PRELIMINARY OFFICIAL STATEMENT DATED APRIL 3, 2013

This Preliminary Official Statement and the information contained herein are subject to completion and amendment. These securities may not be sold nor may offers to buy be accepted prior to the time the Official Statement is delivered in final form. Under no circumstances may this Preliminary Official Statement constitute an offer to sell or the solicitation of an offer to buy, nor may there be any sale of these securities in any jurisdictions in which such offer, solicitation or sale would be unlawful prior to registration or qualification under the securities laws of any such jurisdiction.

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.

$42,165,000*
LOMPOC VALLEY MEDICAL CENTER
(SANTA BARBARA COUNTY, CALIFORNIA)
2013 GENERAL OBLIGATION REFUNDING BONDS

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

The issuance of general obligation bonds in an aggregate amount not to exceed $74,500,000 by Lompoc Valley Medical Center (the "District") was authorized at an election of the registered voters of the District held on September 13, 2005, by more than two-thirds (87%) of the persons voting on the measure. Pursuant to the laws of the State of California (the "State"), and resolutions of the District, the District issued an initial series of such bonds in the amount of $42,000,000 on August 2, 2006 (the "2006 Bonds"), and issued a second series of such bonds in the amount of $32,500,000 on August 7, 2007 (the "2007 Bonds").

The District is issuing this series of general obligation bonds in the amount of $42,165,000,* known as the Lompoc Valley Medical Center (Santa Barbara 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 2006 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 Santa Barbara 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 February 1 and August 1, commencing August 1, 2013. 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 (August 1)	Principal Amount	Interest Rate	Price or Yield	CUSIP†	Maturity (August 1)	Principal Amount	Interest Rate	Price or Yield	CUSIP†
2013	$ 380,000				2025	$1,645,000			
2014	735,000				2026	1,775,000			
2015	795,000				2027	1,900,000			
2016	860,000				2028	2,040,000			
2017	925,000				2029	2,185,000			
2018	1,000,000				2030	2,335,000			
2019	1,075,000				2031	2,500,000			
2020	1,160,000				2032	2,680,000			
2021	1,245,000				2033	2,855,000			
2022	1,335,000				2034	3,050,000			
2023	1,435,000				2035	3,255,000			
2024	1,535,000				2036	3,465,000			

Bids for the purchase of the Bonds will be received by the District on April 16, 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 April 3, 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 May 8, 2013.

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

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* 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.

LOMPOC VALLEY MEDICAL CENTER
SANTA BARBARA COUNTY, CALIFORNIA

BOARD OF DIRECTORS

Frank M. Signorelli, President
Roger J. McConnell, Secretary
David L. McAninch III, M.D., Member
Raymond F. Down, Member
Leslie M. Kelly, Member

DISTRICT SENIOR MANAGEMENT

Jim Raggio, Administrator/Chief Executive Officer
Naishadh Buch, Chief Operating Officer
Robert Baden, Associate Administrator/Chief Financial Officer
Jayne Scalise, Chief Nursing Executive

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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$42,165,000*
LOMPOC VALLEY MEDICAL CENTER
(SANTA BARBARA 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 Lompoc Valley Medical Center (the "District") of $42,165,000* aggregate principal amount of its 2013 General Obligation Refunding Bonds (the "Bonds"). The District was formerly known as Lompoc Hospital District and Lompoc Healthcare District.

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

The District, a local health care district formed in 1946, is a political subdivision of the State of California organized pursuant to the Local Health Care District Law (formerly the Local Hospital District Law) as set forth in the California Health and Safety Code (the "District Law"). The geographic area that make up 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 463 square miles in the northwestern portion of Santa Barbara County (the "County") and includes the City of Lompoc, as well as the neighboring unincorporated areas of Mission Hills, Mesa Oaks, Vandenberg Village and a portion of the Vandenberg Air Force Base. The 2012 population of the City of Lompoc and Santa Barbara County is estimated to be approximately 42,854 and 427,267, respectively. The District owns and operates Lompoc Valley Medical Center (the "Hospital"), the Lompoc Valley Medical Center Comprehensive Care Center (the "CCC"), and various outpatient imaging, laboratory, and other healthcare facilities under the provisions of District Law (collectively, along with the planned Chemical Dependency Rehabilitation Hospital, described herein, referred to as the "Health Facilities"). See "THE DISTRICT," "THE 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 2006 Bonds and to pay 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.

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* Preliminary, subject to change.

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 February 1 and August 1, commencing August 1, 2013 (each an "Interest Payment Date"), during the term of the Bonds.

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 August 1, 2021, may be redeemed prior to maturity at the option of the District beginning on August 1, 2020, and thereafter, at the redemption price of 100% of the par amount of Bonds redeemed, plus accrued interest. The Bonds maturing on August 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 May 8, 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 March 28, 2013 (the "Resolution"). Registered voters of the District authorized the issuance of $74,500,000 of general obligation bonds by approximately 87% of the votes cast September 13, 2005, on the measure. The District sold $42,000,000 in general obligation bonds on July 10, 2006, which bonds were delivered on August 2, 2006 (the "2006 Bonds"), and sold $32,500,000 in general obligation bonds on July 10, 2007, which bonds were delivered on August 7, 2007 (the "2007 Bonds").

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 2006 Bonds and to pay 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 August 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 August 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 August 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 and the 2007 Bonds and the aggregate debt service for both bond issues:

Year Ending (August 1,)	The Bonds				
	Principal Payment	Interest Payment	Total Debt Service	2007 Bonds Total Debt Service	Aggregate Debt Service on the Bonds and 2007 Bonds
2013	$	$	$	$1,660,500.00	$
2014				1,692,250.00	
2015				1,732,250.00	
2016				1,770,000.00	
2017				1,805,500.00	
2018				1,848,750.00	
2019				1,884,250.00	
2020				1,927,250.00	
2021				1,967,250.00	
2022				2,044,250.00	
2023				2,116,250.00	
2024				2,198,250.00	
2025				2,279,500.00	
2026				2,369,750.00	
2027				2,458,250.00	
2028				2,554,750.00	
2029				2,648,500.00	
2030				2,754,250.00	
2031				2,861,000.00	
2032				3,073,250.00	
2033				3,300,250.00	
2034				3,555,500.00	
2035				3,826,750.00	
2036				4,130,475.00	
2037				4,462,350.00	

* 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 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 on the Bonds and other general obligation bonds is not limited as to rate or amount, the risks discussed in this paragraph could affect a taxpayor'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 3.0% as compared to fiscal year 2008-09, and the total assessed valuation for the fiscal year 2012-13 decreased by approximately 1.7% as compared to fiscal year 2011-12. However, the tax delinquencies for the District's *ad volorem* taxes has decreased from a high of 3.68% in the fiscal year 2008-09 to a low of 1.73% 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 completed construction of a new Hospital facility and made other improvements to its Health Facilities in 2010 (the "Project"). Construction of the Project took place in two phases and the former Hospital facility was decommissioned after the new Hospital was placed into service in June 2010. The new Hospital facility was constructed on a separate site from the former Hospital facility, located approximately 1.5 miles east of the former Hospital on a 9-acre site at the entrance of the City of Lompoc from Highway 101. The new 60-bed Hospital was constructed to meet the State of California's SB 1953 seismic requirements and consists of approximately 111,000 square feet of usable space providing a full range of primary and secondary acute care services and comprehensive emergency, outpatient and ambulatory care services.

The entire Hospital floor area was planned on a single story to minimize construction cost, maintain neighborhood scale, and maximize patient flow and public access opportunities. Non-combustible construction was used throughout. Although the facility appears to be a single building, it is technically two adjacent buildings with matching appearance and character, separated by approximately 4 inches. This strategy for the construction of hospitals is relatively new and arises as a direct result of California legislative and regulatory seismic measures. Basically, the contents of a hospital are sorted on the basis of the critical need surrounding the services provided and all non-crucial functions are relegated to an adjacent office building rather than being accommodated in a higher cost hospital building. The building code addresses these occupancies in very different ways and this separation offers distinct advantages to the District and the citizens it serves.

The District funded the cost of construction and equipping of the Project from the issuance of the 2006 Bonds and 2007 Bonds, $4,060,000 in revenue bonds and from approximately $4,000,000 in community-based contributions.

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 – State and Local Government (the "SLGS"), so that the interest thereon and the maturing principal thereof, together with uninvested cash, will be sufficient to redeem the outstanding 2006 Bonds maturing on and after August 1, 2014 (the "Refunded 2006 Bonds"), in full on August 1, 2013, at a redemption price equal to 100% of the principal amount of the Refunded 2006 Bonds.

The mathematical accuracy of the calculation as to the sufficiency of SLGS and cash in the Escrow Fund to meet the payment and redemption requirements of the Refunded 2006 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 has its 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

Lompoc Valley Medical Center (the "District") was created in 1946 by a vote of the registered voters of the proposed district and by resolution of the Board of Supervisors of Santa Barbara County, California. The District’s name was changed on January 1, 2008, from Lompoc Healthcare District to Lompoc Valley Medical Center. The District is organized and operates under The Local Health Care District Law of the State of California (the "District Law"). The District’s boundaries are the Pacific Ocean on the west and south, Highway 101 on the east and the San Antonio River on the north. The only city located within the District is the City of Lompoc. Under the District Law the District may own and operate health care facilities. The District currently owns and operates the Hospital and the CCC and is in the process of converting its former hospital facility into a Chemical Dependency Rehabilitation Hospital (the “CDRH”).

Communities located within the District’s boundaries include, in addition to the City of Lompoc, the communities of Vandenberg Air Force Base, Vandenberg Village, Mesa Oaks and Mission Hills. The District is a political agency and receives operating *ad valorem* property tax revenues annually based upon the assessed value of taxable real property located within the District. The District is able to use these operating tax revenues for general operating purposes. The District also receives special *ad valorem* property tax revenues that are used to repay its general obligation bonds, including the Bonds.

