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Attorney General

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 South Coast Medical Center

Dear Mr. Peters:

The Attorney General hereby conditionally consents, pursuant to Corporations Code section 5920, to the sale of South Coast Medical Center to Mission Regional Hospital Medical Center, as set forth in the Notice filed on February 20, 2009. Corporations Code section 5923 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 two nonprofit corporations or entities. 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,

A handwritten signature in blue ink, appearing to read "Wendi A. Horwitz".

WENDI A. HORWITZ
Deputy Attorney General

For EDMUND G. BROWN JR.
Attorney General

Attachment
cc: James Schwartz, Esq.

LA2008601367
60410397.doc

Conditions to Approval of Sale of South Coast Medical Center

I.

For the purposes of these conditions, and unless the context indicates otherwise, the term "Buyer" shall mean Mission Regional Hospital Medical Center, a California nonprofit public benefit corporation, and St. Joseph Health System, a California nonprofit public benefit corporation, the proposed acquirers of South Coast Medical Center¹, any other subsidiary, parent, general partner, affiliate, successor, or assignee of Mission Regional Hospital Medical Center or St. Joseph Health System, any entity succeeding thereto by consolidation, merger or acquisition of all or substantially all of the assets of South Coast Medical Center, any entity owned by the Buyer that subsequently becomes the owner or licensed operator of South Coast Medical Center, any entity that owns the Buyer that subsequently becomes the owner or licensed operator of South Coast Medical Center, any future entity that purchases South Coast Medical Center from the Buyer, and any entity owned by a future purchaser that subsequently becomes the owner or licensed operator of South Coast Medical Center. These conditions shall be legally binding on any and all future owners or operators of South Coast Medical Center. The term "Seller" shall mean South Coast Medical Center, a California nonprofit public benefit corporation, and Adventist Health System/West, a California nonprofit religious corporation.

II.

The transaction approved by the Attorney General between the Buyer and Seller consists of the Asset Purchase Agreement dated February 4, 2009, Amendment No. 1 to Asset Purchase Agreement dated March 5, 2009, Amendment No. 2 to Asset Purchase Agreement dated March 20, 2009, Transition Services Interim Agreement dated February 4, 2009, Confidentiality Agreement dated September 12, 2008, Amendment to Confidentiality Agreement, Lease dated April 3, 2009, and Guaranty dated April 3, 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 (30) 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 5923.

III.

The Buyer and all future owners or operators of South Coast Medical Center shall be required to provide written notice to the Attorney General sixty (60) 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 South Coast Medical Center.

¹Throughout this document, the term South Coast Medical shall mean the general acute care hospital currently called South Coast Medical Center and any other clinics, laboratories, units, services, or beds included on its license with the Department of Public Health, effective May 30, 2008, unless otherwise indicated.

(B) Transfer control, responsibility, or governance of South Coast 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.

Until December 31, 2012, regardless of seismic retrofit requirements set forth in Health and Safety Code sections 129675-130070, Buyer shall operate and maintain South Coast Medical Center as a licensed general acute care hospital (as defined in California Health and Safety Code Section 1250) and shall maintain the following health care services:

- a) Twenty-four hour emergency medical services as currently licensed (12 emergency stations/beds) with the same types and levels of services;
- b) Acute psychiatric services that include involuntary patients (Welf. & Inst. Code, § 5150) as currently licensed (minimum of 18 beds), and
- c) Intensive care services (minimum of 4 beds).

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.

After December 31, 2012, Buyer shall operate and maintain South Coast Medical Center as a licensed general acute care hospital (as defined in California Health and Safety Code Section 1250) and provide the health care services listed in Condition IV for five years from the date of the transaction closing provided that one of the following occurs:

- a. The current 2013 seismic retrofitting deadline is extended beyond the five-year period;
- b. South Coast Medical Center receives SPC-2 HAZUS approval for all buildings that are required to comply with Health and Safety Code sections 129675-130070;
- c. Otherwise exempt or other legislative or regulatory provisions allow an extension or exemption from Health and Safety Code sections 129675-130070 beyond the five-year period.

