CALIFORNIA & BANK
TRUST

March 2, 2001



Mr. John Browning
Musick, Peeler & Garrett
One Wilshire Boulevard, 20th Floor
Los Angeles, California 90017

Re: PanPacific Health Enterprises, Inc.

Dear Mr. Browning,

Pursuant to the request of Mr. Hal Franceschi of Mardel Group, please find enclosed a copy of the appraisal report for East Valley Hospital.

Please contact Mr. Hal Franceschi for any questions.

Sincerely,

Joe Lui
Vice President &
Manager

Enclosure

ALHAMBRA #342
230 East Valley Boulevard • Alhambra • California • 91801
(626) 457 9666 • Fax (626) 570 1533

VALUATION & INFORMATION GROUP

# An As Is and Prospective Stabilized Appraisal of An Acute-Care Hospital

**Huntington East Valley Hospital**
**150 West Alosta Avenue**
**Glendora, California**

**Prepared For**
**California Bank and Trust**
**1900 Main Street, Suite 200**
**Irvine, California**

**Prepared By**
**Valuation & Information Group**
**6167 Bristol Parkway**
**Suite 430**
**Culver City, California**

VALUATION &
INFORMATION
GROUP

6167 Bristol Parkway
Suite 430
Culver City, CA 90230
Tel 310.342.0123
Fax 310.342.0147
www.valinfo.com

January 24, 2001

Thomas Walker, MAI
Vice President and Regional Manager
California Bank and Trust
1900 Main Street, Suite 200
Irvine, California 92614



RE: Huntington East Valley Hospital
150 West Alosta Avenue
Glendora, California

Dear Mr. Walker:

In accordance with your request, we are pleased to submit this appraisal of the market value of the going concern of the above referenced property. The improvements consist of a wood and poured concrete frame, one-story, acute-care hospital containing 87,550 square feet. Included in the square footage of the subject is a partial basement (24,000 square-feet) and office penthouse (1,055 square feet). The facility was originally constructed in 1958 with additions in 1966, 1969 and 1986. The quality of construction is average and the condition of the improvements is average.

The primary purpose of this valuation is to estimate the as is and prospective stabilized market value of the subject. It is our understanding that this appraisal will be used in connection with financing. This letter of transmittal is accompanied by a complete appraisal report in a self-contained format.

The value reported herein is that of the fee simple estate, which includes the land, improvements, personal property and intangible going concern assets. We have not considered any excess net working capital or working capital deficit.

This appraisal investigation included a visit to the property on January 8, 2001 and all necessary investigation and analyses were made by the appraisers. The appraisal was prepared in accordance with Uniform Standards of Professional Appraisal Practice (USPAP) and the Financial Institutions Reform, Recovery and Enforcement Act (FIRREA).

The scope of this appraisal includes valuing the subject as is and upon stabilization. Historically the subject has been owned and operated by a Southern California Healthcare System (SCHS) who manages two larger facilities in the area. Some of the operational decisions in the past were made to improve the overall profitability of the network rather than the subject. The proposed buyer's consist of a group of local doctors that intend on improving the profitability through increased census and utilization. Therefore, the scope of this appraisal includes the as is value – based upon historic and current operations, as is value – based upon the buyer's projections and prospective stabilized value.

Based upon the procedures outlined in this report and subject to the attached statement of facts and limiting conditions and critical assumptions, it is estimated that the as is fee simple market value based upon the past and current operations of the going concern comprising the subject, as of January 8, 2001, is reasonably represented in the following rounded amount:

| | |
|---|---|
| As Is Market Value (current operations) | $5,050,000 |
| Less Estimated 2002 SB 1953 Upgrades | (170,000) |
| As Is Market Value (current operations), rounded | $4,900,000 |

Under the as is value based upon current operations, it was determined that the 2008 SB 1953 upgrades were not financially feasible and that the subject should be operated until January 1, 2008 and then sold for land value.

Based upon the procedures outlined in this report and subject to the attached statement of facts and limiting conditions and critical assumptions, it is estimated that the as is fee simple market value based upon the buyer's projected operations of the going concern comprising the subject, as of January 8, 2001, is reasonably represented in the following rounded amount:

| | |
|---|---|
| As Is Market Value (buyer's operations) | $13,740,000 |
| Less Estimated 2002 SB 1953 Upgrades | (170,000) |
| Less Estimated 2008 SB 1953 Upgrades | (4,800,000) |
| As Is Market Value (buyer's operations), rounded | $8,800,000 |

Based upon the procedures outlined in this report and subject to the attached statement of facts and limiting conditions and critical assumptions, it is estimated that the prospective market value upon stabilization of the going concern comprising the subject, as of January 1, 2003, is reasonably represented in the following rounded amount:

| | |
|---|---|
| Prospective Stabilized Market Value | $16,110,000 |
| Less 2002 Estimated SB 1953 Upgrades | (170,400) |
| Less 2008 Estimated SB 1953 Upgrades | (4,800,000) |
| As Is Market Value | $11,100,000 |

We have not, as part of this valuation, performed an examination or review in the accounting sense of any of the financial information used and, therefore, do not express an opinion or other form of assurance with regard to the same. We have no responsibility to update our report for events and circumstances occurring after the date of this report. The information furnished to us by others is believed to be reliable, but no responsibility for its accuracy is assumed.

Neither the whole, nor any part of this appraisal nor any reference thereto may be included in any document, statement, appraisal or circular without Valuation and Information Group's prior written approval of the form and context in which it appears.

Respectfully submitted,

Valuation and Information Group

Jean-Pierre LeMonaco, MAI
CA Cert AG011111
President

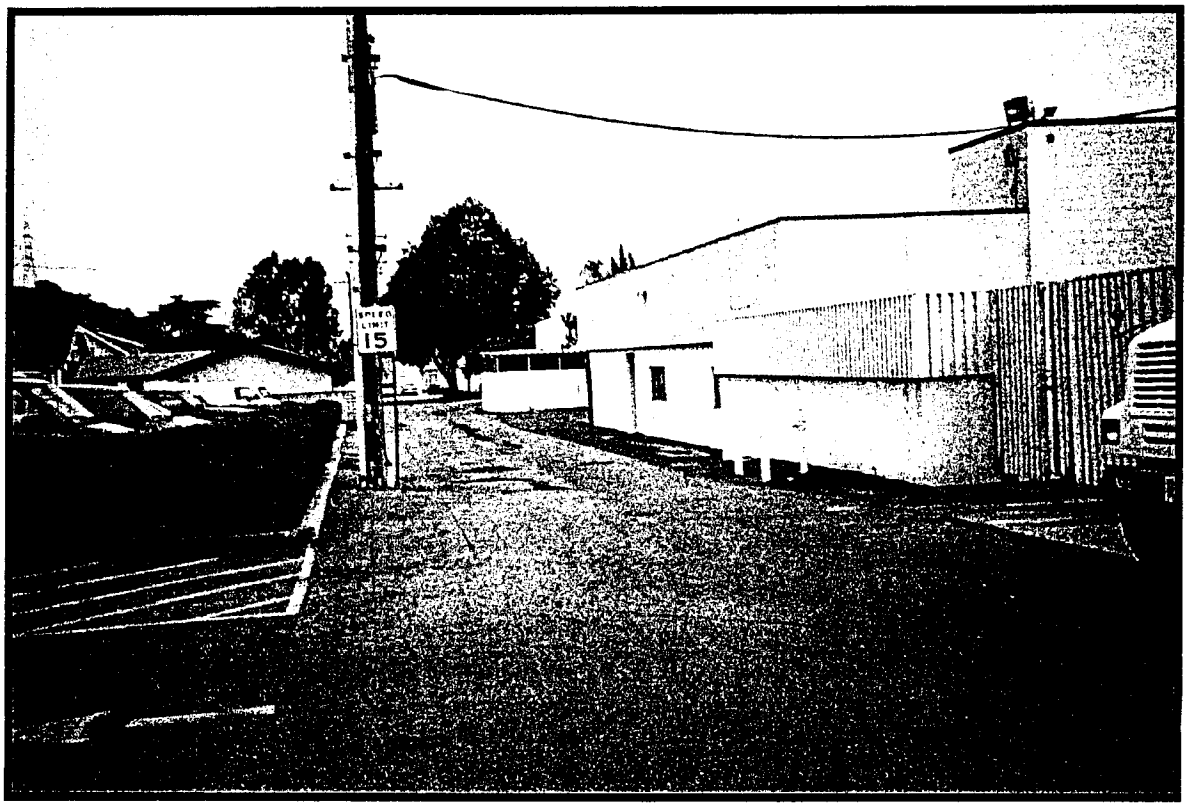
JPL/AV:ad
993097

# SUBJECT PHOTOGRAPHS

Front of Subject

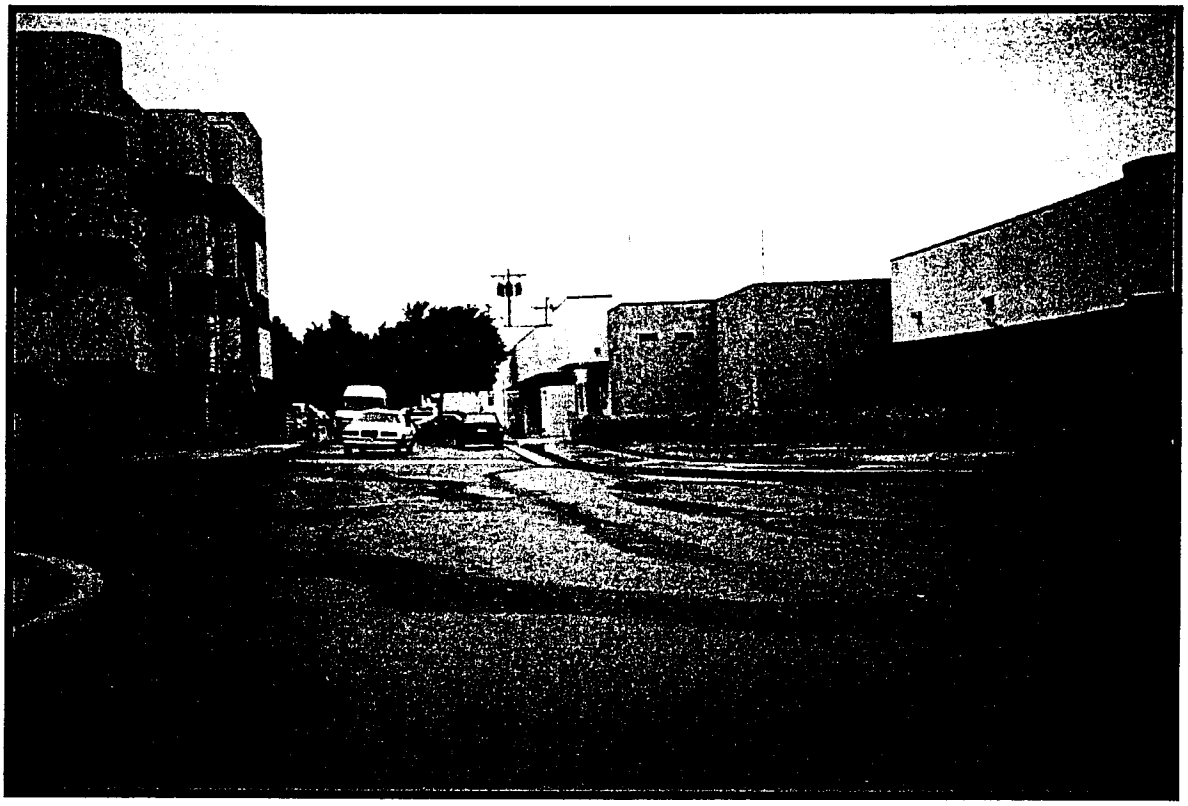
West Parking Lot

East Parking Lot

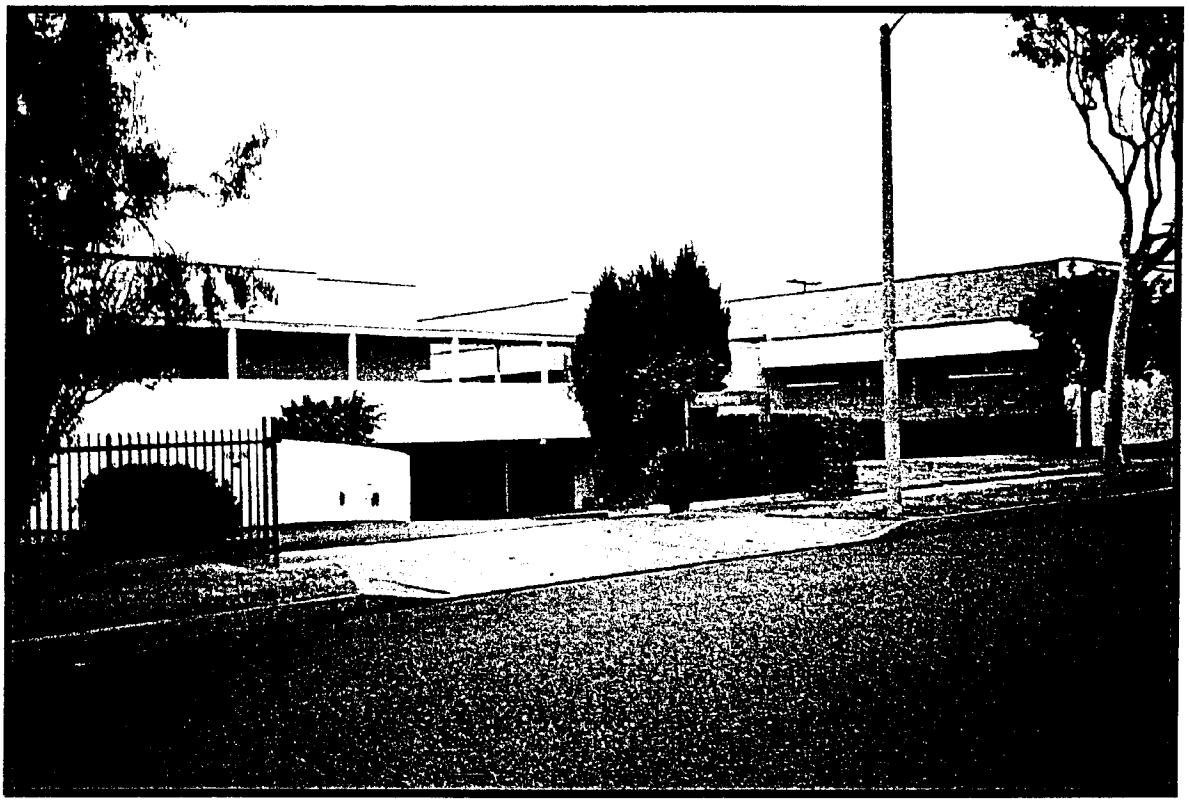



East Side of Subject Looking South

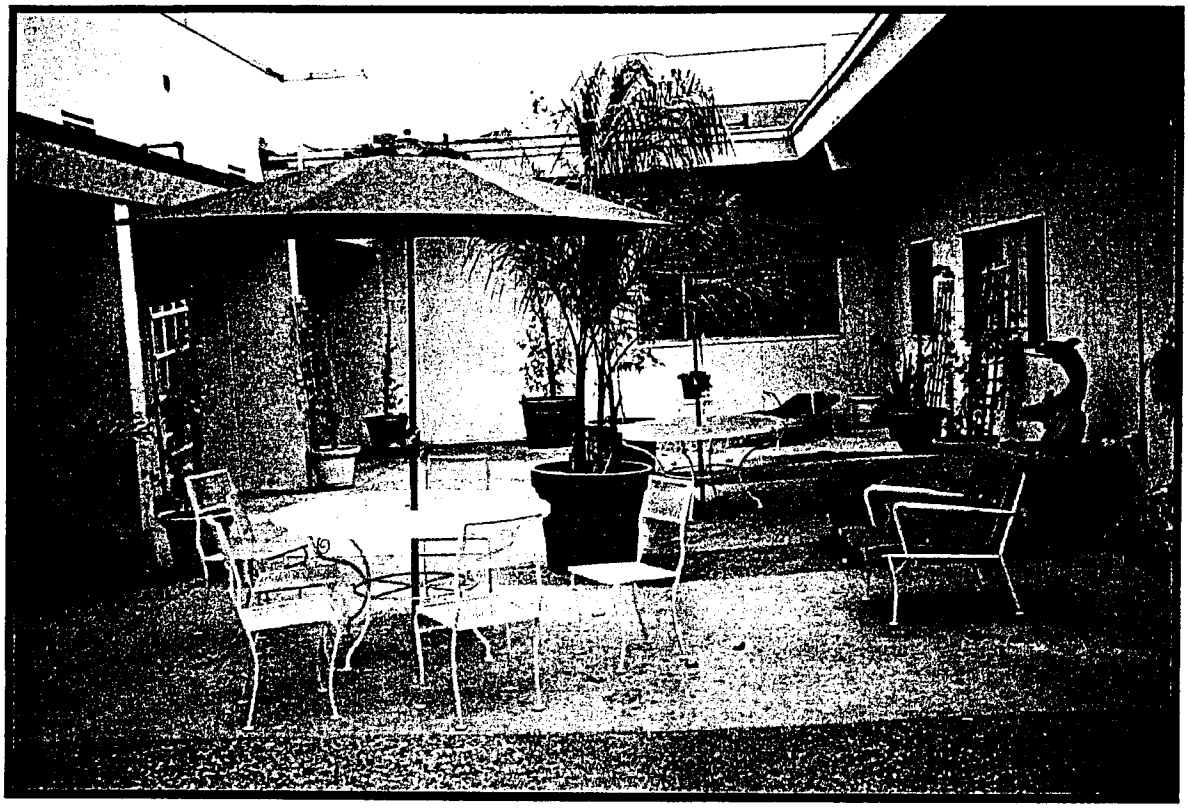
South Side of Subject



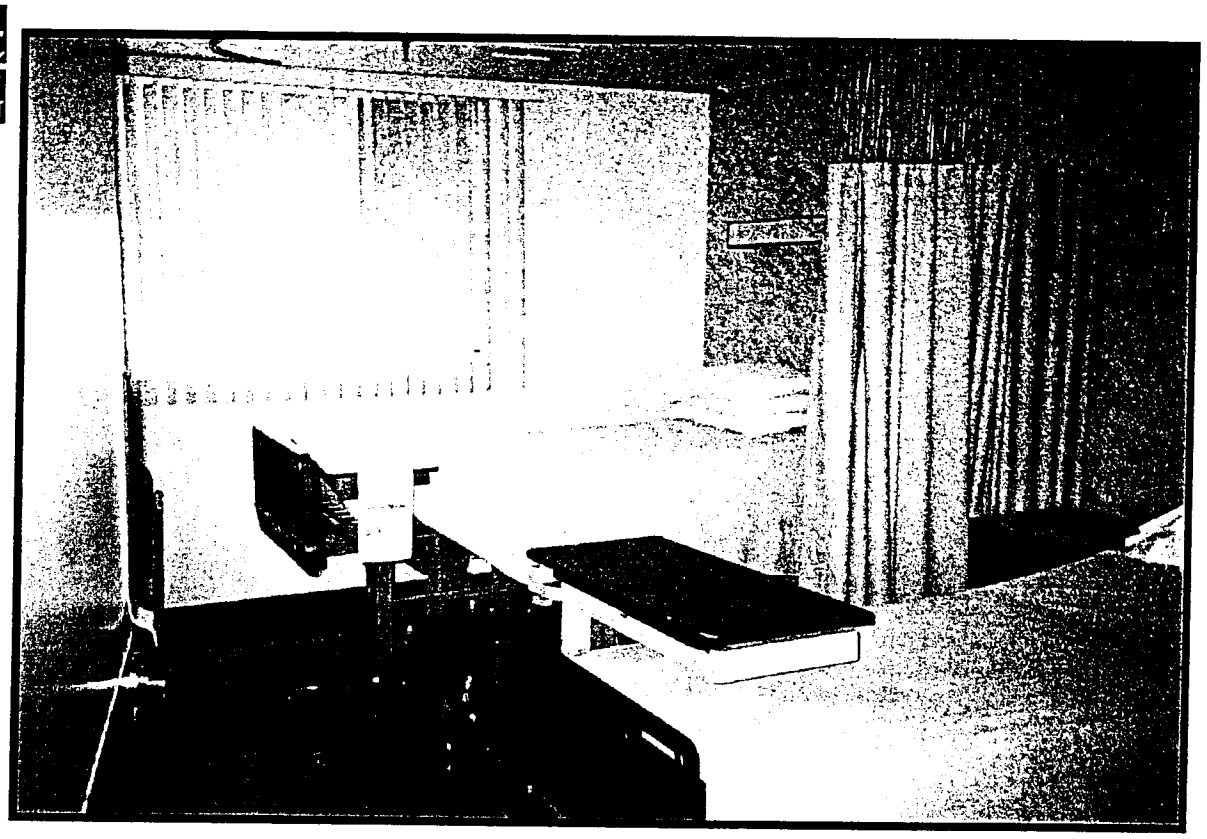
North Side of Subject Looking East



Rear of Subject

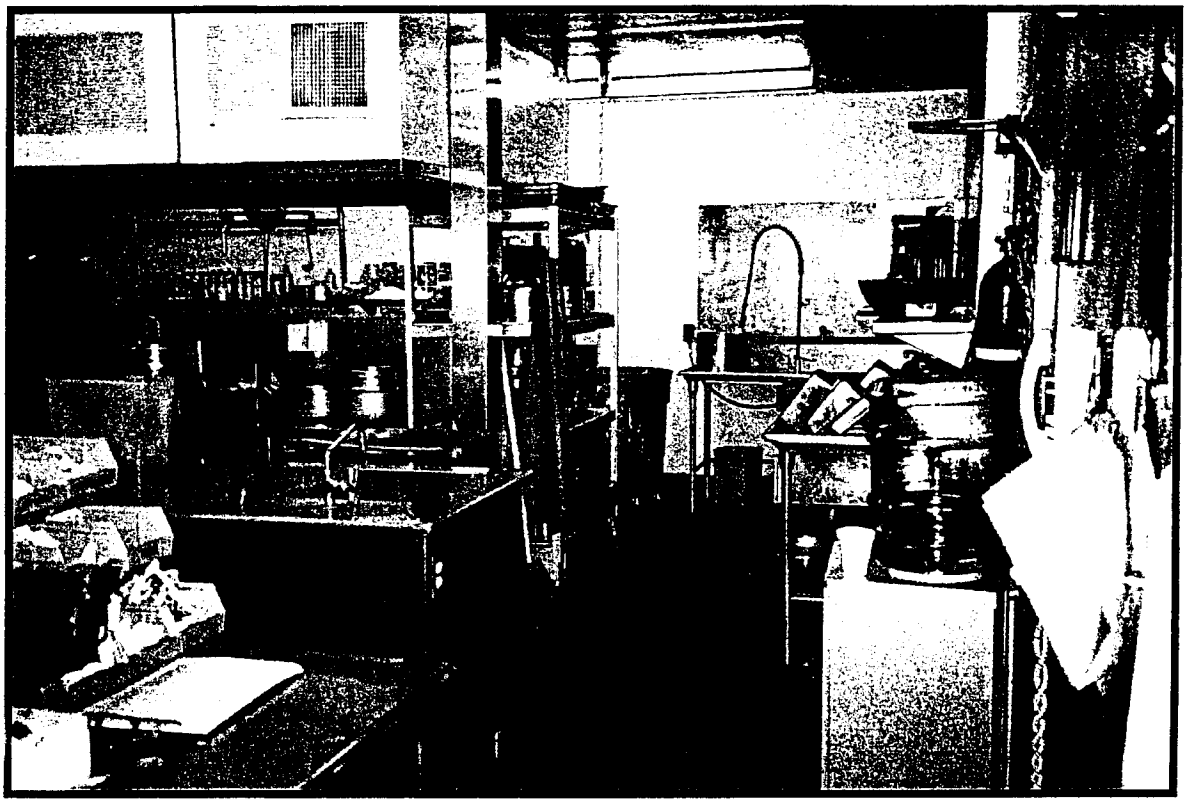


Interior Courtyard

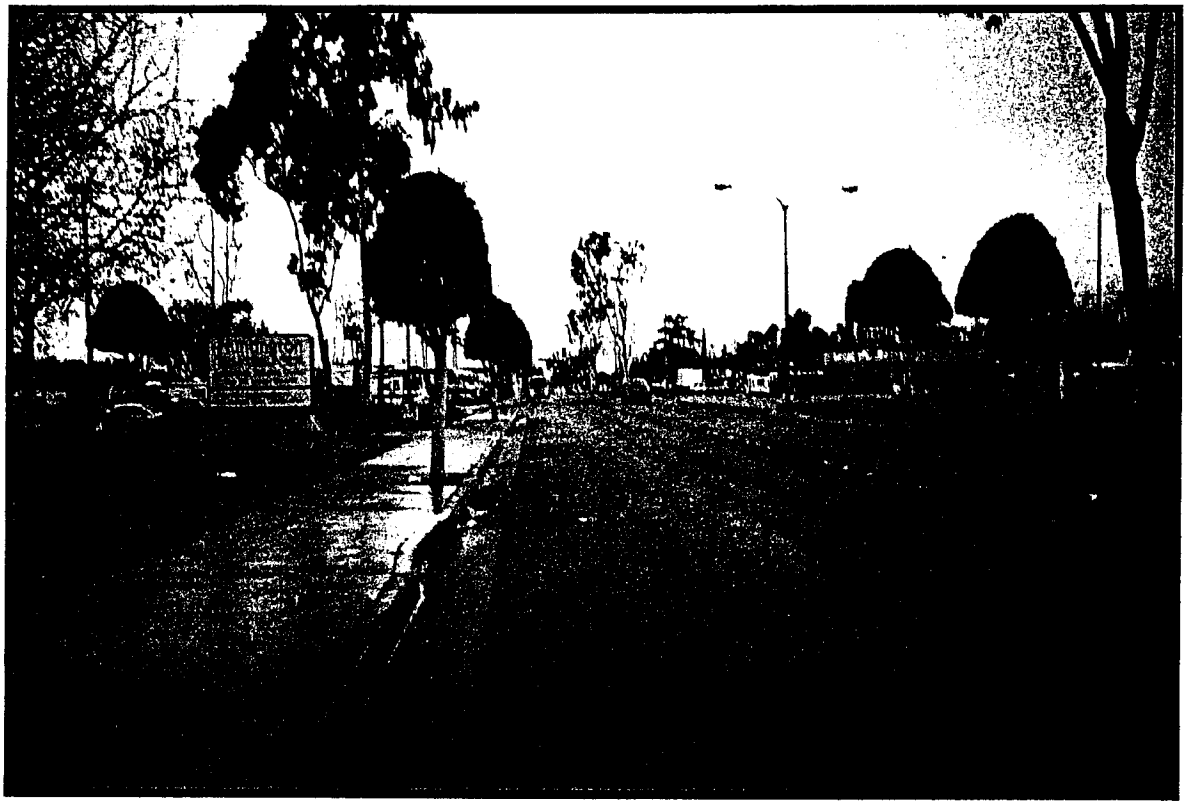


Typical Room

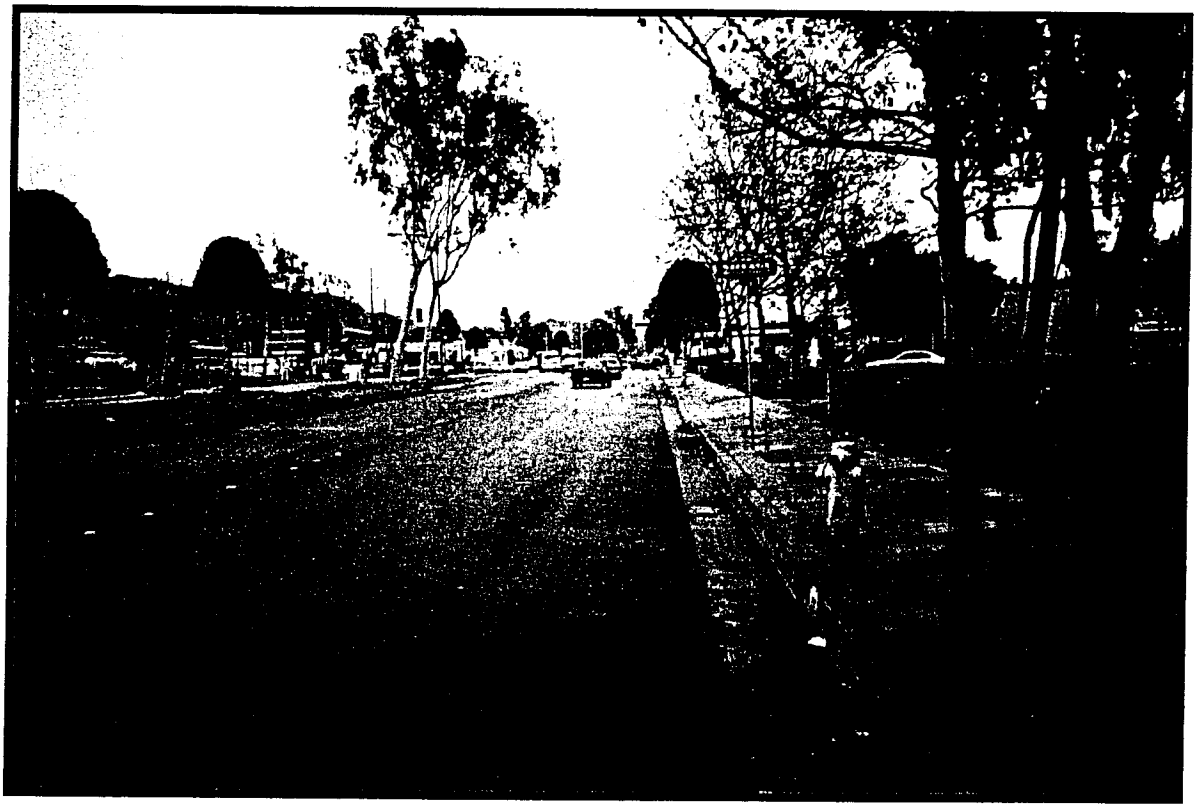
Typical Hallway



Kitchen



Looking West along Alosta Avenue



Looking East along Alosta Avenue

## SUMMARY OF SALIENT FACTS

| | |
|---|---|
| Property | Huntington East Valley Hospital<br>150 West Alosta Avenue<br>Glendora, California |
| Assessor's Parcel Numbers | 8640-005-050 and 8640-005-051 |
| Interest Appraised | Fee Simple Estate |
| Effective Date of Appraisal: | |
| As Is | January 8, 2001 |
| Upon Stabilization | January 1, 2003 |
| Date of Physical Inspection | January 8, 2001 |
| Date of Report | January 24, 2001 |
| Purpose of the Appraisal | To estimate the as is fee simple market value and the market value upon stabilization of the fee simple interest of the subject facility as of the dates specified within this report |
| Intended Use | In connection with financing |
| Land Size | 268,351 square feet, or approximately 6.16 acres |
| Zoning | MS (Medical Services), CM (Commercial-Manufacturing) and R-1 (Residential) |
| Building Description | The improvements consist of a wood and poured concrete frame, one-story, acute-care hospital containing 87,550 square feet. Included in the square footage of the subject is a partial basement (24,000 square-feet) and office penthouse (1,055 square feet). The facility was originally constructed in 1958 with additions in 1966, 1969 and 1986. The quality of construction is average and the condition of the improvements is average. |
| Licensing | 128 beds |
| Highest and Best Use: | |
| As Vacant | Institutional development |
| As Developed | Continue use as is |

Value Indicators:

| | As Is Assuming Current Operations 1/8/01 | As Is Assuming Buyer's Projections 1/8/01 | Upon Stabilization 1/1/03 |
|---|---|---|---|
| **Cost Approach** | | | |
| Land | | $2,550,000 | $2,550,000 |
| Improvements | | 3,370,000 | 3,370,000 |
| Equipment | | 1,290,000 | 1,290,000 |
| Total | N/A | $7,200,000 | $7,200,000 |
| **Sales Comparison Approach** | N/A | N/A | $11,000,000 |
| **Income Capitalization Approach** | | | |
| Direct Capitalization | | | |
| Occupancy Level | 48.6% | | 68.9% |
| Net Income (EBITDA) | $1,150,455 | | $2,900,597 |
| Overall Rate | 18.0% | | 18.0% |
| Total (rounded) | $6,390,000 | | $16,114,430 |
| Less 2002 and 2008 SB 1953 | $4,970,000 | | $4,970,000 |
| | $1,400,000 | N/A | $11,100,000 |
| Discounted Cash Flow | | | |
| Indicated Value | $5,050,000 | $13,740,000 | |
| Less 2002 SB 1953 Upgrades | $170,400 | $170,400 | |
| Less 2008 SB 1953 Upgrades | N/A | $4,800,000 | |
| Value (Rounded) | $4,900,000 | $8,800,000 | N/A |
| Value Conclusions | $4,900,000 | $8,800,000 | $11,100,000 |

The prospective stabilized fee simple value may be allocated as follows:

| | As Is | Upon Stabilization |
|---|---|---|
| Land | $2,550,000 | $2,550,000 |
| Improvements | 3,370,000 | 3,370,000 |
| Equipment | 1,290,000 | 1,290,000 |
| Business Enterprise | 1,600,000 | 3,900,000 |
| Total | $8,800,000 | $11,100,000 |

**Special Limiting Conditions:**

It is assumed that the subject is efficiently managed, with proven and ready operations and is an established business.

In arriving at the opinion expressed in this report, we assumed that the title to the property is free and clear and held under responsible ownership. Management is considered to be a competent and professional healthcare provider.

Some of management's assumptions inevitably may not materialize, and unanticipated events and circumstances may occur; therefore, actual results achieved may vary from management's forecasts and the variations may be material.

Historical operating data was provided by management. It is assumed this financial data is correct and will accurately reflect the operating performance of the subject property. Otherwise, our valuation conclusions may be subject to change.

## CERTIFICATION

We certify that to the best of our knowledge and belief:

1. The statements of fact contained in this report are true and correct.

2. The reported analyses, opinions and conclusions are limited only by the reported assumptions and limiting conditions and are our personal, unbiased professional analyses, opinions and conclusions.

3. We have no present or prospective interest in the property that is the subject of this report, and we have no personal interest or bias with respect to the parties involved.

4. Our compensation is not contingent upon the reporting of a predetermined value or direction in value that favors the cause of the client, the amount of the value estimate, the attainment of a stipulated result, or the occurrence of a subsequent event.

5. Our analyses, opinions and conclusions were developed, and this report has been prepared, in conformity with the Uniform Standards of Professional Appraisal Practice of the Appraisal Institute.

6. Jean-Pierre LoMonaco and Arnold Vieyra have made a personal inspection of the property that is the subject of this report. Arnold Vieyra wrote the descriptive sections of the report and completed the analysis through the Cost Approach. Arnold Vieyra and Jean-Pierre LoMonaco jointly completed the Sales Comparison and Income Capitalization approaches. Jean-Pierre LoMonaco reviewed the report.

7. No one else provided significant professional assistance to the person signing this report, which included data collection and market research.

8. The reported analyses, opinions and conclusions were developed, and this report has been prepared, in conformity with the requirements of the Code of Professional Ethics and the Standards of Professional Appraisal Practice of the Appraisal Institute.

9. The use of this report is subject to the requirements of the Appraisal Institute relating to review by its duly authorized representatives.

10. This appraisal was not based on a requested minimum valuation, a specific valuation, or the approval of a loan.

11. As of the date of this report, Jean-Pierre LoMonaco has completed the requirements of the continuing education program of the Appraisal Institute.

Jean-Pierre LoMonaco, MAI
California Cert. AG011111

Arnold Vieyra
Valuation Consultant

# PROFESSIONAL QUALIFICATIONS

## ARNOLD VIEYRA
## CONSULTANT
## VALUATION & INFORMATION GROUP

**Experience**

General

Mr. Vieyra entered the real estate finance industry in 1997. Mr. Vieyra has performed valuation assignments of vacant land and proposed and existing income-producing properties.

Currently he is a Consultant with Valuation & Information Group, Culver City, CA. Experience includes valuation, due diligence, and market feasibility assignments in the senior housing and healthcare related industry. Property types included senior apartments, independent living, congregate, assisted living, skilled nursing, Alzheimer's care, medical office buildings, rehabilitation hospitals, psychiatric hospitals and general acute-care hospitals. Assignments have been conducted on a nationwide basis.

Prior to joining the Valuation & Information Group, Mr. Vieyra was a Real Estate Analyst at a national consulting company specializing in healthcare related assets. Mr. Vieyra was responsible for the regional analysis and cost approach analysis of appraisals. Duties included market data collection, analysis and assimilation into appraisal reports.

**Professional Affiliations**

Associate member of the Appraisal Institute.

**Education**

Mr. Vieyra is currently fulfilling the educational requirements of the Appraisal Institute and OREA requirements to become a General Appraiser.

Bachelor of Arts, Political Science at the University of California, Los Angeles.

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# PROFESSIONAL QUALIFICATIONS

## JEAN-PIERRE LoMONACO, MAI
## PRESIDENT
## VALUATION & INFORMATION GROUP

**Experience**

General

Mr. LoMonaco entered the real estate consulting industry in 1989. Assignments include market feasibility analysis; limited, summary and complete appraisal reports; lease analysis; highest and best use studies, and general consulting. Mr. LoMonaco's expertise has been used by clients for lending, litigation support, asset allocation, due diligence, lease negotiation, tax appeals, bankruptcy proceedings and market and site selection.

President, Valuation & Information Group, Culver City, CA. Experience includes appraisal and market feasibility assignments for a wide variety of property types in the senior housing and healthcare related industry. Property types included senior apartments, independent living, congregate, assisted living, skilled nursing, Alzheimer's, medical office buildings, surgery centers, dialysis centers, rehabilitation hospitals, psychiatric hospitals, specialty hospitals and general acute-care hospitals. Assignments have been conducted throughout the United States.

Prior to joining the Valuation & Information Group Mr. LoMonaco was Vice President of a national consulting company specializing healthcare related assets. Mr. LoMonaco was responsible for the western real estate division. Duties included client servicing, staff development and general oversight of the western division.

**Professional Affiliations**

Member of the Appraisal Institute (MAI); Certified General Real Estate Appraiser in Arizona, California, Georgia, Texas and Washington; member of the California Assisted Living Facilities Association (CALFA).

**Education**

By continually attending classes, seminars and conferences, Mr. LoMonaco routinely exceeds the minimum continuing education requirements of the Appraisal Institute and State requirements.

Mr. LoMonaco has moderated panels at senior housing / long term care conferences.

Bachelor of Science, Finance, Real Estate Emphasis at the University of Southern California.

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# SENIOR HOUSING/HEALTHCARE INDUSTRY ASSIGNMENTS
## PERFORMED BY JEAN-PIERRE LoMONACO, MAI
## SINCE JANUARY 1, 1996

### *Senior Housing/Assisted-Living Facilities*

Sterling Commons & Inn, Victorville, CA
Emeritus, Several Locations, USA
Assisted Living Concepts, Several Locations, USA
Ridge Wind, Pocatello, ID
Sunshine Villa Living Center, Santa Cruz, CA
Golden Creek Inn, Irvine, CA
Pine Haven, Sugar Land, TX
Encino Riviera, Tarzana, CA
Ontario Residential Manor, Ontario, CA
Hillcrest Inn, Thousand Oaks, CA
Laurel Place, San Bernardino, CA
Paragon Assisted Living, Mission Viejo, CA
Green Valley Assisted Living, Green Valley, AZ
Golden Creek Inn, Irvine, CA
Sterling House at Temecula, Temecula, CA
Glenwood Gardens, Bakersfield, CA
Careage, DuPont, WA
Clarion, Simi Valley, CA
Lakeview Village Assisted Living, Yorba Linda, CA
Astoria Gardens, Vallejo, CA
Chancellor Place of Claremont, Claremont, CA
Assisted Living Foundation, Agoura Hills, CA
Aegis of Fremont, Fremont, CA
Chancellor Place of Windsor, Windsor, CA
Royal Bellingham Gardens, North Hollywood, CA
Evergreen Valley Retirement Center, Spokane, CA
The Breakers, Long Beach, CA
Belmont Hills, Belmont, CA
Heritage Duval Gardens, Austin, TX
Heritage House of Chicago, Chicago, IL
St. Joseph Gardens, Fort Worth, TX
Silverado Senior Living, Escondido CA
Tacoma Lutheran Home, Tacoma, WA
Camino Alto Residence, Vallejo, CA
Citadel, Mesa, AZ

### *Skilled-Nursing Facilities*

Crestwood Portfolio, 30 facilities, CA
Buena Vista Retirement, Clovis, NM
Golden State Health Centers, 24 facilities CA
Mission Manor Health Center, Albuquerque, NM
Convalescent Care of Reseda, Reseda, CA
Horizon Healthcare Corp, Rowell, NM
Golden State Health Center, CA
Mountain Shadow Nursing, Las Cruces, NM
Harbor Convalescent Hospital, Torrance, CA
Harbor Health Care Center, Fullerton, CA
Vista Del Sol, Los Angeles, CA
Citrus Nursing Center, Fontana, CA
Jacobsen Center, Seattle, WA
Millwood Hospital, Arlington, TX
Balch Springs, Balch Springs, TX
Rosenberg Health & Rehab, Rosenberg, TX
Liliha Healthcare Center, Honolulu, HI
Forest Hill Convalescent Home, Richmond, VA
Consolidated Industries, 17 facilities, CA
Heritage Valley Gardens, Brownsville, TX
Heritage Eastwood Gardens, Houston, TX
Heritage Danforth Gardens, Texas City, TX
Heritage House of Seminole, Seminole, FL
Clearview Sanitarium, Gardena, CA

### *Medical Office Buildings/Surgical Centers*

MacGregor Medical, Houston, TX
Park Plaza Professional, Houston, TX
Cambridge Medical Center, San Diego, CA
Mercy Medical Center, Sacramento, CA
Beltway Portfolio, Indianapolis, CA
Pacific Medical Plaza, San Luis Obispo, CA
Family Health Plan, WI
Holt-Krock Clinics, AK

### *Hospitals*

Marian Medical Center, Santa Maria, CA
Redbud Community Hospital, Clearlake, CA
Sharp Healthcare, San Diego, CA
Mt. Diablo Healthcare, Pleasant Hill, CA
French Hospital, San Luis Obispo, CA
Washington Medical Center, Culver City, CA
Specialty Hospital, La Mirada & West Covina, CA
Ojai Valley Community Hospital, Ojai, CA
Focus Healthcare, Maumee, OH
Community Psychiatric Hospitals, 24 facilities
Knollwood Center, Riverside, CA
Heritage Hospital, Rancho Cucamonga, CA
Doctors Hospital of West Covina, West Covina, CA
Queen of Angeles – Hollywood, Los Angeles, CA
Mesa General Hospital, Mesa, AZ
Good Samaritan Medical Center, Phoenix, AZ
Delma Pacifica Hospital, Huntington Beach, CA

## STATEMENT OF FACTS AND LIMITING CONDITIONS

This appraisal report has been made with the following assumptions and limiting conditions:

1. No responsibility is assumed for the legal description provided or for matters pertaining to legal or title considerations. Title to the property is assumed to be good and marketable unless otherwise stated.

2. The property is appraised free and clear of any or all liens or encumbrances unless otherwise stated.

3. Responsible ownership and competent property management are assumed.

4. The information furnished by others is believed to be reliable, but no warranty is given for its accuracy.

5. All engineering studies are assumed to be correct. The plot plans and illustrative material in this report are included only to help the reader visualize the property.

6. It is assumed that there are no hidden or unapparent conditions of the property, subsoil, or structures that render it more or less valuable. No responsibility is assumed for such conditions or for obtaining the engineering studies that may be required to discover them.

7. It is assumed that the property is in full compliance with all applicable federal, state, and local environmental regulations and laws unless the lack of compliance is stated, described, and considered in the appraisal report.

8. It is assumed that the property conforms to all applicable zoning and use regulations and restrictions unless a nonconformity has been identified, described and considered in the appraisal report.

9. It is assumed that all required licenses, certificates of occupancy, consents, and other legislative or administrative authority from any local, state, or national government or private entity or organization have been or can be obtained or renewed for any use on which the value estimate contained in this report is based.

10. It is assumed that the use of the land and improvements is confined within the boundaries or property lines of the property described and that there is no encroachment or trespass unless noted in the report.

11. Unless otherwise stated in this report, the existence of hazardous materials, which may or may not be present on the property, was not observed by the appraiser. The appraiser has no knowledge of the existence of such materials on or in the property. The appraiser, however, is not qualified to detect such substances. The presence of substances such as asbestos, urea-formaldehyde foam insulation, and other potentially hazardous materials may affect the value of the property. The value estimated is predicated on the assumption that there is no such material on or in the property that would cause a loss in value. No responsibility is assumed for such conditions or for any expertise or engineering knowledge required to discover them. The intended user is urged to retain an expert in this field, if desired.

12. Any allocation of the total value estimated in this report between the land and the improvements applies only under the stated program of utilization. The separate values allocated to the land and buildings must not be used in conjunction with any other appraisal and are invalid if so used.

13. Possession of this report, or a copy thereof, does not carry with it the right of publication.

14. The appraiser, by reason of this appraisal, is not required to give further consultation or testimony or to be in attendance in court with reference to the property in question unless arrangements have been previously made.

15. Neither all nor any part of the contents of this report (especially any conclusions as to value, the identity of the appraiser, or the firm with which the appraiser is connected) shall be disseminated to the public through advertising, public relations, news, sales, or other media without the prior written consent and approval of the appraiser.

16. Any value estimates provided in the report apply to the entire property, and any proration or division of the total into fractional interests will invalidate the value estimate, unless such proration or division of interests has been set forth in the report.

17. Only preliminary plans and specifications were available for use in the preparation of this appraisal; the analysis, therefore, is subject to a review of the final plans and specifications when available.

18. Any proposed improvements are assumed to have been completed unless otherwise stipulated; any construction is assumed to conform with the building plans referenced in the report.

19. The appraiser assumes that the reader or user of this report has been provided with copies of available building plans and all leases and amendments, if any, that encumber the property.

20. No legal description or survey was furnished, so the appraiser used the county tax plat to ascertain the physical dimensions and acreage of the property. Should a survey prove this information to be inaccurate, it may be necessary for this appraisal to be adjusted.

21. The forecasts, projections or operating estimates contained herein are based on current market conditions, anticipated short-term supply and demand factors, and a continued stable economy. These forecasts are, therefore, subject to changes with future conditions.

22. The Americans with Disabilities Act (ADA) became effective January 26, 1992. The appraiser has not made a specific compliance survey or analysis of the property to determine whether or not it is in conformity with the various detailed requirements of ADA. It is possible that a compliance survey of the property and a detailed analysis of the requirements of the ADA would reveal that the property is not in compliance with one or more of the requirements of the act. If so, this fact could have a negative impact upon the value of the property. Since the appraiser has no direct evidence relating to this issue, possible noncompliance with the requirements of ADA was not considered in estimating the value of the property.

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# INTRODUCTION

## PROPERTY IDENTIFICATION

The subject property is located at 150 West Alosta Avenue in Glendora, California. The Los Angeles County Assessor identifies the subject property as parcel numbers 8640-005-050 and 8640-005-051. The legal description is contained in the Addendum.

## PURPOSE OF THE APPRAISAL

The purpose of the appraisal is to set forth an estimate of the as is market value, as of January 8, 2001, and the prospective stabilized market value, as of January 1, 2003, of the subject facility.

## INTENDED USE AND INTENDED USERS

This report is to be used in connection with financing. The intended users are representatives of California Bank and Trust.

## SCOPE OF THE APPRAISAL

The scope of this appraisal includes valuing the subject as is and upon stabilization. Historically the subject has been owned and operated by a Southern California Healthcare System (SCHS) who manages two larger facilities in the area. Some of the operational decisions in the past were made to improve the overall profitability of the network rather than the subject. The proposed buyer's consist of a group of local doctors that intend on improving the profitability through increased census and utilization. Therefore, the scope of this appraisal includes the as is value – based upon historic and current operations, as is value – based upon the buyer's projections and prospective stabilized value.

A healthcare facility is a business enterprise with a substantial real estate base. Included in the concept of business enterprise are, all tangible and intangible assets comprising the business. Tangible assets include land, land improvements, building and equipment. These assets are further described and discussed later in this report. In addition to the real and personal property, the subject includes

various intangible assets necessary for the provision of healthcare, dietary, housekeeping, laundry and ancillary services. The provision of these services may create a going concern value beyond the value of the real property. These assets, which tend to increase in value in relation to the level of services provided, include an assembled work force, patient lists, systems and procedures, medical records and goodwill. This appraisal is of the entire business enterprise, one part of which is real estate. For this reason, this appraisal engagement has been conducted using applicable standard appraisal techniques and is in conformity with the Uniform Standards of Professional Appraisal Practice (USPAP) as set forth by the Appraisal Foundation and the Financial Institutions Reform, Recovery and Enforcement Act (FIRREA).

This appraisal engagement has been conducted using applicable standard appraisal techniques. It entails the collection, analysis and description of data pertaining to the physical, legal and economic conditions that affect the use and value of the subject property, and any other relevant data that would pertain to the appraisal of an acute-care facility.

The scope of the appraisal includes, but is not limited to the following:

1. Conducting an inspection of the subject property.
2. Describing the property and its environment.
3. Conducting an analysis of the city and neighborhood.
4. Estimating the market value of the land by the analysis of the land sales identified.
5. Estimating the depreciated replacement cost of the improvements which when added to the land and equipment indicates the market value via the Cost Approach.
6. Conducting a search for (with verification) and analysis of sales of similarly improved properties.
7. Estimating the market value by the analysis of the sales identified via the Sales Comparison Approach.
8. Estimating the market value via the Income Capitalization Approach.
9. Reconciling the three approaches to value for the final value estimate.
10. Preparing a complete appraisal report in a self-contained format based on all findings.

