PRELIMINARY OFFICIAL STATEMENT DATED MAY 31, 2013

NEW ISSUE—-BOOK-ENTRY ONLY

RATING: Moody's: A2
(See "RATING" herein)

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

$36,545,000*
OAK VALLEY HOSPITAL DISTRICT
(STANISLAUS COUNTY, CALIFORNIA)
2013 GENERAL OBLIGATION REFUNDING BONDS

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

The issuance of general obligation bonds in an aggregate amount not to exceed $37,000,000 by Oak Valley Hospital District (the "District") was authorized at an election of the registered voters of the District held on August 31, 2004, by more than two-thirds of the persons voting on the measure. Pursuant to the laws of the State of California (the "State"), and a resolution of the District, the District issued its general obligation bonds in the amount of $37,000,000 on July 12, 2005, known as the Oak Valley Hospital District (Stanislaus County, California) 2005 General Obligation Bonds, Election of 2004 (the "2005 Bonds").

The District is issuing this series of general obligation bonds in the amount of $36,545,000,* known as the Oak Valley Hospital District (Stanislaus County, California), 2013 General Obligation Refunding Bonds (the "Bonds"). See "THE BONDS - Authority for Issuance" herein. Proceeds of the Bonds will be used to advance refund a portion of the 2005 Bonds. See "REFINANCING PLAN" herein.

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

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

The Bonds will be dated the date of their delivery, and will accrue interest from such date, which interest is payable semiannually on each January 1 and July 1, commencing January 1, 2014. The Bonds are issuable in denominations of $5,000 or any integral multiple thereof.

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

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

G.L. Hicks Financial, LLC

MATURITY SCHEDULE*

Maturity (July 1)	Principal Amount	Interest Rate	Price or Yield	CUSIP†	Maturity (July 1)	Principal Amount	Interest Rate	Price or Yield	CUSIP†
2014	$ 270,000				2025	$1,590,000			
2015	810,000				2026	1,710,000			
2016	850,000				2027	1,835,000			
2017	910,000				2028	1,975,000			
2018	970,000				2029	2,120,000			
2019	1,035,000				2030	2,265,000			
2020	1,110,000				2031	2,415,000			
2021	1,185,000				2032	2,575,000			
2022	1,280,000				2033	2,745,000			
2023	1,375,000				2034	2,925,000			
2024	1,480,000				2035	3,115,000			

Bids for the purchase of the Bonds will be received by the District on June 11, 2013, until 9:00 A.M., Pacific Daylight Time. The Bonds will be sold pursuant to the terms of sale set forth in the Official Notice of Sale, dated May 31, 2013.

This cover page contains certain information for reference only. It is not a summary of this issue. Investors must read the entire Official Statement to obtain information essential to the making of an informed investment decision.

The Bonds are offered when, as and if issued, subject to approval as to their legality by Quint & Thimmig LLP, San Francisco, California, Bond Counsel. Certain legal matters will be passed on for the District by its counsel, Jennings, Strouss & Salmon, PLC, Phoenix, Arizona, which firm has also acted as Disclosure Counsel to the District. It is anticipated that the Bonds, in book-entry form, will be available for delivery through the facilities of DTC on or about June 28, 2013.

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

* Preliminary, subject to change.

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

OAK VALLEY HOSPITAL DISTRICT
STANISLAUS COUNTY, CALIFORNIA

BOARD OF DIRECTORS

Dan Cummins, President — Wendell Chun, Ed. D, Vice President

Louise Pooley-Sanders, Secretary/Treasurer

Jim Teter, Member — Edward Chock, M.D., Member

DISTRICT SENIOR MANAGEMENT

John McCormick, Chief Executive Officer
A.L. Diaz, Chief Financial Officer
Joann Saporito, Nurse Administrator
Cheryl C. Koff, Administrator, Oak Valley Care Center

PROFESSIONAL SERVICES

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

Bond Counsel
Quint & Thimmig LLP
San Francisco, California

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

Independent Auditors
TCA Partners
Fresno, California

Registrar, Transfer and Paying Agent
U.S. Bank National Association
San Francisco, California

GENERAL INFORMATION ABOUT THIS OFFICIAL STATEMENT

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

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

Limit of Offering. No dealer, broker, salesperson or other person has been authorized by the District to give any information or to make any representations in connection with the offer or sale of the Bonds other than those contained herein and if given or made, such other information or representation must not be relied upon as having been authorized by the District or the Financial Advisor. This Official Statement does not constitute an offer to sell or the solicitation of an offer to buy nor shall there be any sale of the Bonds by a person in any jurisdiction in which it is unlawful for such person to make such an offer, solicitation or sale.

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

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

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

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OAK VALLEY HOSPITAL DISTRICT
(STANISLAUS COUNTY, CALIFORNIA)
2013 GENERAL OBLIGATION REFUNDING BONDS

INTRODUCTION

This Official Statement, including the cover page, the Table of Contents and the APPENDICES hereto (the "Official Statement"), is provided to furnish information with respect to the sale and delivery by Oak Valley Hospital District (the "District") of $36,545,000* aggregate principal amount of its 2013 General Obligation Refunding Bonds (the "Bonds").

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

The District

Oak Valley Hospital District (the "District"), a local health care district formed in 1968, is a political subdivision of the State of California organized pursuant to the State's Local Health Care District Law (formerly the Local Hospital District Law) as set forth in the State's Health and Safety Code. The geographic area that comprises the District (includes the voting residents who elect the District's Board of Directors and passed the District's general obligation bond measure) encompasses approximately 327 square miles in the northeastern portion of Stanislaus County (the "County") and includes the Cities of Oakdale and Waterford, as well as the neighboring unincorporated areas of Valley Home and Knights Ferry. The 2012 population of the City of Oakdale, the City of Waterford and Stanislaus County was approximately 20,947, 8,533 and 519,940, respectively. The permanent resident population of the District is approximately 80,000. The District operates Oak Valley Hospital, Oak Valley Care Center, Oak Valley Medical Plaza, Escalon Community Health Center, Oak Valley Community Health Clinic, Waterford Medical Clinic, and Riverbank Community Health Center (collectively referred to herein as the "Health Facilities"). The District leases the Oak Valley Care Center and three rural health centers/clinics. See "THE DISTRICT," "THE HOSPITAL AND HEALTH FACILITIES," and "DISTRICT FINANCIAL MATTERS" herein.

The Plan of Finance

Net proceeds of the Bonds will be used to advance refund a portion of the 2005 Bonds and to pay the costs of issuing the Bonds. See "REFINANCING PLAN" herein. See also "THE PROJECT" herein.

Sources of Payment for the Bonds

The Bonds are general obligations of the District, and the District has the power, is obligated and covenants to cause to be levied *ad valorem* taxes upon all property within the District subject to taxation by the District, without limitation of rate or amount, for the payment when due of the principal of and interest on the Bonds. See "THE BONDS - Security for the Bonds" and "THE DISTRICT" herein. All such a*d valorem* taxes will be collected by the County and transferred by the County directly to the Paying Agent (defined below) for payment of the Bonds. In addition, pursuant to Section 32127 of the District Law, the District is required to use moneys in its maintenance and operation fund whenever *ad valorem* taxes are insufficient to pay such principal and interest.

Description of the Bonds

The Bonds will be dated the date of their delivery, will be in denominations of $5,000 each, or integral multiples thereof, and will bear interest at the rate or rates shown on the cover page hereof, with interest payable semiannually on each January 1 and July 1, commencing January 1, 2014 (each an "Interest Payment Date"), during the term of the Bonds.

* Preliminary, subject to change.

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

The Bonds maturing on or after July 1, 2021, may be redeemed prior to maturity at the option of the District beginning on July 1, 2020, and thereafter, at the redemption price of 100% of the par amount of Bonds redeemed, plus accrued interest. The Bonds maturing on July 1, 20__, are subject to mandatory redemption as provided herein. See "THE BONDS - Redemption Provisions" herein.

Tax Matters

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

Professionals Involved in the Offering

All proceedings in connection with the issuance of the Bonds are subject to the approval of Bond Counsel. Bond Counsel will supply a legal opinion approving the validity of the Bonds. See "LEGAL MATTERS - Approval of Legality" herein. U.S. Bank National Association, San Francisco, California, will act as paying agent and registrar for the Bonds (the "Paying Agent"). Jennings, Strouss & Salmon, PLC, Phoenix, Arizona, will act as the District's legal counsel ("District Counsel") and will also act as disclosure counsel ("Disclosure Counsel") to the District in connection with the Bonds. G.L. Hicks Financial, LLC, Provo, Utah, will act as financial advisor ("Financial Advisor") to the District for the Bonds. The fees of all these professionals are contingent on closing of the Bonds.

Offering and Delivery of the Bonds

The Bonds are offered when, as and if issued, subject to approval as to their legality by Bond Counsel. It is anticipated that the Bonds in book-entry only form will be available for delivery through the facilities of DTC on or about June 28, 2013.

Bondholders' Risks

The Bonds are general obligations of the District and the District has the power and is obligated to cause to be levied and collected by the County annual *ad valorem* taxes for payment when due of the principal of and interest on the Bonds upon all property located within the District subject to taxation by the District (except certain personal property which is taxable at limited rates) without limitation as to rate or amount. In the event *ad valorem* taxes are insufficient to pay principal and interest on the Bonds, the District is required to use moneys in its maintenance and operations fund to pay debt service on the Bonds. As described above under "Sources of Payment for the Bonds," the County collects all *ad valorem* taxes on behalf of the District and transfers those funds directly to the Paying Agent for payment of the Bonds. For more complete information regarding the District's financial condition and taxation of property within the District, see "DISTRICT FINANCIAL MATTERS" herein. See also "THE BONDS – Security for the Bonds" and "APPENDIX E – HEALTHCARE RISK FACTORS" herein.

Other Information; Continuing Disclosure

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

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

THE BONDS

Authority for Issuance

The Bonds are general obligation bonds issued pursuant to Chapter 4 of Division 23 (commencing with Section 32300) of the California Health and Safety Code and the provisions of a Resolution of the Board of Directors of the District adopted on April 24, 2013 (the "Resolution"). District voters authorized the issuance of $37,000,000 of general obligation bonds by more than two-thirds of the votes cast by eligible voters within the District on August 31, 2004. The District sold $37,000,000 in general obligation bonds on June 8, 2005, and delivered those bonds on July 12, 2005.

Description of the Bonds

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

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

Purpose of the Issue

Proceeds of the Bonds will be used to advance refund a portion of the 2005 Bonds and to pay the costs of issuing the Bonds. See "THE REFINANCING PLAN" herein. See also "THE PROJECT" herein.

Book-Entry System

The Depository Trust Company, New York, New York, will act as securities depository for the Bonds. The Bonds will be issued as fully-registered bonds registered in the name of Cede & Co. (DTC's partnership nominee) or such other name as may be requested by an authorized representative of DTC. One fully-registered bond certificate will be issued for each maturity, and will be deposited with DTC. See "APPENDIX D – BOOK-ENTRY SYSTEM" for a more complete discussion of DTC and the Book-Entry System.

Sources and Uses of Funds

The following table sets forth the estimated sources and uses of funds relating to the Bonds:

Estimated Sources of Funds:

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

Estimated Uses of Funds:

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

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

Redemption Provisions

Optional Redemption. Bonds maturing on or after July 1, 2021 are subject to redemption prior to their respective stated maturities, at the option of the District, in whole or in part on any date on or after July 1, 2020, at redemption prices equal to the principal amount of Bonds redeemed, plus accrued interest to the date fixed for redemption.

Mandatory Redemption. Bonds maturing on July 1, 20__, are subject to mandatory sinking fund redemption prior to maturity in part, by lot or in any customary manner as determined by the Paying Agent, at 100% of the principal amount thereof plus accrued interest to the date fixed for redemption, without premium, as shown in the table below under "Debt Service Schedule" in the column designated as "Principal Payment."

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

Defeasance

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

Debt Service Schedule

The following table summarizes the annual debt service requirements for the Bonds, the remaining 2005 Bonds assuming the redemption of the 2005 Bonds to be refunded (see "REFINANCING PLAN" herein), and such remaining 2005 Bonds and the Bonds together:

	The Bonds				
Year Ending (July 1)	Principal Payment	Interest Payment	Total Debt Service	Total Debt Service on the Remaining 2005 Bonds	Aggregate Debt Service on the Bonds and Remaining 2005 Bonds
2013				$468,750.00	$468,750.00
2014	$	$	$	517,625.00	
2015					
2016					
2017					
2018					
2019					
2020					
2021					
2022					
2023					
2024					
2025					
2026					
2027					
2028					
2029					
2030					
2031					
2032					
2033					
2034					
2035					

* Mandatory sinking fund payment.

Registration

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

Security for the Bonds

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

A reduction in the assessed valuation of taxable property located in the District, such as may be caused by deflation of property values, economic recession, or other economic crisis, a relocation out of the District by one or more major property owners or employers, or the complete or partial destruction of such property caused by, among other events, an earthquake, wildfire, flood or other natural disaster, could cause a reduction in the assessed value of

the District's tax roll and necessitate an unanticipated increase in the annual tax levy necessary to pay debt service on its general obligation bonds. A significant decrease in assessed valuation or a declaration of bankruptcy by the District, could delay the payment of debt service on the Bonds. The District calculates the tax rate on an annual basis. If in any given fiscal year there are not sufficient funds on deposit with the County to pay debt service on the Bonds for such fiscal year, the District is required to provide funds from its operations to make up any deficiencies to provide for payment of the Bonds. While the levy of *ad valorem* tax to pay debt service of the Bonds and other general obligation bonds is not limited as to rate or amount, the risks discussed in this paragraph could affect a taxpayer's willingness or ability to pay *ad valorem* taxes.

Over the past several years, the real estate market has seen an increased rate of mortgage delinquencies and foreclosures and, there has been a slowdown in new home and other construction. In addition, there has been a decline in the year over year rate of growth and even declines of assessed valuations in the District. For example, the total assessed valuation of real property in the District for the fiscal year 2012-13 decreased by approximately 18.7% as compared to fiscal year 2007-08, the highest year for the District's assessed valuation. However, the total assessed valuation for the fiscal year 2012-13 decreased by less than 0.2% as compared to fiscal year 2011-12. Notably, the tax delinquencies for the County's secured tax charges have decreased from a high of 9.25% in the fiscal year 2007-08 to a low of 2.22% in the fiscal year 2011-12, the most current year for which information is available.

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

THE PROJECT

The District has recently completed the construction of a new two-story, 123,000 square foot hospital facility and is making other improvements to its Health Facilities (the "Project") using, in part, proceeds from the 2005 Bonds. The new hospital facility was constructed in phases. The existing hospital facility will continue to be used for acute care inpatient services. The first floor of the new facility provides a twelve-space emergency room, two endoscopy procedure rooms, seven out-patient surgical prep and recovery rooms, radiology, laboratory and materials management. The second floor is shelled in for future expansion. When all Project costs have been paid, it is estimated that the entire Project cost, including a central plant to service the Health Facilities, will be approximately $106,800,000, with all but approximately $1,025,000 having been paid by the District as of March 31, 2013.

The Project architects were Moon-Mayoras Architects, Inc. of San Diego, California. Turner Construction, a national construction company and project management firm, was engaged by the District to work with the architects on the Project design, constructability of the Project and cost estimation. Acme Construction, Inc. of Modesto, California, acted as the general contractor. Jacobs Engineering, an international firm, served as Project Manager.

REFINANCING PLAN

A portion of the proceeds from the sale of the Bonds will be deposited into an escrow fund (the "Escrow Fund") to be created and maintained by U.S. Bank National Association, as escrow bank (the "Escrow Bank"). A portion of the moneys deposited in the Escrow Fund will be invested in U.S. Treasury Securities, so that the interest thereon and the maturing principal thereof, together with uninvested cash, will be sufficient to redeem in full all 2005 Bonds maturing on and after July 1, 2015 (the "Refunded 2005 Bonds"), at a redemption price equal to 101% of the principal amount of the Refunded 2005 Bonds, on July 1, 2014.

The mathematical accuracy of the calculation as to the sufficiency of the U.S. Treasury Securities and cash in the Escrow Fund to meet the payment and redemption requirements of the Refunded 2005 Bonds will be verified by Grant Thornton LLP, Minneapolis, Minnesota (the "Verification Agent"). See "MISCELLANEOUS – Verification" herein.

STATE CONSTITUTIONAL LIMITATIONS ON DISTRICT REVENUES AND EXPENDITURES

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

Article XIIIA of the California Constitution

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

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

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

Legislation Implementing Article XIIIA

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

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

Unitary Property

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

jurisdictions (including the District) according to statutory formulae generally based on the distribution of taxes in the prior year.

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

Article XIIIB of the California Constitution

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

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

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

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

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

Article XIIIC and Article XIIID of the California Constitution

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

According to the "Title and Summary" of Proposition 218 prepared by the California Attorney General, Proposition 218 limits "the authority of local governments to impose taxes and property-related assessments, fees and charges." Among other things, Article XIIIC establishes that every tax is either a "general tax" (imposed for general governmental purposes) or a "special tax" (imposed for specific purposes), prohibits special purpose government agencies such as hospital districts from levying general taxes, and prohibits any local agency from imposing, extending or increasing any special tax beyond its maximum authorized rate without a two-thirds percent vote; and also provides that the initiative power will not be limited in matters of reducing or repealing local taxes, assessments, fees and charges. Article XIIIC further provides that no tax may be assessed on property other than *ad valorem* property taxes imposed in accordance with Articles XIII and XIIIA of the California Constitution and special taxes approved by a two-thirds percent vote under Article XIIIA, Section 4. Article XIIID deals with

assessments and property-related fees and charges, and explicitly provides that nothing in Article XIIIC or XIIID will be construed to affect existing laws relating to the imposition of fees or charges as a condition of property development.