If (a) – (c) does not occur, Buyer shall pursue any allowable designations as a free-standing emergency department or, at a minimum, provide twenty-four hour urgent care services in Laguna Beach, California for five years from the date of the transaction closing.

VI.

Buyer shall pursue all appropriate and available exemptions for seismic compliance, including, but not limited to, utilizing the HAZUS reclassification (to SPC-2 method, that are necessary for continued operation of South Coast Medical Center as a licensed general acute care hospital beyond December 31, 2012. However, Buyer shall not be obligated to perform any seismic

retrofit or replacement of structurally non-conforming acute care buildings to maintain acute care services beyond December 31, 2012. Buyer shall fully cooperate with the Office of Statewide Health Planning and Development (“OSHPD”) including, but not limited to, timely provision of all information and documentation requested by OSHPD. If Buyer fails to pursue such exemptions and/or fails to cooperate with OSHPD, the California Attorney General shall thereafter be entitled to obtain a court order for specific performance to compel Buyer to immediately comply and other available legal remedies.

VII.

For five years from the date of the transaction closing, the Buyer shall continue to provide mammography services at the Women’s Wellness Center (located at 26732 Crown Valley Parkway, Suite 171, Mission Viejo, CA) or on the current Mission Hospital Regional Medical Center campus.

VIII.

The Buyer shall be certified to participate in the Medi-Cal program for as long as it operates South Coast Medical Center as a general acute care hospital and provides emergency services. For five years from the date of the transactions closing, 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, to provide the same types and levels of emergency and non-emergency services at South Coast Medical Center as required in these Conditions, subject to the provisions of Condition V. 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 South Coast Medical Center as required in these Conditions, subject to the provisions of Condition V herein.

In the event that, pursuant to Condition V, Buyer ceases to operate South Coast Medical Center as a licensed general acute care hospital after December 31, 2012, Buyer shall, for a period of five years after the date of the transaction closing, at Mission Hospital Regional Medical Center: (a) continue to be certified to participate in the Medi-Cal program, (b) have a Medicare Provider number, and (c) continue to contract with CalOptima for the programs listed above on the terms and conditions set forth above.

IX.

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 Transfer Agreement for Public Health Community Clinics.

X.

For five years from the date of the transaction closing, the Buyer shall appoint a local advisory committee/community board for South Coast Medical Center composed of South Coast Medical Center's chief executive officer, physicians on South Coast Medical Center's medical staff, and community representatives. In addition, Buyer shall consult with this local advisory committee/community board prior to eliminating any medical services at South Coast Medical Center, making any changes to community benefit programs, and making any changes to charity care services.

XI.

For five years from the date of the transaction closing, Buyer shall provide community benefit services at South Coast Medical Center at an annual cost of \$418,400. Community benefit commitments shall be decided upon in conjunction with input from the local advisory committee/community board.

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 South Coast 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 Laguna Beach Community Clinic an amount equal to the deficiency and such funds are to be used to provide community benefit services to residents in South Coast Medical Center's service area (21 ZIP codes) as described on page 25 of the Healthcare Impact Report authored by Medical Development Specialists, dated April 16, 2009. (Exhibit 1 hereto) Buyer shall pay the deficiency described in the preceding sentence not more than nine (9) months following the end of such fiscal year.

XII.

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 South Coast Medical Center equal to or greater than \$408,238 (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 South Coast 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.²

² 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."

The Buyer shall use at South Coast Medical Center the same charity care policies that are in effect on January 1, 2009 at Mission Regional Hospital Medical Center, which shall include procedures to advise patients of the availability of charity care services and to qualify them to receive such services. (Exhibit 2 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-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 South Coast 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 Laguna Beach Community Clinic an amount equal to the deficiency and such funds are to be used to provide health care services to residents in South Coast Medical Center's service area (21 ZIP codes) as described on page 25 of the Healthcare Impact Report authored by Medical Development Specialists, dated April 16, 2009. (Exhibit 1 hereto) Buyer shall pay the deficiency described in the preceding sentence not more than nine (9) months following the end of such fiscal year.

XIII.