Board of Directors

The District is governed by a Board of Directors (the "Board") which consists of five members, each elected to four-year staggered terms. The Board has ultimate responsibility for quality patient care, District policies, strategic planning, as well as fiduciary responsibility for protecting and enhancing the District's assets. The Board hires an Administrator/Chief Executive Officer to manage the District's operations and appoints physicians to an organized medical staff. Regular Board meetings are held monthly and are open to the public. All members of the Board are elected at large within the District. The current members of the Board, including their titles, occupations, dates on which their current terms expire and total years as Board members, are set forth in the following table:

Name and Title	Occupation	Term in Office Expires	Board Member Since
Frank M. Signorelli, President	Contractor	12/2014	1972
Roger J. McConnell, Secretary	Business Owner	12/2014	1996
David L. McAninch, III, MD, Member	Radiologist	12/2016	2000
Leslie M. Kelly, Member	Registered Nurse	12/2014	1998
Raymond F. Down, Member	Commercial Banker	12/2016	1973

Source: District records.

Standing committees of the Board include the Building and Planning Committee, the Finance Committee, the Personnel Committee and the Joint Conference Committee. Special committees can be appointed by the President of the Board from time to time as deemed necessary and will be governed by the committee chairman appointed by the President of the Board.

THE HEALTH FACILITIES

The District owns and operates the Hospital, a recently completed general acute care hospital located at 1515 East Ocean Avenue in the City of Lompoc, approximately 1.5 miles east of its previous hospital facility. The Hospital opened for operations as a 60-bed acute care facility on an approximate 9.0 acre site in June of 2010. The new one-story Hospital building includes approximately 111,000 square feet of usable space and provides a full range of primary and secondary acute care services and comprehensive emergency, outpatient and ambulatory care services to the residents of the District and its surrounding areas.

The District also operates the CCC, a 110-bed skilled nursing facility that provides services primarily to the elderly population of the District. The CCC is a single story building that includes approximately 39,000 square feet of space located on an approximate 2.5 acre site at 216 North 3rd Street in the City of Lompoc. The CCC was originally constructed in 1979 and was extensively renovated and expanded in 1984. The District also operates various outpatient diagnostic (including magnetic resonance imaging and mammography), laboratory and sleep study facilities, all located in the City of Lompoc, California.

The District plans to renovate and convert its previous hospital facility (located on an approximate 2.8 acre site at 508 East Hickory Avenue in the City of Lompoc) into the CDRH providing a complete continuum of chemical dependency services including 34 acute medical detoxification inpatient beds (to be licensed by the Department of Public Health), 16 inpatient residential beds (to be licensed by the Department of Drug and Alcohol Programs), 30 sober living beds (non-licensed outpatient residences) and outpatient therapy services. The CDRH building was originally constructed in 1946 and has undergone several improvement projects over the years. In order to convert the old hospital facility into the CDRH, the District plans to (i) demolish the old medical-surgical patient rooms to make room for a new entrance and lobby for the CDRH, (ii) convert the old emergency room into independent residential units, (iii) convert the old obstetrics and maternity department into a residential rehabilitation unit and (iv) construct patient rooms above the current surgery department in space that has been shelled in since the building was constructed. Additional upgrades will be made to the HVAC system, lighting, finishes, main entrance, exterior walls, roofing and landscaping. Only about 45,000 square feet of the old hospital facility will be renovated to provide for the CDRH facility, with the remaining approximate 23,000 square feet of space retained by the District for other healthcare related services yet to be determined. The CDRH will be owned by the District and managed pursuant to an initial two-year management contract with Addiction Medicine Services Inc. ("AMS"). AMS is a for-profit management company that brings experience in starting two successful chemical dependency operations.

The Hospital, the CCC, the CDRH and the District's outpatient facilities are herein referred to collectively as the Health Facilities. The Hospital facility is in compliance with all seismic requirements mandated by SB 1953, which statute requires certain acute care hospital facilities to meet rigorous seismic safety standards. None of the District's other Health Facilities are required to comply with SB 1953 earthquake retrofit requirements.

Administration

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

Jim Raggio, Administrator/CEO. Mr. Raggio began his duties at the Hospital in 1980, after serving many years and holding several positions in the health care field, including research laboratory technician at Children's Hospital of Los Angeles; medical technologist at Saint Mary's Hospital and Medical Center in San Francisco, medical technologist at the Veteran's Administration Hospital of San Francisco; hematology laboratory instructor at San Francisco State University; laboratory consultant at Vandenberg Air Force Base. He held the position of Laboratory Manager and the position of Director of Clinical Services at the Hospital before becoming the Administrator in 1998. He also served as the Administrator of Valley Medical Group of Lompoc, Inc.; Assistant to the Medical Director/Administrator of Mission Valley IPA and continues as Group Practice Consultant to Solvang Medical Clinic.

Mr. Raggio received his Bachelor of Science degree in Biology from Loyola University, Los Angeles, California, in 1974 and a Master of Health Administration degree from Chapman University, Santa Barbara, California, in 1993. He is currently a member of the American Society of Clinical Pathology, the American College of Health Care Executives and the Medical Group Management Association. Mr. Raggio has served on a variety of community and charitable organizations.

Naishadh Buch, Chief Operating Officer. Mr. Buch began his duties at the Hospital in early 2010, in his current position. Mr. Buch previously served as an Intern Pharmacist for Los Angeles County – USC Medical Center in Los Angeles, California; Wal-Mart in Oceanside, CA; Sav-On Drugs in Carlsbad, CA; and Veteran's Administration and Kaiser Permanente Medical Centers, Soripos Mercy Hospital in San Diego, CA (1996-2010). He also served as an Officer for the United States Marine Corps in various positions (1983-1994).

Mr. Buch received his Bachelor of Science degree in Mechanical Engineering from University of Reading, Reading, England, in 1982 and a dual–degree in Doctor of Pharmacy and Master of Business Administration from University of Southern California, Los Angeles, California, in 2001. He is currently a member of the Academy of Managed Care Pharmacy, the American Students' Alliance and serves as a reserve of the U.S. Marine Corps. Mr. Buch has served on a variety of community and charitable organizations.

Robert Baden, Associate Administrator/CFO. Mr. Baden began his duties at the Hospital in 1997, in his current position. Mr. Baden previously served as Administrator/CEO of Bear Valley Community Health Care District, Big Bear Lake, California, as an employee of Brim Healthcare, Inc. (1992-1997); and as Administrator/CEO of Sonoma Valley District Hospital, Sonoma, California (1974-1991). His experience also includes accounting positions in health care and other industries.

Mr. Baden received his Bachelor of Arts degree in Accounting and Economics from the University of North Dakota in 1964, and continued his education in business at Boston University. He is currently a member of the Healthcare Financial Management Association and has served on several health care organization boards and community associations.

Jayne Scalise, Chief Nursing Executive. Ms. Scalise joined the District in 2003, as the Chief Nursing Executive. Ms. Scalise has management responsibility for the nursing departments. She reports to the Administrator/CEO.

Ms. Scalise received her Bachelor of Arts degree in Nursing from the University of Nevada, Reno, Nevada, in 1981. She also received her Masters of Science degree in Nursing from that same university in 1991. Ms. Scalise's professional experience includes other nursing management positions.

Medical Staff

As of December 31, 2012, the medical staff at the Hospital consisted of 104 physicians (49 active staff). Approximately 90% of the active medical staff are board certified. The current medical staff includes 55 physicians who are provisional staff, emergency, courtesy staff or consulting staff members. Active medical staff members are the primary admitters to the Hospital. The Hospital's active medical staff has an average age of 55 years and, management believes, has a strong loyalty to the Hospital as evidenced by their average tenure of over 18 years.

The District has committed to recruiting four new physicians, a gastroenterologist, a general surgeon, an orthopedic surgeon and an internist over a two-year period. To date the District has been successful in recruiting a gastroenterologist, an internist and a general surgeon. Additionally, a psychiatrist and radiation oncologist are expected to be practicing in the Lompoc Valley within the next 12 months.

Health Facilities Staff

As of December 31, 2012, the District employed 637 total staff members with 456 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. Although the Hospital is not unionized, its CCC has one union with two bargaining units. Management is not aware of any pending union activity at the Hospital, and believes that relations with its employees are good.

Related Entities

Lompoc Hospital District Foundation. The Lompoc Hospital District Foundation is a nonprofit 501(c)(3) foundation established in 1990 to assist the District in capital fund-raising, community health education, and public relations (the "Foundation"). The Foundation has a membership of over 2,000 community members, employees, medical staff and an advisory board of approximately 80 trustees. The Foundation has raised just over $7,000,000 for the District since 1990.

Lompoc Hospital District Women's Auxiliary. The Lompoc Hospital District Women's Auxiliary is a nonprofit organization that was founded in the late 1940's to support the charitable purposes of the District. Today, the Auxiliary primarily operates the Hospital Gift Shop and provides services to patients and residents at the CCC.

Lompoc Valley Community Healthcare Organization. The Lompoc Valley Community Healthcare Organization (the "LVCHO") is a 501(c)(3) nonprofit community based organization that provides opportunities for the District to align itself with the community, payers and physicians with a mission of promoting healthy living through education and prevention, exploring innovative partnerships, and building a community-based network creating a coordinated and comprehensive health care system. The LVCHO provides access to healthcare services for the medically underserved within the Lompoc community and provides contracting opportunities with various payer entities. The LVCHO has launched the Healthy Lompoc Coalition, received grants to promote healthy eating for school children and supports the local emergency department on call panel, among other services. The LVCHO also functions as the third party administrator for healthcare services to the local Federal Bureau of Prisons.

Allan Hancock Community College. The District has agreements with the community college to provide clinical training for certified nursing assistants, licensed vocational nurses and registered nurses.