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

Future Initiatives

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

THE DISTRICT

The District was formed in 1968 and is a political subdivision of the State of California. The geographic area that comprises the District encompasses approximately 327 square miles in the northeastern portion of Stanislaus County. The District operates Oak Valley Hospital, Oak Valley Care Center, Oak Valley Medical Plaza, Escalon Community Health Center, Oak Valley Community Health Clinic, and Riverbank Community Health Center (collectively referred to herein as the "Health Facilities"). See "INTRODUCTION – The District" and "THE HOSPITAL AND HEALTH FACILITIES" herein.

THE HOSPITAL AND HEALTH FACILITIES

Oak Valley Hospital (the "Hospital") commenced operations in 1973 with significant expansions completed in 1992, 1995, 2000 and 2011. The Hospital is a general acute care hospital licensed for 35 acute care beds and 11 skilled nursing beds. The Hospital is located in Oakdale, California, approximately 14 miles east of Modesto, California, and approximately 80 miles southeast of Sacramento, California, near the intersection of State Highways 108 and 120. The Hospital is situated on a 12-acre campus and consists of a one-story, 42,629 square foot building and an adjacent two-story, approximate 123,000 square foot building. The first floor of the new building contains a 12-space emergency room, two surgery suites, five post-anesthesia beds, two endoscopy procedure rooms, seven out-patient surgical prep and recovery rooms, radiology, laboratory and materials management. A nutritional services area was shelled out and may be completed in the future. The second floor of the new building is also shelled out to allow for the future addition of up to fifty-eight acute care beds. The new Hospital building has been constructed within seven feet of the existing building with corridors connecting the two structures. The Hospital provides a full range of primary and secondary acute care services, skilled nursing and comprehensive emergency, outpatient and ambulatory care services. The existing hospital facility meets California's earthquake requirements through 2030.

To meet the needs of the residents of its service area, the District has gradually expanded its services over time. The District's primary health facility, the Hospital, was originally constructed as a 32-bed general acute care facility. Since its opening, additions to the Hospital and the expansion into other facilities and services have included the following:

1992 - Emergency Department expansion of the Hospital;

1995 - Expansion of patient rooms and added 11 skilled nursing beds to the Hospital;

2000 - Family Centered Maternity Care – six-bed labor, delivery, recovery and postpartum conversion; and

2011 - Two-story expansion to the Hospital (described above).

In addition to the Hospital, the District operates the following hospital-based facilities:

The District leased the Oak Valley Care Center in 1991 and operates this facility as a 104-bed licensed skilled nursing facility, located immediately adjacent to the Hospital campus. The Oak Valley Care Center is designated as a distinct part skilled nursing facility by the State of California, affording the District a higher rate of

reimbursement than similar freestanding facilities for services provided based upon an allowable cost not to exceed formula. The District purchased a thirteen percent ownership in the Oak Valley Care Center facility in 2006. The Oak Valley Care Center lease is on a month-to-month basis.

The Escalon Community Health Center (a 95-210 rural health clinic) is located in the City of Escalon and was opened in 2004. This 2,885 square foot leased facility is located approximately 10 miles from the Hospital in a leased medical/professional office complex. It is licensed as a Rural Health Clinic by the State Department of Public Health.

The Oak Valley Community Health Clinic (a 95-210 rural health clinic) is located adjacent to the Hospital and is operated in a leased 9,612 square foot building. This clinic facility commenced operation in 1997 and is also licensed as a Rural Health Clinic by the State Department of Public Health.

The Riverbank Community Health Center (also a 95-210 rural health clinic) is located in the City of Riverbank and began operations in 1996. This 3,012 square foot clinic facility is located approximately 6 miles from the Hospital in a leased medical/professional office complex. It is also licensed as a Rural Health Clinic by the State Department of Public Health.

The District owns the Waterford Medical Clinic in Oakdale, leases the Oak Valley Medical Plaza in Oakdale and leases the Family Support Network location in Oakdale.

The District also owns ambulance services located in the Cities of Oakdale, Riverbank and Waterford.

Board of Directors and Hospital Governing Body

The Board of Directors of the District (the "Board"), consists of five members elected to four-year terms by voters who reside within the confines of the District's boundaries. No election is required if a candidate for election to the Board is unopposed. Members of the Board must be registered voters residing within the District.

Effective September 1, 1998, in accordance with the Management Services Agreement between the District and Dignity Health (previously known as Catholic Healthcare West), a subcommittee of the Board (the "Hospital Governing Body") was established. The Hospital Governing Body is composed of ten members including the five members of the Board, two members who reside within the District boundaries and nominated by Dignity Health, one representative of Dignity Health, the Chief of Staff and the Vice Chief of Staff of the Hospital. The current members of the Board and the Hospital Governing Body, their principal occupations, their offices held and the dates on which their terms expire are shown in the following tables. District Board members include the following:

Name	Position	Principal Occupation	Term Expires
Dan Cummins	President	Fire Captain	2014
Wendell Chun, Ed.D	Vice President	Retired School Superintendent	2014
Louis Pooley-Sanders	Secretary/Treasurer	Retired Patient Representative	2016
Jim Teter	Member	Business Owner	2016
Edward Chock, M.D.	Member	Physician	2014

Hospital Governing Body members include the following additional members:

Name	Position	Principal Occupation	Term Expires
Lee Hurwitz, M.D.	Member	Chief of Staff	2014
Al Gelders, M.D.	Member	Vice Chief of Staff	2014
Robert Wikoff	Member	Retired Businessman	2014
Richard Vaughan	Member	Retired Rancher	2013
Don Wiley	Member	Hospital President - Dignity Health Representative	Perpetuity

The Board has delegated the operations and governance of the Health Facilities to the Hospital Governing Body with the exception of (i) a change in the Hospital's mission statement, (ii) any change in the District's charity care policy, (iii) any change in the name of the District, (iv) the establishment of affiliates of the Hospital or the District, (v) the incurrence of new debt in excess of $250,000, (vi) the adoption and amendment of the Hospital's

institutional master plan, (vii) the closure of the Hospital or reduction/elimination of any material services provided by the District, (viii) the amendment of the Management Services Agreement, and (ix) the appointment and removal of the District's Chief Executive Officer (unless 3 of the 5 Board members to the Hospital Governing Body were present at the meeting of the Hospital Governing Body when the subject action to appoint or remove was taken).

Notwithstanding the above, under the Management Services Agreement with the Board has agreed not to take the following actions without the approval of a majority of the Hospital Governing Body that includes a vote in favor by the Dignity Health representative: (i) the removal of any member of the Hospital Governing Body, (ii) the establishment of any affiliate, (iii) the incurrence of indebtedness in excess of $250,000, and (iv) the imposition of any budgeted encumbrance upon District assets.

The Management Services Agreement between the District and Dignity Health will expire in September 2013. At such time the Hospital Governing Board will no longer function, and full management authority will be returned to the Board. See "Related Entities and Affiliations" below

Senior Management

The day-to-day operations and management planning for the Health Facilities are handled by the following key administrative officers:

John J. McCormick, *Chief Executive Officer*. Mr. McCormick has served as the Chief Executive Officer of the Health Facilities since March, 2012. From November 2011 until March 2012 he served as Interim Chief Executive Officer of the Health Facilities. Mr. McCormick also temporarily functioned as the Chief Financial Officer. From 2009 until his employment with the District he was an independent consultant providing management and administrative consulting services principally to rural California hospitals. Mr. McCormick has been in the healthcare industry for over 30 years holding various management positions including Controller, Chief Financial Officer and Chief Executive Officer. He received his Bachelor of Arts degree in Accounting from California State University, Fullerton, Fullerton, California, and his Master of Business Administration degree from Pepperdine University, Malibu, California. He is a member of the American College of Healthcare Executives and is an Advanced Member of the Healthcare Financial Management Association.

A.L. Diaz, *Chief Financial Officer*. Mr. Diaz assumed the duties of Chief Financial Officer in May 2013. He served as Chief Financial Officer of South Bay Family Health Care, a FQHC located in Los Angeles County, from December 2010 until February 2013. Prior to that and, since his professional career began in 1985, he has served in various Chief Financial Officer capacities and other finance officer and consulting positions with several hospitals and other healthcare organizations. Mr. Diaz received his Bachelor of Science degree in Accounting from San Francisco State University and his Master of Business Administration degree from St. Mary's College, Moraga, California. He is a member of the Healthcare Financial Management Association.

Joann L. Saporito, *Nurse Administrator*. Ms. Saporito has held the position of Vice President of Nursing since June 1, 2012. Before that she was Manager, Integrated Quality Services for Sutter Solano Medical Center, Vallejo, California, from 2009 until her employment by the District. From 1999 to 2009 she held progressively more responsible positions with Sutter Delta Medical Center, Antioch, California, beginning as Charge Nurse, and progressing to Nursing Supervisor, Nurse Manager and, lastly, to Quality Management Coordinator. She received her Bachelor of Business Administration degree and Master of Business Administration degree, both in Healthcare Management, from American InterContinental University, Hoffman Estates, Illinois. She is a member of the American College of Healthcare Executives.

Cheryl C. Koff, *Administrator, Oak Valley Care Center*. Mrs. Koff has been the Administrator for the Oak Valley Care Center since March 1988. She has had over 35 years in the skilled nursing and assisted living facility industry, generally serving as the administrator for such facilities. Mrs. Koff received her Bachelor of Arts degree in Fine Arts, from Stanislaus State College, Turlock, California. Her professional association service has included in the past the position of President of the Board of Directors of the American Heart Association and President of the Progress Valley Chapter of California Association of Health Facilities.

Medical Staff

As of March 31, 2013, the Hospital's combined medical staff included 136 physicians with active, provisional, courtesy and consulting privileges. Active and provisional active medical members (55 physicians) are

the primary admitters of patients to the Health Facilities. Approximately 62% of the active medical staff members are board certified.

The top ten admitting physicians, based on number of admissions during the fiscal year ended June 30, 2012, together accounted for approximately 77% of the Hospital's total admissions. The average age of these top ten admitting physicians is 52.

Employees

As of March 31, 2013, the District employed approximately 415 full-time equivalent employees. Included in this group are registered nurses, licensed vocational nurses, technicians, specialists, environment and food service personnel, and various management, supervisory and clerical personnel. District management believes that the compensation and benefits package it offers to its employees is competitive, and that its relations with employees are good. The District is currently in contract renewal negotiations with the National Emergency Medical Services Association who represent all ambulance personnel (approximately 38 employees), and with the United Steelworkers who represent all acute care personnel employed at the Hospital (approximately 185 employees). Management believes these negotiations will be concluded satisfactorily.

Related Entities and Affiliations

The District plans for and evaluates potential affiliations as part of its overall strategic planning process where there are strategic or operational benefits to be realized. The District is affiliated with the following organizations.

In response to continued changes in the healthcare market, in the mid-1990s, District management initiated a review of strategic actions that the District could take to enhance its ability to serve its patients. This led the District to enter into a 15-year Management Services Agreement with Catholic Healthcare West, now Dignity Health, in 1998. This initial affiliation agreement provided that Dignity Health make a $6,132,000 cash transfer to the District in return for the District entering into a 15-year agreement whereby Dignity Health would provide comprehensive management services over the life of the agreement in return for an annual management fee equal to 1.25% of the District's total operating revenues and 25% of District net income. The affiliation agreement has since been modified and now provides for a fixed annual fee. Furthermore, pursuant to the revised agreement, the District agreed to pay $350,000 per year, over the remaining term of the Management Services Agreement, in partial consideration for the aforementioned funds transferred to the District in 1998. The Management Services Agreement, and the attendant rights and obligations of the parties, will expire in September 2013.

The District has established an affiliation with Modesto Junior College in Modesto, California, to provide clinical training for registered nurses and to assist students enrolled in the College's nursing program. This program assists the District in maintaining a full complement of qualified registered nursing staff for the Health Facilities.

The Oak Valley District Auxiliary (the "Auxiliary") is supported by more than 50 community members who donate over 12,000 hours a year of their time to improve the level of patient care delivered at the Health Facilities.

Service Area and Competition

District management regards its primary service area to include a four-zip code area in northeastern Stanislaus County and southeastern San Joaquin County, encompassing the Cities of Oakdale, Waterford, Riverbank and Escalon. This primary service area accounted for a majority of the Hospital's fiscal year 2011-12 inpatient discharges. The District's primary service area includes a significant area outside of the District's geographic boundary. Management estimates that most of the remaining acute care services are provided by Kaiser Hospital, Memorial Medical Center and Doctors Medical Center; all located approximately 12 to 15 miles from the Hospital in Modesto, California. Kaiser Hospital is a member of Kaiser Permanente Health System. Memorial Medical Center is a member of the Sutter Health System and Doctors Medical Center is a member of the Tenet Health System.

For the calendar year 2011, the Hospital maintained a 42% market share for its primary service area based upon acute care discharges reported to the Office of Statewide Health Planning and Development.

In addition, in October of 2008 Kaiser Permanente opened a new 112-bed acute care hospital located in northwest Modesto, approximately 13 miles from the Hospital. The new Kaiser facility provides inpatient acute care services, outpatient services, ancillary services and medical office space. The top two floors of the new patient tower are shelled in for future expansion.

Services

The District provides a range of acute care, long-term care, outpatient and ancillary services at the Health Facilities, including pediatric, intensive care, medical surgical, obstetric (although the District has recently discontinued such services), alternative birthing, orthopedic, laboratory, diagnostic imaging, respiratory therapy, urgent care and emergency services, and skilled nursing services, among others. Diagnostic imaging services include computed tomography, cystoscopy, magnetic resonance imaging (MRI), ultrasonography and x-ray radiology. Surgical services include general, orthopedic, gastroenterology, ophthalmologic, otolaryngolic, plastic podiatry, thoracic and urologic. The District staffs the emergency department full time with medical physicians. To increase access to non-emergent patients and reduce their impact on the Hospital's emergency department, the District operates its Riverbank Community Health Center seven days per week with expanded weekday hours.

Accreditations, Memberships and Designations

The Hospital has been accredited since it was opened in 1973 and the Oak Valley Care Center has been accredited since the District began operations in 1991. The Hospital's and Oak Valley Care Center's most recent three-year accreditations from The Joint Commission will expire around May of 2016. In addition to The Joint Commission accreditations of the Hospital and Oak Valley Care Center, the District's laboratory services have been separately accredited (two year accreditation) by The Joint Commission through approximately December of 2014.

The Hospital is an eligible provider under Medicare, Medi-Cal, Blue Cross and other commercial insurance programs and holds memberships in the California Healthcare Association, the Association of California Healthcare Districts and other professional health care related and community-based organizations. The Hospital is designated as a Small Rural Hospital and as a Disproportionate Share Hospital for Medicare and Medi-Cal purposes. It is also located within a Health Professional Shortage Area as well as a Medically Underserved area.

Bed Complement

The Health Facilities have a combined licensed capacity of 150 beds. The licensed bed count for the Health Facilities, classified by service type and by facility, is as follows:

	Licensed Beds		
	Oak Valley Hospital	Oak Valley Care Center	Total
Medical Surgical	24	0	24
Intensive Care	5	0	5
Perinatal (Obstetrics) [1]	6	0	6
Total Acute Care	35	0	35
Skilled Nursing Care [2]	11	104	115
Total Licensed Beds	46	104	150

Source: District records and State of California Department of Public Health license.

(1) The obstetrics beds will go out of service in July 2013.

(2) The skilled nursing beds are designated by the State of California as distinct part beds, which designation currently provides a significantly higher rate of reimbursement to the District than other skilled nursing facilities not receiving such designation.

Certain Financial Information

The following summaries of the statements of revenues, expenses and changes in net assets of the District are qualified by reference to and should be read in conjunction with the District's audited financial statements, including the notes thereto included as APPENDIX B herein, and "Management's Analysis of Financial Performance" included elsewhere herein. The accounting policies of the District conform to those recommended by the audit and accounting guide, Health Care Organization, published by the American Institute of Certified Public Accountants and the financial statements summarized below were prepared in accordance with the pronouncements

of the Governmental Accounting Standards Board ("GASB"). The statements of revenues, expenses and changes in net assets of the District for the four fiscal years ended June 30, 2009, 2010, 2011 and 2012, are derived from the District's audited financial statements.

The summaries of statements of revenues, expenses and changes in net assets for the nine-month periods ended March 31, 2012 and 2013, have been obtained from unaudited financial statements of the District. These financial statements have been prepared in accordance with generally accepted accounting principles on a basis consistent with the accounting policies reflected in the audited financial statements of the District presented below. They do not, however, include all of the information required by generally accepted accounting principles for complete financial statements. In the opinion of District management, the unaudited financial statements reflect all significant adjustments (which are of a normal, recurring nature) necessary for a fair presentation of the results for the interim periods presented. Operating results for the interim periods presented are not necessarily indicative of the results that may be expected for any other interim period or for the fiscal year as a whole.