Buyer shall invest no less than \$5,000,000 for capital improvements and equipment at South Coast Medical Center during the thirty-six month period following the date of the transaction closing, and at least \$1,800,000 of that amount within twelve months following the date of the transaction closing.

XIV.

By July 31, 2009, Seller shall transfer \$1.8 million to the Irvine Health Foundation to establish a non-endowed fund for cancer and cancer related services to residents in South Coast Medical Center's service area (21 ZIP codes) as described on page 25 of the Healthcare Impact Report authored by Medical Development Specialists, dated April 16, 2009. (Exhibit 1 hereto) For five years from the date of the transaction closing, the fund shall primarily be used to support such services provided at South Coast Medical Center and then to other tax-exempt charitable health care facilities, and clinics that provide such services to residents in the service area (21 ZIP codes) as described on page 25 of the Healthcare Impact Report authored by Medical Development Specialists, dated April 16, 2009. (Exhibit 1 hereto)

XV.

On or before July 31, 2009, Seller shall transfer all remaining restricted funds from the dissolved South Coast Medical Center Foundation (as set forth in Exhibit 3 hereto) except for the two charitable remainder charitable trusts (Cramer and Bruni) to the Irvine Health Foundation to be used at South Coast Medical Center in accordance with those restrictions.

XVI.

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.

XVII.

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.

XVIII.

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

SOUTH COAST MEDICAL CENTER SERVICE AREA ANALYSIS

South Coast Medical Center's Service Area Definition

SCMC's service area is composed of 21 ZIP Codes, from which approximately 74% of the Hospital's discharges emanated in 2007. Approximately half of SCMC's discharges were from the top five ZIP Codes.

South Coast Medical Center Patient Origin and Market Share* 2007							
ZIP Codes	Community	SCMC Total Discharges	% of Discharges	Cum % of Discharges	Total Area Discharges	SCMC Market Share	2008 Population
92651	Laguna Beach	638	13.4%	13.4%	2,009	31.8%	36,362
92677	Laguna Niguel	616	13.0%	26.4%	5,297	11.6%	68,590
92629	Dana Point	553	11.7%	38.1%	2,622	21.1%	28,630
92675	San Juan Capistrano	288	6.1%	44.2%	3,817	7.5%	65,158
92672	San Clemente	274	5.8%	49.9%	3,643	7.5%	48,262
92656	Aliso Viejo	152	3.2%	53.1%	3,257	4.7%	48,639
92673	San Clemente	140	3.0%	56.1%	2,281	6.1%	18,621
92692	Mission Viejo	119	2.5%	58.6%	4,196	2.8%	48,259
92630	Lake Forest	112	2.4%	61.0%	4,940	2.3%	61,898
92688	Rancho Santa Margarita	103	2.2%	63.1%	3,160	3.3%	42,522
92691	Mission Viejo	99	2.1%	65.2%	4,436	2.2%	49,249
92624	Capistrano Beach	83	1.7%	67.0%	771	10.8%	7,742
92653	Laguna Hills	82	1.7%	68.7%	3,036	2.7%	32,344
92694	Ladera Ranch	65	1.4%	70.1%	1,667	3.9%	21,250
92679	Trabuco Canyon	54	1.1%	71.2%	1,896	2.8%	43,806
92660	Newport Beach	38	0.8%	72.0%	2,884	1.3%	34,119
92637	Laguna Woods	28	0.6%	72.6%	4,456	0.6%	15,657
92625	Corona Del Mar	18	0.4%	73.0%	1,266	1.4%	13,015
92652	Laguna Beach PO Box	15	0.3%	73.3%	54	27.8%	n/a
92657	Newport Beach	13	0.3%	73.6%	662	2.0%	9,150
92674	San Clemente PO Box	11	0.2%	73.8%	87	12.6%	n/a
Subtotal		3,501	73.8%		56,437	6.2%	693,273
Other ZIPs		1,243	26.2%	100.0%			
Total		4,744	89.5%				

*Excludes Normal Newborns (DRG 391)

Note: Total discharges are slightly different from discharges reported from OSHPD ALIRTS and Financial Disclosure Reports

