NEW ISSUE—BOOK-ENTRY ONLY

RATING: Moody's: Aa3
(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 for a more complete discussion.

$26,100,000*
TAHOE FOREST HOSPITAL DISTRICT
(PLACER AND NEVADA COUNTIES, CALIFORNIA)
GENERAL OBLIGATION BONDS, ELECTION OF 2007, SERIES C (2012)

Dated: Date of Delivery

Due: August 1 as shown below

The issuance of general obligation bonds in an aggregate amount not to exceed $98,500,000 by Tahoe Forest Hospital District (the "District") was authorized at an election of the registered voters of the District held on September 25, 2007, by approximately 72% of the persons voting on the measure. Pursuant to such voter authorization, the laws of the State of California (the "State") and resolutions of the District, the District issued its $29,400,000 Tahoe Forest Hospital District (Placer and Nevada Counties, California) General Obligation Bonds, Election of 2007, Series A (2008) and its $43,000,000 Tahoe Forest Hospital District (Placer and Nevada Counties, California) General Obligation Bonds, Election of 2007, Series B (2010). The bonds of this issue represent the third and final series of bonds under such authorization and are designated the District's $26,100,000 Tahoe Forest Hospital District (Placer and Nevada Counties, California) General Obligation Bonds, Election of 2007, Series C (2012) (the "Bonds"). See "THE BONDS - Authority for Issuance" herein.

Proceeds of the Bonds will be used to fund the construction and equipping of additions and improvements to the District's health facilities located in the Town of Truckee, California, and pay for costs of issuing the Bonds. See "THE PROJECT" 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 principal of and interest on the Bonds when due. Placer and Nevada Counties will collect all *ad valorem* taxes due the District and disburse them directly to the District for payment to the Paying Agent (defined below) to be applied to the payment of principal of and interest on the Bonds.

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 The Bank of New York Mellon Trust Company, N.A., 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 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 February 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	Yield	Maturity (August 1)	Principal Amount	Interest Rate	Yield
2017	$ 135,000			2030	$ 880,000		
2018	175,000			2031	970,000		
2019	220,000			2032	1,070,000		
2020	265,000			2033	1,175,000		
2021	310,000			2034	1,280,000		
2022	360,000			2035	1,400,000		
2023	415,000			2036	1,525,000		
2024	465,000			2037	1,655,000		
2025	525,000			2038	1,795,000		
2026	580,000			2039	1,940,000		
2027	645,000			2040	2,100,000		
2028	715,000			2041	2,265,000		
2029	795,000			2042	2,440,000		

Bids for the purchase of the Bonds will be received by the District on July 11, 2012, 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 July 2, 2012.

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 the 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, Porter - Simon, Truckee, California, and by Jennings, Strouss & Salmon, PLC, Phoenix, Arizona, 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 August 2, 2012.

The date of this Official Statement is July ___, 2012.

* Preliminary, subject to change.

TAHOE FOREST HOSPITAL DISTRICT
PLACER AND NEVADA COUNTIES, CALIFORNIA

BOARD OF DIRECTORS

Ken Cutler, M.D., MPH, President — Roger Kahn, Vice President

Larry Long, Secretary — John Mohun, Treasurer

Karen Sessler, M.D., Member

DISTRICT SENIOR MANAGEMENT

Robert Schapper, Chief Executive Officer
Crystal Betts, Chief Financial Officer
Judith Newland, Interim Chief Nursing Officer
Maia Schneider, Director of Community and Government Relations

PROFESSIONAL SERVICES

District Counsel
Porter Simon
Truckee, California

Disclosure Counsel
Jennings, Strouss & Salmon, PLC
Phoenix, Arizona

Independent Auditors
Matson and Isom
Chico, California

Bond Counsel
Quint & Thimmig LLP
San Francisco, California

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

Registrar, Transfer and Paying Agent
The Bank of New York Mellon Trust Company
Los Angeles, 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 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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$26,100,000
TAHOE FOREST HOSPITAL DISTRICT
(PLACER AND NEVADA COUNTIES, CALIFORNIA)
GENERAL OBLIGATION BONDS, ELECTION OF 2007, SERIES C (2012)

INTRODUCTION

This Official Statement, including the cover page, the Table of Contents and Appendices hereto (the "Official Statement"), is provided to furnish information with respect to the sale and delivery by Tahoe Forest Hospital District (the "District") of $26,100,000 aggregate principal amount of its General Obligation Bonds, Election of 2007, Series C (2012) (the "Bonds").

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

The District

The District was created in 1949 as a political subdivision of the State of California. The District is organized and operates under The Local Health Care District Law of the State of California, constituting Division 23 of the California Health and Safety Code (the "District Law"). The District is located in portions of Placer and Nevada Counties (herein referred to collectively as the "Counties**"**) and covers an area of approximately 500 square miles. Under District Law the District may own and operate health care facilities. The District currently owns and operates Tahoe Forest Hospital in Truckee, California, and Incline Village Community Hospital in Incline Village, Nevada. See "THE DISTRICT" and "DISTRICT FINANCIAL MATTERS" herein.

The Project

Net proceeds of the Bonds will be used to fund the construction and equipping of additions and improvements to the District's health facilities located in Truckee, California in the approximate amount of $25,950,000 and pay for costs of issuing the Bonds in the approximate amount of $150,000. See "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.

In addition, pursuant to Section 32127 of the District Law, the District is required to use moneys in its maintenance and operation fund whenever *ad valorem* taxes are insufficient to pay such principal and interest.

Description of the Bonds

The Bonds will be dated the date of their delivery, will be in denominations of $5,000 each, or integral multiples thereof, and will bear interest at the rate or rates shown on the cover page hereof, with interest payable semiannually on each February 1 and August 1, commencing February 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, 2020, may be redeemed prior to maturity at the option of the District beginning on August 1, 2019, and thereafter, at the redemption price of 100% of the par amount of Bonds redeemed, plus accrued interest. 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 Quint & Thimmig LLP, San Francisco, California ("Bond Counsel"). Bond Counsel will supply a legal opinion approving the validity of the Bonds. See "LEGAL MATTERS – Approval of Legality" herein. The Bank of New York Mellon Trust Company, N.A., Los Angeles, California, will act as paying agent, transfer agent and registrar for the Bonds (the "Paying Agent"). Porter Simon, Truckee, California, is acting as the District's legal counsel ("District Counsel") and Jennings, Strouss & Salmon, PLC, Phoenix, Arizona, is acting as disclosure counsel ("Disclosure Counsel") to the District in connection with the Bonds. G.L. Hicks Financial, LLC, Provo, Utah, is acting as financial advisor ("Financial Advisor") to the District for 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 August 2, 2012.

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 Counties 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. In the event *ad valorum* taxes are insufficient to pay principal and interest on the Bonds, the District is required to use moneys in its maintenance and operation fund to pay debt service on 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 discussions 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 certain annual financial information and notices of the occurrence of certain 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 June 26, 2012 (the "Resolution"). District voters approved the authorization of a total of $98,500,000 general obligation bonds by more than two-thirds (72%) of the votes cast by registered voters within the District on September 25, 2007. The Bonds represent the third and final issuance of bonds under this authorization. See the cover page of this Official Statement for a description of the first and second series of such authorized general obligation 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 from 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 are to be used to pay the costs of the Project and to pay for costs associated with issuance of the Bonds. See "THE PROJECT" and "THE BONDS – Sources and Uses of Funds" herein.

Book-Entry System

The Depository Trust Company ("DTC"), New York, NY, 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 nominee) or such other name as may be requested by an authorized representative of DTC. The ownership of one fully-registered Bond for each maturity, each in the aggregate principal amount of such maturity, will be registered in the name of Cede & Co. See APPENDIX D "Book-Entry System."

Investment of District Funds and Bond Proceeds

Proceeds from the sale of the Bonds will be deposited in a Tahoe Forest Hospital District (Placer and Nevada Counties, California) General Obligation Bonds, Election of 2007, Series C (2012) Project Fund (the "Project Fund") to be held by the District and will be kept separate and distinct from all other District funds. Bond proceeds will be used for the purpose for which the Bonds are issued. See "THE PROJECT" herein. Any excess proceeds of the Bonds not needed for the purpose for which the Bonds are issued will be applied to the payment of principal of and interest on the Bonds.

Sources and Uses of Funds

The following table sets forth the estimated sources and uses of funds related to the Bonds and to pay for costs associated with the Project and costs of issuance of the Bonds.

Estimated Sources of Funds:	
Principal Amount of the Bonds	$
Original Issue Premium	
Total Sources of Funds	$
Estimated Uses of Funds:	
Deposit to Project Fund	$
Deposit to Costs of Issuance Fund [(1)]	
Underwriter's Discount	
Total Uses of Funds	$

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

Redemption Provisions

Optional Redemption. Bonds maturing on or after August 1, 2020, are subject to redemption prior to their respective stated maturities, at the option of the District, in whole, on any date or, in part, on any interest payment date on or after August 1, 2019, at redemption prices equal to the par amount of Bonds redeemed, together with accrued interest to the date fixed for redemption.

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 or other secured 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 as otherwise provided by law, then such owners shall cease to be entitled to the obligation of the District to cause the Counties to levy and collect taxes on behalf of the District, and such obligation and all agreements and covenants of the District and of the Counties to such owners under the Bonds shall thereupon be satisfied and discharged and shall terminate, except that 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 under the Resolution or otherwise held in trust for such payment.

Debt Service Schedule

The following table summarizes the annual debt service requirements for the Bonds and provides the annual aggregate debt service for the 2008 Bonds, the 2010 Bonds and the annual aggregate debt service for the 2008 Bonds, the 2010 Bonds and the Bonds combined:

Year Ending (August 1)	The Bonds			Annual Debt Service for the 2008 and 2010 Bonds	Aggregate Debt Service for the 2008 and 2010 Bonds and the Bonds
	Principal Payment	Interest Payment	Total Debt Service		
2012				$ 3,633,055	
2013				3,638,055	
2014				3,682,855	
2015				3,945,855	
2016				4,053,255	
2017				4,160,855	
2018				4,273,455	
2019				4,387,905	
2020				4,505,905	
2021				4,627,005	
2022				4,755,705	
2023				4,883,543	
2024				5,011,474	
2025				5,144,036	
2026				5,269,993	
2027				5,402,330	
2028				5,541,515	
2029				5,693,138	
2030				5,850,388	
2031				6,011,350	
2032				6,167,100	
2033				6,324,725	
2034				6,483,150	
2035				6,646,350	
2036				6,813,000	
2037				7,001,500	
2038				7,191,750	
2039				4,067,500	
2040				4,163,250	
2041					
2042					

*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 District has the power and is obligated to cause to be levied and collected by the Counties 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.