	Fiscal Year Ended June 30				Nine Months Ended March 31	
	2009	2010	2011	2012	2012	2013
(000's omitted)	(audited)	(audited)	(audited)	(audited)	(unaudited)	(unaudited)
Operating Revenues:						
Net Patient Service Revenue	$60,736	$57,266	$62,406	$64,510	$47,272	$51,518
Premium Revenue	180	154	117	99	76	58
Other Operating Revenue	464	753	427	1,216	511	1,563
Total Operating Revenues	61,380	58,173	62,950	65,825	47,859	53,139
Operating Expenses:						
Operating Expenses	46,575	45,926	46,103	47,475	35,503	38,391
Depreciation & Amortization	2,440	2,644	2,641	2,343	1,754	1,816
Provision for Bad Debts	10,828	10,915	12,773	15,042	9,701	12,172
Total Operating Expenses	59,843	59,485	61,517	64,860	46,958	52,379
Operating Income (Loss)	1,537	(1,312)	1,433	965	901	760
Non-operating Revenues (Expenses):						
District Tax Revenue	1,934	1,972	2,007	2,045	1,534	1,561
Non-capital Grant Revenues	352	206	153	104	0	0
Investment Income	422	663	400	116	21	109
Interest Expense	(500)	(651)	(642)	(642)	(482)	(482)
Other Non-Operating Income (Expenses)	(1)	143	(170)	(92)	27	27
Net Affiliation Income	35	35	35	35	0	0
Total Net Non-operating Revenues	2,242	2,368	1,783	1,566	1,100	1,215
Excess of Revenues Over Expenses	3,779	1,056	3,216	2,531	2,001	1,975
Capital Grants and Contributions	1,048	673	1,039	530	0	0
Inter-Governmental Transfers	0	0	0	(673)	0	0
Increase in Net Assets	4,827	1,729	4,255	2,388	2,001	1,975
Beginning Net Assets	50,835	55,662	57,391	61,646	61,646	64,034
Ending Net Assets	$55,662	$57,391	$61,646	$64,034	$63,647	$66,009

Source: Fiscal year ended June 30 information has been derived from the District's audited financial statements and data for the nine-month periods ended March 31, has been derived from the District's interim unaudited financial records.

Total Unrestricted Funds and Days Cash on Hand

The following table provides the total unrestricted funds and days cash on hand for the District as of June 30, 2009, 2010, 2011 and 2012. Marketable securities are carried at market value.

	As of June 30			
(000's Omitted)	**2009 (audited)**	**2010 (audited)**	**2011 (audited)**	**2012 (audited)**
Cash and Cash Equivalents	$ 5,107	$ 4,260	$ 6,956	$ 2,888
Board Designated Funds	22,528	22,578	19,593	17,342
Total Unrestricted Funds	$27,635	$26,838	$26,549	$20,230
Average Daily Expenses	$ 128	$ 126	$ 126	$ 130
Days Cash on Hand	217	213	210	156

Source: Audited financial statements of the District for the fiscal years ended June 30, 2009, 2010, 2011 and 2012.

Management's Discussion

Executive Summary

The biggest change during the last 18 months in the District's healthcare operations was a complete change in all members of the administrative team except for one, the Vice President of Long Term Care Services. During this same time frame there have also been six changes in department managers. The District's healthcare operations are divided into four major service lines: acute care, long-term care, clinics and ambulance services. The following discussion will provide an overview as to the major occurrences in each sector. Based on current financial data, as of May 21, 2013, the District expects to end this fiscal year with an EBIDA at approximately 5.5%. It also expects to show gross receivable days at 60 as of June 30, 2013.

Acute Care

One major focus for this area during the last 18 months has been to improve customer service in the emergency department. At the start of this program the emergency department had an average waiting time of 61 minutes for its patients. Waiting time has now decreased to less than 25 minutes. Management also focused on decreasing the "left without being seen" ratio in the emergency department. It has improved from a sub-standard 4% of all patients leaving prior to being seen by a physician to less than 1%. In July 2012 the emergency department was moved from the old Hospital building to the first floor of the new 123,000 two-story facility. The first floor of the new facility contains a 12-bed emergency department, a new surgery department as well as imaging and laboratory departments. As a result of the efforts to improve customer service in the emergency department, plus the move into the new building and more aggressive marketing, the Hospital has seen its emergency department visits increase by 17% for this fiscal year when compared to last fiscal year.

The District has seen similar growth in its outpatient surgeries. For the current fiscal year the Hospital has done 29% more cases than last fiscal year. The District has also seen a 10% growth in outpatient pain management procedures over last fiscal year.

The District ended a relationship early in 2013 with two different rehab service providers for its outpatients, acute inpatients and long-term residents and selected a new firm, Burger Rehabilitation from the Sacramento area. This move is expected to save the District in excess of $150,000 per year from enhanced volumes and a better rate structure for services.

As a cost savings measure, the District will cease offering obstetrics services at the Hospital in July 2013 and close its six-bed maternity unit, which has been an unprofitable service line. The District was only serving 23% of its primary market area for this service, and the majority of the patients it served were covered under the low-paying Medi-Cal system. This action is estimated to provide annual savings of approximately $750,000 for the District.

The new Hospital facility, as well as improved operating performance, has allowed the District to pursue adding more physicians to the medical staff. A search is under way for a fourth physician to be added to the local internal medicine group. The Hospital is also in the midst of finalizing arrangements for the addition of a full-time pediatrician. The other active pediatrician will be decreasing her practice from full-time to modified full-time, working in the District's various clinics. Lastly, the District is recruiting a part-time urologist.

Clinics

The District recently signed a lease to open its fourth rural health clinic in the town of Waterford. In addition, the District has begun to operate two of its three clinics seven days a week, an increase from five days a week previously. This action has resulted in a 7% growth in patient visits at the largest clinic. A decrease in visits at the District's smaller clinics, due primarily to issues with the recruitment of mid-level providers, is in the process of being corrected through improved physician compensation models.

Long-Term Care

The District's inpatient long-term care program is comprised of 115 licensed beds. In December 2012 the District received notification from the Centers for Medicare and Medicaid Services (CMS) that its quality rating was being increased from four stars to five stars on a five-star rating scale. The District has intensified marketing for possible admissions from non-Oak Valley providers and now finds 12% of its admissions come from that focus. While for the first nine months of the current fiscal year, the daily census of this unit is 2% lower than last fiscal year, the District is now enjoying an increase in census over last year for the months of April and May.

Ambulances

The District owns and operates ambulance companies located in three towns. Ambulance services have seen a 4% growth in both the Oakdale and Riverbank locations and a 7% growth at the other location in Waterford when compared to the same time frame last fiscal year. The District also manages an ambulance company in the town of Escalon, but that agreement is in the process of being terminated as managing ambulance services no longer fits into the District's core plans.

Health Facilities Utilization

Selected utilization statistics for the Health Facilities for each of the four fiscal years ended June 30, 2009, 2010, 2011 and 2012, and for the nine-month periods ended March 31, 2012 and 2013, are as follows:

	Fiscal Year Ended June 30				Nine Months Ended March 31	
	2009	2010	2011	2012	2012	2013
Acute Medical Surgical Care: [1]						
Available Beds	35	35	35	35	35	35
Discharges	1,572	1,389	1,330	1,284	1,032	929
Patient Days	5,857	4,577	4,615	4,331	3,415	3,317
Average Length of Stay (Days)	3.8	3.3	3.5	3.4	3.3	3.6
Percent Occupancy	46%	36%	36%	34%	35%	35%
Emergency Visits	19,570	19,598	18,750	19,407	14,312	16,709
Clinic Visits	44,187	44,187	48,091	51,999	39,403	39,211
Total Surgeries	1,739	1,680	1,814	2,069	1,253	1,324
Skilled Nursing Care:						
Available Beds	115	115	115	115	115	115
Patient Days	35,780	35,452	37,051	37,871	28,802	27,995
Percent Occupancy	85%	84%	88%	90%	91%	89%
Combined:						
Available Beds	150	150	150	150	150	150
Patient Days	41,637	40,029	41,666	42,202	32,217	31,312
Percent Occupancy	76%	73%	76%	77%	78%	76%

Source: District records.

[1] Includes adult medical and surgical services, obstetrics, pediatrics, and intermediate care nursery; excludes newborns.

Sources of Patient Service Revenue

The District receives payment for services from commercial insurers and other private payors, the federal government under the Medicare program, the federal government and the State under the Medi-Cal program and directly from patients. The following table shows an apportionment of the District's gross revenues from various sources for the four fiscal years ended June 30, 2009, 2010, 2011 and 2012, and for the nine months ended March 31, 2012 and 2013:

	Fiscal Year Ended June 30				Nine Months Ended March 31	
	2009	2010	2011	2012	2012	2013
Medicare (including Medicare HMO)	36%	35%	36%	34%	33%	32%
Medi-Cal (including Medi-Cal HMO)	30	33	34	35	36	37
Private Pay, Commercial & Other HMO/PPO	32	31	29	30	29	29
County & Charity Programs	2	1	1	1	2	2
Total	100%	100%	100%	100%	100%	100%

Source: District records.

Medicare is a federal program, administered by the Centers for Medicare and Medicaid Services, available to individuals age 65 or over and certain disabled persons. Medicaid is a federal and state program, known as Medi-Cal in California, under which the District furnishes services to program-eligible persons. The District also receives disproportionate share payments from Medicare and Medi-Cal for serving a disproportionate number of low income patients. See "APPENDIX E – HEALTHCARE RISK FACTORS — Patient Service Revenues" in the Official Statement.

Adults who do not meet Medi-Cal eligibility criteria but who are medically indigent, as defined by California law, are eligible for medical services under the state-funded County Medically Indigent Adult program ("MIA"). The District does not receive reimbursement for patients who are eligible for MIA medical services provided at the Hospital.

The District has contracts with prepaid plans and preferred provider discount contractors. The basis for payment to the District under these agreements includes prospectively determined rates per discharge, discounts from established rates and prospectively determined daily rates. Less than 1% of the District's current revenues originate from capitated contracts whereby the District is at-risk for health care services needed by contract members under capitated contracts.

Public and Professional Liability Insurance Considerations

Medical Malpractice Insurance. The District currently carries public and professional liability insurance through a pooled self-insurance program insuring the District and all its employees, while acting within the scope of their duties, against public and professional liability with limits of $20,000,000. The District's current public and professional liability coverage contract is in continuous effect until canceled. The District contracts such coverage through a joint powers authority ("BETA Healthcare Group") under California law authorizing governmental agencies, such as local healthcare districts, to join together for insurance purposes. The District's coverage with BETA Healthcare Group is on a claims made basis.

BETA Healthcare Group is funded by monthly contributions paid by districts and counties participating in BETA Healthcare Group. The contributions are used to fund a reserve for expected losses to be paid by BETA Healthcare Group on a pooled, self-insured basis. The amount of the monthly contribution to be paid by a participant is based on independent actuarial computations taking into account factors such as, among others, total number of beds, outpatient and inpatient visits, surgeries, deductible and loss experience of the participant. The reserve for claims and claims expenses has been determined using the developed loss and loss expense method. For the fiscal year ended June 30, 2012 the District paid approximately $256,605 in net contributions to BETA Healthcare Group.

At December 31, 2012, BETA Healthcare Group had a reserve for claims and claims expenses of $91,598. For the calendar year ended December 31, 2012, BETA Healthcare Group paid claims and claims expenses totaling $10,340. Property, equipment and machinery damage is covered by Driver Alliant Insurance Services, Inc.

The District currently does not have pending any malpractice or professional liability claims or lawsuits for compensatory damages not covered by insurance. Certain claims, suits and complaints arising in the ordinary course of business have been filed or are pending against the District. In the opinion of management and its insurance defense legal counsel, such claims, if disposed of unfavorably, would not have a material adverse effect on the financial position of the District.

Workers' Compensation Self-Insurance. The District is a participant in the Association of California Healthcare District's ALPHA Fund which administers a self-insured worker's compensation plan for participating District employees. The District pays premiums to the ALPHA Fund which are adjusted annually. If participation in the ALPHA Fund is terminated by the District, the District would be liable for its share of any additional premiums necessary for final disposition of all claims and losses covered by the ALPHA Fund. The District has been notified that the ALPHA Fund had no deficit as of June 30, 2012.

Medical Benefits Self-Insurance. The District maintains health benefits for its employees through a self-funded plan funded by District operations. Estimated liabilities are recorded for claims which most likely have been incurred but are not yet reported for claims processing and payment. As of June 30, 2011 and 2012, these amounts were estimated at $581,000 and $707,000, respectively. Commercial insurance is provided for "stop loss" coverage.

Employees' Retirement Plan

The District's employees' retirement plan (the "Retirement Plan") is a single-employer defined contribution pension plan established to provide retirement benefits for District employees. The Retirement Plan covers substantially all District employees and is administered by the District's Chief Executive Officer with oversight by a retirement plan committee appointed by the Board. Employees are eligible to participate after having served one year of service and are 50% vested when they enter and retirement benefits fully vest after six years of service. The annual contribution made by the District is equal to approximately 15.9% of eligible employee salaries. Employee contributions are not allowed under the Retirement Plan. As of June 30, 2011 and 2012, the District contributed total pension costs of $2,643,000 and $2,699,000, respectively.

Service Area Economy

The Health Facilities are located in and serve the Cities of Oakdale and Waterford, and the surrounding unincorporated areas. The City of Oakdale is located in the north-east quadrant of Stanislaus County, the State of California's 16th most populous county as of January 1, 2012. Census figures for 2010 indicated the City of Oakdale was the fifth largest city in Stanislaus County with a population of 20,675. However, since 2012, the resident population of the City of Oakdale is estimated to have grown 1.3% to 20,947. The largest cities located within Stanislaus County, as of the 2010 census, are the Cities of Modesto and Turlock with populations of 201,165 and 68,549, respectively. Stanislaus County covers approximately 1,494 square miles in the north-central portion of California. According to State Department of Finance estimates for 2012, Stanislaus County has experienced considerable population growth in recent years. Since 2000, the resident population of Stanislaus County is estimated to have grown 16% to 519,940. The 2010 United States census showed the population of the Cities of Oakdale and Waterford to be 20,675, and 8,456, respectively. During the past 22 years the populations of the Cities of Oakdale and Waterford have increased 75% and 79%, respectively, while the population of the State of California has increased just 27% over the same period. Population figures as reported for the 1990, 2000 and 2010, census reports and as estimated by the State Department of Finance for 2012 for the Cities of Oakdale and Waterford, Stanislaus County and the State of California are as follows:

	1990	2000	2010	2012	1990-2012 % Change
City of Oakdale	11,961	15,503	20,675	20,947	75%
City of Waterford	4,771	6,924	8,456	8,533	79%
Stanislaus County	370,522	446,997	514,453	519,940	40%
State of California	29,760,021	33,871,648	37,253,956	37,678,563	27%

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

The Hospital's service area, which extends beyond the District boundaries, incorporates a good portion of Stanislaus County. Although Stanislaus County's economy is developing rapidly in the manufacturing, commercial and service sectors, the presence of a strong and diverse agriculture backbone remains. Stanislaus County grows over 100 commercial crops and ranks as the sixth most productive agricultural county in the State. Stanislaus County's agriculturally dominated employment distribution negatively affects Oakdale's job market and unemployment rates.

Although the seasonality of many of the major employers in this area contributes to the area's unemployment data, Stanislaus County's unemployment percentages are above the State of California's average. As indicated above, this is in large part attributed to the area's reliance on agriculture and farming related enterprises that dominate the area served by the Health Facilities. The December 2012 unadjusted labor market data can be divided into the following sectors:

	City of Oakdale	Stanislaus County	State of California
Civilian Labor Force	8,800	234,500	18,489,600
Employment	7,500	199,400	16,689,200
Unemployment	1,300	35,100	1,800,400
Unemployment Rate	15%	15%	10%

Source: State Employment Development Department, December of 2012.

DISTRICT FINANCIAL MATTERS

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

Property Tax Collection Procedures

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

Property taxes on the secured roll are due in two installments, on November 1 and February 1 of each year. If unpaid, such taxes become delinquent after December 10 and April 10, respectively, and a 10% penalty attaches to any delinquent payment. In addition, property on the secured roll with respect to which taxes are delinquent is sent to collection on or about June 30. Such property may thereafter be redeemed by payment of the delinquent taxes and a delinquency penalty, plus a redemption penalty of 1.5% per month to the time of redemption. If taxes are unpaid for a period of five years or more, the property is then subject to sale by the County tax collector. The exclusive means of enforcing the payment of delinquent taxes in respect to property on the secured roll is the sale of the property securing the taxes for the amount of taxes which are delinquent.

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

Property taxes on the unsecured roll are due on the January 1 lien date and become delinquent if unpaid on the following August 31. A 10% penalty is also attached to delinquent taxes in respect to property on the unsecured roll, and further, an additional penalty of 1.5% per month accrues with respect to such taxes beginning the first day

of the third month following the delinquency date. The taxing authority has four ways of collecting unsecured personal property taxes: (1) a civil action against the taxpayer; (2) filing a certificate in the office of the County clerk specifying certain facts in order to obtain a judgment lien on certain property of the taxpayer; (3) filing a certificate of delinquency of record in the County recorder's office, in order to obtain a lien on certain property of the taxpayer and (4) seizure and sale of personal property, improvements or possessory interests belonging or assessed to the assessee.