Source: OSHPD Patient Discharge Database, 2007

EXHIBIT 2

**MISSION HOSPITAL REGIONAL MEDICAL CENTER
A Sisters of St. Joseph of Orange Corporation**

**HOSPITAL POLICY
Patient Financial Services – Financial Services**

Title: Charity Care\Financial Assistance Program

Code: PFS-2009JAN-3.3.3

Title of Responsible Party: Director, Patient Financial Services

Origination Date: 9/1994

Effective Date: 1/2009

Review/Revision Date(s): 2/2000, 4/2000, 6/2001, 5/2002, 5/2003, 5/2004, 9/2005, 2/2006, 1/2007, 12/2007, 1/2008, 1/2009

Key Words: @Financial Assistance, @Charity Care

1.0 PURPOSE

St. Joseph Health System (SJHS) hospitals serve all persons in need within each community where they are located. As values-based ministries, St. Joseph Health System hospitals strive to provide healthcare services within an environment of dignity, respect and compassion. Providing patients in need with financial assistance to pay their SJHS hospital bills and, in turn, to ensure access to needed healthcare is an essential element of fulfilling the St. Joseph Health System mission. This policy defines the SJHS Financial Assistance Program; its criteria, systems, and methods. While providing financial assistance to patients without ability to pay all or part of their hospital bills has been a long-standing SJHS practice and a Full and Partial Charity Care Policy has been in place for many years, this policy is also intended to document SJHS hospitals' compliance with new California Health & Safety Code requirements. The SJHS Financial Assistance Policy exceeds current legal obligations and also provides for full charity care or charity care discounts to patients who financially qualify under the terms and conditions of the St. Joseph Health System Financial Assistance Program.

The SJHS Finance Department has responsibility for general accounting policy and procedure. Included within this responsibility is a duty to ensure the consistent timing, recording and accounting treatment of transactions across all SJHS hospitals. This includes the handling of patient accounting transactions in a manner that supports the mission and values of the St. Joseph Health System.

2.0 SCOPE

This policy will pertain to all St. Joseph Health System hospitals in California. Non-hospital health care providers within SJHS are covered by a separate policy and set of procedures unless otherwise provided. All requests for patient financial assistance from patients, patient families, physicians or hospital staff shall be addressed in accordance with this policy.

3.0 DEFINITION OF TERMS

Charity Care: Charity Care is defined as any medically necessary inpatient or outpatient hospital service provided to a patient whose responsible party has an income below 200% of the current federal poverty level and who meets the requirements of the SJHS Financial Assistance Policy. Discount Payment: Discount Payment through the Financial Assistance Policy is defined as partial charity care which results from any medically necessary inpatient or outpatient hospital service provided to a patient who is uninsured or underinsured and whose responsible party: 1) desires assistance with paying their hospital bill; 2) has an income at or below 500% of the federal poverty level; and 3) meets the requirements of the SJHS Financial Assistance Policy.

SJHS Financial Assistance Eligibility: SJHS financial assistance is dependent on demonstrated eligibility and eligibility is dependent on provision of information reasonably necessary for SJHS to determine eligibility.

Federal Poverty Level (FPL) Guideline: The FPL guidelines establish the gross income and family size eligibility criteria for Charity Care and Discounted Payment status as described in this policy. The FPL guidelines are updated periodically by the United States Department of Health and Human Services.

Average HMO/PPO Payment Rate: The average Hospital Specific HMO/PPO payment is determined annually by each SJHS hospital based upon all hospital HMO/PPO payment rates for inpatients and outpatients.

Medically Necessary Services: Any hospital inpatient, outpatient or emergency care provided pursuant to a physician's order that is not elective for patient comfort and/or convenience. Medical necessity is based upon a local community standard of care and, therefore, determined consistent with medical necessity standards established by the SJHS hospital's medical staff.

Patient's Family: The following shall be applied to all cases subject to the SJHS Financial Assistance Program:

For persons 18 years of age and older, family refers to a spouse, domestic partner, as defined in Section 297 of the Family Code, and dependent children under 21 years of age, whether living at home or not.

For persons under 18 years of age, family refers to a parent, caretaker relatives and other children under 21 years of age of the parent or caretaker relative.