## PROPERTY RIGHT APPRAISED

The property rights appraised herein are the fee simple of the tangible and intangible assets. These interests are defined as follows:

> **Fee Simple Estate**: Absolute ownership unencumbered by any other interest or estate, subject only to the limitation imposed by the governmental powers of taxation, eminent domain, police power, escheat. [1]

## EFFECTIVE DATE OF THE APPRAISAL

The effective date of the as is stabilized value is January 8, 2001. The effective date of the stabilized value is January 1, 2003. The facility was inspected on January 8, 2001.

## APPRAISAL DEFINITIONS

For the purposes of this report, Complete Appraisal is defined as:

> **Complete Appraisal:** the act or process of estimating value or an estimate of value performed without invoking the Departure Provision.[2]

For the purposes of this report, Self-Contained Appraisal Report is defined as:

> **Self-Contained Appraisal Report:** a written report prepared under Standards Rule 2-2(a) of a Complete or Limited Appraisal.[3]

For the purpose of this report, Market Value is defined as follows:

> The most probable price which a property should bring in a competitive and open market under all conditions requisite to a fair sale, the buyer and seller, each acting prudently, knowledgeably and assuming the price is not affected by undue stimulus. Implicit in this definition is the consummation of a sale as of a specified date and the passing of title from seller to buyer under conditions whereby:[4]
>
> a) buyer and seller are typically motivated;

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[1] *The Appraisal of Real Estate*, Eleventh Edition, Appraisal Institute, Chicago, 1996, page 137.

[2] Ibid., page 12.

[3] Ibid.

[4] Ibid. page 23.

b) both parties are well informed or well advised and each acting in what he considers his own best interest;

c) a reasonable time is allowed for exposure in the open market;

d) payment is made in terms of cash in U.S. dollars or in terms of financial arrangements comparable thereto; and

e) the price represents the normal consideration for the property sold unaffected by special or creative financing or sales concessions granted by anyone associated with the sale.

Going-Concern Value is defined as:

> The value of a proven property operation. It includes the incremental value of the business concern, which is distinct from the value of real estate only. It includes an intangible enhancement of the value of the operating business enterprise which is produced by the assemblage of land, building, labor, equipment and marketing operation. This process creates an economically viable business that is expected to continue. Going-concern value refers to the total value of the property, including both real property and intangible personal property attributed to business value.[5]

Personal Property is defined as:

> Movable items of property that are not permanently affixed to, or part of, the real estate.[6]

For purposes of this appraisal, we consider equipment to represent personal property.

Our estimate of value reflects the value in a proven property operation considered as an assembled economic unit. The value estimate is expressed in terms of cash.

## COMPLIANCE

To the best of our knowledge, the analyses, opinions and conclusions that were developed in this report have been prepared in conformity with the regulations of the Uniform Standards of Professional

[5]Ibid., page 26.

[6] Ibid., page 9.

Appraisal Practice (USPAP) of the Appraisal Foundation and The Financial Institutions Reform, Recovery and Enforcement Act (FIRREA).

## COMPETENCY

From our understanding of the assignment to be performed, which we have addressed in the Scope of the Appraisal, it is our opinion that we are competent to perform this appraisal due to the fact that:

1. The appraisers have knowledge and experience in the nature of this assignment.
2. All necessary and appropriate steps have been taken in order to complete the assignment competently.
3. There is no lack of knowledge or experience that would prohibit this assignment from being completed in a professional, competent manner or where a biased or misleading opinion of value is to be rendered.

## SALES HISTORY

We have considered any sales of the subject property that have occurred within a three-year period prior to the effective date of value. The hospital is owned by Southern California Healthcare Systems (SCHS), a non-profit integrated healthcare delivery system, who acquired the facility in April 1995, for $9,801,000. At the time, the subject property included 1.95 acres of leased land adjacent to the facility on which a medical office building was improved. SCHS has subsequently sold the leased fee interest in the land to the leasehold owners.

Southern California Healthcare Systems (SCHS) is under contract to sell the subject to PanPacific Health Enterprises, Inc. (PHE) for a total consideration of $6,500,000.

## REASONABLE EXPOSURE TIME

Reasonable Exposure Time is defined as:

> The estimated length of time the property interest being appraised would have been offered on the market prior to the hypothetical consummation of a sale at market value

> on the effective date of the appraisal; a retrospective estimate based upon an analysis of past events assuming a competitive and open market.[7]

The concept of reasonable exposure time encompasses not only adequate, sufficient and reasonable time, but also adequate, sufficient and reasonable effort. This concept also takes into consideration the type of property being appraised, supply/demand conditions as of the effective date(s) of the appraisal and the analysis of historical sales information (sold after exposure and after completion of negotiations between the seller and buyer). The reasonable exposure period is therefore a function of price, time and use, not an isolated estimate of time alone.

Reasonable exposure time is always presumed to precede the effective date of the appraisal and differs for various types of real estate and under various market conditions. Our estimate of exposure time is therefore based on the subject property's determined highest and best use, in a market where there is evidence of demand for such a facility.

The estimate of reasonable exposure time is not a predication, but rather, only a judgment made by the appraiser based on market conditions preceding the effective date of the appraisal.

Based upon the determination of the highest and best use for the subject, with consideration given to the overall condition and physical characteristics of the subject, it is our opinion that, were the subject property offered for sale, a sale could occur within 12 months.

## OVERVIEW OF THE HOSPITAL INDUSTRY

The rapid increase in the elderly population is the force behind the tremendous expansion of the senior housing and long-term care industries. The U.S. Bureau of the Census estimates that between 1990

[7] *Uniform Standards of Professional Appraisal Practice*, 2000 Edition, The Appraisal Foundation, Washington D.C., pages 80-81.

and 2050, the number of Americans age 65 and older will more than double (from 31 million in 1990, to more than 79 million in 2050).

The United States population statistics and forecasts are provided in the following table:

| U.S. POPULATION GROWTH (1,000S) | | | | | |
|---|---|---|---|---|---|
| | **1990** | **2000** | **% Change** | **2005** | **% Change** |
| Total Population: | 248,709 | 274,691 | 10.4% | 287,123 | 4.5% |
| 65 – 74 Population: | 18,036 | 19,142 | 6.1% | 19,800 | 3.4% |
| % of Total | 7.3% | 7.0% | | 6.9% | |
| 75+ Population | 13,137 | 16,598 | 26.3% | 17,855 | 7.6% |
| % of Total | 5.3% | 6.0% | | 6.2% | |

Data provided by Claritas, Inc.

Over the next five years the fastest growing group is the 75-plus year old population.

In the United States, the proportion of the population made up of persons 65 years of age or older is projected to increase from 13% of the population in 2000 to 20% by 2030 because of the aging of the baby-boom generation and increased longevity. The implications for the delivery and financing of healthcare will be profound, because elderly persons use healthcare services at a greater rate than younger persons. The larger number of elderly persons will put greater pressure on the budget for the Medicare program. Increases in the number of persons 85 years of age or older, who are most likely to require nursing home and other long-term care, will exert similar pressure on the Medicaid program, which pays for about 75% of the total costs of nursing-home care.

A factor contributing to growth in demand for elderly care is the increased life expectancy of the United States population. As the average life expectancy for both men and women continues to increase (as illustrated in the following table) the probability of an elderly person requiring some form of healthcare service also increases.

| UNITED STATES LIFE EXPECTANCY | | | | |
|---|---|---|---|---|
| | Men | | Women | |
| | At Birth | At Age 65 | At Birth | At Age 65 |
| 1990 | 45.6 | 11.4 | 49.1 | 12.0 |
| 1910 | 50.2 | 11.4 | 53.7 | 12.1 |
| 1920 | 54.6 | 11.8 | 56.3 | 12.3 |
| 1930 | 58.0 | 11.4 | 61.4 | 12.9 |
| 1940 | 60.9 | 11.9 | 65.3 | 13.4 |
| 1950 | 65.3 | 12.8 | 70.9 | 15.1 |
| 1960 | 66.6 | 12.9 | 73.2 | 15.9 |
| 1970 | 67.1 | 13.1 | 74.8 | 17.1 |
| 1980 | 69.9 | 14.0 | 77.5 | 18.4 |
| 1990 | 72.3 | 15.1 | 79.9 | 19.9 |
| 2000E | 73.4 | 15.7 | 81.1 | 20.8 |

Source: United States Bureau of the Census

## MEDICARE AND MEDICAID

With the advent of Medicare and Medicaid programs in 1966, the healthcare industry in the United States began its phenomenal growth. The purpose of these two congressional mandates was to ensure for everyone equal access to the best the healthcare industry had to offer. In the initial three years, actual healthcare expenditures increased 50%. During the years 1965 through 1982, the percentage of the gross national product devoted to healthcare climbed significantly.

## THIRD PARTY PAYOR AND THE REIMBURSEMENT SYSTEM

Prior to 1966, two major segments of the population were not protected from the prohibitive costs of healthcare: the aged and those just above the poverty level. In order to provide for the medical needs of these groups, President Lyndon B. Johnson signed into law, in 1965, the Medicare and Medicaid programs (Titles XVII and XIX of the Social Security Act, respectively).

The Medicare program began July 1, 1966 as a national program administered by the federal government and designed to provide health insurance for those aged 65 and older and certain disabled people. The program covers both hospital inpatient care (Part A) and hospital outpatient and physician care (Part B). It is financed by FICA contributions from employees, federal tax revenues and

appropriations and supplemental Part B premiums. The payments provided to hospitals for services rendered to Medicare patients were based on a retrospective reimbursement methodology.

The Medicaid program was established to serve the health needs of the indigent; it is administered on a state level but receives federal reimbursement. While states must comply with basic federal requirements, they are allowed considerable latitude. Medicaid also reimbursed medical providers under a retrospective methodology.

The retrospective reimbursement methodology is based upon reasonable costs incurred by each institution during a reporting period calculated by each separate third-party payor. These reasonable costs were not finalized for reimbursement purposes until after the conclusion of that period. In calculating reimbursements, the major third-party payors did not use the charges billed by a hospital as a foundation upon which to base their hospital reimbursements. Instead, they calculated their own formulas to ensure payment only for the "reasonable costs" actually incurred by the hospital for the services provided. The reasoning for this method of payment was twofold: first, the hospital charges may have included an unacceptably high profit factor; and second, charges may have incorporated items the payor could not or would not support. In addition, the charge structures for costs and services varied greatly among institutions.

Consequently, third-party payors determined a hospital's revenue by establishing formulas to calculate reimbursement rates. These formulas were applied to a hospital's total costs incurred in operations to arrive at allowable costs, which were those costs attributable to direct patient care.

Other formulas and ceiling limitations were then applied to the allowable costs to determine the reimbursement costs the third-party payor would pay.

Two additional considerations of the cost-based reimbursement methodology made the environment in which the hospital sector functioned increasingly hostile and financially less viable. First, since third-party reimbursement formulas were based upon costs, a hospital had to prove an increase in the costs

of providing services in order to increase its rate of reimbursement, while at the same time, ceiling limitations on costs were imposed upon the hospital. Second, the third-party payors imposed a cash flow squeeze on hospitals by maintaining a two to three-month lag in payments.

The portion of revenues not paid by Medicaid and Medicare was covered by commercial insurance carriers and by the patients themselves. Commercial insurance companies would pay hospitals established charges for services as stated in the patient's contract, and those patients, who are most frequently without insurance coverage and no visible means of paying for services rendered, would end up paying a small fraction of their bills.

The national system of Medicare reimbursement was changed as of October 1, 1983. Rates are no longer determined retrospectively, nor is the unit of payment a day of services. The methodology, or Federal Prospective Payment System (PPS), employs a per-case payment based on diagnosis related groups (DRGs) for all its hospital inpatient services. Diagnosis related groups define the unit of payment in the prospective payment system. They classify patients (diagnosis cases) into homogeneous groups that utilize the same types of treatment, medication and X-rays and that require approximately the same number of days in the hospital (length of stay). Since all patients are not exactly the same, DRGs are based on averages and variables, such as age, complications and conditions. The DRGs are grouped by organ systems (eye, ear, nose and throat, etc.); there are 23 major diagnostic categories (MDCs) and 467 DRGs.

DRGs are only one part of the changed federal prospective payment system; two other aspects are that it is prospective and that cost cutting incentives are offered. Hospitals that know the DRGs reflected by their patient population will be better equipped to plan for the future. Also, unlike the retrospective system, this system offers incentives to cut expenses.

Hospital care expenditures in 1965 were $14 billion and totaled $839 billion in 1992, an increase of 16.4% per year, on an annual compounded basis. According to the Commerce Department, national health expenditures were $1.06 trillion in 1994. The U.S. Department of Health and Human Services projects that total healthcare expenditures will reach $1.7 trillion by the year 2000.

TRENDS

Typically, hospital revenues are derived from the services rendered to patients. However, unlike most businesses, hospitals retain very little control over future increases in revenues because the majority of their patient revenue is paid for by third-party payors such as Medicare, Medicaid or Blue Cross. These payors base their payments on what they consider the "reasonable costs incurred" by the hospital.

The spiraling inflation of hospital costs has been the focus of attention in the healthcare industry for the past decade. These patterns of increases in costs have drawn the attention of federal and state governments and health insurance organizations because they are the payors of the bulk of medical expenses. Their investigations into the causes of the steadily increasing costs and the possible solutions have resulted in legislative action on both federal and state levels. New regulations have replaced the retrospective reimbursement system with a prospective payment system, which is intended to reward efficiently managed hospitals.

Factors contributing to the growth of healthcare expenditures include increased per capita consumption of healthcare services and an aging population. However, most of the increased expenditures can be attributed to an increase in hospital care prices over and above the general rate of inflation. One important factor that has increased, and will continue to increase, healthcare expenditures is the rising longevity of the population. This has been a major element in the growth of the industry given the high incidence of serious illnesses in the elderly. Census figures show the aging of the United States population; in 1980, there were approximately 24 million Americans over the age of 65. By 1990, the figure reached 33 million. It is estimated that by 1995 that figure will be 36 million, a 50% increase in 15 years. Additionally, the increase in the over-75 category is estimated to be 70% in 15 years. The over-65 group uses 29.6% of total healthcare dollars and has 23.0% of the hospital discharges, 35.0% of patient drugs and a 50.0% longer length of stay.

The combination of increased demand and increased costs has brought about the enactment of the Tax Equity and Fiscal Responsibility Act of 1982 and the subsequent Social Security Amendment of 1983. This legislation has dramatically changed the federal cost-based retrospective reimbursement system.

Political, social, technological and environmental changes also have created a new climate for the hospital industry. Some of the factors contributing to this new climate are as follows:

- The federal government has been attempting to transfer the burden of healthcare costs to state and local governments as well as to the private sector;
- The elderly represent an increasingly powerful force in demanding healthcare;
- The advent of contracts, health maintenance organizations (HMOs) and other plans is popular with hospitals in lieu of guaranteed revenues from other sources;
- The increasing advances in technology create a demand for further advances and lead to ever-increasing costs to meet these demands;
- A shift of healthcare services to more specialized entities, such as surgery, emergency and rehabilitation centers, offers more affordable and higher quality healthcare at a more reasonable expense. This diffusion of technology outside of the hospital environment will increase competitive pressure on hospitals and medical staffs.

According to the 1996/97 AHA Guide to the Health Care Field, there are 283 multi-hospital healthcare systems consisting of 2,909 hospitals and 538,296 beds. A multi-hospital system is defined as two or more hospitals owned, leased, sponsored, or contract-managed by a central organization. The 283 systems include 71 church related, 162 not-for-profit, 45 investor owned and five federal government systems. Of the 283 systems, there are 219 systems that only own, lease or sponsor, three systems that only contract-manage, and 61 systems that manage, own, lease or sponsor. As a percentage of all systems, church related systems own, lease or sponsor 22.4% of the hospitals with 25.4% of the beds and contract manage 9.2% of the hospitals with 6.9% the of beds; other not-for-profit systems own, lease or sponsor 30.5% of the hospitals with 35.7% of beds and contract manage 26% of the hospitals and 24.2% of beds. Investor-owned systems own, lease or sponsor 34.6% of the hospitals with 22.9% of the beds and contract manage 64.7% of the hospitals with 68.9% of the beds; and the federal government owns, leases or sponsors 12.5% of the hospitals and 16.0% of the beds and does not contract-manage any of the hospitals.

REGULATORY LIMITATIONS

The hospitals receive reimbursement under the Medicare program for services rendered to Medicare beneficiaries. Substantial changes to the Medicare program have been effected under recent federal legislation that will result in diminished payments under that program.

In 1991, the Health Care Financing Administration issued new regulations extending Medicare's fixed fee system for hospital inpatient reimbursement to include payments for hospital capital costs and physicians' fees.

The prospective payment system has already resulted in a number of profound changes in the delivery of healthcare in this country. Because Medicare accounts for nearly 40% of hospital revenues, hospitals have become more selective in admitting patients. The result has been declining trends in inpatient admissions, average lengths of stay and other utilization measures.

Healthcare facilities are subject to federal, state and local government regulations and are subject to periodic inspection by state licensing agencies to determine whether the standards of medical care, equipment and sanitation necessary for continued licensing are maintained. We have assumed that no material noncompliance exists with federal, state and local regulations. Obtaining a license for new facilities to be constructed, and for renovation of and additions to existing facilities also is subject to various governmental requirements, such as approval of sites and findings of need for additional healthcare facilities and services.

The federal government and most states have health planning laws that generally require, with certain exemptions and exceptions, governmental approval prior to the construction of new hospitals or the addition of new beds and certain services to existing hospitals. There is little consistency among the different provisions. In recent years, health planning laws have become substantially less restrictive.

Recent healthcare legislation, known as COBRA (Consolidated Omnibus Reconciliation Act), has made substantial changes in the Medicare program. A 5% increase in rates for Medicare's prospective payment system became effective May 1, 1986. The phased transition from a hospital-specific reimbursement to a federal PPS rate, which originated with a 50%-50% federal/hospital specific blend, remained at that blend during the first seven months of the first cost-reporting period beginning after September 1986, and then moved to a 55% federal/45% hospital specific blend for the remainder of the fiscal year. The blend then changed in the next fiscal year to 75%/federal 25%/hospital-specific, and to 100% federal in the following year.

Effective March 1, 1986, cuts in federal spending required by the Gramm-Rudman-Hollings' balanced budget amendment have resulted in a general 1% reduction in Medicare payments, though judicial efforts continue to have these reductions retroactively reversed. The ultimate effect of Graham-Rudman-Hollings, in light of the Supreme Court decision ruling portions unconstitutional, remains unclear.

Prior federal legislation establishing the Prospective Payment System (PPS) system, required Medicare to phase capital payments into the PPS payment rates. The Reagan Administration was substantially behind schedule in ultimately making a proposal, and both its proposed budget for 1986 and proposed regulations for the fourth year of the PPS system issued in June 1986 attempted to phase such capital payments without legislative approval of the procedure. However, legislation has been enacted instituting a one-year moratorium (until the cost-reporting period beginning after September 1987) on any capital payments under PPS and continuing instead to reimburse hospitals for capital on the basis of cost for an additional year.

The finalized regulations for the fourth year of the PPS's system provided a 0.5% increase and eliminated the periodic interim payment (PIP) system in July 1987, which slowed down Medicare payments to hospitals. Budget reconciliation legislation, in October 1986, increased rates by 1.5% and eliminated the PIP program for facilities with over 100 beds.

Subsequently, all private insurance carriers reimburse their policyholders or make direct payments to hospitals on a fee-for-service basis for covered services. The patient is generally responsible for any difference between the insurance reimbursement and total charges.

Acute-care hospital occupancy levels and the average length of hospital stays have generally been declining since reimbursement under the federal Medicare program under a prospective payment system based on diagnostic related groups (DRGs). More stringent utilization review procedures, increased use of non-hospital and outpatient surgical and diagnostic facilities, use of home healthcare services and the growth of health maintenance organizations have also contributed to this decline.

Managed care, such as HMOs, are expected to be the cornerstone of the future healthcare system. HMOs contract with healthcare providers such as doctors and hospitals for the delivery of their services to enrolled members who typically pay a fixed fee which entitles them to services from the providers affiliated with the HMO. These types of managed care plans will provide individuals or groups who will be responsible for reviewing patient treatment plans, require second opinions prior to surgery, prior authorization before admission to a hospital, and the use of primary physicians to screen patients before referral to specialists. Several major trends are gaining momentum as healthcare providers position themselves to take advantage of the untapped potential of managed care:

- The downsizing of employees will be enforced. The work force typically makes up more than half of operating budgets. Hospitals are downsizing across the board from top management to labor. Physicians are being replaced with "advanced practical nurses" and nurses are being replaced with "unlicensed assistive personnel."
- Investor-owned hospital chains will continue to merge and buy hospitals in selected markets. Hospitals and insurers will initiate moves to own and manage groups of salaried physicians.
- More physicians are banding together in large groups to guarantee referrals and build market share. (Physicians represent more than $150 million in revenues, or 19% of the healthcare budget) The successful group practices will have a strong base of primary-care physicians.
- Independent home infusion and medical equipment providers and home-care staffing agencies will merge to position themselves for contracts with hospitals and healthcare systems.

- Hospitals will form joint ventures with outpatient surgery centers to capture the outpatient surgery market.
- Long-term care providers will add new services to attract patients and managed-care contracts. New services will include home care, sub-acute-care, pharmacies and long-term care insurance (long-term care insurance currently represents less than 1% of nursing home revenues).
- Rural hospitals will form alliances to create physician-hospital organizations (PHOs). Rural hospitals have reversed the decline experienced in the late 1980s and have developed rural referral networks to serve sparsely populated areas.
- Rehabilitation care will shift its attention from inpatient care to expanding outpatient services and will add sub-acute-care to its rehabilitation-care delivery system. Successful rehabilitation providers will establish strong alliances and regional networks which combine inpatient and outpatient care with specialties such as occupational and sports rehabilitation.
- Cost-effective measures in technology will include the adoption of equipment, previously considered too expensive to use, to be a necessary agent to speedy and less costly recovery. Hospitals and healthcare providers will heighten efforts to adopt new technology.
- Generic drugs will drive name brand pharmaceuticals into the generic market through mergers and alliances with unknown biotechnology companies.

In summary, consolidation, joint ventures and other strategic business alliances are expected to increase within the healthcare industry as companies seek to improve their competitive market positions for the future.

## STANDARD & POOR'S HEALTHCARE HOSPITAL MANAGEMENT OVERVIEW

Fundamentally, the underlying trends remain positive in terms of pricing, admissions and operating margins, and the sector is insulated from negative foreign fluctuations pressuring revenues in other areas of healthcare. Year to date through December 11, 2000, the S&P Health Care (Hospital Management) Index was up 51.3%, versus a 3.9% decline for the Super 1500 Index and surpassing the 31.3% surge in S&P's consolidated Health Care Index.

Hospital revenues and margins have been significantly eroded by Medicare inpatient rate reductions enacted as part of the Balanced Budget Act (BBA) of 1997, which included a freeze to average Medicare rates in fiscal 1998 (September) and only a 0.5% increase for fiscal 1999. Realizing that

BBA has lowered Medicare expenditures by nearly twice the original $115 billion projection, according to Congressional Budget Office estimates, Congress and the President have passed legislation, the Balanced Budget Refinement Act of 1999, that should boost federal Medicare provider payments by about $18 billion through 2003.

Regarding inpatient admission trends, S&P believes that the return to more normalized 3% to 5% same-facility admissions growth is likely into 2001, following a 3% to 4% gain in 2000. Revenue growth prospects are further supported by the most favorable private pricing environment in recent memory, with rate hikes averaging 5% to 6% for most of the large hospital chains. Additionally, a renewed focus on collections is resulting in lower bad debt costs and improved cash flows, which can in turn be utilized to strengthen balance sheets, repurchase stock and/or make strategic acquisitions.

S&P believes that the more favorable operating trends, a less hostile regulatory environment and reasonable valuations relative to the S&P 500 will allow for further gains in hospital stocks over the coming six to nine months.

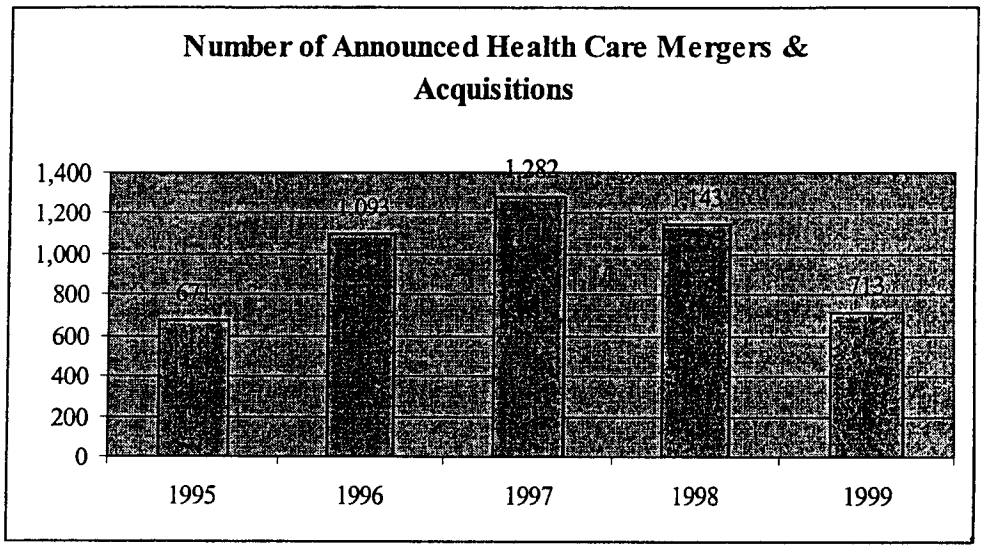
**OVERVIEW OF MERGERS AND ACQUISITIONS**

According to the Hospital Acquisition Report, Sixth Edition 2000 published by Irvine Levin Association, much of the industry is still suffering from the damage inflicted upon it by The Balanced Budget Act of 1997. This legislation limited reimbursement increases for hospitals, reduced payments dramatically for home healthcare and various forms of therapy and mandated a change in reimbursement methodology for the nursing-home industry. Some of the financial pain in this Act has been reversed in 2000, but the overall health of the healthcare industry is still far from robust.

The financial distress of the industry can also be noted by the overall decline in the number of merger and acquisition transactions of the various segments of the healthcare services industry. Calendar 1999 marks the second year of declining merger activity, a trend likely to continue in the year 2000. This is in marked contrast to the period up to 1997 when merger and acquisition activity was growing at a fast-paced rate for the industry. The slowdown in merger activity actually began in the fourth

quarter of 1997, but the real drop in activity began in the second half of 1998, when the effects of reduced earnings were becoming known throughout the industry.

The chart[8] below shows the volume of publicly-announced healthcare mergers and acquisitions for each of the years 1995 to 1999 for the combined sectors of the healthcare services market incorporated in our database. Activity in 1999 just barely exceeded that of 1995. This was before the great wave of consolidations within the industry driven by the need for highly fragmented, high-cost healthcare services to be consolidated into more efficient business practices.



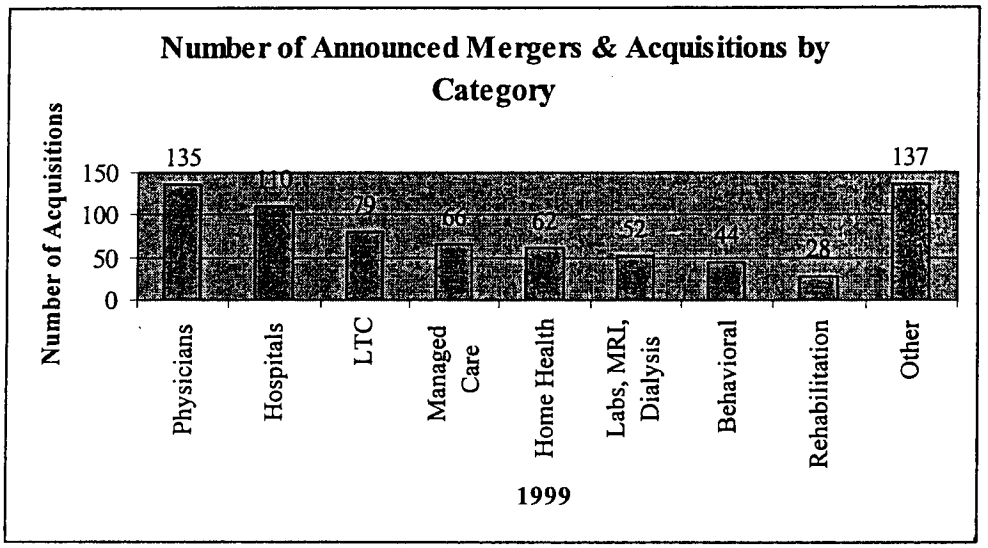

An analysis of the announced healthcare merger and acquisition activity by sector shows that hospital acquisitions in 1999 took second place, behind only physician group mergers, in terms of the total number of deals. Hospital mergers had been second in terms of announced totals in 1996 and 1997, third in 1998, and first in 1995.

Besides hospitals, sectors included in our compilations are: Behavioral Health (formerly Psychiatric); Home Health Care; Laboratories, MRI and Dialysis; Long-term Care; Managed Care (formerly

[8] *The Hospital Acquisition Report*, 6th Edition, Irving Levin Associates, Inc., page 1.

HMOs); Physician Medical Groups; Rehabilitation; and Other. The Other category includes, *inter alia*, transactions for dental group practices, ambulance companies and institutional pharmacies. Because "Other" encompasses a number of unrelated business segments, it is not used in the ranking of the most active sectors.

Only one sector showed an increase in merger activity from 1998 to 1999. Managed Care, which registered an 8% increase in announced transactions. Declines in other sectors ranged from a 17% decrease in announced Behavioral Health transactions to a 49% decline in the number of announced Physician Medical Group acquisitions. The following chart[9] shows the number of acquisitions by category.




Healthcare expenditures nationwide exceed $1 trillion a year. Hospital billings account for the single largest piece of that expenditure total, at nearly one third of total healthcare costs. Payment for healthcare expenses comes from three primary sources: the largest is private health insurance and private source payments which fund nearly half of all expenses. Medicare and Medicaid make up the remaining payor sources for the industry.

[9] Ibid., page 2.

During the 1980s, healthcare expenditures were rising at a double-digit annual rate. Reforms instituted in the 1990s slowed this rate of growth to an average of 5% for the years 1993 to 1998. The year 2000 is likely to see double-digit increases in health costs as premiums on private insurance plans rise to reflect higher drug costs and as health insurers find they are unable to secure additional cost concessions from the healthcare providers. In addition, the general aging of the U.S. population contributes to increased healthcare utilization.

Acquisition activity in the hospital sector has now declined for two years in a row. Hospitals have been affected by the decrease in healthcare reimbursements from the Balanced Budget Act of 1997. Current topics of debate that could fuel major reimbursement changes in the industry include a possible doubling in the number of DRGs used by Medicare to determine hospital reimbursements. If enacted, reform to this system would be aimed at providing higher payments to more medically complex illnesses, an issue that is not addressed by the current single DRG reimbursement coding. This change would benefit large urban teaching facilities and decrease payments for small and rural providers. However, refinement of the payment system is not expected to be released before June 2000.

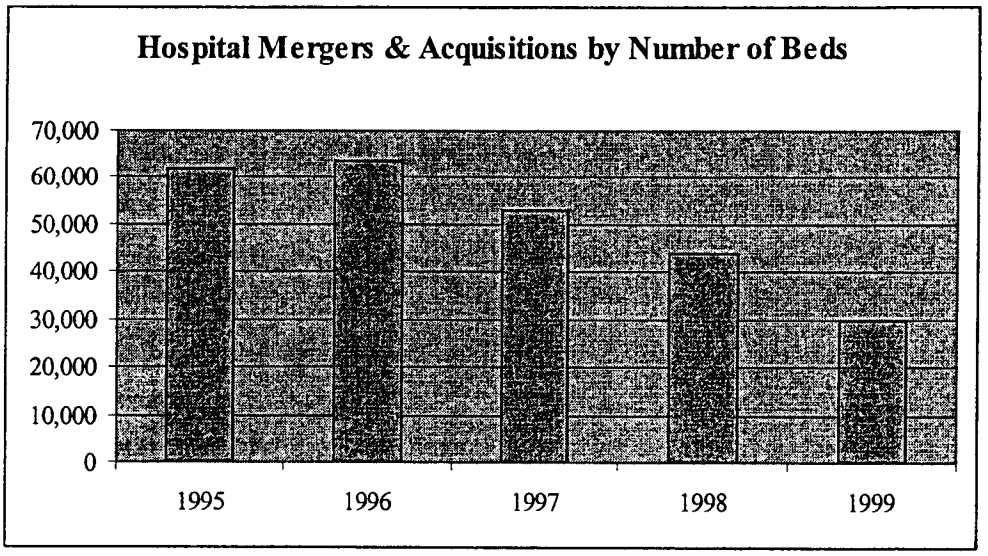
Historically, one major factor in the hospital acquisition market has been Columbia/HCA. This changed abruptly in 1997 when the company became the target of numerous federal government investigations. Columbia/HCA acquisition activity came to a virtual halt in 1997, and in 1998, Columbia/HCA became a net seller of hospital facilities. In 1999, Columbia spun off two entities, Triad Hospitals and LifePoint Hospitals, both of which became publicly listed companies on the Nasdaq.

Owners of Columbia/HCA received one share of LifePoint for every 19 shares of Columbia/HCA stock held. At the time of the spin-off, LifePoint was comprised of 23 hospitals and related healthcare facilities in nine southern and western states.

Similarly, Triad was spun off using the same stock proportions. Triad commenced operations with 38 hospitals and 14 ambulatory surgery centers located in 11 states. Triad's facilities are concentrated in small cities also in the southern and western regions of the U.S

Excluding the Columbia/HCA spin-offs, in 1999 the number of announced hospital acquisitions was down 24%, but the number of hospitals acquired was down even more, at 41%. The decline from 1997 to 1998 was less significant, with a decline of 27% in announced transactions but only a 4% decline in the number of hospitals acquired. At a rate of 1.6 hospitals per transaction, the average size of each acquisition in 1999 was in line with 1997, the most active year for acquisitions.

The number of beds acquired declined again in 1999 to the lowest level of the past five years. In 1998, the number of beds acquired was down 18% from 1997; a larger decline of 32% was experienced from 1998 to 1999. Earlier acquisitions often involved bigger facilities. Besides a decline in the total number of facilities, a focus on rural hospital acquisitions over the past two years particularly by certain publicly owned companies, has continued to bring down the average size of the facilities being acquired. The following chart[10] shows the number of beds that were involved in mergers and acquisitions.




[10] Ibid., page 5.

The following chart represents a five-year compilation of all the statistics for each announced transaction. The first block of data gives a summary of the transaction volume for each of the past five years. The second and third blocks show financial data summaries for these transactions. The last four blocks summarize the financial terms of the aggregate acquisition market. Most industry participants consider price/EBITDA ratios the most important measure for valuing an acquisition.

**SUMMARY OF ACQUISITIONS**

| | 1999 | 1998 | 1997 | 1996 | 1995 |
|---|---|---|---|---|---|
| Number of Deals | 110 | 144 | 197 | 161 | 129 |
| Number of Beds | 29,751 | 43,827 | 53,133 | 63,762 | 61,681 |
| Number of Hospitals | 175 | 298 | 310 | 310 | 268 |
| Total Acquired Revenues | $10,879,454,440 | $17,531,289,465 | $20,237,225,438 | $21,582,114,169 | $20,694,136,000 |
| Average Revenue/Deal | $99,811,509 | $127,038,329 | $107,075,267 | $138,346,886 | $169,624,066 |
| Median Revenue/Deal | $39,730,840 | $56,073,232 | $55,503,059 | $71,550,000 | $82,250,000 |
| Deal Count | 109 | 138 | 189 | 156 | 122 |
| Average EBITDA/Deal | $5,269,417 | $6,384,794 | $6,042,000 | $11,430,524 | $11,694,273 |
| Median EBITDA/Deal | $1,938,966 | $4,450,983 | $3,983,068 | $4,396,202 | $6,613,425 |
| Deal Count | 41 | 60 | 93 | 107 | 86 |
| Total Purchase Price | $2,932,734,000 | $4,191,297,000 | $3,286,033,541 | $7,668,888,000 | $9,246,484,000 |
| Average Price/Deal | $59,851,714 | $73,531,526 | $54,767,226 | $139,434,327 | $205,477,422 |
| Median Price/Deal | $23,000,000 | $49,700,000 | $19,450,000 | $41,611,000 | $65,120,000 |
| Deal Count | 49 | 57 | 60 | 55 | 45 |
| Price/Revenue Average | 0.76 | 1.02 | 0.92 | 0.88 | 0.95 |
| Price/Revenue Median | 0.61 | 0.92 | 0.79 | 0.82 | 0.80 |
| Deal Count | 44 | 54 | 57 | 52 | 42 |
| Price/EBITDA Average | 9.46 | 8.21 | 6.99 | 5.98 | 5.84 |
| Price/EBITDA Median | 8.29 | 8.33 | 5.46 | 5.41 | 6.12 |
| Deal Count | 10 | 18 | 23 | 30 | 25 |
| Price/Bed Average | $243,226 | $330,331 | $222,116 | $247,955 | $279,467 |
| Price/Bed Median | $174,996 | $213,592 | $201,117 | $192,308 | $259,831 |
| Deal Count | 46 | 55 | 60 | 55 | 43 |

Source: *The Hospital Acquisition Report*, 6th Edition, Irving Levin Associates, Inc., page 6.

Numerous interviews with industry participants consistently reveal their exclusive use of this financial measure for pricing acquisitions. The average and median price/EBITDA ratios in 1999 were higher than in any of the previous five years. This may reflect a trend to pay a greater multiple for facilities, but given the number of data points, may only be reflective of the data made publicly available. Our sources in the industry show the consistent use of trailing audited EBITDA adjusted for out of period entries and other unusual items. Ratios of three to five times EBITDA are paid for older facilities,

including those being purchase for replacement facilities. The upper end of the multiple range is generally eight times EBITDA for premium facilities.

### CONCLUSION

Although the healthcare industry, as a whole, has experienced good growth over the past several years, the news is not all positive. An estimated 38 million Americans have no health insurance coverage at all, with children accounting for 36% of this total. Currently, as many as another fifty million Americans are believed to have inadequate coverage. The percentage of U.S. GNP devoted to healthcare continues to increase with each passing year, and it is estimated that it will consume 28% of the GNP by the year 2010.

Escalating regulation and inadequate reimbursement from Medicaid have squeezed industry profits. In an effort to remain profitable, many providers have diversified into medical-specialty units, which tend to be more profitable than typical nursing care. The elderly-care segment of the healthcare industry continues to evolve in response to dynamic social and economic influences.

The number of announced healthcare mergers and acquisitions have declined since 1997. Although hospital stocks have suffered from weakening admission trends for much of 1999, these trends began to reverse in December 1999 and positive comparisons continued into January 2000.

## FACILITY OVERVIEW

The subject facility is licensed for 128 beds. The subject offers inpatient and outpatient surgery, intensive and cardiac care, maternity, diagnostic imaging, MRI, senior mental health services, radiology, physical therapy, community outreach programs and 24-hour emergency medicine.

## MANAGEMENT OVERVIEW

Since the successful operation of a going concern is dependent upon effective management, a perusal of facility management can provide an indication of the potential for growth or the risk of achieving budgeted cash flows. Professional management with a high level of experience and expertise can improve the stability of operations, reducing the risk associated with the assets.

Upon completion of the sales agreement, the Mardel Group, Inc. will manage the facility. They have been involved with a wide variety of healthcare industry clients *(both Governmental and private)*. Selected assignments have included:

- Organizational Change
- Strategic Partnership
- Integration of Services
- Interim Management
- Information Management
- Facility Design and Construction
- Health Education
- Feasibility Studies
- Clinical Practice Management
- Operations Management
- Business Plan Management
- Financial Consulting
- Human Resource Consulting
- Performance Improvement
- Medical Staff Relations

Below are a number of the companies the Mardel Group, Inc. has provided professional services for:

- Action Collection Agency
- Alcott Skilled Nursing Facility
- Arlington Health Services Corporation
- Armed Forces Hospital, Riyadh, Saudi Arabia
- Costa Mesa Medical Group
- Cook County Hospital
- Costa Mesa Medical Center
- Eisenhower Medical Center
- El Centro Regional Medical Center
- French Hospital
- KPC Global Care, Inc. and Affiliates
- Lloyd Emergency Medical Group
- Physician and Surgeons Hospital
- San Antonio Community Hospital
- San Diego General Hospital
- Scottsdale Memorial Hospital
- Twenty-nine Palms Marine Corps Hospital
- US Family Care Medical Center
- Long Beach Psychiatric Hospital
- Parkview Community Hospital Medical Center
- Parkview Hospital Management Services, LLC

The Mardel Group's founder and President/CEO is Mr. Norm Martin, who has more than twenty years of experience in operational and financial management. He has worked in leadership roles such as Chief Executive Officer, President and Chief Financial Officer of major medical institutions. His

expertise is in problem solving and efficient systems development. His excellent interpersonal and communication skills have resulted in a high demand for his services on numerous boards, particularly those that are community focused. He is a member of the U.S. Chamber of Commerce, American Institute of Certified Public Accountants, The Urban League, and a Life Member of the National Association for the Advancement of Colored People.

Ms. Susan L. Medel, Chief Financial Officer, graduated with a Bachelor of Arts in Business. She also holds a Masters in Business Administration. She has completed postgraduate work in multiple healthcare, financial and operational management topics. She has over 20 years healthcare experience in for-profit and non-profit organizations. Positions held include: Auditor, Controller, Contract Chief Administrative Officer/Chief Financial Officer, Executive Director of Finance and Chief Financial Officer. She has testified before the California Legislature as an expert witness on healthcare issues. Clients have included hospitals, skilled-nursing facilities, university departments, health plans and medical groups.

Since forming a corporate relationship with two bigger hospitals, the subject has not done as well as expected. Problems at the subject were caused by capitation arrangement negotiated by Southern California Healthcare Systems (SCHS), its parent corporation. As a result, the subject reported a loss from the insufficient reimbursement of managed care contracts in 1999. In 2000, the subject was put on the market for sale through Shattuck Hammond Partners, a division of Pricewaterhouse Coopers Securities, LLC. Southern California Healthcare Systems (SCHS) and PanPacific Health Enterprises, Inc. are currently under contract for a total consideration of $6,500,000.

PanPacific Health Enterprises, Inc. believes that it is uniquely positioned and capable of capitalizing on the opportunity to acquire the subject for two principal reasons:

1. Substantial improvements in hospital occupancy will be achieved by providing value added services to more easily recruit physicians and create a physician-friendly environment, which illustrates the impact of recruiting eight more physicians.
2. An experienced and dedicated management team will be committed to enhancing quality and improving productivity while reducing unnecessary costs and promoting employee and physician loyalty, through strong and effective leadership.

PanPacific Health Enterprises, Inc. was organized by twelve local investors in October 2000. Since the beginning, all of the investors have committed to capitalizing two million in cash as the down payment for acquiring the subject. Mr. C. Joseph Chang is the principal investor that has worked in the field of healthcare for more than fourteen years at San Gabriel Valley Medical Center. He initiated this hospital purchase with the help and assistance of The Mardel Group, Inc. In addition, Mr. Norm Martin, C.E.O. and Mr. Hal Franceschi, C.O.O. from The Mardel Group will manage the subject once PanPacific Health Enterprises, Inc. takes over Huntington East Valley Hospital's ownership.

## THE PROSPECTIVE BUYER'S GOALS

- The hospital is owned by a group of local investors who will focus upon recruiting more local physicians and patients.
- Negotiate a master lease for the medical office building on the hospital campus to support physician recruitment and retention efforts, or purchase the (MOB) as a joint venture with the physicians.
- PanPacific Health Enterprises, Inc. is in discussions with Medical Pathways, one of the largest IPA networks in Southern California. Medical Pathways is interested in giving more capitation business to the subject after new ownership is formed. Management is making efforts to link up with those existing IPAs and develop more business with IPAs that have never utilized the subject.
- The current management team at Huntington East Valley Hospital will remain in place if they so desire and are performing to the standards set by senior and corporate management. The new management team will be committed to enhancing quality, improving productivity while reducing unnecessary costs through strong and effective leadership.
- Mardel Group, Inc. can assemble the most relevant group of experts in the most cost effective manner. All of the hospital's service contracts can be renegotiated to reduce their costs through Mardel's network relationship. As an example, medical supplies, food services, and employee's benefit packages can be evaluated to reach a global discount agreement with Mardel's two other hospitals: Parkview Community Hospital and Chino Medical Center in the future.
- Continue to improve the utilization review function in the hospital to decrease costs per patient day, reduce average Medicare lengths of stay and greatly reduce denials. Those efforts will maximize Medicare and Medi-Cal's reimbursement.

- Creation of new services to boost revenues:

  a. Due to a dramatic increase in sports injuries at the nearby Glendora Country Club, the prospective buyer is considering the establishment of a sports medicine clinic in conjunction with the country club. Discussions between the buyer and a highly respected physical therapist known for his treatment results are ongoing.

  b. Due to the high proportion of business executives working and/or residing in the subject area, the prospective buyer is seeking to develop a unique and personal "executive check-up" program with an attractive cash package deal.

  c. There is a large population of uninsured in the San Gabriel Valley who can afford medical services on a fee-for-service basis. Such a program, including a courtesy discount, has been promoted to surgeons by the West San Gabriel Valley Hospital. The prospective buyer is seeking to extend this idea to the East San Gabriel Valley, in order to provide an affordable cash package to outpatients that do not have health insurance.

- Huntington East Valley Hospital is a Federal and State designated disproportionate share (DSH) hospital. The hospital receives disproportionate share funds based on Medicare, Medi-Cal and charity-care volume. The prospective buyer looks to emphasize that Huntington East Valley Hospital is a Medi-Cal-friendly hospital.

### CONCLUSION OF MANAGEMENT AND OWNERSHIP

Based upon The Mardel Group's experience and relationships within the region, Management is considered competent. The proposed buyers of the subject comprise a group of local doctors who are familiar with the continuum of care within the community and have established ties to the area. It is the plan of the prospective buyers to retain the onsite administration.

The current owner of the subject operates two larger facilities in the area and historically has focused on operating those facilities. The subject will be the prospective buyers' sole facility. Based upon Mardel's management experience and local ownership, the proposed combination of management and owner appears to support improved operations.

### COMPETITION

A search for competition consisted of an interview with the subject's management, and a review of HCIA's U.S. Hospital Profiles. Photographs and maps indicating the location of each facility are

included in the Addendum. The following table contains a summary of pertinent information for each competitive hospital.

| | General Care Hospital Facility Name/Location | Licensed Beds | Payor Mix | ALOS (in days) | Occ. |
|---|---|---|---|---|---|
| 1. | Foothill Presbyterian Hospital<br>250 South Grand Avenue<br>Glendora, California | 106 | 72.3% Private/Other<br>4.4% Medi-Cal<br>23.3% Medicare | 3.3 | 46% |
| 2. | Inter-Community Medical Center<br>210 West San Bernardino Road<br>Covina, California | 246 | 57.0% Private/Other<br>16.0% Medi-Cal<br>27.0% Medicare | 4.6 | 63% |
| 3. | City of Hope National Medical Center<br>1500 East Duarte Road<br>Duarte, California | 212 | 63.2% Private/Other<br>19.1% Medi-Cal<br>17.7% Medicare | 10.3 | 74% |
| 4. | Santa Teresita Hospital<br>819 Buena Vista Street<br>Duarte, California | 253 | 57.5% Private/Other<br>19.0% Medi-Cal<br>23.5% Medicare | 22.7 | 66% |
| 5. | San Dimas Community Hospital<br>1350 West Covina Boulevard<br>San Dimas, California | 93 | 48.3% Private/Other<br>30.4% Medi-Cal<br>21.3% Medicare | 6.3 | 56% |
| 6. | Citrus Valley Medical Center<br>1115 South Sunset Avenue<br>West Covina, California | 508 | 55.1% Private/Other<br>16.1% Medi-Cal<br>28.8% Medicare | 4.6 | 69% |
| | **Subject:**<br>Huntington East Valley Hospital<br>150 West Alosta Avenue<br>Glendora, California | 128 | 43.2% Private/Other<br>27.8% Medi-Cal<br>29.0% Medicare | 4.7 | 38% |

GENERAL ACUTE-CARE HOSPITALS

**1) Foothill Presbyterian Hospital** is located approximately one-half mile northwest of the subject. The primary land uses are single-family residential built in the 1950s in average condition, with commercial uses along main thoroughfares. Interstate 210 (Foothill Freeway) is located three-quarters of a mile south. This hospital is in average condition and well maintained. This hospital provides general acute-care services, is licensed for 106 beds and had an occupancy rate of 46%, based upon OSHPD cost reports. The top Diagnosis-Related Groups (DRGs) in descending order are heart failure and shock, simple pneumonia and pleurisy, (ages 17-plus) with complications, chronic obstructive pulmonary disease, specific cerebrovascular disorders except TIA and kidney and urinary tract infections (ages 17-plus) with complications.

2) **Inter-Community Medical Center** is located approximately three and one-half miles south west. The primary land uses are single-family residential built between 1950 and 1960, in average to good condition, with commercial and medical-office uses along main thoroughfares. The hospital is adjacent to Covina Park. Interstate 10 (San Bernardino Freeway) is located one mile south. This hospital is in average condition and well maintained. This hospital provides general acute-care services, is licensed for 246 beds and had an occupancy rate of 63%, based upon OSHPD cost reports. The top DRGs in descending order are psychoses, heart failure and shock, simple pneumonia and pleurisy, (ages 17-plus) with complications, chronic obstructive pulmonary disease and chest pain.