Unitary Taxation for Utility Property

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

Assessed Valuations

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

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

The District has a 2012-13 assessed valuation of $3,398,090,081, which accounts for approximately 10% of the County's assessed valuation of $33,486,609,191, as of the same period. Assessed values of property within the District have increased by approximately 34% from 2003-04 to 2012-13, while assessed values for the County have increased by approximately 26% over the same period. The summary below shows a ten-year history of the total secured and unsecured assessed property valuations for the District and total assessed valuations for the County.

	Assessed Valuations [1]				
Fiscal Year	Local Secured	Utility	Unsecured	District Assessed Valuations	County Assessed Valuations
2003-04	$2,446,702,643	$1,726,843	$ 91,579,983	$2,540,009,469	$26,540,713,401
2004-05	2,711,194,415	1,049,742	93,099,997	2,805,344,154	29,160,150,955
2005-06	3,067,523,264	1,079,227	107,413,936	3,176,016,427	33,476,100,273
2006-07	3,674,817,863	1,554,081	122,932,330	3,799,304,274	39,155,801,284
2007-08	4,048,647,416	1,050,006	132,344,210	4,182,041,632	42,974,745,064
2008-09	3,850,951,081	533,823	144,550,073	3,996,034,977	40,026,418,777
2009-10	3,490,595,653	281,459	149,381,921	3,640,259,033	36,888,053,381
2010-11	3,392,445,606	281,459	143,286,716	3,536,013,781	35,164,946,676
2011-12	3,295,605,747	281,459	108,178,508	3,404,065,714	34,346,872,085
2012-13	3,290,311,690	414,602	107,363,789	3,398,090,081	33,486,609,191

Source: California Municipal Statistics, Inc.
[1] Based on 100% of full cash value before redevelopment increment.

Tax Levies and Delinquencies

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

The following table shows a nine-year history of the secured tax charge, the tax amount delinquent and percentage of taxes delinquent each year as of June 30, for the County. Similar information was not available for the fiscal year 2012-13 or for the District itself.

Secured Tax Charges and Delinquencies for Stanislaus County

Fiscal Year	Secured Tax Charge [1]	Delinquent as of June 30 Amount	Percent
2003-04	$286,449,348	$ 7,269,857	2.54%
2004-05	316,400,352	6,847,627	2.16
2005-06	376,561,640	11,671,503	3.10
2006-07	437,629,068	26,374,570	6.03
2007-08	506,644,920	46,880,351	9.25
2008-09	454,764,544	22,479,686	4.94
2009-10	424,251,265	14,218,355	3.35
2010-11	414,118,855	10,608,959	2.56
2011-12	405,492,190	8,986,182	2.22

Source: California Municipal Statistics, Inc. and State of California Controller's Office.

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

Tax Rates

The base tax rate for all taxing entities within a particular tax code area is $1 per $100 (1%) of assessed valuation in accordance with the State Constitution. To this may be added whatever tax rates are necessary to meet debt service on indebtedness approved by the voters. The Board of the District annually conveys by July 1 to the County Tax Collector the rate to be levied for the debt service on the Bonds. The table below provides the total tax rates for the Tax Rate Area 84-010, a tax rate area within the District, for the ten fiscal years ending with the fiscal year 2012-13.

Typical Total Tax Rates for Tax Rate Area 84-010

Fiscal Year	General	Oak Valley Hospital District	Oakdale Joint Unified School District	Yosemite Community College District	Total
2003-04	1.000000	-	.051000	-	1.051000
2004-05	1.000000	-	.008600	-	1.008600
2005-06	1.000000	.056676	.028064	.017996	1.102736
2006-07	1.000000	.051000	.031717	.014524	1.097241
2007-08	1.000000	.036550	.043814	.017188	1.097552
2008-09	1.000000	.047379	.038786	.014466	1.100631
2009-10	1.000000	.055000	.043920	.020152	1.119072
2010-11	1.000000	.056441	.046288	.025952	1.128681
2011-12	1.000000	.058532	.046993	.024632	1.130157
2012-13	1.000000	.061000	.048700	.028800	1.138500

Source: California Municipal Statistics, Inc.

District Budget

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

Direct and Overlapping Bonded Debt

Set forth below is a direct and overlapping debt report (the "Debt Report") prepared by California Municipal Statistics, Inc., and dated April 1, 2013. The Debt Report is included for general information purposes only. The District has not reviewed the Debt Report for completeness or accuracy and makes no representations in connection therewith.

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

2012-13 Assessed Valuation: $3,398,090,081

DIRECT AND OVERLAPPING TAX AND ASSESSMENT DEBT:	**% Applicable**	**Debt 4/1/13**	
Yosemite Community College District	7.206%	$21,972,043	
Oakdale Joint Unified School District	98.372	15,665,741	
Waterford Unified School District	99.807	2,208,479	
Other Unified School Districts	Various	1,965,610	
Valley Home Joint School District	77.188	995,162	
Oak Valley Hospital District	**100.000**	**35,395,000**	(1)
City of Oakdale Community Facilities Districts	100.000	8,155,000	
City of Waterford 1915 Act Bonds	100.000	1,359,735	
TOTAL DIRECT AND OVERLAPPING TAX AND ASSESSMENT DEBT		87,716,770	
OVERLAPPING GENERAL FUND DEBT:			
Stanislaus County Certificates of Participation	10.148%	6,459,709	
Stanislaus County Pension Obligations	10.148	1,119,832	
Stanislaus County Office of Education Certificates of Participation	10.148	401,861	
Riverbank Unified School District Certificates of Participation	11.392	1,178,259	
City of Oakdale General Fund Obligations	100.000	2,505,000	
City of Waterford General Fund Obligations	100.000	1,969,662	
TOTAL OVERLAPPING GENERAL FUND DEBT		13,634,323	
OVERLAPPING TAX INCREMENT DEBT:		21,275,987	
COMBINED TOTAL DEBT		$122,627,080	(2)

(1) Excludes general obligation bonds to be sold.
(2) Excludes tax and revenue anticipation notes, enterprise revenue, mortgage revenue and non-bonded capital lease obligations.

Ratios to 2012-13 Assessed Valuation:

Direct Debt ($35,395,000)	**1.04%**
Total Direct and Overlapping Tax and Assessment Debt	2.58%
Combined Total Debt	3.61%

Ratios to Redevelopment Incremental Valuation ($290,033,770):

Total Overlapping Tax Increment Debt	7.34%

Source: California Municipal Statistics, Inc.

Largest Taxpayers

The 20 largest taxpayers in the District as shown on the 2012-13 secured tax roll, and the approximate amounts of their aggregate level for all taxing jurisdictions within the District are shown below. These 20 largest taxpayers had a total tax levy value of $314,838,405 or 9.57% of the District's 2012-13 secured assessed value.

Largest 2012-13 Local Secured Taxpayers in the District

	Property Owner	Primary Land Use	2012-13 Assessed Valuation	% of Total [(1)]
1.	Hunt Wesson Foods Inc.	Food Processing	$114,016,776	3.47%
2.	Ball Metal Food Container LLC	Light Industrial	46,595,650	1.42
3.	Fresno Farming LLC	Agricultural	24,996,682	0.76
4.	VA Rodden Inc.	Agricultural	15,349,430	0.47
5.	Sconza Properties LLC	Food Processing	12,271,412	0.37
6.	Individual	Agricultural	11,376,495	0.35
7.	Pallios Properties LLC	Grocery Store	9,817,399	0.30
8.	Riddle Ranch Properties LP	Agricultural	9,209,897	0.28
9.	Foothill Oaks Shopping Center Inc.	Shopping Center	8,270,276	0.25
10.	Oak Valley Medical Office Building LLC	Office Building	7,873,000	0.24
11.	IMA Oakdale LLC	Commercial	6,655,500	0.20
12.	Harvest/Oakdale	Apartments	6,250,000	0.19
13.	Individual	Agricultural	6,165,116	0.19
14.	Burchell Nursery Inc.	Agricultural	5,856,085	0.18
15.	Individual	Agricultural	5,550,486	0.17
16.	MSF Oakdale LLC	Commercial	5,400,000	0.16
17.	Blue Diamond Growers	Agricultural	4,970,768	0.15
18.	Individual	Agricultural	4,908,998	0.15
19.	Individual	Agricultural	4,669,215	0.14
20.	Oakdale Golf & Country Club	Country Club	4,635,220	0.14
	Total		$314,838,405	9.57%

Source: California Municipal Statistics, Inc.
(1) 2012-13 Local Secured Assessed Valuation for the District is $3,290,311,690.

Largest Employers

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

Largest Employers in the County

Company	Product/Service	Employees
Stanislaus County	County Services	3,607
E&J Gallo Winery	Winery	3,181
Memorial Medical Center	Hospital	3,023
Modesto City Schools	School	3,010
Seneca Foods	Food Industry	2,100
Doctors Medical Center	Hospital	1,962
Stanislaus Food Products	Food Industry	1,784
Kaiser Permanente	Hospital	1,759
Del Monte Foods	Food Industry	1,700
Save Mart Supermarkets	Grocery	1,661

Source: Stanislaus County Alliance as of 2011.

Commercial Activity

The City of Oakdale is the retail center for the District and experienced a 12% decline in retail sales from 2008 to 2010, and the County experienced a 9% decline in retail sales over the same period. The following table summarizes the total number of sales tax permits and total taxable sales in the City of Oakdale and the County for the calendar years 2008, 2009 and 2010. Information is not yet available for the full year of 2011.

City of Oakdale and Stanislaus County
Taxable Transactions and Total Sales Tax Permits
2008-2010

(in 000's)	2008	2009	2010
City of Oakdale			
Sales Tax Permits	638	557	564
Taxable Sales	$ 271,488	$ 232,214	$ 237,566
Stanislaus County			
Sales Tax Permits	10,928	9,644	9,881
Taxable Sales	$6,728,692	$5,847,057	$6,098,614

Source: State Board of Equalization.

Construction Activity

The County's housing prices, construction costs and industrial/commercial rental and lease rates are lower than many other areas of the State. For 2012, the City of Oakdale experienced its most productive year over the past four years in new construction with 362 new building permits issued totaling over $15,847,554. This compares with just $11,929,595 in new construction permitted in 2011. The following table summarizes historical building permit valuations for the City of Oakdale for the calendar years 2009, 2010, 2011 and 2012.

City of Oakdale
Building Permit Valuation
2009-2012

	2009	2010	2011	2012
Valuation:				
Residential	$12,551,414	$ 7,213,936	$10,047,870	$11,289,215
Commercial	2,560,265	5,945,074	1,881,725	4,558,339
Total	$15,111,679	$13,159,010	$11,929,595	$15,847,554

Source: City of Oakdale, Planning Department.

Agriculture

The County region is one of the most agriculturally diverse and productive in the United States. Livestock, poultry, apples, apricots, cherries, beans, hay, melons, herbs, tomatoes, peaches, nectarines, walnuts and almonds are a few of the agricultural products grown in the region which form the basis of the County's economy. The County grows over 100 commercial crops and ranks as the sixth most productive agricultural county in the State of California. The County is one of the leading producers of milk and creamery products in the United States and its farmers rank high in many other products. The following table summarizes historical agricultural production within the County for the years 2008 through 2011.

Stanislaus County
Estimated Value Agricultural Production
(000's Omitted)

	2008	2009	2010	2011
Fruit & Nut Crops	$ 756,392	$ 766,741	$ 703,874	$1,061,047
Vegetable Crops	104,930	208,944	244,263	166,420
Field Crops	265,724	184,294	233,440	319,359
Other Agriculture	9,540	19,619	25,646	26,194
Seed Crops	813	1,153	643	1,470
Nursery Products	101,207	96,795	114,363	95,645
Organic Products	10,055	15,000	8,000	41,244
Apiary Products	43,911	46,847	48,630	50,643
Livestock & Poultry	434,125	463,056	552,892	500,480
Livestock & Poultry Products	747,146	507,621	640,683	807,321
Total	$2,473,843	$2,310,070	$2,572,434	$3,069,823

Source: Stanislaus County Agricultural Commissioner.

LEGAL MATTERS

No Material Litigation

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

Legality for Investment in California

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

Tax Matters

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

Subject to the District's compliance with the above-referenced covenants, under present law, in the opinion of Quint & Thimmig LLP, San Francisco, California, Bond Counsel, interest on the Bonds (i) is excludable from the gross income of the owners thereof for federal income tax purposes, (ii) is not included as an item of tax preference

in computing the federal alternative minimum tax for individuals and corporations, and (iii) is not taken into account in computing "adjusted current earnings" as described below.

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

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

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

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

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

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

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

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

The Internal Revenue Service (the "IRS") has an ongoing program of auditing tax exempt obligations to determine whether, in the view of the IRS, interest on such tax exempt obligations is includable in the gross income of the owners thereof for federal income tax purposes. It cannot be predicted whether or not the IRS will commence

an audit of the Bonds. If an audit is commenced, under current procedures the IRS may treat the Issuer as a taxpayer and the Bondholders may have no right to participate in such procedure. The commencement of an audit could adversely affect the market value and liquidity of the Bonds until the audit is concluded, regardless of the ultimate outcome.

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

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

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

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

Approval of Legality

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

RATING

Moody's has assigned the rating of "A2" (stable outlook) to the Bonds based upon the District's own credit and the source of payment for the Bonds. No application was made by the District to any other rating agency for the purpose of obtaining additional ratings on the Bonds.

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

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

MISCELLANEOUS

Underwriting

The Bonds will be purchased pursuant to the terms of the public bid dated June 11, 2013, for re-offering by _____ (the "Underwriter"). The Underwriter has agreed to purchase the Bonds for $_____, which includes the principal amount of $_____, plus a net original issue premium of $_____, and less the Underwriter's discount of $_____. The Underwriter will be obligated to purchase all the Bonds if any are purchased.

Continuing Disclosure

The District has covenanted for the benefit of bondholders and Beneficial Owners of the Bonds to disseminate certain financial information and operating data relating to the District, and to provide notices of the occurrence of certain enumerated events. See "APPENDIX C - FORM OF CONTINUING DISCLOSURE CERTIFICATE." These covenants have been made in order to assist the Underwriter in complying with Rule 15c2-12 promulgated by the Securities and Exchange Commission. The District has had continuing disclosure obligations with respect to the 2005 Bonds and revenue bonds issued by it in 2004 and 2010.

The District has determined that from time to time certain continuing disclosure information with respect to the 2005 Bonds, its 2004 revenue bonds and its 2010 revenue bonds was submitted late or was not submitted. Consequently, the District has been supplementing its continuing disclosure submissions to Electronic Municipal Market Access ("EMMA"). While the lateness of submissions cannot be cured itself, the District has now submitted to EMMA all required disclosure for the 2005 Bonds, the 2004 revenue bonds and the 2010 revenue bonds. Additionally, the District has implemented new procedures to maintain compliance in the future.

Verification

The Verification Agent, upon delivery of the Bonds, will deliver a report of the mathematical accuracy of certain computations, contained in schedules provided to the Verification Agent on behalf of the District, relating to (i) the sufficiency of the anticipated amount of proceeds of the Bonds and other funds available to pay, when due, the principal, whether at maturity or upon prior redemption, interest and redemption premium requirements of the Refunded 2005 Bonds and (ii) the "yield" of the deposits in the Escrow Fund and on the Bonds considered by Bond Counsel in connection with the opinion rendered by such firm that the Bonds are not "arbitrage bonds" within the meaning of section 148 of the Internal Revenue Code of 1986, as amended.

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

Additional Information

The summaries or descriptions of provisions of the Bonds, the Resolution and all references to other materials not purporting to be quoted in full are only brief outlines of some of the provisions thereof and do not purport to summarize or describe all of the provisions thereof. Reference is made to said documents for full and complete statements of the provisions of such documents. The APPENDICES attached hereto are a part of this Official Statement. Copies, in reasonable quantity, of the Resolution may be obtained during the offering period upon request to the Financial Advisor at (801) 225-0731 and thereafter upon request to the principal corporate trust office of the Paying Agent.

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

OAK VALLEY HOSPITAL DISTRICT

By: _____

Title: Chief Executive Officer

APPENDIX A

FORM OF BOND COUNSEL OPINION

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APPENDIX A

FORM OF FINAL OPINION OF BOND COUNSEL

[Letterhead of Quint & Thimmig LLP]

[Closing Date]

Board of Directors of the
Oak Valley Hospital District
350 South Oak Avenue
Oakdale, California 95361

OPINION: $36,545,000* Oak Valley Hospital District (Stanislaus County, California) 2013 General Obligation Refunding Bonds

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Members of the Board of Directors:

We have acted as bond counsel to the Oak Valley Hospital District (the "District") in connection with the issuance by the District of $36,545,000* principal amount of Oak Valley Hospital District (Stanislaus County, California) 2013 General Obligation Refunding Bonds (the "Bonds"), pursuant to Article 9 of Chapter 3 (commencing with section 53550) of Division 2 of Title 5 of the California Government Code (the "Act"), Resolution No. 2013-01, adopted by the Board of Directors (the "Board") of the District on April 24, 2013 (the "Resolution"). We have examined the law and such certified proceedings and other papers as we deemed necessary to render this opinion.