4.0 POLICY

A. Introduction

Jesus was a healer of persons who attended to spirit as well as body; therefore we minister to the needs of the whole person. Persons are created by a loving God and are therefore inherently good and worthy of respect. Like God, persons are relational and therefore need the support of others in the community. Scripture records God's special compassion for the poor, weak, and vulnerable; therefore we are called to this same compassion (A Vision of Value, 1986, Rev.1991).

We believe that as a Catholic health service organization, SJHS has a social responsibility and moral obligation to make quality health services accessible to the medically poor. We further believe all persons have a right to an adequate level of health care and that the provision of health care for those who require it is an obligation of justice as well as charity or mercy (A Vision of Value, 1986, Rev. 1991).

Standard Seven of the Values Standards and Key Indicators (2001) states: St. Joseph Health System commits resources to improving the quality of life in the communities we serve, with special emphasis on the needs of the poor and under-served. Each SJHS hospital will demonstrate a commitment to charity care and will report the monetary value of such care according to the St. Joseph Health System Financial Assistance Policy.

B. Full Charity and Partial Charity Discount Reporting

All SJHS hospitals located within California will report actual charity write-offs and discounts provided in accordance with regulatory requirements of the California Office of Statewide Health Planning and Development (OSHPD) as contained in the Accounting and Reporting Manual for Hospitals, Second Edition. To comply with regulation, each hospital will maintain written documentation regarding its criteria and, for individual patients, written documentation regarding all eligibility determinations. As required by OSHPD, charity discounts provided to patients will be recorded on the basis of actual charges for services rendered.

Each SJHS hospital will provide OSHPD with a copy of this Financial Assistance Policy which includes the full and partial discount policies within this single document. The Financial Assistance Policy also contains: 1) all eligibility and patient qualification procedures; 2) the unified application for full charity and partial charity discounts; and 3) the review process for both full charity care and discount partial charity care. These documents shall be supplied to OSHPD every two years or whenever a significant change is made.

Charity write-offs and discounts will be reported as an element of each hospital's annual Community Benefit Report submitted to the Board of Trustees and any appropriate governmental agencies.

C. Full and Partial Discount Eligibility: General Process and Responsibilities

Eligibility exists for any patient whose family income is less than 500% of the current federal poverty level, and if not covered by third party insurance or if covered by third party insurance and unable to pay the patient liability amount owed after insurance has paid its portion of the account.

The SJHS Financial Assistance Program utilizes a single, unified patient application for both Full Charity and Partial Charity Discounts. The process to obtain assistance is designed to give each applicant an opportunity to receive the maximum financial assistance benefit for which they may qualify. The financial assistance application provides patient information necessary for the hospital to determine patient eligibility and such information will be used to qualify the patient or family representative for maximum coverage under the SJHS Financial Assistance Program.

Eligible patients may qualify for the SJHS Financial Assistance Program by following application instructions and making every reasonable effort to provide the hospital with documentation and health benefits coverage information such that the hospital may make a determination of the patient's qualification for coverage under the program. Eligibility alone is not an entitlement to coverage under the SJHS Financial Assistance Program, but eligibility begins a process of evaluation to determine coverage before full charity or partial charity discounts may be granted.

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

SJHS Financial Assistance Program participation is dependent on providing accurate and timely patient financial information and a financial assistance application will be used to begin eligibility determinations. All patients who demonstrate lack of financial coverage by third party insurers will be offered an opportunity to complete the financial assistance application, and will also be offered information, assistance and referral as appropriate to government sponsored programs for which they may be eligible. Insured patients who are unable to pay the bill remaining after insurance, or those who experience high medical costs may also be eligible for financial assistance. Any patient who requests financial assistance will be afforded the opportunity to apply and be considered.

The financial assistance application should be completed as soon as there is an indication the patient may be in need of financial assistance. The application form may be completed prior to service, during a patient stay, or after services are completed and the patient has been discharged. The application is intended to provide the hospital with necessary information for the hospital to determine if the patient has income sufficient to pay for services and to document the hospital's commitment to providing financial assistance. If such information is otherwise provided, the hospital may extend assistance without need for a formal application.