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 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 District's general obligation 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 general obligation 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 general obligation bonds. While the levy of *ad valorem* tax to pay debt service of the Bonds and other general obligation bonds is not limited as to rate or amount, the risks discussed in this paragraph could affect a tax payor'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. The total assessed valuation of real property in the District for the fiscal year 2009-10 increased by 4% as compared to fiscal year 2008-09. The total assessed valuation for the fiscal year 2010-11 decreased by 5% as compared to fiscal year 2009-10. The total assessed valuation of real property in the District for the fiscal year 2011-12 decreased by 2% as compared to fiscal year 2010-11. Also, there has been an increase in property owner requests for temporary reductions in assessed valuation.

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

District voters authorized the issuance of not to exceed $98,500,000 in general obligation bonds on September 25, 2007, for the purpose of financing and refinancing the expansion, improvement, acquisition, construction, equipping and renovation of health facilities of the District, and to pay costs incident thereto (the "Project"). The Project was more fully defined in the ballot measure placed before registered voters residing within the District as follows:

> "To maintain a full service hospital in our community; expand and enhance the Emergency Room to ensure access to lifesaving care; maintain critical medical services including pediatrics, maternity, long-term care for seniors and cancer care; and upgrade facilities that are outdated or do not meet state-mandated earthquake safety standards, shall Tahoe Forest Hospital issue $98.5 million in bonds to improve healthcare facilities with an independent citizens' oversight committee and all funds being spent on local projects?"

The District has, with the issuance of the Bonds, issued three series of general obligations bonds that, in the aggregate, total $98,500,000. The first authorized issuance was in August of 2008 with the issuance of the 2008 Bonds in the principal amount of $29,400,000. The purpose of the 2008 Bonds was to fund portions of the master planning, design and/or construction and equipping of five project components. Proceeds from the 2008 Bonds were used to fund the master planning costs associated with these projects, architectural and engineering costs associated with most of these projects and construction costs, projected through December 31, 2010, relating to two of these projects.

The second issuance in the amount of $43,000,000 was used to fund approximately $39,300,000 in costs associated with preconstruction, soft costs and construction costs relating to several projects including: radiology upgrades, the new cancer center facility, skilled nursing facility improvements, central plant upgrades, south building improvements, birthing center improvements, dietary relocation, medical records, respiratory therapy, emergency room and sterile processing improvements. Project-related expenditures funded or to be funded with proceeds of the 2010 Bonds are projected to be through March 2013. Proceeds of the 2010 Bonds were also used to refinance $3,500,000 in outstanding debt of the District and pay for approximately $200,000 in cost of issuing the 2010 Bonds.

This third and last issuance in the amount of $26,100,000 will be used to fund approximately $25,950,000 in costs to complete all of the following components of the Project, as described in greater detail below.

Campus Wide Master Planning

The firm of FreemanWhite (the "Master Planner") was selected by the District through a competitive process that evaluated several firms to perform master planning services related to the Project. The Master Planner conducted a campus-wide planning assessment that concluded with a final master plan in February 2009. Thereafter additional budgetary and design assessments were undertaken resulting in a facilities development plan in August 2009. In a process of solicitation, interviews, evaluation and award, the District selected its team of project specific design architects, engineers, contractors and other consultants that met competitive bid requirements imposed on the District. The Master planning work continues to address research and entitlement processes that affect all of the Project components listed below.

Radiology Upgrades

This project involves the remodeling of the existing fluoroscope and nuclear medicine camera rooms and the installation of a new fluoroscope and nuclear medicine camera. Approximately 1,000 square feet of Hospital space was affected by the renovation of these two rooms. This project component was completed in September 2010. The final cost for remodeling and new equipment was approximately $2.3 million.

Cancer Center Facility

Development of the new cancer center facility was initiated by District management in conjunction with its Cancer Advisory Council, a group of community stakeholders appointed by the Board of Directors of the District to assist in the development of the cancer center. The District conducted a public bid process culminating in the award of contracts for construction of the cancer center in August 2010. The cancer center project is a freestanding two-story building containing approximately 20,000 square feet of space that will support a diagnostic and cancer treatment center, including a linear accelerator, PET/CT imaging and medical oncology infusion area on the first floor. The second floor will contain approximately 13,000 square feet of space for future cancer center and Hospital related expansion. Construction began in September 2010 and concluded in June 2012. The District anticipates project occupancy in July 2012. The cancer center is not subject to OSHPD plan check, review and approval. The budget for the cancer center has been revised to approximately $31.8 million, with approximately $14.0 million funded from the 2010 Bond proceeds.

Skilled Nursing Facility Expansion and Renovation

The skilled nursing facility project included the removal of six patient rooms located in a non-compliant building and the addition of seven new patient rooms as part of a new addition and entry way to the skilled nursing facility. This project added approximately 3,500 square feet of new space to the skilled nursing facility. The District conducted a public bid process and awarded contracts for construction in February 2011. Construction was completed in June 2012 and the new facility will be occupied in July 2012. The budget for these improvements was approximately $5.5 million, with approximately $3.1 million funded from the 2010 Bond proceeds.

Central Plant Upgrades

This central plant project involves adding capacity and reliability to the emergency electrical power plant, increasing the capacity of the chill water plant and providing electrical, heating, cooling, fire sprinkler and medical gas services to all buildings to be located on the Hospital campus. Several construction contracts were awarded for this work and construction commenced in July 2010. Construction was completed in March 2012. The budget for these upgrades was approximately $15.5 million, with approximately $9.3 million funded from the 2010 Bond proceeds.

Infill projects (Interim Medical Records, Phase 1 Dietary, Pharmacy Relocation, Respiratory Therapy and Interim Birthing)

This multi-phase project is in various stages of architectural design and engineering, OSHPD approval and construction. Permits for interim medical records, phase 1 dietary and pharmacy relocation projects were issued or will be issued from December 2010 through July 2012. Permits for interim birthing are expected in September 2012. Upon the various permit issuances, public bidding for construction was completed. Construction of the pharmacy relocation began in February 2011 with all phases completed in August 2011. All remaining phases of this infill project are expected to be completed by June, 2013. The budget for the infill projects is approximately $9.1 million, with approximately $5.3 million funded from the 2010 Bond proceeds.

South Building Upgrades (Birthing, Phase II Dietary, Nurse Manager and Medical Records)

This multi-phase project is in the OSHPD permitting phase with completion of construction expected on or about May 2014. This new two-story building will expand dietary services and provide for a new 14,000 square foot birthing center. The new birthing center will include four labor and delivery rooms, four post-partum rooms, a C-section room and needed ancillary space. Approximately $7.0 million of the 2010 Bond proceeds were used to fund the south building upgrades and related projects.

Emergency Room/Sterile Processing

This project component is in the OSHPD review and permit phase. Currently, the District expects it will begin construction of this project sometime during July 2012, with completion of construction expected on or about February 2013. This project includes approximately 7,000 square feet of new space and approximately 4,000 square feet of renovated space. Approximately $600,000 of the 2010 Bond proceeds were used to fund the emergency room and sterile processing projects.

IT Data Center

The District's data center was relocated into a newly constructed building located adjacent to the Hospital's old intensive care unit. In addition, fiber optic cabling was installed to provide connectivity and redundancy for all Hospital buildings. The project was completed in September 2010 at a total cost of approximately $1,500,000.

CONSTITUTIONAL AND STATUTORY PROVISIONS AFFECTING DISTRICT REVENUES AND APPROPRIATIONS

The principal of and interest on the Bonds are payable from the proceeds of an ad valorem tax levied by the Counties 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 Counties 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 percent 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 for payment of 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 Counties 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

Certain information concerning the District, its operations and revenues derived from its operations are discussed below. As discussed under "THE BONDS – Security for the Bonds" herein, the Bonds are payable from the proceeds of an *ad valorem* tax required to be levied by the Counties in an amount sufficient for the payment of the Bonds. The District is required by Section 32127 of The Local Health Care District Law to use moneys in its maintenance and operation fund whenever *ad valorem* taxes will be insufficient to pay principal and interest on its general obligation bonds. Accordingly, potential investors are encouraged to review this information about the District, including "APPENDIX B – Audited Financial Statements of the District for the Fiscal Years Ended June 30, 2010 and 2011" and "APPENDIX E – Healthcare Risk Factors."

The District was created in 1949 as a political subdivision of the State of California. The District is organized and operates under The Local Health Care District Law of the State of California, constituting Division 23 of the California Health and Safety Code (the "District Law"). The District is located in portions of Placer and Nevada Counties and covers an area of approximately 500 square miles. The permanent resident population of the District is approximately 40,000 persons with an estimated two-thirds of the year-round residents under the age of 45. Seasonal influxes increase the resident population to over 70,000 persons, due to recreational and other attractions. Under District Law the District may own and operate health care facilities. The District currently owns and operates Tahoe Forest Hospital and Incline Village Community Hospital under the provisions of District Law.

Cities and communities located within the District's boundaries include, in addition to the Town of Truckee, to the west, Norden, Soda Springs and Emigrant Gap and to the southeast along the Lake Tahoe shoreline, Crystal Bay, Kings Beach, Tahoe Vista, Carnelian Bay, Tahoe City, Tahoe Pines, Homewood and Tahoma. The District is a political agency and collects operating tax revenues annually based upon the assessed value of taxable

property located within its boundaries. The District is able to use its tax revenues for general operating purposes. These operating tax revenues are not pledged to the Paying Agent for the repayment of the Bonds.

Health Facilities

The District operates Tahoe Forest Hospital in Truckee, California, and Incline Village Community Hospital in Incline Village, Nevada (the "Health Facilities"), representing an aggregate of 76 beds (39 acute and 37 skilled nursing beds) licensed by the State of California Department of Health Services and the State of Nevada, Department of Human Resources, Division of Health, Bureau of Licensure and Certification. Incline Village Community Hospital is located outside the District's boundaries and was acquired by the District in 1996. The District also operates outpatient facilities located in Tahoe City and Truckee, California. These outpatient facilities provide laboratory and physical therapy services, among other services.

Tahoe Forest Hospital is located in the southeastern quadrant of Nevada County off Interstate 80 in the Town of Truckee, California, approximately 15 miles northwest of Lake Tahoe and 35 miles southwest of Reno, Nevada. It opened in 1952 as a 12-bed acute care hospital. The first expansion of Tahoe Forest Hospital occurred in 1966 when it expanded to a total of 42 beds. In 1986, services were expanded in the areas of emergency care and ancillary services and its intensive care unit was expanded to 6 beds and a skilled nursing unit was added. Also in 1986, the District initiated a development program to modernize and expand its services to meet the projected needs of its service area residents. This development included the expansion and renovation of surgery suites, laboratory and admissions, the remodeling of general hospital areas, a renovation and expansion of the obstetrics department as well as the replacement of radiology equipment. It also included an upgrade of the intensive care unit, a remodeling of the emergency room and an expansion of the cafeteria and dining facilities. In 1995, the District completed the construction of a three-story medical office complex adjacent to Tahoe Forest Hospital comprising approximately 30,000 square feet of new space. Some of this building has been sold to physicians on a condominium basis with the remaining footage housing the District's retail pharmacy and other related hospital services. In 2005, the District developed a new Center for Health and Sports Performance. In 2006, the District opened its 40,000 square foot Western Addition including medical, surgical and intensive care beds, clinical laboratory, women's imaging, magnetic resonance imaging, cardiac rehabilitation, outpatient surgery and expanded space for dietary, ancillary and admission services. In 2006, Tahoe Forest Hospital started an oncology program with a newly recruited medical oncologist. Over its first two years of operation the Tahoe Forest Cancer Center expanded its scope of services to include chemotherapy and in early 2008 it became part of the University of California at Davis Cancer Care Network. The Tahoe Forest Cancer Center affiliation with the University of California at Davis Cancer Care Network provided access to clinical trials offerings for Truckee – Tahoe region patients beginning in 2008. In 2007, the District also developed a hospital based multi-specialty clinic providing expanded hospital based clinics for ENT, pulmonary medicine, cardiology, gastroenterology, and internal medicine services. In 2008, oncology, urology and orthopedics were added as new service lines. In 2009 and early 2010, the District added sports medicine and audiology services. In 2011 and 2012, the District added pediatrics, general surgery, and radiation oncology services.