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

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

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

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

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

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

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* Preliminary, subject to change.

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

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

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

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

Respectfully submitted,

APPENDIX B

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

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Audited Financial Statements

OAK VALLEY HOSPITAL DISTRICT

June 30, 2012

TCA Partners, LLP
Certified Public Accountants

Oak Valley Hospital District

Audited Financial Statements

June 30, 2012

Table of Contents

TCA Partners, LLP

Certified Public Accountants

1111 East Herndon, Suite 211, Fresno, California 93720

Voice: (559) 431-7708 Fax:(559) 431-7685

Report of Independent Auditors

The Board of Directors
Oak Valley Hospital District
Oakdale, California

We have audited the accompanying balance sheets of Oak Valley Hospital District (the Hospital) as of June 30, 2012 and 2011, and the related statements of revenues, expenses, and changes in net assets, and cash flows for the years then ended. These financial statements are the responsibility of the Hospital's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Oak Valley Hospital District at June 30, 2012 and 2011, and the results of its operations and its cash flows for the years then ended, in conformity with accounting principles generally accepted in the United States of America.

Management's discussion and analysis is not a required part of the financial statements but is supplementary information required by accounting principles generally accepted in the United States of America. We have applied limited procedures, which consisted principally of inquiries of management regarding the methods of measurement and presentation of the supplementary information. However, we did not audit the information and express no opinion on it.

TCA Partners, LLP

August 10, 2012

OAK VALLEY HOSPITAL DISTRICT

Management's Discussion and Analysis

June 30, 2012

Introduction

This discussion and analysis has been prepared by the management of Oak Valley Hospital District (District) in order to provide an overview of the District's financial and operating performance for the fiscal year ended June 30, 2012, in accordance with the Governmental Accounting Standards Board Statement No. 34, *Basic Financials Statements; Management's Discussion and Analysis for State and Local Governments.* Read in conjunction with the District's audited financial statements and accompanied notes to the financial statements, it is intended to help the reader better understand the District's financial performance and position. It should be noted that the audited financial statements prepared by TCA Partners, LLP, include an unqualified opinion regarding the financial statements.

Financial Highlights

- Net assets increased $2.4 million from fiscal year ended June 30, 2011. Current assets decreased $18.8 million while net capital assets increased $18.5 million as we purchased replacement capital items and continued to make excellent progress on the hospital replacement project.

- Current liabilities decreased $752 thousand from 2011, mainly due to a decrease in accounts payable and accrued expenses at June 30, 2012.

- Debt borrowing decreased $735 thousand due to principal payments on the outstanding bonds.

- Operating income was $966 thousand compared to $1.4 million operating income in fiscal year 2011. Net patient revenue increased 3.37% while operating expenses increased 5.43%.

Overview of Oak Valley Hospital District's Activities and Financial Statements

These audited financial statements reflect the District's financial position and operating results for the fiscal years ended June 30, 2012 and 2011. They include the report of the independent auditors, balance sheets, statements of revenues, expenses and changes in net assets, statements of cash flows, and notes to the financial statements.

- The balance sheets include all of the District's assets and liabilities based on the accrual method of accounting for the years ended June 30, 2012 and 2011.

- The statements of revenues, expenses and changes in net assets present the operating activities of the District during the fiscal years ended June 30, 2012 and 2011.

- The statements of cash flows report the net cash provided by operating activities as well as other sources and uses of cash from various District financial activities.

Condensed assets and liabilities (in thousands):

	2012	2011	Change from 2011 Amount	Change from 2011 Percent
Assets:				
Current assets	$ 24,062	$ 42,831	$ (18,769)	(43.82)
Assets whose use is limited	12,219	11,596	623	5.37
Capital assets, net	104,510	86,006	18,504	21.51
Other assets	2,666	2,785	(120)	(4.29)
Total Assets	$ 143,456	$ 143,218	$ 239	0.17
Liabilities:				
Current liabilities	$ 9,348	10,100	$ (752)	(7.44)
Long term debt, less current maturities	68,925	69,865	(940)	(1.35)
Deferred revenue	1,149	1,607	(458)	(28.50)
Total liabilities	79,422	81,572	(2,150)	(2.64)
Net assets:				
Invested in capital assets, net of related debt	28,173	25,421	2,751	10.82
Temporarily Restricted	870	2,140	(1,270)	(59.34)
Unrestricted	34,992	34,085	907	2.26
Total net assets	64,034	61,646	2,388	3.87
Total liabilities and net assets	$ 143,456	$ 143,218	$ 239	0.17

Cash and Cash Equivalents

As of June 30, 2012, the District's cash and cash equivalents decreased $4 million. The average days of cash-on-hand decreased to 156 as of June 30, 2012 compared to 210 at June 30, 2011. For the same period, the current ratio decreased from 4.24 to 2.57. Long term assets whose use is limited increased by $623 thousand. The decreases were planned in order to complete our hospital replacement project.

Capital Assets

The historical cost of capital assets (net) increased $19.4 million and accumulated depreciation (net) increased $.9 million, netting an increase to capital assets of $18.5 million. Construction on the hospital replacement project began December 2008 and has remained on budget.

Capital Projects

The District, through special election, successfully passed a $37 million general obligation bond issue on August 31, 2004, that provided partial funding of a complete facilities replacement project. The project originally estimated to cost $60 million increased to greater than $105 million. Initial funding for the project included; $18 million – revenue bonds, series 2004 (sold 11/04 at 5.22% true interest cost); $37 million – general obligation bonds, series 2005 (sold 7/05 at 4.45% true interest cost); $3 million – capital fund raising campaign, and $2 million – operating reserves. Following two unsuccessful elections for additional general obligation bonds in 2008, the project was redefined to include the full replacement facility with inpatient nursing services to be shelled out and remain in the current facility pending future funding and completion. Approved cost of the remaining project was $69 million. The additional $17.595 million revenue bonds, 2011 issue, and $9 million operating reserves will provide funding necessary to complete the project. The project is scheduled for completion in the 4th quarter of the 2012 calendar year.

The District received a grant from the California Medical Assistance Commission in April of 2012 in the amount of $350 thousand. The funds are being used in the Intensive Care Unit to acquire new patient monitors and beds and make renovations.

The District has applied for meaningful use funds to help complete our electronic health records project. In June of 2012 we received $758 thousand from the Department of Health Care Services. Over the next several years we will be establishing a completely electronic health record for our patients.

Liabilities

The District's current liabilities decreased by $752 thousand in fiscal year 2012, and total liabilities decreased $2.2 million, including bond principle reductions of $735 thousand.

Key Patient Service Operating Statistics

	2012	2011	Change from 2011 Amount	Change from 2011 Percentage
Inpatient admissions	1,284	1,330	(46)	(3.46%)
Skilled nursing facility admissions	286	260	26	10.00%
Revenue adjusted admissions	5,649	5,357	292	5.46%
Newborn deliveries	261	256	5	1.95%
Total inpatient days	4,331	4,615	(284)	(6.15%)
Total skilled nursing facility days	37,871	37,051	820	2.21%
Revenue adjusted patient days	51,569	49,090	2,478	5.05%
Average length of stay	3.37	3.47	(0.10)	(2.79%)
Emergency department visits	19,407	18,750	657	3.35%
Ambulance runs	10,563	9,415	1,148	17.15%
Clinic visits	51,999	48,091	3,908	8.46%
Outpatient referral visits	113,335	108,000	5,335	6.09%
Total surgeries (including endoscopy)	2,069	1,814	255	15.18%

Workload Indicators

The overall workload, measured in revenue adjusted admissions, increased 5.46% in fiscal year ended June 30, 2012. Emergency room visits increased 3.35% and inpatient admissions decreased 3.46%. Skilled nursing admits increased 10.00%, and skilled nursing days increased 2.21%. Newborn deliveries increased 1.95% with a total of 261 deliveries. The average length of stay decreased 2.79% to 3.37 days. Ambulance services realized a 17.15% growth in runs in 2012, mainly due to new wheelchair transport contracts with skilled nursing facilities. Clinic visits continued to increase an additional 8.46% this fiscal year, and total surgeries increased 15.18%.

Revenues, expenses and changes in net assets for the year ended June 30 (in thousands):

			Change from 2011	
	2012	2011	Amount	Percent
Operating Revenues:				
Net patient service revenues	$ 64,510	$ 62,406	$ 2,104	3.37
Premium revenue	99	117	(18)	(15.31)
Other revenue	1,216	427	790	185.05
Total operating revenue	65,826	62,950	2,876	4.57
Operating Expenses:				
Salaries & benefits	28,970	28,230	740	2.62
Provision for doubtful accounts	15,042	12,773	2,269	17.76
Professional fees & purchased services	9,440	9,040	400	4.43
Supplies & other	7,148	6,885	264	3.83
Rent & lease	1,916	1,949	(33)	(1.67)
Depreciation & amortization	2,344	2,641	(298)	(11.27)
Total Expenses	64,860	61,518	3,343	5.43
Operating income (loss)	966	1,433	(467)	(32.60)
Non-operating revenues and (expenses):				
District Tax Revenue	2,045	2,007	38	1.91
Grant Revenues	104	153	(48)	(31.70)
Investment Income	116	400	(284)	(71.03)
Interest Expense	(642)	(642)	0	0.00
Gain on Sale of Assets	(93)	(170)	77	(45.51)
Affiliation income and consideration, net	35	35	0	0.00
Total non-operating revenues (expenses)	1,566	1,783	(217)	(12.16)
Excess of revenues over expenses	2,532	3,216	(684)	(21.27)
Inter-governmental Transfers	(673)	0	(673)	
Capital grants and contributions	530	1,039	(510)	(49.04)
Increase in net assets	2,388	4,225	(1,867)	(43.87)
Total net assets, beginning of year	61,646	57,391	4,255	7.41
Total net assets, end of year	$ 64,034	$ 61,646	$ 2,388	3.87

Net Patient Service Revenues

The fiscal year ended June 30, 2012 experienced a 3.37% increase in net patient revenues. This increase was impacted by an average rate increase of 7% (effective August 1, 2011). Billings for all services provided to patients are based on a standard schedule of rates and charges, however, reimbursement from patients, governmental programs (e.g. Medicare and Medi-Cal) and third party payors vary according to predetermined contractual agreements in existence. Deductions from revenues include any amount of gross patient revenues (billings) not reimbursed due to a contractual arrangement between a third party payor, Medicare or Medi-Cal and the Hospital. These deductions increased by 9.20% for fiscal year ended June 30, 2012, as compared to the previous year. This is compared to a 7.19% increase in gross patient revenue. Net patient service revenues are the resulting difference between gross patient revenues and deductions from revenues and reflect the actual amount of collections available to the Hospital to cover expenses and purchases of capital equipment.

Operating Expenses

Total operating expenses increased $3.3 million (5%) in fiscal year ending June 30, 2012. Productivity, measured as full time equivalents per adjusted occupied bed increased 1% from 2.73 to 2.77. Employee benefits decreased $119 thousand (1.2%), due primarily to a decrease in health plan utilization. The declining economy negatively impacted the provision for doubtful accounts, which increased 14% in fiscal year ended June 30, 2012. All other operating expense changes from prior year were insignificant.

Non-operating Revenues and (Expenses)

District tax revenues reflect the general obligation bond debt service provided by property tax assessments within the district. Debt service increased $38,250 (1.91%) in 2012. Investment income decreased from $284 thousand to $75 thousand as we utilized investments on capital projects. Loss on sale of assets of $93 thousand was primarily due to the early retirement of several electronic medication management stations.

Future Activities and Next Year's Budget

On June 27, 2012, the District's Board of Directors approved the operating budget for fiscal year ending June 30, 2012. The budget projects small increases in patient activity. The budgeted operating deficit of $3.5 million reflects the actualizing of the capitalized project related interest expense and increased depreciation when the new hospital project becomes operational in the fourth quarter of calendar year 2012.

Regulatory Matters

The District successfully completed a 3-year accreditation survey in FY10. We expect to participate in another survey during the next fiscal year.

The District's California Senate Bill 1953 (seismic) requirements have been extended to 2030.

The largest challenges remain economy instability and associated uninsured patients, State of California budgetary struggles, and definition of federal healthcare reform.

OAK VALLEY HOSPITAL DISTRICT

Balance Sheets

	June 30 2012	June 30 2011
Assets		
Current assets:		
Cash and cash equivalents	$ 2,888,145	$ 6,956,339
Patient accounts receivable, net of allowances	7,608,786	8,996,431
Other receivables and physician advances	674,671	1,269,686
Assets limited as to use, current	9,938,009	22,475,820
Estimated third party payor settlements	1,356,949	1,627,069
Supplies	947,863	934,172
Prepaid expenses and deposits	647,472	571,244
Total current assets	24,061,895	42,830,761
Assets limited as to use	12,219,219	11,596,185
Capital assets, net of accumulated depreciation	104,509,728	86,005,696
Other assets, net of accumulated amortization	2,665,590	2,785,144
Total assets	$ 143,456,432	$ 143,217,786
Liabilities and Net Assets		
Current liabilities:		
Current maturities of debt borrowings	$ 940,000	$ 735,000
Accounts payable and accrued expenses	5,321,651	5,625,893
Accrued payroll and related liabilities	2,574,673	3,169,693
Deferred revenue	511,996	569,368
Total current liabilities	9,348,320	10,099,954
Debt borrowings, net of current maturities	68,925,000	69,865,000
Deferred revenue	1,148,969	1,606,899
Total liabilities	79,422,289	81,571,853
Net assets:		
Invested in capital assets, net of related debt	28,172,535	25,421,391
Temporarily restricted	869,903	2,139,565
Unrestricted	34,991,705	34,084,977
Total net assets	64,034,143	61,645,933
Total liabilities and net assets	$ 143,456,432	$ 143,217,786

See accompanying notes and auditor's report

OAK VALLEY HOSPITAL DISTRICT

Statements of Revenues, Expenses and Changes in Net Assets

	Year Ended June 30	
	2012	2011
Operating revenues		
Net patient service revenue	$ 64,510,360	$ 62,406,364
Premium revenue	99,416	117,389
Other operating revenue	1,216,247	426,672
Total operating revenues	65,826,023	62,950,425
Operating expenses		
Salaries and wages	21,629,931	20,721,247
Employee benefits	7,340,014	7,508,611
Professional fees	3,464,300	3,212,640
Purchased services	5,975,736	5,827,249
Supplies	4,786,961	4,688,023
Rentals and leases	1,916,228	1,948,753
Repairs and maintenance	429,180	468,941
Insurance	408,424	406,192
Provision for bad debts	15,042,204	12,773,149
Depreciation and amortization	2,343,516	2,641,188
Other operating expenses	1,523,859	1,321,666
Total operating expenses	64,860,353	61,517,659
Operating income (loss)	965,670	1,432,766
Non-operating revenues (expenses)		
District tax revenue	2,045,438	2,007,188
Non-capital grant revenues	104,463	152,944
Investment income	115,882	399,997
Interest expense	(642,071)	(642,070)
Other non-operating income (expense), net	(92,766)	(170,237)
Affiliation income and consideration, net	35,364	35,364
Total net non-operating revenues (expenses)	1,566,310	1,783,186
Excess of revenues over expenses	2,531,980	3,215,952
Inter-governmental transfers	(673,368)	-0-
Capital grants and contributions	529,598	1,039,206
Increase in net assets	2,388,210	4,255,158
Net assets at beginning of the year	61,645,933	57,390,775
Net assets at end of the year	$ 64,034,143	$ 61,645,933

See accompanying notes and auditor's report

OAK VALLEY HOSPITAL DISTRICT

Statements of Cash Flows

	Year Ended June 30 2012	2011
Cash flows from operating activities:		
Cash received from patients and third-parties on behalf of patients	$ 51,225,337	$ 49,140,878
Cash received from operations, other than patient services	1,811,262	(337,293)
Cash payments to suppliers and contractors	(18,898,849)	(18,884,785)
Cash payments to employees and benefit programs	(29,564,965)	(28,195,283)
Net cash provided by operating activities	4,572,785	1,723,517
Cash flows from non-capital financing activities:		
Non-capital grant revenues	104,463	152,944
Affiliation income and consideration, net	35,364	35,364
Net cash provided by non-capital financing activities	139,827	188,308
Cash flows from capital and related financing activities:		
District tax revenues	2,045,438	2,007,188
Capital grants and contributions	529,598	1,039,206
Purchase of capital assets, net of disposals	(20,836,349)	(31,538,067)
Gain (loss) on disposal of assets	(92,766)	(57,582)
Proceeds from new debt borrowings	-0-	-0-
Principal payments on debt borrowings	(735,000)	(670,000)
Interest payments on debt borrowings	(3,610,456)	(3,639,577)
Net cash used in capital and related financing activities	(22,699,535)	(32,858,832)
Cash flows from investing activities:		
Net (purchase), transfers or sale of investments	13,802,847	33,243,816
Interest and dividends received from investments	115,882	399,997
Net cash provided by investing activities	13,918,729	33,643,813
Net increase (decrease) in cash and cash equivalents	(4,068,194)	2,696,806
Cash and cash equivalents at beginning of year	6,956,339	4,259,533
Cash and cash equivalents at end of year	$ 2,888,145	$ 6,956,339

See accompanying notes and auditor's report

OAK VALLEY HOSPITAL DISTRICT

Statements of Cash Flows (continued)

	Year Ended June 30	
	2012	2011
Reconciliation of operating income to net cash provided by operating activities:		
Operating income (loss)	$ 965,670	$ 1,432,766
Adjustments to reconcile operating income to net cash provided by operating activities:		
Depreciation and amortization of other assets	2,343,516	2,641,188
Changes in operating assets and liabilities:		
Patient accounts receivables	1,387,645	167,297
Other receivables	595,015	(763,965)
Supplies	(13,691)	27,470
Prepaid expenses and deposits	(76,228)	20,826
Accounts payable and accrued expenses	(304,242)	(1,059,617)
Accrued payroll and related liabilities	(595,020)	34,575
Estimated third party payor settlements	270,120	(777,023)
Net cash provided by operating activities	$ 4,572,785	$ 1,723,517

See accompanying notes and auditor's report

OAK VALLEY HOSPITAL DISTRICT

Notes to Financial Statements

June 30, 2012

NOTE 1 - ORGANIZATION AND ACCOUNTING POLICIES

Reporting Entity: Oak Valley Hospital District (the Hospital) is a public entity organized under Local Hospital District Law as set forth in the Health and Safety Code of the State of California. The Hospital is a political subdivision of the State of California and is generally not subject to federal or state income taxes. The Hospital is owned and operated by the District and governed by a Board of Directors, elected from within the healthcare district to specified terms of office. The Hospital is located in Oakdale, California and operates a full-service acute care facility and provides services to both inpatients and outpatients. The Hospital also provides skilled nursing care. The Hospital provides health care services primarily to individuals who reside in the local geographic area.