5.0 PROCEDURES

A. Qualification: Full Charity and Partial Charity Discounts

1. Qualification for full or partial financial assistance shall be determined without discrimination based in any way on age, gender, sexual orientation, ethnicity, national origin, veteran status, disability or religion.
2. The patient and/or patient family representative who requests or is in need of financial assistance relative to the hospital bill shall make every reasonable effort to provide information necessary for the hospital to make a financial assistance qualification determination, and direct assistance shall be provided to patients or their family representative as necessary to help complete applications. Completion of the financial assistance application and submission of any or all required supplemental information may be required for establishing qualification for the Financial Assistance Program.
3. Financial Assistance Program qualification is determined after the patient and/or patient family representative 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, consistent with laws and regulations, to establish and revise from time to time objective eligibility criteria and determine when a patient demonstrates qualification for financial assistance using such objective criteria.
4. Patients or their family representative who are provided an application for the Financial Assistance Program and who elect to complete it on their own shall be told of the availability of assistance to complete the application, where to turn in the application once complete, and what they can expect in follow-up.
5. Personnel who have been trained to review financial assistance applications for completeness and accuracy will review completed applications as quickly as possible and provide a timely response.
6. A financial assistance determination will be made only by approved hospital personnel according to the following levels of authority:
 - Financial Assistance Coordinator: Accounts less than \$2,500
 - Director of Patient Financial Services: Accounts less than \$25,000
 - Chief Financial Officer: Accounts less than \$100,000
 - Chief Executive Officer: Accounts greater than \$100,000
7. Factors to consider when determining whether an individual is qualified for financial assistance pursuant to this policy may include:
 - No insurance under any government coverage program or other third party insurer;
 - Family income based upon tax returns or recent pay stubs; and

- Family size as defined by the California Health & Safety Code
 - Camino Health Center financial assistance referrals will be accepted as financial assistance applicants (Mission Hospital specific)
8. Financial assistance eligibility and extent will be determined based on financial need in accordance with the Financial Assistance Program eligibility criteria contained in this policy.
 9. Once qualification has been determined for the specific services and service dates for which the application has been made, the hospital may, at its sole discretion, treat continuing care as a single case for which qualification applies to all related on-going services provided by the hospital. Other pre-existing patient account balances outstanding at the time of qualification may be eligible for full or partial charity care at the sole discretion of management.
 10. Patient obligations for Medi-Cal/Medicaid Share of Cost payments will not be written-off as charity care under any circumstance. However, after collection of the patient Share of Cost portion, any other unpaid balance such as TAR denials or other Medi-Cal Program non-payment relating to a Medi-Cal/Medicaid Share of Cost patient may be considered for financial assistance.
 11. Patients at or below 350% of the FPL will not be billed for more than Medicare would typically pay for a similar episode of service. This shall apply to all necessary hospital inpatient, outpatient and emergency services provided.

B. Full and Partial Charity Discount Income Qualification Levels

1. If the patient's family income is 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, the entire (100%) patient liability portion of the bill for services will be written off.
2. If the patient's family income is between 201% and 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 a percentage of the gross amount the Medicare program would have paid for the service if the patient were a Medicare beneficiary. The actual percentage paid by any individual patient shall be based on the sliding scale shown in Table 1 below:

TABLE 1

Sliding Scale Payment Schedule

Family Income Percentage of FPL	Percentage of Medicare Amount Payable
201 – 215%	10%
216 – 230%	20%
231 – 245%	30%
246 – 260%	40%
261 – 275%	50%
276 – 290%	60%
291 - 305%	70%
306 - 320%	80%
321 – 335%	90%
336 – 350%	100%