3) **City of Hope National Medical Center** is located approximately six miles west of the subject. The primary land uses are single-family residential built in the 1960s in average condition. The Santa Fe flood control basin is located just east of this hospital. The Interstate 10 (San Bernardino Freeway) and Interstate 605 (San Gabriel Freeway) interchange is located one mile east. This hospital is in good condition and well maintained. This hospital provides general acute-care services and is a nationally known institute for the research and treatment of cancer. The center is licensed for 212 beds and had an occupancy rate of 74%, based upon OSHPD cost reports. The top DRGs in descending order are chemotherapy without acute leukemia as secondary diagnosis and other circulatory system diagnosis without complications.

4) **Santa Teresita Hospital** is located approximately six and one-half miles west of the subject. The primary land uses are commercial with some multifamily residential in average condition. Interstate 210 (Foothill Freeway) is located one-quarter of a mile south. This hospital provides general acute-care and skilled nursing care services, is licensed for 253 beds and had an occupancy rate of 66%, based upon OSHPD cost reports. The top DRGs in descending order are heart failure and shock and simple pneumonia and pleurisy, (ages 17-plus) with complications.

5) **San Dimas Community Hospital** is located approximately three miles southeast of the subject. Primary land uses are single-family residential built between 1960 to the present, with multifamily residences in average condition to the west. Interstate 210 (Foothill Freeway) is located approximately one mile east. This hospital is in good condition and well maintained. This hospital provides general acute-care services, is licensed for 93 beds and had an occupancy rate of 56%, based

upon OSHPD cost reports. The top DRGs in descending order are simple pneumonia and pleurisy, (ages 17-plus) with complications, heart failure and shock, Nutritional and miscellaneous metabolic disorders (ages 17-plus) with complications, specific cerebrovascular disorders except TIA, and G.I. hemorrhage with complications.

**6) Citrus Valley Medical Center** is located approximately seven miles southwest of the subject. The primary land use is single-family residential built between 1950 and 1960 in average condition, with a two-story multi-family residences north of the hospital. Interstate 10 (San Bernardino Freeway) is located one mile north. This hospital provides general acute-care services, is licensed for 508 beds and had an occupancy rate of 69%, based upon OSHPD cost reports. The top DRGs in descending order are heart failure and shock, simple pneumonia and pleurisy, (ages 17-plus) with complications, kidney and urinary tract infections (ages 17-plus) with complications, chronic obstructive pulmonary disease and rehabilitation.

SUMMARY

The subject facility is one of seven acute-care hospitals in the immediate market. Although the San Gabriel Valley includes additional facilities, those selected are located within a seven-mile radius and are most similar to the subject, thus represent the strongest competitors.

## REGIONAL ANALYSIS

The subject property is located in the city of Glendora, California, Los Angeles County. The city of Glendora is located approximately 27 miles east of downtown Los Angeles. Glendora is nestled at the base of the San Gabriel Mountains and offers convenient access to major commercial, cultural, educational and recreational areas in Southern California. Founded in 1887, Glendora was officially incorporated as a city in 1911. The city remained a small citrus-producing community until the late 1950s, when agriculture gave way to large-scale residential and commercial development.

| Population Growth | | | | | | | |
|---|---|---|---|---|---|---|---|
| | 1980 | 1990 | % Change | 2000 | % Change | 2005 | % Change |
| Total Population | | | | | | | |
| Glendora | 45,103 | 47,828 | 6.0% | 51,923 | 8.6% | 54,931 | 5.8% |
| Los Angeles County | 7,477,506 | 8,863,164 | 18.5% | 9,529,721 | 7.5% | 10,050,616 | 5.5% |
| United States | 226,545,776 | 248,709,872 | 9.8% | 274,691,936 | 10.4% | 287,123,328 | 4.5% |
| 65+ Population | | | | | | | |
| Glendora | N/A | 5,057 | N/A | 7,586 | 50.0% | 8,181 | 7.8% |
| Los Angeles County | N/A | 854,734 | N/A | 973,528 | 13.9% | 1,055,190 | 8.4% |
| United States | N/A | 31,172,858 | N/A | 35,740,327 | 14.7% | 37,655,941 | 5.4% |
| 65+ Population, as a % of Total Population | | | | | | | |
| Glendora | | 10.6% | | 14.6% | | 14.9% | |
| Los Angeles County | | 9.6% | | 10.2% | | 10.5% | |
| United States | | 12.5% | | 13.0% | | 13.1% | |
| Median Age | | | | | | | |
| Glendora | | 33.6 | | 38.7 | | 39.4 | |
| Los Angeles County | | 30.5 | | 33.8 | | 35.2 | |
| United States | | 32.8 | | 35.8 | | 36.9 | |

Source: Claritas, Inc.

## POPULATION

The following table summarizes the population trends in Glendora, Los Angeles County and the nation.

The total population is forecasted to grow over the next five years by 5.8% in the city, 5.5% in the county and 4.5% in the nation. The 65-plus aged population is expected to increase by 7.8% in the city, 8.4% in the county and 5.4% in the nation. The median age is expected to increase in the city, county and nation.

## HOUSING

There is a variety of housing available in Glendora, California. The November 2000 median home price for a resale single-family home in the zip codes 91740 and 91741 in the city of Glendora were $235,000 and 279,000, respectively. The 91740 zip code area shows a 32.8% increase from the previous year and the 91741 zip code area shows an 18.5% increase from the previous year. The following table shows the median home values within the Southern California market.

| | Date | Latest Period | Previous Period | Year Ago |
|---|---|---|---|---|
| Median Home Price-Resale (in thousands of dollars) | | | | |
| Los Angeles County | Oct-00 | 219.8 | $223.2 | $195.1 |
| Orange County | Oct-00 | 321.2 | 325.3 | 277.6 |
| San Diego County | Oct-00 | 279.1 | 268.4 | 235.0 |
| Ventura County | Oct-00 | 303.4 | 297.1 | 263.2 |
| Riverside/San Bernardino County | Oct-00 | 144.2 | 140.9 | 131.0 |
| Affordability Index (as percentage of households able to afford median price) | | | | |
| Los Angeles County | Oct-00 | 35% | 34% | 40% |
| Orange County | Oct-00 | 28% | 27% | 32% |
| San Diego County | Oct-00 | 23% | 24% | 31% |
| Ventura County | Oct-00 | 31% | 32% | 38% |
| Riverside/San Bernardino County | Oct-00 | 46% | 47% | 51% |
| Souce: Los Angeles Times, December 10, 2000 | | | | |

**TRANSPORTATION**

The city of Glendora is reasonably well located, benefiting from general proximity to metropolitan centers in the Southern California region. Interstate 210 (Foothill Freeway) runs through the southern portion of the city and provides access to downtown Los Angeles and beach cities to the west, as well as access to San Bernardino Counties to the east. Interstate 605 (San Gabriel Freeway) traverses in a north-south direction, which provides access to Orange County cities. Local transportation is provided by a public bus system.

Ontario International Airport is located sixteen miles east of the subject. This international airport provides air freight and passenger service. Ontario Airport also serves as a regional hub for United Parcel Service, which operates shipping activities by truck, air and train. Los Angeles International Airport is located twenty miles southwest of the city of Alhambra.

Glendora is served by the Metrolink, which provides access to the Los Angeles metropolitan area, Ventura County, Orange County and San Bernardino County.

## EDUCATION

The University of La Verne is located six miles east and the California State Polytechnic University-Pomona is located six miles south. In addition, California State University-Los Angeles is located eighteen miles west, and University of Southern California is located twenty-five miles west, both in the city of Los Angeles. There are six elementary schools, two middle schools and two high schools in the city of Glendora.

## HEALTHCARE

Excluding the subject, there are six acute-care hospitals providing 1,418 beds within a seven-mile radius from the subject. The closest facilities to the subject are summarized as follows:

| Facility | Beds | Distance from Subject (in miles) |
|---|---|---|
| Foothill Presbyterian Hospital | 106 | 0.5 |
| Inter-Community Medical Center | 246 | 3.5 |
| City of Hope National Medical Center | 212 | 6.0 |
| Santa Teresita Hospital | 253 | 6.5 |
| San Dimas Community Hospital | 93 | 3.0 |
| Citrus Valley Medical Center | 508 | 7.0 |
| **Total** | **1,418** | |

## EMPLOYMENT

The following table lists the top employers in Los Angeles County.

| Employer Name | Location | Industry |
|---|---|---|
| Boeing Aircraft Co | Long Beach | Aircraft & Parts |
| Hollywood Park Inc | Inglewood | Misc. Amusement, Recreation Services |
| Hughes Aircraft Co | El Segundo | Search and Navigation Equipment |
| Litton Systems Inc | Woodland Hills | Search and Navigation Equipment |
| Mattel Inc | El Segundo | Toys & Sporting Goods |
| Northrop Grumman Corp | Los Angeles | Aircraft & Parts |
| On Assignment Inc | Calabasas | Personnel Supply Services |
| Ralph's Grocery Co | Compton | Grocery Stores |
| Southern California Edison Co | Rosemead | Electric Services |
| UCLA | Los Angeles | Colleges & Universities |
| Walt Disney Co | Burbank | Motion Picture Production & Services |

Source: California Employment Development Department

As indicated in the following table, the unemployment rates have steadily declined at all levels, over the past three years. Glendora has the lowest level of unemployment, compared to the county and state.

**HISTORICAL UNEMPLOYMENT RATES**

| | 1998 Average | 1999 Average | Year-to-Date Average 2000 |
|---|---|---|---|
| Glendora | 3.8% | 3.4% | 2.7%* |
| Los Angeles County | 6.5% | 5.9% | 5.5% |
| California | 5.9% | 5.2% | 4.9% |

*December 2000 unemployment rate
Source: California Economic Development Department

Historical and forecasted income data for the city and county are summarized in the following table.

| Income Growth | | | | | | | |
|---|---|---|---|---|---|---|---|
| | 1979 | 1990 | % Change | 2000 | % Change | 2005 | % Change |
| Average Household | | | | | | | |
| Glendora | $25,679 | $54,209 | 111.1% | $78,331 | 44.5% | $90,530 | 15.6% |
| Los Angeles County | $22,481 | $47,313 | 110.5% | $65,859 | 39.2% | $74,534 | 13.2% |
| United States | $20,313 | $38,499 | 89.5% | $58,875 | 52.9% | $70,868 | 20.4% |
| Median Household | | | | | | | |
| Glendora | $23,860 | $46,219 | 93.7% | $62,016 | 34.2% | $67,036 | 8.1% |
| Los Angeles County | $17,554 | $35,011 | 99.4% | $44,692 | 27.7% | $47,123 | 5.4% |
| United States | $16,846 | $30,097 | 78.7% | $42,280 | 40.5% | $47,506 | 12.4% |

Source: Claritas, Inc.

The city's median household income is significantly higher than the county and nation and is expected to increase by 8.1% in the city, 5.4% in the county and 12.4% for the nation.

### CONCLUSION

The subject is located in Alhambra, California. The city's overall population growth over the next five years is consistent with the nation. The city's elderly population is expected to increase 7.8%, which is slightly lower than the county (8.4%), yet higher than the nation (5.4%). Income growth is expected to remain stable over the next five years. Based upon the forecasted increase in Glendora's population, the demand for acute-care facilities, should remain relatively constant.

## NEIGHBORHOOD ANALYSIS

Neighborhoods may be devoted to such uses as residential, commercial, industrial, agricultural, and cultural and civic activities, or a mixture of these uses. Analysis of the neighborhood in which a particular property is located is important due to the fact that the various economic, social, political and physical forces that affect the neighborhood also directly influence the individual properties within it. An analysis of these various factors as they affect the value of the subject property is presented in the following discussion.

The subject is located in the western part of the city of Glendora. The district comprises two zip codes (91740 and 91741). The neighborhood boundaries are defined as Foothill Boulevard to the north, East Base Line Road to the south, Lorraine Avenue to the east and Barranca Avenue to the west. The nearest freeways are Interstate 210 (Foothill Freeway) and Interstate 605 (San Gabriel Freeway).

According to demographic information provided by Claritas Inc., the City of Alhambra had a population of 47,828 in 1990 and grew by 0.8% per year to 51,923 in 2000. The population is projected to increase modestly to 54,931 by 2005, an increase of 1.1% per year. The elderly population (age 65-plus) was 5,057 in 1990, or 10.6% of the population, and increased by 5.0% per year to 7,586 in 2000; or to 14.6% of the total population. It is expected to increase by 2.1% per year to 8,181 by 2005; or 14.9% of the total population. The median household income was $46,219 in 1990 and was estimated at $62,016 in 2000, a 3.0% increase per year. The median household income is projected to increase to $67,036 by 2005, a 1.6% increase per year.

Access to the neighborhood is provided by Interstate 210 (Foothill Freeway) and surface streets. The major east-west thoroughfares are Alosta Avenue and Foothill Boulevard. The major north-south thoroughfare is Grand Avenue. Alosta Avenue is a four-lane, with median, major thoroughfare that experiences moderate to heavy traffic. Grand Avenue is a secondary thoroughfare that experiences moderate to heavy traffic.

The neighborhood is approximately 95% built out and has new construction in progress. The Glendora Center, adjacent north across Alosta Avenue, is currently being remodeled. The subject is located in the western part of the city. Most properties in the area are in average condition. Alosta Avenue, a four-lane, with median, thoroughfare that experiences moderate to heavy traffic, is primarily developed with commercial and retail buildings. East of the subject is Glendora Avenue, which is primarily single-family residential built between 1950 and 1960. South of the subject is Colorado Avenue, which is primarily single-family residential built between 1950 and 1980. West of the subject is Santa Fe Avenue, which is primarily single-family residential built in the 1960s. Further southeast is South Hills Park and further west is Citrus College, a two-year college. The neighborhood is currently in a stable stage of its life cycle.

Overall, the neighborhood provides all of the services and amenities needed to support an acute-care facility.

## SITE DESCRIPTION

### LOCATION, ACCESS, FRONTAGE, SIZE AND SHAPE

The subject is located at 150 West Alosta Avenue, in Glendora, California. It is a double-corner site located at southeast corner of Alosta Avenue and Santa Fe Avenue and the northeast corner of Colorado Avenue and Santa Fe Avenue. The site has frontage along Alosta Avenue, Santa Fe Avenue, Colorado Avenue and Glendora Avenue. The subject is accessible via curb cuts along Alosta Avenue, Santa Fe Avenue, Glendora and Colorado Avenue. The subject site is comprised of two parcels (8640-005-050 and 8640-005-051). The hospital is constructed on parcel 8640-005-050 and parcel 8640-005-051 is utilized as parking. The subject site contains an area of 268,351 square feet, and is irregular in shape. A plat map is available in the Addendum.

### TOPOGRAPHY AND DRAINAGE

The site is slightly sloping north to south and at street grade. The entire site is useable. Although the site was observed in a dry condition, drainage appears adequate.

### SOILS HAZARDS

We were not given any information regarding the condition of the sub-soils. No unusual soil conditions were reported to exist by management. No negative impact on property values due to soil conditions is assumed to exist.

## FLOOD ZONE / FAULT HAZARDS

The subject is identified as being in zone C, an area of minimum flooding, according to map 065031, dated August 19, 1975. According to the City of Glendora, the subject site is not located within an earthquake risk area.

## UTILITIES

All typical urban services exist and are available to the subject site, including sewer, water, gas, electricity, sanitation, fire and police protection. Utilities are provided from the following suppliers:

| | | |
|---|---|---|
| Electricity | — | Southern California Edison |
| Gas | — | Southern California Gas Company |
| Water | — | City of Glendora |
| Sewer | — | Los Angeles County |
| Telephone | — | Verizon |

## ZONING

The subject site is zoned MS (Medical Services), CM (Commercial-Manufacturing) and R-1 (Residential) by the City of Glendora, California. Approximately 197,800 square feet is zoned MS, approximately 52,000 square feet is zoned CM and approximately 18,750 square feet is zoned R-1. The MS zone is intended to provide for the development of hospitals, health care and other medical related facilities. The CM zone is intended to provide for the development of commercial areas for retail and service establishments, professional offices, and related enterprises. The R-1 zone is intended to provide for single-family residences, accessory buildings and city facilities. The subject is using the R-1 zoned parcel for ancillary parking. The permitted uses under MS zoning include medical offices, laboratories, pharmacies, limited to the sales of drugs and supplies only, associated with a hospital, medical office or care facility.

The subject is a legal conforming use that will be allowed to continue or be rebuilt if destroyed, with a conditional use permit and with accordance with current development standards, according to the City of Glendora.

The general development restrictions for the subject are as follows.

| Zone | Setbacks | Maximum Building Height | Maximum Density Ratio | Parking Requirements |
|---|---|---|---|---|
| MS | 25 ft. - front yard<br>20 ft. – side yard<br>25 ft. – rear yard | 35 feet or two stories | one bed per 800 feet of building area | one space per bed |
| CM | 20 ft. – front yard<br>20 ft. – side yard<br>10 ft. – rear yard | 35 feet or two stories | none | one space per bed |
| R-1 | 20 ft. – front yard<br>20 ft. – side yard<br>10 ft. – rear yard | 25 feet or two stories | | |

## EASEMENTS/ENCROACHMENTS/RESTRICTIONS

We did not review a property profile on the subject property. It is assumed typical easements exist and provide for availability of utilities such as water, gas and electricity. The easements are deemed to be of the type normally found on a developed parcel and therefore do not adversely affect the marketability of the subject site.

## ASSESSMENT AND TAXES

The subject property is assessed by the Los Angeles County Assessor for the 2000/2001 tax year, and is identified as Assessor's Parcel Numbers 8640-005-050 and 8640-005-051. The subject's real estate tax rate is 1.046452% of assessed value. In addition to the base taxes, there are direct assessments. The subject is owned by a non-profit organization and is exempt from paying the base tax amount. The subject's only real estate tax liability is direct assessments. Upon transfer to a for-profit, the subject will be liable for all taxes. The assessment and taxes applicable to the subject are shown below.

| APN | Land Value | Improvement Value | Direct Assessments | Total Assessed Value | Taxes |
|---|---|---|---|---|---|
| 8640-005-050 | $275,396 | $26,223 | $729.99 | $301,619 | $729.99 |
| 8640-005-051 | $3,472,586 | $3,804,821 | $9,792.47 | $7,277,407 | $9,792.47 |
| **Total** | $3,747,982 | $3,831,044 | $10,522.46 | $7,579,026 | $10,522.46 |

Taxes are reassessed when there is a change in ownership or new construction. In California, real estate assessments are established at the time of transfer or new construction and are thereafter limited to a 2% annual increase. Therefore, the use of comparable tax data is not appropriate.

## IMPROVEMENTS DESCRIPTION

### BUILDING

Building plans for the subject were available for review. The following is based on a personal inspection on January 8, 2001 and discussions with the facility engineer. It is assumed that all information provided by Management is correct. The subject site is improved with an acute-care hospital.

A detailed description of the subject hospital facility is summarized below.

| | |
|---|---|
| GENERAL INFORMATION | |
| Name of building | Huntington East Valley Hospital |
| Occupancy | general acute-care hospital |
| Number of Beds | 128 |
| Quality of Construction | average |
| General Condition | average |
| Number of Stories | one, plus partial basement and penthouse |
| Size | 87,550 square feet which includes a 24,000 square foot partial basement and 1,055 square foot office penthouse |
| Date of Construction | 1958 with additions in 1966, 1969 and 1986 |
| GENERAL CONSTRUCTION | |
| Site Preparation | Excavation and grading |
| Foundation | Reinforced concrete |
| Frame | wood and poured concrete |
| Exterior Walls | built up painted stucco on wire mesh and poured reinforced concrete |

| | |
|---|---|
| Floors | basement levels are reinforced concrete slab on a compacted base |
| Roof | flat |
| FINISH CONSTRUCTION | |
| Roof Cover | 0.045 mil E.P.D.M. Centrimark fully adhered roofing system with rubber flashings |
| Partitioning and Built-In Items | drywall over mainly wood studs divides the facility into three surgical suites, four nursing stations, administrative and medical staff offices, cafeteria, intensive care, geropsych department, laboratory, patient rooms, nurses' stations, post partum/womens health department and physical therapy department<br>poured concrete divides the mechanical rooms, engineering department, receiving, utility/storage rooms and diagnostic imaging/X-ray |
| Ceilings | mainly drywall along corridors, with the remaining being acoustic panels |
| Floor Coverings | primarily vinyl tile along corridors with commercial carpeting in administrative offices and ceramic tile in kitchen |
| MECHANICAL EQUIPMENT | |
| Plumbing | typical hospital plumbing system, consisting of toilets, sinks, urinals, waste soil, one tub in ER, eight shower rooms, medical gas and two public restrooms, patient rooms include a toilet and sink |
| Heating, Ventilating and Air Conditioning | forty-one roof-mounted package units, one (Rite) 30 hp boiler and two (one Bryant and one Parker) 35 hp boilers, two 60-ton cooling towers, one 20-ton chiller, one 25-ton chiller, one 75-ton chiller, one 1,500-gallon liquid oxygen tank |
| Electrical | 1,200-amp, 480-volt, 3-phase, 4-wire main panel; one 115 KW (Onan) and one 100 KW (Caterpillar) emergency generator with a 550-gallon subterranean diesel tank |
| OTHER FEATURES | 100% wet sprinkler coverage; fire alarms, smoke detectors, emergency call system, infant abduction alarm system, one elevator, one commercial washer and one large-capacity dryer |

LAYOUT

The subject consists of the following type and number of beds:

| Type of Room | Number of Beds |
|---|---|
| Perinatal | 30 |
| Coronary | 5 |
| Intensive Care | 5 |
| General Acute/Med Surg | 67 |
| Acute Psychiatric | 21 |
| Total | 128 |

**SENATE BILL 1953**

California Senate Bill 1953 imposes stringent new earthquake standards for all general acute-care hospitals in California. According to an article in Modern Healthcare,[11] the requirements could cost the state's hospitals in excess of $24 billion. The main deadlines for compliance are summarized as follows.

| SENATE BILL 1953 DEADLINES | |
|---|---|
| January 1, 2001 | Submit a seismic evaluation report, including compliance and cost plans, to the Office of Statewide Health Planning and Development (OSHPD) |
| January 1, 2002 | Comply with standards for communication systems, emergency power supply bulk medical gas systems and fire alarms |
| January 1, 2008 | Complete upgrades designed to prevent a structural collapse |
| January 1, 2030 | Comply with standard to ensure continued operation after a quake |

In September 2000, Governor Gray Davis signed three bills (SB 1801, SB 2006 and AB 2194) to extend, in most cases by five years, the 2008 deadline hospitals to discontinue acute-care services in buildings considered unsafe. The three bills Davis signed:

- Extend preliminary compliance with most seismic upgrades to 2013 from 2008. In exchange, by 2013 hospital will have to have a least one basic service housed in a structure that is up to the final seismic regulations, which go into effect 2030.

[11] *Modern Healthcare* – "California Hospital on Shaky Ground," by Ron Shinkman and Mary Chris Jaklevic, July 10, 2000.

- Allow hospitals in zones less prone to major earthquakes the opportunity to push back preliminary compliance with the laws to 2030 from 2008.
- Grant the two state agencies that monitor hospitals (OSHPD and Department of Health Services) the power to license temporary structures to house patients while upgrades take place.

Management has indicated that the probable construction costs for structural, non-structural, and ADA upgrade work required before 2002 (upgrade to NPC 2) to permit acute-care operations beyond 2002 is $170,400. In addition, Management has indicated that the probable construction costs for structural, non-structural, and ADA upgrade work required before 2008 (upgrade to SPC 2 and SPC 3) to permit acute-care operations beyond 2008 is $4,800,000. The total construction costs to permit acute-care operations until 2030 is $4,970,400.

## SITE IMPROVEMENTS

The subject site is improved with asphalt paving, concrete walks, parking lot, courtyard areas, signage and mature landscaping with an automatic irrigation system. The parking area can accommodate approximately 181 cars. In addition, there is a large loading area in connection with the south side of the hospital. The subject is required to have a total of 64 parking spaces (one space per one bed). The subject is a legal conforming use that will be allowed to continue or be rebuilt, if destroyed.

## DEPRECIATION

### PHYSICAL

The subject's improvements were constructed in 1958 with additions in 1966, 1969 and 1986, with additions completed in 1966 and 1969. The ICU was built in 1986. The roof was replaced at an estimated cost of $298,120. Plant operations coordinator indicated that the old 550-gallon subterranean diesel fuel tank for the emergency generator will be replaced; however, no estimate has been established. The facility and grounds were in average condition at the time of our inspection with no significant deferred maintenance. The mechanical components appeared and were reported to be in adequate working order. The interior is maintained and in average repair. No significant roof leakage was reported, and no leakage or water stains were apparent at inspection. The quality of construction is average.

FUNCTIONAL

The overall utility of the design of the subject improvements is typical and adequate for their current use as a hospital. No functional obsolescence was noted.

ECONOMIC/EXTERNAL

No adjacent land uses appear detrimental to the use of the subject. Demographics indicate stability for future demand. No alternative use is suggested that would generate a higher net return to the land.

**EQUIPMENT**

Equipment includes the normal complement of items (nursing, patient care, office, laundry, kitchen, dining, activities and therapy) necessary to serve an acute-care hospital. A detailed inventory of the equipment is beyond the scope of this assignment. The equipment appeared to be of adequate quantity and quality to adequately service patient needs and is in average condition.

**SUMMARY**

The subject improvements comprise an acute-care hospital facility. The improvements are of average quality and in average condition and exhibit no significant signs of deferred maintenance. No significant functional or economic obsolescence was noted and the subject is well suited to provide acute-care services.

## HIGHEST AND BEST USE

Highest and best use may be defined as:

> "the reasonably probable and legal use of vacant land or an improved property, which is physically possible, appropriately supported, financially feasible, and that results in the highest value."[12]

[12] *The Appraisal of Real Estate*, page 297.

For existing properties, two analyses of highest and best use are required. The first is the highest and best use "as vacant," which assumes that the actual improvements do not exist. The outcome of the highest and best use "as vacant" determines how the land value will be determined. The second highest and best use analysis is "as improved," which considers the actual improvements.

The highest and best use of the land "as vacant" may be different from the highest and best use of the improved property. This may be true when the improvement is not the maximally productive use yet still makes a contribution to the total property in excess of land value.

The highest and best use of both the land as though vacant and the property as improved must meet four criteria. The highest and best use must be legally permissible, physically possible, financially feasible and maximally productive.

**Legally Permissible** – uses that are allowed by private restrictions, zoning, building codes, historic districts, environmental regulations and possible long term leases.

**Physically Possible** - considers the size, shape, area, terrain, accessibility of a parcel and the risk of natural disasters such as floods or earthquakes.

**Financially Feasible** - which uses are likely to satisfy operating expenses, financial obligation, and capital amortization. All uses that are expected to produce a positive return are regarded as financially feasible.

**Maximally Productive** - of the financially feasible uses, the use that produces the highest residual land value consistent with the rate of return warranted by the market for that use is the highest and best use.

## HIGHEST AND BEST USE AS THOUGH VACANT

Highest and best use as though vacant assumes that the subject site is vacant and available for development.

LEGALLY PERMISSIBLE

The subject site is zoned MS (Medical Services), CM (Commercial-Manufacturing) and R-1 (Residential), by the City of Glendora. Approximately 197,800 square feet is zoned MS, approximately 52,000 square feet is zoned CM and approximately 18,750 square feet is zoned R-1. The MS zone is intended to provide for the development of hospitals, health care and other medical related facilities. The CM zone is intended to provide for the development of commercial areas for retail and service establishments, professional offices, and related enterprises. The R-1 zone is intended to provide for single-family residences, accessory buildings and city facilities. The subject is using the R-1 zoned parcel for ancillary parking. The permitted uses under MS zoning include medical offices, laboratories, pharmacies, limited to the sales of drugs and supplies only, associated with a hospital, medical office or care facility.

The subject is a legal conforming use that will be allowed to continue or be rebuilt if destroyed, with a conditional use permit and with accordance with current development standards, according to the City of Glendora.

Only typical utility easements exist on the subject site, which do not limit its potential development.

PHYSICALLY POSSIBLE

The size, shape, available utilities, terrain, accessibility and risk of natural disasters all affect potential development of the subject site. The subject site is irregular in shape, slightly sloping north to south and at street grade. It contains 268,351 square feet and is a double-corner lot.

The subject site provides good functional utility for several potential developments. The site soils appear adequate to support a variety of development types. All public utilities are available and of adequate capacity to support a wide variety of development. The subject's most limiting physical characteristic is its size. The subject could support most of the legally permitted uses.

Based upon the legal constraints, as set forth by the zoning district and the surrounding uses in the subject's immediate area in conjunction with the site's physical characteristics, the most probable use is some type of medical related use.

FINANCIALLY FEASIBLE

The next step in the analysis is to consider the financial feasibility of those uses which are legally permitted and physically possible. Any use of the subject site, which provides an acceptable financial return to the land is financially feasible. The primary test is whether the particular use results in a market value that is high enough to cover all development costs, or whether the income generated by the property is sufficient to satisfy all operating expenses. Based upon the development activity of sites in the area, a hospital and medical related uses are financially feasible.

MAXIMALLY PRODUCTIVE

The use that produces the highest residual land value is the highest and best use. Therefore, the maximally productive use of the subject, assuming it is vacant and available for development, is as a site for a medical center.

## HIGHEST AND BEST USE AS IMPROVED

This analysis considers the property with the existing improvements in place. The highest and best use of the property as improved is analyzed for the following two reasons.

1. To identify the property use that can be expected to produce the highest overall return for each dollar of capital invested.
2. The principle of consistent use applies the collection and selection of data. All the comparable data used later in this report were partially selected due to their similar highest and best use.

The same four tests that are applied to arrive at the highest and best use as though vacant are also applied to determine the highest and best use as improved.

LEGALLY PERMISSIBLE

The subject site is presently improved with a wood and poured concrete frame, one-story, acute-care hospital containing 87,550 square feet licensed for a total of 128 beds. The improvements are legally conforming to current zoning regulations and may be rebuilt, with a conditional use permit and in accordance with current zoning requirements if destroyed. Considering the density and configuration of the existing improvements, any addition to the property is not warranted.

PHYSICALLY POSSIBLE

The current improvements consist of an 87,550-square-foot hospital facility, which adequately serves its intended function, and therefore, pass the physically possible test. Considering the density and configuration of the existing improvements, any addition to the property is not warranted. As indicated in the description of improvements deferred maintenance was not noted. In order to continue operations past January 1, 2002 and January 1, 2008, earthquake upgrades will be necessary. The cost of work to comply with SB 1953 is estimated by Management at $170,400 by January 1, 2002 and $4,800,000 by January 1, 2008.

FINANCIALLY FEASIBLE AND MAXIMALLY PRODUCTIVE

Three basic questions addressed in the financially feasible analysis are as follows.

- Do the improvements contribute to the land value?
- Should the improvements be modified?
- Should the improvements be left alone?

The method used to determine if the existing improvements are contributing to the overall property is to compare the estimated total market value derived in this report to the value of the site less the cost of demolition. If the latter is higher, this indicates that the existing improvements should be replaced. If it is similar to the total value, then the existing improvements are an interim use. But, if the value of the site less demolition is much lower than the overall value, the existing improvements reflect a financially feasible use.

Based on the conclusions within this report, the value of the subject property after the cost of SB 1953 earthquake upgrades is higher than the value of the subject site. Therefore, existing improvements add considerable value to the site and are a financially feasible use.

No other use is feasible considering the cost of conversion and the subject's surrounding uses. The financially feasible and maximally productive use of the subject is for continuation of its current use and the completion of SB 1953 upgrades.

## VALUATION METHODOLOGY

An appraisal is an orderly process in which the data used to estimate the value of the subject property is acquired, classified, analyzed and presented. Appraisal methodology applied to any specific property or property types must emulate the rationale of market participants. The first step is defining the appraisal problem, i.e., the identification of the real estate, the effective date of value, the property rights being appraised and the type of value sought. Once this has been accomplished, the appraiser collects and analyzes the factors that affect the market value of the subject property.

There are three recognized approaches in the valuation of real property: the cost, sales comparison and income capitalization approaches. The type and age of the property and the quality and quantities of available data affect the applicability of each approach in a specific appraisal situation.

The basic tenet of all three appraisal approaches is the principle of substitution. This principle is defined as follows:

> "When several similar or commensurate commodities, goods, or services are available, the one with the lowest price attracts the greatest demand and widest distribution."[13]

[13] *The Appraisal of Real Estate*, page 43.

This principle assumes rational, prudent market behavior, with no undue cost due to delay. According to the principle of substitution, a buyer will not pay more for a property than another that is equally desirable. It affirms that a prudent purchaser has three alternative courses of action available: to buy a vacant site and build a similar property (Cost Approach), to acquire an equally desirable existing property offering comparable utility (Sale Comparison Approach) or to acquire a substitute income stream of comparable quality, quantity and durability (Income Capitalization Approach).

> In the **Cost Approach**, the current cost of constructing the subject improvements is estimated, less all forms of depreciation plus the market value of the underlying land. The result is the indicated property value via the Cost Approach.
>
> The **Sales Comparison Approach** involves a search for recent sales and current listings of comparable properties and an analysis of the selected data as they relate to the subject. The two indicators of value employed in this approach are the price per bed and the earnings before interest, taxes, depreciation and amortization multipliers (EBITDA). In valuing hospitals, the most common unit of comparison is the EBITDA. The first method is based on selecting an EBITDA multiplier, which is derived from the market data, and multiplying it by the subject's estimated EBITDA. The second method, price per bed, is used as a check of reasonableness. Based upon these two techniques, an estimate of value via the Sales Comparison Approach is determined.
>
> The **Income Capitalization Approach** involves an estimate of a property's capacity to produce income. This method involves estimating market rent for the subject property, typical vacancy and credit loss rates and expenses. From this, an estimate of the net operating income can be generated. There are two primary methods to value the income stream of a property, one is the Direct Capitalization Method which capitalizes the net operating income by a single rate derived from the market. The second method is a Discounted Cash Flow Analysis which projects the income and expense streams for a specified holding period. The ultimate reversion from the sale of the property at the end of the holding period is also considered. Since the property is not at a stabilized operating level, the Discounted Cash Flow Analysis will be employed.

The final step in the valuation process is the reconciliation of the three value indications into a single conclusion of value for the subject. The reliability and precision of each approach are considered along with possible inconsistencies with the other approaches. Thus, certain approaches may be emphasized because of more reliable data and analyses, or because of a greater degree of relevance to the behavior of the marketplace.

The subject will be valued utilizing all three approaches to value. The Cost Approach will be presented first followed by the Sales Comparison Approach and the Income Capitalization Approach. The valuation will conclude with a reconciliation of the three approaches and a final estimate of value.

Value estimates determined by the Cost, Sales Comparison and Income Capitalization approaches are rounded to the nearest $10,000.

## COST APPROACH

The Cost Approach is divided into three segments: the land value estimate, the estimated cost new of the improvements, and the depreciation estimate. The Cost Approach is also known as the summation approach because at the end of the approach the three segments are brought together to derive an indication of value. Each one of these three processes is further described later in this section.

### LAND VALUATION

Anticipation, change, supply, and demand, substitution and balance are appraisal principles that influence land value. The subject is valued in accordance with its highest and best use and assumed to be vacant. The procedures used to value vacant land are as follows.

**Sales Comparison** - sales of similar parcels of land are analyzed, compared and adjusted to provide a value indication for the land being appraised.

**Allocation** - allocates total value, including improvements, to land and building. The principles of balance and related concept of contribution affirms that there is a typical ratio of land value to property value for specific categories of real estate in specific locations. This method is typically used when adequate land sales do not exist.

**Extraction** - land value is extracted from the sale price of an improved property by deducting the value contribution of the improvements, estimated at their depreciated costs.

**Income Capitalization** – converts, via a capitalization or discount rate, a cash flow attributable to the land into value.

The Sales Comparison procedure is the most common technique for valuing land and it is the preferred method when comparable sales are available. Based upon the quantity and quality of the available data herein, the Sales Comparison procedure is used to estimate land value.

SURVEY OF COMPARABLE LAND DATA

In order to estimate the value of the subject site, an extensive survey was conducted for comparable sales, sales negotiations and offerings of vacant or minimally improved sites within the surrounding area. Commercially zoned land in the subject area is purchased, sold and valued on a price per square foot basis. The unit of comparison used in this analysis is the price per square foot. The data most pertinent in formulating an opinion of value are presented below. A sheet summarizing the sales along with a map is located in the Addendum.

**Huntington East Valley Hosptial**
**Summary of Comparable Land Data**

| | Land Sale 1 | Land Sale 2 | Land Sale 3 |
|---|---|---|---|
| Location | 456 E. Foothill Bl. | 100 W. Foothill Bl. | NEC Irwindale/Cam. Cantera |
| City | San Dimas | San Dimas | Irwindale |
| Date | 4/6/00 | 9/20/99 | 3/5/99 |
| Zoning | CH | AP | M2S |
| Size | 53,580 | 67,953 | 44,640 |
| Price | $532,000 | $638,000 | $500,000 |
| Price/SF | $9.93 | $9.39 | $11.20 |

The above comparables indicate an unadjusted price range of $9.39 to $11.20 per square foot.

Adjustments were made for factors such as property rights conveyed, financing terms, conditions of sale, market conditions (time), location, access and visibility, and physical characteristics, such as topography, shape and size and zoning.

EXPLANATION OF ADJUSTMENTS

**Property Rights:** All of the comparables reflect fee simple estates. Therefore, no adjustments are required.

**Financing:** Our verification process indicates that the prices of the transactions used in this analysis are considered to be cash-equivalent prices. No adjustments are warranted for this factor.

**Conditions of Sale:** This adjustment takes into account any unusual conditions or circumstances that may affect the sales or listing price. Utilities and off-site improvements were available to all of the comparables. All the comparable sales sold vacant and ready for development. Information gathered through the search and verification process indicates that all buyers and sellers were typically motivated with no undue influences. No adjustments are required to these sales.

**Market Conditions:** The next adjustment was made to account for the influence of change in market conditions between the transaction dates and the date of valuation. The land comparables have transacted within the last 22 months. During this time, there has been no significant pressure on land prices. Therefore, adjustments are not applied for market conditions.

**Location:** The location adjustment is the next category considered. Factors such as the quality of the surrounding improvements, proximity to arterials and business centers, and convenience to residential neighborhoods are all influences that affect the location, and hence, the value of a site. The subject is located in the western part of the city of Glendora. The neighborhood is approximately 95% built out and has new construction in progress. The Glendora Center, adjacent north across Alosta Avenue, is currently being remodeled. The subject is located in the western part of the city. Most properties in the area are in average condition. Alosta Avenue, a four-lane, with median, thoroughfare that experiences moderate to heavy traffic, is primarily developed with commercial and retail buildings. East of the subject is Glendora Avenue, which is primarily single-family residential built between 1950 and 1960. South of the subject is Colorado Avenue, which is primarily single-family residential built between 1950 and 1980. West of the subject is Santa Fe Avenue, which is primarily single-family residential built in the 1960s. Further southeast is South Hills Park and further west is Citrus College, a two-year college. The neighborhood is currently in a stable stage of its life cycle.

Comparable Land Sale 1 is located three and one-half miles east of the subject. The site is currently vacant. The intended use is to build a two-story office building. The primary neighborhood land uses south of the site are single-family residences in average condition built in the 1970s. The primary land uses along Foothill Boulevard are commercial with some townhomes northeast of the site. Foothill

Boulevard is a moderately traveled thoroughfare. The overall access, visibility, quality and condition of the surroundings are inferior. An upward adjustment is warranted.

Comparable Land Sale 2 is located three miles east of the subject. This site has been improved with a church. The primary neighborhood land uses are single-family residential in average to good condition built between 1970 to the present. East of the site is a plant nursery and to the west is a three-story office building. Foothill Boulevard is a moderately traveled thoroughfare. The overall access, visibility, quality and condition of the surroundings are inferior. An upward adjustment is warranted.

Comparable Land Sale 3 is located four miles west of the subject. This site has been improved with a "Farmer Boys" fast food restaurant. The primary neighborhood land uses are commercial light industrial and office. These improvements are in average to good condition. The site is approximately two hundred feet north of Interstate 210 (Foothill Freeway). Irwindale Avenue is a major thoroughfare that experiences moderate to heavy traffic. The overall access, visibility, quality and condition of the surroundings are superior. A downward adjustment is warranted.

**Zoning:** The subject property is zoned MS, CM and R-1. Approximately 197,800 square feet is zoned MS, approximately 52,000 square feet is zoned CM and approximately 18,750 square feet is zoned R-1. The MS zone is intended to provide for the development of hospitals, health care and other medical related facilities. The CM zone is intended to provide for the development of commercial areas for retail and service establishments, professional offices, and related enterprises. The R-1 zone is intended to provide for single-family residences, accessory buildings and city facilities. The subject is using the R-1 zoned parcel for ancillary parking. The permitted uses under MS zoning include medical offices, laboratories, pharmacies, limited to the sales of drugs and supplies only, associated with a hospital, medical office or care facility. Surrounding land uses are primarily commercial with some single-family residential uses.

All of the comparable land sales have similar commercial zoning, which allow for similar uses. Therefore, no adjustments are warranted.

**Topography:** The subject property's topography is slightly sloping north to south and at street grade, which does not hinder its overall utility. All of the comparable sales have similar topography and do not require adjustment.

**Shape:** The shape of a land parcel is a primary factor in determining the utility of the site. It limits, as well as strongly influences the type of configuration of the improvements developed on the land. The subject site is irregular in shape. The shape is adequate for most types of development. Comparable sales 1 and 3 are rectangular in shape; therefore a downward adjustment is warranted. Comparable Sale 2 is irregular in shape and does not require adjustment.

**Corner/Interior:** The adjustment takes into consideration the positive effect upon the value of a corner site versus an interior location. The subject site is a double-corner site that has frontage on Alosta Avenue, Santa Fe Avenue, Glendora Avenue and Colorado Avenue. Alosta is a main thoroughfare that experiences moderate to heavy traffic. Comparable sales 1 and 3 are interior lots and warrant upward adjustments.

**Size:** The subject property contains an area of 268,351 square feet of land. The land comparables range in size from 44,640 square feet to 67,953 square feet. Typically, a larger property will sell for a lower price per square foot compared to an otherwise similar but smaller property due to economies of scale and other factors. All the comparable land sales are smaller and warrant downward adjustments.

The Comparable Land Sales Adjustment Grid is presented on the following page:

**Huntington East Valley Hosptial**
**Comparable Land Data Adjustment Grid**

| | Subject<br>150 West Alosta Avenue<br>Glendora | | Land Sale 1<br>456 E. Foothill Bl.<br>San Dimas | Land Sale 2<br>100 W. Foothill Bl.<br>San Dimas | Land Sale 3<br>NEC Irwindale/Cam. Cantera<br>Irwindale |
|---|---|---|---|---|---|
| Parcel Data | | | | | |
| Assessor's ID | 8640-005-050 and 051 | | 8861-018-034, -035 | 8661-013-036, -037, -040 | 8616-022-027 |
| Zoning | MS, CM and R-1 | | CH | AP | M2S |
| Topography | Level | | Slightly Sloping | Level | Level |
| Shape | Irregular | | Rectangular | Irregular | Rectangular |
| Corner/Interior | Interior | | Interior | Corner | Interior |
| Size (SF) | 270,453 | | 53,580 | 67,953 | 44,640 |
| Sales Data | | | | | |
| Recording | N/A | | 0513964 | 1779461 | 0365877 |
| Date | N/A | | 4/6/00 | 9/20/99 | 3/5/99 |
| Interest | Fee Simple | | Fee simple | Fee simple | Fee simple |
| Price | N/A | | $532,000 | $638,000 | $500,000 |
| Price Per SF | N/A | | $9.93 | $9.39 | $11.20 |
| Adjustments | | | | | |
| Property Rights | | | 0 | 0 | 0 |
| | | | 532,000 | 638,000 | 500,000 |
| Financing | | | 0 | 0 | 0 |
| | | | 532,000 | 638,000 | 500,000 |
| Conditions of Sale | | | 0 | 0 | 0 |
| | | | 532,000 | 638,000 | 500,000 |
| Market Conditions | | | 0 | 0 | 0 |
| Adjusted Sale Price | | | 532,000 | 638,000 | 500,000 |
| Adjusted Price Per SF | | | $9.93 | $9.39 | $11.20 |
| Adjustments | | | | | |
| Location | | | 5.0% | 5.0% | -10.0% |
| Zoning | | | 0.0% | 0.0% | 0.0% |
| Topography | | | 0.0% | 0.0% | 0.0% |
| Shape | | | -5.0% | 0.0% | -5.0% |
| Corner/Interior | | | 5.0% | 0.0% | 5.0% |
| Size | | | -5.0% | -5.0% | -5.0% |
| Overall Adjustment | | | 0.0% | 0.0% | -15.0% |
| Adjusted Price Per SF | | | $9.93 | $9.39 | $9.52 |
| Low | $9.39 | | | | |
| High | $9.93 | | | | |
| Median | $9.52 | | | | |
| Mean | $9.61 | | | | |
| Conclusion | $9.50 | X | 268,351 | = | $2,549,335 |
| Rounded | | | | | $2,550,000 |

## CONCLUSION OF LAND VALUE

After adjustments, the above comparables indicate a range in value of $9.39 to $9.93 per square foot, with a mean and median of $9.61 per square foot and $9.52 per square foot, respectively. Comparable sales 1 and 2 are most similar to the subject due to location, surrounding land uses and requiring the least amount of overall adjustments (0%) and are given primary emphasis. Comparable Sale 3 required an overall adjustment of 15% due to location, access and frontage along a major thoroughfare and the close proximity to Interstate 210 (Foothill Freeway). This land sale was given secondary emphasis.

Based on our analysis, it is our opinion that the indicated value of the subject site is $9.50 per square foot. Land value is therefore estimated as follows:

| | | | | |
|---|---|---|---|---|
| $9.50 PSF | x | 268,351 SF | = | $2,549,335 |
| Rounded | | | | $2,550,000 |

**BUILDING AND SITE IMPROVEMENTS VALUATION**

The building and land improvements have been valued on the basis of replacement cost new less accrued depreciation. The cost new was estimated via the calculator cost method with cost factors obtained from *Marshall Valuation Service*, a nationally recognized cost manual. The unit cost is based on gross building area. *Marshall Valuation Service* includes all direct costs and the following indirect costs:

- Plans, specifications and building permits
- The cost of interim money during normal periods of construction, not discount points or permanent financing charges.
- Sales tax on materials.
- Contractor's overhead and profit, includes workman's compensation, fire and liability insurance and unemployment insurance.

DIRECT COSTS

Direct costs include only the hard costs associated with the construction of the building. We have utilized the Calculator Cost Method from *Marshall Valuation Service*. This method provides the average base cost for typical buildings classified by construction class and quality of construction. The subject building is a wood and poured concrete frame one-story, with partial basement and penthouse, acute-care hospital containing 87,550 square feet. The subject is of average quality construction. The base cost per square foot of gross building area is as follows.

| | |
|---|---|
| Category | General Hospitals |
| Section/Page | 15/24 |
| Quality | average |
| Base Cost | $106.55 |

Adjustments to the base cost include fire sprinklers, elevators, height, perimeter, time and location.

Site improvements include all improvements excluding the building. These typically include parking lots, signage, fencing, lighting, landscaping and walkways. In calculating these costs, we used the cost-per-square-foot method from *Marshall Valuation Service* and added any extra improvement costs not covered by this method. Site improvements are estimated at $2.00 per square foot of the site area less the building footprint, or $2.00 x (268,351 square feet – 62,495 square-foot building footprint), equating to $410,000, rounded.

INDIRECT COSTS

The indirect costs include such items as financing points, the property taxes on land during construction and entrepreneurial profit.

**Financing:** Financing points are estimated at 2.0%, based on a 75% loan-to-value ratio of the direct costs of the building and site improvement plus land value and equipment.

**Property Taxes:** Taxes are calculated based on the market value of the land during construction, assumed to take twelve months. This time frame is based on estimations received from contractors who specialize in the construction of convalescent hospitals.

**Entrepreneurial Profit:** This profit is a necessary element in the enticement for undertaking the cost and risks associated with developing a property such as the subject. The amount of entrepreneurial profit varies according to economic conditions and types of development, exhibiting a fairly wide range. An entrepreneurial profit of 10.0% of direct and indirect costs is utilized in this analysis.

DEPRECIATION

Depreciation of a structure is its loss in value due to physical deterioration, and obsolescence. These terms are defined as follows:

**Physical Deterioration:** The loss in value due to ordinary wear and tear, i.e. age and natural forces taking their toll on the improvements. This begins at the time the building is completed and continues throughout its physical life.

**Functional Obsolescence:** An element of accrued depreciation resulting from deficiencies or super adequacies in the structure.

**External Obsolescence:** An element of accrued depreciation; a defect, usually incurable, caused by negative influences outside a site and general incurable on the part of the owner, landlord or tenant.

In estimating the overall economic life of the improvements, data on economic lives taken from *Marshall Valuation Service* was considered. The assignment of an economic life assumes that, except for the building shell and foundation, shorter-lived building components will be replaced periodically over the life of the building.

The amount of depreciation and obsolescence in the subject building is judged to be typical for a facility of its age. Inspection of the property indicated that the structure and related component parts have been adequately maintained through a continuous maintenance service program.

The subject property was built in 1958 with additions in 1966, 1969 and 1986. The subject physical plant is in average condition. The actual age of the building is 15 to 43 years and the effective age of is estimated at 25 years. Based on tables in *Marshall Valuation Service*, the building is estimated to have an economic life of 45 years. Economic life is the period over which the improvements to the real estate contribute to the value of the property.

The amount of depreciation attributable to the property has been estimated on a straight-line age/life basis. Straight-line depreciation is founded on the assumption that depreciation of a property occurs at the same rate throughout its economic life. The straight-line depreciation percentage is estimated at 55.6% (25 years / 45 years).

The elements that make up site improvements typically have shorter economic lives than the life of the building. We have estimated the aggregate economic lives of these items to be 20 years, with an effective age of 10 years. The straight-line depreciation percentage is estimated at 50.0% (10 years / 20 years).

No functional or external obsolescence was noted.