Basis of Preparation: The accounting policies and financial statements of the Hospital generally conform with the recommendations of the audit and accounting guide, *Health Care Organizations*, published by the American Institute of Certified Public Accountants. The financial statements are presented in accordance with the pronouncements of the Governmental Accounting Standards Board (GASB). For purposes of presentation, transactions deemed by management to be ongoing, major or central to the provision of health care services are reported as operational revenues and expenses.

The Hospital uses enterprise fund accounting. Revenues and expenses are recognized on the accrual basis using the economic resources measurement focus. Based on GASB Statement Number 20, *Accounting and Financial Reporting for Proprietary Funds and Other Governmental Entities That Use Proprietary Fund Accounting*, as amended, the Hospital has elected to apply the provisions of all relevant pronouncements as the Financial Accounting Standards Board (FASB), including those issued after November 30, 1989, that do not conflict with or contradict GASB pronouncements.

Financial Statement Presentation: The Hospital has adopted the provisions of GASB 34, *Basic Financial Statements - and Management's Discussion and Analysis - for State and Local Governments* (Statement 34), as amended by GASB 37, *Basic Financial Statements - and Management's Discussion and Analysis - for State and Local Governments: Omnibus*, and Statement 38, *Certain Financial Statement Note Disclosures*. Statement 34 established financial reporting standards for all state and local governments and related entities. Statement 34 primarily relates to presentation and disclosure requirements. This relates to the format of the financial statements; the inclusion of management's discussion and analysis; and the preparation of the statement of cash flows on the direct method. The application of these accounting standards has no impact on the total net assets.

Management's Discussion and Analysis: Statement 34 requires that financial statements be accompanied by a narrative introduction and analytical overview of the Hospital's financial activities in the form of "management's discussion and analysis" (MD&A). This analysis is similar to the analysis provided in the annual reports of organizations in the private sector.

NOTE 1 - ORGANIZATION AND ACCOUNTING POLICIES (continued)

Use of Estimates: The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amount of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Cash and Cash Equivalents and Investments: The Hospital considers cash and cash equivalents to include certain investments in highly liquid debt instruments, when present, with an original maturity of a short-term nature or subject to withdrawal upon request. Exceptions are for those investments which are intended to be continuously invested. Investments in debt securities are reported at market value. Interest, dividends and both unrealized and realized gains and losses on investments are included as investment income in non-operating revenues when earned.

Patient Accounts Receivable: Patient accounts receivable consist of amounts owed by various governmental agencies, insurance companies and private patients. The Hospital manages its receivables by regularly reviewing the accounts, inquiring with respective payors as to collectibility and providing for allowances on their accounting records for estimated contractual adjustments and uncollectible accounts. Significant concentrations of patient accounts receivable are discussed further in the footnotes.

Supplies: Inventories are consistently reported from year to year at cost determined by average costs and replacement values which are not in excess of market. The Hospital does not maintain levels of inventory values such as those under a first-in, first out or last-in, first out method.

Assets Limited as to Use: Assets limited as to use include assets held by trustees under indenture agreements and for the hospital expansion project, and designated assets set aside by the Board of Directors for future capital improvements, over which the Board retains control and may at its discretion subsequently use for other purposes.

The Board has established a policy of saving for future capital expenditures, to the extent that funds are available, to be used for replacement, expansion, or for other capital purposes of the Hospital.

Capital Assets: Capital assets consist of property and equipment and are reported on the basis of cost, or in the case of donated items, on the basis of fair market value at the date of donation. Routine maintenance and repairs are charged to expense as incurred. Expenditures which increase values, change capacities, or extend useful lives are capitalized. Depreciation of property and equipment and amortization of property under capital leases are computed by the straight-line method for both financial reporting and cost reimbursement purposes over the estimated useful lives of the assets, which range from 10 to 30 years for buildings and improvements, and 3 to 10 years for equipment. The Hospital periodically reviews its capital assets for value impairment. As of June 30, 2012 and 2011, the Hospital has determined that no capital assets are impaired.

NOTE 1 - ORGANIZATION AND ACCOUNTING POLICIES (continued)

Compensated Absences: Hospital employees earn vacation benefits at varying rates depending on years of service. Employees also earn sick leave benefits based on varying rates depending on years of service. Both benefits can accumulate up to specified maximum levels. Employees are not paid for accumulated sick leave benefits if they leave either upon termination or before retirement. However, accumulated vacation benefits are paid to an employee upon either termination or retirement. Accrued vacation liabilities as of June 30, 2012 and 2011 are $1,248,546 and $1,173,072 respectively.

Risk Management: The Hospital is exposed to various risks of loss from torts; theft of, damage to, and destruction of assets; business interruption; errors and omissions; employee injuries and illnesses; natural disasters; and medical malpractice. Commercial insurance coverage is purchased for claims arising from such matters. In the case of employee health coverage, the Hospital is self-insured for those claims and is discussed further in the footnotes.

Net Assets: Net assets are presented in three categories. The first category is net assets "invested in capital assets, net of related debt". This category of net assets consists of capital assets (both restricted and unrestricted), net of accumulated depreciation and reduced by the outstanding principal balances of any debt borrowings that were attributable to the acquisition, construction, or improvement of those capital assets.

The second category is "restricted" net assets. This category consists of externally designated constraints placed on those net assets by creditors (such as through debt covenants), grantors, contributors, law or regulations of other governments or government agencies, or law or constitutional provisions or enabling legislation.

The third category is "unrestricted" net assets. This category consists of net assets that do not meet the definition or criteria of the previous two categories.

Net Patient Service Revenues: Net patient service revenues are reported in the period at the estimated net realized amounts from patients, third-party payors and others including estimated retroactive adjustments under reimbursement agreements with third-party programs. Normal estimation differences between final reimbursement and amounts accrued in previous years are reported as adjustments of current year's net patient service revenues.

Charity Care: The Hospital accepts all patients regardless of their ability to pay. A patient is classified as a charity patient by reference to certain established policies of the Hospital. Essentially, these policies define charity services as those services for which no payment is anticipated. Because the Hospital does not pursue collection of amounts determined to qualify as charity care, they are not reported as net patient service revenues. Services provided are recorded as gross patient service revenues and then written off entirely as an adjustment to net patient service revenues.

NOTE 1 - ORGANIZATION AND ACCOUNTING POLICIES (continued)

Grants and Contributions: From time to time, the Hospital receives grants from various governmental agencies and private organizations. The Hospital also receives contributions from related foundation and auxiliary organizations, as well as from individuals and other private organizations. Revenues from grants and contributions are recognized when all eligibility requirements, including time requirements are met. Grants and contributions may be restricted for either specific operating purposes or capital acquisitions. These amounts, when recognized upon meeting all requirements, are reported as components of the statement of revenues, expenses and changes in net assets.

Operating Revenues and Expenses: The Hospital's statement of revenues, expenses and changes in net assets distinguishes between operating and non-operating revenues and expenses. Operating revenues result from exchange transactions associated with providing health care services, which is the Hospital's principal activity. Operating expenses are all expenses incurred to provide health care services, other than financing costs. Non-operating revenues and expenses are those transactions not considered directly linked to providing health care services.

Other Assets: Other assets include various non-capital assets including, debt issuance costs, early extinguishment costs, and capitalized affiliation agreement costs related to the affiliation agreement entered into with St. Joseph's Regional Health System, dba CHW San Joaquin-Sierra (CHW). Debt issuance costs incurred in connection with the issuance of tax-exempt bonds have been deferred and are being amortized over the term of the bonds using a straight-line method. Early extinguishment costs are those costs associated with bonds which have been defeased and are being amortized, under GASB pronouncements, over the lesser of the original life of the bonds for which the costs related to, or the life of the affiliation agreement (an agreement which provided the funds to defease the original bonds). Capitalized affiliation agreement costs consist of costs incurred with regard to the formation of the affiliation agreement and are being amortized over the life of the affiliation agreement.

Premium Revenue: The Hospital has agreements with various health maintenance organizations (HMO's) to provide medical services to subscribing participants. Under these agreements, the Hospital receives monthly capitation premium payments for enrollment. These monthly capitation payments are recorded as premium revenue. The ultimate cost of providing the health care coverage for the participants may be more or less than the amounts collected under the premium concept and may be more or less than the accrued expenses for such claims. The difference between the estimated reserves and the actual settlement for claims is recognized in the period the claims are settled.

Reclassifications: Certain financial statement amounts as presented in the prior year financial statements have been reclassified in these, the current year financial statements, in order to conform to the current year financial statement presentation.

NOTE 2 - CASH, CASH EQUIVALENTS AND INVESTMENTS

As of June 30, 2012 and 2011, the Hospital had deposits invested in various financial institutions in the form of cash and cash equivalents amounting to $25,045,373 and $41,028,344. All of these funds were held in deposits, which are collateralized in accordance with the California Government Code (CGC), except for $250,000 per account that is federally insured.

Under the provisions of the CGC, California banks and savings and loan associations are required to secure the Hospital's deposits by pledging government securities as collateral. The market value of pledged securities must equal to at least 110% of the Hospital's deposits. California law also allows financial institutions to secure Hospital deposits by pledging first trust deed mortgage notes having a value of 150% of the Hospital's total deposits. The pledged securities are held by the pledging financial institution's trust department in the name of the Hospital.

Investments consist of U.S. Government securities and state and local agency funds invested in U. S. Government securities and are stated at quoted market values. Changes in market value between years are reflected as a component of investment income in the accompanying statement of revenues, expenses and changes in net assets.

NOTE 3 - NET PATIENT SERVICE REVENUES AND REIMBURSEMENT PROGRAMS

The Hospital renders services to patients under contractual arrangements with the Medicare and Medi-Cal programs, health maintenance organizations (HMOs) and preferred provider organizations (PPOs). Patient service revenues from these programs approximate 91% of gross patient service revenues.

The Medicare Program reimburses the Hospital on a prospective payment system for inpatient hospital services. The prospective rates are predetermined amounts based on the Medicare inpatient discharge diagnosis including capital. Skilled nursing services are reimbursed on a program similar in nature to the inpatient services.

The Hospital contracts to provide services to Medi-Cal, HMO and PPO inpatients on negotiated rates. Certain outpatient reimbursement is subject to a schedule of maximum allowable charges for Medi-Cal and to a percentage discount for HMOs and PPOs. The skilled nursing facility (SNF) is reimbursed by the Medi-Cal program on a prospective per diem basis subject to audit by the state. The results of the state audits are incorporated prospectively and are subject to appeal by the provider.

Both the Medicare and Medi-Cal program's administrative procedures preclude final determination of amounts due to the Hospital for services to program patients until after patients' medical records are reviewed and cost reports are audited or otherwise reviewed by and settled with the respective administrative agencies. The Medicare and Medi-Cal cost reports are subject to audit and possible adjustment. Management is of the opinion that no significant adverse adjustment to the recorded settlement amounts will be required upon final settlement.

NOTE 3 - NET PATIENT SERVICE REVENUES AND REIMBURSEMENT PROGRAMS (continued)

Medicare and Medi-Cal revenue accounts for approximately 74% in 2012 and 72% in 2011 of the Hospital's net patient revenues for each year. Laws and regulations governing the Medicare and Medi-Cal programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term.

NOTE 4 - CONCENTRATION OF CREDIT RISK

The Hospital grants credit without collateral to its patients and third-party payors. Patient accounts receivable from government agencies represent the only concentrated group of credit risk for the Hospital and management does not believe that there are any credit risks associated with these governmental agencies. Contracted and other patient accounts receivable consist of various payors including individuals involved in diverse activities, subject to differing economic conditions and do not represent any concentrated credit risks to the Hospital. Concentration of patient accounts receivable at June 30, 2012 and 2011 were as follows:

	2012	2011
Medicare	$ 6,193,108	$ 5,377,426
Medi-Cal and Medi-Cal pending	6,960,486	4,946,717
Other third party payors	4,975,139	3,648,458
Self pay and other	16,245,707	13,183,800
Gross patient accounts receivable	34,374,440	27,156,401
Less allowances for contractual adjustments and bad debts	(26,765,654)	(18,159,970)
Net patient accounts receivable	$ 7,608,786	$ 8,996,431

NOTE 5 - OTHER RECEIVABLES

Other receivables as of June 30, 2012 and 2011 were comprised of the following:

	2012	2011
Advances to physicians, notes and related receivables	$ 541,111	$ 398,004
Receivable from health plan stop loss carrier	25,509	417,119
Hospital Fee Program deposit	-0-	357,246
Rent receivable	41,983	31,248
Other	66,068	66,069
	$ 674,671	$ 1,269,686

Advances to physicians are comprised of physician income guarantees and/or business loans to those physicians requiring assistance to begin a local practice. The Hospital has entered into agreements with certain physicians whereby the Hospital guarantees their income for a specified period of time. These agreements are structured so that if a physician maintains a practice in the area for a specified period of time, the income guarantee advances are forgiven.

NOTE 6 - ASSETS LIMITED AS TO USE

Assets limited as to use as of June 30, 2012 and 2011 were comprised of cash and cash equivalents held by trustees under indenture agreements and for the hospital expansion project and designated by the board for specific purposes. Interest income, dividends, and both realized and unrealized gains and losses on investments are recorded as investment income. These amounts were $115,882 and $399,997 (net of interest income capitalized as part of the hospital expansion project) for the years ended June 30, 2012 and 2011, respectively. Total investment income includes both income from operating cash and cash equivalents and cash and cash equivalents related to assets limited as to use. Debt securities, when present, are recorded at market price or the fair market value as of the date of each balance sheet.

NOTE 7 - CAPITAL ASSETS

Capital assets as of June 30, 2012 and 2011 were comprised of the following:

	Balance at June 30, 2011	Transfers & Additions	Transfers, Retirements & Adjustments	Balance at June 30, 2012
Land and land improvements	$ 806,915	$ -0-	$ -0-	$ 806,915
Buildings and improvements	29,523,180	93,472	(167,374)	29,449,278
Equipment	16,189,314	1,277,053	(1,268,716)	16,197,651
Construction-in-progress	65,236,372	19,465,823	-0-	84,702,195
Totals at historical cost	111,755,781	$ 20,836,348	$ (1,436,090)	131,156,039
Less accumulated depreciation	(25,750,085)	$ (2,239,550)	$ 1,343,324	(26,646,311)
Capital assets, net	$ 86,005,696			$ 104,509,728

	Balance at June 30, 2010	Transfers & Additions	Transfers & Retirements	Balance at June 30, 2011
Land and land improvements	$ 806,915	$ -0-	$ -0-	$ 806,915
Buildings and improvements	29,261,892	656,718	(395,430)	29,523,180
Equipment	15,626,781	602,353	(39,820)	16,189,314
Construction-in-progress	34,957,376	30,278,996	-0-	65,236,372
Totals at historical cost	80,652,964	$ 31,538,067	$ (435,250)	111,755,781
Less accumulated depreciation	(23,486,564)	$ (2,641,188)	$ 377,667	(25,750,085)
Capital assets, net	$ 57,166,400			$ 86,005,696

NOTE 8 - DEBT BORROWINGS

Long-term debt consists of the following:

	June 30, 2012	June 30, 2011
Oak Valley Hospital District Health Facility Revenue Bonds, Series 2004, original amount of $18,000,000 of term bonds maturing annually on November 1 through 2034, interest payable semi-annually on May 1, and November 1, at rates varying from 3.20% to 5.35%.	$ 16,485,000	$ 16,885,000
Oak Valley Hospital District 2005 General Obligation Bonds, Election of 2004, original amount of $37,000,000 of term bonds maturing annually on July 1 through 2035, interest payable semi-annually on January 1 and July 1, at rates varying from 2.70% to 5.0%.	35,785,000	36,120,000
Oak Valley Hospital District Health Facility Revenue Bonds, Series 2010 A&B, original amount of $17,595,000 of term bonds maturing annually on November 1 through 2039, interest payable semi-annually on May 1, and November 1, at rates varying from 5.00% to 9.00%.	17,595,000	17,595,000
Total debt borrowings	69,865,000	70,600,000
Less current portion	940,000	735,000
	$ 68,925,000	$ 69,865,000

Future principal maturities for debt borrowings for the succeeding years are: $940,000 in 2013; $1,020,000 in 2014; $1,105,000 in 2015; $1,195,000 in 2016; $1,290,000 in 2017; and $64,315,000 thereafter.