- 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 an amount equal to the difference between what insurance has paid and the gross amount that Medicare would have paid for the service if the patient were a Medicare beneficiary. If the amount paid by insurance exceeds what Medicare would have paid, the patient's remaining bill will be written off.
3. If the patient's family income is between 351% and 500% 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 total patient payment obligation will be the hospital specific total gross amount based on the Average HMO/PPO Payment Rate.
- 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 an amount equal to the remaining patient liability multiplied by the Average HMO/PPO Payment Rate.
- C. Payment Plan
A patient qualified for a partial discount shall have the option to pay any or all outstanding amount due in one lump sum payment, or through a scheduled term payment plan. Payment plans are established on a case-by-case basis through

consideration of the total amount owed by the patient to the SJHS hospital and the patient's or patient family representative's financial circumstances. Payment plans generally require a minimum monthly payment of an amount such that the term of the payment plan term shall not exceed twelve (12) months. Payment plans are free of any interest charges or set-up fees. Some situations may necessitate special payment plan arrangements based on negotiation between the hospital and patient or their representative. Payment plans may be arranged by contacting a Patient Financial Services representative. Once a payment plan has been agreed upon, changes to it require the agreement of both parties.

Once a payment plan has been approved by the SJHS hospital, any failure to pay all consecutive payments due during a 90-day period will constitute a payment plan default. It is the patient or guarantor's responsibility to contact the SJHS hospital Patient Financial Services department if circumstances change and payment plan terms cannot be met. However, in the event of a payment plan default, each SJHS hospital will make a reasonable attempt to contact the patient or their representative by telephone and also give notice of the default in writing. The patient shall have an opportunity to renegotiate the payment plan and may do so by contacting a Patient Financial Services representative within Fourteen (14) Days from the date of the written notice of payment plan default. If the patient fails to request renegotiation of an extended payment plan within Fourteen (14) Days, the payment plan will be deemed inoperative and the account will become subject to collection.

D. Other Special Circumstances

If the patient is determined to be homeless and without third party insurance coverage, he/she will be deemed as automatically eligible for charity care.

Deceased patients who do not have any third party insurance coverage, an identifiable estate or for whom no probate hearing is to occur, shall be deemed automatically eligible for charity care.

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 account notes as an essential part of the documentation process.

The following requirements must be satisfied to treat a patient as medically indigent for purposes of claiming Medicare bad debt pursuant to Medicare Provider Reimbursement Manual (PRM) § 310.

1. The patient's indigence must be determined by the provider, not by the patient. A patient's signed declaration of his inability to pay his hospital bill is not proof of indigency.
2. The provider should take into account a patient's total resources which would include, but are not limited to, an analysis of assets (only those convertible to

cash and unnecessary for the patient's daily living), liabilities, and income and expenses.

3. The provider must determine that no source other than the patient would be legally responsible for the patient's hospital bill.
4. The patient's file should contain documentation of the method by which indigence was determined in addition to all backup information to substantiate the determination.

If the hospital does not claim a Medicare bad debt relative to the unpaid account, the following shall apply:

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/Medicaid, and (c) which is not reimbursed by Medicare as a bad debt, may be eligible for financial assistance if:

1. The patient is a beneficiary under Medi-Cal/Medicaid 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.

Those patients that are eligible for government sponsored low-income assistance program (e.g. Medi-Cal/Medicaid, Healthy Families, California Children's Services and any other applicable state or local low-income program) are deemed to be indigent. Therefore such patients are eligible under the Financial Assistance Policy 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 Program coverage. Under the hospital's Financial Assistance Policy, these types of non-reimbursed patient account balances are eligible for full write-off. Specifically included as eligible are charges related to denied stays, denied days of care, and non-covered services. All Treatment Authorization Request (TAR) denials and any lack of payment for non-covered services provided to Medi-Cal/Medicaid and other patients covered by qualifying low-income programs, and other denials (e.g. restricted coverage) are eligible for financial assistance.

Any patient whose income exceeds 500% of the FPL and experiences a catastrophic medical event may become eligible for financial assistance. Such patients who have high incomes do not qualify for routine full charity care or discount partial charity care. However, consideration as a catastrophic medical event may be made on a case-by-case basis. 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. As a general guideline, any

account with a patient liability for services rendered that exceeds \$75,000 may be considered for eligibility as a catastrophic medical event.