Tahoe Forest Hospital has a heliport on its site which allows helicopter ambulances to bring emergency patients to and from Tahoe Forest Hospital. Helicopter ambulances are often used because of the mountainous terrain in the District's service area. Tahoe Forest Hospital also operates a Women's and Family Center which provides a combination of clinical and educational services. Obstetrical services provided include labor, delivery, recovery and postpartum units. Home health services offered by Tahoe Forest Hospital include skilled nursing assessment and monitoring, infusion services, post surgical care, wound care, ostomy care, medical social services, nutrition counseling, and occupational, speech and physical therapies. The District also operates a retail pharmacy, a medical and radiation oncology program and a children's care center, all located adjacent to Tahoe Forest Hospital.

Incline Village Community Hospital is located in Incline Village, Nevada, approximately 18 miles east of Tahoe Forest Hospital near the northeast shore of Lake Tahoe. It is located outside of the District's boundaries but within the District's service area. Incline Village Community Hospital is operated primarily as an outpatient medical center with only occasional inpatient admissions. It provides a fully equipped and staffed 24-hour emergency room and an active surgicenter as well as radiology, laboratory, pharmacy, physical therapy and a sleep disorder clinic.

Approximately 80% of the Health Facilities' admissions originate from District residents. A majority of the remaining admissions originate from visitors to Lake Tahoe area ski resorts or from auto accidents along the

Interstate 80 corridor between Auburn, California, and Reno, Nevada. Both Tahoe Forest Hospital and Incline Village Community Hospital are designated as Critical Access Hospitals for Medicare reimbursement purposes.

Board of Directors

The District is governed by a Board of Directors (the "Board"), which consists of five members, each elected at large to four-year 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 a 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. 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	Years as a Board Member
Ken Cutler, M.D., MPH President	Physician, Public Health Officer	12/2014	3
Roger Kahn Vice President	Retired Business Owner	12/2014	7
Larry Long Secretary	Vintner, Retired District CEO	12/2014	10
John Mohun Treasurer	Attorney at Law	12/2012	2
Karen Sessler, M.D. Member	Physician/Business Owner	12/2012	12

The District incorporates an area of mountainous terrain having an elevation ranging between 5,800 and 9,600 feet above sea level. Within the District's boundaries are well established summer and winter resort areas which include the northwest quadrant of Lake Tahoe and several winter ski resorts. Summer recreation areas around Lake Tahoe include the shoreline communities of Tahoe City, Kings Beach, Tahoe Vista, Crystal Bay, Tahoe Pines, Carnelian Bay, Incline Village and Homewood. Other summer recreation areas are located at and around Donner Lake, Prosser Reservoir, Donner Summit and Boca Reservoir near the Town of Truckee. Winter ski areas include Squaw Valley, Alpine Meadows, Tahoe Donner, Northstar at Tahoe, Boreal Ridge, Soda Springs, Sugar Bowl, Homewood Mountain Resort and Mount Rose, among others.

Senior Management

The principal members of the administrative staff responsible for the daily operations of the Health Facilities are profiled below:

Robert A. Schapper, Chief Executive Officer. Mr. Schapper has held the position of Chief Executive Officer of the Health Facilities since October of 2002. He directs all functions of the Health Facilities and other District activities in accordance with the policies established by the Board. Prior to his employment with the District, Mr. Schapper was Chief Executive Officer of Palm Drive Hospital, a 49-bed rural district hospital located in Sebastopol, California, from 2000 through August 2002, and had previously served that hospital in 1998 as interim chief executive officer for Columbia/HCA Healthcare. He held the position of Chief Executive Officer of Hollywood Community Hospital, a 160-bed nonprofit acute care medical center in Hollywood, California, from 1999 to 2000 and was Chief Operating Officer/Chief Executive Officer of Mt. Sinai Health Care System in Cleveland, Ohio, from 1996 to 1999. Mr. Schapper has held upper level management positions in several health care organizations since 1978. Mr. Schapper received a Bachelor of Science degree in Community Health Education from Brigham Young University, Provo, Utah, a Masters degree in Public Health and a Masters of Science degree in Health Services/Hospital Administration from California State University at Northridge, California. Mr. Schapper also pursued additional post-graduate studies in community health, community medicine and management at the University of Utah, Salt Lake City, Utah. Mr. Schapper has participated in various professional organizations and currently is involved in the American College of Healthcare Executives and served as a member of the board of directors of the Association of California Healthcare Districts and the California Council of Excellence.

Crystal Betts, CPA (inactive), Chief Financial Officer. Ms. Betts has been with the District since March of 2004, initially as its Controller and since March 2007, as its Chief Financial Officer. She is responsible for all aspects of the financial operations of the District's activities. From 2000 to 2004, Ms. Betts was with Trinity Hospital, a 65-bed acute care facility located in Weaverville, California, as the Controller and then as the Chief Financial Officer. From 1996 to 2000, she was the Audit Senior/Accountant at Matson and Isom Accountancy Corporation located in Chico, California, where she was responsible for conducting audits for governmental, not-for-profit and for-profit entities including eleven healthcare entities. Ms. Betts received a Bachelor of Science degree in Accounting and Management Information Systems from California State University at Chico in Chico, California, and is a Certified Public Account, licensed in the State of California.

Judith B. Newland, Interim Chief Nursing Officer. Ms. Newland was appointed to serve as Interim Chief Nursing Officer in April 2012. She has spent most of her career with the District, first serving as a staff nurse in the Medical/Surgical Unit and then in the Emergency Department from 1980 to 1985; from 1985 to 2001 she was the Director of Emergency Services; from 2001 to 2011 she was the Director of Quality and Regulations; and just prior to her present position she was the Director of Operations/Chief Nursing Officer at Incline Village Community Hospital – a position she continues to hold. Ms. Newland earned her Bachelor's of Science degree in Nursing from California State University, Fresno, in 1979. Ms. Newland has continued her education and is presently obtaining her Executive MBA degree in Healthcare Administration through the University of Colorado, Denver, with an anticipated completion date of July 2012.

Maia Schneider, Director of Community and Government Relations. Ms. Schneider has been with the District since 2002 and directed the Hospital capital campaign which raised $6.2 million for the western addition. She was the volunteer campaign manager for Measure C in 2007, which successfully passed with 72% of the vote for facilities improvements for the Hospital. Currently, she educates and works with elected representatives on legislative issues affecting rural health care, as well as coordinates programs to strengthen the tie between the Health Facilities and the community they serve. Ms. Schneider has 19 years of experience in the banking and financial word, including operations, lending, and management. Most recently she held the position of Vice President and manager of two branches for a retail community bank. She hosts "Truckee Talks" on local TV which has taped and aired over 170 episodes. Her past accomplishments include serving as Mayor for the Town of Truckee, as Council member on the Truckee Town Council; conceiving and organizing the Town Portrait in 2000 and conceiving and coordinating Truckee Day, a town-wide cleanup and civic pride event that started in 2003 and continues annually.

Employees

As of May 31, 2012, the District employed approximately 522 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.

Most of the District's employees are covered by collective bargaining agreements. The District has two employee non-unionized bargaining groups covering licensed and non-licensed employees. These bargaining groups provide representation and advocacy for District employees, particularly in the area of compensation. The informal bargaining relationship has been in existence for many years. The District believes that its employee relations are good.

Medical Staff

As of May 31, 2012, the medical staff at the Health Facilities consisted of 114 physicians, 58 of whom were active or provisional active medical staff members. Approximately 98% of the active medical staff members are board certified. The current medical staff includes approximately 56 physicians who are courtesy staff or consulting staff members. Active medical staff members are the primary admitters to the Health Facilities. The Health Facilities' active medical staff has an average age of approximately 52 years.

The top ten admitting physicians of the District, based upon gross inpatient revenues for the fiscal year ended June 30, 2011, represented approximately 62% of total inpatient revenues of the District for the same period. Management of the District recently recruited a new pediatrician to be added to the medical staff of the Hospital.

Service Area and Competition

The service area for the Health Facilities extends beyond the District's boundaries to include Sierra and Plumas counties to the north, Incline Village in Washoe County, Nevada, to the east and the Pla-Vada/Royal Gorge

areas to the west. Tahoe Forest Hospital is the only acute care hospital within the District's boundaries, its primary service area. There are no other acute care hospitals, urgent care centers or skilled nursing facilities located within the District. In 2003, a free standing ambulatory surgery center owned and operated by physicians practicing at the Health Facilities began operating in the Town of Truckee. In 2010 the District became a 51% partner in this free-standing ambulatory surgery center.

The closest acute care hospitals are located approximately 35 miles northeast of Tahoe Forest Hospital in the city of Reno, Nevada. The next closest acute care hospitals located within the state of California are Barton Memorial Hospital (42 miles south), a 112-bed hospital, located in South Lake Tahoe, California, Sutter Auburn Faith Hospital (65 miles southwest), a 105-bed acute care hospital, located in the City of Auburn, Sierra Nevada Memorial Hospital (50 miles southwest), a 107-bed acute care hospital, located in Nevada City, California, and Eastern Plumas Hospital (50 miles northwest), a 24-bed (9 acute care and 27 long-term care) rural hospital, located in Portola, California.

Approximately 80% of Tahoe Forest Hospital admissions originate from residents living within the District's boundaries with 20% from adjacent areas. Located within the Health Facilities' service area, for which the Health Facilities are the nearest acute care hospitals, are fifteen winter ski resorts, including Squaw Valley, Sugar Bowl, Soda Springs, Northstar at Tahoe and Alpine Meadows, among others. For services not provided at the Health Facilities, patients are usually referred to Prime Healthcare Services - Reno or Renown Medical Center, both located in Reno, Nevada or to UC Davis Medical Center located in Sacramento, California. Services not currently provided at the Health Facilities include neonatal ICU and cardiology surgery, among others.