Service Area and Competition

The Hospital is the only acute care hospital located within its service area. The Hospital's service area is comprised of the west central portion of the County and includes the City of Lompoc and the communities of Buellton, Solvang, Santa Maria and Santa Ynez. The Hospital serves a semi-rural population with a large majority of its admissions coming from within its service area. The County is located in southwest California and has a current population of just over 427,000.

The Hospital's primary competitors include Santa Barbara Cottage Hospital, located approximately 50 miles southeast of the Hospital in the City of Santa Barbara, and Marian Medical Center, located approximately 30 miles north of the Hospital in the City of Santa Maria. The District refers patients primarily to Santa Barbara Cottage Hospital and UCLA Medical Center for services which are not provided at the Hospital. Services not provided at the Hospital include high risk obstetrics, angioplasty, cardiac cath and some high intensive cancer related cases. Based upon Office of Statewide Health Planning and Development data for the calendar year 2010, the Hospital maintained a 49% market share of inpatient discharges for its primary service area defined as the City of Lompoc. For the same period, Santa Barbara Cottage Hospital and Marin Medical Center captured 35% and 6%, respectively, of the Hospital's primary service area. The remaining 9% market share was spread among several other regional medical centers.

Services

The District presently offers a range of inpatient and outpatient services at the Hospital, including basic medical, surgical and obstetrical services, in addition to its general and administrative services. Medical and surgical services currently include the following:

Medical Services

Cardiopulmonary Therapy	Laboratory, Clinical	Pediatrics
CT/PET Scan	Laboratory, Pathology	Pharmacy
Diagnostic Radiology	Low Risk Maternity	Physical Therapy
General (FP/GP)	Magnetic Resonance Imaging (MRI)	Pulmonary Testing
Gynecology	Mammography	Respiratory Therapy
Hematology	Newborn Nursery	Sleep Lab
Intensive Care	Nuclear Medicine	Telemetry
Internal Medicine	Occupational Therapy	Ultrasound

Surgical Services

Anesthesiology	Ophthalmology	Outpatient
General	Orthopedics	Urology
Gynecology	Otolaryngology	Vascular

In addition, the Hospital provides 24-hour emergency medical services with a licensed physician on duty at all times. The District also provides long-term care services for the elderly at the CCC. Upon completion of the CDRH, the District will also provide a full continuum of chemical dependency services including acute medical detoxification, inpatient rehabilitation, residential level rehabilitation, partial hospitalization, an intensive outpatient program and sober housing units to extend care on an outpatient level.

Accreditations, Memberships and Designations

The Hospital is fully accredited by The Joint Commission with its most recent three-year accreditation effective beginning April 20, 2011, which is generally valid for a three-year cycle. Hospital management staff does not anticipate any difficulty in securing renewal of The Joint Commission accreditation upon the expiration of its current accreditation. The District has also received accreditations from the College of American Pathologist (laboratory services), the American Association of Blood Banks (blood bank services) and the American College of Radiology (diagnostic services).

The Health Facilities are eligible providers under Medicare, Medi-Cal, Blue Cross and other commercial insurance programs and the District holds memberships in the California Healthcare Association, the District Hospital Leadership Forum, and the Healthcare Association of Southern California.

The District plans for and evaluates potential affiliations as part of its overall strategic planning. At present, the District has affiliated with Amerinet to provide group purchasing services. No other affiliation agreements are in place and no serious discussions are occurring with other potential affiliation partners.

Bed Complement

The District currently has a licensed capacity of 170 beds (60 acute and 110 skilled nursing). It is anticipated that the District's licensed bed capacity will increase by a total of 50 licensed beds after completion of the CDRH. The current and proposed licensed bed count after completion of the CDRH classified by service type is as follows.

	Licensed Beds	
Service	Current	Proposed
Medical/Surgical	48	48
Intensive Care	6	6
Perinatal/Obstetrics	6	6
CDRH[1]	0	34
Residential[2]	0	16
Skilled Nursing	110	110
Total	170	220

Source: Current license by the State of California, Department of Public Health license and Proposed by Management of the District.
[1] Expected to be licensed by the State of California, Department of Public Health on a separate license from the Hospital.
[2] Expected to be licensed by the State of California, Department Drug and Alcohol Programs on a separate license from the Hospital.

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, and "Management's Analysis of Financial Performance" below. 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 are prepared in accordance with the pronouncements of the Governmental Accounting Standards Board ("GASB"). The statements of revenue, expenses and changes in net assets of the District for the three fiscal years ended June 30, 2012, are derived from the District's audited financial statements.

The summaries of the District's statements of revenue, expenses and changes in net assets for the eight-month periods ended February 29, 2012 and February 28, 2013, are unaudited and have been obtained from internally prepared 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 and footnotes 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 year as a whole.

(000's Omitted)	Fiscal Year Ended June 30 2010 (audited)	2011 (audited)	2012 (audited)	Eight-Months Ended February 29 or 28 2012 (unaudited)	2013 (unaudited)
Revenue:					
Net patient service revenue	$45,353	$53,755	$56,205	$34,941	$37,968
Other operating revenue	883	907	2,232	777	862
Total operating revenues	46,236	54,662	58,437	35,718	38,830
Total operating expenses	43,887	56,330	60,711	39,278	39,739
(Loss) gain from operations	2,349	(1,668)	(2,274)	(3,560)	(909)
Net nonoperating gains[(1)]	5,105	2,426	1,259	669	629
Increase (decrease) in net assets	$7,454	$ 758	$ (1,015)	$(2,891)	$(280)

Sources: Audited and unaudited financial statements of the District as indicated above.

(1) Tax revenues not provided as security for debt service on the Bonds for the fiscal years ended June 30, 2010, 2011 and 2012 were $3,635,944, $3,858,038 and $3,902,521, respectively.

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, 2010, 2011 and 2012. Marketable securities are carried at market value.

(000's Omitted)	As of June 30 2010 (audited)	2011 (audited)	2012 (audited)
Cash and cash equivalents	$ 6,764	$ 8,509	$ 7,023
Board designated funds	3,493	3,610	3,465
Total unrestricted funds	$10,257	$12,119	$10,488
Average daily expenses	$ 117	$ 147	$ 161
Days cash on hand	87	82	65

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

Management's Analysis of Financial Performance

Over the past three fiscal years, the District has realized a combined increase in net assets of $7,197,000 although in the fiscal year ended June 30, 2012, the District experienced a decrease in net assets of $1,015,000. District management believes that results for the fiscal year ending June 30, 2013, will again reflect an increase in net assets as improvements in cost monitoring and controls are reflecting improving profitability between the eight month period ended February 29, 2012 and the eight month period ended February 28, 2013, in spite of some slower patient activity in the latter period. The decrease in net assets for the eight month period ending February 29, 2012 was a negative $2,891,000 and the same eight month period ending on February 28, 2013 produced an improvement to a negative $280,000. The District also expects that when fully operational, the new CDRH will generate additional profitability that will help stabilize the fluctuations in the acute hospital environment.

Net patient revenue continues to increase, primarily due to a continued improvement in managed care contracting rates which were renegotiated in fiscal year 2012 and will benefit the District for the next three years. Another factor of increasing patient revenue is the availability of Inter Governmental Transfers ("IGTs") between the District, the State and the Federal government which provides matching funds equal to the amount the District supplies for the transfer. For example, the District sends $2,500,000 through the Medi-Cal Managed Care contractor

which in turn is passed on to the Federal Government. The Federal Government matches the $2,500,000 and passes it back to the State who in turn passes it to the Medi-Cal Managed Care contractor. The resulting $5,000,000 held by the Medi-Cal Managed Care contractor is passed on to the District to cover costs related to providing services to Medi-Cal patients covered by the Managed Care Plan.

Additionally, the District continues to recruit new physicians to the community to help further increase its market share of available patients. In the past two years, the District has recruited a new general surgeon, an OB/GYN, an urologist and a gastroenterologist who have all helped improve the Hospital's revenue generation. The District is currently in the process of recruiting for a new orthopedic surgeon, a psychiatrist and a radiation oncologist. Management believes that these cumulative key physician additions combined with its new Hospital facility will improve patient utilization at the Hospital.

Management also believes that as the economy of California begins to generate a surplus, business will begin hiring and small businesses that did not succeed during the past few years will be replaced. Management also expects that demand for District healthcare services will continue to increase as the impacts of the Affordable Care Act begin expanding coverage to currently uninsured patients.

These factors make management optimistic about the future financial growth and the long-term financial viability of the District and its Health Facilities.

Hospital Utilization

The table below presents selected statistical indicators of inpatient and outpatient activity at the Hospital and the CCC during the past three fiscal years ended June 30, 2010, 2011 and 2012 and for the eight-month periods ended February 29, 2012 and February 28, 2013.

	Fiscal Year Ended June 30			Eight Months Ended February 29 or 28	
	2010	**2011**	**2012**	**2012**	**2013**
Hospital:					
Licensed Beds	60	60	60	60	60
Patient Days[(1)]	8,089	8,821	8,767	5,488	5,517
Discharges	2,410	2,424	2,534	1,627	1,547
Occupancy	37%	40%	40%	37%	38%
Average Length of Stay (days)	3.36	3.64	3.46	3.37	3.57
Outpatient Visits	41,221	41,695	42,061	27,965	27,251
Emergency Room Visits	18,013	19,534	20,551	13,704	14,127
CCC:					
Licensed Beds	110	110	110	110	110
Patient Days	35,937	37,519	36,846	24,443	24,754
Occupancy	90%	93%	92%	91%	93%

Source: District records.
(1) Excludes newborn days.

Sources of Patient Service Revenue

The District participates in the Medicare and Medi-Cal programs. The percentage of gross patient revenues derived from Medicare, Medi-Cal, insurance and managed care contracts and all other sources for each of the past three fiscal years ended June 30, 2010, 2011 and 2012 is set forth below. Because of varying contractual allowances to third-party payors, net patient revenues may not correspond directly to gross patient revenues.