On November 1, 2004, the Hospital issued $18,000,000 of Series 2004 Health Facility Revenue Bonds. The proceeds of the Series 2004 Bonds are being used to finance the construction and equipping of the Hospital's Master Plan expansion project. In accordance with the terms of the revenue bond agreement, the Hospital has established fund accounts, which are limited as to use for the Hospital Master Plan expansion project and repayment of the bonds, and are maintained by a trustee.

On July 1, 2005, the Hospital issued $37,000,000 of Series 2005 General Obligation Bonds, Election of 2004. The proceeds of these bonds are being used to finance the construction of the Hospital's Master Plan expansion project. In accordance with the terms of the general obligation bond agreement, the Hospital has established fund accounts, which are limited as to use for the Hospital master plan expansion project. A special district property tax assessment to be used to meet debt service obligations for the general obligation bonds was approved by district voters in 2004. Taxes are collected by Stanislaus County and are used to meet the debt service obligations as they become due and payable to bond holders. The total debt service obligation on the general obligation bonds for the year ending June 30, 2012 amounted to $2,045,437. This amount has been recognized as district tax income by the Hospital in the corresponding fiscal year. Stanislaus County collected additional taxes under this arrangement in the amount of $54,067 as of June 30, 2012. This amount has been recorded as deferred property tax revenue in the corresponding fiscal year.

NOTE 8 - DEBT BORROWINGS (continued)

On January 28, 2010, the Hospital issued $17,595,000 of Series 2010 A&B Health Facility Revenue Bonds. The proceeds of the Series 2010 A&B Bonds are being used to finance the construction and equipping of the Hospital's Master Plan expansion project. In accordance with the terms of the revenue bond agreement, the Hospital has established fund accounts, which are limited as to use for the Hospital Master Plan expansion project and repayment of the bonds, and are maintained by a trustee.

The unexpended portion of these funds and funds held under an indenture agreement, consisting of investments in money market funds and corporate obligations, is included in the accompanying balance sheet as of June 30, 2012 and 2011 as "assets limited as to use" in the amount of $4,815,301 and $13,196,476 respectively.

NOTE 9 - RETIREMENT PLANS

The Hospital has a defined contribution pension plan which covers substantially all employees in lieu of participation in the Social Security program. The annual contribution made by the Hospital is equal to approximately 15.9% of eligible employee salaries. Employees are eligible to enter the plan after one year of employment and are 50% vested when they enter and 100% vested after six years. Total pension costs for the years ended June 30, 2012 and 2011 were approximately $2,699,000 and $2,643,000, respectively.

NOTE 10 - COMMITMENTS AND CONTINGENCIES

Construction-in-Progress: As of June 30, 2012 and 2011, the Hospital had recorded $84,702,195 and $65,236,372, respectively, as construction-in-progress representing cost capitalized for various remodeling, major repair, and the Master Plan expansion project on the Hospital's premises. Interest in the amount of $2,938,369 (net of interest income from bond proceed funds) was capitalized under FAS 62 during the year ended June 30, 2012 in association with the Master Plan expansion project. A total of $10,757,442 has been capitalized under FAS 62 in association with the Master Plan expansion project as June 30, 2012. Estimated cost to complete obligated projects as of June 30, 2012 are approximately $5,400,000. Costs are to be financed with Hospital reserves, the Series 2004 Revenue Bonds, Series 2005 General Obligation Bonds and Series 2010 A&B Revenue Bonds proceeds and continued Hospital operations.

Operating Leases: The Hospital leases various equipment and facilities under operating leases expiring at various dates. Total building and equipment rent expense for the years ended June 30, 2012 and 2011, were $1,916,228 and $2,017,900, respectively. Future minimum lease payments for the succeeding years under operating leases with a remaining term in excess of one year as of June 30, 2012 are as follows: $964,921 in 2013; $888,962 in 2014; $863,199 in 2015; $802,589 in 2016; and $486,114 in 2017.

NOTE 10 - COMMITMENTS AND CONTINGENCIES (continued)

Litigation: The Hospital may from time-to-time be involved in litigation and regulatory investigations which arise in the normal course of doing business. After consultation with legal counsel, management estimates that matters existing as of June 30, 2012 will be resolved without material adverse effect on the Hospital's future financial position, results from operations or cash flows.

Employee Health Insurance: The Hospital provides health benefits to employees through a self-funded plan financed by the Hospital operations. Estimated liabilities are recorded for claims which most likely have been incurred but are not yet reported for claims processing and payment (IBNR). As of June 30, 2012 and 2011, these amounts were estimated at $707,000 and $581,000, respectively. Commercial insurance is provided for "stop-loss" coverage.

Workers Compensation Program: The Hospital is a participant in the Association of California Hospital District's ALPHA Fund which administers a self-insured worker's compensation plan for participating hospital employees of its member hospitals. The Hospital pays a premium to the ALPHA Fund which is adjusted annually. If participation in the ALPHA Fund is terminated by the Hospital, the Hospital would be liable for its share of any additional premiums necessary for final disposition of all claims and losses covered by the ALPHA Fund.

Health Insurance Portability and Accountability Act: The Health Insurance Portability and Accountability Act (HIPAA) was enacted August 21, 1996, to ensure health insurance portability, reduce health care fraud and abuse, guarantee security and privacy of health information, and enforce standards for health information. Organizations are subject to significant fines and penalties if found not to be compliant with the provisions outlined in the regulations. Management continues to evaluate the impact of this legislation on its operations including future financial commitments that will be required.

Health Care Reform: The health care industry is subject to numerous laws and regulations of federal, state and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, governmental health care program participation requirements, reimbursement for patient services, and Medicare and Medi-Cal fraud and abuse. Government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statues and regulations by health care providers. Violations of these laws and regulations could result in expulsion from government health care programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. Management believes that the Hospital is in compliance with fraud and abuse as well as other applicable government laws and regulations. While no material regulatory inquiries have been made, compliance with such laws and regulations can be subject to future government review and interpretation as well as regulatory actions unknown or unasserted at this time.

NOTE 11 - FAIR VALUE OF FINANCIAL INSTRUMENTS

The Hospital uses certain methods and assumptions in estimating its fair value disclosures for financial instruments. For cash and cash equivalents, the Hospital uses the carrying amounts which approximate fair value due to the short maturity of any financial instrument considered as a cash equivalent. For debt borrowings (including capital lease obligations), the fair values are estimated using discounted cash flow analysis, based on the Hospital's current incremental borrowing rates for similar types of borrowing arrangements. As of June 30, 2012 and 2011, the fair values of debt borrowings were not considered to be materially different from the carrying values.

NOTE 12- CHARITY CARE AND COMMUNITY BENEFIT EXPENSE

The Hospital maintains records to identify and monitor the level of charity care and community service it provides. These records include: the amount of charges foregone, (based on established rates), for services and supplies furnished under its charity care and community service policies, the estimated cost of those services and supplies, and statistics quantifying the level of charity care as a percentage of expenses of the Hospital as a whole.

The following is a summary of the Hospital's charity care and community benefit expense for the years ended June 30, 2012 and 2011, in terms of services to the poor and benefits to the broader community:

	2012	2011
Benefits for the poor:		
Traditional charity care and related programs	$ 2,391,829	$ 1,420,967
Total quantifiable benefits for the poor	2,391,829	1,420,967
Benefits for the broader community:		
Unpaid Medicare program charges	10,670,743	10,222,440
Unpaid MediCal program charges	7,025,803	5,133,412
Total quantifiable benefits for the broader community	17,696,546	15,355,852
Total quantifiable community benefits	$ 20,088,375	$ 16,776,819

NOTE 13 - RELATED PARTY TRANSACTIONS

The Oak Valley Hospital District Foundation (the Foundation), has been established as a nonprofit public benefit corporation to solicit contributions on behalf of the Hospital. Substantially all funds raised, except for funds required for operation of the Foundation, are distributed to the Hospital or held for the benefit of the Hospital. The Foundation's funds, which represent the Foundation's unrestricted resources, are distributed to the Hospital in amounts and in periods determined by the Foundation's Board of Trustees, who may also restrict the use of such funds for Hospital property and equipment replacement , expansion, or other specific purposes. Donations by the Foundation for the years ended June 30, 2012 and 2011 were $1,401,492 and $780,800, respectively.

In addition, the Hospital's auxiliary is also a separate entity with a like-kind mission as the foundation. The auxiliary made donations totaling $38,201 during the year ended June 30, 2012 and no donations during the year ended June 30, 2011.

NOTE 14 - AFFILIATION AGREEMENT

Effective September 1, 1998, the Hospital signed a fifteen-year management service agreement (also referred to as an affiliation agreement) with St. Joseph's Regional Health Systems (dba Catholic Healthcare West, Northern California Division)(CHW). The agreement was designed to provide long-term management of the Hospital. Terms of the agreement also provided for $6,132,000 to be transferred to the Hospital upon inception of the agreement, which the Hospital will recognize as revenue over the period of the agreement. In consideration of the management and funds transferred to the Hospital, CHW earned, subject to certain provisions, management fees which were calculated at 1.25% of the Hospital's total operating revenue each year. In addition CHW was entitled to 25% of the Hospital's net income each year as a consideration for the funds transferred. In the event of an operating loss, CHW would share in 50% of the loss. Other provisions for earnings were also part of the agreement.

During the year ended June 30, 2004, the hospital reached an agreement with CHW whereas the original management service agreement (mentioned above) was amended, based on a fixed fee for service arrangement and calling for the Hospital to pay back a portion of the original amount transferred to the Hospital.

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APPENDIX C

FORM OF CONTINUING DISCLOSURE CERTIFICATE

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APPENDIX C

FORM OF CONTINUING DISCLOSURE CERTIFICATE

This Continuing Disclosure Certificate (the "Disclosure Certificate") is executed and delivered by the OAK VALLEY HOSPITAL DISTRICT (the "District") in connection with the issuance by the District of its $36,545,000* Oak Valley Hospital District (Stanislaus County, California) 2013 General Obligation Refunding Bonds (the "Bonds"). The Bonds are being issued pursuant to a resolution adopted by the Board of Directors of the District on April 24, 2013 (the "Resolution"). The District covenants and agrees as follows:

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

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

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

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

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

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

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

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

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

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

Section 3. Provision of Annual Reports.

(a) *Delivery of Annual Report*. The District shall, or shall cause the Dissemination Agent to, not later than nine months after the end of the District's fiscal year (which currently ends on May 310), commencing with the report for the 2012-13 Fiscal Year, which is due not later than March 31, 2014, file with EMMA, in a readable PDF or other electronic format as prescribed by the MSRB, an Annual Report

* Preliminary, subject to change.

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

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

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

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

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

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

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

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

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

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

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

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

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

Section 5. Reporting of Listed Events.

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

(1) Principal and interest payment delinquencies.

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

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

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

(5) Defeasances.

(6) Rating changes.

(7) Tender offers.

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

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

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

(1) Non-payment related defaults.

(2) Modifications to rights of security holders.

(3) Bond calls.

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

(5) The consummation of a merger, consolidation, or acquisition involving an obligated person or the sale of all or substantially all of the assets of the obligated person, other than in the ordinary course of business, the entry into a definitive agreement to undertake such an action or the termination of a definitive agreement relating to any such actions, other than pursuant to its terms.

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

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

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

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

Section 8. Dissemination Agent.

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

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

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

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

(a) *Change in Circumstances*. If the amendment or waiver relates to the provisions of Sections 3(a), 4 or 5(a) or (b), it may only be made in connection with a change in circumstances that arises from a change in legal requirements, change in law, or change in the identity, nature, or status of an obligated person with respect to the Bonds, or the type of business conducted.

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

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

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

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

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

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

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

Date: [Closing Date]

OAK VALLEY HOSPITAL DISTRICT

By _____
John McCormick
Chief Executive Officer

ACKNOWLEDGED:

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

By _____
Gary L. Hicks
President

EXHIBIT A

NOTICE TO EMMA OF FAILURE TO FILE ANNUAL REPORT

Name of Issuer: Oak Valley Hospital District

Name of Issue: Oak Valley Hospital District (Stanislaus County, California) 2013 General Obligation Refunding Bond

Date of Issuance: [Closing Date]

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

Dated: _____

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

By _____
Name _____
Title _____

cc: Paying Agent

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APPENDIX D

BOOK-ENTRY SYSTEM

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

The Depository Trust Company, New York, New York, will act as securities depository for the Bonds. The Bonds will be issued as fully-registered Bonds registered in the name of Cede & Co. (DTC's partnership nominee) or such other name as may be requested by an authorized representative of DTC. One fully-registered bond will be issued for each maturity, and will be deposited with DTC.

DTC, the world's largest depository, is a limited-purpose trust company organized under the New York Banking Law, a "banking organization" within the meaning of the New York Banking Law, a member of the Federal Reserve System, a "clearing corporation" within the meaning of the New York Uniform Commercial Code, and a "clearing agency" registered pursuant to the provisions of Section 17A of the Securities Exchange Act of 1934. DTC holds and provides assets servicing for over 3.5 million issues of U.S. and non-U.S. equity issues, corporate and municipal debt issues, and money market instruments from over 100 countries that DTC's participants ("Direct Participants") deposit with DTC. DTC also facilitates the post-trade settlement among Direct Participants of sales and other securities transactions in deposited securities, through electronic computerized book-entry transfers and pledges between Direct Participants' accounts. This eliminates the need for physical movement of securities bonds. Direct Participants include both U.S. and non-U.S. securities brokers and dealers, banks, trust companies, clearing corporations, and certain other organizations. DTC is a wholly-owned subsidiary of The Depository Trust & Clearing Corporation ("DTCC"). DTCC is the holding company for DTC, National Securities Clearing Corporation and Fixed Income Clearing Corporation, all of which are registered clearing agencies. DTCC is owned by the users of its regulated subsidiaries. Access to the DTC system is also available to others such as both U.S. and non-U.S. securities brokers and dealers, banks, trust companies and clearing corporations that clear through or maintain a custodial relationship with a Direct Participant, either directly or indirectly ("Indirect Participants"). DTC has Standard & Poor's rating of AA+. The DTC Rules applicable to its Participants are on file with the Securities and Exchange Commission. More information can be found at www.dtcc.com.

Purchases of the Bonds under the DTC system must be made by or through Direct Participants, which will receive a credit for the Bonds on DTC's records. The ownership interest of each actual purchaser of each Bond ("Beneficial Owner") is in turn to be recorded on the Direct Participants' and Indirect Participants' records. Beneficial Owners will not receive written confirmation from DTC of their purchases, but Beneficial Owners are expected to receive written confirmations providing details of the transaction, as well as periodic statements of their holdings, from the Direct Participant or Indirect Participant through which the Beneficial Owner entered into the transaction. Transfers of ownership interests in the Bonds are to be accomplished by entries made on the books of the Direct Participants and Indirect Participants acting on behalf of Beneficial Owners. Beneficial Owners will not receive bonds representing their ownership interests in the Bonds except in the event that use of the book-entry system for the Bonds is discontinued.

To facilitate subsequent transfers, all Bonds deposited by Direct Participants with DTC are registered in the name of DTC's partnership nominee, Cede & Co., or such other name as may be requested by an authorized representative of DTC. The deposit of the Bonds with DTC and their registration in the name of Cede & Co. or such other nominee do not effect any change in beneficial ownership. DTC has no knowledge of the actual Beneficial Owners of the Bonds; DTC's records reflect only the identity of the Direct Participants to whose accounts such Bonds are credited, which may or may not be the Beneficial Owners. The Direct Participants and Indirect Participants will remain responsible for keeping account of their holdings on behalf of their customers.

Conveyance of notices and other communications by DTC to Direct Participants, by Direct Participants to Indirect Participants, and by Direct Participants and Indirect Participants to Beneficial Owners will be governed by arrangements among them, subject to any statutory or regulatory requirements as may be in effect from time to time. Beneficial Owners of the Bonds may wish to take certain steps to augment transmission to them of notices of

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

Redemption notices will be sent to DTC. If less than all of the Bonds within a maturity are being redeemed, DTC's practice is to determine by lot the amount of the interest of each Direct Participant in such Bonds to be redeemed.

Neither DTC nor Cede & Co. (nor such other DTC nominee) will consent or vote with respect to the Bonds. Under its usual procedures, DTC mails an Omnibus Proxy to the Paying Agent as soon as possible after the record date. The Omnibus Proxy assigns Cede & Co.'s consenting or voting rights to those Direct Participants to whose accounts the Bonds are credited on the record date (identified in a listing attached to the Omnibus Proxy).