## EQUIPMENT VALUATION

Depreciated equipment values for hospitals range from $10,000 to $50,000 per bed. The low end of this range represents equipment that is either spare in quantity, low in quality or highly depreciated. The upper end of the range maybe would be expected at a newer facility, a facility with a higher percentage of outpatient equipment, or a hospital with very advanced equipment. A detailed inventory and valuation of the equipment is beyond the scope of this assignment. According to Management, the value of the equipment, net depreciation for the year-end December 31, 2000, was $1,287,074. This equates to $10,055 per bed. For the purposes of this report, the net depreciated value has been utilized.

| | | |
|---|---|---|
| Net Book Value | = | $1,287,074 |
| Rounded | | $1,290,000 |

The Cost Approach is summarized on the following page:

| Huntington East Valley Hosptial<br>Summary of Cost Approach - As Is Value | | |
|---|---|---|
| Base Cost | $106.55 | |
| $/SF Adjustments | | |
| Sprinklers | $1.50 | |
| Elevators | $0.00 | |
| | $108.05 | |
| Multipliers | | |
| Stories | 1.00 | |
| Perimeter | 1.00 | |
| Time | 1.04 | |
| Location | 1.13 | |
| Adjusted Base Cost | $126.98 | |
| Gross Building Area | 87,550 | |
| Direct Cost - Building | | 11,117,131 |
| Direct Cost - Site Improvements | | 410,000 |
| Total Direct Costs | | $11,527,131 |
| Indirect Costs | | |
| Financing Points | 224,357 | |
| Taxes During Construction | 31,875 | |
| Entrepreneurial Profit | 1,140,000 | |
| Total Indirect Costs | | 1,396,232 |
| Replacement Cost New | | 12,513,362 |
| Depreciation | | |
| SB 1953 Upgrades | 4,970,400 | |
| Physical - Buildings | 4,041,485 | |
| Physical - Site Improvements | 134,145 | |
| Functional Obsolescence | - | |
| External Obsolescence | - | |
| Total Depreciation | | 9,146,030 |
| Depreciated Replacement Cost | | 3,367,333 |
| Land Value | | 2,550,000 |
| Equipment | | 1,290,000 |
| Indicated Value - Cost Approach | | 7,207,333 |
| Rounded | | 7,200,000 |

COST APPROACH SUMMARY

Based on the aforementioned data and analysis, the market value via the Cost Approach of the assets comprising the subject property, is represented in the following rounded amount:

| | |
|---|---|
| Land | $2,550,000 |
| Improvements | 3,370,000 |
| Equipment | 1,290,000 |
| Total Via Cost Approach | $7,200,000 |

## SALES COMPARISON APPROACH

The Sales Comparison Approach is a method of estimating value by comparing prices paid for similar properties. Property prices are a direct function of the balance between supply and demand for real estate. This approach, like the Cost Approach, is based upon the principle of substitution. The principle of substitution implies that a prudent investor will not pay more for a property than it would cost to buy a substitute property with similar utility and desirability. The reliability of this approach is dependent upon the availability of recent sales or listings of competitive properties in the market and the degree of comparability of each sale with the appraised property.

The primary unit of comparison used in this approach is a multiple of EBITDA or EBDIT. EBITDA stands for earnings before interest, taxes, depreciation and amortization. EBDIT is the same, minus amortization. The purchase of hospitals traditionally has been based on a per-bed multiple, but buyers and sellers today indicate EBITDA and EBDIT numbers are a more accurate indicator of how much a hospital is worth. This is especially true since approximately 30% of the average hospital's revenues were generated from outpatient services in 1995, according to HCIA, a Baltimore-based healthcare research firm. A multiplier in the range of four to eight times EBITDA is considered reasonable by most of the investor-owned chains.

We have carefully investigated the public markets within the health-care industry to identify publicly traded companies, which operate acute-care hospitals. Four companies were identified which are

judged to have a reasonable degree of comparability with the subject. Although the selected comparable companies differ in important respects from the subject, they are generally influenced by similar business, economic and regulatory conditions and are considered to offer alternative investment opportunities. The financial data for these companies is summarized on the following pages.

**Market Comparative Companies**
**Income Statement Data**
**($ Millions)**

| | Quorum Health Group, Inc. | Tenet Healthcare Corp. | Universal Health Services, Inc. | HCA Healthcare Company |
|---|---|---|---|---|
| **Years Ended** | **Jun-00** | **May-00** | **Dec-99** | **Dec-99** |
| Sales | 1,762.8 | 11,414.0 | 2,042.4 | 16,657.0 |
| Cost of Goods Sold | 445.5 | 4,120.0 | 828.8 | 5,841.0 |
| Gross Operating Profit | 1,317.3 | 7,294.0 | 1,213.6 | 10,816.0 |
| S, G & A Expense | 1,058.1 | 5,359.0 | 944.0 | 8,018.0 |
| Operating Profit (EBITDA) | 259.2 | 1,935.0 | 269.6 | 2,798.0 |
| Depreciation & Amort. | 108.5 | 533.0 | 108.3 | 1,094.0 |
| **Operating Profit (EBIT)** | **150.7** | **1,402.0** | **161.3** | **1,704.0** |
| Other Income | 18.2 | 71.0 | (5.3) | (130.0) |
| Special Income/Charges | (8.5) | (355.0) | 0.0 | 181.0 |
| Total Income Available for Interest Expense | 160.4 | 1,118.0 | 156.0 | 1,755.0 |
| Interest Expense | 67.2 | 479.0 | 26.9 | 471.0 |
| Minority Interest | 2.1 | 21.0 | 6.3 | 57.0 |
| **Pre-tax Income** | **91.1** | **618.0** | **122.8** | **1,227.0** |
| Income Taxes | 35.6 | 278.0 | 45.0 | 570.0 |
| **Net Income** | **55.5** | **340.0** | **77.8** | **657.0** |
| Preferred Dividends | 0.00 | 0.01 | 0.00 | 0.06 |
| Common Dividends | 0.00 | 0.00 | 0.00 | 0.00 |
| Retained Earnings (in Thousands) | 425,709.0 | 1,627,000.0 | 482,960.0 | 4,599,000.0 |

## Market Comparative Companies
## Balance Sheet Data
## ($ Millions)

| | Quorum Health Group, Inc. | Tenet Healthcare Corp. | Universal Health Services, Inc. | HCA Healthcare Company |
|---|---|---|---|---|
| **Years Ended** | **Jun-00** | **May-00** | **Dec-99** | **Dec-99** |
| **Assets** | | | | |
| Current Assets: | | | | |
| Cash and Equivalents | 13.9 | 135.0 | 6.2 | 190.0 |
| Receivables | 348.0 | 2,506.0 | 307.3 | 2,051.0 |
| Inventories | 41.1 | 223.0 | 41.2 | 383.0 |
| Other Current Assets | 48.0 | 730.0 | 48.6 | 973.0 |
| Total Current Assets | 451.0 | 3,594.0 | 403.3 | 3,597.0 |
| Property, Plant & Equipment: | | | | |
| Property, Plant & Equipmet, Gross | 1,245.2 | 8,141.0 | 1,214.9 | 14,084.0 |
| Accumulated Depreciation | 392.3 | 2,247.0 | 437.8 | 5,594.0 |
| Net Property, Plant & Equipment | 852.9 | 5,894.0 | 777.1 | 8,490.0 |
| Other Long Term Assets: | | | | |
| Long-Term Investments | | | | |
| Intangibles | 222.2 | 3,329.0 | 276.0 | 2,319.0 |
| Other Long-Term Assets | 330.2 | 344.0 | 41.7 | 2,479.0 |
| Total Long-Term Assests | 1,405.3 | 9,567.0 | 1,094.8 | 13,288.0 |
| **Total Assets** | **1,856.3** | **13,161.0** | **1,498.1** | **16,885.0** |
| | | | | |
| **Liabilities and Equity** | | | | |
| Current Liabilities: | | | | |
| Short Term Debt | 0.8 | 9.0 | 3.5 | 1,160.0 |
| Accounts Payable | 97.5 | 671.0 | 105.3 | 657.0 |
| Income Taxes Payable | 0.0 | 0.0 | 0.0 | 0.0 |
| Other Current Liabilities | 98.9 | 1,232.0 | 108.4 | 1,515.0 |
| Total Current Liabilities | 197.2 | 1,912.0 | 217.2 | 3,332.0 |
| Long-Term Liabilities: | | | | |
| Long-Term Debt | 851.0 | 5,668.0 | 419.2 | 5,284.0 |
| Other Long-Term Liabilities | 44.9 | 10,224.0 | 73.7 | 1,889.0 |
| Deferred Taxes & Investment Tax Credit | 31.0 | 491.0 | 30.6 | 0.0 |
| Minority Interest | 64.1 | 0.0 | 115.6 | 763.0 |
| Total Long-Term Liabilities | 991.0 | 16,383.0 | 639.1 | 7,936.0 |
| **Total Liabilities** | **1,188.2** | **18,295.0** | **856.3** | **11,268.0** |
| Shareholders' Equity: | | | | |
| Preferred Stock | 0.0 | 0.0 | 0.0 | 0.0 |
| Common Stock Equity | 668.1 | 4,066.0 | 641.6 | 5,617.0 |
| Retained Earnings | 425,709.0 | 1,627,000.0 | 482,960.0 | 4,599,000.0 |
| **Total Shareholders' Equity** | **668.1** | **4,066.0** | **641.6** | **5,617.0** |
| | | | | |
| **Total Liabilities and Equity** | **1,856.3** | **22,361.0** | **1,497.9** | **16,885.0** |

## Market Comparative Companies
## Financial Data
## ($ Millions)

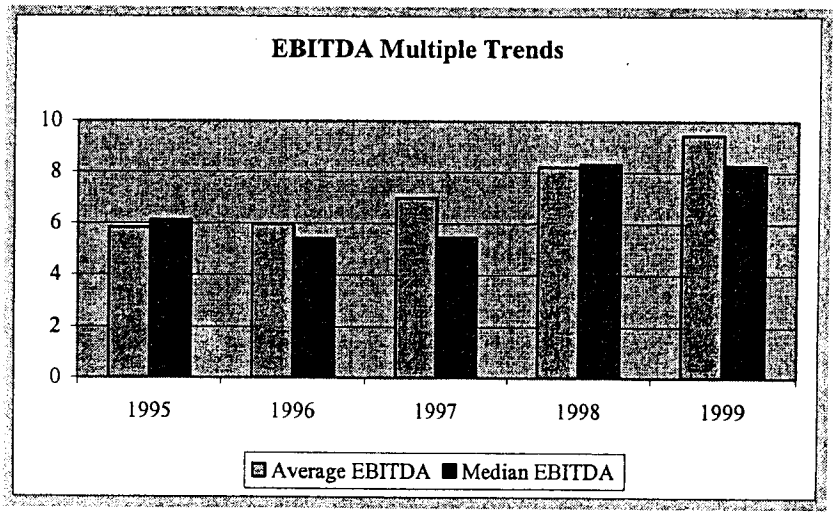
| Years Ended | Quorum Health Group, Inc. Jun-00 | Tenet Healthcare Corp. May-00 | Universal Health Services, Inc. Dec-99 | HCA Healthcare Company Dec-99 | High | Low | Average | Median |
|---|---|---|---|---|---|---|---|---|
| Net Sales | 1,317.3 | 7,294.0 | 1,213.6 | 10,816.0 | 10,816.0 | 1,213.6 | 5,160.2 | 4,305.7 |
| EBITDA | 259.2 | 1,935.0 | 269.6 | 2,798.0 | 2,798.0 | 259.2 | 1,315.5 | 1,102.3 |
| Depreciation and Amortization | 108.5 | 533.0 | 108.3 | 1,094.0 | 1,094.0 | 108.3 | 461.0 | 320.8 |
| EBIT | 150.7 | 1,402.0 | 161.3 | 1,704.0 | 1,704.0 | 150.7 | 854.5 | 781.7 |
| Interest Expense | 67.2 | 479.0 | 26.9 | 471.0 | 479.0 | 26.9 | 261.0 | 269.1 |
| Net Income | 55.5 | 340.0 | 77.8 | 657.0 | 657.0 | 55.5 | 282.6 | 208.9 |
| Preferred Dividends | 0.0 | 0.0 | 0.0 | 0.1 | 0.1 | 0.0 | 0.0 | 0.0 |
| Current Assets | 451.0 | 3,594.0 | 403.3 | 3,597.0 | 3,597.0 | 403.3 | 2,011.3 | 2,022.5 |
| Net Fixed Assets | 852.9 | 5,894.0 | 777.1 | 8,490.0 | 8,490.0 | 777.1 | 4,003.5 | 3,373.5 |
| Total Assets | 1,856.3 | 13,161.0 | 1,498.1 | 16,885.0 | 16,885.0 | 1,498.1 | 8,350.1 | 7,508.7 |
| Debt in Current Liabilities | 0.8 | 9.0 | 3.5 | 1,160.0 | 1,160.0 | 0.8 | 293.3 | 6.3 |
| Current Liabilities | 197.2 | 1,912.0 | 217.2 | 3,332.0 | 3,332.0 | 197.2 | 1,414.6 | 1,064.6 |
| Long-Term Debt | 851.0 | 5,668.0 | 419.2 | 5,284.0 | 5,668.0 | 419.2 | 3,055.6 | 3,067.5 |
| Total Liabilities | 1,188.2 | 18,295.0 | 856.3 | 11,268.0 | 18,295.0 | 856.3 | 7,901.9 | 6,228.1 |
| Minority Interest | 64.1 | 0.0 | 115.6 | 763.0 | 763.0 | 0.0 | 235.7 | 89.9 |
| Common Equity | 668.1 | 4066.0 | 641.6 | 5617.0 | 5,617.0 | 641.6 | 2,748.2 | 2,367.1 |
| Shareholders' Equity | 668.1 | 4066.0 | 641.6 | 5617.0 | 5,617.0 | 641.6 | 2,748.2 | 2,367.1 |
| Comm Shares Outst | 71.3 | 313.5 | 30.7 | 564.3 | | | | |
| Stock Price - Five Year Avg. & YTD 2000 | 16.21 | 27.32 | 46.33 | 35.78 | | | | |
| Most Recent Qtrly. Data - As of: | | | | | | | | |
| Growth Rates: | | | | | | | | |
| Sales - Most Recent Year | 1,762.8 | 11,414.0 | 2,042.4 | 16,657.0 | 16,657.0 | 1,762.8 | 7,969.1 | 6,728.2 |
| Sales - 3 Years Average | 1,662.6 | 10,729.7 | 1,786.5 | 18,052.3 | 18,052.3 | 1,662.6 | 8,057.8 | 6,258.1 |
| EPS - From Recent Year | 0.72 | 1.02 | 2.43 | 1.11 | 2.4 | 0.7 | 1.3 | 1.1 |
| EPS - 3 Years Average | 0.79 | 1.03 | 2.28 | 0.44 | 2.3 | 0.4 | 1.1 | 0.9 |
| Market Value of Common Stock | 1,155.8 | 8,563.3 | 1,422.2 | 20,191.6 | 20,191.6 | 1,155.8 | 7,833.2 | 4,992.7 |
| Price per Book Value | 1.5 | 3.0 | 3.9 | 4.3 | 4.3 | 1.5 | 3.2 | 3.4 |
| Price Per Cash Flow | 6.3 | 14.2 | 14.2 | 17.8 | 17.8 | 6.3 | 13.1 | 14.2 |
| **Mkt Value of Comm Stock to:** | | | | | | | | |
| Earnings before Depr and Taxes (EBITDA) | 6.0 | 5.9 | 5.9 | 8.7 | 8.7 | 5.9 | 6.6 | 6.0 |
| Net Income | 20.8 | 25.2 | 18.3 | 30.7 | 30.7 | 18.3 | 23.8 | 23.0 |
| Cash Flow | 7.0 | 9.8 | 7.6 | 11.5 | 11.5 | 7.0 | 9.0 | 8.7 |
| Book Value of Common Equity | 1.7 | 2.1 | 2.2 | 3.6 | 3.6 | 1.7 | 2.4 | 2.2 |

The capitalization multiple applied in our analysis is the ratio of the market value of fixed and intangible assets (MVF and IA) to earnings before interest, taxes, depreciation and amortization (EBITDA). These capitalization multiples are then analyzed to determine a representative multiple applicable to Huntington East Valley Hospital. The selected multiple is then applied to the subject's corresponding financial results to produce an indication of fixed and intangible asset value for the hospital.

The capitalization multiples indicated by the selected publicly traded companies ranged from 5.9 to 8.7. These are investor quality healthcare corporations. The appropriate multiple is required to account for a controlling interest position in the subject, the relative lack of marketability of the hospital's assets, the hospital's size relative to the comparable companies, and risks and benefits unique to the subject.

In a May 1994 survey, HCIA estimated EBDIT multiples generally range from three to six times EBITDA for acute-care facilities. Modern Healthcare, October 2, 1995, indicates that hospital chains typically pay between five and seven times EBITDA.

As further support for current EBITDA multiples in the market place, we have reviewed *The Hospital Acquisition Report, Sixth Edition, 2000* published by Irving Levin Associates, Inc. The accompanying table summaries the report's findings.



To calculate the value of the facility, based upon an EBITDA multiple, consideration was given to the overall expense ratio and the subject's occupancy. Based upon an analysis of the subject's revenue located in the Income Capitalization Approach section of this report, the subject hospital's EBITDA is estimated to be $2,900,597. It is our opinion that the subject's value would be reasonably represented by an EBDIT multiple of 5.5. This would indicate an overall value estimate for the subject facility as follows.

| | | | | |
|---|---|---|---|---|
| $2,900,597 | x | 5.5 | = | $15,953,284 |
| Less BD 1953 Costs | | | | 4,970,000 |
| Rounded | | | | $11,000,000 |

This method of valuation has been cross-referenced by the sales price per bed method. The sales price per bed is calculated by dividing the sales price of the hospital by the number of licensed beds.

In conducting this analysis, we have researched the national marketplace for the purpose of identifying recent sales of hospitals. From the information that was developed, the sales utilized have been selected as being indicative of the level of value for facilities similar to the subject. To the best of our knowledge, all property rights transferred were fee simple and included all equipment. The sales were considered arm's-length transactions and did not include any special or creative financing, except where noted. For the purpose of our analysis, we assume that the transactions contain all assets of the business enterprise, including working capital and intangible assets.

Numerous factors can influence the purchase price and resulting purchase price per bed of hospital facilities. The facilities utilized in our analysis vary in terms of size, physical features, bed licensure, occupancy, payor mix, profitability, geographic location, market niche and conditions and services offered.

Overall occupancy and the commercial insurance and private-pay ratio are two important factors impacting the profitability of a hospital. Generally, the higher a facility's occupancy rate and private pay ratio, the higher its revenues will be. Of utmost importance in the operation of a hospital is the utilization review and management function in which treatments and DRGs are monitored as to maximize both the quality of care and hospital profitability. In a well managed facility in which

expenses are contained at reasonable levels and utilization and DRGs are closely monitored, an increase in revenue may result in an increase in profitability. Since the profitability of a business is a key element in determining its value, facilities with a high occupancy level and private-pay ratio tend to be more valuable. In some situations, specialization in certain treatments and special programs may enhance the value of a hospital. For example, the availability of obstetrical, gynecological, ontological, rehabilitation and other program services may be highly profitable for a hospital. In this regard, facilities with the ability to provide such services within a market area demanding these services may exhibit increased profitability and sell for higher prices per bed.

In the final analysis, future expected profitability is the most important element in determining the market value of a business enterprise. To a large degree, the profitability of a hospital depends upon many of the factors previously discussed, such as building size, age, condition, location, competitive environment, payor mix, occupancy rates, special programs and treatment specializations.

It is important to stress the limitations of the Sales Comparison Approach in valuing a hospital. Although a market analysis can provide a general barometer of how investors in the marketplace price similar facilities, the operations, financial performance, assets and potential of each hospital differ.

As previously discussed, hospitals may transfer at prices substantially above and also below the aforementioned range. In certain situations the price per bed at the low end of the range may relate to under-performing hospitals, hospitals which operate in highly competitive market areas with an over saturation of beds and/or other physical or operational attributes which exert downward pressure on the purchase price per bed. Numerous factors may result in comparatively lower prices per bed; however, given the variation that exists between hospitals, it may be difficult to determine which factors have substantially influenced the purchase price. However, in the case of under-performing hospitals, the market is useful in that it provides an estimate of per bed values associated with under-performing hospitals that may be exhibiting operating losses. In these instances, a Discounted Cash Flow Analysis may not be meaningful in that it often yields a conclusion below that which an investor or the market would place on such a facility. In some cases, the sales reflecting lower prices per bed may relate to hospitals operating at low profitability levels or losses and/or may reflect the price a buyer is paying for the facility with the intention of either a "turnaround" situation or an alternate use

scenario. In some cases, these types of sales may approach a real estate value. However, it is important to note that the market has indicated that under-performing hospitals, including those exhibiting operating losses, have value in the marketplace.

The comparable acute-care hospital sales used in our analysis are included on the following page.

## Acute Care Hospital Sales

| Date | Name | Location | Beds | Price | $/Bed |
|---|---|---|---|---|---|
| Dec-99 | Medical Center of Southern Indiana | Charelstown, Indiana | 80 | $2,000,000 | $25,000 |
| Dec-99 | Orange County Hospital | Paoli, Indiana | 37 | $1,800,000 | $48,649 |
| Dec-99 | Palm Drive Hospital | Sebastopol, California | 38 | $5,900,000 | $155,263 |
| Nov-99 | Greater Southeast Community Hospital | Washington, DC | 260 | $22,300,000 | $85,769 |
| Nov-99 | Holly Springs Memorial Hospital | Holly Springs, Mississippi | 20 | $1,000,000 | $50,000 |
| Oct-99 | Atlantic Medical Center-Ormond | Ormond Beach, Florida | 99 | $13,900,000 | $140,404 |
| Oct-99 | Atlantic Medical Center-Daytona | Daytona Beach, Florida | 172 | $14,000,000 | $81,395 |
| Oct-99 | Phoenix Regional Medical Center | Phoenix, Arizona | 174 | $29,500,000 | $169,540 |
| Oct-99 | Lloyd Noland Hospital | Fairfield, Alabama | 294 | $21,200,000 | $72,109 |
| Oct-99 | Olympia Fields Osteopathic Hospital | Olympia Fields, Illinois | 163 | $40,000,000 | $245,399 |
| Oct-99 | Senatobia Community Hospital | Senatobia, Mississippi | 72 | $4,700,000 | $65,278 |
| Oct-99 | Northwest Medical Center | Franklin, Pennsylvania | 222 | $52,000,000 | $234,234 |
| Oct-99 | MacNeal Health Network | Berwyn, Illinois | 427 | $210,000,000 | $491,803 |
| Oct-99 | Trinity Valley & Minden Medical | Palestine, TX & Minden, LA | 274 | $77,000,000 | $281,022 |
| Sep-99 | De Queen Regional Medical Center | De Queen, Arkansas | 116 | $4,500,000 | $38,793 |
| Sep-99 | Stones River Hospital | Woodbury, Tennessee | 41 | $2,000,000 | $48,780 |
| Sep-99 | West Anaheim & Huntington Beach | Anaheim & Huntington Beach, CA | 304 | $40,700,000 | $133,882 |
| Sep-99 | Delta Medical Center | Memphis, Tennessee | 151 | $3,584,000 | $23,735 |
| Aug-99 | Culver Union Hospital | Crawfordsville, Indiana | 98 | $70,000,000 | $714,286 |
| Aug-99 | 5 Paracelsus Hospitals | Salt Lake City, Utah | 640 | $280,000,000 | $437,500 |
| Aug-99 | 10 Tenent Hospitals | Arizona, Florida & Texas | 1,780 | $520,000,000 | $292,135 |
| Aug-99 | Evanston Regional Hospital | Evanston, Wyoming | 38 | $10,000,000 | $263,158 |
| Aug-99 | Panhandle Surgical Hospital | Amarillo, Texas | 21 | $27,900,000 | $1,328,571 |
| Jul-99 | Columbia Regional Hospital | Columbia, Missouri | 210 | $34,500,000 | $164,286 |
| Jun-99 | Selma District Hospital | Selma, California | 57 | $8,200,000 | $143,860 |
| Jun-99 | Beaumont & Silsbee Hospital | Beaumont, Texas | 284 | $13,600,000 | $47,887 |
| Jun-99 | Kendall Regional Medical Center | Miami, Florida | 235 | $105,000,000 | $446,809 |
| May-99 | Highsmith-Rainey Memorial Hospital | Fayetteville, North Carolina | 139 | $37,000,000 | $266,187 |
| May-99 | Forbes Metropolitan Hospital | Pittsburgh, Pennsylvania | 155 | $5,200,000 | $33,548 |
| Apr-99 | Bossier Medical Center | Bossier City, Louisiana | 113 | $27,900,000 | $246,903 |
| Apr-99 | Paracelsus Bledsoe County Hospital | Pikeville, Tennessee | 32 | $2,200,000 | $68,750 |
| Apr-99 | Glades General Hospital | Belle Glade, Florida | 65 | $16,700,000 | $256,923 |
| Apr-99 | Hood River Memorial Hospital | Hood River Oregon | 32 | $19,500,000 | $609,375 |
| Apr-99 | Community Hospital of Lancaster | Lancaster, Pennsylvania | 124 | $19,500,000 | $157,258 |
| Mar-99 | Caritas/Canton Healthcare | Cleveland, Ohio | 1,022 | $65,000,000 | $63,601 |
| Mar-99 | Palm Drive Hospital | Sebastopol, California | 38 | $2,800,000 | $73,684 |
| Feb-99 | Allegheny University Hospitals West | Pittsburgh, Pennsylvania | 1,274 | $495,000,000 | $388,540 |
| Feb-99 | Nassau County Medical Center | East Meadow, New York | 531 | $70,000,000 | $131,827 |
| Jan-99 | Grant Hospital | Chicago, Illinois | 199 | $17,500,000 | $87,940 |

The data utilized in our analysis reflects a price per licensed-bed range of $23,735 to $1,328,571 with a mean and median of $220,874 and $143,860, respectively. Numerous factors can influence the purchase price and resulting purchase price per bed of hospital facilities. The facilities utilized in our analysis vary in terms of size, physical features, bed licensure, occupancy, payor mix, profitability, geographic location, market niche and conditions and services offered. Due to the large number of variables that can impact the purchase price of a hospital, a direct comparison between the subject and the sale properties based on specific adjustments is not considered to be meaningful.

### SALES COMPARISON APPROACH CONCLUSION

Most weight in this analysis has been placed on the EBITDA multiplier method as outpatient revenues account for a large portion of gross revenues and is not adequately considered in the sales price per bed method. Based on the subject's 128 licensed beds, the value indicated by the EBITDA multiple method equates to a value of $85,938 per bed. Also, the price per bed method of determining value for a hospital is not considered to be meaningful due to the myriad of variables involved in the sale properties' physical plants and management of the hospital operations. Therefore, based on the EBITDA multiplier method, the indicated fee simple value of the assets comprising the subject, via the Sales Comparison Approach, is reasonably represented in the rounded amount as follows:

$11,000,000

## INCOME CAPITALIZATION APPROACH

Properties such as the subject are normally valued based on their ability to generate an income stream characterized by their quality, quantity and desirability. Hence, analysis of a property in terms of its ability to provide sufficient net annual return on investment capital is an important means of developing a value indication. This estimate is developed in the Income Capitalization Approach by capitalizing the projected net income at a rate commensurate with investment risks inherent to the ownership of the property. Such conversion of income considers competitive returns offered by alternative investment opportunities. When properly applied, this approach provides a reliable indication of value for income-producing properties.

An initial step in the Income Capitalization Approach is to estimate the gross income which can be generated by the appraised property. The projected income stream is based on an estimate of the gross annual income applicable to an acute-care facility less allowances for contractual deductions and uncollectible accounts. Once this estimate is established, we can derive an estimate of net revenue (effective gross income) for the subject. Expenses are then deducted to arrive at a property's net operating income. The value of the property can then be estimated through two capitalization techniques: Direct Capitalization Method and/or a Discounted Cash Flow Analysis (DCF).

In this report, the Direct Capitalization Method and Discounted Cash Flow Analysis are employed to estimate the fee simple value since the subject is currently not a stabilized operation.

**HISTORICAL PERFORMANCE**

In estimating income and expenses for the subject property, we have relied upon financial data provided by the subject's management, the State of California, as well as on our experience in appraising properties of this nature.

The historical data provided by Management includes income/expense statements and census data for fiscal years ended December 30, 1997, 1998, 1999 and annualized eleven months ending November 30, 2000. In addition, the perspective buyer has provided an income and expense pro forma for 2001, 2002 and 2003.

The available revenue and expense data is analyzed on an occupied bed basis and as a percentage of revenue. This historical and forecast data is summarized on the following pages.

**Huntington East Valley Hosptial**
**Table 1 - Historical Census Data**

| | Year Ending 12/31/97 | Year Ending 12/31/98 | Year Ending 12/31/99 | Annualized 11 Months 11/30/00 | Prospective Buyer's Budget 12/31/01 | Prospective Buyer's Budget 12/31/02 | Prospective Buyer's Budget 12/31/03 |
|---|---|---|---|---|---|---|---|
| Adjusted Patient Days | 21,064 | 24,774 | 21,829 | 21,851 | 24,875 | 25,933 | 26,992 |
| Average Daily Census | 57.7 | 67.9 | 59.8 | 59.9 | 68.2 | 71.0 | 74.0 |
| Licensed Beds | 144 | 144 | 144 | 144 | 144 | 144 | 144 |
| Available Patient Days | 52,560 | 52,560 | 52,560 | 52,560 | 52,560 | 52,560 | 52,560 |
| Occupancy Rate | 40.1% | 47.1% | 41.5% | 41.6% | 47.3% | 49.3% | 51.4% |
| Discharges | 3,101 | 3,366 | 3,528 | 3,337 | 3,656 | 3,656 | 3,656 |
| Average Length of Stay | 6.79 | 7.36 | 6.19 | 6.55 | 6.80 | 7.09 | 7.38 |
| Outpatient Visits | 14,947 | 15,399 | 15,846 | 15,993 | 17,166 | 17,896 | 18,597 |
| Inpatient Days | 13,361 | 16,083 | 16,501 | 16,469 | 17,155 | 17,885 | 18,615 |

**Huntington East Valley Hosptial**
**Table 2 - Income and Expense Data, Per Patient Day**

| | Year Ending 12/31/97 | | Year Ending 12/31/98 | | Year Ending 12/31/99 | | Annualized 11 Months 11/30/00 | | Prospective Buyer's Budget 12/31/01 | | Prospective Buyer's Budget 12/31/02 | | Prospective Buyer's Budget 12/31/03 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | $ | PPD | $ | PPD | $ | PPD | $ | PPD | $ | PPD | $ | PPD | $ | PPD |
| Patient Revenue | | | | | | | | | | | | | | |
| Routine | 10,492,281 | $498.11 | 12,585,323 | $508.01 | 13,254,251 | $607.19 | 12,306,097 | $563.19 | - | $0.00 | - | $0.00 | - | $0.00 |
| Inpatient | 26,137,764 | 1,748.70 | 31,592,352 | 2,113.62 | 34,512,653 | 1,581.05 | 31,774,974 | 1,454.18 | - | 0.00 | - | 0.00 | - | 0.00 |
| Outpatient | 12,396,233 | 588.50 | 15,213,426 | 614.09 | 16,377,304 | 750.25 | 18,840,390 | 862.23 | - | 0.00 | - | 0.00 | - | 0.00 |
| Net Capitation | - | 0.00 | - | 0.00 | 141,857 | 6.50 | 150,934 | 6.91 | - | 0.00 | - | 0.00 | - | 0.00 |
| Gross Patient Revenue | 49,026,278 | 2,327.49 | 59,391,101 | 2,397.32 | 64,286,065 | 2,944.98 | 63,072,396 | 2,886.50 | | 0.00 | | 0.00 | | 0.00 |
| Total Deductions From Revenue | 29,145,765 | 1,383.68 | 38,256,158 | 1,544.21 | 43,530,211 | 1,994.15 | 42,544,690 | 1,947.05 | - | 0.00 | - | 0.00 | - | 0.00 |
| Net Patient Revenue | 19,880,513 | 943.81 | 21,134,943 | 853.11 | 20,755,854 | 950.84 | 20,527,706 | 939.45 | 25,399,916 | 1,021.10 | 27,287,939 | 1,052.25 | 29,088,105 | 1,077.66 |
| Other Revenue | 2,123,744 | 100.82 | 3,617,007 | 146.00 | 716,522 | 32.82 | 225,345 | 10.31 | 96,000 | 3.86 | 96,000 | 3.70 | 96,000 | 3.56 |
| Net Revenue | 22,004,257 | 1,044.64 | 24,751,950 | 999.11 | 21,472,376 | 983.66 | 20,753,051 | 949.76 | 25,495,916 | 1,024.96 | 27,383,939 | 1,055.95 | 29,184,105 | 1,081.21 |
| Operating Expenses: | | | | | | | | | | | | | | |
| Salaries & Wages | 10,551,042 | 500.90 | 11,793,835 | 476.06 | 11,262,485 | 515.94 | 11,563,560 | 529.20 | 12,442,361 | 500.20 | 13,077,716 | 504.29 | 13,739,608 | 509.03 |
| Professional Fees | 2,196,029 | 104.26 | 2,699,802 | 108.98 | 2,598,098 | 119.02 | 2,483,214 | 113.64 | 2,672,617 | 107.44 | 2,704,378 | 104.28 | 2,841,140 | 105.26 |
| Supplies | 2,455,072 | 116.55 | 2,748,520 | 110.94 | 2,846,763 | 130.41 | 3,016,121 | 138.03 | 3,525,079 | 141.71 | 3,675,082 | 141.71 | 3,825,086 | 141.71 |
| Utilities | 452,799 | 21.50 | 434,861 | 17.55 | 417,300 | 19.12 | 426,554 | 19.52 | 450,000 | 18.09 | 450,000 | 17.35 | 450,000 | 16.67 |
| Purchased Services | 1,464,936 | 69.55 | 3,118,682 | 125.89 | 3,431,980 | 157.22 | 2,056,215 | 94.10 | 2,213,338 | 88.98 | 2,239,640 | 86.36 | 2,352,901 | 87.17 |
| Insurance | 352,462 | 16.73 | 235,601 | 9.51 | 285,379 | 13.07 | 333,432 | 15.26 | 350,000 | 14.07 | 350,000 | 13.50 | 350,000 | 12.97 |
| Building Rental | 295,607 | 14.03 | 294,062 | 11.87 | 287,906 | 13.19 | 287,688 | 13.17 | 286,535 | 11.52 | 295,131 | 11.38 | 303,985 | 11.26 |
| Equipment Rental | 163,196 | 7.75 | 218,587 | 8.82 | 114,037 | 5.22 | 166,546 | 7.62 | 166,127 | 6.68 | 171,111 | 6.60 | 176,244 | 6.53 |
| Bad Debt | 848,848 | 40.30 | 322,431 | 13.01 | 983,622 | 45.06 | 511,464 | 23.41 | 362,999 | 14.59 | 391,319 | 15.09 | 418,322 | 15.50 |
| Property Tax | - | 0.00 | - | 0.00 | - | 0.00 | - | 0.00 | - | 0.00 | - | 0.00 | - | 0.00 |
| Other | 675,978 | 32.09 | 738,087 | 29.79 | 728,080 | 33.35 | 424,478 | 19.43 | 675,827 | 27.17 | 716,118 | 27.61 | 749,119 | 27.75 |
| Management Fee | 216,000 | 10.25 | 283,200 | 11.43 | 219,658 | 10.06 | 216,257 | 9.90 | 300,000 | 12.06 | 300,000 | 11.57 | 300,000 | 11.11 |
| Reserves for Replacement | - | 0.00 | - | 0.00 | - | 0.00 | - | 0.00 | - | 0.00 | - | 0.00 | - | 0.00 |
| Total Operating Expenses | 19,671,969 | 933.91 | 22,887,668 | 923.86 | 23,175,308 | 1,061.68 | 21,485,528 | 983.28 | 23,444,883 | 942.51 | 24,370,495 | 939.75 | 25,506,405 | 944.96 |
| EBITDA | $2,332,288 | 110.72 | $1,864,282 | 75.25 | -$1,702,932 | -78.01 | -$732,477 | -33.52 | $2,051,033 | 82.45 | $3,013,444 | 116.20 | $3,677,700 | 136.25 |

Annualixed 2000 includes the following adjustments through the eleven month period.

Note:adjust the other revenue for $204,000-to reverse revenue asssociated with joint venture which was terminated.

Note: adjust medical physician fees $80,000-to reserve for cost of recruiting physician.

**Huntington East Valley Hosptial**

**Table 3 - Income and Expense Data, % of Revenue**

| | Year Ending 12/31/97 | | Year Ending 12/31/98 | | Year Ending 12/31/99 | | Annualized 11 Months 11/30/00 | | Prospective Buyer's Budget 12/31/01 | | Prospective Buyer's Budget 12/31/02 | | Prospective Buyer's Budget 12/31/03 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | $ | % of Rev. | $ | % of Rev. | $ | % of Rev. | $ | % of Rev. | $ | % of Rev. | $ | % of Rev. | $ | % of Rev. |
| Patient Revenue | | | | | | | | | | | | | | |
| Routine | $10,492,281 | 21.4% | $12,585,323 | 21.2% | $13,254,251 | 20.6% | $12,306,097 | 19.5% | $0 | | $0 | | $0 | |
| Inpatient | 26,137,764 | 53.3% | 31,592,352 | 53.2% | 34,512,653 | 53.7% | 31,774,974 | 50.4% | 0 | | 0 | | 0 | |
| Outpatient | 12,396,233 | 25.3% | 15,213,426 | 25.6% | 16,377,304 | 25.5% | 18,840,390 | 29.9% | 0 | | 0 | | 0 | |
| Gross Patient Revenue | 49,026,278 | 100.0% | 59,391,101 | 100.0% | 64,286,065 | 100.0% | 63,072,396 | 100.0% | 0 | | 0 | | 0 | |
| Total Deductions From Revenue | 29,145,765 | | 38,256,158 | | 43,530,211 | | 38,931,305 | | 0 | | 0 | | 0 | |
| Net Patient Revenue | 19,880,513 | | 21,134,943 | | 20,755,854 | | 20,527,706 | | 25,399,916 | | 27,287,939 | | 29,088,105 | |
| Other Revenue | 2,123,744 | | 3,617,007 | | 716,522 | | 225,345 | | 96,000 | | 96,000 | | 96,000 | |
| Net Revenue | 22,004,257 | 100.0% | 24,751,950 | 100.0% | 21,472,376 | 100.0% | 20,753,051 | 100.0% | 25,495,916 | 100.0% | 27,383,939 | 100.0% | 29,184,105 | 100.0% |
| Operating Expenses: | | | | | | | | | | | | | | |
| Salaries & Wages | 10,551,042 | 53.1% | 11,793,835 | 55.8% | 11,262,485 | 54.3% | 11,563,560 | 56.3% | 12,442,361 | 49.0% | 13,077,716 | 47.9% | 13,739,608 | 47.2% |
| Professional Fees | 2,196,029 | 11.0% | 2,699,802 | 12.8% | 2,598,098 | 12.5% | 2,483,214 | 12.1% | 2,213,338 | 8.7% | 2,704,378 | 9.9% | 2,841,140 | 9.8% |
| Supplies | 2,455,072 | 12.3% | 2,748,520 | 13.0% | 2,846,763 | 13.7% | 3,016,121 | 14.7% | 3,525,079 | 13.9% | 3,675,082 | 13.5% | 3,825,086 | 13.2% |
| Utilities | 452,799 | 2.3% | 434,861 | 2.1% | 417,300 | 2.0% | 426,554 | 2.1% | 450,000 | 1.8% | 450,000 | 1.6% | 450,000 | 1.5% |
| Purchased Services | 1,464,936 | 7.4% | 3,118,682 | 14.8% | 3,431,980 | 16.5% | 2,056,215 | 10.0% | 2,213,338 | 8.7% | 2,239,640 | 8.2% | 2,352,901 | 8.1% |
| Insurance | 352,462 | 1.8% | 235,601 | 1.1% | 285,379 | 1.4% | 333,432 | 1.6% | 350,000 | 1.4% | 350,000 | 1.3% | 350,000 | 1.2% |
| Building Rental | 295,607 | 1.5% | 294,062 | 1.4% | 287,906 | 1.4% | 287,688 | 1.4% | 286,535 | 1.1% | 295,131 | 1.1% | 303,985 | 1.0% |
| Equipment Rental | 163,196 | 0.8% | 218,587 | 1.0% | 114,037 | 0.5% | 166,546 | 0.8% | 166,127 | 0.7% | 171,111 | 0.6% | 176,244 | 0.6% |
| Bad Debt | 848,848 | 4.3% | 322,431 | 1.5% | 983,622 | 4.7% | 511,464 | 2.5% | 362,999 | 1.4% | 391,319 | 1.4% | 418,322 | 1.4% |
| Property Tax | - | 0.0% | - | 0.0% | - | 0.0% | - | 0.0% | - | 0.0% | - | 0.0% | - | 0.0% |
| Other | 675,978 | 3.4% | 738,087 | 3.5% | 728,080 | 3.5% | 424,478 | 2.1% | 675,827 | 2.7% | 716,118 | 2.6% | 749,119 | 2.6% |
| Management Fee | 216,000 | 1.1% | 283,200 | 1.3% | 219,658 | 1.1% | 216,257 | 1.1% | 300,000 | 1.2% | 300,000 | 1.1% | 300,000 | 1.0% |
| Reserves for Replacement | - | 0.0% | - | 0.0% | - | 0.0% | - | 0.0% | - | 0.0% | - | 0.0% | - | 0.0% |
| Total Operating Expenses | 19,671,969 | 89.4% | 22,887,668 | 92.5% | 23,175,308 | 107.9% | 21,485,528 | 103.5% | 23,444,883 | 92.0% | 24,370,495 | 89.0% | 25,506,405 | 87.4% |
| EBITDA | $2,332,288 | 11.7% | $1,864,282 | 8.8% | -$1,702,932 | -8.2% | -$732,477 | -3.6% | $2,051,033 | 8.1% | $3,013,444 | 11.0% | $3,677,700 | 12.6% |

## OCCUPANCY LEVELS AND UTILIZATION

The subject's historical payor mix and census are in Table 1. The subject census is comprised of two groups: inpatient and outpatient.

Historically, the number of inpatient days was 13,361 in 1997, 16,083 in 1998, 16,501 in 1999 and 15,308 in annualized 2000. The prospective buyer's pro forma indicates 17,155 for 2001, 17,885 for 2002 and 18,615 for 2003. Inpatient acute-care patient days are estimated at 18,615.

Historically, the number of outpatient visits was 14,947 in 1997, 15,399 in 1998, 15,846 in 1999 and 15,993 in annualized 2000. The prospective buyer's pro forma indicates 17,166 for 2001, 17,896 for 2002 and 18,597 for 2003. 18,597 outpatient visits have been utilized in this analysis.

Based upon our estimate of inpatient days of 18,615 and outpatient visits of 18,597, 26,992 adjusted patient days are implied.

The buyer's proposed census assumes outpatient volumes will continue at least at the current levels relative to inpatient volumes. The buyer's proposed census increase is summarized in the following table.

| Patient Volume Changes<br>Level of completion of incremental physician activity | # Patients/Yr | ALOS | #Pt Days | # Pt/Day | 2001<br>60% | 2002<br>75% | 2003<br>100% |
|---|---|---|---|---|---|---|---|
| OB will expand reach to La Puente with key new physician relationship | 300 | 1.5 | 450 | 1.233 | 0.740 | 0.925 | 1.233 |
| Monrovia Podiatry Center will move outpatient procedures to East Valley Hospital | 300 | 3.6 | 1,080 | 2.959 | 1.775 | 2.219 | 2.959 |
| An internal medicine practice in West Covina will shift inpatients to East Valley Hospital | 200 | 3.6 | 720 | 1.973 | 1.184 | 1.479 | 1.973 |
| An internal medicine practice in Hacienda Heights will shift inpatients to East Valley Hospital | 200 | 3.6 | 720 | 1.973 | 1.184 | 1.479 | 1.973 |
| Resident physicians will be recruited to supplement the practices of those on medical staff over age 50, to position the turnover of their practices | 50 | 2.5 | 125 | 0.342 | 0.205 | 0.257 | 0.342 |
| Improvements in teleradiology and pathology services will result in additional admissions by existing medical staff | 20 | 4 | 80 | 0.219 | 0.132 | 0.164 | 0.219 |
| Consideration will be given to converting some OB beds to NICU | 100 | 6 | 600 | 1.644 | 0.986 | 1.233 | 1.644 |
| Gero-Psych unit patient days will be supplemented by expanded reach above | | | | | **6.205** | **7.757** | **10.342** |
| Total additional inpatient volume | | | | | | | |
| Starting Average Daily Census | | | | | 41 | 41 | 41 |
| Projected Census | | | | | 47.205 | 48.757 | 51.342 |
| Projected Census Rounded | | | | | 47.000 | 49.000 | 51.000 |

The following table summarizes the stabilized census and utilization estimates used in this analysis:

| | |
|---|---|
| Licensed Beds | 128 |
| Available Patient Days | 46,720 |
| **Census:** | |
| Inpatient Days | 18,615 |
| Outpatient Visits | 18,625 |
| Adjusted Patient Days | 26,992 |
| Average Daily Census | 74.0 |
| Occupancy Rate | 57.8% |

The competitive acute-care facilities, discussed in the competition section, indicate occupancy rates of 46% to 69%, with a weighted average of 63.6%. Santa Teresita Hospital was excluded from the weighted average due to providing skilled-nursing care, which requires an extended inpatient care. City of Hope National Medical Center was excluded from the weighted average due to being a cancer institute and research center. Based upon the subject's historical census and the local competition, our census projections are reasonable.

REVENUE

Management has categorized historical revenues into three groups: Routine, Inpatient And Outpatient. The historical data presents the gross figures for this category (before contractual deductions and adjustments). The subject ended their capitation program in July 2000. The prospective buyer's budget provides two revenue groups: Gross Patient And Other. These revenue sources are discussed below.

**Routine**

These revenues represent the revenue paid for routine services by Medicare, Medi-Cal and Private/Other payors. Historically, this revenue has been $785.29 per patient day in 1997, $782.52 in 1998, $803.24 in 1999 and $803.89 in annualized 2000. The prospective buyer's pro forma has placed this revenue category in Net Patient Revenue.

**Inpatient**

These revenues represent the revenue paid for inpatient services by Medicare, Medi-Cal and Private/Other payors. Historically, this revenue has been $1,748.70 per patient day in 1997, $2,113.62 in 1998, $2,091.55 in 1999 and $2,075.69 in annualized 2000. The prospective buyer's pro forma has placed this revenue category in net patient revenue.

**Outpatient**

Outpatient revenues represent the revenue paid for outpatient services by Medicare, Medi-Cal and Private/Other payors. Historically, this revenue has been $927.79 per patient day in 1997, $945.93 in 1998, $992.50 in 1999 and $1,230.74 in annualized 2000. The prospective buyer's pro forma has placed this revenue category in Net Patient Revenue.

**Deductions**

Deductions from revenues include contractual allowances from insurance, Medicare and Medi-Cal payors. Historically, this revenue has been $2,181.41 per patient day in 1997, $2,378.67 in 1998, $2,638.03 in 1999 and $2,779.22 in annualized 2000. The prospective buyer's pro forma accounted for this deduction in net patient revenue.

**Other Revenue**

Other revenues comprise minor items such as cafeteria and vending machine sales. On a per patient day basis, these revenues were $100.82 per patient day in 1997, $146.00 in 1998, $32.82 in 1999 and $10.31 in annualized 2000. In 1999, Other revenue dropped as the subject shifted lab services to other hospitals within the owner's network. The buyer's projection as indicated in Table 2 and 3 has been adjusted to exclude $1,625,000 in Other revenue. The buyer projects that a joint venture with Medical Pathways in association with several IPAs will eventually benefit the subject. However, the relationship with Medical Pathways is easily transferable and is primarily tied to the proposed management company, Mardel Group. The prospective buyer's pro forma indicates $3.86 for 2001, $3.70 for 2002 and $3.56 for 2003. An estimate of $30.00 per patient day is utilized in this analysis.

**Net Revenue**

Net Revenue in this analysis is estimated at $29,191,848, or $1,081.50 per patient day. This compares with $22,004,257 in 1997, 24,751,950 in 1998, $21,472,376 in 1999 and $20,753,051 in the annualized 2000. The prospective buyer's pro forma indicates $25,495,916 for 2001, $27,383,939 for 2002 and $29,184,105 for 2003. Estimate net revenue is in line with the prospective buyer's pro forma and is reasonable.

OPERATING EXPENSES

Operating expenses consist of variable expenses that change with the occupancy, fixed expenses that do not change with occupancy and reserves for replacement of short-lived items. As presented in Table 2 and 3, we obtained historical operating statements for the subject. These operating expenses are analyzed on a per-patient-day basis and percentage of net revenue. An explanation of the expense amounts used in this analysis is as follows.

**Salaries and Wages**

This category includes all salaries and wages for hospital staff. This expense was $500.90 per patient day in 1997, $476.06 in 1998, $515.94 in 1999 and $529.20 in annualized 2000. The prospective buyer's proforma for this expense category is $500.20 for 2001, $504.29 for 2002 and $509.03 for 2003. An expense of $510.00 per patient day is utilized.

**Professional Fees**

This category includes consulting, legal audit and management fee expenses. This expense was $104.26 per patient day in 1997, $108.98 in 1998, $119.02 in 1999 and $113.64 in annualized 2000. The prospective buyer's proforma for this expense category is $107.44 for 2001, $104.28 for 2002 and $105.26 for 2003. As of 2001, inpatient and outpatient psychiatric services will be brought in-house. An expense of $105.00 per patient day is utilized.