	Fiscal Year Ended June 30		
	2010	2011	2012
Medicare	34%	38%	38%
Medi-Cal	26	25	25
Insurance, contracts & other	40	37	37
Total	100%	100%	100%

Source: District records.

Medicare is a federal program, administered by the Centers for Medicare and Medicaid Services ("CMS"), 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.

Adults who do not meet Medi-Cal eligibility criteria but who are medically indigent are eligible for medical services under the state-funded County Medically Indigent Adult's Program ("MIA"). For patients who are eligible for MIA medical services provided at the Hospital, the District contracts with the County of Santa Barbara. The MIA contract accounts for approximately 1% of gross patient revenues generated at the Hospital.

The District has contracts with approximately 30 prepaid plans and preferred provider discount contractors which comprise approximately 35% of its revenues. 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.

The Hospital and the CCC are Disproportionate Share providers and serve a medically underserved population. Both facilities receive more favorable reimbursement for Medi-Cal beneficiaries who are treated at their facilities as a result of the Disproportionate Share designations.

Public and Professional Liability Insurance Considerations

The District currently carries comprehensive liability insurance through a pooled self-insurance program insuring the Hospital, the CCC and all District employees, while acting within the scope of their duties, against malpractice liability with limits of $10,000,000 per claim and annual aggregate. The District's current comprehensive liability insurance contract is in continuous effect until July 1, 2013. The District contracts such insurance through a joint powers authority (the "BETA Risk Management Authority") under California law authorizing governmental agencies, such as local health care districts, to join together for insurance purposes. Currently, 91 participants representing health care districts, nonprofit, city and county hospitals participate in the BETA Risk Management Authority. Coverage is on a claims-made basis.

The BETA Risk Management Authority is funded by monthly contributions paid by participating members. The contributions are used to fund a reserve for expected losses to be paid by the BETA Risk Management Authority 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 $265,089 in net contributions to the BETA Risk Management Authority.

As of June 30, 2012, the BETA Risk Management Authority had a reserve for claims and claims expenses relating to the District of $132,426. For the fiscal year ended June 30, 2012, the BETA Risk Management Authority paid claims and claims expenses on behalf of the District totaling $514,847.

The District is unaware of any claim paid on its behalf which was not covered by insurance. There are no material malpractices or professional liability claims or lawsuits now pending against the District which exceed insurance coverage. The District does not currently have pending any malpractice or professional liability claims or lawsuits for compensatory damages not covered by insurance. In California, district health care providers like the District are not subject to punitive damage awards.

Property damage liability is covered by Alliant Insurance Services. The District carries earthquake and flood insurance to cover the Hospital, the CDRH and the CCC against damages with a $40,000,000 coverage amount.

The District is self-funded for its workers' compensation and has been issued a Certificate of Consent to self-insure by the State of California, Department of Industrial Relations. The District purchases excess liability insurance to provide coverage for workers' compensation claim exposures over its self-insurance retention limit of $750,000. Workers' compensation expense for the years ended June 30, 2011 and 2012, was $294,094 and $1,118,259, respectively.

The District is carrying separate insurance covering its risks on the CDRH during construction with Alliant Insurance Services.

Employees' Retirement Plan

The District has a deferred compensation employee retirement plan under Internal Revenue Code Section 457 in which the majority of employees who have completed three or more years of continuous service are eligible to participate. Individual employee contributions are allowed in accordance with the terms of the plan. The District is required to contribute from 4% to 13% of an employee's salary, in accordance with the retirement plan terms, to the retirement plan if the employee elects eligibility. Amounts expensed totaled $512,453 and $685,700 during the fiscal years ended June 30, 2011 and 2012, respectively.

Plan benefits are not available to employees until termination, retirement, death or an unforeseeable emergency. The plan assets were considered the property of the District, subject to claims of the District's general creditors, until paid or made available to the participating employees. During 1997, the District placed the assets of the deferred compensation plan into a trust, where the assets are no longer subject to the claims of the District's general creditors. As a result of the assets being transferred, they are no longer reflected on the District's balance sheet. Investments are managed by the plan trustee with the choice of investment options made by the plan participants.

Since July 1, 2011, the District offers a 401(a) employer funded retirement plan to eligible employees. Employees are vested based upon a "tiered" schedule, with 100% vesting after three years.

Service Area Economy

During the past thirty-two years the populations of the City of Lompoc and Santa Barbara County have increased 63% and 43%, respectively, while the population of the State of California has increased 59% over the same period. Population figures as reported for the 1990, 2000 and 2010 census reports and estimates for 2012 for the City of Lompoc, Santa Barbara County, and the State of California are as follows:

	1980	1990	2000	2010	2012	% Change
City of Lompoc	26,267	37,649	41,103	42,434	42,854	63%
Santa Barbara County	298,694	369,608	399,347	423,895	427,267	43%
California	23,667,764	29,760,021	33,871,648	37,253,956	37,678,563	59%

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 figures are estimates as of January 1.

Although the area served by the Hospital is known primarily for agriculture, other industries such as government, retail and manufacturing industries play a significant role in the local economy. Unemployment in the City of Lompoc and Santa Barbara County during December of 2012 was 13.7% and 7.7%, respectively, while unemployment for the State of California for the same period was 9.7%.

	City of Lompoc	Santa Barbara County	State of California
Civilian Labor Force	21,100	229,400	18,489,600
Employment	18,200	211,800	16,689,200
Unemployment	2,900	17,600	1,800,400
Percentage Unemployment	13.7%	7.7%	9.7%

Source: State Employment Development Department, December, 2012.

Capital Expenditures

Aside from construction and equipping costs related to the construction of the CDRH, total capital expenditures of approximately $2,500,000 are expected to occur over the next three years beginning with the fiscal year ended June 30, 2013. Funding for the CDRH will include a combination of operating cash flows, community donations and proceeds from revenue bonds of the District. As for the other planned capital expenditures over the next three years, they represent regular annual expenditures made in connection with the normal routine maintenance and equipment replacement for the Health Facilities and are planned to be funded from cash reserves and community-based contributions.

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 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 $4,311,101,588, which accounts for approximately 6.9% of the County's assessed valuation of $62,524,066,192, as of the same period. Assessed values of property within the District have increased by approximately 76% from 2001-02 to 2012-13, while assessed values for the County have increased by approximately 78% over the same period. The summary below shows an twelve-year history of the total secured and unsecured assessed property valuations for the District and total assessed valuations for Santa Barbara County.

Assessed Valuations [(1)]

Fiscal Year	Local Secured	Utility	Unsecured	District Assessed Valuations	County Assessed Valuations
2001-02	$2,159,318,246	$1,999,704	$290,759,603	$2,452,077,553	$35,146,006,886
2002-03	2,294,729,229	2,724,671	439,084,252	2,736,538,152	37,832,721,832
2003-04	2,495,977,472	3,087,026	347,931,393	2,846,995,891	40,598,686,081
2004-05	2,803,183,766	3,324,460	426,809,636	3,233,317,862	44,150,370,776
2005-06	3,188,930,240	3,197,428	443,224,139	3,635,351,807	48,826,220,433
2006-07	3,633,152,425	3,102,667	475,758,677	4,112,013,769	53,808,515,838
2007-08	3,901,995,149	1,692,215	446,335,873	4,350,023,237	57,684,783,543
2008-09	4,002,597,106	1,422,215	438,157,764	4,442,177,085	60,373,089,637
2009-10	3,848,535,449	1,273,429	443,258,610	4,293,067,488	60,928,015,580
2010-11	3,887,240,812	1,273,429	461,328,602	4,349,842,843	61,185,807,716
2011-12	3,961,232,307	1,273,429	423,717,778	4,386,223,514	61,995,729,403
2012-13	3,902,847,801	84,520	408,169,267	4,311,101,588	62,524,066,192

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 tables show a ten-year history (ending with the fiscal year 2011-12) of the secured tax charge, the tax amount delinquent and percentage of taxes delinquent each year as of June 30, for the County and a six-year history for the District (ending with fiscal year 2011-12) containing the same information. Information was not available for the fiscal year 2012-13.

Secured Tax Charges and Delinquencies for Santa Barbara County

Fiscal Year	Secured Tax Charge [1]	Delinquent as of June 30 Amount	Delinquent as of June 30 Percent
2002-03	$388,324,409	$ 3,917,438	1.01%
2003-04	418,817,553	2,531,528	0.60
2004-05	456,066,957	4,842,493	1.06
2005-06	509,476,318	6,595,483	1.29
2006-07	568,885,392	11,879,297	2.09
2007-08	611,512,910	14,643,336	2.39
2008-09	643,298,916	17,631,803	2.74
2009-10	649,532,347	15,163,809	2.33
2010-11	655,635,036	10,538,710	1.61
2011-12	663,045,069	8,029,628	1.21

Source: California Municipal Statistics, Inc.

[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.

Secured Tax Charges and Delinquencies for the District

Fiscal Year	Secured Tax Charge [1]	Delinquent as of June 30 Amount	Delinquent as of June 30 Percent
2006-07	$2,183,488.13	$ 71,239.81	3.26%
2007-08	2,296,025.95	80,561.97	3.51
2008-09	3,552,034.04	130,642.08	3.68
2009-10	3,426,827.51	113,982.40	3.33
2010-11	3,461,985.51	89,995.46	2.60
2011-12	3,432,693.10	59,466.86	1.73

Source: California Municipal Statistics, Inc.

[1] District's general obligation bond debt service levy.

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 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 1-000, a tax rate area within the District, for the ten fiscal years ending with the fiscal year 2012-13.