Services

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

Medical Services

Alternate Birthing Center	Hospice Care	Oncology (Radiation and Medical)
Audiology	Intensive Care	Pain Center
Cardiac Rehabilitation	Internal Medicine	Pharmacy
Cardiopulmonary Therapy	Laboratory, Clinical	Physical Therapy
Clinic	Laboratory, Pathology	Pulmonary Testing
CT Scanning (including PET CT)	LDRP Maternity	Radiology
Diagnostic	Mammography	Respiratory Therapy
EKG, EEG and Endoscopy	MRI Scanning	Sleep Center
General (FP/GP)	Newborn Nursery	Speech Therapy
Gynecology	Nuclear Medicine	Sports Medicine Services
Hematology	Occupational Health	Telemetry
Home Health	Occupational Therapy	Ultrasound

Surgical Services

Ambulatory	General	Outpatient
Anesthesiology	Gynecology	Urology
Dental	Ophthalmology	Vascular
Cosmetic	Orthopedics	
Gastroenterology	Otolaryngology	

Tahoe Forest Hospital provides 24-hour emergency medical service and trauma care with a licensed physician on duty at all times. The District also provides skilled nursing services at Tahoe Forest Hospital. Home health services offered include skilled nursing assessment and monitoring, infusion services, post surgical care, wound care, ostomy care, nutritional support, medical social services and occupation, speech and physical therapies.

Accreditations, Designations, Memberships and Affiliations

Tahoe Forest Hospital has been fully accredited since it was opened in 1952. Tahoe Forest Hospital's and associated multispecialty clinic's most recent three-year accreditation from the American Osteopathic Association's Bureau of Healthcare Facilities Accreditation expires on or about July 2, 2014. Incline Village Community Hospital's and associated multispecialty clinic's most recent three-year accreditation from the American Osteopathic Association's Bureau of Healthcare Facilities Accreditation expires on or about September 8, 2014. Laboratory services at Tahoe Forest Hospital and satellite operations located in Tahoe City, California, and Incline Village, Nevada, are accredited by the College of American Pathologists. Incline Village Community Hospital received Critical Access Hospital designation in 2000 and Tahoe Forest Hospital received its Critical Access Hospital

designation in 2007. Critical Access Hospitals are also certified by the Department of Health and Human Services and are eligible for more favorable cost-based reimbursement from Medicare for Medicare program beneficiaries treated at these hospitals.

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 Hospital Association, the Association of California Healthcare Districts and other professional health care organizations.

The District plans for and evaluates potential affiliations as part of its overall strategic planning. At present, the District has an affiliation with Premier to provide group purchasing services, selected consulting services and educational opportunities and with UC Davis Health System to provide Services related to cancer care, cancer research and rural health care.

Bed Complement

The Health Facilities have a licensed capacity of 76 beds (39 acute and 37 skilled nursing). The current bed count classified by service type is as follows:

Service	Tahoe Forest	Incline Village	Total
Medical/Surgical [(1)]	25	4	29
Intensive Care	6	--	6
Prenatal/Obstetrics	4	--	4
Skilled Nursing	37	--	37
Total	72	4	76

Source: State of California, Department of Public Health License and State of Nevada, Department of Health and Human Services.

[(1)] Ten medical/surgical beds at Tahoe Forest Hospital were placed in suspense on July 1, 2007, for use as patient observation extended recovery beds. Ten medical/surgical beds were also designated as swing beds, as of the same date. Designated swing beds can be used for the treatment of medical/surgical patients or skilled nursing patients, as needed. Two skilled nursing beds were placed in suspense on April 18, 2011.

Certain Financial Information

The following summary of statements of revenues, expenses and changes in net assets of the District for each of the five fiscal years ended June 30, 2011, were prepared from audited financial statements of the District, of which the 2010 and 2011 fiscal years appear in Appendix B to this Official Statement. These summaries should be read in conjunction with the financial statements and notes thereto (which are an integral part of the financial statements) included in APPENDIX B to this Official Statement.

The summaries of statements of revenues, expenses and changes in net assets for the eleven-month periods ended May 31, 2011 and 2012, are unaudited and have been obtained from unaudited financial statements of the District. These financial statements have been prepared in accordance with generally accepted accounting principles on a basis consistent with the accounting policies reflected in the audited financial statements of the District presented below. They do not, however, include all of the information 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 2007 (Audited)	2008 (Audited)	2009 (Audited)	2010 (Audited)	2011 (Audited)	Eleven Months Ended May 31 2011 (Unaudited)	2012 (Unaudited)
Net Patient Revenue [1]	$ 80,522	$ 87,501	$ 96,470	$ 92,422	$ 94,324	$ 89,644	$ 95,961
Other Revenue	6,723	6,755	7,024	6,335	6,596	6,300	6,406
Total Operating Revenues	87,245	94,256	103,494	98,757	100,920	95,944	102,367
Salaries, Benefits & Professional Fees	51,022	56,441	64,778	63,097	65,941	60,234	65,613
Depreciation & Amortization	5,901	6,275	5,696	5,303	5,372	5,561	4,915
Provision for Bad Debts [1]	6,830	6,259	6,853	0	0	5,337	5,535
Other Operating Expenses	21,657	23,417	25,480	25,278	26,894	24,385	23,902
Total Operating Expenses	85,410	92,392	102,807	93,678	98,207	95,517	99,965
Operating Income	1,835	1,864	687	5,079	2,713	427	2,402
Nonoperating Income	4,559	4,537	6,206	4,426	3,695	3,589	4,072
Excess of Revenues Over Expenses	$ 6,394	$ 6,401	$ 6,893	$ 9,505	$ 6,408	$ 4,016	$ 6,474

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

[1] The provision for bad debts, in the amounts of $6,377,717 and $5,606,618 were deducted from net patient revenue instead of itemized as an operating expense for the fiscal years ended June 30, 2010 and 2011, respectively.

The District is in the process of securing $6,000,000 in municipal lease financing with Banc of America Public Capital Corp (the "Lease Financing") to fund the purchase of equipment for the Health Facilities. The Lease Financing is expected to be funded on or about July 13, 2012. Proceeds of the Lease Financing will fund upgrades to the District's CT scanner and MRI imaging equipment as well as fund equipment for the cancer center, skilled nursing facility, dietary, surgery, therapy, laboratory and other areas of the Health Facilities.

Total Unrestricted Funds and Days Cash on Hand

The following table provides total unrestricted funds and day's cash on hand for the District as of June 30, 2007 through June 30, 2011, and as of May 31, 2012. Marketable securities are carried at market.

(000's omitted)	As of June 30 2007 (Audited)	2008 (Audited)	2009 (Audited)	2010 (Audited)	2011 (Audited)	As of May 31 2012 (Unaudited)
Cash and Cash Equivalents	$15,491	$20,223	$18,579	$16,324	$16,019	$16,324
Board Designated Funds	14,035	14,243	23,688	39,024	38,919	38,410
Total Unrestricted Funds	$29,526	$34,466	$42,267	$55,348	$54,938	$54,734
Daily Expenses	$ 224	$ 242	$ 276	$ 242	$ 254	$ 271
Days Cash on Hand[1]	132	142	153	229	216	202

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

[1] Determined by adding cash and cash equivalents plus board designated funds for capital replacement; and dividing that sum by total operating expenses minus depreciation and amortization expenses plus interest expense divided by 365 or 335 for the interim period as of May 31, 2012 (daily expenses).

Management's Analysis of Financial Performance

The District's audited excess of revenues over expenses for the fiscal year ended June 30, 2011, was $6,408,000, which is approximately $3,097,000 below fiscal year ended June 30, 2010, results. Over the past five years the District's excess of revenues over expenses has averaged approximately $7,120,000, per annum. The

District's fiscal year 2012 operating plan and budget provides a 3.3% return on equity and a 3.0% return on gross revenue. However, projected fiscal year 2012 return on equity is targeting 6.2% and return on gross revenue is targeting 4.0%. The District, historically, has required a 10% return on equity, however, Board approval was received for the reduced return on equity based on the additional depreciation costs anticipated with the completion of the Western Addition project and bond related projects.

Over the past several years, the District has consistently maintained a market share of approximately 70% for its service area. This strong market dominance along with a combined Medicare/Medicaid payor mix of only 46%, have provided positive margins for the District over those years. The District's service area has enjoyed a growth rate of more than twice that of the state of California over the past twenty-five years and has generally experienced lower unemployment rates than the state of California as a whole. The economic base of the District's service area continues to remain strong, with available jobs growing in market segments other than simply the recreation and resort industries.

Over the past ten years, the District has made substantial investments in its Health Facilities through the construction of a $5,700,000 medical office complex adjacent to Tahoe Forest Hospital and the purchase of an acute care health facility located in nearby Incline Village, Nevada, for $3,500,000. The District completed a $5,800,000 expansion to its Tahoe Forest Hospital facility with the addition of two new operating suites and an upgrade of its central plant, among other improvements. In 2006/2007, the District opened the new 40,000 square foot, $36,000,000, Western Addition project including medical, surgical, intensive care beds and expanded space for ancillary and admission services. The District maintains an improving liquidity position with its day's cash on hand increasing from 143 days as of June 30, 2005, to 202 days as of May 31, 2012, and a good leverage position as indicated by its present debt to capital ratio of 28% for revenue-based debt.

Both Tahoe Forest Hospital and Incline Village Community Hospital are designated as Critical Access Hospitals, and they are the only acute care hospitals located within the District's primary service area. The District operates the closest hospitals to twelve of the most active winter ski resorts in California.

The District desires to remain an independently governed community health services provider that delivers highly competent and personalized emergency, primary, and prevention services with a focus on operational excellence and innovation. The District's Mission is to be "The Best Mountain Community Health System in the Nation."

Health Facilities Utilization

The table below provides selected statistical indicators of inpatient and outpatient activity for the Health Facilities during the past five fiscal years ended June 30, 2011, and for the eleven-month period ended May 31, 2011 and 2012:

	Fiscal Year Ended June 30					Eleven Months Ended May 31	
	2007	2008	2009	2010	2011	2011	2012
Acute Care:							
Licensed Beds	39	29	29	29	29	29	29
Patient Days	5,490	5,542	5,311	5,496	5,449	4,851	4,561
Admissions	1,957	1,932	1,814	1,794	1,812	1,642	1,535
Occupancy	39%	52%	50%	52%	51%	50%	47%
Acute Length of Stay (Days)	2.81	2.87	2.93	2.93	3.00	2.95	2.97
Emergency Room Visits	19,672	18,685	17,905	17,372	17,348	16,113	14,981
Total Surgery Cases	1,928	1,890	1,952	1,916	1,751	1,579	1,836
Skilled Nursing:							
Licensed Beds	37	37	37	37	37	37	37
Patient Days[(1)]	10,981	12,380	12,416	12,366	11,446	10,486	10,812
Occupancy[(1)]	81%	92%	92%	92%	85%	85%	87%
Combined:							
Licensed Beds	76	66	66	66	66	66	66
Patient Days	16,471	17,922	17,727	17,862	16,895	15,337	15,373
Occupancy	59%	74%	74%	74%	70%	69%	69%

Source: District records.