**Supplies**

This category includes medical and non-medical supplies. This expense was $116.55 per patient day in 1997, $110.94 in 1998, $130.41 in 1999 and $138.03 in annualized 2000. The prospective buyer's pro forma for this expense category is $141.71 for 2001, 2002 and 2003. An expense of $140.00 per patient day is utilized.

**Utilities**

This category relates to on-site utilities such as electricity, gas, water, waste removal and telephone. This expense was $21.50 per patient day in 1997, $17.55 in 1998, $19.12 in 1999 and $19.52 in annualized 2000. The prospective buyer's pro forma for this expense category is $18.09 for 2001, $17.35 for 2002 and $16.67 for 2003. An expense of $17.00 per patient day is utilized.

**Purchased Services**
This expense includes contracted medical services, repairs and maintenance and collection services. This expense was $69.55 per patient day in 1997, $125.89 in 1998, $157.22 in 1999 and $94.10 in annualized 2000. The prospective buyer's pro forma for this expense category is $88.98 for 2001, $86.36 for 2002 and $87.17 for 2003. In 1999, $350,000 in capitated claims was reclassified under purchased services. The subject ended their capitation program in July 2000. An expense of $87.00 per patient day is utilized.

**Insurance**
This expense was $16.73 per patient day in 1997, $9.51 in 1998, $13.07 in 1999 and $15.26 in annualized 2000. The prospective buyer's pro forma for this expense category is $14.07 for 2001, $13.50 for 2002 and $12.97 for 2003. An expense of $13.00 per patient day is utilized.

**Building Rental**
This expense includes 16,000 square-feet of rented space in the adjacent medical office building. This expense was $14.03 per patient day in 1997, $11.87 in 1998, $13.19 in 1999 and $13.17 in annualized 2000. The prospective buyer's pro forma for this expense category is $11.52 for 2001, $11.38 for 2002 and $11.26 for 2003. An expense of $11.00 per patient day is utilized.

**Equipment Rental**
This expense includes copy machine rental, pyxis, surgical laser equipment and a van. This expense was $7.75 per patient day in 1997, $8.82 in 1998, $5.22 in 1999 and $7.62 in annualized 2000. The prospective buyer's pro forma for this expense category is $6.68 for 2001, $6.60 for 2002 and $6.53 for 2003. An expense of $6.50 per patient day is utilized.

**Bad Debt**
Bad debt expense was $40.30 per patient day in 1997, $13.01 in 1998, $45.06 in 1999 and $23.41 in annualized 2000. The prospective buyer's pro forma for this expense category are $14.59 for 2001, $15.09 for 2002 and $15.50 for 2003. In 1999, the subject's auditors reclassified reserves in this category. In addition, in 1999 Management focused upon qualifying patients for Medi-Cal. The subject currently has an on-campus Medi-Cal eligibility worker. An expense of $15.50 per patient day is utilized.

**Property Taxes**
The subject is a non-profit, therefore tax-exempt property. However, based upon the definition of market value we have assumed the payment of real estate taxes. Real estate taxes are calculated based upon the Cost Approach's value conclusion in this report multiplied by the current tax rate plus direct assessments.

**Other**
This expense includes advertisement, dues, subscriptions, training sessions, travel, recruiting, licenses and taxes on rental equipment. This expense was $32.09 per patient day in 1997, $29.79 in 1998, $33.35 in 1999 and $19.43 in annualized 2000. The prospective buyer's pro forma for this expense category is $27.17 for 2001,

$27.61 for 2002 and $27.75 for 2003. An expense of $28.00 per patient day is utilized.

**Management Fee**
A management fee is paid to Southern California Healthcare Systems. Management fees typically range from 2.0% to 3.0% of net revenue (effective gross income) for healthcare facilities of the subject's scope and level of services. This expense has been estimated at 2.5% of net revenue.

**Reserves for Replacement**
Not included in the subject operating statement is a reserve for replacement. This reserve is for the replacement of short-lived items, general modernization, renovation. This expense has been estimated at 1.0% of net revenue.

**Total Expenses**

Total expenses are estimated at $26,291,251 or $974.04 per patient day or 90.1% of net revenue. This compares to historical expenses of $19,671,969 in 1997 or $933.91 per patient day or 89.4% of net revenue, $22,887,668 or $923.86 per patient day or 92.5% of net revenue in 1998, $23,175,308 or $1,061.68 per patient day or 107.09% of net revenue in 1999 and $21,485,528 or $942.51 per patient day or 103.5% of net revenue in annualized 2000. The prospective buyer's pro forma for total expenses is $23,444,883 or $939.75 per patient day or 92.0% of net revenue for 2001, $24,370,495 or $939.75 per patient day or 89.0% of net revenue for 2002 and $25,506,405 or $944.96 or 87.4% of net revenue for 2003.

The estimated total expenses for the subject are higher than historical levels (years ending 1997, 1998, 1999 and annualized 2000) due to the higher census. The estimated total expenses are higher than the buyer's projected expenses due to the inclusion of property taxes, management fees and reserves for replacement.

## EARNINGS BEFORE INTEREST, TAXES, DEPRECIATION AND AMORTIZATION (EBITDA)

PROSPECTIVE STABILIZED PROFORMA –ASSUMING NEW OWNERSHIP

In this analysis, net operating income has been considered before deducting interest, income taxes, depreciation and amortization. Deducting stabilized expenses from stabilized total net revenue indicates an EBITDA of $2,900,597.

The revenue and expenses used in this analysis are summarized in the following table.

**Huntington East Valley Hosptial**
**Table 4 - Prospective Stabilized Proforma - Assuming New Ownership**

| | |
|---|---|
| Licensed Beds | 128 |
| Available Patient Days | 46,720 |
| **Census:** | |
| Inpatient Days | 18,615 |
| Outpatient Visits | 18,625 |
| Adjusted Patient Days | 26,992 |
| Average Daily Census | 74.0 |
| Occupancy Rate | 57.8% |

| | $ | PPD | % of Rev. |
|---|---|---|---|
| Net Patient Revenue | 29,097,376 | 1,078.00 | |
| Other Revenue | 94,472 | 3.50 | |
| Net Revenue | 29,191,848 | 1,081.50 | 100.0% |
| Operating Expenses: | | | |
| Salaries & Wages | 13,765,920 | 510.00 | 47.2% |
| Professional Fees | 2,834,160 | 105.00 | 9.7% |
| Supplies | 3,778,880 | 140.00 | 12.9% |
| Utilities | 458,864 | 17.00 | 1.6% |
| Purchased Services | 2,348,304 | 87.00 | 8.0% |
| Insurance | 350,896 | 13.00 | 1.2% |
| Building Rental | 296,912 | 11.00 | 1.0% |
| Equipment Rental | 175,448 | 6.50 | 0.6% |
| Bad Debt | 418,376 | 15.50 | 1.4% |
| Property Tax | 86,000 | 3.19 | 0.3% |
| Other | 755,776 | 28.00 | 2.6% |
| Management Fee | 729,796 | 27.04 | 2.5% |
| Reserves for Replacement | 291,918 | 10.82 | 1.0% |
| Total Operating Expenses | 26,291,251 | 974.04 | 90.1% |
| EBITDA | 2,900,597 | $107.46 | 9.9% |

AS IS PROFORMA

In this analysis, net operating income has been considered before deducting interest, income taxes, depreciation and amortization. Deducting stabilized expenses from stabilized total net revenue indicates an EBITDA of $1,150,455.

The revenue and expenses used in this analysis are summarized in the following table.

**Huntington East Valley Hosptial**
**Table 4a - As Is Proforma**

| | |
|---|---|
| Licensed Beds | 128 |
| Available Patient Days | 46720 |
| **Census:** | |
| Inpatient Days | 16,500 |
| Outpatient Visits | 18,500 |
| Adjusted Patient Days | 22,729 |
| Average Daily Census | 62.3 |
| Occupancy Rate | 48.6% |

| | $ | PPD | % of Rev. |
|---|---|---|---|
| Net Patient Revenue | 22,728,956 | 1,000.00 | |
| Other Revenue | 227,290 | 10.00 | |
| Net Revenue | 22,956,246 | 1,010.00 | 100.0% |
| Operating Expenses: | | | |
| Salaries & Wages | 11,591,768 | 510.00 | 50.5% |
| Professional Fees | 2,500,185 | 110.00 | 10.9% |
| Supplies | 2,954,764 | 130.00 | 12.9% |
| Utilities | 431,850 | 19.00 | 1.9% |
| Purchased Services | 1,704,672 | 75.00 | 7.4% |
| Insurance | 340,934 | 15.00 | 1.5% |
| Building Rental | 295,476 | 13.00 | 1.3% |
| Equipment Rental | 164,785 | 7.25 | 0.7% |
| Bad Debt | 500,037 | 22.00 | 2.2% |
| Property Tax | 86,000 | 3.78 | 0.4% |
| Other | 431,850 | 19.00 | 1.9% |
| Management Fee | 573,906 | 25.25 | 2.5% |
| Reserves for Replacement | 229,562 | 10.10 | 1.0% |
| Total Operating Expenses | 21,805,791 | 959.38 | 95.0% |
| EBITDA | 1,150,455 | $50.62 | 5.0% |

## CAPITALIZATION PROCESS

After estimating cash flow from operations, it is necessary to process it into a value. This has been accomplished via the Direct Capitalization Method. In this method, a capitalization rate is used to convert the estimate of stabilized net operating income into a value. This rate should represent the annual rate of return necessary to attract investment capital. Inherent in our selected overall capitalization rate is both a return on and a return of, invested capital.

Capitalization rates are derived from the market. Rates achieved by the sales used in the Sales Comparison Approach were reviewed. Sales with negative net incomes or those hospitals with capitalization rates under 10.0% have not been considered since they represent facilities in turn-around situations or facilities that were purchased for strategic synergies. The remaining sales, together with their capitalization rates, are summarized as follows:

**Acute Care Hospital Sales**

| Date | Name | Location | Beds | Capitalization Rate |
|---|---|---|---|---|
| Nov-99 | Greater Southeast Community Hospital | Washington, DC | 260 | 11.6% |
| Oct-99 | Phoenix Regional Medical Center | Phoenix, Arizona | 174 | 11.7% |
| Oct-99 | Lloyd Noland Hospital | Fairfield, Alabama | 294 | 30.2% |
| Oct-99 | Senatobia Community Hospital | Senatobia, Mississippi | 72 | 48.3% |
| Aug-99 | 5 Paracelsus Hospitals | Salt Lake City, Utah | 640 | 16.7% |
| Aug-99 | 10 Tenent Hospitals | Arizona, Florida & Texas | 1,780 | 14.3% |
| Jul-99 | Columbia Regional Hospital | Columbia, Missouri | 210 | 10.7% |
| Jun-99 | Beaumont & Silsbee Hospital | Beaumont, Texas | 284 | 16.9% |
| Jun-99 | Kendall Regional Medical Center | Miami, Florida | 235 | 16.3% |
| Apr-99 | Glades General Hospital | Belle Glade, Florida | 65 | 17.2% |
| Feb-99 | Nassau County Medical Center | East Meadow, New York | 531 | 31.4% |
| | **Low** | | | **10.7%** |
| | **High** | | | **48.3%** |
| | **Average** | | | **20.5%** |
| | **Median** | | | **16.7%** |

Based upon our knowledge of the financial history of the subject, the demand for acute-care beds in the subject market area, we are of the opinion that a capitalization rate of 18.0% would be appropriate for the subject property. Applying the capitalization rate to the net operating income (EBITDA) results in the following computation of value:

| | Prospective Stabilized Value Assuming New Ownership | As Is Value |
|---|---|---|
| EBITDA | $1,150,455 | $1,150,455 |
| Capitalization Rate | 18.0% | 18.0% |
| Indicated Value | $16,114,430 | $6,391,418 |
| Less SB 1953 Upgrades | -4,970,000 | -4,970,000 |
| Rounded | $11,100,000 | $1,400,000 |

## DIRECT CAPITALIZATION SUMMARY

It is our opinion that the prospective stabilized value of the subject facility assuming new ownership, in fee simple, via the Income Capitalization Approach, is represented in the rounded amount of:

$11,100,000

It is our opinion that the as is value of the subject facility based upon historical performance, in fee simple, via the Income Capitalization Approach, is represented in the rounded amount of:

$1,400,000

Since the as is value of the subject, after deductions for SB 1953 upgrades, is less than the land value, the completion of SB 1953 upgrades is not financially feasible. The existing hospital under current management represents an interim use. If SB 1953 work is not completed, the subject will be allowed to continue operations through January 1, 2008. The present value of the cash flow through 2008 plus the reversion will be estimated in one of two discounted cash flow models contained in the appraisal.

## DISCOUNTED CASH FLOW – ASSUMING NEW OWNER

The next step in the Income Capitalization Approach is to convert the prospective stabilized cash flow assuming new ownership into an as is value. This has been accomplished using a discounted cash flow model. In this method, a discount rate is used to convert the cash flows into an as is value. This discount rate represents the annual rate of return necessary to attract investment capital. Tables 5, 6 and 7 on the following pages are a summary of the assumptions used for the discounted cash flow.

**Huntington East Valley Hosptial**
**Table 5 - Utilization and Revenue Projections**

| | Stabilized Year | | | | | |
|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 |
| Inpatient Days (Adjusted) | 24,875 | 25,933 | 26,992 | 26,992 | 26,992 | 26,992 |
| Average Daily Census | 68 | 71 | 74 | 74 | 74 | 74 |
| Available Beds | 128 | 128 | 128 | 128 | 128 | 128 |
| Occupancy Rate | 53% | 56% | 58% | 58% | 58% | 58% |
| ***Revenue Per Patient Day*** | | | | | | |
| Net Patient Revenue | 1,021.10 | 1,052.25 | 1,078.00 | 1,110.34 | 1,143.65 | 1,177.96 |
| Other Revenue | 3.86 | 3.70 | 3.50 | 3.61 | 3.71 | 3.82 |
| ***Annual Revenue*** | | | | | | |
| Net Patient Revenue | 25,399,863 | 27,287,999 | 29,097,376 | 29,970,297 | 30,869,406 | 31,795,488 |
| Other Revenue | 96,018 | 95,952 | 94,472 | 97,306 | 100,225 | 103,232 |
| Net Revenue | $25,495,880 | $27,383,951 | $29,191,848 | $30,067,603 | $30,969,632 | $31,898,720 |

**Huntington East Valley Hosptial**
**Table 6 - Revenure and Expenses, as a % of Revnue and Per Patient Day**

| | Stabilized Year | | | | | |
|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 |
| **% of Revenue** | | | | | | |
| Net Revenue | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Expenses | | | | | | |
| Salaries & Wages | 48.8% | 47.8% | 47.2% | 47.2% | 47.2% | 47.2% |
| Professional Fees | 8.8% | 9.9% | 9.7% | 9.7% | 9.7% | 9.7% |
| Supplies | 13.7% | 13.3% | 12.9% | 12.9% | 12.9% | 12.9% |
| Utilities | 1.8% | 1.6% | 1.6% | 1.6% | 1.6% | 1.6% |
| Purchased Services | 8.8% | 8.0% | 8.0% | 8.0% | 8.0% | 8.0% |
| Insurance | 1.4% | 1.3% | 1.2% | 1.2% | 1.2% | 1.2% |
| Building Rental | 1.1% | 1.1% | 1.0% | 1.0% | 1.0% | 1.0% |
| Equipment Rental | 0.7% | 0.6% | 0.6% | 0.6% | 0.6% | 0.6% |
| Bad Debt | 1.4% | 1.4% | 1.4% | 1.4% | 1.4% | 1.4% |
| Property Tax | 0.3% | 0.3% | 0.3% | 0.3% | 0.3% | 0.3% |
| Other | 2.6% | 2.6% | 2.6% | 2.6% | 2.6% | 2.6% |
| Management Fee | 2.5% | 2.5% | 2.5% | 2.5% | 2.5% | 2.5% |
| Reserves for Replacement | 1.0% | 1.0% | 1.0% | 1.0% | 1.0% | 1.0% |
| Total Operating Expenses | 92.8% | 91.5% | 90.1% | 90.1% | 90.1% | 90.1% |
| EBITDA | 7.2% | 8.5% | 9.9% | 9.9% | 9.9% | 9.9% |
| **Per Patient Day** | | | | | | |
| Net Revenue | 1,024.96 | 1,055.95 | 1,081.50 | 1,113.95 | 1,147.36 | 1,181.78 |
| Expenses | | | | | | |
| Salaries & Wages | 500.00 | 505.00 | 510.00 | 525.30 | 541.06 | 557.29 |
| Professional Fees | 90.00 | 105.00 | 105.00 | 108.15 | 111.39 | 114.74 |
| Supplies | 140.00 | 140.00 | 140.00 | 144.20 | 148.53 | 152.98 |
| Utilities | 18.00 | 17.00 | 17.00 | 17.51 | 18.04 | 18.58 |
| Purchased Services | 90.00 | 85.00 | 87.00 | 89.61 | 92.30 | 95.07 |
| Insurance | 14.00 | 13.50 | 13.00 | 13.39 | 13.79 | 14.21 |
| Building Rental | 11.50 | 11.50 | 11.00 | 11.33 | 11.67 | 12.02 |
| Equipment Rental | 7.00 | 6.50 | 6.50 | 6.70 | 6.90 | 7.10 |
| Bad Debt | 14.50 | 15.00 | 15.50 | 15.97 | 16.44 | 16.94 |
| Property Tax | 3.32 | 3.25 | 3.19 | 3.25 | 3.31 | 3.38 |
| Other | 27.00 | 27.50 | 28.00 | 28.84 | 29.71 | 30.60 |
| Management Fee | 25.62 | 26.40 | 27.04 | 27.85 | 28.68 | 29.54 |
| Reserves for Replacement | 10.25 | 10.56 | 10.82 | 11.14 | 11.47 | 11.82 |
| Total Operating Expenses | 951.20 | 966.21 | 974.04 | 1,003.23 | 1,033.29 | 1,064.26 |
| EBITDA | 73.76 | 89.74 | 107.46 | 110.72 | 114.07 | 117.53 |

**Huntington East Valley Hosptial**
**Table 7 - Growth Assumptions**

| | 1 | 2 | Stabilized Year 3 | 4 | 5 |
|---|---|---|---|---|---|
| Per Patient Day | | | | | |
| Net Revenue | 100.0% | 100.0% | 3.0% | 3.0% | 3.0% |
| Expenses | | | | | |
| Salaries & Wages | 1.0% | 1.0% | 3.0% | 3.0% | 3.0% |
| Professional Fees | 16.7% | 0.0% | 3.0% | 3.0% | 3.0% |
| Supplies | 0.0% | 0.0% | 3.0% | 3.0% | 3.0% |
| Utilities | -5.6% | 0.0% | 3.0% | 3.0% | 3.0% |
| Purchased Services | -5.6% | 2.4% | 3.0% | 3.0% | 3.0% |
| Insurance | -3.6% | -3.7% | 3.0% | 3.0% | 3.0% |
| Building Rental | 0.0% | -4.3% | 3.0% | 3.0% | 3.0% |
| Equipment Rental | -7.1% | 0.0% | 3.0% | 3.0% | 3.0% |
| Bad Debt | 3.4% | 3.3% | 3.0% | 3.0% | 3.0% |
| Property Tax | 2.0% | 2.0% | 2.0% | 2.0% | 2.0% |
| Other | 1.9% | 1.8% | 3.0% | 3.0% | 3.0% |
| Management Fee | 3.0% | 2.4% | 3.0% | 3.0% | 3.0% |
| Reserves for Replacement | 3.0% | 2.4% | 3.0% | 3.0% | 3.0% |
| Total Operating Expenses | 1.6% | 0.8% | 3.0% | 3.0% | 3.0% |
| EBITDA | 21.7% | 19.7% | 3.0% | 3.0% | 3.0% |
| | | | | | |
| Total | | | | | |
| Net Revenue | 7.4% | 6.6% | 3.0% | 3.0% | 3.0% |
| Expenses | | | | | |
| Salaries & Wages | 5.3% | 5.1% | 3.0% | 3.0% | 3.0% |
| Professional Fees | 21.6% | 4.1% | 3.0% | 3.0% | 3.0% |
| Supplies | 4.3% | 4.1% | 3.0% | 3.0% | 3.0% |
| Utilities | -1.5% | 4.1% | 3.0% | 3.0% | 3.0% |
| Purchased Services | -1.5% | 6.5% | 3.0% | 3.0% | 3.0% |
| Insurance | 0.5% | 0.2% | 3.0% | 3.0% | 3.0% |
| Building Rental | 4.3% | -0.4% | 3.0% | 3.0% | 3.0% |
| Equipment Rental | -3.2% | 4.1% | 3.0% | 3.0% | 3.0% |
| Bad Debt | 7.8% | 7.6% | 3.0% | 3.0% | 3.0% |
| Property Tax | 2.0% | 2.0% | 2.0% | 2.0% | 2.0% |
| Other | 6.2% | 6.0% | 3.0% | 3.0% | 3.0% |
| Management Fee | 7.4% | 6.6% | 3.0% | 3.0% | 3.0% |
| Reserves for Replacement | 7.4% | 6.6% | 3.0% | 3.0% | 3.0% |
| Total Operating Expenses | 5.9% | 4.9% | 3.0% | 3.0% | 3.0% |
| EBITDA | 26.8% | 24.6% | 3.0% | 3.0% | 3.0% |

DISCOUNT RATE

A discount rate is a yield rate used to convert anticipated future payments into present value. The resulting present value represents the amount of capital to be invested so that the investor's expected yield equals the specified discount rate. For the purposes of this analysis, the discount rate is applied before loan payments, depreciation, amortization and income taxes.

The discount rate is based upon the quality and risk of the cash flow and the potential opportunity costs associated with the subject. The discount rate is determined by a review of national investors surveys.

The *Korpacz Real Estate Investor Survey, Fourth Quarter 2000* indicates that discount rates range between 9.00% and 15.00%. A summary of the survey is outlined as follows.

**FOURTH QUARTER 2000 INVESTOR SURVEY**

| | Discount Rates | |
|---|---|---|
| **Property Type** | **Average** | **Range** |
| Regional Mall | 11.41% | 9.75% - 13.50% |
| CBD Office | 11.04% | 9.75% - 13.50% |
| Suburban Office | 11.01% | 9.75% - 13.00% |
| Industrial | 10.88% | 9.50% - 12.50% |
| Apartment | 11.41% | 10.00% - 15.00% |
| Full Service Hotel | 13.28% | 9.00% - 15.00% |

Compared to those property types surveyed, the subject is most similar to a full service hotel. As previously determined, the capitalization rate for the subject was determined to be 18.0%. Since the cash flow and reversion are both expected to grow over time, the capitalization rate establishes the lower limits of discount rates. Based upon the published surveys, and our experience in these types of properties, a discount rate of 21.0% is warranted for the subject.

Based upon our knowledge of the subject and the demand for acute-care services, we are of the opinion that a terminal capitalization rate of 18.5% is appropriate for the subject property.

## SALES COSTS

Upon the sale of the subject and the end of the holding period, a 3% deduction for selling and closing costs is deducted.

## CONCLUSION

The sum of the present value of the cash flow and the reversion represents the total value of the subject. Table 8 on the following page contains the discounted cash model – assuming new ownership and indicates a value of:

As is Value – Assuming New Ownership Projections – $8,800,000

**Huntington East Valley Hosptial**
**Table 8 - Discounted Cash Flow - As Is Valuation Assuming New Ownership**

| | | Stabilized Year | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Year | | 1 | 2 | 3 | 4 | 5 | | 6 |
| Net Patient Revenue | | 25,399,863 | 27,287,999 | 29,097,376 | 29,970,297 | 30,869,406 | | 31,795,488 |
| Other Revenue | | 96,018 | 95,952 | 94,472 | 97,306 | 100,225 | | 103,232 |
| Net Revenue | | 25,495,880 | 27,383,951 | 29,191,848 | 30,067,603 | 30,969,632 | | 31,898,720 |
| Operating Expenses: | | | | | | | | |
| Salaries & Wages | | 12,437,500 | 13,096,165 | 13,765,920 | 14,178,898 | 14,604,265 | | 15,042,392 |
| Professional Fees | | 2,238,750 | 2,722,965 | 2,834,160 | 2,919,185 | 3,006,760 | | 3,096,963 |
| Supplies | | 3,482,500 | 3,630,620 | 3,778,880 | 3,892,246 | 4,009,014 | | 4,129,284 |
| Utilities | | 447,750 | 440,861 | 458,864 | 472,630 | 486,809 | | 501,413 |
| Purchased Services | | 2,238,750 | 2,204,305 | 2,348,304 | 2,418,753 | 2,491,316 | | 2,566,055 |
| Insurance | | 348,250 | 350,096 | 350,896 | 361,423 | 372,266 | | 383,434 |
| Building Rental | | 286,063 | 298,230 | 296,912 | 305,819 | 314,994 | | 324,444 |
| Equipment Rental | | 174,125 | 168,565 | 175,448 | 180,711 | 186,133 | | 191,717 |
| Bad Debt | | 360,688 | 388,995 | 418,376 | 430,927 | 443,855 | | 457,171 |
| Property Tax | | 82,661 | 84,314 | 86,000 | 87,720 | 89,474 | | 91,264 |
| Other | | 671,625 | 713,158 | 755,776 | 778,449 | 801,803 | | 825,857 |
| Management Fee | | 637,397 | 684,599 | 729,796 | 751,690 | 774,241 | | 797,468 |
| Reserves for Replacement | | 254,959 | 273,840 | 291,918 | 300,676 | 309,696 | | 318,987 |
| Total Operating Expenses | | 23,661,016 | 25,056,710 | 26,291,251 | 27,079,128 | 27,890,625 | | 28,726,449 |
| EBITDA | | 1,834,864 | 2,327,241 | 2,900,597 | 2,988,475 | 3,079,007 | | 3,172,272 |
| Discount Factor | 21.0% | 0.8264463 | 0.6830135 | 0.5644739 | 0.4665074 | 0.3855433 | Terminal Cap | 18.50% |
| Present Value | | 1,516,416 | 1,589,537 | 1,637,312 | 1,394,146 | 1,187,090 | Indicate Value | 17,147,414 |
| | | | | | | | Selling Cost | 514,422 |
| Indicated Value | | | | | | | Reversion | 16,632,992 |
| Cash Flow | | 7,324,501 | | | | | PV Factor | 0.3855433 |
| Reversion | | 6,412,738 | | | | | Present Value | 6,412,738 |
| Indicated Value | | 13,737,239 | | | | | | |
| Less 2002 SB 1953 Costs | | 170,400 | | | | | | |
| Less 2008 SB 1953 Costs | | 4,800,000 | | | | | | |
| Indicated As Is Value | | 8,766,839 | | | | | | |
| Rounded | | 8,800,000 | | | | | | |

## DISCOUNTED CASH FLOW – AS IS

The primary reason to conduct a discounted cash flow analysis of the as is operation is to test the financial feasibility of proceeding with SB 1953 earthquake work. If the SB 1953 work is not completed, acute-care operations at the subject cannot be conducted beyond January 1, 2008.

The as is value of the current operations at the subject, less the cost of complete SB 1953 work, has been previously determined in this report at $1,500,000. The as is discounted cash flow will assume that the SB 1953 will not be undertaken and that operations at the subject will end on December 31, 2007, at which time the subject will be sold for land value less demolition costs.

The cash flows in the discounted cash flow as is are based upon the income and expenses as estimated in Table 4a. Income and expenses are projected to increase at 3.0% per year. The as is discounted cash flow contained in Table 9 indicates a present value of the subject of $4,900,000.

**Huntington East Valley Hosptial**
**Table 9 - Discounted Cash Flow - AS IS**

| **Assumptions** | |
|---|---|
| Income & Expense Growth | 3.00% |
| Discount Rate | 21.00% |
| Land Value Today | 2,550,000 |
| Land Value 1/1/08 | 3,136,178 |
| Demolition Costs Today (PSF) | 2.50 |
| Demolition Costs (1/1/08) | 3.07 |
| Selling Costs | 4.00% |

| Date | 12/31/01 | 12/31/02 | 12/31/03 | 12/31/04 | 12/31/05 | 12/31/06 | 12/31/07 |
|---|---|---|---|---|---|---|---|
| Year | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Net Revenue | 22,956,246 | 23,644,933 | 24,354,281 | 25,084,910 | 25,837,457 | 26,612,581 | 27,410,958 |
| Expenses | 21,805,791 | 22,459,964 | 23,133,763 | 23,827,776 | 24,542,609 | 25,278,888 | 26,037,254 |
| EBITDA | 1,150,455 | 1,184,969 | 1,220,518 | 1,257,133 | 1,294,847 | 1,333,693 | 1,373,704 |
| Land Value | | | | | | | 3,136,178 |
| Less Demolition Costs | | | | | | | -269,189 |
| | | | | | | | 2,866,990 |
| Less Selling Costs | | | | | | | -114,680 |
| Net Reversion | | | | | | | 2,752,310 |
| Cash Flow | 1,150,455 | 1,184,969 | 1,220,518 | 1,257,133 | 1,294,847 | 1,333,693 | 4,126,014 |
| Discount Factor | 0.8264463 | 0.6830135 | 0.5644739 | 0.4665074 | 0.3855433 | 0.3186308 | 0.2633313 |
| Present Value | 950,789 | 809,350 | 688,951 | 586,462 | 499,220 | 424,956 | 1,086,508 |

| | |
|---|---|
| Indicated Value | 5,046,236 |
| Less 2002 SB 1953 Costs | 170,400 |
| Indicated Value | 4,875,836 |
| Rounded | 4,900,000 |

## CORRELATION OF VALUE

Three traditional approaches to value have been considered. While the approaches are independently developed, the same fundamental principles of valuation and economics form the logical basis for each approach. The indications of value by the three approaches are as follows:

| | As Is Current Operations 1/8/01 | As Is Assuming Buyer's Operations 1/8/01 | Prospective Stabilized Assuming Buyer's Operations 1/1/2003 |
|---|---|---|---|
| Cost Approach | N/A | $7,200,000 | N/A |
| Sales Approach | N/A | N/A | $11,000,000 |
| Income Capitalization Approach – Capitalization | | N/A | $11,100,000 |
| Income Capitalization Approach – DCF | $4,900,000 | $8,800,000 | N/A |

The Cost Approach is indicative of the value of the land plus the depreciated replacement cost of the building, land improvements and equipment. The reliability of this approach depends on the property age and whether or not it has obsolescence. The fact that the subject was built in 1958 with additions in 1966, 1969 and 1986 makes it questionable whether we can reasonably measure the amount of depreciation in the subject improvements. In light of the complexity of estimating the replacement cost and depreciation, it is not necessarily the most reliable of value estimates. Furthermore, the Cost Approach, as performed herein, failed to include intangible assets, such as, but not limited to, the assembled work force, business enterprise assemblage, referral network, marketing plan, medical records, libraries, systems and procedures. In comparison to the other two approaches, we consider its applicability to be less relevant than both the Sales Comparison and Income Capitalization approaches.

The Sales Comparison Approach reflects competitive conditions based on the value of the assets, business enterprise and other intangible assets associated with the operation of a nursing-home-type facility. In the case of special-purpose properties such as the subject, this approach is particularly difficult to apply due to the subjectivity involved in making adjustments for intangible assets and numerous economic considerations that are not always known. The sales comparables used in our

analysis are located throughout the United States. The Sales Comparison Approach in this appraisal is considered less relevant than the Income Capitalization Approach.

The estimated net operating income for the subject is based on actual subject operating history, as well as the buyer's projected operations. We have relied upon financial data provided by the subject's management and our experience in appraising facilities of this kind. We consider our estimate of income and expenses to be reliable and a reasonable measure of market levels. The capitalization and discount rates were derived from the marketplace based upon the sales of similar facilities and our review of other current market data. Overall, the Income Capitalization Approach, utilizing the Direct Capitalization Method and a Discounted Cash Flow Analysis, was considered the best indicator of value for the fee simple interest in the subject property.

**AS IS VALUE BASED UPON HISTORICAL OPERATIONS**

Two methods were used to determine the as is value of the subject based upon historic operations. Historically, the subject has been owned and operated by a non-profit group that operates two larger facilities in Southern California. In the past a number of operational decisions were based upon efficiently operating the group of hospitals rather than solely on the optimal use of the subject as a freestanding facility. The single most problematic operational decision for the subject was a capitation arrangement in which the subject had to pay another hospital to treat its more acute patients. This capitation agreement was ended during 2000 and the subject started to indicate a stronger performance in the three-month period ending November 2000.

The Direct Capitalization Method, after deducting $4,970,000 for the cost of SB 1953 upgrades, results in a value of $1,500,000 and indicates that the cost of the upgrades is not financially feasible. Therefore, a Discounted Cash Flow Analysis was utilized to determine the present value of the cash flows during the remaining life of the subject assuming that the upgrades were not undertaken.

Therefore, it is our opinion that the as is market value based upon historical operations of the fee simple interest in the going concern identified as Huntington East Valley Hospital, as of January 8, 2001 is represented in the rounded amount of:

**$4,900,000**

**AS IS VALUE ASSUMING BUYER'S OPERATIONS**

The proposed buyer of the subject is a group of local doctors that intends to improve the profitability of the subject through increasing the census. Through the requirement of more referring doctors, the buyers intend to increase the inpatient census by 10 patients per day over the next three years.

The two methods to determine the present value of the subject during the transition period are the cost approach and the Discounted Cash Flow Analysis.

The cost approach indicates a value of $7,200,000. The reliance of this approach is limited due to the difficult in estimating effective age of a hospital that was originally built in 1958 with several additions throughout the years. In addition, the Cost Approach as performed within this appraisal failed to value intangible assets such as assemble work force, medical records, medical libraries and goodwill.

Once the value of the subject was established assuming new ownership, the cost of SB 1953 was subtracted to arrive at the as is value. Based upon the as is value assuming buyer's operations, the cost of SB 1953 upgrades is financially feasible and maximally productive.

Therefore, it is our opinion that the prospective value upon stabilization of the fee simple interest in the going concern identified as Huntington East Valley Hospital, as of January 8, 2001, is represented in the rounded amount of:

**$8,800,000**

## PROSPECTIVE STABILIZED VALUE ASSUMING BUYER'S OPERATIONS

The prospective stabilized value is based upon the buyer's stabilized operating projection. Management's assumptions are determined to be reasonable and were accepted as the basis of this valuation with the exception of $1,626,000 in annual income generated by a joint venture between Medical Pathways and the subject. The prospective stabilized value is based upon the Income Capitalization Approach less the cost of SB 1953 earthquake upgrades.

Therefore, it is our opinion that the prospective value upon stabilization of the fee simple interest in the going concern identified as Huntington East Valley Hospital, as of January 8, 2001, is represented in the rounded amount of:

**$11,100,000**

The fee simple value may be allocated as follows:

| | As Is | Upon Stabilization |
|---|---|---|
| Land | $2,550,000 | $2,550,000 |
| Improvements | 3,370,000 | 3,370,000 |
| Equipment | 1,290,000 | 1,290,000 |
| Business Value | 1,600,000 | 3,900,000 |
| Total Value | $8,800,000 | $11,100,000 |

# AREA MAP


South Fork Campground
Paradise Springs
Mt Oak Campground
Upper Pacifico Campground
Lake Campground
Big Pines
Little Rock Creek
Vista Picnic Ground
Three Points
Mill Creek Picnic Grounds
Chilao Campground
Crystal Lake Recreation Area
San Gabriel River
Hidden Springs
Angeles National Forest
Wickiup Campground
Falling Springs
Shortcut Picnic Grounds
San Gabriel Wilderness Area
East Fork San Gabriel River
West Fork San Gabriel River
Devore Campground
Glen Campground
North Fork San Gabriel River
San Gabriel River
Eldoradoville Campground
Mt Baldy
Mt Wilson
Hoegee Campground
San Dimas Experimental Forest
Altadena
Eaton Canyon Park
Arcadia Wilderness Park
Sierra Madre
Monrovia
Duarte
Arcadia
SUBJECT
Azusa
San Dimas Canyon Park
San Marino
Butler
Temple City
Irwindale
College Heights
Alhambra
Live Oak Park
Hollenbeck Park
San Dimas
Covina
Claremont
Baldwin Park
Puddingstone Reservoir State Recreation
South El Monte
South Hills Country Club
Pomona
Montclair
Whittier
Pellissier Spur
La Puente
Walnut
Hacienda Heights
Hillgrove
Chino
Rowland Heights
Los Serranos
Los Nietos
La Habra Heights
Los Serranos Country Club
Sleepy Hollow
Downey
La Habra
Chino Hills
La Mirada
La Vida Mineral Springs
Norwalk
Carlton
Yorba Linda
Bellflower
Fullerton
Placentia
Artesia
Cerritos
Atwood
Lakewood
Anaheim Hills
Olive
Esperanza
Sycamore Park
Yorba
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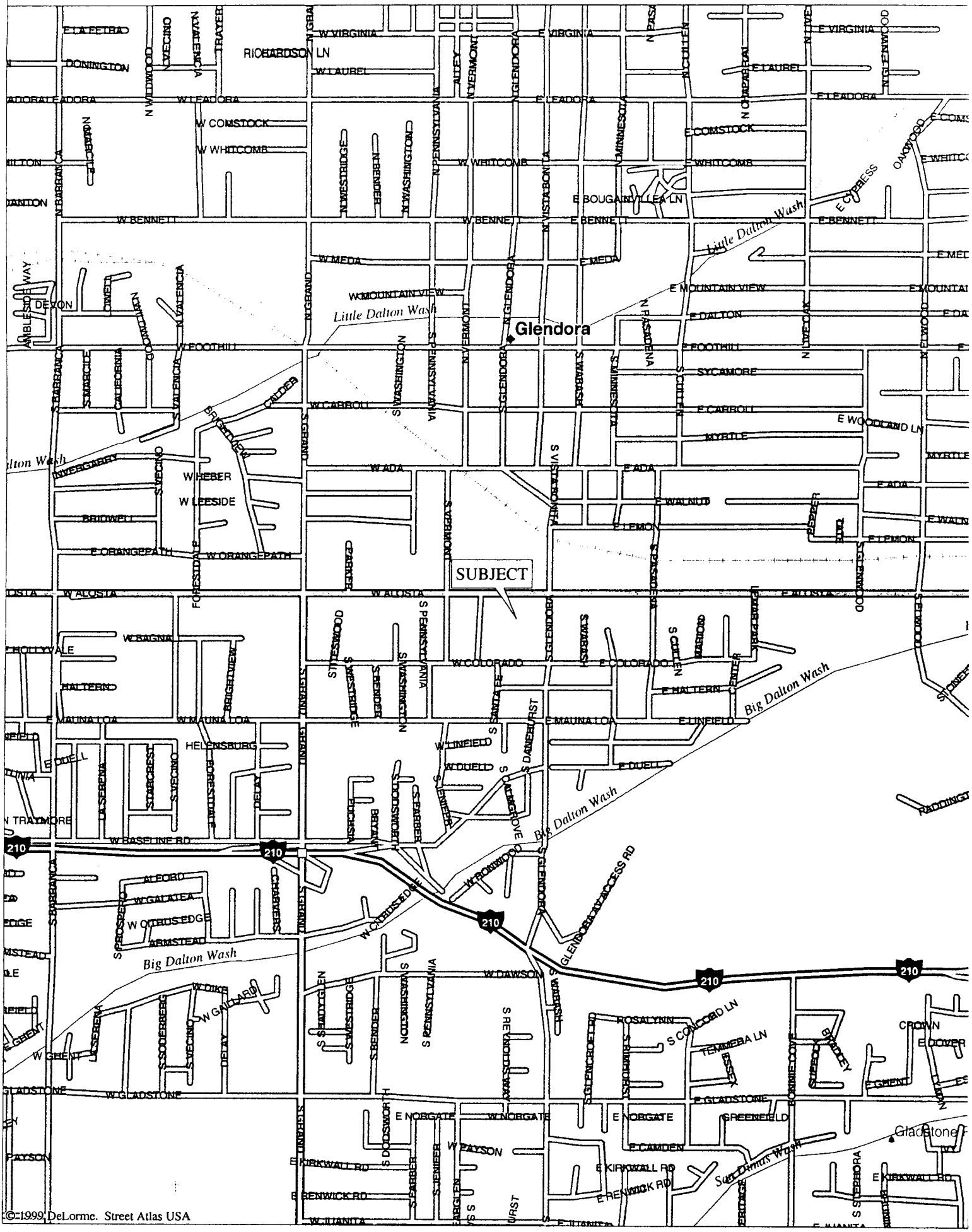
# NEIGHBORHOOD MAP



CONNECT STUDY REPORT OF AGE,HOUSEHOLD TREND
IN CITY OF GLENDORA
Claritas Inc.
Sales (800)234-5973

6-JAN-01
Support (800)780-4237

Study area name: CITY OF GLENDORA

## Age Report



| Age | Population 1990 | | Population 2000 Est. | | Population 2005 Proj. | |
|---|---|---|---|---|---|---|
| Total..... | 47828 | 100.0% | 51923 | 100.0% | 54931 | 100.0% |
| under 5... | 3684 | 7.7% | 3443 | 6.6% | 3502 | 6.4% |
| 5 to 9... | 3459 | 7.2% | 3394 | 6.5% | 3551 | 6.5% |
| 10 to 14... | 3468 | 7.3% | 3504 | 6.7% | 3607 | 6.6% |
| 15 to 17... | 2076 | 4.3% | 2095 | 4.0% | 2250 | 4.1% |
| 18 to 20... | 1941 | 4.1% | 1845 | 3.6% | 2017 | 3.7% |
| 21 to 24... | 2436 | 5.1% | 2443 | 4.7% | 2857 | 5.2% |
| 25 to 29... | 3724 | 7.8% | 3269 | 6.3% | 3228 | 5.9% |
| 30 to 34... | 4295 | 9.0% | 3209 | 6.2% | 3475 | 6.3% |
| 35 to 39... | 3961 | 8.3% | 3700 | 7.1% | 3379 | 6.2% |
| 40 to 44... | 3723 | 7.8% | 4233 | 8.2% | 3841 | 7.0% |
| 45 to 49... | 2951 | 6.2% | 3982 | 7.7% | 4348 | 7.9% |
| 50 to 54... | 2568 | 5.4% | 3733 | 7.2% | 4150 | 7.6% |
| 55 to 59... | 2370 | 5.0% | 3008 | 5.8% | 3685 | 6.7% |
| 60 to 64... | 2115 | 4.4% | 2479 | 4.8% | 2860 | 5.2% |
| 65 to 69... | 1792 | 3.7% | 2262 | 4.4% | 2357 | 4.3% |
| 70 to 74... | 1247 | 2.6% | 1986 | 3.8% | 2036 | 3.7% |
| 75 to 79... | 844 | 1.8% | 1554 | 3.0% | 1680 | 3.1% |
| 80 to 84... | 592 | 1.2% | 916 | 1.8% | 1137 | 2.1% |
| 85 + ..... | 582 | 1.2% | 868 | 1.7% | 971 | 1.8% |
| Median..... | 33.6 | | 38.7 | | 39.4 | |

| Age | Population 1990 Male | Population 1990 Female | Population 2000 Est. Male | Population 2000 Est. Female | Population 2005 Proj. Male | Population 2005 Proj. Female |
|---|---|---|---|---|---|---|
| Total..... | 48.8% | 51.2% | 49.0% | 51.0% | 49.1% | 50.9% |
| under 5... | 3.9% | 3.8% | 3.4% | 3.3% | 3.2% | 3.2% |
| 5 to 9... | 3.7% | 3.5% | 3.3% | 3.2% | 3.3% | 3.2% |
| 10 to 14... | 3.7% | 3.5% | 3.5% | 3.3% | 3.3% | 3.2% |
| 15 to 17... | 2.2% | 2.2% | 2.1% | 2.0% | 2.1% | 2.0% |
| 18 to 20... | 2.0% | 2.0% | 1.8% | 1.7% | 1.9% | 1.7% |
| 21 to 24... | 2.6% | 2.5% | 2.5% | 2.2% | 2.7% | 2.5% |
| 25 to 29... | 3.9% | 3.9% | 3.2% | 3.1% | 3.1% | 2.8% |
| 30 to 34... | 4.4% | 4.6% | 3.1% | 3.0% | 3.2% | 3.1% |
| 35 to 39... | 4.1% | 4.2% | 3.7% | 3.5% | 3.1% | 3.0% |
| 40 to 44... | 3.8% | 4.0% | 4.0% | 4.1% | 3.6% | 3.4% |
| 45 to 49... | 3.0% | 3.2% | 3.8% | 3.9% | 3.9% | 4.0% |
| 50 to 54... | 2.6% | 2.8% | 3.6% | 3.6% | 3.8% | 3.8% |
| 55 to 59... | 2.4% | 2.5% | 2.9% | 2.9% | 3.3% | 3.4% |
| 60 to 64... | 2.1% | 2.3% | 2.3% | 2.5% | 2.5% | 2.7% |
| 65 to 69... | 1.8% | 2.0% | 2.0% | 2.3% | 1.9% | 2.3% |
| 70 to 74... | 1.2% | 1.5% | 1.7% | 2.1% | 1.7% | 2.0% |
| 75 to 79... | 0.7% | 1.1% | 1.3% | 1.7% | 1.3% | 1.8% |
| 80 to 84... | 0.4% | 0.9% | 0.6% | 1.2% | 0.8% | 1.3% |
| 85 + ..... | 0.3% | 0.9% | 0.4% | 1.3% | 0.4% | 1.3% |
| Median..... | 32.7 | 34.6 | 37.2 | 40.3 | 37.7 | 41.0 |

2000 estimates and 2005 projections produced by Claritas Inc.

CONNECT STUDY REPORT OF AGE,HOUSEHOLD TREND
IN LA COUNTY 2005
Claritas Inc.
Sales (800)234-5973

25-SEP-00
Support (800)780-4237

Study area name: LA COUNTY 2005

## Household Trend Report

| Universe | 1980 Census | 1990 Census | % Chg 80-90 | 2000 (Est.) | % Chg 90-00 | 2005 (Proj.) | % Chg 00-05 |
|---|---|---|---|---|---|---|---|
| Population.... | 7477506 | 8863164 | 18.5 | 9529721 | 7.5 | 10050616 | 5.5 |
| Households.... | 2730471 | 2989552 | 9.5 | 3175119 | 6.2 | 3358672 | 5.8 |
| Families..... | 1811593 | 2013926 | 11.2 | 2079124 | 3.2 | 2168030 | 4.3 |
| Housing Units. | 2855576 | 3163343 | 10.8 | 3339754 | 5.6 | 3532825 | 5.8 |
| Grp Qrt. Pop.. | 142059 | 172065 | 21.1 | 178371 | 3.7 | 179657 | 0.7 |
| Household Size | 2.69 | 2.91 | 8.2 | 2.95 | 1.3 | 2.94 | -0.2 |

| Income | 1979 (Census) | 1989 (Census) | % Chg 79-89 | 2000 (Est.) | % Chg 89-00 | 2005 (Proj.) | % Chg 00-05 |
|---|---|---|---|---|---|---|---|
| Aggregate($MM) | 62085 | 142608 | 129.7 | 209977 | 47.2 | 251978 | 20.0 |
| Per Capita.... | 8303 | 16090 | 93.8 | 22034 | 36.9 | 25071 | 13.8 |
| Avg. Household | 22481 | 47313 | 110.5 | 65859 | 39.2 | 74534 | 13.2 |
| Median Hhold.. | 17554 | 35011 | 99.5 | 44692 | 27.7 | 47123 | 5.4 |
| Avg. Family HH | 25865 | 53717 | 107.7 | 75714 | 40.9 | 85555 | 13.0 |
| Med. Family HH | 21123 | 40697 | 92.7 | 51860 | 27.4 | 53392 | 3.0 |
| Avg. HH Wealth | | | | 164340 | | 178133 | 8.4 |
| Med. HH Wealth | | | | 45057 | | 51937 | 15.3 |

| | Households | | | | | |
|---|---|---|---|---|---|---|
| Household Income | 1990 Census | | 2000 Estimate | | 2005 Proj. | |
| Total..... | 2989552 | | 3175119 | | 3358672 | |
| Less than $5,000..... | 141826 | 4.7% | 103443 | 3.3% | 92999 | 2.8% |
| $5,000 to $9,999..... | 239693 | 8.0% | 170284 | 5.4% | 164636 | 4.9% |
| $10,000 to $14,999..... | 224722 | 7.5% | 205660 | 6.5% | 202096 | 6.0% |
| $15,000 to $19,999..... | 222360 | 7.4% | 190401 | 6.0% | 206485 | 6.1% |
| $20,000 to $24,999..... | 231443 | 7.7% | 197386 | 6.2% | 204161 | 6.1% |
| $25,000 to $29,999..... | 217755 | 7.3% | 187635 | 5.9% | 183989 | 5.5% |
| $30,000 to $34,999..... | 216477 | 7.2% | 182746 | 5.8% | 191590 | 5.7% |
| $35,000 to $39,999..... | 189630 | 6.3% | 178377 | 5.6% | 170924 | 5.1% |
| $40,000 to $44,999..... | 179719 | 6.0% | 181452 | 5.7% | 180733 | 5.4% |
| $45,000 to $49,999..... | 148017 | 5.0% | 137187 | 4.3% | 161386 | 4.8% |
| $50,000 to $59,999..... | 254817 | 8.5% | 283070 | 8.9% | 257714 | 7.7% |
| $60,000 to $74,999..... | 264220 | 8.8% | 328644 | 10.4% | 347574 | 10.3% |
| $75,000 to $99,999..... | 223372 | 7.5% | 347596 | 10.9% | 376008 | 11.2% |
| $100,000 to $124,999..... | 100956 | 3.4% | 161470 | 5.1% | 201788 | 6.0% |
| $125,000 to $149,999..... | 43198 | 1.4% | 107024 | 3.4% | 112274 | 3.3% |
| $150,000 to $249,999..... | 53769 | 1.8% | 133914 | 4.2% | 179431 | 5.3% |
| $250,000 to $499,999..... | 24223 | 0.8% | 50756 | 1.6% | 82716 | 2.5% |
| $500,000 or More..... | 13355 | 0.4% | 28074 | 0.9% | 42168 | 1.3% |

NOTE: When the median household wealth for an area is less than $25,000 it will be listed on this report as $24,999.