Typical Total Tax Rates

Fiscal Year	General	Lompoc Unified School District	Lompoc Valley Medical Center	Allan Hancock Community College District	Total
2003-04	1.00000	.05995	-	-	1.05995
2004-05	1.00000	.04684	-	-	1.04684
2005-06	1.00000	.05135	-	-	1.05135
2006-07	1.00000	.05084	.06104	.02500	1.13688
2007-08	1.00000	.04982	.05986	.02475	1.13443
2008-09	1.00000	.06000	.09080	.02500	1.17580
2009-10	1.00000	.06000	.09080	.02500	1.17580
2010-11	1.00000	.06000	.09080	.02500	1.17580
2011-12	1.00000	.06360	.09080	.02500	1.17940
2012-13	1.00000	.07123	.09988	.02500	1.19611

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 March 18, 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: $4,311,101,588

DIRECT AND OVERLAPPING TAX AND ASSESSMENT DEBT:	% Applicable	Debt 3/1/13
Allan Hancock Joint Community College District	19.907%	$ 25,986,837
Lompoc Unified School District	99.924	31,756,817
Buellton Union School District	1.965	176,555
Lompoc Valley Medical Center	**100.**	**73,610,000**[1]
Lompoc Park Maintenance and City Pool Assessment District No. 2	100.	2,265,000
TOTAL DIRECT AND OVERLAPPING TAX AND ASSESSMENT DEBT		133,795,209
OVERLAPPING GENERAL FUND DEBT:		
Santa Barbara County Certificates of Participation	6.895%	4,789,267
Santa Ynez Valley Union High School District Certificates of Participation	3.084	97,300
Buellton Union School District Certificates of Participation	1.867	10,175
TOTAL OVERLAPPING GENERAL FUND DEBT		4,896,742
OVERLAPPING TAX INCREMENT DEBT:		14,405,000
COMBINED TOTAL DEBT		$153,096,951[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 ($73,610,000) 1.71%
Total Direct and Overlapping Tax and Assessment Debt 3.10%
Combined Total Debt 3.55%

Ratios to Redevelopment Incremental Valuation ($267,157,268):
Total Overlapping Tax Increment Debt 5.39%

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 $504,934,446 or 12.94% of the District's 2012-13 secured assessed value.

	Property Owner	Primary Land Use	2012-13 Assessed Valuation	% of Total [1]
1.	Celite Corporation	Industrial – Mining	$105,503,507	2.70%
2.	Plains Exploration & Production	Petroleum/Gas	68,570,078	1.76
3.	Windscape Apartments I LLC	Apartments	44,416,598	1.14
4.	Raytheon Company	Industrial	29,074,224	0.74
5.	Foley Estates Vineyard & Winery	Vineyards	21,573,121	0.55
6.	Shoot the Breeze Ltd.	Apartments	20,148,907	0.52
7.	KW Ravenswood LLC	Apartments	19,000,000	0.49
8.	Castle Mountain Ranch West LLC	Agricultural/Rural	18,608,419	0.48
9.	Terlato Wine Group Ltd.	Vineyards	18,177,195	0.47
10.	Centro Watt Property Owner II LLC	Shopping Center	17,500,000	0.45
11.	California California Oaks LLC	Agricultural/Rural	17,476,618	0.45
12.	Majestic Advisors LLC	Shopping Center	16,926,568	0.43
13.	Remington Parcels LLC	Agricultural/Rural	15,407,276	0.39
14.	California Ocean Oaks LLC	Agricultural/Rural	15,248,717	0.39
15.	California Ocean Gardens LLC	Agricultural/Rural	14,744,913	0.38
16.	Preston Parcels LLC	Agricultural/Rural	13,306,741	0.34
17.	California Mountain Gardens LLC	Agricultural/Rural	13,028,145	0.33
18.	California Mountain Oaks LLC	Agricultural/Rural	12,569,249	0.32
19.	Rancho Salsipuedes Vineyard LLC	Vineyards	11,924,170	0.31
20.	Heritage Villas LP	Assisted Living Facility	11,730,000	0.30
	Total		$504,934,446	12.94%

Source: California Municipal Statistics, Inc.
(1) 2012-13 Local Secured Assessed Valuation for the District is: $3,902,847,801

Largest Employers

The City of Lompoc and the County enjoy a diverse labor pool as a result of their role as a regional manufacturing, service and retail center. The County's agriculturally dominated employment distribution affects the City of Lompoc's job market and unemployment rates. Because of the need to retrain workers as the economy evolves, the City of Lompoc and the County utilize a network of job training providers to ensure the maintenance of an abundant and 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.

Santa Barbara County
Largest Employers

Company	Product/Service	Employees
UC Santa Barbara	Education	6,200
County of Santa Barbara	Government	4,000
Santa Barbara Cottage Hospital	Healthcare	2,500
Santa Barbara City College	Education	2,000
Santa Barara High School District	Education	1,800
Sansum Medical Clinic	Healthcare	1,500
Raytheon	Manufacturer	1,500
City of Santa Barbara	Government	1,000
U.S. Postal Service	Government	1,000
Santa Barbara Bank & Trust [1]	Banking	950

Source: Santa Barbara Chamber of Commerce and City of Santa Barbara.
[1] Acquired by Union Bank in 2012.

Commercial Activity

The City of Lompoc is the retail center for the District and experienced a 11.9% decline in retail sales from 2008 to 2010, and the County experienced an 9.8% 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 Lompoc and the County for the calendar years 2008, 2009 and 2010. Information is not yet available for the full year of 2011.

City of Lompoc and Santa Barbara County
Taxable Transactions and Total Outlets
2008-2010

	2008	2009	2010
City of Lompoc			
Sales Tax Permits	886	795	786
Taxable Sales	$330,816,000	$283,281,000	$291,357,000
Santa Barbara County			
Sales Tax Permits	13,114	12,303	12,298
Taxable Sales	$5,883,938,000	$5,104,186,000	$5,309,768,000

Source: State Board of Equalization.

Agriculture

The County region is one of the most agriculturally diverse and productive in the United States. Livestock, poultry, strawberries, broccoli, wine grapes, head lettuce, cauliflower, celery, avocados, gerbera cut flowers, leaf lettuce and lilly cut flowers 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 fourteenth 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.

Santa Barbara County
Estimated Value Agricultural Production
(000s Omitted)

	2008	2009	2010	2011
Vegetable Crops	$ 451,513,643	$ 469,315,254	$ 436,289,402	$ 437,149,140
Fruit & Nut Crops	451,599,763	547,395,656	558,194,581	519,664,230
Nursery Products	176,512,770	170,322,274	172,378,357	179,288,684
Field Crops	12,677,926	12,271,609	12,090,451	11,890,527
Seed Crops	10,390,359	10,336,557	9,777,837	9,635,385
Livestock & Poultry	26,388,307	23,608,424	23,176,168	28,662,090
Livestock, Poultry & Apiary Products	8,267,350	8,150,727	8,088,609	8,089,000
Total	$1,137,350,118	$1,241,400,501	$1,219,995,405	$1,194,379,056

Source: Santa Barbara 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 April 16, 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 revenue bonds issued by it in 1998 and 2009 and with respect to the 2006 Bonds and the 2007 Bonds.

The District has acknowledged that with respect to the 2006 Bonds and 2007 Bonds certain information for 2009, 2010 and 2011 concerning assessed values of taxable property in the District, tax levies and delinquencies was submitted late to Electronic Municipal Market Access ("EMMA"), but such information is currently available on EMMA and has been since March of 2012. Additionally, the District has determined that with respect to its 2009 revenue bonds, certain continuing disclosure was submitted somewhat late and one quarterly report in 2010 was not submitted. These revenue bonds have been fully repaid.

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 2006 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.

LOMPOC VALLEY MEDICAL CENTER

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
Lompoc Valley Medical Center
1515 East Ocean Avenue
Lompoc, California 93436

OPINION: $42,165,000* Lompoc Valley Medical Center (Santa Barbara 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 Lompoc Valley Medical Center (the "District") in connection with the issuance by the District of $42,165,000* principal amount of Lompoc Valley Medical Center (Santa Barbara 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. 291, adopted by the Board of Directors (the "Board") of the District on March 28, 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

LOMPOC VALLEY MEDICAL CENTER

June 30, 2012

TCA Partners, LLP
Certified Public Accountants

Audited Financial Statements

LOMPOC VALLEY MEDICAL CENTER

June 30, 2012

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Management's Discussion and Analysis

LOMPOC VALLEY MEDICAL CENTER

June 30, 2012

The management of the Lompoc Valley Medical Center (the Hospital) has prepared this annual discussion and analysis in order to provide an overview of the Hospital's 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.* The intent of this document is to provide additional information on the Hospital's historical financial performance as a whole in addition to providing a prospective look at revenue growth, operating expenses, and capital development plans. This discussion should be reviewed in conjunction with the audited financial statements for the fiscal year ended June 30, 2012 and accompanying notes to the financial statements to enhance one's understanding of the Hospital's financial performance.

Financial Summary

- Total assets increased by $2.6 million over the prior fiscal year. Total operating cash and cash equivalents decreased by $1.5 million over the prior year (see the *Statements of Cash Flows* for changes). In addition, net patient accounts receivable decreased by $287,000. As a result, net days in patient accounts receivable were 43.21 at June 30, 2012 as compared to 47.00 in the prior year.
- Current assets increased by $3.0 million and current liabilities increased by $2.4 million over the prior fiscal year to provide a current ratio of 2.3 for 2012 versus 2.6 for the prior year.
- The operating loss was $(2.3) million for fiscal year 2012 as compared to an operating loss of $1.7 million for the prior year.
- The decrease in net assets was $1.0 million for the current fiscal year as compared to an increase in net assets of $758,000 for the prior fiscal year.
- Net patient revenues increased by $2.5 million while operating expenses increased by $4.4 million for the year.
- Governmental supplemental programs combined for approximately $5.9 million in additional reimbursement for the year.