(1) The District has utilized licensed medical/surgical beds when the need has arisen for the treatment of patients who require skilled nursing care.

Sources of Patient Service Revenue

The District participates in the Medicare and Medi-Cal/Medicaid programs. The percentage of gross patient revenues derived from Medicare, Medi-Cal/Medicaid, managed care contracts and commercial insurance for each of the past five fiscal years ended June 30, 2011, and for the eleven-month periods ended May 31, 2011 and 2012, is set forth below.

	Percent of Gross Patient Service Revenue Fiscal Year Ended June 30					Eleven Months Ended May 31	
	2007	2008	2009	2010	2011	2011	2012
Medicare	27%	27%	29%	30%	32%	32%	33%
Medi-Cal/Medicaid[(1)]	12	11	12	9	10	12	13
Commercial, HMO, PPO & Private	61	62	59	61	58	56	54
Total	100%	100%	100%	100%	100%	100%	100%

Source: District records.
(1) Less than 1% of the District's revenues are derived from the Nevada Medicaid program.

Medicare is a federal program, administered by the Centers for Medicare and Medicaid Services available to individuals age 65 or over and certain disabled persons. Medicaid is a federal and state program, known as Medi-Cal in California, under which the Health Facilities furnish services to program eligible persons.

The Health Facilities' inpatient acute and outpatient services rendered to Medicare program beneficiaries are reimbursed under a cost reimbursement methodology pursuant to their designation as a "Critical Access Hospital." Effective July 1, 2007, Tahoe Forest Hospital received Critical Access Hospital Designation. Costs incurred are reimbursed at tentative rates with final settlement determined after submission of annual cost reports and audits thereof by the Medicare fiscal intermediary. The District's Medicare cost reports have been audited by the Medicare fiscal intermediary through June 30, 2010, and final settlements have been received through that date.

Inpatient services rendered to Medi-Cal program beneficiaries are reimbursed based upon a cost reimbursement methodology. Reimbursement is at tentative rates with final settlement determined after submission of annual cost reports by the District and audits by the Medi-Cal fiscal intermediary. Medi-Cal cost reports have been audited by the Medi-Cal fiscal intermediary through June 30, 2009, and final settlements have been received through that date. Outpatient services rendered are paid at prospectively determined rates per procedure.

Adults who do not meet Medi-Cal eligibility criteria but who are medically indigent, as defined by California law, are eligible for medical services under the state-funded "MIA" program. Placer County administers the MIA program by contracting with providers on a per diem basis for patients requiring inpatient services. Nevada County contracts with the State of California to administer its MIA program, with the District receiving reimbursement on a cost-based methodology for patients treated at the Health Facilities. The MIA contract accounts for approximately 1% of gross patient revenues of the District.

The District has contracts with approximately 42 prepaid plans and preferred provider discount contractors which comprise approximately 51% 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.

Affiliations

Tahoe Forest Health System Foundation. The Tahoe Forest Health System Foundation (the "Foundation") was organized in 1987 and is a California nonprofit 501(c)(3) public benefit corporation organized for the purpose of soliciting and distributing contributions and property to facilitate the building of a healthier community and the ongoing enhancement of the District's health care system. The Foundation contributed a total of approximately $6 million in community wide contributions towards the construction and equipping of the Western Addition. Donations to the Foundation are passed directly to the District, either to restricted purchases or programs per the donor's directions or retained in the Foundation's general funds. Of those funds, 15% are withheld each year and will be distributed to the District in amounts and in periods determined by the Foundation's board of trustees, who may also restrict the use of the general funds for plant replacement or expansion or other specific purposes.

The Foundation has a membership of over 5,000 donors and a governing board of five trustees. The Foundation has raised just over $10.2 million for Tahoe Forest Hospital since 2000. The Foundation is not liable for repayment of the Bonds.

Incline Village Community Hospital Foundation. The Incline Village Community Foundation (the "Incline Village Foundation") was organized in 2004 and is an independent Nevada nonprofit 501(c)(3) corporation organized for the purpose of soliciting and distributing contributions and property for the benefit of the Incline Village Community Hospital. The Incline Village Foundation concluded a capital campaign that contributed a total of approximately $1.5 million in community wide contributions towards the construction and equipping of an emergency room expansion and remodel. A second capital campaign is expected to generate approximately $500,000 in contributions to renovate and equip Incline Village Hospital's imaging department. The Incline Village Foundation's general funds, which represent its unrestricted resources, will be distributed to the District in amounts and in periods determined by the Foundation's board of trustees, who may also restrict the use of the general funds for plant replacement or expansion or other specific purposes. The Incline Village Foundation has a membership of over 1,500 donors and a governing board of approximately thirteen trustees. The Foundation has raised just over $2.5 million for Incline Village Community Hospital since 2004. The Foundation is not liable for repayment of the Bonds.

Tahoe Forest Hospital Auxiliary. The Tahoe Forest Hospital Auxiliary (the "Auxiliary") was formed in 1978 and has been an active participant in the delivery of healthcare services at Tahoe Forest Hospital since that time. The Auxiliary provides volunteer support to the Health Facilities in several areas, including fundraising, office staff assistance, operating of the gift shop, the thrift shop, staffing of health fairs, the Health Facilities' lobby, assisting patients, among other services. Auxiliary volunteers provide in excess of 10,000 hours annually in support of the Health Facilities and their patients. The Auxiliary is not liable for repayment of the Bonds.

Tahoe Institute for Rural Health Research. The Tahoe Institute for Rural Health Research (the "Research Institute") was formed in 2009 by the District as a California nonprofit public benefit corporation and has applied to the Internal Revenue Service for a determination of charitable, exempt status under Sections 501(a) and 501(c)(3) of the Code. The District is the sole member of the Research Institute. It is anticipated that the Research Institute will be a vehicle through which scientific research and collaboration with medical practitioners will produce innovative solutions for rural health care issues. The Research Institute is not liable for repayment of the Bonds.

UC Davis Health System. The District has entered into a participation and license agreement with the University of California Health System pursuant to its UC Davis Cancer Care Network to provide cancer care expertise and support to the District and to patients treated at the District's Cancer Center. Advanced cancer therapies and clinical trial opportunities are made available to oncology patients treated at the Cancer Center. The affiliated status affords the District expertise, technology and training opportunities not otherwise available to its oncology programs. The District is also a site for the UC Davis Rural Prime Program that, among other benefits, provides access to ongoing training and support for over twenty of the District's medical staff members who serve on the volunteer medical staff of UC Davis Medical Center located in Sacramento, California. The Tahoe Institute for Rural Health Network has also entered into a separate affiliation agreement with UC Davis Health System for the sharing of resources relating to research opportunities. UC Davis Health System is not liable for payment of the Bonds.

Other Affiliations. The District contracts with various other medical providers to provide clinical and professional services in the areas of non-invasive cardiology, pathology, anesthesia, emergency medicine, and mobile lithotripsy. The District plans for and evaluates potential affiliations as part of its overall strategic planning. Tahoe Forest Hospital has a number of training affiliations with various colleges and educational institutions to advance its employees' training in medicine, nursing and other ancillary medical professional fields. Some of these affiliations include: University of Nevada, Reno, Stanford, California State University at Chico, Feather River College, Sierra College, Northern California Training Institute, University of Vermont, Touro University, Midwestern University, University of Nevada at Las Vegas, and University of St. Francis. No other affiliation agreements are in place and no serious discussions are occurring with other potential affiliation partners.

Public and Professional Liability Insurance Considerations

The District currently carries comprehensive liability insurance through a pooled self-insurance program insuring the Hospital 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 June 30, 2012. The District contracts such insurance through a joint

powers authority ("BETA Healthcare Group") under California law authorizing governmental agencies, such as local health care districts, to join together for insurance purposes. Currently, ninety-three participants representing health care districts, city and county hospitals participate in BETA Healthcare Group. Coverage is on a claims-made basis.

BETA Healthcare Group is funded by monthly contributions paid by the health care providers participating in BETA Healthcare Group. The contributions are used to fund a reserve for expected losses to be paid by BETA Healthcare Group on a pooled, self-insured basis. The amount of the monthly contribution to be paid by a participant is based on independent actuarial computations taking into account factors such as, among others, total number of beds, outpatient and inpatient visits, surgeries, deductible and loss experience of the participant. The reserve for claims and claims expenses has been determined using the developed loss and loss expense method. For the fiscal year ended June 30, 2011, the District paid $575,868 in net contributions to BETA Healthcare Group.

At June 30, 2011, BETA Healthcare Group had a reserve for claims and claims expenses relating to the District of $308,446. For the fiscal year ended June 30, 2011, BETA Healthcare Group paid claims and claims expenses on behalf of the District totaling $41,380.

The District is unaware of any claim paid on its behalf which was not covered by insurance. There are no material malpractice 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 facilities like the Health Facilities are not subject to punitive damage awards. Property damage is covered by Driver Alliant Insurance Services.

The District does not maintain separate flood insurance coverage or earthquake insurance covering its Health Facilities against damages caused by flooding or seismic activity. The District is self-insured for employee medical, dental and vision insurance.

Employees' Retirement Plan

The District has a defined contribution pension plan covering any employee who completes 1,000 hours of service in a calendar year. The District is required to make annual contributions equal to 3% of each employee's annual compensation plus 3% of each employee's annual compensation in excess of the social security tax wage base. Employee contributions are voluntary and limited to 10% of an employee's annual compensation.

The District also offers its employees a deferred compensation plan created in accordance with Internal Revenue Code Section 457. The plan, available to all employees, permits them to defer a portion of their current salary until future years. The District matches participation deferrals up to 3% to 7% of earnings for full-time and regular part-time participants. Employee contributions are limited to 100% of total employee compensation or $16,500, whichever is less. Since January 1, 2006, the employer matching contributions under this deferred compensation plan are deposited into employee accounts in the money purchase pension plan.

Total employer contributions under the above benefit programs were $2,394,604 and $2,223,650 in 2010 and 2011, respectively.

Town of Truckee, Placer and Nevada Counties

During the past twenty-two years the populations of Nevada County and Placer County have increased 24% and 106%, respectively, while the population the State of California has increased 27% over the same period. Population figures as reported for the 1990, 2000 and 2010 census reports and estimated for 2012 for Nevada County, Placer County and the State of California (the Town of Truckee does not have population data for 1990, due to it being unincorporated at that time,) are as follows:

	1990	2000	2010	2012	1990-2012 % Change
Town of Truckee	N/A	13,864	16,180	15,918	N/A
Nevada County	78,510	92,033	98,764	97,182	24%
Placer County	172,796	248,399	348,432	355,328	106%
California	29,760,021	33,871,648	37,253,956	37,678,563	27%

Source: California State Department of Finance. The 1990, 2000 and 2010 are census figures reported as of April 1 in each of those years and 2012 figures are estimates by the Department of Finance reported as of January 1, 2012.
N/A: Not available

The District boundaries and Tahoe Forest Hospital service area, which extends beyond the District boundaries, incorporates a good portion of both Nevada and Placer Counties. Although the seasonality of many of the major employers in this area contributes to the area's unemployment data, both Placer County and Nevada County unemployment percentages are below the State of California's average. This is in large part attributed to the diversity of employment in these areas. The March 2012 labor market can be divided into the following sectors:

	Nevada County	Placer County	State of California
Civilian Labor Force	50,770	174,700	18,368,900
Employed	45,950	157,900	16,436,700
Unemployed	4,820	16,800	1,932,200
Percentage Unemployment	9.5%	9.6%	10.5%

Source: State Employment Development Department, March 2012.