Data on income are expressed in "current" dollars for each year.
Decennial Census data reflects prior year income.
2000 estimates and 2005 projections produced by Claritas Inc.

CONNECT STUDY REPORT OF AGE,HOUSEHOLD TREND
IN LA COUNTY 2005
Claritas Inc.
Sales (800)234-5973

25-SEP-00
Support (800)780-4237

Study area name: LA COUNTY 2005

Age Report



| Age | Population 1990 | | Population 2000 Est. | | Population 2005 Proj. | |
|---|---|---|---|---|---|---|
| Total..... | 8863164 | 100.0% | 9529721 | 100.0% | 10050616 | 100.0% |
| under 5... | 762493 | 8.6% | 758403 | 8.0% | 762188 | 7.6% |
| 5 to 9... | 641951 | 7.2% | 733216 | 7.7% | 746615 | 7.4% |
| 10 to 14... | 581713 | 6.6% | 718436 | 7.5% | 742256 | 7.4% |
| 15 to 17... | 361615 | 4.1% | 381578 | 4.0% | 445526 | 4.4% |
| 18 to 20... | 448686 | 5.1% | 379957 | 4.0% | 391951 | 3.9% |
| 21 to 24... | 656702 | 7.4% | 503236 | 5.3% | 549582 | 5.5% |
| 25 to 29... | 901294 | 10.2% | 704362 | 7.4% | 641459 | 6.4% |
| 30 to 34... | 852241 | 9.6% | 769317 | 8.1% | 720697 | 7.2% |
| 35 to 39... | 722933 | 8.2% | 820284 | 8.6% | 778033 | 7.7% |
| 40 to 44... | 599808 | 6.8% | 787615 | 8.3% | 807520 | 8.0% |
| 45 to 49... | 461669 | 5.2% | 684989 | 7.2% | 787741 | 7.8% |
| 50 to 54... | 372779 | 4.2% | 566180 | 5.9% | 679542 | 6.8% |
| 55 to 59... | 329566 | 3.7% | 421129 | 4.4% | 547006 | 5.4% |
| 60 to 64... | 314980 | 3.6% | 327491 | 3.4% | 395310 | 3.9% |
| 65 to 69... | 287331 | 3.2% | 282899 | 3.0% | 306935 | 3.1% |
| 70 to 74... | 216327 | 2.4% | 251034 | 2.6% | 257767 | 2.6% |
| 75 to 79... | 163584 | 1.8% | 199314 | 2.1% | 214972 | 2.1% |
| 80 to 84... | 101843 | 1.1% | 122571 | 1.3% | 144258 | 1.4% |
| 85 + ..... | 85649 | 1.0% | 117710 | 1.2% | 131258 | 1.3% |
| Median..... | 30.5 | | 33.8 | | 35.2 | |

| Age | Population 1990 Male | Population 1990 Female | Population 2000 Est. Male | Population 2000 Est. Female | Population 2005 Proj. Male | Population 2005 Proj. Female |
|---|---|---|---|---|---|---|
| Total..... | 49.9% | 50.1% | 49.9% | 50.1% | 49.9% | 50.1% |
| under 5... | 4.4% | 4.2% | 4.0% | 3.9% | 3.8% | 3.7% |
| 5 to 9... | 3.7% | 3.5% | 3.9% | 3.8% | 3.8% | 3.7% |
| 10 to 14... | 3.4% | 3.2% | 3.9% | 3.7% | 3.8% | 3.6% |
| 15 to 17... | 2.1% | 2.0% | 2.1% | 1.9% | 2.3% | 2.2% |
| 18 to 20... | 2.7% | 2.4% | 2.1% | 1.9% | 2.0% | 1.9% |
| 21 to 24... | 4.0% | 3.5% | 2.8% | 2.5% | 2.8% | 2.6% |
| 25 to 29... | 5.3% | 4.8% | 3.9% | 3.5% | 3.4% | 3.0% |
| 30 to 34... | 4.9% | 4.7% | 4.3% | 3.8% | 3.8% | 3.3% |
| 35 to 39... | 4.1% | 4.0% | 4.4% | 4.2% | 4.1% | 3.6% |
| 40 to 44... | 3.3% | 3.4% | 4.1% | 4.1% | 4.1% | 4.0% |
| 45 to 49... | 2.6% | 2.7% | 3.5% | 3.7% | 3.9% | 4.0% |
| 50 to 54... | 2.1% | 2.1% | 2.9% | 3.0% | 3.3% | 3.5% |
| 55 to 59... | 1.8% | 1.9% | 2.2% | 2.3% | 2.7% | 2.8% |
| 60 to 64... | 1.7% | 1.9% | 1.6% | 1.8% | 1.9% | 2.1% |
| 65 to 69... | 1.4% | 1.8% | 1.3% | 1.6% | 1.4% | 1.7% |
| 70 to 74... | 1.0% | 1.4% | 1.1% | 1.5% | 1.1% | 1.4% |
| 75 to 79... | 0.7% | 1.1% | 0.8% | 1.2% | 0.9% | 1.3% |
| 80 to 84... | 0.4% | 0.7% | 0.5% | 0.8% | 0.5% | 0.9% |
| 85 + ..... | 0.3% | 0.7% | 0.3% | 0.9% | 0.4% | 0.9% |
| Median..... | 29.4 | 31.6 | 32.7 | 35.1 | 34.0 | 36.4 |

2000 estimates and 2005 projections produced by Claritas Inc.

Study area name: LA COUNTY 2005

## Age Report



### Female Population

| Age | 1990 | | 2000 Est. | | 2005 Proj. | |
|---|---|---|---|---|---|---|
| Total..... | 4442180 | 100.0% | 4777556 | 100.0% | 5039894 | 100.0% |
| under 5... | 372932 | 8.4% | 373360 | 7.8% | 375625 | 7.5% |
| 5 to 9... | 313673 | 7.1% | 361139 | 7.6% | 367515 | 7.3% |
| 10 to 14... | 284050 | 6.4% | 351293 | 7.4% | 365080 | 7.2% |
| 15 to 17... | 173352 | 3.9% | 185062 | 3.9% | 216145 | 4.3% |
| 18 to 20... | 208912 | 4.7% | 181129 | 3.8% | 189645 | 3.8% |
| 21 to 24... | 306257 | 6.9% | 238152 | 5.0% | 264856 | 5.3% |
| 25 to 29... | 429514 | 9.7% | 329837 | 6.9% | 303903 | 6.0% |
| 30 to 34... | 415106 | 9.3% | 361772 | 7.6% | 336464 | 6.7% |
| 35 to 39... | 358588 | 8.1% | 397353 | 8.3% | 363955 | 7.2% |
| 40 to 44... | 304062 | 6.8% | 393410 | 8.2% | 398641 | 7.9% |
| 45 to 49... | 235061 | 5.3% | 348140 | 7.3% | 399602 | 7.9% |
| 50 to 54... | 190279 | 4.3% | 289594 | 6.1% | 346840 | 6.9% |
| 55 to 59... | 170816 | 3.8% | 215473 | 4.5% | 280193 | 5.6% |
| 60 to 64... | 168360 | 3.8% | 171085 | 3.6% | 206113 | 4.1% |
| 65 to 69... | 159270 | 3.6% | 154686 | 3.2% | 166594 | 3.3% |
| 70 to 74... | 124504 | 2.8% | 142640 | 3.0% | 144868 | 2.9% |
| 75 to 79... | 99448 | 2.2% | 118965 | 2.5% | 127406 | 2.5% |
| 80 to 84... | 66385 | 1.5% | 79306 | 1.7% | 92003 | 1.8% |
| 85 + ..... | 61611 | 1.4% | 85160 | 1.8% | 94446 | 1.9% |
| Median..... | 31.6 | | 35.1 | | 36.4 | |

### Male Population

| Age | 1990 | | 2000 Est. | | 2005 Proj. | |
|---|---|---|---|---|---|---|
| Total..... | 4420984 | 100.0% | 4752165 | 100.0% | 5010722 | 100.0% |
| under 5... | 389561 | 8.8% | 385043 | 8.1% | 386563 | 7.7% |
| 5 to 9... | 328278 | 7.4% | 372077 | 7.8% | 379100 | 7.6% |
| 10 to 14... | 297663 | 6.7% | 367143 | 7.7% | 377176 | 7.5% |
| 15 to 17... | 188263 | 4.3% | 196516 | 4.1% | 229381 | 4.6% |
| 18 to 20... | 239774 | 5.4% | 198828 | 4.2% | 202306 | 4.0% |
| 21 to 24... | 350445 | 7.9% | 265084 | 5.6% | 284726 | 5.7% |
| 25 to 29... | 471780 | 10.7% | 374525 | 7.9% | 337556 | 6.7% |
| 30 to 34... | 437135 | 9.9% | 407545 | 8.6% | 384233 | 7.7% |
| 35 to 39... | 364345 | 8.2% | 422931 | 8.9% | 414078 | 8.3% |
| 40 to 44... | 295746 | 6.7% | 394205 | 8.3% | 408879 | 8.2% |
| 45 to 49... | 226608 | 5.1% | 336849 | 7.1% | 388139 | 7.7% |
| 50 to 54... | 182500 | 4.1% | 276586 | 5.8% | 332702 | 6.6% |
| 55 to 59... | 158750 | 3.6% | 205656 | 4.3% | 266813 | 5.3% |
| 60 to 64... | 146620 | 3.3% | 156406 | 3.3% | 189197 | 3.8% |
| 65 to 69... | 128061 | 2.9% | 128213 | 2.7% | 140341 | 2.8% |
| 70 to 74... | 91823 | 2.1% | 108394 | 2.3% | 112899 | 2.3% |
| 75 to 79... | 64136 | 1.5% | 80349 | 1.7% | 87566 | 1.7% |
| 80 to 84... | 35458 | 0.8% | 43265 | 0.9% | 52255 | 1.0% |
| 85 + ..... | 24038 | 0.5% | 32550 | 0.7% | 36812 | 0.7% |
| Median..... | 29.4 | | 32.7 | | 34.0 | |

# LEGAL DESCRIPTION

PARCEL 1:

THE WESTERLY 100 FEET OF THE NORTH 270 FEET OF LOT "A" OF TRACT NO. 2998, OF LE MAR'S ADDDITION TO THE TOWN OF ALOSTA, IN THE CITY OF GLENDORA, COUNTY OF LOS ANGELES, STATE OF CALIFORNIA, AS PER MAP RECORDED IN BOOK 36 PAGE 81 OF MAPS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY.

EXCEPT THEREFROM, THE SOUTHERLY 15 FEET.

ALSO EXCEPT THEREFROM THAT PORTION OF DESCRIBED AS FOLLOWS:

BEGINNING AT THE NORTHWEST CORNER OF SAID WEST 100 FEET OF THE SOUTH 235 FEET OF THE NORTH 255 FEET OF AFOREMENTIONED LOT A, SAID CORNER BEING ON THE SOUTHERLY LINE OF ALOSTA AVENUE AND SAID CORNER BEING ALSO ON THE EASTERLY LINE OF SANTA FE AVENUE; THENCE EASTERLY ALONG THE SOUTHERLY LINE OF ALOSTA AVENUE 24.63 FEET TO THE BEGINNING OF A TANGENT CURVE CONCAVE SOUTHEASTERLY HAVING A RADIUS OF 25 FEET AND AN ARC LENGTH OF 38.88 FEET; THENCE SOUTHWESTERLY ALONG SAID CURVE 38.88 FEET TO A POINT ON THE EASTERLY LINE OF SANTA FE AVENUE, THENCE NORTHERLY ALONG SAID EASTERLY LINE OF SANTA FE AVENUE 24.63 FEET TO THE POINT OF BEGINNING, AS GRANTED TO THE CITY OF GLENDORA, COUNTY OF LOS ANGELES, STATE OF CALIFORNIA, BY A DEED RECORDED FEBRUARY 10, 1964 AS INSTRUMENT NO. 3791.

PARCEL 2:

THE EASTERLY 100 FEET OF THE WESTERLY 200 FEET OF THE NORTH 270 FEET OF LOT A, OF TRACT NO. 2998, IN LE MAR'S ADDITION TO THE TOWN OF ALOSTA, IN THE CITY OF GLENDORA, COUNTY OF LOS ANGELES, STATE OF CALIFORNIA, AS PER MAP RECORDED IN BOOK 36 PAGE 81 OF MAPS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY.

PARCEL 3:

THE WESTERLY 200 FEET OF THE SOUTH 50 FEET OF THE NORTH 320 FEET OF LOT "A" IN TRACT NO. 2998, IN THE CITY OF GLENDORA, COUNTY OF LOS ANGELES, STATE OF CALIFORNIA, AS PER MAP RECORDED IN BOOK 36 PAGE 81, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY.

PARCEL 4:

THE SOUTHERLY 15 FEET OF THE WESTERLY 100 FEET OF THE NORTH 270 FEET OF LOT "A" OF TRACT NO. 2998, OF LE MAR'S ADDITON TO THE TOWN OF ALOSTA, IN THE CITY OF GLENDORA, COUNTY OF LOS ANGELES, STATE OF CALIFORNIA, AS PER MAP RECORDED IN BOOK 36 PAGE 81 OF MPAS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY.

PARCEL 5:

PARCEL 2 OF PARCEL MAP NO. 13990 IN THE CITY OF GLENDORA, COUNTY OF LOS ANGELES, STATE OF CALIFORNIA, AS PER MAP FILED IN BOOK 146 PAGES 21 AND 22 OF PARCEL MAPS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY.

PARCEL 6:

LOTS 2 AND 3 BLOCK 12 OF LE MAR'S ADDITION TO THE TOWN OF ALOSTA, IN THE CITY OF GLENDORA, COUNTY OF LOS ANGELES, STATE OF CALIFORNIA, AS PER MAP RECORDED IN BOOK

# LEGAL DESCRIPTION

16 PAGES 75 AND 76 OF MISCELLANEOUS RECORDS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY.

PARCEL 7:

LOTS 1 AND 2 OF TRACT 8387, IN THE CITY OF GLENDORA, COUNTY OF LOS ANGELES, STATE OF CALIFORNIA, AS PER MAP RECORDED IN BOOK 118 PAGE 19 OF MAPS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY.

PARCEL 8:

LOT 3, OF TRACT 8387, IN THE CITY OF GLENDORA, COUNTY OF LOS ANGELES, STATE OF CALIFORNIA, AS PER MAP RECORDED IN BOOK 118 PAGE 19 OF MAPS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY.

PARCEL 9:

PARCEL 1, IN THE CITY OF GLENDORA, COUNTY OF LOS ANGELES, STATE OF CALIFORNIA, AS SHOWN ON PARCEL MAP NO. 13990, AS PER MAP RECORDED IN BOOK 146, PAGES 21 AND 22 OF PARCEL MAPS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY.

LICENSE NUMBER: 93000
LICENSE EFFECTIVE DATE: 03/31/
LICENSE EXPIRATION DATE: 03/30/
TOTAL LICENSED CAPACITY:

# State of California

# Department of Health Services

In accordance with applicable provisions of the Health and Safety Code of California and its rules and regulations, the Department of Health Services hereby issues

# this License to

HUNTINGTON EAST VALLEY HOSPITAL

to operate and maintain the following GENERAL ACUTE CARE HOSPITAL

HUNTINGTON EAST VALLEY HOSPITAL
150 W. ALOSTA AVE, GLENDORA, CA 91740

BED CLASSIFICATIONS/SERVICES

107 General Acute Care
30 Perinatal
5 Coronary Care
5 Intensive Care
67 Unspecified General Acute Care

OTHER APPROVED SERVICES

Basic Emergency
Outpatient Services at 130 W. ALOSTA AVE., GLENDORA
Nuclear Medicine
Outpatient Services
Respiratory Care Svs

HUNTINGTON EAST VALLEY HOSPITAL D/P APH
150 W. ALOSTA AVENUE, GLENDORA, CA 91740

21 Acute Psychiatric

This LICENSE is not transferable and is granted solely upon the following conditions, limitations and comments:

3 Perinatal beds in suspense are being used for 2 Alternative Birth Center.

Diana M. Bonta', R.N., Dr. P.H.
DIRECTOR

Eric Stone, REHS
AUTHORIZED REPRESENTATIVE

Refer complaints regarding these facilities to The County of Los Angeles, Health Facilities Division, Acute Ancillary Services Section, 5555 Ferguson Drive, 3rd Floor, Commerce, CA 90022, (323)869-8207

HS 203 A (6/98)

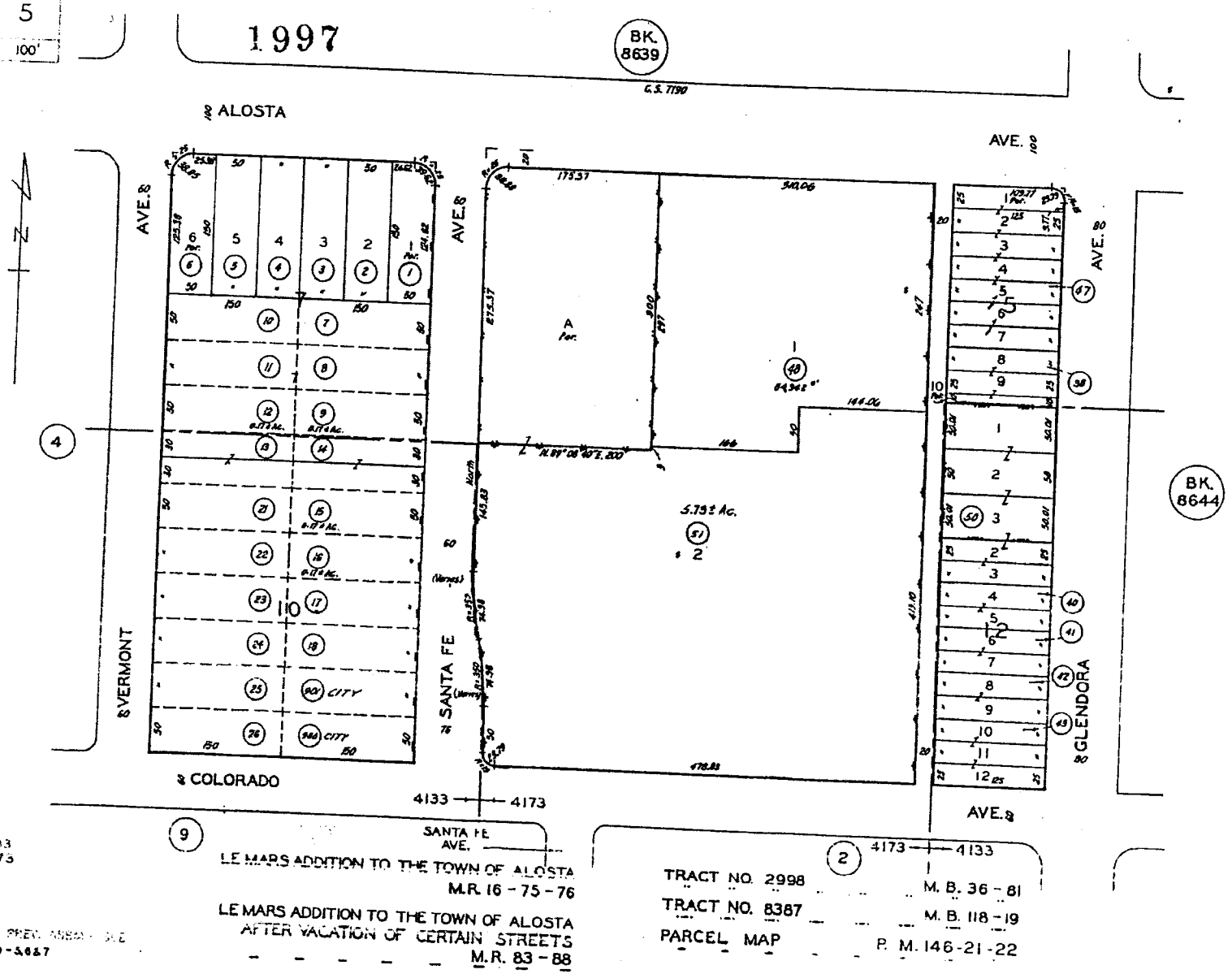
POST IN A PROMINENT PLACE

County of Los Angeles: Rick Auerbach, Assessor

8640 5

SCALE 1" = 100'

1997




LE MARS ADDITION TO THE TOWN OF ALOSTA
M.R. 16 - 75 - 76

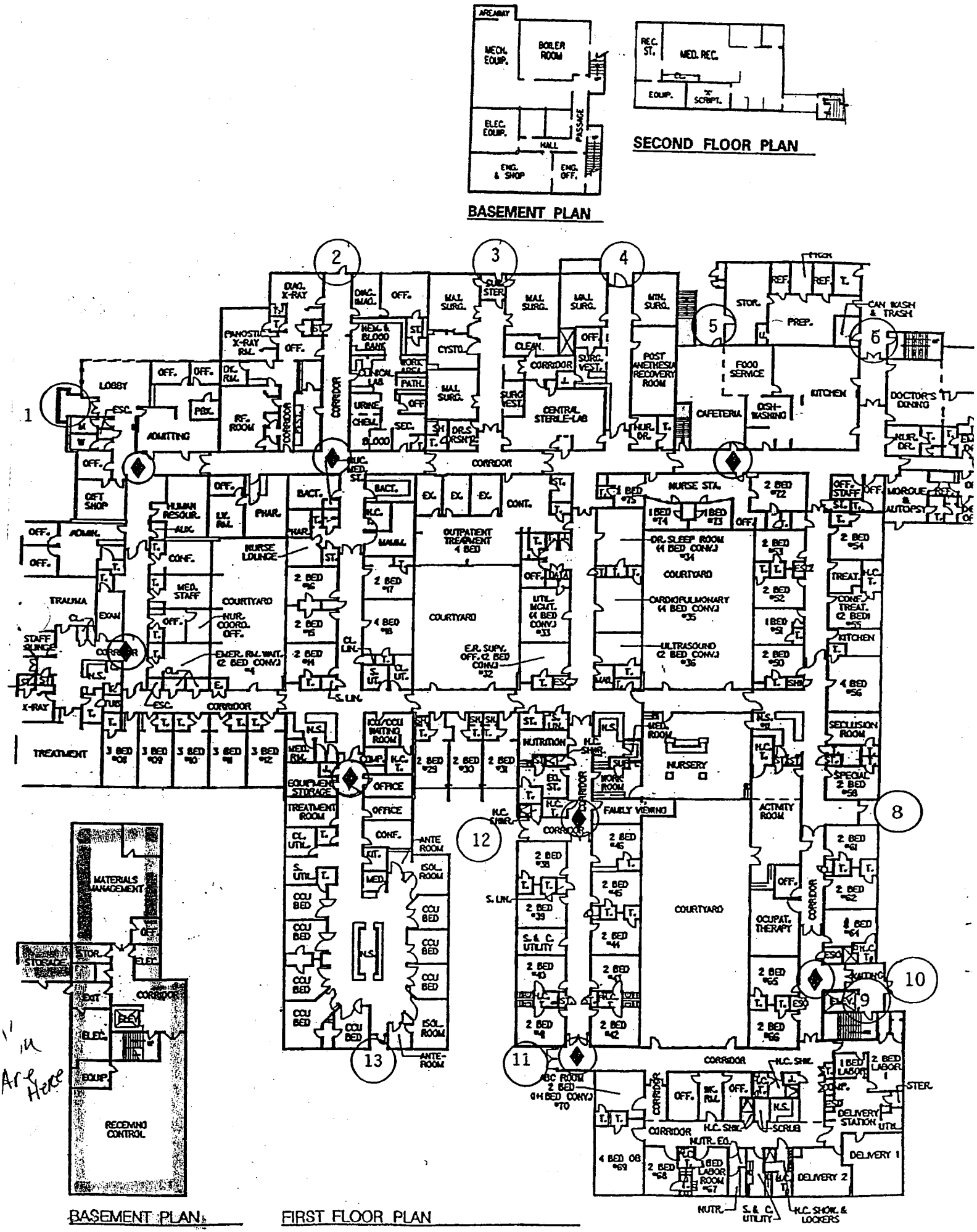
LE MARS ADDITION TO THE TOWN OF ALOSTA
AFTER VACATION OF CERTAIN STREETS
M.R. 83 - 88

TRACT NO. 2998 M. B. 36 - 81

TRACT NO. 8387 M. B. 118 - 19

PARCEL MAP P. M. 146-21-22

FOR PREV. ASSM'T SEE
8640 - 5 & 7


AREAWAY
MECH. EQUIP.
BOILER ROOM
ELEC. EQUIP.
PASSAGE
HALL
ENG. & SHOP
ENG. OFF.
REC. ST.
MED. REC.
EQUIP.
SCRIPT.
SECOND FLOOR PLAN
BASEMENT PLAN
1
2
3
4
5
6
8
9
10
11
12
13
LOBBY
ADMITTING
CORRIDOR
DIAG. X-RAY
PANOSTIL X-RAY RM.
RF. ROOM
PBX.
GIFT SHOP
HUMAN RESOUR.
ADMIN.
LAB.
PHAR.
BACT.
NURSE LOUNGE
MED. STAFF
COURTYARD
NUR. COORD. OFF.
TRAUMA
EXAM
STAFF SURGE
X-RAY
TREATMENT
3 BED #8
3 BED #9
3 BED #10
3 BED #11
3 BED #12
EMER. RM. WAIT. (2 BED CONV.) #4
2 BED #6
2 BED #7
2 BED #15
2 BED #14
4 BED #18
OUTPATIENT TREATMENT 4 BED
COURTYARD
E.R. SUPV. OFF. (2 BED CONV.) #32
UTIL. MGMT. (4 BED CONV.) #33
MAL. SURG.
CYSTO.
CENTRAL STERILE-LAB
CLEAN.
SURG. VEST.
POST ANESTHESIA RECOVERY ROOM
FOOD SERVICE
KITCHEN
CAFETERIA
DISH-WASHING
DOCTORS DINING
STOR.
PREP.
REF.
CAN WASH & TRASH
NURSE STA.
1 BED #74
1 BED #73
2 BED #72
OR. SLEEP ROOM (4 BED CONV.) #34
CARDIOPULMONARY (4 BED CONV.) #35
ULTRASOUND (2 BED CONV.) #36
2 BED #53
2 BED #52
1 BED #51
2 BED #50
2 BED #54
TREAT.
CONF. TREAT. (2 BED) #55
KITCHEN
4 BED #56
SECLUSION ROOM
SPECIAL 2 BED #58
MORGUE & AUTOPSY
OFF. STAFF
NURSERY
MED. ROOM
NUTRITION
WORK ROOM
FAMILY VIEWING
ACTIVITY ROOM
OCCUPAT. THERAPY
2 BED #61
2 BED #62
1 BED #64
2 BED #65
2 BED #66
2 BED #45
2 BED #46
2 BED #44
2 BED #43
2 BED #42
2 BED #38
2 BED #39
2 BED #40
2 BED #41
S. & C. UTILITY
COURTYARD
ICU/CCU WAITING ROOM
EQUIPMENT STORAGE
TREATMENT ROOM
OFFICE
CONF.
ANTE ROOM
ISOL. ROOM
CCU BED
2 BED #29
2 BED #30
2 BED #31
MATERIALS MANAGEMENT
STOR.
ELEC.
EXIT
CORRIDOR
EQUIP.
RECEIVING CONTROL
ISOL. ROOM 2 BED (4 BED CONV.) #70
1 BED LABOR
2 BED LABOR
STER.
DELIVERY STATION
UTIL.
SCRUB
DELIVERY 1
DELIVERY 2
4 BED OB #59
2 BED #58
1 BED LABOR ROOM #57
NUTR.
NUTR. EQ.
S. & C. UTILITY
H.C. SHOW. & LOCKERS
BASEMENT PLAN
FIRST FLOOR PLAN

# DETAILED SB 1953 SEISMIC EVALUATION
# STRUCTURAL AND NON-STRUCTURAL COMPONENTS

# Huntington East Valley Hospital

150 West Alosta Avenue
Glendora, California 91740

FOR

## Southern California Healthcare Systems

BY

▲▲ INTEGRATED DESIGN SERVICES, INC.
Structural Engineers

Job No. 20.147

December 29, 2000

# Table of Contents



## Appendix

▲▲ INTEGRATED DESIGN SERVICES, INC.
250 N. Golden Circle Drive, Suite 105
Santa Ana, CA 92705
Tel: 714-541-5440
Fax: 714-541-5330

December 29, 2000

Jim Maki
President & CEO
Huntington East Valley Hospital
150 West Alosta Avenue
Glendora, California 91740

Re: Detailed SB 1953 Seismic Evaluation
For Structural and Non-Structural Components

# EXECUTIVE SUMMARY

Huntington East Valley Hospital is an acute care hospital (housing 128 beds), which serves the Glendora area in Los Angeles County, California. The main hospital extends over 87,550 sq. ft. This includes additions completed in 1966 and 1969 and alterations to ICU in 1986. A partial basement includes 24,000 sq. ft.

IDS performed a seismic evaluation of the facility to determine the structural and non-structural seismic vulnerability. Strengthening schemes are proposed in order to meet OSHPD's deadlines of years 2002, 2008, and 2030. In order to minimize the interruption of the operation of the hospital during construction, it is proposed to implement the work in several construction phases.

The buildings at Huntington East Valley Hospital are non-compliant buildings according to SB 1953. The structural and non-structural systems are classified as SPC 1 and NPC 1, respectively. Based on our evaluation of the subject property the following summarizes the cost estimates for various required upgrade work:

- Probable construction costs for structural, non-structural, and ADA upgrade work required before 2002 (upgrade to NPC 2) to permit acute care operations beyond 2002 is $170,400.

- Probable construction costs for structural, non-structural, and ADA upgrade work required before 2008 (upgrade to SPC 2 and NPC 3) to permit acute care operations beyond 2008 is $4,800,000.

The probable construction cost to permit acute care operations until 2030 is $4,970,400.

- Probable construction costs for structural and ADA upgrade work required before 2030 to permit acute care operations beyond 2030 is $1,000,000.

- Probable construction costs for non-structural, and ADA upgrade work required before 2030 (upgrade to NPC 5) to permit acute care operations beyond 2030 is $154,000.

The probable additional construction cost to permit acute care operations after 2030 is $1,154,000.

# 1.0 INTRODUCTION

Integrated Design Services, Inc. (IDS) was retained by Huntington East Valley Hospital to perform the required preliminary structural analysis and cost estimates to comply with the State of California Senate Bill 1953 regulations. This report addresses the findings for Huntington East Valley Hospital.

Senate Bill 1953 (SB1953) was signed into law by California legislature on September 22, 1994, following the January 17, 1994 Northridge Earthquake. This bill requires all acute care hospitals to conform to minimum seismic standards established by the Alfred E. Alquist Hospital Facilities Seismic Safety Act of 1983.

The Northridge Earthquake demonstrated that hospitals built in accordance with this act suffered little damage, while several hospitals built prior to the act suffered major damages. An earthquake survivability inventory of California's hospitals, which was completed by OSHPD, indicated that over 20% of the 90,000 plus hospital beds are in buildings posing significant risks of collapse since they were built before present day earthquake codes were established. The existing bill (SB 1953), under the jurisdiction of the Office of Statewide Health Planning and Development, established a program of seismic safety building standards for certain hospitals constructed on and after March 1, 1973.

## 1.1 SPC AND NPC CLASSIFICATIONS

According to SB 1953, by January 1, 2001, all hospitals shall submit the seismic evaluation report to OSHPD for review and approval. The seismic evaluation report shall determine the seismic performance categories for both the Structural Performance Category (SPC) and the Non-Structural Performance Category (NPC). The bill requires that after January 1, 2008, general acute care hospital buildings that are determined to pose certain risks shall only be used for non-acute care hospital purposes.

The evaluation report places the building in the appropriate SPC based on the qualitative and quantitative results of the procedures and the list of deficiencies. There are five classifications for the SPC, ranging from SPC1 to SPC5. Buildings with SPC1 classification are the most critical and require to be upgraded to the SPC2 level by January 1, 2008. SPC5 is assigned to buildings with adequate seismic behavior. These buildings may be used without restriction through January 1, 2030 and beyond.

The following table (Table 1) describes the SPC classifications and the corresponding time frames. It is taken from Table 2.5.3 from SB 1953 seismic evaluation procedure for hospital buildings published by OSHPD.

**Table 1. Structural Performance Categories (SPC)**

| Time Frames | SPC | Description |
|---|---|---|
| | SPC 1 | Buildings posing a significant risk of collapse and danger to the public. These buildings must be brought up to the SPC 2 level by January 1, 2008 or will be removed from acute care service. |
| Jan. 1, 2008 | SPC 2 | Buildings in compliance with the pre-1973 California Building Standards Code or other applicable standards but not in compliance with the structural provisions of the Alquist Hospital Facilities Seismic Safety Act. These buildings do not significantly jeopardize life, but may not be repairable or functional following strong ground motion. These buildings must be brought into compliance with the structural provisions of the Alquist Hospital Facilities Seismic Safety Act; its regulations, or its retrofit provisions by January 1, 2030 or be removed from acute care service. |
| Jan. 1, 2030 | SPC 3 | Buildings in compliance with the structural provisions of the Alquist Hospital Facilities Seismic Safety Act utilizing steel moment resisting frames in regions of high seismicity as defined in Section 4.2.10 and constructed under a permit issued prior to October 25, 1994. These buildings may experience structural damage which does not significantly jeopardize life, but may not be repairable or functional following strong ground motion. Buildings in this category will have been constructed or reconstructed under a building permit obtained through OSHPD. These buildings may be used through January 1, 2030 and beyond. |
| Jan. 1, 2030 | SPC 4 | Buildings in compliance with the structural provisions of the Alquist Hospital Facilities Seismic Safety Act but may experience structural damage which may inhibit ability to provide services to the public following strong ground motion. Buildings in this category will have been constructed or reconstructed under a building permit obtained through OSHPD. These buildings may be used through January 1, 2030 and beyond. |
| Jan 1, 2030 | SPC 5 | Buildings in compliance with the structural provisions of the Alquist Hospital Facilities Seismic Safety Act and are reasonably capable of providing services to the public following strong ground motion. Buildings in this category will have been constructed or reconstructed under a building permit obtained through OSHPD. These buildings may be used without restriction through January 1, 2030 and beyond. |

The evaluation report places the buildings in the appropriate SPC based on the qualitative and quantitative results of the evaluation procedure and the list of deficiencies. There are five classifications for SPC, ranging from SPC 1 to SPC 5. Buildings with SPC 1 classification are the most critical and require to be upgraded to the SPC 2 level by January 1, 2008 or only be used for non-acute care hospital purposes after that date. SPC 5 is assigned to buildings with adequate seismic performance; these buildings may be used without restriction through January 1, 2030 and beyond.

Table 1 above describes the SPC classifications and the corresponding time frame for upgrade. It is taken from Table 2.5.3 of SB 1953 seismic evaluation procedure for hospital buildings published by OSHPD.

Similarly, there are five classifications for NPC, ranging from NPC 1 to NPC 5. The following Table 2 describes NPC classifications and the corresponding time frames. It is taken from Table 11.1 of the SB 1953 seismic evaluation procedure for hospital buildings published by OSHPD.

The non-structural items include medical equipment, heating, ventilation, air-conditioning (HVAC) system, piping, lights, etc. Damage to these components can disable a hospital's operations even if it is structurally safe following an earthquake. Patients and staff are particularly vulnerable to serious injury from damaged, non-structural elements. If not anchored sufficiently for seismic forces, heavy overhead objects such as light fixtures, patient-room TV's, and pieces of medical equipment are particularly hazardous. Bracing can be installed to resist the additional seismic loads, or safety chains can be fastened to the floor or roof to keep these objects from falling or swinging.

It is not uncommon for large equipment to slide several feet during an earthquake. Compressed gas cylinders are extremely prone to overturning unless adequately restrained. As a general rule, equipment whose height is

twice its width is vulnerable to overturning. Large-capacity hot water boilers and other pressure vessels and broken distillation pipes can release fluids at high temperatures. Several areas of a health care facility, (including the kitchen, laundry room, and sterilization rooms), are particularly hazardous in this respect. Electrical equipment including generators, transformers, free-standing switchboards, emergency generators, and lighting systems can overturn or slide off their supports causing not only damage and injury but also fire.

OSHPD has defined the Non-Structural Performance Categories (NPC) as a means to measure the probable seismic performance of building contents and non-structural systems critical to providing basic services to in-patients and the public following an earthquake, as defined in Article 11, Table 11.1. Basically, the following systems are considered a priority for upgrading: communications systems, emergency power systems, bulk medical gas systems, and fire alarm systems. The Federal Emergency Management Agency for Seismic Considerations of Health Care Facilities, (FEMA Report No. 150), has also listed other areas of concern for non-structural items and addressed that four areas should be reflected in a hospital disaster plan relative to earthquake preparedness. These four areas are structural safety, non-structural hazards, occupant preparedness and prior arrangements for a post-event response.

**Table 2. Non-structural Performance Categories (NPC)**

| Upgrade by | NPC | Description |
|---|---|---|
| | NPC 1 | Buildings with equipment and systems not meeting the bracing and anchorage requirements of any other NPC. |
| January 1, 2002 | NPC 2 | The following are braced or anchored in accordance with Part 2, Title 24:<br>Communications systems<br>Emergency power supplies<br>Bulk medical gas systems, and<br>Fire alarm systems |
| January 1, 2008 | NPC 3 | The building meets the criteria for NPC 2 and in Critical Care Areas, clinical laboratory services spaces, pharmaceutical service spaces, radiological services spaces, and central and sterile supply areas, the following components meet the bracing and anchorage requirements of Part 2, Title 24:<br>Nonstructural components, listed in the 1995 CBC, Part 2, Title 24, Table 16A-O, Part 2; and<br>Equipment, as listed in the 1995 CBC, Part 2, Table 16A-O, "Equipment" including equipment in the physical plant that service these areas.<br>*Exceptions:*<br>1. Seismic restraints need not be provided for cable trays, conduit and HVAC ducting. Seismic restraints may be omitted from piping systems, provided that an approved method of preventing release of the contents of the piping system in the event of a break is provided.<br>2. Only elevator(s) selected to provide service to patient, surgical, obstetrical, and ground floors during interruption of normal power need meet the structural requirements of Part 2, Title 24.<br>Fire sprinkler systems comply with the bracing and anchorage requirements of NFPA 13, 1994 edition or subsequent applicable standards.<br>*Exception:* Acute care hospital facilities in both a rural area as defined by Section 70059.1, Division 5 of Title 22 and Seismic Zone 3 shall comply with the bracing and anchorage requirements of NFPA 13, 1994 edition or subsequent applicable standards by January 1, 2013. |
| | NPC 4 | The building meets the criteria for NPC 3 and all architectural, mechanical, electrical systems, components, and hospital equipment meet the bracing and anchorage requirements of Part 2, Title 24. This category is for classification purposes of the Office of Emergency Services. |
| January 1, 2030 | NPC 5 | The building meets the criteria for NPC 4 and on-site supplies of water and holding tanks for wastewater, sufficient for 72 hours of emergency operations, are integrated into the building's plumbing systems. As an alternative, hook-ups to allow for the use of transportable sources of water and sanitary waste disposals have been provided. An on-site emergency system as defined within Part 3; Title 24 is incorporated into the building's electrical system for critical care areas. Additionally, the system shall provide for radiological services and an on-site fuel supply for 72 hours of acute care operation. |

### 1.2 REQUIREMENTS FOR COMPLIANCE PLANS

According to OSHPD, a compliance plan shall be prepared and submitted for each building subject to these regulations. All general care hospital owners shall formulate a compliance plan that shall indicate the facilities' intent to do any of the following:

1. Building retrofit for compliance with these regulations for continued acute care operation beyond 2030;
2. Partial retrofit for initial compliance with closure or replacement expected by 2002, 2008 or 2030;
3. No action for non-compliant buildings; removal from acute care service with conversion to non-acute care health facility use, or closure, demolition or replacement.

This plan must clearly state the actions to be taken by the facility and must be in accordance with the time frames indicated in the tables above for both the SPC and NPC classifications.

Very recently Senate Bill 1801 passed which allows hospitals to extend the 2008 deadline to 2013 provided that the hospital move at least one 'basic service' to an area rebuilt to SPC 5 and NPC 5 standards with conditions prior to 2013. The impact of this requirement is being interpreted by OSHPD and the engineering community.

## 2.0 STRUCTURAL EVALUATION

### 2.1 BUILDING DESCRIPTION

Huntington East Valley Hospital is an acute care hospital (housing 128 beds), which serves the Glendora area in Los Angeles County, California. The main hospital extends over 87,550 sq. ft. (including basement). This includes additions completed in 1966 and 1969 and alterations to ICU in 1986. A partial basement includes 24,000 sq. ft.

According to OSHPD building types, the one-story building is considered building type 13. Appendix A includes several photographs taken of the exterior of the buildings. These photos were taken during our field visits.

### 2.2 GRAVITY AND LATERAL LOAD RESISTING SYSTEMS

The gravity load-carrying system consists of exterior reinforced concrete core-deck or concrete block walls. The roof structure is wood framed with plywood sheathing. Interior walls are a combination of masonry and wood stud walls. The building foundation consists of continuous and spread concrete footings. There is a 4" thick concrete slab on grade.

The lateral force resisting system includes exterior concrete core deck and masonry walls with plywood roof sheathing serving as the roof diaphragm. In general, the building is considered to be a Type 13, according to OSHPD buildings types.

### 2.3 REVIEW OF PREVIOUS WORK

IDS reviewed the previous preliminary work performed by Taylor & Gaines dated June 1998. This report basically address the preliminary classifications of the buildings according to SB 1953, presents partial calculations, and provides a preliminary seismic upgrade construction cost.

Table 3 below shows summaries of the SPC and NPC classifications and cost estimates to comply with OSHPD requirements as given in the Taylor & Gaines report. For comparison, Table 3 also shows the cost estimate that we obtained based on our current work.

**Table 3. Previous Assessment of the Huntington East Valley Hospital**

| | Description | Area S.F. | # of Stories | SPC | NPC | Year | Previous Cost Estimate To Comply[1] | Current Estimate[2] |
|---|---|---|---|---|---|---|---|---|
| Huntington East Valley Hospital | Original Building<br>Emergency Building<br>1966 Addition<br>1969 Addition<br>ICU/CCU Alterations | | 1<br>1<br>1<br>1<br>1 | 1<br>1<br>1<br>1<br>1 | 1<br>1<br>1<br>1<br>1 | 2008 | $ 9.0M | $ 4.97M |
| | | | | | | 2030 | - | $1.15M |
| Total | | 87,550 | | | | | - | $6.12M |

[1]Taylor & Gaines estimate
[2]Integrated Design Services estimate

## 2.4 DATA GATHERING AND REVIEW OF EXISTING CONDITIONS

IDS's project team performed several site visits to the Huntington East Valley Hospital. The intent of the site visits was to collect sufficient information regarding the structural and non-structural elements of the buildings. We examined existing conditions and gathered relevant structural and non-structural information needed to guide the development and phasing of the compliance plans and reports to meet SB 1953. The accuracy of this information is critical to the overall retrofit project and the decisions made. This information will also help department heads, users, and facility managers in their immediate and short-range planning endeavors.

During the site visits we obtained some existing drawings for the original hospital buildings. However, the plans (because of the maturity of the buildings) were incomplete and a general field assessment was needed to examine existing structural systems and details.

During the visits we verified the following: (a) building boundaries, (b) major renovations with general descriptions, and (c) department boundaries. In addition, we collected data regarding the anchorage and bracing of selected non-structural elements and systems to assist us in the assignment of non-structural performance categories. This includes data for architectural, mechanical, electrical and hospital equipment in addition to associated conduit, ductwork, piping and machinery.

The site visits focused on confirmation of the information as shown on the original construction documents, as well as an initial assessment of non-structural and equipment anchorage and bracing conditions. The structural site review was also used to supplement information shown on structural drawings. An understanding of the functional aspects of the building was developed and general notations of possible locations where retrofit measures may be more practical to construct were made.

## 2.5 PRELIMINARY BUILDING EVALUATION

IDS performed a preliminary seismic evaluation of the structural, architectural, mechanical and electrical systems. The Structural Performance Categories (SPC's) and Non-Structural Performance Categories (NPC's), which have a preliminary assignment in the previous study, were verified based on our new assessment of collected information. Buildings within the facility are identified as "compliant" or "non-compliant," based on this review. General estimates of measures required to meet the seismic upgrade mandates were developed for non-compliant buildings.

The seismic analyses performed consisted of two-dimensional computer analyses and calculations. The analyses identified the preliminary demand/capacity ratios for the lateral force resisting elements. The details of the structural evaluation are provided in Appendix C of this report. The ENERCALC computer program was used to perform a seismic distribution analysis.

Based on the site examination of the existing conditions and the structural evaluation of the lateral resisting system for both structural and non-structural components, we assigned the following SPC and NPC values as shown in Table 4 below. Detailed data for NPC and SPC categorizations are shown in a tabular format in Appendix E, which lists the item, location, item quantity, current anchorage or bracing descriptions, and design standards used in original installation (if identifiable).

**Table 4. Summary of Building Information**

| Building Name/ Designation | OSHPD (or Local Building Permit Date/Number | Governing Building Code | Construction Completion Date | Building Type (Per Section 2.2.3 | SPC | NPC |
|---|---|---|---|---|---|---|
| Original Building | City of Glendora | 1957 UBC | 1958 | 13 | 1 | 1 |
| Emergency Building | City of Glendora | 1964 UBC | 1966 | 13 | 1 | 1 |
| 1966 Addition | City of Glendora | 1964 UBC | 1966 | 13 | 1 | 1 |
| 1969 Addition | City of Glendora | 1967 UBC | 1069 | 13 | 1 | 1 |
| ICU/CCU Alterations | City of Glendora | 1985 UBC & CBC | 1986 | 13 | 1 | 1 |

In addition, because of the lack of existing detailed structural drawings, IDS recommends that field structural testing and geotechnical exploration be performed during the engineering phase of work required for the SPC 2 upgrade, as also required by OSHPD. It is possible that hospital personnel may be able to perform some of this assessment work. This field structural testing is needed to evaluate material types and strengths, to establish concrete and masonry strengths and to validate reinforcement details for critical lateral load resisting elements.

# 3. DETAILED SEISMIC EVALUATION AND DEVELOPMENT OF RETROFIT SCHEMES

IDS performed detailed seismic reviews in order to more completely define specific retrofit alternatives, develop more accurate seismic retrofit cost estimates, and develop facility operational interruption scenarios needed to accomplish required seismic retrofit work.

## 3.1 STRUCTURAL PERFORMANCE UPGRADE

As part of this study, IDS has performed detailed seismic reviews in order to define specific retrofit alternatives and associated cost estimates. In this regard, several seismic retrofit alternatives were considered and reviewed by the management of the Huntington East Valley Hospital. This process involved careful considerations of architectural and MEP issues. As a result of this process, a cost-effective retrofit scheme was selected which minimized the facility interruption during construction and provided the least impact on the facilities' current functional configurations. IDS developed conceptual 11"x17" AutoCAD drawings of the selected retrofit scheme for each portion of the hospital. The AutoCAD drawings identify the extent of the retrofit work and illustrate the locations of the new structural elements.

Based on our discussion with the Huntington East Valley Hospital, the construction will be implemented in phases and will span over an extended period of time. The main objective is to minimize the impact on the facility operation, meet the constraints of the allocated annual budget, and utilize the construction expertise of the in-house construction staff of the hospital.

Details of the structural schemes are provided in Appendix C of this report. A summary of the major structural deficiency and proposed remedies is provided in Table 5 below:

The main structural (SPC) strengthening measures for Huntington East Valley Hospital include:

(1) **Roof diaphragm:** Provide new ½" Structural I plywood with nailing over existing plywood. Existing roofing will be removed. Existing roof mounted equipment and piping to be moved and reset. New roofing would be installed over the new plywood.

(2) **Exterior concrete core deck walls and masonry walls subject to overturning:** Saw-cut existing slabs, excavate under each end of masonry wall subject to overturning. Install reinforcement, dowel into existing footings, and pour new concrete footings. See Detail 11, Appendix C.

(3) **Top of brick wall anchorage (out of plane):** Provide straps on top of new plywood with new through-bolts into existing masonry walls. See Details 7, and 9, Appendix C.

(4) **Ledger attachment to concrete core deck walls and masonry regarding in-plane shear transfer:** Add new oversized steel plate washers to existing ledger anchor bolts. Add new epoxy bolts with oversized steel plate washers between existing anchor bolts to mitigate the 'cross-grain bending' hazard for the wood ledgers. See Detail 8, Appendix C.

(5) **New shear walls and footings in basement.** See basement plan in Appendix D.

(6) **Interior shear wall weakness.** Provide new concrete exterior buttress walls with steel members attached to plywood roof diaphragm. See Details 3 and 4 in Appendix C.

(7) **ADA Upgrades:** Facilities will need to be upgraded to be accessible to the handicapped. The total cost of the construction upgrade work must include 20% for ADA upgrade work.