Cash and Investments

For the fiscal year ended June 30, 2012, the Hospital's operating and board designated cash and investments totaled $8.4 million as compared to $10.2 million in fiscal year 2011. At June 30, 2012, days cash on hand was 52.50 as compared to the target of 100. At June 30, 2011, days cash on hand was 68.85. The Hospital maintains sufficient cash and cash equivalent balances to pay all short-term liabilities.

Current Liabilities

As previously noted, current liabilities of the Hospital increased by $2.4 million. This was due mainly to a significant increase in current maturities of debt, accounts payable and accrued expenses of $2.1 million coupled with minor increases and decreases in the other areas of current liabilities.

Capital Assets

Capital assets increased by $331,000 with new assets of $6.0 million being purchased but offset by $5.9 million in depreciation. The $6.0 million increase in capital assets was due mainly to $5.5 million in new construction projects for the improvement of areas of the hospital.

Volumes

- Acute patient days were 8,767 for fiscal year 2012 as compared to 8,821 for the prior year representing a 1% decrease over the prior year. The 54-patient day decrease was not a significant change from the prior year.

- The hospital-based skilled nursing unit had an ADC of 100.67 for the fiscal year 2012, equaling a total of 36,846 patient days. The prior year ADC was 102.79 for a total of 37,519 patient days.

- Surgery cases for the fiscal year 2012 were slightly higher than the prior year. There were 2,347 cases as compared to 2,335 cases for the prior fiscal year.

- There was a 1% increase in Lab tests; 185,856 in the fiscal year 2012 as compared to 184,483 for the prior fiscal year.

- There was an increase in Emergency Room visits; 20,551 in the fiscal year 2012 as compared to 19,534 for the prior year.

- There was a slight 1% increase in Outpatient visits; 42,061 visits in the year 2012 as compared to 41,695 visits for the prior year.

- X-Ray procedures were 16,364 in 2012 as compared to 18,804 in the prior year. MRI procedures were 2,366 in 2012 as compared to 2,315 in 2011. CT Scans were 5,203 in 2012 as compared to 5,882 in 2011.

Gross Patient Charges

The Hospital charges all its patients equally based on its established pricing structure for the services rendered. Generally, on an annual basis, the Hospital increases its charges.

Acute inpatient gross charges increased by $1.8 million. As previously stated, the Hospital generally increases its charges on an annual basis. Other changes are accounted for by volumes between years.

Outpatient gross charges increased by $3.4 million. These increases are due to a combination of price increases and volume changes in service areas.

Deductions From Revenue

Deductions from revenue are comprised of contractual allowances and provisions for bad debts. Contractual allowances are computed deductions based on the difference between gross charges and the contractually agreed upon rates of reimbursement with third party government-based programs such as Medicare and Medi-Cal and other third party payors such as Blue Cross.

Traditional charity care, uncompensated care, administrative write-offs and the provision for bad debts for fiscal year 2012 and fiscal year 2011 were $7.6 million and $4.2 million, respectively. As a percentage of gross patient charges, the write off increased from 4.4% in fiscal year 2011 to 7.6% in fiscal year 2012.

Contractual allowances and the provision for bad debts (as a percentage of gross patient charges) were 44.01% for fiscal year 2012 as compared to 43.48% for prior fiscal year. The decrease in contractual allowances was due primarily to the increase in government sponsored supplemental programs as previously mentioned.

Net Patient Service Revenues

Net patient service revenues are the resulting difference between gross patient charges and the deductions from revenue. Net patient service revenues increased by $2.5 million in fiscal year 2012 over the prior year due to a combination of rate increases, the increase in governmental supplemental programs (treated as reimbursement) and volume increases.

Operating Expenses

Total operating expenses were $60.7 million for fiscal year 2012 compared to $56.3 million for the prior fiscal year. The 7.8% increase was due generally to volume increases and inflationary factors. Noted changes occurred primarily in the following areas:

- A $3.0 million increase in salaries, wages and benefits. Full time equivalents (FTE's) increased from 444 in 2011 to 457 in 2012. Increases in worker's compensation accounted for just over $1.1 million.
- Variable expense categories generally subject to volumes (professional fees, registry, supplies, and purchased services) increased by only $586,000 as management was able to hold these expenses in check.
- Depreciation expense remained fairly the same with just a slight decrease of $330,000 as certain equipment exceeded their useful life.
- All other expense categories (utilities, insurance and other) increased by $1.1 million, due mainly to the State fees associated with the intergovernmental transfers.

Economic Factors and Next Fiscal Year's Budget

The Hospital's Board approved the fiscal year ending June 30, 2013 budget at its July 2012 meeting. For fiscal year 2013, the Hospital has used the following assumptions to develop their budget for the next year:

- A conservative increase in volumes for fiscal year 2013 was budgeted, with consideration given to the limited number of new programs the Hospital will have the ability to fund.
- The government-based providers and other third party insurers are not raising their reimbursement rates in relation to the budgeted increase in gross charges. Therefore, the percentage of contractual allowances is budgeted to increase and the percentage of net patient service revenues should decrease.
- Operating expenses are expected to increase at a higher percentage than revenues. The cost for nursing and other medically trained staff increases at a higher rate than the increase in net revenue. The cost of supplies, such as pharmaceuticals, is increasing at a higher rate than gross charges. In addition, with the new hospital now in service, depreciation expense is projected to increase and interest expense is now a "period" expense recorded in the Statement of Revenues, Expenses and Changes in Net Assets rather than a "capital" expense which was formerly capitalized as part of the construction costs of the new hospital. Interest expense will also increase due to new equipment purchases being funded by new financing arrangements.

In order to increase the number of inpatients at the acute facility, the Hospital is continuing its search for new primary care physicians and other specialists.

TCA Partners, LLP

A Certified Public Accountancy Limited Liability Partnership
1111 East Herndon Avenue, Suite 211, Fresno, California 93720
Voice: (559) 431-7708 Fax: (559) 431-7685 Email: rjctcpa@aol.com

Report of Independent Auditors

The Board of Directors
Lompoc Valley Medical Center
Lompoc, California

We have audited the accompanying balance sheets of Lompoc Valley Medical Center, a district hospital (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. Our audits included consideration of internal controls over financial reporting as a basis of designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Hospital's internal controls over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, 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 the Hospital at June 30, 2012 and 2011, and the changes in its net assets 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

October 12, 2012

Balance Sheets

LOMPOC VALLEY MEDICAL CENTER

	June 30	
	2012	2011
Assets		
Current assets:		
Cash and cash equivalents	$ 7,022,700	$ 8,508,971
Assets limited as to use available for current debt service	2,712,890	2,286,913
Patient accounts receivable, net of allowances	6,635,457	6,922,308
Other receivables and physician advances	8,350,995	4,183,010
Inventories	656,812	673,092
Prepaid expenses and deposits	1,026,173	855,550
Total current assets	26,405,027	23,429,844
Assets limited as to use	3,832,780	4,424,574
Capital assets, net of accumulated depreciation	95,773,468	95,442,666
Other assets	412,505	486,055
Total assets	$126,423,780	$123,783,139
Liabilities and Net Assets		
Current liabilities:		
Current maturities of debt borrowings	$ 2,377,051	$ 1,514,538
Accounts payable and accrued expenses	4,538,106	3,293,816
Accrued payroll and related liabilities	3,546,921	3,333,694
Workers' compensation claims payable, current portion	486,780	408,647
Estimated third party payor settlements, net	354,606	398,339
Total current liabilities	11,303,464	8,949,034
Workers' compensation claims payable, less current portion	1,356,670	1,319,561
Debt borrowings, net of current maturities	80,355,871	79,091,801
Total liabilities	93,016,005	89,360,396
Net assets:		
Invested in capital assets, net of related debt	15,132,744	16,785,410
Restricted, by bond indenture agreements for debt service	3,081,118	3,100,857
Unrestricted	15,193,913	14,536,476
Total net assets	33,407,775	34,422,743
Total liabilities and net assets	$126,423,780	$123,783,139

See accompanying notes and auditor's report

Statements of Revenues, Expenses and Changes in Net Assets

LOMPOC VALLEY MEDICAL CENTER

	Year Ended June 30	
	2012	2011
Operating revenues		
Net patient service revenue	$ 56,205,067	$ 53,754,698
Other operating revenue	2,232,138	907,467
Total operating revenues	58,437,205	54,662,165
Operating expenses		
Salaries and wages	25,111,527	23,732,868
Employee benefits	9,330,859	7,741,075
Professional and other fees	1,789,840	1,911,764
Registry	1,797,149	2,021,599
Supplies	8,615,261	8,359,440
Purchased services	3,756,049	3,079,589
Utilities	1,054,538	1,055,922
Insurance	510,035	522,880
Depreciation and amortization	5,967,030	6,297,482
Other operating expenses	2,778,401	1,606,959
Total operating expenses	60,710,689	56,329,578
Operating income (loss)	(2,273,484)	(1,667,413)
Nonoperating revenues (expenses)		
District tax revenues	4,712,320	4,668,645
Investment income	22,599	40,181
Interest expense	(3,946,406)	(3,887,436)
Gain on disposals of property	2,215	17,030
Grants and contributions	467,788	1,587,131
Total nonoperating revenues (expenses)	1,258,516	2,425,551
Increase (decrease) in net assets	(1,014,968)	758,138
Net assets at beginning of the year	34,422,743	33,664,605
Net assets at end of the year	$ 33,407,775	$ 34,422,743