Capital Expenditures

Aside from construction and equipping costs related to the Project, total capital expenditures of approximately $19,400,000 are expected to occur over the next three years beginning in the fiscal year ended June 30, 2013. 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 District's Health Facilities and equipment related to the Project that cannot be funded with general obligation bond proceeds. These capital expenditures are planned to be funded from capital lease obligations, cash reserves and community based contributions. The District does not contemplate the issuance of revenue bonds over the next three years.

DISTRICT FINANCIAL MATTERS

Both the Placer County Assessor and the Nevada County Assessor assess 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 particular county's 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 1-1/2% per month to the time of redemption. If taxes are unpaid for a period of five years or more, the property is deeded to the State and then is subject to sale by the county's tax collector. The exclusive means of enforcing the payment of delinquent taxes in respect of property on the secured roll is the sale of the property securing the taxes to the State 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 Taxation 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 of property on the unsecured roll, and further, an additional penalty of 1-1/2% 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 by the State of California Board of Equalization. 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 from taxation. State law exempts 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 2011-12 assessed valuation of $15,176,131,340 which accounts for approximately 22% of the assessed valuation of $68,521,341,271 for the Counties as of the same period. Assessed values of property within the District have increased by approximately 84% over the ten-year period ended 2011-12, while assessed values for the Counties have increased by approximately 65% over the same period. The summary below shows a ten-year history of the total secured and unsecured assessed property valuations for the District and total assessed valuations for the Counties.

	Assessed Valuations [1]				
Fiscal Year	Local Secured	Utility	Unsecured	District Assessed Valuations	Counties Assessed Valuations
2002-03	$ 8,014,757,643	$8,980,352	$240,399,632	$ 8,264,137,627	$41,475,978,143
2003-04	8,798,508,356	8,743,355	238,668,718	9,045,920,429	46,398,421,409
2004-05	10,401,314,651	9,573,980	236,619,173	10,647,507,804	51,990,348,817
2005-06	11,929,585,153	8,982,887	254,766,090	12,193,334,130	59,295,987,515
2006-07	12,620,177,492	8,853,841	264,205,839	12,893,237,172	68,376,071,417
2007-08	14,083,290,518	9,148,584	284,440,683	14,376,879,785	74,393,361,393
2008-09	15,279,457,024	7,847,990	304,341,434	15,591,646,448	76,281,431,182
2009-10	15,945,911,167	7,802,236	306,155,218	16,259,868,621	75,155,052,961
2010-11	15,203,616,293	7,802,102	292,229,875	15,503,648,270	70,430,302,181
2011-12	14,895,779,814	5,699,921	274,651,605	15,176,131,340	68,521,341,271

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 Counties' Tax Collectors for property falling 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 three-year history (ending with the fiscal year 2010-11) of the secured tax charge, the tax amount delinquent and percentage of taxes delinquent each year as of June 30, related to the debt service levy for the 2008 Bonds and the 2010 Bonds for the Placer County portion and Nevada County portion, respectively, of the District.

Secured Tax Charges and Delinquencies (Placer County Portion)

	Secured	Delinquent as of June 30	
Fiscal Year	Tax Charge	Amount	Percent
2008-09	$ 977,406.64	$35,694.91	3.65%
2009-10	997,120.11	27,844.24	2.79
2010-11	1,834,216.42	42,089.33	2.29

Source: California Municipal Statistics, Inc.

In 2010-11 Placer County charged $1,834,216 in taxes related to the debt service for the 2008 Bonds and the 2010 Bonds. Delinquencies amounted to $42,089 or 2.29%.

Secured Tax Charges and Delinquencies (Nevada County Portion)

	Secured	Delinquent as of June 30	
Fiscal Year	Tax Charge	Amount	Percent
2008-09	$ 562,902.14	$21,843.39	3.88%
2009-10	566,108.30	18,402.03	3.25
2010-11	1,007,627.85	25,354.83	2.52

Source: Nevada County

In 2010-11 Nevada County charged $1,007,628 in taxes related to debt service for the 2008 Bonds and the 2010 Bonds. Delinquencies amounted to $25,355 or 2.52%.

Tax Rates

The base tax rate for all taxing entities within a particular tax code area is $1 per $100 (1%) of assessed valuation in accordance with the State Constitution. To this may be added whatever tax rates are necessary to meet debt service on indebtedness approved by the voters. The Board of the District annually will convey to the County Tax Collector the rate to be levied for the debt service on the Bonds. Typical tax rates are shown below for the Counties for representative tax rate areas ("TRA") located within the District.

Typical Total Tax Rates

Placer County (TRA 91-003)

	2002-03	2003-04	2004-05	2005-06	2006-07
General	1.000000	1.000000	1.000000	1.000000	1.000000
Tahoe-Truckee Joint Unified School District	.010900	.011100	.009829	.009338	.008655
Tahoe-Truckee Joint Unified School District SFID No. 2	.032500	.019900	.044290	.038108	.058132
Sierra Community College District SFID No. 1	-	-	-	.013822	.012488
Tahoe Public Utility District	.008900	.008000	.004100	.003400	.003000
Tahoe Forest Hospital District	-	-	-	-	-
Total	1.052300	1.039000	1.058219	1.064668	1.082275

	2007-08	2008-09	2009-10	2010-11	2011-12
General	1.000000	1.000000	1.000000	1.000000	1.000000
Tahoe-Truckee Joint Unified School District	.008103	.007073	.007066	.007824	.004543
Tahoe-Truckee Joint Unified School District SFID No. 2	.051910	.049228	.052393	.057261	.048883
Sierra Community College District SFID No. 1	.009418	.008986	.009082	.010592	.011434
Tahoe Public Utility District	.002800	.002600	002500	.000500	-
Tahoe Forest Hospital District	-	.010140	. 009850	.018760	.021000
Total	1.072231	1.078027	1.090891	1.094937	1.085860

Nevada County (TRA 3-001)

	2002-03	2003-04	2004-05	2005-06	2006-07
General	1.0000	1.0000	1.0000	1.0000	1.0000
Tahoe-Truckee Joint Unified School District	.0109	.0111	.0262	.0093	.0086
Tahoe-Truckee Joint Unified School District SFID No. 1	.0459	.0312	.0277	.0398	.0375
Sierra Community College District SFID No. 1	-	-	-	.0138	.0125
Tahoe Forest Hospital District	-	-	-	-	-
Total	1.0568	1.0423	1.0539	1.0629	1.0586

	2007-08	2008-09	2009-10	2010-11	2011-12
General	1.0000	1.0000	1.0000	1.0000	1.0000
Tahoe-Truckee Joint Unified School District	.0081	.0071	.0071	.0079	.0046
Tahoe-Truckee Joint Unified School District SFID No. 1	.0343	.0309	.0335	.0373	.0377
Sierra Community College District SFID No. 1	.0094	.0090	.0091	.0106	.0114
Tahoe Forest Hospital District	-	.0101	.0099	.0188	.0210
Total	1.0518	1.0571	1.0596	1.0746	1.0747

District Budget

The fiscal year of the District begins on the first day of July each year and ends on the thirtieth day of June 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., on June 1, 2012. 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 generally are 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.

TAHOE FOREST HOSPITAL DISTRICT

2011-12 Assessed Valuation:	$15,176,131,340
Redevelopment Incremental Valuation:	817,840,761
Adjusted Assessed Valuation:	$14,358,290,579

DIRECT AND OVERLAPPING TAX AND ASSESSMENT DEBT:	% Applicable	Debt 6/1/12	
Sierra Joint Community College District School Facilities Improvement District No. 1	99.985%	$ 33,610,931	
Tahoe-Truckee Joint Unified School District	95.070	9,150,488	
Tahoe-Truckee Joint Unified School District School Facilities Improvement District No. 1	99.974	26,573,046	
Tahoe-Truckee Joint Unified School District School Facilities Improvement District No. 2	89.140	40,401,883	
Placer Union High School District	0.065	22,268	
Tahoe Forest Hospital District	**100.**	**72,400,000**	(1)
Sierra Lakes County Water District	100.	240,000	
Truckee Donner Public Utility District Community Facilities District No. 03-1	100.	11,895,000	
Truckee Donner Public Utility District Community Facilities District No. 04-1	100.	33,770,000	
Northstar Community Services District Community Facilities District No. 1	100.	113,415,000	
TOTAL DIRECT AND OVERLAPPING TAX AND ASSESSMENT DEBT		$341,478,616	
OVERLAPPING GENERAL FUND DEBT:			
Nevada County Certificates of Participation	34.611%	$ 2,943,666	
Placer County General Fund Obligations and Office of Education Certificates of Participation	18.561	8,967,747	
Sierra Joint Community College District Certificates of Participation	21.119	2,633,539	
Tahoe-Truckee Joint Unified School District Certificates of Participation	95.070	4,896,105	
Placer Union High School District Certificates of Participation	0.065	4,683	
Town of Truckee General Fund Obligations	99.981	10,093,082	
Tahoe City Public Utility District Certificates of Participation	79.115	134,496	
Truckee Donner Recreation and Park Certificates of Participation	99.974	23,448,902	
Placer County Mosquito and Vector Control District Certificates of Participation	18.561	832,461	
TOTAL DIRECT AND OVERLAPPING GENERAL FUND DEBT		$ 53,954,681	
COMBINED TOTAL DEBT		$395,433,297	(2)

(1) Excludes general obligation bonds to be sold.

(2) Excludes tax and revenue anticipation notes, enterprise revenue, mortgage revenue and tax allocation bonds and non-bonded capital lease obligations.

Ratios to 2011-12 Assessed Valuation:

Direct Debt ($72,400,000)..... 0.48%

Total Direct and Overlapping Tax and Assessment Debt 2.25%

Ratios to Adjusted Assessed Valuation:

Combined Total Debt 2.75%

STATE SCHOOL BUILDING AID REPAYABLE AS OF 6/30/11: $0

Largest Taxpayers

The 20 largest taxpayers in the District as shown on the 2011-12 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 assessed value of $630,911,435 or 4.24% of the District's 2011-12 local secured assessed value.

