the foregoing, during the period commencing on the Closing Date and ending on the five (5) year anniversary of the Closing Date, Purchaser agrees that it shall invest no less than Forty-Five Million Dollars ($45,000,000.00) into the Hospital Business for capital improvements, equipment, and/or working capital at the Hospital during such period including at least Seven Million Dollars ($7,000,000.00) during the first year following the Closing Date.

7.2 Retention of Existing Medical Staff Appointments. Purchaser shall retain all current members of the Hospital medical staff as of Closing, subject to compliance by such medical-staff members with applicable Legal Requirements and the bylaws, rules, regulations, policies and procedures of the Hospital and the medical staff.

7.3 Post-Closing Maintenance of and Access to Information.

(a) Seller and/or Memorial may need access to information or documents in the control or possession of Purchaser for the purposes of concluding the transactions herein contemplated, preparing Tax Returns or conducting Tax audits, complying with the Government Payment Programs and other Legal Requirements, and prosecuting or defending Third Party Claims. Accordingly, Purchaser shall keep, preserve and maintain in the ordinary course of business, and as required by Legal Requirements and relevant insurance carriers, all books, records (including, but not limited to, patient medical records, workers' compensation, disability or other employee files or employee data), documents and other information in the possession or control of such Party and relevant to the foregoing purposes for a period of not less than seven (7) years after the Closing Date (or for such longer period of time as may be required by applicable statute of limitations or extensions thereof) and thereafter will dispose thereof only after they shall have given Seller and Memorial ninety (90) days' prior written notice of such impending disposition and the opportunity (at Seller's expense) to remove and retain such information as permitted by law.

(b) Purchaser shall cooperate fully with, and make available for inspection and copying by, Seller and Memorial, and their respective employees, agents, counsel and accountants and/or Governmental Authorities, upon written request and at no expense to Seller or Memorial (other than reasonable copying expenses and out of pocket third party expenses), such books, records documents and other information to the extent reasonably necessary to facilitate the foregoing purposes and subject to all applicable Legal Requirements. In addition,

EXHIBIT 5

MARSHALL STONESTREET M.D.
ENDOWMENT FUND

Guidelines and Policy

As a tribute/memorial to the late Marshall Stonestreet, M.D., the STONESTREET ENDOWMENT is held and managed in trust by the AMH Foundation which is charged to:

1. Accumulate corpus (principal) in the fund. As a rule, the fund cannot sufficiently meet its intended objectives until the corpus exceeds $250,000. The ultimate goal is for the fund to accumulate $1 million or more, however.
2. Expend annually no more than 50 per cent of earnings.
3. Divide spending among two directions:
   a. Aiding indigent/ill people by providing care and services (health education) in line with the hospital's mission and programs (The Foundation for Sharing - Patient Assistance Fund).
   b. Provide funds for equipment needs of the hospital. Selection of equipment purchases will be made in accordance with hospital purchasing policies.
4. Review of the Endowment Fund progress and plans for building its corpus will be the charge of an ad hoc committee of the AMH Foundation, including representation by the Stonestreet family.