See accompanying notes and auditor's report

Statements of Cash Flows

LOMPOC VALLEY MEDICAL CENTER

	Year Ended June 30	
	2012	2011
Cash flows from operating activities:		
Cash received from patients and third-parties on behalf of patients	$ 53,948,185	$ 52,629,619
Cash received from operations, other than patient services	564,153	171,282
Cash payments to suppliers and contractors	(28,542,185)	(29,003,943)
Cash payments to employees and benefit programs	(24,783,058)	(23,388,046)
Net cash provided by operating activities	1,187,095	408,912
Cash flows from noncapital financing activities:		
District tax revenues	809,799	810,607
Grants and contributions	467,788	1,587,131
Net cash provided by noncapital financing activities	1,277,587	2,397,738
Cash flows from capital and related financing activities:		
District tax revenues related to capital financing from bonds	3,902,521	3,858,038
Purchase of capital assets, including gain or loss on disposals	(6,222,067)	(5,182,243)
Proceeds from debt borrowings	4,000,000	3,900,000
Principal payments on debt borrowings	(1,873,417)	(5,608,550)
Interest on debt borrowings, net of capitalized interest	(3,946,406)	(3,887,436)
Net cash (used in) capital financing activities	(4,139,369)	(6,920,191)
Cash flows from investing activities:		
Net (purchase) or sale of investments and other assets	165,817	5,818,190
Interest received from investments, net of capitalized interest	22,599	40,181
Net cash provided by investing activities	188,416	5,858,371
Net increase (decrease) in cash and cash equivalents	(1,486,271)	1,744,830
Cash and cash equivalents at beginning of year	8,508,971	6,764,141
Cash and cash equivalents at end of year	$ 7,022,700	$ 8,508,971

See accompanying notes and auditor's report

Statements of Cash Flows (continued)

LOMPOC VALLEY MEDICAL CENTER

	Year Ended June 30	
	2012	2011
Reconciliation of operating income to net cash provided by operating activities:		
Operating income (loss)	$ (2,273,484)	$ (1,667,413)
Adjustments to reconcile operating income to net cash provided by operating activities:		
Depreciation and amortization	5,967,030	6,297,482
Provision for uncollectible accounts	5,205,267	3,023,839
Changes in operating assets and liabilities:		
Patient accounts receivables	(4,918,416)	(4,288,318)
Other receivables	(4,167,985)	(736,185)
Inventories	16,280	(3,311)
Prepaid expenses and deposits	(170,623)	(479,810)
Accounts payable and accrued expenses	1,244,290	(2,221,594)
Accrued payroll and related liabilities	213,227	566,398
Estimated third party payor settlements	(43,733)	139,400
Workers' compensation claims payable	115,242	(221,576)
Net cash provided by (used in) operating activities	$ 1,187,095	$ 408,912

See accompanying notes and auditor's report

NOTE A - ORGANIZATION AND SIGNIFICANT ACCOUNTING POLICIES

Reporting Entity: Lompoc Valley Medical Center (the Hospital) is a public entity healthcare district 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 governed by a five-member Board of Directors, elected from within the district to specified terms of office. The Hospital is located in Lompoc, California and operates a 60-bed acute care facility, a 110-bed skilled nursing facility, and other patient services. 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.

Changes in Financial Statement Presentation: Effective July 1, 2002, the Hospital 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. The impact of this change was related 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 had 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 A - ORGANIZATION AND SIGNIFICANT 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 nonoperating 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.

Inventories: Inventories are consistently reported from year to year at cost determined on combination of first-in, first-out (FIFO) basis for certain types of inventory and replacement values which are not in excess of market, for other types of inventory.

Assets Limited as to Use: Assets limited as to use include contributor restricted funds, amounts designated by the Board of Directors for replacement or purchases of capital assets, and other specific purposes, and amounts held by trustees under specified agreements. Assets limited as to use consist primarily of deposits on hand with local banking and investment institutions, and bond trustees.

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 significantly impaired.

NOTE A - ORGANIZATION AND SIGNIFICANT ACCOUNTING POLICIES (continued)

Bond Issue Costs: Bond issue costs are comprised of deferred financing cost of the issuance of revenue bonds and the general obligation bonds. Amortization of these issuance costs is computed by the straight-line method over the life of the repayment agreements. For current and advance refundings which result in defeasance of debt, the difference between the reacquisition price and the net carrying amount of the old debt, together with any unamortized deferred financing costs, is deferred and amortized over the remaining life of the old debt or the life of the new debt, whichever is shorter, in accordance with GASB 23. Net amortization and accretion were $73,550 and $61,182 for the years ended June 30, 2012 and 2011, respectively.

Compensated Absences: The Hospital's employees earn paid-time-off (PTO) benefits at varying rates depending on years of service. PTO benefits can accumulate up to specified maximum levels. Employees are paid for PTO accumulated benefits if they leave either upon termination or before retirement. Accrued PTO liabilities as of June 30, 2012 and 2011 were $1,926,406 and $2,081,723, 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.

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.

NOTE A - ORGANIZATION AND SIGNIFICANT ACCOUNTING POLICIES (continued)

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.

District Tax Revenues: The Hospital receives approximately 10% of its financial support from property taxes. These funds are used to support operations and meet required debt service agreements. They are classified as non-operating revenue as the revenue is not directly linked to patient care. Property taxes are levied by the County on the Hospital's behalf during the year, and are intended to help finance the Hospital's activities during the same year. Amounts are levied on the basis of the most current property values on record with the County. The County has established certain dates to levy, lien, mail bills, and receive payments from property owners during the year. Property taxes are considered delinquent on the day following each payment due date.

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 nonoperating 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. Nonoperating revenues and expenses are those transactions not considered directly linked to providing health care services.

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 B - CASH AND CASH EQUIVALENTS

As of June 30, 2012 and 2011, the Hospital had deposits invested in various financial institutions in the form of operating cash and cash equivalents amounted to $7,889,125 and $7,939,754. All of these funds were held in deposits, which are collateralized in accordance with the California Government Code (CGC), which are 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 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.

NOTE C - NET PATIENT SERVICE REVENUES

The Hospital has agreements with third-party payors that provide for payments to the Hospital at amounts different from its established rates. A summary of the payment arrangements with major third-party payors follows:

Medicare: Payments for inpatient acute care services rendered to Medicare program beneficiaries are based on prospectively determined rates, which vary accordingly to the patient diagnostic classification system. Outpatient services are generally paid under an outpatient classification system subject to certain limitations. The Hospital is, generally, no longer subject to cost reimbursable services. Certain reimbursement areas are still subject to final settlement determined after submission of annual cost reports and audits thereof by the Medicare fiscal intermediary. At June 30, 2012, cost reports through June 30, 2007 have been audited or otherwise final settled.

Medi-Cal: For traditional Medi-Cal services, payments for inpatient services rendered to patients are made based on reasonable costs while outpatient payments are based on pre-determined charge screens. The Hospital is paid for cost reimbursement services at an interim rate with final settlement determined after submission of annual cost reports and audits thereof by Medi-Cal. At June 30, 2012, cost reports through June 30, 2010, have been audited or otherwise final settled.

Other: Payments for services rendered to other than Medicare and Medi-Cal patients are based on established rates or on agreements with certain commercial insurance companies, health maintenance organizations and preferred provider organizations which provide for various discounts from established rates.

NOTE C - NET PATIENT SERVICE REVENUES (continued)

Net patient service revenues summarized by payor are as follows:

	2012	2011
Inpatient services	$ 49,890,394	$ 48,048,738
Outpatient services	50,493,326	47,058,081
Gross patient service revenues	100,383,720	95,106,819
Less contractual allowances and provision for bad debts	(44,178,653)	(41,352,121)
Net patient service revenues	$ 56,205,067	$ 53,754,698

Medicare and Medi-Cal revenue accounts for approximately 63% of the Hospital's gross 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 D - 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	$ 1,819,205	$ 1,920,023
Medi-Cal	1,039,257	1,063,967
Other third party payors	2,991,053	3,061,365
Self pay and other	3,115,671	3,131,802
Gross patient accounts receivable	8,965,186	9,177,157
Less allowances for contractual adjustments and bad debts	(2,329,729)	(2,254,849)
Net patient accounts receivable	$ 6,635,457	$ 6,922,308

NOTE E - OTHER RECEIVABLES

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

	2012	2011
Advances to physicians, net of allowances	$ 533,785	$ 337,985
Interest receivable from various investments	1,710	5,742
Employee loans	6,031	16,870
Receivable from Hospital Fee and IGT program	7,735,065	3,786,931
Other various receivables	74,404	35,482
	$ 8,350,995	$ 4,183,010

Advances to physicians are comprised of business loans to those physicians requiring assistance in their local practice. The Hospital has entered into these agreements for a specified period of time as an aid to recruitment. Some of the agreements, from time to time, may be structured so that if a physician maintains a practice in the area for a specified period of time, certain amounts may be forgiven.