Largest 2011-12 Local Secured Taxpayers

	Property Owner	Primary Land Use	2011-12 Assessed Valuation	% of Total [1]
1.	Highlands Hotel Company LLC	Hotel	$ 88,902,602	0.60%
2.	Trimont Land Company	Recreational/Ski Lodge	72,195,574	0.48
3.	Squaw Valley Development Co.	Recreational/Ski Lodge	53,092,847	0.36
4.	Homewood Village Resorts LLC	Recreational/Ski Lodge	52,644,988	0.35
5.	RitzCarlton Development Company	Residential Properties	46,451,877	0.31
6.	Squaw Creek Associates	Hotel/Golf	39,032,662	0.26
7.	Sugar Bowl Corporation	Recreational/Ski Lodge	34,510,315	0.23
8.	Northstar Group Commercial Properties LLC	Commercial	26,456,207	0.18
9.	Alpine Sierra Ventures LLC	Recreational/Ski Lodge	23,462,426	0.16
10.	Individuals	Residential	20,385,000	0.14
11.	Family Trust	Recreational/Ski Lodge	20,102,842	0.13
12.	Joerger Associates LLC	Commercial	19,367,219	0.13
13.	Gateway at Donner Pass LP	Commercial	18,772,205	0.13
14.	Family Trust	Residential	17,446,091	0.12
15.	Safeway Inc.	Commercial	17,437,577	0.12
16.	Tahoe CRT LLC	Residential	17,069,011	0.11
17.	Family Trust	Hotel	16,310,039	0.11
18.	Family Trust	Residential	16,000,000	0.11
19.	Family Trust	Residential	15,887,437	0.11
20.	Family Trust	Residential	15,384,516	0.10
	Total		$630,911,435	4.24%

Source: California Municipal Statutes, Inc.
[1] 2011-12 Local Secured Assessed Valuation: $14,895,779,814

Largest Employers

The Town of Truckee and the Counties enjoy a diverse labor pool as a result of their role as a destination for recreation, regional manufacturing, service and retail center. Nevada County's recreation dominated employment distribution affects the Town of Truckee's job market and unemployment rates. Placer 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 and is one of the fastest growing business communities in California at this time. The following table summarizes the ten largest private and public employers in the Counties. It should be noted, however, that none of these employers have a main facility within the District's boundaries.

Placer and Nevada Counties
Largest Employers

Company	Product/Service	Employees
Hewlett Packard	Computer Hardware Manufacturing	3,500
Kaiser Foundation	Healthcare	3,147
Sutter Health	Healthcare	2,144
Thunder Valley Casinos	Casinos	2,025
Union Pacific Railroad Co. Inc	Transportation, Railroad	2,000
Northstar-at-Tahoe Resort	Ski Resort	1,950
County of Nevada	Government	1,025
Raley's Inc.	Retail Groceries	1,000
Nevada County Publishing Co	Publisher	1,000
Automata Inc.	Agriculture Monitoring	1,000
PRIDE Industries Inc.	Manufacturing & Logistics Services	878
Wells Fargo & Co	Financial Services	778
SureWest Communications	Telecommunication Services	616

Source: Placer County Economic Development and Nevada County Economic Development Corporation.

Commercial Activity

The Town of Truckee is the retail center for the District and experienced a 13% decline in retail sales from 2008 to 2010, while Placer County experienced a 9% decline in retail sales and Nevada County experienced a 15% 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 Town of Truckee, Placer County and Nevada County for the calendar years 2008, 2009 and 2010. Information is not yet available for the full year of 2011.

Town of Truckee, Placer and Nevada Counties
Taxable Transactions and Total Outlets
2008-2010

(000's)	2008	2009	2010
Town of Truckee			
Sales Tax Permits	673	630	622
Taxable Sales	259,004	215,503	224,482
Placer County			
Sales Tax Permits	12,104	11,135	11,439
Taxable Sales	6,634,810	5,796,644	6,017,542
Nevada County			
Sales Tax Permits	4,176	3,871	3,938
Taxable Sales	1,187,429	983,220	1,011,819

Source: State Board of Equalization.

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 Bond Counsel, interest on the Bonds is excludable from the 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 interest on the Bonds is taken into account, however, in computing an adjustment used in determining the federal alternative minimum tax for certain corporations.

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.

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.

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 Investors Service ("Moody's") has assigned a rating of "Aa3" (with a "Stable Outlook") to the Bonds. No application was made 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 ratings 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 ratings or to oppose any such proposed revision or withdrawal. Any such downward change in or withdrawal of the ratings might have an adverse effect on the market price or marketability of the Bonds.

MISCELLANEOUS

Underwriting

The Bonds are being purchased pursuant to the terms of the public bid dated July 11, 2012, for re-offering by _____ (the "Underwriter"). The Underwriter has agreed to purchase the Bonds for $_____, which includes the principal amount of $_____ plus an original issue premium of $_____, less the Underwriter's discount of $_____. The Underwriter will be obligated to purchase all the Bonds.

Continuing Disclosure

The District has covenanted for the benefit of bondholders and Beneficial Owners of the Bonds to disseminate as described below certain financial information and operating data relating to the District upon written request of any bondholder or Beneficial Owner, 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 "Rule"). The District has continuing disclosure obligations with respect to its revenue bonds since 1999 and since 2008 with respect to its general obligation bonds. The District has represented that it has complied with those obligations.

Additional Information

The foregoing and subsequent 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 such 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.

TAHOE FOREST HOSPITAL DISTRICT

By: _____

Title: Chief Executive Officer

APPENDIX A

FORM OF FINAL OPINION OF BOND COUNSEL

[Letterhead of Quint & Thimmig LLP]

[Closing Date]

Board of Directors
Tahoe Forest Hospital District
10121 Pine Avenue
Truckee, California 96160

OPINION: $26,100,000 Tahoe Forest Hospital District (Placer and Nevada Counties, California) General Obligation Bonds, Election of 2007, Series C (2012)

Members of the Board of Directors:

We have acted as bond counsel to the Tahoe Forest Hospital District (the "District") in connection with the issuance by the District of $26,100,000 principal amount of Tahoe Forest Hospital District (Placer and Nevada Counties, California) General Obligation Bonds, Election of 2007, Series C (2012) (the "Bonds"), pursuant to Chapter 4 of Division 23 (commencing with section 32300) of the California Health and Safety Code (the "Act"), and a resolution adopted by the Board of Directors of the District on June 26, 2012 (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 local health care district with the power to cause the Board to issue the Bonds in its name 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 Board Resolution for the security of the Bonds.

3. The Bonds have been duly authorized, executed and delivered by the Board and are valid and binding general obligations of the District. The Board 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 (i) is excludable from gross income of the owners thereof for federal income tax purposes, (ii) 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, and (iii) interest on the Bonds is not taken into account in computing adjusted current earnings, which is used as an adjustment in determining the federal alternative minimum tax for certain corporations. Failure to comply with certain of such covenants could cause interest on the Bonds to be includable in gross income for federal income tax purposes retroactively to the date of issuance of the Bonds.

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 Resolutions 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 Years Ended June 30, 2010 and 2011

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TAHOE FOREST
HOSPITAL DISTRICT

Truckee, California

FINANCIAL STATEMENTS WITH
INDEPENDENT AUDITORS' REPORT

June 30, 2011 and 2010

Matson and Isom

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Tahoe Forest Hospital District

June 30, 2011 and 2010

matson and isom

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INDEPENDENT AUDITORS' REPORT

To the Board of Directors
Tahoe Forest Hospital District
Truckee, California

We have audited the accompanying balance sheets of Tahoe Forest Hospital District (the District), a California political subdivision, as of June 30, 2011 and 2010, and the related statements of revenues, expenses, and changes in net assets, and cash flows for the years then ended, which collectively comprise the basic financial statements of the District as the primary government. These financial statements are the responsibility of the District's management. Our responsibility is to express an opinion on these financial statements based on our audits.

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

The financial statements do not include financial data for the District's legally separate component units, which should have been presented as aggregate discretely presented component units. Accounting principles generally accepted in the United States of America require the financial data for those components units to be reported with the financial data of the primary government unless the District also issues financial statements for the financial reporting entity that includes the financial data for its component units. The District has not issued such reporting entity financial statements. The assets, liabilities, net assets, revenues and expenses of the component units not presented are disclosed in note 12 to the financial statements.

In our opinion, because of the omission of the discretely presented component units, as discussed previously, the financial statements referred to previously do not present fairly, in conformity with accounting principles generally accepted in the United States of America, the financial position of the aggregate discretely presented component units of the District as of June 30, 2011 and 2010, or the changes in financial position thereof for the years then ended.

Further, in our opinion, the financial statements referred to previously present fairly in all material respects, the financial position of the District as the primary government, as of June 30, 2011 and 2010, 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.

INDEPENDENT AUDITORS' REPORT

Continued

Accounting principles generally accepted in the United States of America require that the management's discussion and analysis on pages 3 through 11 be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board, who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Matson and Isom

October 7, 2011

MANAGEMENT'S DISCUSSION AND ANALYSIS
(Required Supplementary Information)

OVERVIEW OF THE FINANCIAL STATEMENTS

This annual report consists of Management's Discussion and Analysis, financial statements, and notes to those statements. These statements are organized to present the Tahoe Forest Hospital District (the District) as a financial whole, an entire operating entity. The statements then proceed to provide an increasingly detailed look at specific financial activities. Readers should also review the accompanying notes to the financial statements to enhance their understanding of the District's financial performance.

The Balance Sheets, the Statements of Revenues, Expenses, and Changes in Net Assets and Statements of Cash Flows provide an indication of the District's financial health. The Balance Sheets include all of the District's assets and liabilities, using the accrual basis of accounting, as well as an indication about which assets can be utilized for general purposes and which are restricted as a result of bond covenants, donor restrictions, or other purposes. The Statements of Revenues, Expenses, and Changes in Net Assets report all of the revenues, expenses, increases and decreases in net assets during the time period indicated that resulted from the District's operating and non-operating transactions and capital contributions during the year. The Statements of Cash Flows report the cash provided and used by operating activities, as well as other cash sources such as investment income, repayment of bonds, and capital additions and improvements.

FINANCIAL HIGHLIGHTS

- Total assets increased $46.6 million in 2011. Total cash and cash equivalents decreased $.3 million in 2011. Net patient accounts receivable increased $2.3 million. Days net patient service revenue in net patient accounts receivable increased 8 days to 59 days at June 30, 2011. Capital assets increased $14.8 million. Assets Limited as to Use – Net increased $24.1 million.

- Total liabilities increased $40.0 million, current liabilities increased $1.9 million, and noncurrent liabilities increased $38.1 million.

- The increase in net assets for 2011 was $6.6 million.

FINANCIAL ANALYSIS OF THE DISTRICT

The District's net assets increased $6.6 million from a year ago to $93.5 million. Table 1 provides a summary of the District's net assets for 2011 and 2010.