## Table 5. Structural Deficiencies and Proposed Remedies

| Item | Location | Apparent Deficiency | D/C Ratio | Remedies | Details |
|---|---|---|---|---|---|
| Roof Plywood Diaphragm | Original and Building Additions | Diaphragm Weakness | 2 | a. New plywood over exist.<br>b. Add Shear Walls or where possible add Exterior 'buttress' walls with steel members Over roof plywood. Re-Roof | 3, 4 |
| Exterior and Interior CMU Walls | Original and Building Additions | Over-stressed and unstable for seismic overturning | 1.4 | Add new buttress walls with new footings and steel members over roof plywood. | 3, 4 |
| Exterior CMU Walls | Area 3 Additions | Inadequate soil bearing pressure | 6 | Add new CMU walls with new footings | |
| Top of Masonry Wall anchorage (out of plane) | Building Additions | No existing Attachment. Weakness in 'cross-grain' bending. | - | Add straps to top of plywood. | 3, 4 |
| Ledger attachment to Masonry (in-plane Shear transfer) | Building Additions | Too few or no anchor bolts and oversized washers | - | Add epoxy bolts and oversized washers to ledger. | 5 |
| Existing Basement Shear Walls | 1969 Building Addition | Overstressed and unstable for seismic overturning | 1.2 | Add gunnite or new fiber wrapping and new footings or caissons. As an alternative, add alternative add new concrete walls with footings. | 8 |
| Steel Braced Frames at First Floor above Basement | Building Addition | Weak shear walls | 1.4 | Add new braced steel frames at main level and new steel posts in basement below. | 1 |
| Top of Masonry Wall anchorage (in-plane and out-of-plane) | Original Building | No existing attachment. | | Remove a portion of existing plywood sheathing, add new brackets to joists and epoxy bolts to concrete core-deck walls. | 10 |

### 3.2 NON-STRUCTURAL PERFORMANCE UPGRADE

The scope of this study included the development of a preliminary inventory to address all NPC retrofit items for the year 2002, 2008, and 2030 deadlines. Non-structural items and equipment were inventoried and reviewed for their seismic supports according to the regulations of SB 1953. Appendix B shows recent photos of the existing condition of the non-structural elements.

Non-structural items required to undergo upgrades for earthquake protection by SB 1953 by 2002 include exit corridor partitions, communication systems, emergency power systems, bulk medical gas tanks, emergency corridor lights, and the fire alarm system. The total cost of the construction upgrade work must include 20% for ADA upgrade work.

NPC upgrades typically do not involve extensive long-term interruption to the operation. In most areas, required measures such as ceiling or piping bracing can be completed quite rapidly. However, work is distributed over a large area of the hospital. Therefore, proper construction phasing is needed to reduce the impact of the operation to the facility.

Details of the NPC strengthening measures are provided in Appendix C.

## 4. CONSTRUCTION COST ESTIMATES

IDS prepared a ±20% cost-estimate for the construction needed to comply with SB 1953. Retrofit measures will focus on year 2008 retrofit requirements and will include structural and non-structural retrofit schemes. We addressed year 2030 SPC retrofit requirements only in cases where a small marginal cost is associated in meeting year 2030 requirements.

Based on our evaluation of the subject property the following summarizes the cost estimates for various required upgrade scopes of work:

- Probable construction cost of structural, non-structural, and ADA upgrade work required before 2002 (upgrade to NPC 2) to permit acute care operations beyond 2002 is $170,400.

- Probable construction cost of structural, non-structural, and ADA upgrade work required before 2008 (upgrade to SPC 2 and NPC 3) to permit acute care operations beyond 2008 is $4,800,000.

The estimate of probable construction costs to permit acute care operations until 2030 is $4,970,000.

- Probable construction costs of structural and ADA upgrade work required before 2030 (upgrade to SPC 5) to permit acute care operations beyond 2030 is $1,000,000.

- Probable construction cost of non-structural, and ADA upgrade work required before 2030 (upgrade to NPC 5) to permit acute care operations beyond 2030 is $154,000.

The estimate of probable additional construction costs to permit acute care operations until 2030 is $1,154,000.

Details of the construction cost estimate are given in Appendix E of this report.

## 5. SUMMARY AND CONCLUSIONS

Huntington East Valley Hospital building has been shown to be weak in seismic resistance in several structural areas including roof diaphragms, overturning of masonry walls, out-of-plane attachment of masonry walls to roof structure, in-plane attachment of masonry wall ledgers and basement shear walls.

Because of the lack of existing detailed structural drawings, IDS recommends that field structural and geotechnical testing be performed during the engineering work required for the SPC 2 upgrade, as also required by OSHPD. It is possible that hospital personnel may be able to perform much of this assessment work. This field structural testing is needed to evaluate material types and strengths, to establish concrete and masonry strengths, determine soil conditions, and to validate reinforcement details for critical lateral load resisting elements.

In summary, based on our evaluation of the subject property the following presents the cost estimates for various required upgrade scopes of work:

- Probable construction cost of structural, non-structural, and ADA upgrade work required before 2002 (upgrade to NPC 2) to permit acute care operations beyond 2002 is $170,400.

- Probable construction cost of structural, non-structural, and ADA upgrade work required before 2008 (upgrade to SPC 2 and NPC 3) to permit acute care operations beyond 2008 is $4,800,000.

The estimate of probable construction costs to permit acute care operations until 2030 is $4,970,000.

- Probable construction cost of structural and ADA upgrade work required before 2030 (upgrade to SPC 5) to permit acute care operations beyond 2030 is $1,000,000.
- Probable construction cost of non-structural, and ADA upgrade work required before 2030 (upgrade to NPC 5) to permit acute care operations beyond 2030 is $154,000.

The estimate of probable additional construction costs to permit acute care operations beyond 2030 is $1,154,000

Respectfully Submitted,
Integrated Design Services, Inc.

Robert Freeman, AIA
Project Manager

Said Hilmy, Ph.D., S.E.
Principal Engineer

n. Wall materials shall be chosen that will withstand abuse by vandals or accidental damage from machinery and equipment.

o. Roller shutter doors shall be located on the inside of buildings.

6. Roofs:

a. Roof lines shall not exceed 50 feet in length without an offset or jog.

b. Nearly vertical roofs shall not be permitted. Mansard roofs shall wrap around the entire building perimeter.

c. Corrugated metal, high contrast surfaces, brightly colored surfaces, highly reflective surfaces and illuminated roofing shall not be permitted.

7. Awnings:

a. Awnings used along a row of contiguous buildings shall be of the same form and uniformly located with a minimum vertical clearance of eight feet.

b. Awnings shall be of canvas, treated canvas, matte finish vinyl or fabric.

c. Internally lit awnings shall not be permitted.

8. Lighting:

a. Adequate lighting shall be provided for the security and safety of areas such as parking areas, loading areas, vehicle and pedestrian circulation areas, building entrances and working areas.

b. Light fixtures and supports shall be compatible with building architecture and site design. Illuminators shall be integrated within the architectural design of buildings.

c. Lighting shall be shielded to prevent spillover. (Ord. 1648 § 1, 1996: Ord. 1618 § 1 Exh. A, 1993)

**21.05.020 Medical Services Zone:**

A. Purpose: The purpose of this zone is to provide for the development of hospitals, health care and other medical related facilities in a manner that implements the policies and programs of the General Plan. These regulations are designed to ensure that adequate land area is provided and that the facilities are aesthetically pleasing.

B. Permitted Uses:

1. Medical offices and laboratories;

2. Pharmacies, limited to the sale of drugs and supplies only, associated with a hospital, medical office or care facility.

C. Uses Permitted Subject To Conditional Use Permit:

1. Community care, convalescent and nursing facilities;

2. Hospitals;

3. Senior housing;

4. Accessory buildings and dormitories.

D. Development Standards:

1. Lot Area: The minimum lot area shall be 60,000 square feet.

2. Lot Width: The minimum lot width shall be 100 feet.

3. Lot Depth: The minimum lot depth shall be 200 feet.

4. Front Yard: The minimum front yard shall be 25 feet.

5. Side Yards: The minimum side yard shall be 20 feet.

6. Rear Yard: The minimum rear yard shall be 25 feet.

7. Height: The maximum height shall be 35 feet, but not exceeding two stories.

8. Building Area: The minimum gross floor area for each building shall be 1,600 square feet.

# Section 21.04.010 Single-Family Residence

A. Purpose. The purpose of single-family residential zones is to protect and promote the unique single-family nature of the city by limiting the uses in such zones to residential and residentially compatible uses and by requiring standards for the use, maintenance, and development of single-family residential zoned properties. The single-family residence zones are:

1. R-1 (Single-Family Residence).

2. E-3, E-4, E-5, E-6, and E-7 (Single-Family Estate).

3. RHR (Rural Hillside Residential).

B. Permitted Uses.

1. One single-family residence and accessory buildings.

2. City facilities. Development shall be subject to development plan review prior to the issuance of permits in accordance with section 21.02.040.

3. Home occupations as an accessory use to a single-family residence. The establishment and conduct of home occupations shall comply with all of the following requirements to ensure that the use will be compatible with, and not detrimental to, the neighborhood:

a. There shall be no exterior evidence of the conduct of a home occupation.

b. The home occupation shall be conducted only within the enclosed living area of the residence or an enclosed, roofed accessory building.

c. There shall be no storage of hazardous materials.

d. Only the residents of the residence shall be engaged in the home occupation.

e. There shall be no sale of goods on the premises.

f. The establishment and conduct of the home occupation shall not change the principal character of the residence.

g. There shall be no signs posted other than those permitted in the zone in which the residence is located.

h. The required residential off-street parking shall be maintained.

i. The conduct of the home occupation shall not create greater vehicular or pedestrian traffic than is normal for the zone in which it is located.

j. There shall be no outside storage of goods, supplies, equipment, or other materials.

k. There shall be no pickups or delivery of goods, supplies, equipment, or other materials, except between the hours of 7 a.m. and 6 p.m.

l. The conduct of the home occupation use shall not create noise levels in excess of those permitted in the zone in which the residence is located.

C. Uses Permitted Subject to Conditional Use Permit.

1. Second-kitchen units.

5. Guest Houses.

   a. The guest house shall be limited to one bedroom and one bathroom.

   b. The guest house shall not include kitchen facilities.

   c. One covered parking stall shall be provided for the guest house.

   d. The guest house shall meet the development standards for accessory buildings.

6. Churches.

   a. The minimum lot area shall be 1 gross acre.

   b. The maximum building height shall be 35 feet, but not exceeding 2 stories.

   c. A 6-foot-high masonry wall shall be constructed and maintained on all property lines abutting residentially zoned properties.

   d. Church sites shall abut and have vehicular access directly from a minimum 30-foot-wide public street, as measured from curb to curb.

   e. No building shall be located closer than 25 feet to any property line constituting the parcel boundary.

   f. A detached single-family residence shall conform to the development standards specified in Table A.

7. Educational Schools.

   a. The minimum lot area shall be 5 gross acres.

   b. The maximum building height shall be 35 feet, but not exceeding 2 stories.

   c. No building shall be located closer than 25 feet to any property line constituting the parcel boundary.

8. Lodge Halls. The minimum lot area shall be twice that specified in Table A. The minimum lot width, lot depth, floor area ratio, floor area, setbacks, and building height shall be as specified in Table A.

F. Rural Hillside Residential (RHR). Properties in the RHR zone shall be subject to the requirements of section 21.04.030 and the following:

1. For any subdivision, the minimum average net area per lot shall be determined by the formula, $A = 1 \div [1.089 - 0.01778(S)]$, where A is the minimum average net area per lot in acres and S is the average slope of the subdivision in percentage (S=x%) as computed pursuant to section 21.04.030. When the average slope exceeds 45 percent, the minimum average net area per lot shall be 10 acres.

2. The maximum number of lots shall be determined by dividing the net area of the subdivision by the minimum average net area per lot and rounding down to the next whole number.

3. For any subdivision, no lot that can be further subdivided under this section shall be included in the formula to determine the minimum average net area per lot, unless the development rights beyond one dwelling unit for such lot are dedicated to the city.

4. For any subdivision, lots in excess of the maximum number permitted may be created if dedicated to the city.

SECTION 21.03.020 OFF-STREET PARKING AND LOADING M-S

A. Purpose. The purpose of this section is to ensure that sufficient off-street parking and loading areas are provided and properly designed and located in order to meet the parking and loading needs of specific uses and to protect the public health, safety, and welfare.

B. Regulations for Off-Street Parking.

1. Off-street parking shall be provided according to the provisions of this section for:

a. Any new structure.

b. Any new use.

c. Any addition to, or change in the use of, a structure. The additional off-street parking shall be required only for the addition or change of use and not for the entire structure or use, except when the addition expands the original structure by twenty five percent or more or when the change in use involves twenty five percent or more of the area of the original use, then the parking area for the entire structure or use shall be brought into conformance with this section.

2. Required off-street parking shall be provided on the same parcel as the structure or use for which the parking is required, unless reciprocal parking or other arrangement is authorized pursuant to this title.

3. Required off-street parking shall be maintained in accordance with the requirements of this section for the duration of the use.

4. Required off-street parking shall be used exclusively for the temporary parking of vehicles and shall not be used for the sale, display, repair, or storage of vehicles, merchandise, or equipment or for any other use, unless authorized pursuant to this title.

C. Development Standards.

1. Parking Stall Dimensions.

| Parking Stall | Width | Depth |
|---|---|---|
| Standard | 9' | 20' |
| Standard, adjacent to a side wall | 10' | 20' |
| Parallel | 10' | 25' |
| Compact | 8' | 17' |

2. Parking Aisle Widths.

| Angle of Parking Stall | Aisle Width One-Way | Aisle Width Two-Way |
|---|---|---|
| Parallel | 14' | 18' |
| 30 Degree | 14' | 18' |
| 45 Degree | 18' | 20' |
| 60 Degree | 18' | 20' |
| 90 Degree | 26' | 26' |

3. Compact Parking Stalls. For any use that provides more than ten open parking stalls, a maximum of twenty five percent of the parking stalls in excess of ten may be compact parking stalls. All compact parking stalls shall be clearly marked: "Compact".

e. Reciprocal parking and access agreements between adjacent properties shall be provided when possible.

f. Vehicle access shall be provided along side streets when possible to minimize pedestrian/vehicular conflicts.

g. Vehicle access shall be minimized and located as far as possible from street intersections to provide adequate stacking.

h. Parking areas and pedestrian circulation shall be visible from buildings, especially entrances.

i. The circulation system shall be designed so that pedestrian circulation will be parallel with vehicle traffic.

j. The circulation system shall be designed to minimize the need for pedestrians to cross parking aisles and landscape areas.

k. The circulation system shall be designed to provide pedestrian links between buildings and the street sidewalk system.

l. The circulation system shall include adequate directional signs for entrances, exits, parking areas, loading areas, and other areas.

D. Single Family Residence Standards.

1. Dwelling Unit Parking. For each single family residence unit there shall be a minimum of two parking stalls located within a garage.

2. Location of Carports. Carports that are not an integral part of the main residence shall be located no closer than forty feet to any street and no closer than the residence to any adjacent street.

3. Driveways. A paved driveway shall be provided from a street or alley to garages and carports. Each driveway shall have a minimum vertical clearance of eight feet and a minimum width of eight feet.

4. Vehicle Backout. A minimum unobstructed distance of twenty five feet shall be provided for vehicle backout from garages, carports, and other parking stalls as measured to a street or the opposite side of an alley.

E. Multiple Family Residence Standards.

1. Dwelling Unit Parking.

a. For each dwelling unit, there shall be one parking stall within a garage and one parking stall which may be open or covered, i.e. carport, at the discretion of the applicant. Additional parking stalls within a garage may be provided; however, they will not be counted toward required parking.

b. Dwelling units having more than two bedrooms shall increase parking by two-tenths (0.2) of a parking stall for each bedroom in excess of two in each unit.

c. Tandem parking may be permitted if the parking stalls are located on a driveway which leads to a garage, carport, or open parking stall and does not impede vehicular and/or pedestrian traffic.

d. Whenever the computation of the required number of parking stalls results in a fraction, the next higher whole number shall be the required number of parking stalls. For example, a multiple family development consisting of four units with three bedrooms each shall have 8.8 required parking stalls and 1.2 guest parking stalls. The 8.8 would change to 9 required parking stalls and the 1.2 would change to 2 guest parking stalls.

2. Handicapped Parking. For each dwelling unit designed to accommodate the physically handicapped, the required parking shall be designed for the handicapped as required by the State of California.

| | |
|---|---|
| Manufacturing, industrial, and wholesale uses. | One for each five hundred square feet of gross floor area for the first ten thousand square feet and one for each one thousand square feet of gross floor area thereafter. |
| Offices. | One for each two hundred fifty square feet of gross floor area, but not less than eight. |
| Recreation and sports facilities, gyms, spas, and health and fitness centers. | The number shall be established by a parking study as prescribed in section 21.03.020-H. |
| Restaurants and other places where food or beverages are served with a drive-through. | One for each one hundred square feet of gross floor area and one for each employee. |
| Restaurants and other places where food or beverages are served without a drive-through. | One for each three seats/capacity and one for each employee. |
| Retail sales and services. | One for each two hundred fifty square feet of gross floor area. |
| Retail sales and services, including shopping centers, with over fifty thousand square feet of gross floor area. | One for each two hundred fifty square feet of gross floor area or the number may be established by a parking study as prescribed in section 21.03.020-H. |
| School, Educational. | One for each employee, one for each twenty elementary and junior high school students; one for each five senior high school students; and ten for each twenty college classrooms. |
| School, Vocational. | One for each employee and one for each of the maximum number of students. |
| Swap meet, Indoor. | The number shall be established by a parking study as prescribed in section 21.03.020-H. |
| Warehousing. | One for each one thousand square feet of gross floor area for the first five thousand square feet of gross floor area. One for each two thousand square feet of gross floor over five thousand square feet, plus one for each vehicle stored on the premises. |
| Uses not otherwise specified in this subsection. | The number shall be established by a parking study as prescribed in section 21.03.020-H. |

2. Drive-Through Businesses. A stacking space at least one hundred twenty feet long and ten feet wide with eight feet of vertical clearance shall be provided for drive-through businesses. The stacking space shall not block any parking stalls or any portion of a traffic lane.

3. Driveways. The minimum width of driveways shall be twenty six feet. Driveways shall have a minimum vertical clearance of eight feet.

H. Parking and Loading Study.

1. The Director may require a parking and loading study. The parking and loading study shall be submitted to the Director for approval. The action of the Director shall be final unless appealed as prescribed in section 21.01.030-F.

2. The parking and loading study shall be prepared by a registered traffic engineer. The study shall describe all proposed uses and show the recommended number and layout of parking stalls and loading areas including:

c. Wholesale, warehousing, and industrial uses:

| Gross floor area | Spaces required |
|---|---|
| Less than 10,000 sq ft | One |
| Each additional 20,000 sq ft. | One additional |

d. Requirements for uses not specifically listed shall be determined by the Director based upon the requirements for comparable uses and upon the particular characteristics of the proposed use.

2. The following design standards shall apply to all off-street loading spaces:

a. Dimensions. Required loading spaces shall be not less than fifteen feet in width, fifty feet in length, with fourteen feet of vertical clearance.

b. Lighting. Loading spaces shall have lighting capable of providing adequate illumination for security and safety. Lighting standards shall be in scale with the height and use of buildings. Any illumination shall be directed away from adjacent properties and public rights-of-way. Low level lighting shall be used were possible.

c. Location. Loading spaces shall be located and designed to ensure that all vehicular turning maneuvers occur on site. Loading spaces shall not be located in any required yard setback which is adjacent to a public right-of-way.

d. Screening. Loading areas adjacent to residentially zoned property shall have a six foot high solid architecturally treated wall with a stucco or equivalent finish or material approved by the Director.

e. Striping. Loading areas shall be striped indicating the loading spaces and identifying the spaces for loading only. The striping shall be maintained in a clear and visible manner.

f. Surfacing. Loading areas shall be surfaced with a minimum thickness of four inches of asphaltic concrete over a minimum thickness of six inches of an aggregate base material or as otherwise approved by the City Engineer.

March, 1995

## SECTION 21.05.010 COMMERCIAL AND PROFESSIONAL ZONES

A. Purpose. To provide for the development of commercial areas for retail and service establishments, professional and office uses, and related enterprises in a manner that implements the general plan and accommodates the needs of community residents. Specifically, these regulations are designed to provide appropriate locations for retail, service, office, and professional uses; promote and encourage convenient access to developments; promote and encourage aesthetically pleasing design; and ensure adequate size, shape, and space to meet the needs of development. The commercial and professional zones are as follows:

1. C-1 (Professional).
2. C-2 (Limited Retail Business).
3. C-3 (Retail Commercial).
4. CM (Commercial-Manufacturing).

B. Permitted Uses. Uses permitted are specified in Table C.

C. Permitted Uses Subject to a Conditional Use Permit. Uses permitted subject to a conditional use permit are specified in Table C.

D. Development Standards.

1. General Standards. The minimum lot area, minimum lot width, minimum setbacks, maximum building height, and minimum floor area shall be as specified in Table D.
2. Required Walls. Masonry walls of six feet, measured from the highest adjacent grade, shall be provided on property lines contiguous to residential zones.
3. Refuse Areas. Refuse areas shall be provided for the storage of refuse containers. All refuse shall be deposited in refuse containers in the refuse areas which shall be screened by walls six feet in height and a solid gate not less than five feet in height. The gate shall be maintained in good working order and shall remain closed except when in use. The refuse containers shall be of sufficient size to accommodate the trash generated.
4. Adult Businesses. Adult businesses shall not be located any closer than one thousand feet to any residential zone; church; school; or day care facility.
5. Service Stations. Service stations shall be permitted subject to conditional use permit approval only in the zones specified in Table C. When authorized by a conditional use permit, the following minimum standards shall apply. This subsection shall not replace or reduce any minimum zoning, building, or other ordinance requirements; however, when the requirements of this subsection are more restrictive, the requirements of this subsection shall control.
    a. Service stations shall be permitted only at the intersections of arterial and/or collector streets. The total number of service stations permitted at the intersection of two or more through streets shall not exceed two. The total number of service stations permitted at "T" intersections shall not exceed one. Service stations shall not be permitted within two hundred fifty feet of any property used as a school, church, theater, or other place of assembly.
    b. A minimum of four pumps shall be provided before a convenience store is permitted.
    c. The minimum lot area for a full-service station shall be twenty two thousand five hundred square feet with minimum street frontage of hundred fifty feet on each adjacent street.
    d. The minimum building floor area for a full-service station without a convenience store shall be one thousand two hundred square feet. One accessory structure of not less than one hundred fifty square feet may be provided when located beneath a canopy. No other accessory structures except public phone booths and refuse areas shall be permitted.

6. Convenience Stores.

   a. The site shall have frontage along an arterial or collector street. The site shall not have direct access to a local residential street.

   b. One access drive shall be permitted on each street frontage. The design and location of access drives shall be subject to the approval of the Director.

   c. A bicycle rack designed to accommodate a minimum of three bicycles shall be installed in a convenient location visible from the inside of the store.

   d. Restrooms shall be provided within the store.

   e. Public pay telephones provided on-site shall be featured with call out service only.

   f. Video games shall not be installed or operated on the premises.

7. Hotels and Motels. Hotels and motels shall be permitted subject to conditional use permit approval only in the zones specified in Table C. When authorized by a conditional use permit, the following minimum standards shall apply:

   a. The minimum floor area for a guest room shall be two hundred seventy five square feet, except that a guest room with a kitchenette shall have a minimum floor area of three hundred square feet.

   b. The minimum floor area for a manager's unit shall meet the dwelling unit floor area requirements of the R-3, Multiple Family Residence zone.

   c. The minimum lot area to develop a hotel or motel shall be three acres.

   d. The maximum number of vending machines shall be limited to a ratio of one machine for every five guest rooms. All outdoor vending machines are to be enclosed on three sides and located so as not to be visible from a public street.

8. Public Storage Facilities. Public storage facilities shall be permitted subject to conditional use permit approval only in the zones specified in Table C. When authorized by a conditional use permit, the following minimum standards shall apply:

   a. The use shall be limited to the lease or rental of separate storage spaces. On-site, twenty four hour management shall be provided. Outdoor storage, sale, washing, repair, or maintenance of boats, vehicles, or other equipment or materials shall not be permitted.

   b. The use shall only be permitted along arterial streets.

   c. The minimum lot area shall be forty thousand square feet and the minimum street frontage shall be two hundred feet.

   d. The maximum building height shall be twenty five feet, but not exceeding two stories, except that any building or portion of a building within twenty five feet of the front or street side setback shall have a maximum height of ten feet, but not exceeding one story.

9. Swap meets, Indoor. Indoor swap meets shall be permitted subject to conditional use permit approval only in the zones specified in Table C. When authorized by a conditional use permit, the following minimum standards shall apply:

   a. The use shall not be located on any parcel within two hundred fifty feet of a residential zone.

   b. The minimum building size shall be thirty thousand square feet.

   c. Each business tenant shall conduct the sale of new or used goods and merchandise from a tenant enclosure.

   d. Each tenant enclosure shall have a minimum area of nine hundred square feet with a minimum dimension of thirty feet.

g. Boxed and tubbed plants in day or wood containers shall be provided, especially along pedestrian walks.

h. Landscaping shall be maintained to provide adequate visibility.

3. Walls and Fences.

a. Walls and fences shall not be used, unless needed or required for screening, security, or buffering land uses. Walls and fences shall be as low as possible while performing these functions.

b. Walls shall be compatible with building architecture and site design. Landscaping shall be used in combination with such walls when possible.

c. Chain link fences shall not be visible from public rights-of-way.

d. Long expanses of fence or wall surfaces shall be architecturally designed to prevent monotony. Landscape pockets shall be provided.

4. Screening. Screening shall be compatible with building architecture and site design.

5. Architectural Design Standards.

a. Buildings shall relate to open spaces to allow adequate sun and ventilation, provide protection from prevailing winds, create views of mountains and hills, and minimize obstruction of views of mountains and hills.

b. Buildings shall be compatible with the height and scale of surrounding buildings. The height of new buildings shall transition from the height of adjacent buildings to the maximum height of the proposed buildings.

c. Planes of exterior walls shall be varied in depth and/or direction. Wall planes shall not exceed fifty feet in length without an offset.

d. The height of a building shall be varied to give the appearance of divided, distinct massing elements.

e. Different parts of a building facade shall be articulated by the use of color, the arrangement of elements, or a change in materials.

f. Building scale shall be reduced through window patterns, structural bays, roof overhangs, siding, awnings, moldings, fixtures, and other details.

g. Building scale shall be related to pedestrian areas such as plazas and courtyards.

h. Large buildings shall be broken up by creating horizontal emphasis through the use of trim; adding awnings, eaves, windows, or other architectural ornamentation; using combinations of complementary colors; and using landscape materials.

i. Large areas of intense white or dark colors shall be avoided. Subdued colors shall be used as dominant overall colors. Bright colors shall only be used for trim.

j. Colors shall be compatible with that of adjacent buildings, unless colors of adjacent buildings strongly diverge from these standards.

k. The number of colors on building exteriors shall not exceed three.

l. Primary colors shall only be used to accent building elements, such as door and window frames and architectural details.

m. Architectural detailing shall be painted to complement the facade and adjacent buildings.

n. Wall materials shall be chosen that will withstand abuse by vandals or accidental damage from machinery and equipment.

o. Rolling shutter doors shall be located on the inside of buildings.

## DEVELOPMENT STANDARDS
## COMMERCIAL AND INDUSTRIAL ZONES

| zone | minimum lot area | minimum lot width | minimum lot depth | minimum front setback | minimum side setback | minimum street side setback | minimum rear setback | minimum rear setback adjacent to res. zone | maximum lot coverage | minimum gross floor area for each building | maximum height |
|---|---|---|---|---|---|---|---|---|---|---|---|
| C-1<br>C-2<br>C-3<br>CM | 10,000 sq ft | 100 ft | n/a | 15 ft for lots under 200 ft in depth. 20 ft for all other lots. | 20 ft when adjacent to residential zone. | 15 ft for lots under 200 ft in depth. 20 ft for all other lots. | 10 ft* | 20 ft | n/a | 1,600 sq ft | 2 stories not to exceed 35 ft |
| M-1 | 10,000 sq ft | 100 ft | 100 ft | 20 ft | 10 ft | 20 ft | 10 ft | 20 ft | n/a | n/a | |
| M-1A | 1 acre | | | 30 ft | 20 ft | 30 ft | 20 ft | 40 ft | 50 % | | |
| IP | 40,000 sq ft | | 200 ft | | | | | | 40 % | | |

*Not required when adjacent to a flood control, railroad, or public utility right-of-way to the rear.

HUNTINGTON EAST VALLEY HOSPTIAL
INCOME STATEMENT CURRENT AND 3 PREVIOUS MONTHS VS BUDGET
FOR THE MONTH ENDING DEC 97

| | CURRENT AMOUNT | NOV 97 ACTUAL | OCT 97 ACTUAL | SEP 97 ACTUAL | YEAR TO DATE | YTD BUDGET | YTD VARAINCE |
|---|---|---|---|---|---|---|---|
| Adjusted Patient Days | 2,068 | 1,765 | 2,009 | 1,899 | 21,064 | 0 | 21,063 |
| Gross Patient Revenue | | | | | | | |
| Routine | 1,010,090 | 857,874 | 1,000,667 | 937,319 | 10,492,281 | 0 | (10,492,281) |
| Inpatient | 2,820,420 | 2,224,295 | 2,385,842 | 2,333,360 | 26,137,764 | 0 | (26,137,764) |
| Outpatient | 1,073,902 | 1,014,817 | 1,299,732 | 1,176,072 | 12,396,223 | 0 | (12,396,223) |
| Total Gross Patient Revenue | 4,904,412 | 4,096,986 | 4,686,240 | 4,446,751 | 49,026,268 | 0 | (49,026,268) |
| Net Capitation Revenue | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Gross Patient Service Revenue | 4,904,412 | 4,096,986 | 4,686,240 | 4,446,751 | 49,026,268 | 0 | (49,026,268) |
| Deductions from Revenue | 3,235,594 | 2,611,602 | 2,835,737 | 2,679,322 | 29,145,765 | 0 | 29,145,765 |
| Net Patient Revenue | 1,668,818 | 1,485,384 | 1,850,503 | 1,767,429 | 19,880,503 | 0 | (19,880,503) |
| Other Revenue | 290,303 | 240,102 | 306,257 | 169,607 | 2,123,744 | 0 | (2,123,744) |
| Total Net Patient Revenue | 1,959,122 | 1,725,487 | 2,156,760 | 1,937,036 | 22,004,247 | 0 | (22,004,247) |
| Operating Expenses | | | | | | | |
| MANAGEMENT AND SUPERVISION | 100,844 | 107,171 | 108,231 | 80,020 | 1,313,994 | 0 | 1,313,994 |
| TECHNICIANS AND SPECIALISTS | 32,954 | 31,789 | 34,925 | 29,930 | 382,222 | 0 | 382,222 |
| REGISTERED NURSES | 314,291 | 302,575 | 315,820 | 296,215 | 3,449,672 | 0 | 3,449,672 |
| LICENSED VOCATIONAL NURSES | 15,564 | 15,898 | 18,948 | 17,246 | 198,986 | 0 | 198,986 |
| AIDES AND ORDERLIES | 23,538 | 27,165 | 23,962 | 18,152 | 265,501 | 0 | 265,501 |
| CLERICAL AND OTHER ADM | 79,707 | 74,706 | 88,376 | 75,175 | 959,734 | 0 | 959,734 |
| ENVIRONMENTAL AND FOOD SERVICE | 50,207 | 47,672 | 50,806 | 47,752 | 569,985 | 0 | 569,985 |
| TECHNOLOGIST | 178,065 | 168,682 | 182,687 | 113,218 | 1,443,092 | 0 | 1,443,092 |
| VACATION,HOLIDAY,& SICK LEAVE | 46,055 | 73,125 | 45,669 | 62,129 | 617,519 | 0 | 617,519 |
| TRANSFERS FR OTH - SAL & WAGES | 4,751 | 2,820 | 4,027 | 5,569 | 44,675 | 0 | 44,675 |
| TRANSFERS FR OTH-EMP BENEFITS | 892 | 672 | 1,033 | 1,041 | 12,063 | 0 | 12,063 |
| Salary & Wages | 846,867 | 852,273 | 874,483 | 746,446 | 9,257,443 | 0 | 9,257,443 |
| REGISTRY NURSES | 28,174 | 13,113 | 18,273 | 6,277 | 160,218 | 0 | 160,218 |
| Registry | 28,174 | 13,113 | 18,273 | 6,277 | 160,218 | 0 | 160,218 |
| FICA | 62,416 | 59,839 | 63,204 | 55,073 | 676,701 | 0 | 676,701 |
| SUI AND FUI | 19,985 | 4,103 | 4,176 | 2,705 | 106,640 | 0 | 106,640 |
| GROUP HEALTH INSURANCE | 12,472 | 12,369 | 11,599 | 10,682 | 143,640 | 0 | 143,640 |
| GROUP LIFE INSURANCE | (937) | 751 | 909 | 1,256 | 8,263 | 0 | 8,263 |
| PENSION AND RETIREMENT | (6,232) | (19,814) | 186 | 20,186 | 30,677 | 0 | 30,677 |
| WORKERS COMPENSATION INSURANCE | 13,837 | 19,801 | 13,637 | (10,045) | 137,269 | 0 | 137,269 |
| DENTAL INSURANCE | 3,058 | 1,565 | 2,162 | 2,103 | 26,717 | 0 | 26,717 |
| GROUP VISION INSURANCE | 482 | 275 | 542 | 507 | 3,475 | 0 | 3,475 |

HUNTINGTON EAST VALLEY HOSPTIAL
INCOME STATEMENT CURRENT AND 3 PREVIOUS MONTHS VS BUDGET
FOR THE MONTH ENDING DEC 97

| | CURRENT AMOUNT | NOV 97 ACTUAL | OCT 97 ACTUAL | SEP 97 ACTUAL | YEAR TO DATE | YTD BUDGET | YTD VARAINCE |
|---|---|---|---|---|---|---|---|
| Employee Benefits | 105,082 | 78,890 | 96,414 | 82,467 | 1,133,381 | 0 | 1,133,381 |
| MEDICAL PHYSICIANS | 50,635 | 43,519 | 42,488 | 43,867 | 621,952 | 0 | 621,952 |
| CONSULTING AND MANAGEMENT FEES | 149,351 | 128,644 | 129,143 | 131,190 | 1,477,874 | 0 | 1,477,874 |
| LEGAL | 4,964 | 810 | 3,364 | 3,232 | 18,402 | 0 | 18,402 |
| AUDIT | 6,083 | 6,083 | 6,083 | 6,083 | 77,800 | 0 | 77,800 |
| Professional Fees | 211,033 | 179,056 | 181,078 | 184,372 | 2,196,029 | 0 | 2,196,029 |
| PROSTHESIS | 14,350 | 11,299 | 14,152 | 15,519 | 134,937 | 0 | 134,937 |
| SUTURES AND SURGICAL NEEDLES | 3,127 | 4,411 | 4,178 | 6,499 | 61,301 | 0 | 61,301 |
| SURGICAL PACKS AND SHEETS | 24,137 | 12,301 | 12,090 | 12,000 | 157,436 | 0 | 157,436 |
| ANESTHETIC MATERIALS | 2,514 | 1,650 | 1,610 | 3,028 | 21,043 | 0 | 21,043 |
| OXYGEN AND OTHER MEDICAL GASES | 4,063 | 1,844 | 3,834 | 1,049 | 27,478 | 0 | 27,478 |
| IV SOLUTIONS | 8,513 | 6,302 | 2,630 | 25,631 | 63,431 | 0 | 63,431 |
| PHARMACEUTICALS | 25,934 | 30,742 | 28,644 | 45,345 | 377,631 | 0 | 377,631 |
| RADIOACTIVE MATERIALS | 1,030 | 1,345 | 1,255 | 1,030 | 10,195 | 0 | 10,195 |
| RADIOLOGY FILMS | 3,029 | 2,265 | 2,092 | 1,734 | 25,557 | 0 | 25,557 |
| OTHER MEDICAL SUPPLIES | 136,306 | 72,733 | 75,002 | 67,521 | 830,788 | 0 | 830,788 |
| FOOD - MEATS, FISH, & POULTRY | 5,213 | 5,694 | 5,413 | 6,378 | 64,921 | 0 | 64,921 |
| FOOD - OTHER | 16,414 | 15,195 | 15,960 | 18,446 | 183,550 | 0 | 183,550 |
| CLEANING SUPPLIES | 4,986 | 3,654 | 5,570 | 2,550 | 42,354 | 0 | 42,354 |
| OFFICE SUPPLIES | 16,020 | 11,973 | 13,578 | 5,777 | 135,802 | 0 | 135,802 |
| EMPLOYEE WEARING APPAREL | 3,458 | 182 | 259 | 264 | 5,445 | 0 | 5,445 |
| OTHER NON-MEDICAL SUPPLIES | 32,699 | 39,029 | 34,186 | 22,034 | 313,204 | 0 | 313,204 |
| Supplies | 301,793 | 220,619 | 220,451 | 234,805 | 2,455,072 | 0 | 2,455,072 |
| PURCHASED SERVICE - MEDICAL | 37,519 | 35,865 | 36,826 | 38,944 | 459,869 | 0 | 459,869 |
| REPAIRS AND MAINTENANCE | 39,184 | 32,574 | 24,079 | 25,544 | 383,224 | 0 | 383,224 |
| COLLECTION AGENCIES | 6,608 | 1,014 | 2,185 | 8,170 | 46,755 | 0 | 46,755 |
| PURCHASED SERVICES - OTHER | 66,937 | 59,910 | 51,168 | 32,362 | 575,088 | 0 | 575,088 |
| Purchased Services | 150,248 | 129,363 | 114,257 | 105,019 | 1,464,936 | 0 | 1,464,936 |
| UTILITIES - ELECTRICITY | 4,327 | 19,543 | 23,771 | 25,028 | 219,294 | 0 | 219,294 |
| UTILITIES - GAS | 7,863 | 4,500 | 3,822 | 4,000 | 86,049 | 0 | 86,049 |
| UTILITIES - WATER | 1,314 | 1,000 | 1,338 | 900 | 11,082 | 0 | 11,082 |
| UTILITIES - OTHER | 729 | 869 | 814 | 800 | 9,644 | 0 | 9,644 |
| TELEPHONE/TELEGRAPH | 14,304 | 10,900 | 11,157 | 8,170 | 126,729 | 0 | 126,729 |
| Utilities | 28,537 | 36,812 | 40,901 | 38,899 | 452,799 | 0 | 452,799 |
| INSURANCE - MALPRACTICE | 25,897 | 12,755 | 12,755 | 12,750 | 162,564 | 0 | 162,564 |
| INSURANCE - OTHER | 5,853 | 13,211 | 13,711 | 14,628 | 189,899 | 0 | 189,899 |
| Insurance | 31,750 | 25,966 | 26,466 | 27,378 | 352,462 | 0 | 352,462 |
| RENTAL/LEASE COSTS - BUILDINGS | 24,096 | 24,096 | 24,096 | 24,096 | 295,607 | 0 | 295,607 |
| Building Rental | 24,096 | 24,096 | 24,096 | 24,096 | 295,607 | 0 | 295,607 |
| RENTAL/LEASE COSTS - EQUIPMENT | 20,482 | 9,522 | 13,316 | 12,298 | 163,196 | 0 | 163,196 |

HUNTINGTON EAST VALLEY HOSPTIAL
INCOME STATEMENT CURRENT AND 3 PREVIOUS MONTHS VS BUDGET
FOR THE MONTH ENDING DEC 97

| | CURRENT AMOUNT | NOV 97 ACTUAL | OCT 97 ACTUAL | SEP 97 ACTUAL | YEAR TO DATE | YTD BUDGET | YTD VARAINCE |
|---|---|---|---|---|---|---|---|
| Equipment Rental | 20,482 | 9,522 | 13,316 | 12,298 | 163,196 | 0 | 163,196 |
| DEPRECIATION - BUILDINGS & IMP | 16,763 | 16,638 | 16,433 | 14,820 | 164,432 | 0 | 164,432 |
| DEPRECIATION - LEASEHOLD IMP | 1,612 | 233 | 233 | 233 | 2,312 | 0 | 2,312 |
| DEPRECIATION - MAJOR EQUIPMENT | 22,600 | 21,750 | 22,352 | 20,278 | 244,415 | 0 | 244,415 |
| DEPRECIATION - LEASED EQUIP. | 16,646 | 16,646 | 16,646 | 16,646 | 199,757 | 0 | 199,757 |
| DEPRECIATION - MINOR EQUIP. | 80 | 72 | 72 | 72 | 876 | 0 | 876 |
| Depr. & Amortization | 57,702 | 55,340 | 55,737 | 52,050 | 611,792 | 0 | 611,792 |
| MANAGEMENT SERVICES | 18,000 | 18,000 | 18,000 | 18,000 | 216,000 | 0 | 216,000 |
| Parent Allocation | 18,000 | 18,000 | 18,000 | 18,000 | 216,000 | 0 | 216,000 |
| FINANCE CHARGES | 1,205 | 899 | 1,481 | 527 | 17,594 | 0 | 17,594 |
| INTEREST - LOANS | 78,394 | 55,207 | 56,197 | 55,750 | 708,160 | 0 | 708,160 |
| INTEREST - LEASES | 19,050 | 4,873 | 5,027 | 5,278 | 83,148 | 0 | 83,148 |
| INTEREST - INSURANCE FINANCING | 0 | 0 | 0 | 0 | 374 | 0 | 374 |
| Interest | 98,649 | 60,978 | 62,705 | 61,556 | 809,276 | 0 | 809,276 |
| Provision For Bad Debt | (129,789) | (176,796) | 133,813 | 89,802 | 848,848 | 0 | 848,848 |
| LICENSES & TAXES | 2,013 | 7,624 | 4,372 | 3,186 | 52,835 | 0 | 52,835 |
| ADVERTISEMENT | 23,522 | 19,244 | 5,074 | 21,030 | 198,596 | 0 | 198,596 |
| DUES AND SUBSCRIPTIONS | 10,479 | 8,501 | 8,697 | 12,622 | 129,350 | 0 | 129,350 |
| OUTSIDE TRAINING SESSIONS | 565 | 675 | 1,541 | 125 | 17,730 | 0 | 17,730 |
| TRAVEL | 3,171 | 1,776 | 2,055 | 2,104 | 27,700 | 0 | 27,700 |
| RECRUITING | 3,071 | 0 | 7,544 | 1,689 | 42,316 | 0 | 42,316 |
| OTHER DIRECT EXPENSES | 34,962 | 19,905 | 8,066 | 14,734 | 170,570 | 0 | 170,570 |
| OTHER NON-OPERATING EXPENSES | 0 | 0 | 0 | 4,855 | 36,881 | 0 | 36,881 |
| Other Operating Expense | 77,782 | 57,724 | 37,348 | 60,345 | 675,978 | 0 | 675,978 |
| Total Operating Expenses | 1,870,406 | 1,584,956 | 1,917,338 | 1,743,810 | 21,093,035 | 0 | 21,093,035 |
| EXCESS (DEFICIT) | 88,715 | 140,531 | 239,422 | 193,226 | 911,211 | 0 | (911,211) |

HUNTINGTON EAST VALLEY HOSPTIAL
INCOME STATEMENT CURRENT AND 3 PREVIOUS MONTHS VS BUDGET
FOR THE MONTH ENDING DEC 98

| | CURRENT AMOUNT | NOV 98 ACTUAL | OCT 98 ACTUAL | SEP 98 ACTUAL | YEAR TO DATE | YTD BUDGET | YTD VARAINCE |
|---|---|---|---|---|---|---|---|
| Adjusted Patient Days | 2,294 | 2,289 | 2,110 | 2,207 | 24,774 | 0 | 24,773 |
| Gross Patient Revenue | | | | | | | |
| Routine | 1,096,740 | 1,171,975 | 1,114,600 | 1,204,376 | 12,585,323 | 0 | (12,585,323) |
| Inpatient | 2,791,003 | 2,837,774 | 2,892,437 | 3,106,688 | 31,592,352 | 0 | (31,592,352) |
| Outpatient | 1,479,397 | 1,359,570 | 1,398,346 | 1,195,206 | 15,213,426 | 0 | (15,213,426) |
| Total Gross Patient Revenue | 5,367,140 | 5,369,319 | 5,405,383 | 5,506,269 | 59,391,101 | 0 | (59,391,101) |
| Net Capitation Revenue | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Gross Patient Service Revenue | 5,367,140 | 5,369,319 | 5,405,383 | 5,506,269 | 59,391,101 | 0 | (59,391,101) |
| Deductions from Revenue | 4,422,419 | 3,319,547 | 3,432,671 | 3,449,093 | 38,256,158 | 0 | 38,256,158 |
| Net Patient Revenue | 944,720 | 2,049,771 | 1,972,712 | 2,057,177 | 21,134,943 | 0 | (21,134,943) |
| Other Revenue | 647,384 | 209,428 | 227,596 | 222,348 | 3,617,007 | 0 | (3,617,007) |
| Total Net Patient Revenue | 1,592,104 | 2,259,200 | 2,200,308 | 2,279,525 | 24,751,950 | 0 | (24,751,950) |
| Operating Expenses | | | | | | | |
| MANAGEMENT AND SUPERVISION | 107,565 | 111,711 | 103,424 | 103,976 | 1,311,030 | 0 | 1,311,030 |
| TECHNICIANS AND SPECIALISTS | 30,976 | 31,995 | 32,105 | 29,390 | 341,980 | 0 | 341,980 |
| REGISTERED NURSES | 316,125 | 341,656 | 343,916 | 351,498 | 3,865,779 | 0 | 3,865,779 |
| LICENSED VOCATIONAL NURSES | 19,704 | 26,663 | 24,153 | 25,824 | 257,534 | 0 | 257,534 |
| AIDES AND ORDERLIES | 38,048 | 41,959 | 44,265 | 36,647 | 374,303 | 0 | 374,303 |
| CLERICAL AND OTHER ADM | 81,809 | 84,635 | 88,732 | 77,125 | 976,319 | 0 | 976,319 |
| ENVIRONMENTAL AND FOOD SERVICE | 58,795 | 63,264 | 58,883 | 50,162 | 639,470 | 0 | 639,470 |
| TECHNOLOGIST | 99,879 | 113,705 | 116,031 | 115,084 | 1,592,863 | 0 | 1,592,863 |
| VACATION,HOLIDAY,& SICK LEAVE | 41,136 | 37,687 | 64,092 | 44,863 | 545,408 | 0 | 545,408 |
| TRANSFERS FR OTH - SAL & WAGES | 8,378 | 0 | 7,535 | 0 | 45,387 | 0 | 45,387 |
| TRANSFERS FR OTH-EMP BENEFITS | 2,513 | 0 | 2,261 | 0 | 3,135 | 0 | 3,135 |
| Salary & Wages | 804,929 | 853,274 | 885,397 | 834,569 | 9,953,210 | 0 | 9,953,210 |
| REGISTRY NURSES | 55,232 | 83,585 | 130,060 | 24,362 | 604,659 | 0 | 604,659 |
| Registry | 55,232 | 83,585 | 130,060 | 24,362 | 604,659 | 0 | 604,659 |
| FICA | 59,486 | 62,809 | 61,625 | 62,566 | 740,581 | 0 | 740,581 |
| SUI AND FUI | 1,439 | 671 | 622 | 681 | 65,951 | 0 | 65,951 |
| GROUP HEALTH INSURANCE | 18,072 | 17,004 | 12,765 | 15,170 | 175,153 | 0 | 175,153 |
| GROUP LIFE INSURANCE | 2,399 | 724 | 183 | 284 | 12,003 | 0 | 12,003 |
| PENSION AND RETIREMENT | (5,983) | 5,695 | 5,750 | 5,732 | 53,086 | 0 | 53,086 |
| WORKERS COMPENSATION INSURANCE | 14,070 | 15,156 | 21,156 | 15,072 | 155,893 | 0 | 155,893 |
| DENTAL INSURANCE | 2,864 | 1,940 | 1,417 | 1,063 | 28,549 | 0 | 28,549 |
| GROUP VISION INSURANCE | 459 | 417 | 71 | 211 | 4,751 | 0 | 4,751 |