NOTE F - ASSETS LIMITED AS TO USE

Assets limited as to use as of June 30, 2012 and 2011 were comprised of the following:

	2012	2011
Internally designated or restricted for capital acquisitions:		
Cash in banks and other financial institutions	$ 3,291,887	$ 3,438,578
Certificates of deposit (cash equivalents)	172,665	172,052
Total cash and cash equivalents	3,464,552	3,610,630
Held by trustee for specific purposes:		
Cash, cash equivalents and debt securities	3,081,118	3,100,857
	6,545,670	6,711,487
Less assets limited as to use available for current debt service	(2,712,890)	(2,286,913)
	$ 3,832,780	$ 4,424,574

NOTE G - CAPITAL ASSETS

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

	Balance at June 30, 2011	Transfers & Additions	Retirements	Balance at June 30, 2012
Land and land improvements	$ 12,292,112	$ 351,594		$ 12,643,706
Buildings and improvements	86,021,061	290,638		86,311,699
Equipment	35,164,881	747,208	(510,925)	35,401,164
Construction-in-progress	666,544	4,967,493		5,634,037
Totals at historical cost	134,144,598	6,356,933	(510,925)	139,990,606
Less accumulated depreciation for:				
Land and land improvements	(1,012,033)	(813,308)		(1,825,341)
Buildings and improvements	(19,413,087)	(1,574,158)		(20,987,245)
Equipment	(18,276,812)	(3,610,380)	482,640	(21,404,552)
Total accumulated depreciation	(38,701,932)	(5,997,846)	482,640	(44,217,138)
Capital assets, net	$ 95,442,666	$ 359,087	$ (28,285)	$ 95,773,468

	Balance at June 30, 2010	Transfers & Additions	Retirements	Balance at June 30, 2011
Land and land improvements	$ 4,956,592	$ 7,335,520		$ 12,292,112
Buildings and improvements	15,241,068	70,779,993		86,021,061
Equipment	22,211,178	15,287,236	(2,333,533)	35,164,881
Construction-in-progress	88,887,050	(88,220,506)		666,544
Totals at historical cost	131,295,888	5,182,243	(2,333,533)	134,144,598
Less accumulated depreciation for:				
Land and land improvements	(989,991)	(22,042)		(1,012,033)
Buildings and improvements	(14,351,921)	(5,061,166)		(19,413,087)
Equipment	(19,476,440)	(1,133,905)	2,333,533	(18,276,812)
Total accumulated depreciation	(34,818,352)	(6,217,113)	2,333,533	(38,701,932)
Capital assets, net	$ 96,477,536	$ (1,034,870)	$	$ 95,442,666

NOTE H - DEBT BORROWINGS

As of June 30, 2012 and 2011, debt borrowings were as follows:

	2012	2011
Lompoc Healthcare District General Obligation Bonds, Election of 2005, Series A (2006); original amount of $42,000,000; principal payments due each August 1st at various amounts to maturity on August 1, 2036; interest payable semi-annually on August 1st and February 1st, charged at coupon rates from 3.75% to 5.00%; collateralized by District property tax revenues:	$ 41,485,000	$ 41,770,000
Lompoc Healthcare District General Obligation Bonds, Election of 2005, Series B (2007); original amount of $32,500,000; principal payments due each August 1st at various amounts to maturity on August 1, 2037; interest payable semi-annually on August 1st and February 1st, charged at coupon rates from 3.75% to 5.00%; collateralized by District property tax revenues:	32,500,000	32,500,000
Lompoc Healthcare District Insured Health Facility Refunding Revenue Bonds, Series 1998; original amount of $6,060,000 of outstanding series 1990 Bonds; maturing at various dates through 2016; interest payable semi-annually on January 1st, and July 1st, at rates varying from 3.41% to 4.75%; collateralized by Hospital revenues and other property:	1,980,000	2,415,000
Capital lease obligations and other bank notes:	6,767,922	3,921,339
	82,732,922	80,606,339
Less current maturities of debt borrowings	(2,377,051)	(1,514,538)
	$ 80,355,871	$ 79,091,801

Future principal maturities for debt borrowings for the next five succeeding years are: $2,377,051 in 2013; $2,537,188 in 2014; $2,687,918 in 2015; $2,864,250 in 2016; and $1,241,515 in 2017.

NOTE I - EMPLOYEES' RETIREMENT PLAN

The Hospital offers a 457 deferred compensation plan (the Plan) to eligible employees. The Plan allows participants to defer income during peak years and set it aside as retirement savings. The employee funds set aside are pre-tax dollars and therefore reduce the amount of current income taxable to the employee. The Hospital has established certain requirements in order for employees to qualify for the Plan. All contributions are voluntary by the employee and they are 100% vested at inception.

Effective July 1, 2011, the Hospital will offer a 401(a) employer funded retirement plan to eligible employees. Employees will be vested based upon a "tiered" schedule, with 100% vesting after three years.

NOTE J - COMMITMENTS AND CONTINGENCIES

Construction-in-Progress: As of June 30, 2012, the Hospital has recorded $5,634,037 as construction-in-progress representing cost capitalized for the building of a new hospital and other various remodeling expansion projects on the Hospital's premises. Future expected cost to complete all projects as of June 30, 2012 are considered minor.

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, was $514,734 and $461,924, respectively. Future minimum lease payments for the succeeding years under operating leases as of June 30, 2012, that have initial or remaining lease terms in excess of one year are not considered material.

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.

Medical Malpractice Insurance: The Hospital maintains commercial malpractice liability insurance coverage under a claims made and reported policy covering losses up to $10 million per claim and $10 million in the annual aggregate, with a per claim deductible of $10,000. The Hospital plans to maintain the insurance coverage by renewing its current policy, or by replacing it with equivalent insurance.

Workers Compensation Program: The Hospital is self-funded for its workers' compensation and has been issued a Certificate of Consent to Self-Insure by the State of California, Department of Industrial Relations. The Hospital purchases excess liability insurance to provide coverage for workers' compensation claim exposures over its self-insurance retention limit of $750,000. Workers's compensation expense for the years ended June 30, 2012 and 2011, were $1,118,259 and $294,094, respectively.

NOTE J - COMMITMENTS AND CONTINGENCIES (continued)

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 believes the Hospital is in compliance with HIPAA as of June 30, 2012 and 2011.

Regulatory Environment: 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, government 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 actions unknown or unasserted at this time.

NOTE K - FAIR VALUE OF ASSETS AND LIABILITIES

The Hospital adopted Statement of Financial Accounting standards No. 157, *Fair Value Measurements* (FAS 157). FAS 157 fair value establishes a framework for measuring fair value and expands disclosures about fair value measurements. FAS defines fair value as the price that would be received to sell an asset in an orderly transaction between market participants at the measurement date. FAS 157 establishes a fair value hierarchy which requires an entity to maximize the use of observable inputs and minimize the use of unobservable inputs when measuring fair value. The standard describes three levels of inputs that may be used to measure fair value:

Level 1: Quoted prices in active markets for identical assets or liabilities;

Level 2: Observable inputs other than Level 1 prices, such as quoted prices for similar assets or liabilities; quoted prices in markets that are not active; or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities;

Level 3: Unobservable inputs for the assets or liabilities that are supported by little or no market activity and that are significant to the fair value of the underlying assets or liabilities.

NOTE K - FAIR VALUE OF ASSETS AND LIABILITIES (continued)

The following is a description of the valuation methodologies used for assets measured at fair value on a recurring basis and recognized in the Hospital's balance sheets, as well as the classification pursuant to the valuation hierarchy.

Financial Instruments: Where quoted market prices are available in an active market, investments are classified within Level 1 of the valuation hierarchy. Level 1 instruments include a variety of financial instruments as listed below. There are no Level 2 or Level 3 types within the balance sheet of the Hospital. The following table summarizes the financial instruments measured at fair value on a recurring basis in accordance with FAS 157 as of June 30, 2012:

	Fair Value	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Other Unobservable Inputs (Level 3)
Cash equivalents	$ 2,594,715	$ 2,594,715		
Cash in County and State treasurys	3,855,244	3,855,244		
Gov't & agency debt securities	744,027	744,027		
Totals of financial instruments	$ 7,193,986	$ 7,193,986		

The following table summarizes the financial instruments measured at fair value on a recurring basis in accordance with FAS 157 as of June 30, 2011:

	Fair Value	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Other Unobservable Inputs (Level 3)
Cash equivalents	$ 3,163,790	$ 3,163,790		
Cash in County and State treasurys	6,179,206	6,179,206		
Gov't & agency debt securities				
Totals of financial instruments	$ 9,342,996	$ 9,342,996		

NOTE L - RELATED PARTY TRANSACTIONS

The Lompoc Hospital District Foundation (the Foundation), has been established as a nonprofit public benefit corporation under the Internal Revenue Code Section 501(c)(3) 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 are distributed to the Hospital in amounts and in period determined by the Foundation's Board of Directors, who may also restrict the use of funds for Hospital property and equipment replacement or expansion or other specific purposes. Donations by the Foundation were $460,000 and $1,050,000 for the years ended June 30, 2012 and 2011, respectively.

NOTE M - CHARITY CARE AND COMMUNITY BENEFIT EXPENSE

The Hospital monitors the level of charity care and community service it provides. The amount of charges foregone, (based on established rates), for services and supplies furnished under its charity care policies are presented in the following summary which is a compilation 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:

Benefits for the poor:	2012	2011
Uncompensated care	$ 815,727	$ 691,933
Less: subsidies for uncompensated care	(21,523)	(238,633)
Net uncompensated care	794,204	453,300
Traditional charity care	1,509,240	584,792
Administrative write-offs	81,967	144,175
Total net charity and uncompensated care	2,385,411	1,182,267
Unpaid Medi-Cal and County indigent program charges	7,126,430	7,424,989
Total quantifiable benefits for the poor	9,511,841	8,607,256
Benefits for the broader community:		
Unpaid Medicare program charges	23,054,376	21,341,372
Total quantifiable benefits for the broader community	23,054,376	21,341,372
Total quantifiable community benefits	$ 32,566,217	$ 29,948,628

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 LOMPOC VALLEY MEDICAL CENTER (the "District") in connection with the issuance by the District of its $42,165,000* Lompoc Valley Medical Center (Santa Barbara 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 March 28, 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 June 30), commencing with the report for the 2012-13 Fiscal Year, which is due not later than March 31, 2014, file with EMMA, in a

* Preliminary, subject to change.

readable PDF or other electronic format as prescribed by the MSRB, an Annual Report 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]

LOMPOC VALLEY MEDICAL CENTER

By ____
James Raggio
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: Lompoc Valley Medical Center

Name of Issue: Lompoc Valley Medical Center (Santa Barbara 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.

Since the law only pushes off the automatic cuts and difficult negotiations are expected in Congress over these cuts and related issues, 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 effective, 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 has provided 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, however, 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 increased healthcare spending.

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 challenges may return in the future. California then 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.

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 50%, 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 November 1, 2012, 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 25% 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.

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.

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 18% 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 2013. In February 2012, DHHS announced its intent to delay the ICD-10 compliance date. 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.