Any services primarily designed to expand access to care for the medically poor may be considered eligible for financial assistance when the following conditions are met:

1. the services are identified in the hospital community benefit plan;
2. the services are targeted at populations which would qualify for financial assistance as identified within the community benefit plan;
3. the services are recorded at full established hospital rates as gross patient revenue;
4. the services are provided by a licensed healthcare professional; and
5. the services are those medical diagnostic or therapeutic services for which a medical record is maintained

Nominal payments may be accepted from patients to assist funding of access to care programs. Any or all self-pay patients may be offered a financial assistance screening form. However, any patient served through an access to care program shall be deemed as qualified without absolute requirement for submission of a financial assistance application.

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

E. Criteria for Re-Assignment from Bad Debt to Charity Care

All outside collection agencies contracted with SJHS 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 (including governmental coverage programs or other third party payers); and
2. The patient or family representative must have a credit score and behavior rating within the lowest 25th percentile of credit scores for any credit evaluation method used; and
3. The patient or family representative has not made a payment within 150 days of assignment to the collection agency; and
4. The collection agency has determined that the patient/family representative is unable to pay; and/or

5. The patient or family representative does not have a valid Social Security Number and/or an accurately stated residence address in order to determine a credit score

All accounts returned from a collection agency for re-assignment from Bad Debt to Charity Care will be evaluated by hospital personnel prior to any re-classification within the hospital accounting system and records.

F. Dispute Resolution

In the event that a dispute arises regarding qualification, the patient may file a written appeal for reconsideration with a complete explanation of the patient's dispute and rationale for reconsideration.

All appeals will be initially reviewed by the hospital Director of Patient Financial Services. The Director shall consider all written statements of dispute and any attached documentation. After completing a review of the patient's claims, the Director shall provide the patient with a written explanation of findings and determination.

In the event that the patient believes a dispute remains after consideration of the appeal by the Director of Patient Financial Services, the patient may request in writing, a review by the hospital Chief Financial Officer. The Chief Financial Officer shall review the patient's written appeal and documentation, as well as the findings of the Director of Patient Financial Services. The Chief Financial Officer shall make a determination and provide a written explanation of findings to the patient. The internal dispute resolution process concludes with a final decision by the Chief Financial Officer.

G. Public Notice

Each SJHS hospital shall post notices informing the public of the Financial Assistance Program. Such notices shall be posted in high volume inpatient and outpatient service areas of the hospital including but not limited to the emergency department, billing office, inpatient admission and outpatient registration areas or other common patient waiting areas of the hospital. Notices shall also be posted at any location where a patient may pay their bill. 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 5% or greater of patients in the hospital's service area.

A patient information brochure that describes the features of the SJHS Financial Assistance Program will be made available to patients and members of the general public. A copy of this Financial Assistance Policy will be made available to the public on a reasonable basis.

H. 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 should be guided by SJHS values and strive for such interactions to be sacred encounters.

I. Good Faith Requirements

Every SJHS hospital makes arrangements for financial assistance for qualified patients in good faith and relies on the fact that information presented by the patient or family representative 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 or purposely inaccurate information has been provided by the patient or family representative. In addition, the SJHS hospital reserves the right to seek all remedies, including but not limited to civil and criminal damages from those patients or family representatives who have provided fraudulent or purposely inaccurate information in order qualify for the SJHS Financial Assistance Program.

Approval

Department Head

Date

Medical Staff
(If applicable)

Date

Administration
(If applicable)

Date

Board of Trustees
(If applicable)

Date

EXHIBIT 3

**SOUTH COAST MEDICAL CENTER FOUNDATION'S
RESTRICTED ASSETS: Balances as of 12/31/08**

1. List of specific non-endowed funds to be used at South Coast Medical Center

Transportation	\$106,573
Patient TV/Equipment	784
Emergency Room	7,509
Cardiac Rehab	78,347
Physical Therapy	5,000
Radiation Oncology	62,656
Nursing	9,607
Cancer Care	44,765
Memorial	82,567
TOTAL	\$397,808

2. The "Marge Swanson Revolving Loan Fund" in the amount of \$80,754
3. The "Marge Swanson Education Fund" in the amount of \$80,754
4. The "HIV/AIDS Endowment Fund" in the amount of \$25,000