HUNTINGTON EAST VALLEY HOSPTIAL
INCOME STATEMENT CURRENT AND 3 PREVIOUS MONTHS VS BUDGET
FOR THE MONTH ENDING DEC 98

| | CURRENT AMOUNT | NOV 98 ACTUAL | OCT 98 ACTUAL | SEP 98 ACTUAL | YEAR TO DATE | YTD BUDGET | YTD VARAINCE |
|---|---|---|---|---|---|---|---|
| Employee Benefits | 92,806 | 104,417 | 103,589 | 100,779 | 1,235,966 | 0 | 1,235,966 |
| MEDICAL PHYSICIANS | 24,830 | 27,912 | 24,642 | 28,947 | 365,855 | 0 | 365,855 |
| CONSULTING AND MANAGEMENT FEES | 158,185 | 238,086 | 208,720 | 244,426 | 2,268,697 | 0 | 2,268,697 |
| LEGAL | 1,500 | 1,990 | 3,259 | 4,169 | 22,550 | 0 | 22,550 |
| AUDIT | (24,217) | 6,083 | 6,083 | 6,083 | 42,700 | 0 | 42,700 |
| Professional Fees | 160,299 | 274,071 | 242,704 | 283,625 | 2,699,802 | 0 | 2,699,802 |
| PROSTHESIS | 32,637 | 26,659 | 34,048 | 19,868 | 256,446 | 0 | 256,446 |
| SUTURES AND SURGICAL NEEDLES | 7,471 | 7,731 | 8,161 | 9,895 | 97,881 | 0 | 97,881 |
| SURGICAL PACKS AND SHEETS | 9,405 | 12,992 | 13,229 | 13,865 | 133,967 | 0 | 133,967 |
| ANESTHETIC MATERIALS | 1,618 | 1,869 | 1,760 | 2,339 | 21,100 | 0 | 21,100 |
| OXYGEN AND OTHER MEDICAL GASES | 5,401 | 4,116 | 3,415 | 3,153 | 37,851 | 0 | 37,851 |
| IV SOLUTIONS | 4,938 | 4,568 | 4,826 | 3,334 | 58,596 | 0 | 58,596 |
| PHARMACEUTICALS | 47,200 | 65,782 | 71,936 | 60,089 | 589,730 | 0 | 589,730 |
| RADIOACTIVE MATERIALS | 1,655 | 1,725 | 1,765 | 1,500 | 20,373 | 0 | 20,373 |
| RADIOLOGY FILMS | 3,778 | 3,348 | 3,769 | 3,585 | 38,548 | 0 | 38,548 |
| OTHER MEDICAL SUPPLIES | 51,465 | 44,852 | 51,013 | 46,090 | 556,114 | 0 | 556,114 |
| FOOD - MEATS, FISH, & POULTRY | 6,139 | 6,174 | 6,145 | 7,349 | 72,780 | 0 | 72,780 |
| FOOD - OTHER | 9,068 | 19,619 | 19,952 | 22,089 | 217,089 | 0 | 217,089 |
| CLEANING SUPPLIES | 3,838 | 5,035 | 6,023 | 2,701 | 45,920 | 0 | 45,920 |
| OFFICE SUPPLIES | 15,174 | 13,528 | 16,220 | 20,992 | 157,294 | 0 | 157,294 |
| EMPLOYEE WEARING APPAREL | 459 | 263 | 197 | 2,186 | 11,484 | 0 | 11,484 |
| OTHER NON-MEDICAL SUPPLIES | 38,335 | 43,457 | 41,674 | 33,883 | 433,350 | 0 | 433,350 |
| Supplies | 238,580 | 261,717 | 284,131 | 252,918 | 2,748,520 | 0 | 2,748,520 |
| PURCHASED SERVICE - MEDICAL | 59,421 | 62,063 | 71,243 | 46,726 | 596,434 | 0 | 596,434 |
| REPAIRS AND MAINTENANCE | 50,000 | 36,020 | 15,801 | 17,940 | 265,137 | 0 | 265,137 |
| COLLECTION AGENCIES | 2,024 | 2,078 | (1,556) | 0 | 15,640 | 0 | 15,640 |
| PURCHASED SERVICES - OTHER | 351,658 | 190,786 | 213,503 | 148,996 | 2,241,470 | 0 | 2,241,470 |
| Purchased Services | 463,103 | 290,946 | 298,992 | 213,662 | 3,118,682 | 0 | 3,118,682 |
| UTILITIES - ELECTRICITY | 11,629 | 11,264 | 9,171 | 26,019 | 183,662 | 0 | 183,662 |
| UTILITIES - GAS | 7,811 | 2,256 | 5,204 | 4,076 | 51,940 | 0 | 51,940 |
| UTILITIES - WATER | 3,814 | 930 | 2,514 | 1,050 | 14,679 | 0 | 14,679 |
| UTILITIES - OTHER | 814 | 813 | 775 | 800 | 9,722 | 0 | 9,722 |
| TELEPHONE/TELEGRAPH | 18,153 | 18,879 | 16,879 | 15,318 | 174,859 | 0 | 174,859 |
| Utilities | 42,221 | 34,142 | 34,543 | 47,263 | 434,861 | 0 | 434,861 |
| INSURANCE - MALPRACTICE | (33,598) | (2,744) | 12,975 | 12,975 | 91,736 | 0 | 91,736 |
| INSURANCE - OTHER | 9,938 | 9,746 | 8,741 | 9,746 | 143,865 | 0 | 143,865 |
| Insurance | (23,660) | 7,002 | 21,715 | 22,720 | 235,601 | 0 | 235,601 |
| RENTAL/LEASE COSTS - BUILDINGS | 25,531 | 25,531 | 27,174 | 23,888 | 294,062 | 0 | 294,062 |
| Building Rental | 25,531 | 25,531 | 27,174 | 23,888 | 294,062 | 0 | 294,062 |
| RENTAL/LEASE COSTS - EQUIPMENT | 27,216 | 26,134 | 28,153 | 37,956 | 218,587 | 0 | 218,587 |

HUNTINGTON EAST VALLEY HOSPTIAL
INCOME STATEMENT CURRENT AND 3 PREVIOUS MONTHS VS BUDGET
FOR THE MONTH ENDING DEC 98

| | CURRENT AMOUNT | NOV 98 ACTUAL | OCT 98 ACTUAL | SEP 98 ACTUAL | YEAR TO DATE | YTD BUDGET | YTD VARAINCE |
|---|---|---|---|---|---|---|---|
| Equipment Rental | 27,216 | 26,134 | 28,153 | 37,956 | 218,587 | 0 | 218,587 |
| DEPRECIATION - BUILDINGS & IMP | 21,462 | 20,752 | 20,752 | 23,939 | 229,055 | 0 | 229,055 |
| DEPRECIATION - LEASEHOLD IMP | 2,754 | 2,754 | 2,754 | 5,599 | 27,335 | 0 | 27,335 |
| DEPRECIATION - MAJOR EQUIPMENT | 29,084 | 29,856 | 27,302 | 27,149 | 308,210 | 0 | 308,210 |
| DEPRECIATION - LEASED EQUIP. | (5,181) | 8,019 | 8,019 | 8,019 | 143,417 | 0 | 143,417 |
| DEPRECIATION - MINOR EQUIP. | 4,923 | 52 | 52 | 52 | 5,642 | 0 | 5,642 |
| Depr. & Amortization | 53,041 | 61,432 | 58,877 | 64,757 | 713,660 | 0 | 713,660 |
| MANAGEMENT SERVICES | 23,600 | 23,600 | 23,600 | 23,600 | 283,200 | 0 | 283,200 |
| Parent Allocation | 23,600 | 23,600 | 23,600 | 23,600 | 283,200 | 0 | 283,200 |
| FINANCE CHARGES | 12,966 | 13,274 | 16,810 | 17,217 | 102,825 | 0 | 102,825 |
| INTEREST - LOANS | 47,610 | 46,507 | 46,516 | 48,799 | 593,156 | 0 | 593,156 |
| INTEREST - LEASES | (705) | 2,693 | 2,802 | 2,968 | 38,710 | 0 | 38,710 |
| Interest | 59,871 | 62,473 | 66,128 | 68,983 | 734,690 | 0 | 734,690 |
| Provision For Bad Debt | (211,476) | 46,904 | 89,837 | 172,082 | 322,431 | 0 | 322,431 |
| LICENSES & TAXES | 17,210 | 10,846 | 8,646 | 4,263 | 70,080 | 0 | 70,080 |
| ADVERTISEMENT | 9,624 | 27,756 | 15,287 | 3,319 | 196,426 | 0 | 196,426 |
| DUES AND SUBSCRIPTIONS | 16,947 | 13,847 | 13,726 | 14,766 | 160,023 | 0 | 160,023 |
| OUTSIDE TRAINING SESSIONS | 2,633 | 225 | 500 | 2,835 | 14,563 | 0 | 14,563 |
| TRAVEL | 9,851 | 6,364 | 2,468 | 12,411 | 48,271 | 0 | 48,271 |
| RECRUITING | 625 | 0 | 0 | 0 | 44,616 | 0 | 44,616 |
| OTHER DIRECT EXPENSES | 68,889 | 17,924 | 20,297 | 7,524 | 204,108 | 0 | 204,108 |
| Other Operating Expense | 125,780 | 76,962 | 60,923 | 45,117 | 738,087 | 0 | 738,087 |
| Total Operating Expenses | 1,937,072 | 2,232,189 | 2,355,822 | 2,216,281 | 24,336,017 | 0 | 24,336,017 |
| EXCESS (DEFICIT) | (344,968) | 27,010 | (155,514) | 63,244 | 415,933 | 0 | (415,933) |

HUNTINGTON EAST VALLEY HOSPTIAL
INCOME STATEMENT CURRENT AND 3 PREVIOUS MONTHS VS BUDGET
FOR THE MONTH ENDING DEC 99

| | CURRENT AMOUNT | NOV 99 ACTUAL | OCT 99 ACTUAL | SEP 99 ACTUAL | YEAR TO DATE | YTD BUDGET | YTD VARAINCE |
|---|---|---|---|---|---|---|---|
| Adjusted Patient Days | 1.636 | 1.787 | 1.821 | 1.732 | 21.829 | 0 | 21.829 |
| Gross Patient Revenue | | | | | | | |
| Routine | 1.147.730 | 1.066.508 | 1.100.629 | 1.044.323 | 13.254.251 | 0 | (13.254.251) |
| Inpatient | 2.996.180 | 2.821.302 | 2.531.996 | 2.861.030 | 34.512.653 | 0 | (34.512.653) |
| Outpatient | 1.301.820 | 1.263.549 | 1.195.394 | 1.249.663 | 16.377.304 | 0 | (16.377.304) |
| Total Gross Patient Revenue | 5.445.730 | 5.151.359 | 4.828.019 | 5.155.016 | 64.144.208 | 0 | (64.144.208) |
| Net Capitation Revenue | (1.273.403) | 1.767.691 | (38.031) | (37.438) | 141.857 | 0 | (141.857) |
| Gross Patient Service Revenue | 4.172.327 | 6.919.050 | 4.789.988 | 5.117.578 | 64.286.065 | 0 | (64.286.065) |
| Deductions from Revenue | 1.897.084 | 6.660.901 | 3.448.433 | 3.510.718 | 43.530.211 | 0 | 43.530.211 |
| Net Patient Revenue | 2.275.243 | 258.149 | 1.341.554 | 1.606.860 | 20.755.855 | 0 | (20.755.855) |
| Other Revenue | (29.897) | (7.520) | 76.487 | 30.189 | 716.522 | 0 | (716.522) |
| Total Net Patient Revenue | 2.245.346 | 250.629 | 1.418.041 | 1.637.049 | 21.472.377 | 0 | (21.472.377) |
| Operating Expenses | | | | | | | |
| MANAGEMENT AND SUPERVISION | 144.433 | 125.710 | 127.241 | 137.334 | 1.476.047 | 0 | 1.476.047 |
| TECHNICIANS AND SPECIALISTS | 31.012 | 25.723 | 28.070 | 26.839 | 342.668 | 0 | 342.668 |
| REGISTERED NURSES | 361.448 | 360.239 | 375.008 | 352.048 | 4.143.365 | 0 | 4.143.365 |
| LICENSED VOCATIONAL NURSES | 26.276 | 26.433 | 28.883 | 26.193 | 292.892 | 0 | 292.892 |
| AIDES AND ORDERLIES | 37.583 | 33.409 | 34.497 | 35.515 | 428.389 | 0 | 428.389 |
| CLERICAL AND OTHER ADM | 79.728 | 74.169 | 84.111 | 78.937 | 1.010.865 | 0 | 1.010.865 |
| ENVIRONMENTAL AND FOOD SERVICE | 43.489 | 62.671 | 53.463 | 52.406 | 648.652 | 0 | 648.652 |
| TECHNOLOGIST | 24.091 | 25.598 | 29.501 | 25.943 | 580.730 | 0 | 580.730 |
| VACATION,HOLIDAY,& SICK LEAVE | 48.116 | 47.876 | 82.973 | 47.963 | 637.176 | 0 | 637.176 |
| TRANSFERS FR OTH - SAL & WAGES | 14.167 | 0 | 0 | 1.357 | 38.505 | 0 | 38.505 |
| TRANSFERS FR OTH-EMP BENEFITS | 3.642 | 0 | 0 | 2.828 | 10.749 | 0 | 10.749 |
| Salary & Wages | 813.984 | 781.828 | 843.746 | 787.363 | 9.610.037 | 0 | 9.610.037 |
| REGISTRY NURSES | 29.465 | 19.562 | 11.925 | 43.030 | 455.580 | 0 | 455.580 |
| Registry | 29.465 | 19.562 | 11.925 | 43.030 | 455.580 | 0 | 455.580 |
| FICA | 57.171 | 54.107 | 56.227 | 57.871 | 689.633 | 0 | 689.633 |
| SUI AND FUI | 1.672 | (5.359) | 4.565 | 756 | 21.234 | 0 | 21.234 |
| GROUP HEALTH INSURANCE | 14.773 | 18.044 | 13.285 | 18.767 | 209.881 | 0 | 209.881 |
| LONG TERM DISABILITY | 1.457 | 1.454 | 1.451 | 1.451 | 17.355 | 0 | 17.355 |
| GROUP LIFE INSURANCE | 73 | 434 | 439 | 502 | 4.362 | 0 | 4.362 |
| PENSION AND RETIREMENT | (27.204) | 4.074 | 5.187 | 5.217 | 23.839 | 0 | 23.839 |
| WORKERS COMPENSATION INSURANCE | 14.894 | 14.692 | 20.901 | 16.030 | 189.117 | 0 | 189.117 |
| DENTAL INSURANCE | 2.872 | 3.876 | 2.676 | 3.466 | 35.596 | 0 | 35.596 |
| GROUP VISION INSURANCE | 665 | 581 | 275 | 563 | 5.851 | 0 | 5.851 |

HUNTINGTON EAST VALLEY HOSPTIAL
INCOME STATEMENT CURRENT AND 3 PREVIOUS MONTHS VS BUDGET
FOR THE MONTH ENDING DEC 99

| | CURRENT AMOUNT | NOV 99 ACTUAL | OCT 99 ACTUAL | SEP 99 ACTUAL | YEAR TO DATE | YTD BUDGET | YTD VARAINCE |
|---|---|---|---|---|---|---|---|
| Employee Benefits | 66,373 | 91,901 | 105,008 | 104,621 | 1,196,868 | 0 | 1,196,868 |
| MEDICAL PHYSICIANS | 9,290 | 27,430 | 26,329 | 27,330 | 300,251 | 0 | 300,251 |
| CONSULTING AND MANAGEMENT FEES | 95,004 | 145,928 | 147,141 | 188,814 | 2,193,630 | 0 | 2,193,630 |
| LEGAL | 2,120 | 400 | 500 | 533 | 15,834 | 0 | 15,834 |
| AUDIT | 8,217 | 16,792 | 8,217 | 8,217 | 88,384 | 0 | 88,384 |
| Professional Fees | 114,630 | 190,549 | 182,186 | 224,893 | 2,598,098 | 0 | 2,598,098 |
| PROSTHESIS | 19,720 | 21,983 | 23,530 | 14,284 | 229,694 | 0 | 229,694 |
| PROSTHESIS, ORTHOPEDIC | 31 | 0 | 0 | 0 | 31 | 0 | 31 |
| SUTURES AND SURGICAL NEEDLES | 10,929 | 7,855 | 7,615 | 8,778 | 129,169 | 0 | 129,169 |
| SURGICAL PACKS AND SHEETS | 19,360 | 19,295 | 10,714 | 19,029 | 166,279 | 0 | 166,279 |
| SURGICAL SUPPLIES GENERAL | 4,242 | 0 | 0 | 0 | 4,242 | 0 | 4,242 |
| ANESTHETIC MATERIALS | 1,747 | 1,858 | 2,303 | 1,782 | 20,749 | 0 | 20,749 |
| OXYGEN AND OTHER MEDICAL GASES | 4,766 | 2,914 | 3,683 | 4,798 | 43,215 | 0 | 43,215 |
| IV SOLUTIONS | 2,109 | 10,321 | 2,398 | 10,981 | 54,424 | 0 | 54,424 |
| IV SET, SUPPLIES | 40 | 0 | 0 | 0 | 40 | 0 | 40 |
| PHARMACEUTICALS | 49,807 | 45,660 | 44,999 | 60,898 | 602,892 | 0 | 602,892 |
| RADIOACTIVE MATERIALS | 1,000 | 1,500 | 2,545 | 755 | 18,815 | 0 | 18,815 |
| RADIOLOGY FILMS | 3,655 | 1,765 | 850 | 1,745 | 31,444 | 0 | 31,444 |
| OTHER MEDICAL SUPPLIES | 75,903 | 40,083 | 24,862 | 66,024 | 692,145 | 0 | 692,145 |
| FOOD - MEATS, FISH, & POULTRY | 6,771 | 9,174 | 2,547 | 5,766 | 78,138 | 0 | 78,138 |
| FOOD - OTHER | 21,318 | 15,613 | 20,609 | 18,205 | 228,013 | 0 | 228,013 |
| CLEANING SUPPLIES | 4,136 | 6,633 | 7,236 | 6,576 | 56,140 | 0 | 56,140 |
| OFFICE SUPPLIES | 12,598 | 7,207 | 8,087 | 23,772 | 131,049 | 0 | 131,049 |
| FORMS & PRINTED MATERIALS | 123 | 0 | 0 | 0 | 123 | 0 | 123 |
| EMPLOYEE WEARING APPAREL | 387 | 199 | 81 | (867) | 6,426 | 0 | 6,426 |
| INSTRUMENTS & MINOR MED EQUIP | 0 | 0 | 450 | 0 | 614 | 0 | 614 |
| OTHER NON-MEDICAL SUPPLIES | 34,922 | 28,678 | 34,240 | 30,280 | 353,122 | 0 | 353,122 |
| Supplies | 273,564 | 220,736 | 196,748 | 272,803 | 2,846,763 | 0 | 2,846,763 |
| PURCHASED SERVICE - MEDICAL | 389,404 | 48,185 | 44,465 | 42,679 | 920,514 | 0 | 920,514 |
| REPAIRS AND MAINTENANCE | 21,513 | 17,321 | 24,416 | 20,831 | 248,676 | 0 | 248,676 |
| COLLECTION AGENCIES | (349) | 2,411 | 750 | 1,397 | 30,038 | 0 | 30,038 |
| PURCHASED SERVICES - OTHER | 253,634 | 201,525 | 184,451 | 218,011 | 2,232,752 | 0 | 2,232,752 |
| Purchased Services | 664,202 | 269,441 | 254,081 | 282,919 | 3,431,980 | 0 | 3,431,980 |
| UTILITIES - ELECTRICITY | 4,522 | 9,637 | 19,896 | 25,275 | 192,212 | 0 | 192,212 |
| UTILITIES - GAS | 9,668 | 5,055 | 5,055 | 2,805 | 60,026 | 0 | 60,026 |
| UTILITIES - WATER | 2,276 | 1,045 | 2,149 | 2,000 | 16,001 | 0 | 16,001 |
| UTILITIES - OTHER | 748 | 812 | 816 | 802 | 9,512 | 0 | 9,512 |
| TELEPHONE/TELEGRAPH | 20,142 | 8,420 | 9,321 | 11,008 | 139,549 | 0 | 139,549 |
| Utilities | 37,356 | 24,969 | 37,237 | 41,890 | 417,300 | 0 | 417,300 |
| INSURANCE - MALPRACTICE | 2,927 | 12,185 | 12,185 | 12,183 | 143,823 | 0 | 143,823 |
| INSURANCE - OTHER | 16,358 | 15,474 | 16,400 | 15,474 | 141,557 | 0 | 141,557 |

HUNTINGTON EAST VALLEY HOSPTIAL
INCOME STATEMENT CURRENT AND 3 PREVIOUS MONTHS VS BUDGET
FOR THE MONTH ENDING DEC 99

| | CURRENT AMOUNT | NOV 99 ACTUAL | OCT 99 ACTUAL | SEP 99 ACTUAL | YEAR TO DATE | YTD BUDGET | YTD VARAINCE |
|---|---|---|---|---|---|---|---|
| Insurance | 19,285 | 27,659 | 28,585 | 27,657 | 285,379 | 0 | 285,379 |
| RENTAL/LEASE COSTS - BUILDINGS | 22,623 | 21,697 | 22,623 | 27,185 | 287,906 | 0 | 287,906 |
| Building Rental | 22,623 | 21,697 | 22,623 | 27,185 | 287,906 | 0 | 287,906 |
| RENTAL/LEASE COSTS - EQUIPMENT | 21,367 | 10,424 | 12,728 | 12,922 | 114,037 | 0 | 114,037 |
| Equipment Rental | 21,367 | 10,424 | 12,728 | 12,922 | 114,037 | 0 | 114,037 |
| DEPRECIATION - BUILDINGS & IMP | 24,990 | 24,540 | 24,479 | 22,494 | 269,062 | 0 | 269,062 |
| DEPRECIATION - LEASEHOLD IMP | 2,754 | 2,754 | 2,754 | 2,754 | 33,043 | 0 | 33,043 |
| DEPRECIATION - MAJOR EQUIPMENT | 38,654 | 37,797 | 35,818 | 35,420 | 418,678 | 0 | 418,678 |
| DEPRECIATION - LEASED EQUIP. | 8,256 | 18,823 | 7,200 | 7,200 | 97,390 | 0 | 97,390 |
| DEPRECIATION - MINOR EQUIP. | 30 | 30 | 30 | 30 | 500 | 0 | 500 |
| Depr. & Amortization | 74,684 | 83,944 | 70,281 | 67,898 | 818,672 | 0 | 818,672 |
| MANAGEMENT SERVICES | 19,000 | 19,000 | 19,000 | 19,000 | 219,658 | 0 | 219,658 |
| Parent Allocation | 19,000 | 19,000 | 19,000 | 19,000 | 219,658 | 0 | 219,658 |
| FINANCE CHARGES | 264 | 1,973 | 8,268 | 7,689 | 39,926 | 0 | 39,926 |
| INTEREST - LOANS | 41,408 | 41,352 | 41,408 | 43,040 | 519,969 | 0 | 519,969 |
| INTEREST - LEASES | 1,530 | 1,633 | 1,707 | 1,810 | 24,034 | 0 | 24,034 |
| Interest | 43,203 | 44,958 | 51,383 | 52,538 | 583,930 | 0 | 583,930 |
| Provision For Bad Debt | 597,080 | 260,390 | (183,977) | (29,415) | 983,622 | 0 | 983,622 |
| LICENSES & TAXES | 5,364 | (3,234) | 3,216 | 4,803 | 60,502 | 0 | 60,502 |
| ADVERTISEMENT | 8,039 | 49,172 | 4,356 | (17,930) | 230,618 | 0 | 230,618 |
| DUES AND SUBSCRIPTIONS | 12,632 | 10,305 | 11,235 | 16,112 | 137,993 | 0 | 137,993 |
| OUTSIDE TRAINING SESSIONS | 0 | 1,547 | 484 | 910 | 6,832 | 0 | 6,832 |
| TRAVEL | 6,888 | 1,040 | 400 | 4 | 26,651 | 0 | 26,651 |
| RECRUITING | 2,500 | 2,387 | 3,812 | 1,366 | 53,719 | 0 | 53,719 |
| OTHER DIRECT EXPENSES | 33,797 | 14,538 | 42,851 | 11,207 | 211,767 | 0 | 211,767 |
| Other Operating Expense | 69,220 | 75,755 | 66,354 | 16,471 | 728,080 | 0 | 728,080 |
| Total Operating Expenses | 2,866,035 | 2,142,814 | 1,717,908 | 1,951,776 | 24,577,911 | 0 | 24,577,911 |
| EXCESS (DEFICIT) | (620,690) | (1,892,184) | (299,867) | (314,727) | (3,105,534) | 0 | 3,105,534 |

HUNTINGTON EAST VALLEY HOSPTIAL
INCOME STATEMENT CURRENT AND 3 PREVIOUS MONTHS VS BUDGET
FOR THE MONTH ENDING NOV 2000

| | CURRENT AMOUNT | OCT 2000 ACTUAL | SEP 2000 ACTUAL | AUG 2000 ACTUAL | YEAR TO DATE | YTD BUDGET | YTD VARAINCE |
|---|---|---|---|---|---|---|---|
| Adjusted Patient Days | 1.945 | 1.832 | 1.846 | 1.984 | 19.995 | 21.314 | (1.242) |
| Gross Patient Revenue | | | | | | | |
| Routine | 1.126.700 | 1.064.786 | 976.159 | 1.018.156 | 11.260.922 | 12.417.730 | 1.156.808 |
| Inpatient | 2.914.230 | 2.824.300 | 2.296.744 | 2.513.667 | 29.076.278 | 32.415.088 | 3.338.810 |
| Outpatient | 1.482.626 | 1.423.518 | 1.596.080 | 1.882.166 | 17.240.247 | 16.057.085 | (1.183.162) |
| Total Gross Patient Revenue | 5.523.556 | 5.312.603 | 4.868.983 | 5.413.989 | 57.577.446 | 60.889.903 | 3.312.457 |
| Net Capitation Revenue | 5.233 | (10.760) | (4.865) | (4.149) | 138.115 | 668.784 | 530.669 |
| Gross Patient Service Revenue | 5.528.789 | 5.301.843 | 4.864.119 | 5.409.840 | 57.715.561 | 61.558.687 | 3.843.126 |
| Deductions from Revenue | 3.615.039 | 3.514.509 | 2.896.018 | 3.503.498 | 38.931.305 | 42.893.634 | (3.962.330) |
| Net Patient Revenue | 1.913.750 | 1.787.335 | 1.968.101 | 1.906.342 | 18.784.256 | 18.665.053 | (119.203) |
| Other Revenue | 27.162 | (193.321) | 15.541 | 49.698 | 21.345 | 320.009 | 298.664 |
| Total Net Patient Revenue | 1.940.912 | 1.594.014 | 1.983.642 | 1.956.040 | 18.805.601 | 18.985.062 | 179.461 |
| Operating Expenses | | | | | | | |
| Salaries & Wages | 832.753 | 906.912 | 824.584 | 838.527 | 9.028.541 | 8.812.005 | 216.536 |
| Registry | 43.392 | 21.940 | 30.023 | 33.460 | 278.148 | 62.497 | 215.651 |
| Employee Benefits | 106.945 | 119.081 | 129.272 | 117.003 | 1.274.760 | 1.154.077 | 120.683 |
| Professional Fees | 267.170 | 194.971 | 196.425 | 166.186 | 2.272.311 | 2.233.797 | 38.514 |
| Supplies | 253.149 | 249.296 | 248.940 | 279.985 | 2.759.957 | 2.710.874 | 49.083 |
| Purchased Services | 129.216 | 139.928 | 175.986 | 177.182 | 1.961.578 | 2.599.838 | (638.261) |
| Utilities | 29.082 | 40.578 | 49.930 | 51.774 | 390.326 | 343.994 | 46.332 |
| Insurance | 19.473 | 17.973 | 23.094 | 30.882 | 305.112 | 328.058 | (22.946) |
| Building Rental | 23.658 | 33.030 | 17.061 | 23.080 | 263.254 | 214.132 | 49.122 |
| Equipment Rental | 14.993 | 15.379 | 20.492 | 14.029 | 152.401 | 149.039 | 3.362 |
| Depreciation & Amortization | 73.860 | 75.181 | 74.987 | 76.007 | 827.249 | 756.409 | 70.840 |
| Parent Allocation | 17.990 | 17.990 | 17.990 | 17.990 | 197.890 | 197.567 | 323 |
| Interest | 42.267 | 43.686 | 45.077 | 58.876 | 505.176 | 473.512 | 31.664 |
| Provision For Bad Debt | 7.675 | 115.712 | 95.742 | 109.258 | 468.025 | 252.083 | 215.942 |
| Other Operating Expenses | 41.048 | 2.216 | 75.762 | 29.174 | 388.426 | 525.956 | (137.530) |
| Total Operating Expenses | 1.902.670 | 1.993.873 | 2.025.366 | 2.023.412 | 21.073.152 | 20.813.838 | 259.314 |
| EXCESS (DEFICIT) | 38.242 | (399.860) | (41.724) | (67.372) | (2.267.551) | (1.828.776) | 438.775 |

**HUNTINGTON EAST VALLEY HOSPITAL**
**Three Year Forecast**
Reflecting material purchase adjustments

**INCOME STATEMENT**

| | 2000 PROJECTED | 2001 PROJECTED | 2002 PROJECTED | 2003 PROJECTED | TOTAL PROJECTED | 2001 PER APD | 2002 PER APD | 2003 PER APD | TOTAL PER APD |
|---|---|---|---|---|---|---|---|---|---|
| Net Patient Service Revenue | 19,801,823 | 24,199,916 | 26,087,939 | 27,888,105 | 78,175,960 | 973 | 1,006 | 1,033 | 1,005 |
| Disproportionate Share Revenue | 1,200,000 | 1,200,000 | 1,200,000 | 1,200,000 | 3,600,000 | 48 | 46 | 44 | 46 |
| Net Capitation Revenue | 148,506 | 0 | 0 | 0 | 0 | - | - | - | - |
| Total Patient Service Revenue | 21,150,329 | 25,399,916 | 27,287,939 | 29,088,105 | 81,775,960 | 1,021 | 1,052 | 1,078 | 1,051 |
| Total Other Operating Revenue | 203,965 | 96,000 | 96,000 | 96,000 | 288,000 | 4 | 4 | 4 | 4 |
| **TOTAL OPERATING REVENUE** | **21,354,294** | **25,495,916** | **27,383,939** | **29,184,105** | **82,063,960** | **1,025** | **1,056** | **1,081** | **1,055** |
| **Operating Expenses :** | | | | | | | | | |
| Variable Direct | 9,203,646 | 10,961,360 | 11,867,331 | 12,809,183 | 35,637,874 | 441 | 458 | 475 | 458 |
| Fixed Direct | 3,927,205 | 4,076,617 | 4,195,353 | 4,314,089 | 12,586,059 | 164 | 162 | 160 | 162 |
| Indirect | 9,537,503 | 9,900,355 | 10,188,714 | 10,477,074 | 30,566,143 | 398 | 393 | 388 | 393 |
| Bad Debts | 357,426 | 362,999 | 391,319 | 418,322 | 1,172,639 | 15 | 15 | 15 | 15 |
| TOTAL OPERATING EXPENSES | 23,025,781 | 25,301,330 | 26,642,718 | 28,018,668 | 79,962,716 | 1,017 | 1,027 | 1,038 | 1,028 |
| ***Depreciation adjustment*** | | ***(451,650)*** | ***(449,186)*** | ***(444,094)*** | ***(1,344,930)*** | | | | |
| ***Interest Adjustment*** | | ***3,731*** | ***(33,158)*** | ***(71,654)*** | ***(101,081)*** | | | | |
| **SURPLUS (DEFICIT) FROM OPERATIONS** | **(1,671,487)** | **642,506** | **1,223,565** | **1,681,184** | **3,547,255** | **8** | **29** | **43** | **27** |
| Add : Depreciation & Amortization | 907,221 | 952,582 | 1,000,211 | 1,050,222 | 3,003,015 | 38 | 39 | 39 | 39 |
| ***Depreciation adjustment*** | | ***(451,650)*** | ***(449,186)*** | ***(444,094)*** | ***(1,344,930)*** | | | | |
| **CASH FLOW** | **(764,266)** | **1,143,438** | **1,774,591** | **2,287,312** | **5,205,340** | **46** | **67** | **82** | **66** |
| **ADC** | 41 | 47 | 49 | 51 | | 47 | 49 | 51 | |
| **OP Factor** | 146% | 145% | 145% | 145% | | | | | |
| **APD** | 60.2 | 68.2 | 71.1 | 74.0 | | 68.2 | 71.1 | 74.0 | |
| **PATIENT DAYS** | 15,005 | 17,155 | 17,885 | 18,615 | | 17,155 | 17,885 | 18,615 | |
| **ADJUSTED PATIENT DAYS** | 22,041 | 24,875 | 25,933 | 26,992 | 77,800 | 24,875 | 25,933 | 26,992 | 77,800 |
| MONTHS IN PROJECTION | 4 | 12 | 12 | 12 | | | | | |
| DAYS IN YEAR | 366 | 365 | 365 | 365 | | | | | |
| INFLATION FACTORS | | | | | | | | | |
| REVENUE | | 2.9% | 2.9% | 2.9% | | | | | |
| VARIABLE DIRECT | | 4.0% | 4.0% | 4.0% | | | | | |
| FIXED DIRECT | | 3.0% | 3.0% | 3.0% | | | | | |
| INDIRECT | | 3.0% | 3.0% | 3.0% | | | | | |

HUNTINGTON EAST VALLEY HOSPITAL
3 Year Forecast

INCOME STATEMENT

| | 2001 PROJECTED | 2002 PROJECTED | 2003 PROJECTED |
|---|---|---|---|
| Net Patient Service Revenue | 24,199,916 | 26,087,939 | 27,888,105 |
| Disproportionate Share Revenue | 1,200,000 | 1,200,000 | 1,200,000 |
| Total Patient Service Revenue | 25,399,916 | 27,287,939 | 29,088,105 |
| Total Other Operating Revenue | 1,296,000 | 1,596,000 | 1,596,000 |
| **TOTAL OPERATING REVENUE** | **26,695,916** | **28,883,939** | **30,684,105** |
| **Operating Expenses :** | | | |
| Salaries, Wages & Benefits | 12,442,361 | 13,077,716 | 13,739,608 |
| Outside Services | 5,185,955 | 5,244,018 | 5,494,041 |
| Supplies | 3,525,079 | 3,675,082 | 3,825,086 |
| Depreciation & Amortization | 500,932 | 551,025 | 606,128 |
| Interest | 633,537 | 623,181 | 612,113 |
| Rental - Building & Equipment | 452,662 | 466,242 | 480,229 |
| Parent Allocation | 224,515 | 233,496 | 242,836 |
| Provision for Bad Debt | 362,999 | 391,319 | 418,322 |
| Other | 1,251,312 | 1,282,622 | 1,306,283 |
| **TOTAL OPERATING EXPENSES** | **24,579,353** | **25,544,702** | **26,724,645** |
| **SURPLUS (DEFICIT) FROM OPERATIONS** | **2,116,563** | **3,339,238** | **3,959,460** |
| | | | |
| **ADC** | 47 | 49 | 51 |
| **OP Factor** | 145% | 145% | 145% |
| **ADJUSTED ADC** | 68.2 | 71.1 | 74.0 |
| **PATIENT DAYS** | 17,155 | 17,885 | 18,615 |
| **ADJUSTED PATIENT DAYS** | 24,875 | 25,933 | 26,992 |

# LAND SALES MAP

# COMPARABLE LAND SALE 1

| | |
|---|---|
| Location | 456 E. Foothill Bl. |
| City | San Dimas |
| State | CA |
| Assessor's Parcel | 8861-018-034, -035 |

***Site Data***

| | |
|---|---|
| Size (SF) | 53,580 |
| Size (Acres) | 1.23 |
| Zoning | CH |
| Topography | Level |
| Shape | Rectangular |
| Corner/Interior | Interior |

***Transaction Data***

| | |
|---|---|
| Seller | Glen E. Corporation |
| Buyer | English Language Institute/China |
| Interest | Fee simple |
| Recording | 0513964 |
| Date | April 6, 2000 |
| Terms | All cash to seller |
| Price | $532,000 |
| Price Per SF | $9.93 |
| Price Per Acre | $432,511 |

***Addition Information***

The site is currently vacant. The intended use is to build a two-story office building. The primary land uses south of the site are single-family residences in average condition built in the 1970s. The primary land uses along Foothill Boulevard are commercial with some townhomes northeast of the site. Foothill Boulevard is a moderately traveled thoroughfare.

# COMPARABLE LAND SALE 2

| | |
|---|---|
| Location | 100 W. Foothill Bl. |
| City | San Dimas |
| State | CA |
| Assessor's Parcel | 8661-013-036, -037, -040 |

***Site Data***

| | |
|---|---|
| Size (SF) | 67,953 |
| Size (Acres) | 1.56 |
| Zoning | AP |
| Topography | Level |
| Shape | Irregular |
| Corner/Interior | Corner |

***Transaction Data***

| | |
|---|---|
| Seller | Pae Greene Properties, et al |
| Buyer | Foothills Vineyard Fellowship |
| Interest | Fee simple |
| Recording | 1779461 |
| Date | September 20, 1999 |
| Terms | All cash to seller |
| Price | $638,000 |
| Price Per SF | $9.39 |
| Price Per Acre | $408,978 |

***Addition Information***

This site has been improved with a church. The primary land uses are single-family residential in average to good condition built between 1970 to the present. East of the site is a plant nursery and to the west is a three-story office building. Foothill Boulevard is a moderately traveled thoroughfare.

# COMPARABLE LAND SALE 3

| | |
|---|---|
| Location | NEC Irwindale/Cam. Cantera |
| City | Irwindale |
| State | CA |
| Assessor's Parcel | 8616-022-027 |

***Site Data***

| | |
|---|---|
| Size (SF) | 44,640 |
| Size (Acres) | 1.02 |
| Zoning | MS2 |
| Topography | Level |
| Shape | Rectangular |
| Corner/Interior | Interior |

***Transaction Data***

| | |
|---|---|
| Seller | Calmat Properties Co. |
| Buyer | Havadijas Holdings, Inc. |
| Interest | Fee simple |
| Recording | 0365877 |
| Date | March 5, 1999 |
| Terms | All cash to seller |
| Price | $500,000 |
| Price Per SF | $11.20 |
| Price Per Acre | $487,903 |

***Addition Information***

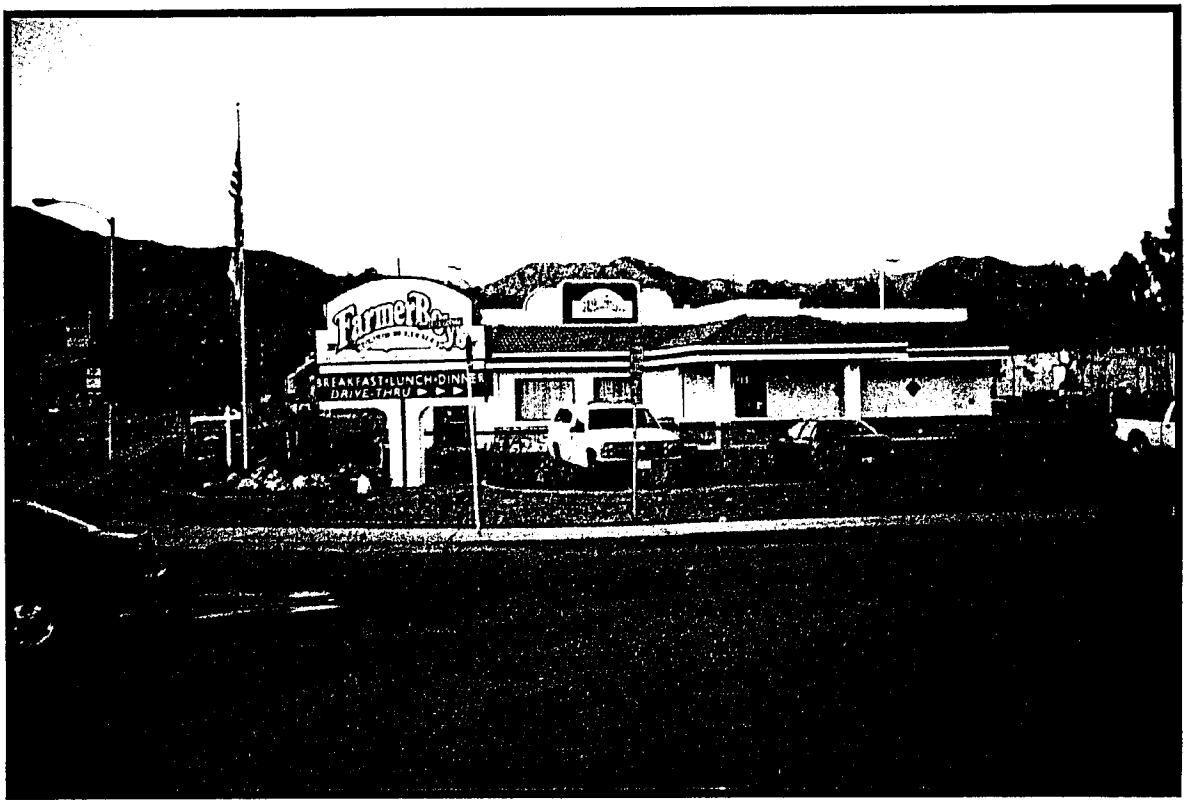
This site has been improved with a "Farmer Boys" fast food restaurant. The primary land uses are commercial light industrial and office. These improvements are in average to good condition. The site is approximately two hundred feet north of Interstate 210 (Foothill Freeway). Irwindale Avenue is a major thoroughfare that experiences moderate to heavy traffic.

# LAND SALE PHOTOGRAPHS

Land Sale 1

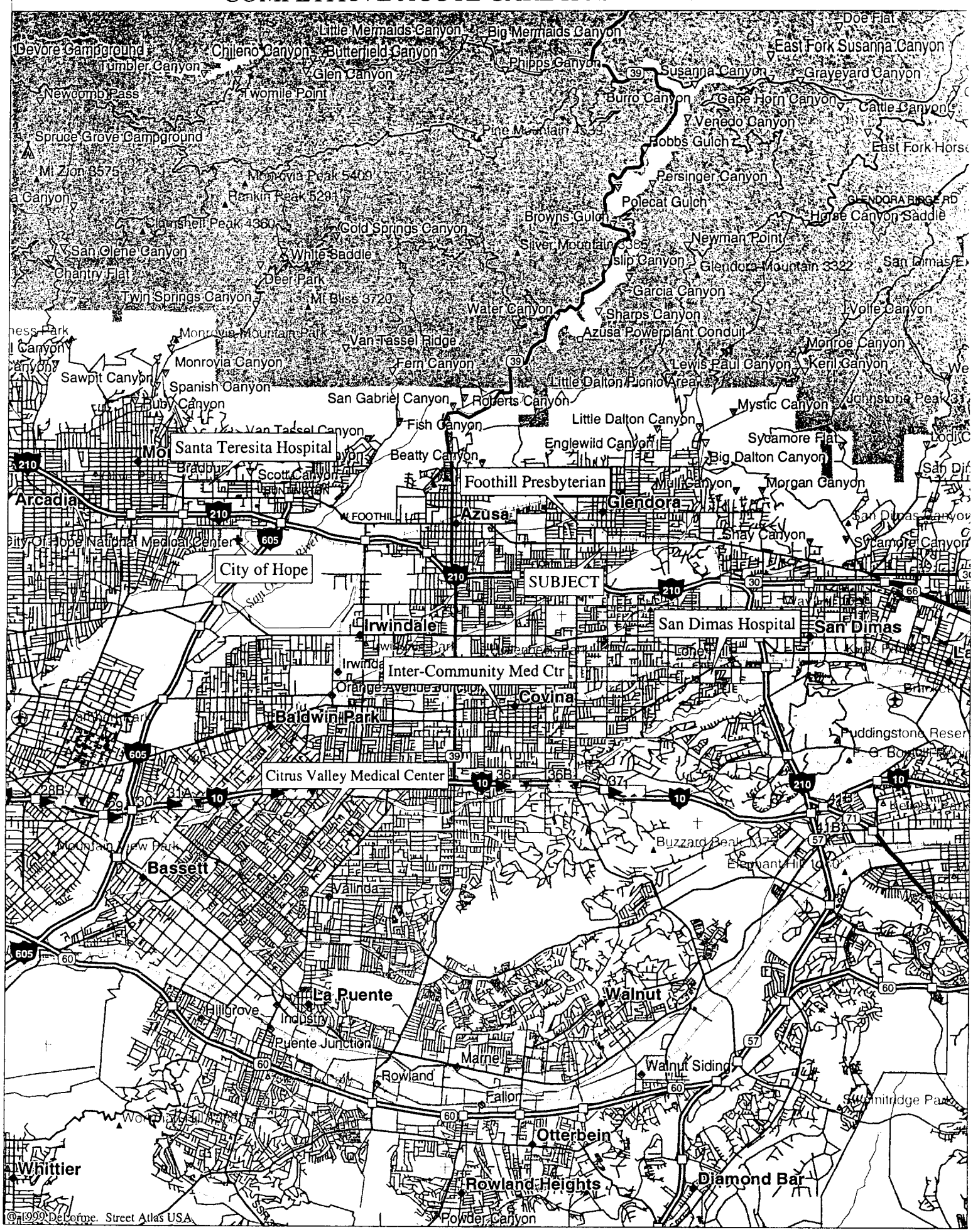
Land Sale 2

Land Sale 3




Land Sale 4

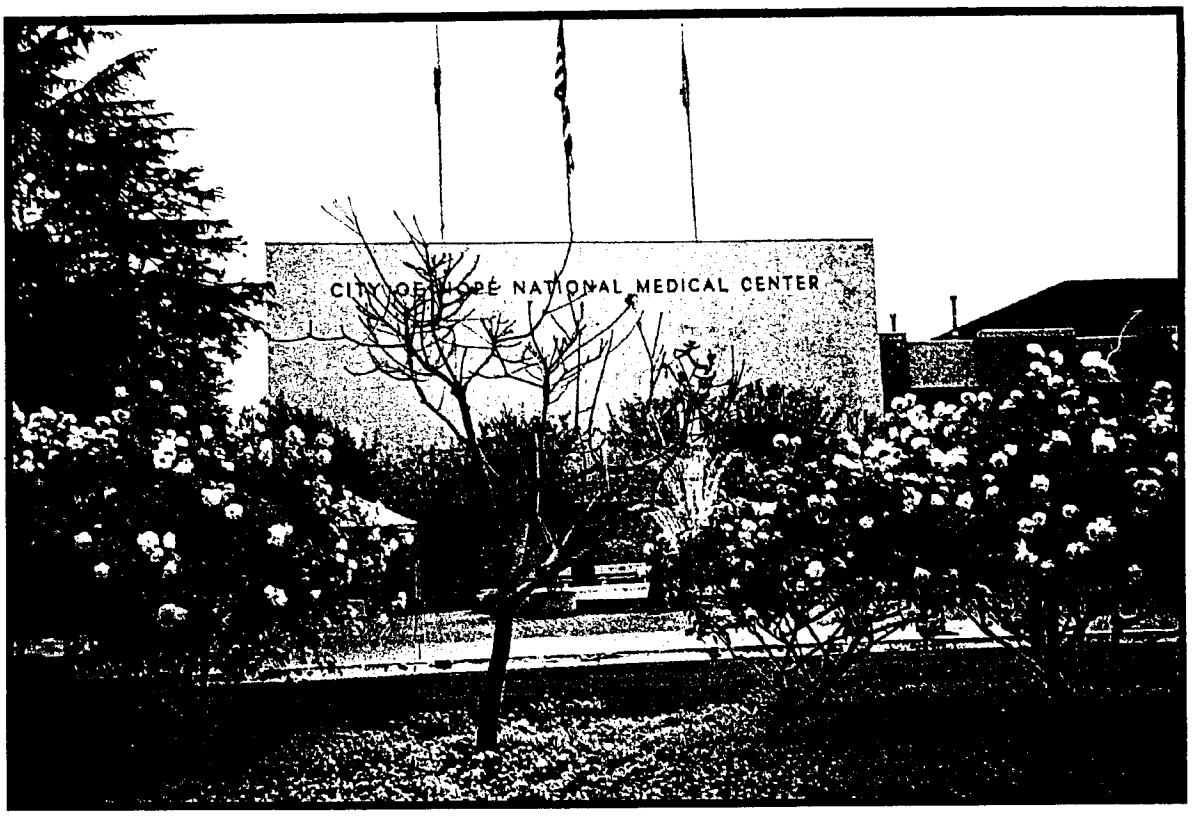
# COMPETITIVE ACUTE CARE HOSPITALS MAP



# COMPETITION PHOTOGRAPHS

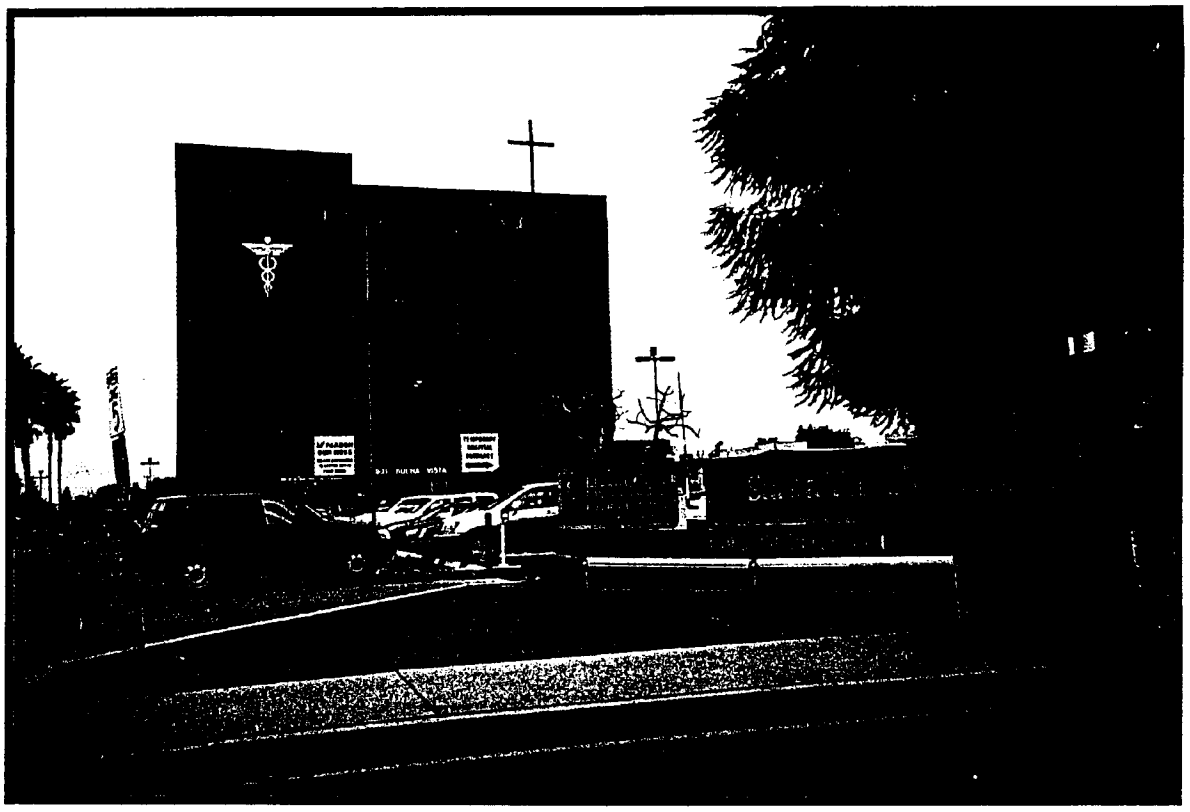
Foothill Presbyterian Hospital

Inter-Community Medical Center




City of Hope National Medical Center

San Dimas Community Hospital



Santa Teresita Hospital

Citrus Valley Medical Center