Principal and interest payments with respect to the Bonds will be made to Cede & Co., or such other nominee as may be requested by an authorized representative of DTC. DTC's practice is to credit Direct Participants' accounts, upon DTC's receipt of funds and corresponding detail information from the Trustee or Paying Agent on a payable date in accordance with their respective holdings shown on DTC's records. Payments by Direct Participants or Indirect Participants to Beneficial Owners will be governed by standing instructions and customary practices, as is the case with securities held for the accounts of customers in bearer form or registered in "street name," and will be the responsibility of such Direct Participant or Indirect Participant and not of DTC, the Paying Agent or the District, subject to any statutory or regulatory requirements as may be in effect from time to time. Payment of principal and interest to Cede & Co. (or such other nominee as may be requested by an authorized representative of DTC) is the responsibility of the Paying Agent, disbursement of such payments to Direct Participants shall be the responsibility of DTC, and disbursement of such payments to the Beneficial Owners shall be the responsibility of Direct Participants and Indirect Participants.

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

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

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

APPENDIX E

HEALTHCARE RISK FACTORS

General

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

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

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

Significant Risk Areas Summarized

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Federal Budget Cuts

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

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

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

On January 2, 2013, President Obama signed into law the American Taxpayer Relief Act of 2012, covering, among other matters, Medicare provider payments. The law includes a one-year Medicare physician fee schedule overriding the BCA reduction and delayed until March 2013 the automatic, across-the-board cuts imposed by the BCA on Medicare provider reimbursements. CMS has indicated that the automatic reductions to provider reimbursement will be implemented from April 2013 through March 2014.

Continued difficult negotiations are expected in Congress over these cuts, their retroactive elimination and related issues. Accordingly, the District is unable to predict what initiatives may be proposed by Congress or whether Congress will attempt to suspend or restructure the automatic budget cuts further. However, if continued, these reductions could have a material adverse effect on the financial condition of the District. Moreover, with no long-term resolution in place for federal deficit reduction, hospital and physician reimbursement are likely to continue to be targets for reductions with respect to any interim or long-term federal deficit reduction efforts.

California State Budget

California has faced in the past severe financial challenges, including erosion of general fund tax revenues, falling real estate values, slow economic growth and high unemployment. Shortfalls between revenues and spending have in the past and may in the future result in cutbacks to State and local government healthcare programs. Failure by the California legislature to approve budgets prior to the start of a new fiscal year can also result in a temporary

hold on or delay of Medi-Cal reimbursement. However, the relatively recent addition of legislative incentives to pass the State budget on time makes this less likely than in the past.

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

Notably, on January 10, 2013, California's Governor Brown predicted a balanced budget over the next four fiscal years and indicated that the State should expect a surplus of about $785 million for the current fiscal year ending June 30, 2013, and a surplus of about $851 million under his proposed budget for the 2013-2014 fiscal year, beginning July 1, 2013. Included in his proposed budget is some increased healthcare spending. Surpluses now predicted exceed those predicted in January, but there is no assurance Medi-Cal providers will benefit from these surpluses.

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

Additionally, in October 2011 CMS approved the State's request for 10% reductions in Medi-Cal payments for certain outpatient services and long-term care. Those reductions were suspended while challenged in federal court, but the Ninth Circuit Court of Appeals upheld the reductions in December 2012. Unless these cuts are reversed as proposed in California Assembly Bill 900 retroactive to 2011, there would be material financial consequences for long-term care providers such as the District by lowering current reimbursement and requiring payback of the 10% reimbursement overages for 2008, for a portion of 2011 and all of 2012 and 2013. Without legislative reversal, the rate reduction would also apply to all years going forward. This would result in providers, such as the District, needing to restate prior financial statements and to notify indenture trustees of non-compliance with certain financial covenants.

Local Ballot Measures

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

Healthcare Regulation and Reform

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

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

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

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

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

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

The changes in the healthcare industry brought about by the ACA will likely have both positive and negative effects, directly and indirectly, on the nation's hospitals and other healthcare providers, including the District. For example, the projected increase in the numbers of individuals with healthcare insurance occurring as a consequence of voluntary Medicaid expansion, creation of health insurance exchanges, subsidies for insurance purchase and the mandate for individuals to purchase insurance, could result in lower levels of bad debt and charity care and increased utilization or profitable shifts in utilization patterns for hospitals. The ACA also provides for substantial reductions in payments to Medicare providers, both through reduction in the annual market basket updates and reduction or elimination of reimbursement for preventable patient readmissions and hospital-acquired conditions. The ACA similarly mandates that states no longer reimburse providers for specified provider-preventable conditions. The ACA also significantly reduces both Medicare and Medicaid disproportionate share hospital funding between 2011 and 2020. A significant negative impact to the hospital industry overall will likely result from substantial scheduled, and cumulative, reductions in Medicare payments. Industry experts also expect that government cost reduction actions may be followed by similar actions by private insurers and other payors. Since approximately 38% of the revenues of the District (for fiscal year ended June 30, 2012) were from Medicare spending, the reductions may have a material adverse impact, and could offset any positive effects of the ACA. See also "Patient Service Revenues - The Medicare Program" below.

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

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

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

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

California Healthcare Reform. The State has passed several laws to implement the ACA. The State has established a state health insurance exchange, initially called the "California Health Benefit Exchange" now named "Covered California," as required by the ACA. In addition, 47 California counties are participating in the "Bridge to Reform" program, which implements the ACA's Medicaid expansion ahead of schedule. The California legislature is debating additional legislation related to the implementation of the ACA and reformation of individual coverage in the State, including provisions establishing essential health benefits and prohibiting insurers from denying health

coverage to individuals of any age with pre-existing conditions. Any such legislation or regulation concerning healthcare reform could have a material adverse effect on the District.

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

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

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

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

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

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

The foregoing are some examples of the challenges and examinations facing the healthcare industry organizations. They are indicative of a greater scrutiny of the billing, collection and other business practices of these organizations and may indicate an increasingly difficult operating environment for healthcare organizations. The challenges and examinations, and any resulting legislation, regulations, judgments, or penalties, could have a material adverse effect on hospitals and healthcare providers, including the District.

Patient Service Revenues

The Medicare Program. Medicare is the federal health insurance system under which hospitals are paid for services provided to eligible elderly and disabled persons. Medicare is administered by CMS, which delegates to the states the process for certifying hospitals to which CMS will make payment. In order to achieve and maintain Medicare certification, hospitals must meet CMS's "Conditions of Participation" on an ongoing basis, as determined by the State and/or The Joint Commission. The requirements for Medicare certification are subject to change, and, therefore, it may be necessary for hospitals to effect changes from time to time in their facilities, equipment,

personnel, billing, policies and services. For the fiscal year ended June 30, 2012, Medicare payments represented approximately 34%, of the District's gross patient service revenue.

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

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

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

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

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

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

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

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

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

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

Physician Services. Payments for physician services, other than those performed in a rural health clinic which are reimbursed as described below, under Part B of the Medicare program are based on a national fee schedule. The fee schedule is based on a resource based relative value scale ("RBRVS"), whereby physician work for a service is assigned a value reflecting the relative resources such as time, intensity, and risk required to perform the service. Values are also assigned to each service for practice expenses – for example, billing, rent, office personnel, and supplies, and for malpractice expenses. Payments are calculated by multiplying the combined costs of a service by a conversion factor. The conversion factor is a monetary amount that is currently determined by CMS's Sustainable Growth Rate ("SGR") system. The SGR system annually takes into account changes in the Medicare fee-for-services enrollment, input prices, spending due to law and regulation, and gross domestic product. In recent years, CMS has proposed payment cuts for physician services. On December 15, 2010, the Medicare and Medicaid Extenders Act of 2010 ("MMEA") was signed into law, temporarily sparing hospitals, physicians and other health service providers from numerous significant payment cuts. On November 2, 2011, CMS announced that it would implement an across-the-board Medicare payment reduction of approximately 27% for physicians and non-physician practitioners starting on January 1, 2012. In December 2011, Congress passed a two-month extension on this payment cut. On February 17, 2012, Congress passed the Middle Class Tax Relief and Job Creations Act of 2012, which included a provision directing CMS to continue to pay physicians at 2011 rates through the end of 2012. Congress recently approved additional rate-freezing legislation through 2013. There is no guarantee that reimbursement for physician services will cover the cost of those services to beneficiaries.

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

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

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

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

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

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

- the debt must be related to covered services and derived from deductible and coinsurance amounts;
- the provider must be able to establish that reasonable collection efforts were made;
- the debt was actually uncollectible when claimed as worthless; and

- sound business judgment established that there was no likelihood of recovery at any time in the future.

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

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

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

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

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

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

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

Most California hospitals are reimbursed for inpatient Medi-Cal services based on contracts between the hospital and Medi-Cal or based on cost reimbursement where there are no contracts. However, beginning July 1, 2013, general acute care hospitals, other than non-designated public hospitals like the Hospital, will be compensated

under the State's new DRG system (discussed below). For the fiscal year ended June 30, 2012, the District received approximately 35% of its gross patient service revenues from services covered by Medi-Cal programs.

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

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

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

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

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

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

With respect to SB 90, a companion bill to AB 113, it established a similar IGT program for non-designated public hospitals for the Medi-Cal population enrolled in Medi-Cal managed care programs. Under the Medi-Cal managed care IGT program, hospitals receive transfer amounts in the form of grants. The District has received and expects to receive managed care IGT grant funds through the 2014 program year.

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

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

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

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

Health Plans and Managed Care. Most private health insurance coverage is provided by various types of "managed care" plans, including health maintenance organizations ("HMOs") and preferred provider organizations ("PPOs") that generally use discounts and other economic incentives to reduce or limit the cost and utilization of healthcare services. Medicare and Medicaid also purchase healthcare using managed care options. Payments to healthcare organizations from managed care plans typically are lower than those received from traditional indemnity or commercial insurers.

In California, managed care plans have replaced indemnity insurance as the primary source of non-governmental payment for healthcare services, and healthcare organizations must be capable of attracting and maintaining managed care business, often on a regional basis. Regional coverage and aggressive pricing may be required. However, it is also essential that contracting healthcare organizations be able to provide the contracted services without significant operating losses, which may require multiple forms of cost containment.

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

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

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

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

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

International Classification of Diseases, 10th Revision Coding System

In 2009, CMS published the final rule adopting the International Classification of Diseases, 10th Revision coding system ("ICD-10"), requiring healthcare organizations to implement ICD-10 no later than October 2014. ICD-10 provides a common approach to the classification of diseases and other health problems, allowing the United States to align with other nations to better share medical information, diagnosis, and treatment codes. ICD-10 is not without risk as hospital staff will need to be retrained, processes redesigned, and computer applications modified as the current available codes and digit size will dramatically increase. Additionally, there is a potential for temporary coding and payment backlog, as well as potential increases in claims errors. Healthcare organizations will be dependent on outside software vendors, clearinghouses and third-party billing services to develop products and services to allow timely, full and successful implementation of ICD-10. Delays in the required implementation may occur if such ICD-10 products and services are not available to healthcare organizations from these outside sources well in advance of October 2013 to allow for adequate testing and installation.

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

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

Enforcement Affecting Clinical Research

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

Clinical trials are not conducted at the Hospital.

Regulatory Environment

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

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

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

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

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

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

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

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

Medicare may deny payment for all services related to a prohibited referral and a hospital that has billed for prohibited services may be obligated to refund the amounts collected from the Medicare program. For example, if an office lease between a hospital and a large group of heart surgeons is found to violate Stark, the hospital could be obligated to repay CMS for the payments received from Medicare for all of the heart surgeries performed by all of the physicians in the group for the duration of the lease, a potentially significant amount. The government may also seek substantial civil monetary penalties, and in some cases, a hospital may be liable for fines up to three times the amount of any monetary penalty, and/or be excluded from the Medicare and Medicaid programs. Settlements,

fines or exclusion for a Stark violation or alleged violation could have a material adverse impact on a hospital. Increasingly, the federal government is prosecuting violations of the Stark statute under the FCA, based on the argument that claims resulting from an illegal referral arrangement are also false claims for FCA purposes. See the discussion under the subheading "False Claims Act" above.

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

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

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

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

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

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

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

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

Enforcement Activity. Enforcement activity against healthcare providers has increased, and enforcement authorities have adopted aggressive approaches. In the current regulatory climate, it is anticipated that many hospitals and physician groups will be subject to an audit, investigation, or other enforcement action regarding the healthcare fraud laws mentioned above.

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

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

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

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

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

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

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

Hospitals may be subject to requirements related to investigating and remedying hazardous substances located on their property, including such substances that may have migrated off the property. Typical hospital operations include the handling, use, storage, transportation, disposal and/or discharge of hazardous, infectious, toxic, radioactive, flammable and other hazardous materials, wastes, pollutants and contaminants. As such, hospital operations are particularly susceptible to the practical, financial and legal risks associated with the environmental laws and regulations. Such risks may result in damage to individuals, property or the environment; may interrupt operations and/or increase their cost; may result in legal liability, damages, injunctions or fines; may result in investigations, administrative proceedings, civil litigation, criminal prosecution, penalties or other governmental agency actions; and may not be covered by insurance.

Business Relationships and Other Business Matters

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

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

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

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

financial reserve holdings of risk-bearing organizations, may also introduce complexity, risk and additional costs in organizing and operating integrated delivery systems.

Physician Financial Relationships. In addition to the physician integration relationships referred to above, hospitals and health systems frequently have various additional business and financial relationships with physicians and physician groups. These are in addition to hospital physician contracts for individual services performed by physicians in hospitals. They potentially include: joint ventures to provide a variety of outpatient services; recruiting arrangements with individual physicians and/or physician groups; loans to physicians; medical office leases; equipment leases from or to physicians; and various forms of physician practice support or assistance. These and other financial relationships with physicians (including hospital physician contracts for individual services) may involve financial and legal compliance risks for the hospitals involved. From a compliance standpoint, these types of financial relationships may raise federal and state "anti-kickback" and federal and state "Stark" issues (see "Regulatory Environment," above), as well as other legal and regulatory risks, and these could have a material adverse impact on hospitals.

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

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

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

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

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

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

Indigent Care. Hospitals often treat large numbers of indigent patients who are unable to pay in full for their medical care. Treatment of such patients results in significant expenses being incurred by the hospitals without adequate compensation or repayment. Typically, inner-city hospitals and other healthcare providers may treat significant numbers of indigents. These hospitals and healthcare providers may be susceptible to economic and

political changes that could increase the number of indigents or their responsibility for caring for this population. General economic conditions that affect the number of employed individuals who have health coverage affects the ability of patients to pay for their care. Similarly, changes in governmental policy, which may result in coverage exclusions under local, county, state and federal healthcare programs (including Medicare and Medicaid) may increase the frequency and severity of indigent treatment by such hospitals and other providers.

Hospital Medical Staff. The primary relationship between a hospital and physicians who practice in it is through the hospital's organized medical staff. Medical staff bylaws, rules and policies establish the criteria and procedures by which a physician may have his or her privileges or membership curtailed, denied or revoked. Physicians who are denied medical staff membership or certain clinical privileges or who have such membership or privileges curtailed or revoked often file legal actions against hospitals and medical staffs. Such actions may include a wide variety of claims, some of which could result in substantial uninsured damages to a hospital. In addition, failure of the hospital governing body to adequately oversee the conduct of its medical staff may result in hospital liability to third parties.

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

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

Freestanding ambulatory surgery centers may attract significant commercial outpatient services traditionally performed at hospitals. Commercial outpatient services, currently among the most profitable for hospitals, may be lost to competitors who can provide these services in an alternative, less costly setting. Full-service hospitals rely upon the revenues generated from commercial outpatient services to fund other less profitable services, and the decline of such business may result in reduced income. Competing ambulatory surgery centers, more likely a for-profit business, may not accept indigent patients or low paying programs and would leave these populations to receive services in the full-service hospital setting. Consequently, hospitals are vulnerable to competition from ambulatory surgery centers.

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

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

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

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

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

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

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

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

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

Professional Liability Claims and General Liability Insurance. In recent years, the number of professional and general liability suits and the dollar amounts of damage recoveries have increased in healthcare

nationwide, resulting in substantial increases in malpractice insurance premiums, higher deductibles and generally less coverage. Professional liability and other actions alleging wrongful conduct and seeking punitive damages are often filed against healthcare providers. Insurance does not provide coverage for judgments for punitive damages; however, California District hospitals are not subject to punitive damages.

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

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

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

Information Systems

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

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

Seismic Requirements

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

A significant earthquake could have a material adverse effect on the District which could result in material damage and temporary or permanent cessation of operations of the Health Facilities. The Health Facilities are covered by earthquake insurance.

Other Factors

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

- A change in the federal income tax or other federal, State or local laws to require the District to render substantially greater services without charge or at a reduced charge;
- Unionization issues employee strikes and other adverse labor actions or disputes with members of the medical staff;
- Shortages of professional and technical staff;
- Natural disasters, including floods, which could damage the Health Facilities or otherwise impair the operations of the Health Facilities and the general revenues from the Health Facilities;
- Decrease in the population within the service area of the Health Facilities;
- Increased unemployment or other adverse economic conditions which could increase the proportion of patients who are unable to pay fully for the cost of their healthcare; and
- Power outages.