Table 1
SUMMARY OF ASSETS, LIABILITIES, AND NET ASSETS
(In thousands)
AS OF JUNE 30

Assets:	**2011**	**2010**
Current assets	$38,812	$35,504
Board-designated and restricted funds	87,458	63,320
Net capital assets	89,939	75,143
Other assets	8,574	4,214
Total Assets	**$224,783**	**$178,181**
Liabilities:		
Current liabilities	20,794	18,871
Noncurrent liabilities	110,535	72,422
Total Liabilities	**131,329**	**91,293**
Net Assets:		
Unrestricted	63,991	57,742
Invested in capital assets, net of related debt	29,236	28,931
Restricted by donor for specific uses	227	215
Total Net Assets	**93,454**	**86,888**
Total Liabilities and Net Assets	**$224,783**	**$178,181**

In 2011, the District's cash and investment position decreased $.3 million.

Table 2
SUMMARY OF CASH AND INVESTMENTS
(In thousands)

Account:	**2011**	**2010**
Cash and cash equivalents and short-term investments	$16,019	$16,324
Board designated fund	38,255	38,060
Specific purpose fund	110	48
Workers' compensation fund	7	12
Unexpended capital bond fund	50,454	27,180
Total Available Cash and Investments	**$104,845**	**$81,624**

The District maintains sufficient cash balances to cover all short-term liabilities. All excess cash is transferred to the Board Designated funds for future needs. The Unexpended Capital Bond Fund shows an increase of $23.3 million over the prior year due to the second issuance of general obligation bonds in the amount of $43 million offset by expenditure of project funds directly related to capital asset projects approved as part of the general obligation bonds (Measure C).

CAPITAL ASSETS, NET

Net capital assets increased $14.8 million to $89.9 million at June 30, 2011. This increase resulted from $25.6 million in capital additions offset by $5.5 million in depreciation, $5.2 million of asset transfers from construction in progress, and $146,000 (net) of retired assets. The capital additions include $7.1 million in equipment, building and land improvements (of which $5.2 million were transfers from construction in progress), and $18.6 million in construction in progress. Major capital additions during the year included a new nuclear medicine camera/fluoroscope unit, new telemetry for our cardiac rehabilitation program, investment in surgical equipment for both facilities, upgrades to our Incline Village surgical suite and sterile processing equipment, continued investment in our computer information and phone systems, and construction for projects related to Measure C on the Tahoe Forest Hospital campus.

DEBT ADMINISTRATION

The District has debt obligations as follows:

	2011	2010
General Obligation Bonds Series 2008 (Measure C)	$72,400,000	$29,400,000
Revenue Bonds Series 2006	26,005,000	26,630,000
Revenue Bonds Series 1999 A and 1999 B	0	3,040,000
Variable Rate Demand Revenue Bonds Series 2002	10,690,000	10,940,000
Bank equipment leases	1,466,574	2,339,583
Municipal leases	0	138,773
Total	**$110,561,574**	**$72,488,356**

With the second issuance of general obligation bonds, the District saw an increase in its General Obligation Bonds Series 2008 (Measure C) debt. However, $3.5 million of the funds received from the second issuance was used to pay off the Revenue Bonds Series 1999A, as well as the Municipal leases.

REVENUES AND EXPENSES

Table 3 shows the revenues, expenses, and net assets for 2011 and 2010.

Table 3
SUMMARY OF REVENUES, EXPENSES, AND CHANGES IN NET ASSETS
(In thousands)
YEAR ENDED

Operating Revenues:	**2011**	**2010**
Net patient service revenue	$94,323	$92,422
Other	6,596	6,335
Total Operating Revenues	**100,919**	**98,757**
Operating Expenses:		
Salaries and wages	33,897	33,519
Employee benefits	19,358	17,352
Supplies	13,878	12,949
Professional fees	12,686	12,226
Purchased services	7,107	6,741
Depreciation	5,372	5,303
Insurance	750	388
Other operating expenses	5,159	5,200
Total Operating Expenses	**98,207**	**93,678**
OPERATING INCOME	**2,712**	**5,079**
Non-Operating Revenues and Expenses		
District tax revenue	7,824	6,223
Income from joint venture	31	0
Interest income	280	854
Donations	567	664
Interest expense	(4,867)	(3,356)
Rental income net	7	9
Gain (Loss) on sale of assets	(146)	32
Total Non-Operating Revenues and Expense	**3,696**	**4,426**
Capital Contributions	158	131
Increase in Net Assets	6,566	9,637
Total Net Assets, Beginning of Year	86,888	77,251
Total Net Assets, End of Year	**$93,454**	**$86,888**

NET PATIENT SERVICE REVENUES

For the year ended June 30, 2011, net patient service revenues increased by $1.9 million or 2%. This was due to positive impacts from prior period settlements and a decline in provision for bad debts. Net patient service revenue is composed of gross patient service revenue, less contractual allowances, charity care, prior period settlements, and provision for bad debts.

Gross patient service revenues actually decreased by $2 million or 1.3% due to a decline in volumes compared to our previous year. Significant volume percentage decreases were as follows: OB days 20.1%, Deliveries 6.2%, Surgical cases 11.2%, GI/Endoscopy cases 9.2%, Diagnostic Imaging exams 7.3%, CT Scans 7.4%. However, our oncology program continues to be quite successful, showing a 22.4% increase in volumes. This program generates additional ancillary service revenue for Tahoe Forest Hospital (TFH) in the areas of diagnostic imaging, CT, and PET CT. In addition, we continue to see growth in our multi-specialty clinics.

Contractual allowances as a percent of gross patient service revenues decreased slightly from prior year by .63%. However, when incorporating the effect of the prior period settlements the District received in FY 2011 that pertained to FY 2010, FY 2011 actually saw a .77% increase in contractual allowances as a percent of gross patient service revenues. This reflects the shifting in the gross revenue payer mix the District experienced in FY 2011. (See DEDUCTIONS FROM REVENUE below).

Charity care remained consistent with prior year at approximately 3% of gross patient service revenues. (See CHARITY CARE AND COMMUNITY BENEFIT below). However, provision for bad debts as a percent of gross patient service revenues showed a .43% decline compared to previous year.

INPATIENT BUSINESS ACTIVITY

Total admissions increased by 11 and total patient days decreased by 90 reflecting a slight decrease in our average length of stay. TFH became a critical access hospital effective July 1, 2007, reducing its acute care beds to 25, down from 35. Table 4 presents a summary of inpatient business activity.

Table 4
INPATIENT BUSINESS ACTIVITY

Acute	**2011**	**2010**
Admissions	1,778	1,767
Length of stay	2.95	3.02
Average daily census	14.4	14.6
Occupancy percentage	57.5%	58.5%
Patient days	5,245	5,335
Total ICU days	1,170	1,294
Total medical/surgical days	3,344	3,126
Total obstetrics days	731	915
Total M/S swing days	204	151
Nursery days	788	887
Deliveries	379	404
Skilled Nursing Unit		
Patient days	11,446	12,366
Average daily census	31	34
Occupancy percentage	84.8%	91.6%

OUTPATIENT BUSINESS ACTIVITY

The District's outpatient revenue was .39% lower than the prior year. The decrease is attributable to a decline in volumes related to radiology exams, CAT scan exams, and surgery cases. However, this decrease was almost completely offset by the continued success of the oncology program, and increased volumes in the area of laboratory and ultrasound exams. We have also added additional multi-specialty clinics.

Table 5
OUTPATIENT BUSINESS ACTIVITY

	2011	2010
Emergency department visits	17,348	17,372
Laboratory tests	168,384	140,018
Home health visits	4,080	4,423
Radiology exams	10,483	11,075
Ultrasound exams	3,666	3,542
Cat scan exams (including PET CT)	4,458	4,828
MRI scan exams	1,648	1,680
Surgery cases	1,001	1,131
Surgery minutes	76,229	88,731

DEDUCTIONS FROM REVENUE

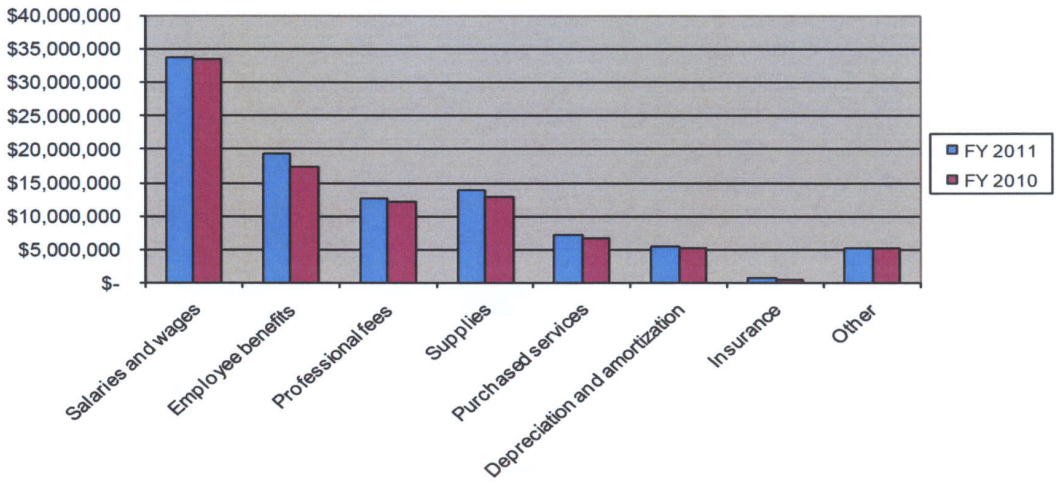
Contractual allowance adjustments (expressed as a percentage of gross revenues) were 32.2% for fiscal year 2011 and 32.7% for fiscal year 2010. The District's payer mix for fiscal year 2011 was 32.0% Medicare, 11.8% Medi-Cal, 0.5% County, 7.0% Other, and 48.7% Insurance compared to fiscal year 2010 mix of 30.3% Medicare, 11.5% Medi-Cal, 0.2% County, 8.0% Other, and 50.0% Insurance. The State programs, as well as some federal programs, continue to hold reimbursements to the District below actual increases (inflation) in costs. TFH became a critical access hospital effective July 1, 2007, which changed its Medicare reimbursement methodology to cost-based reimbursement.

CHARITY CARE AND COMMUNITY BENEFIT

The District provides care without charge or at amounts less than established rates to patients who meet certain criteria under its charity care policy. Charity allowances are based upon the customary charges for the services provided under this program. The District recorded $4.6 million in charity care for patient services during fiscal year 2011 and $4.9 million for fiscal year 2010.

OPERATING EXPENSES

Total operating expenses were $98.2 million for the year ended June 30, 2011, and $93.7 million for the year ended June 30, 2010, as summarized in the graph.



Total operating expenses increased $4.5 million, or 4.8% from the prior year.

The District experienced increases in the areas of salaries and wages, and employee benefits, which increased by a total of $2.4 million as a result of wage increases as outlined in the employee bargaining unit agreements (approximately $970,000) and an increase in our health insurance costs under our self-insured program (approximately $1.4 million). Professional fees increased $460,000 due to additional physicians joining our multi-specialty clinics, as well as a new hematologist/oncologist for our cancer program. Supplies increased $929,000 primarily due to the increased pharmaceutical costs related to increased volumes in our cancer program.

ECONOMIC FACTORS AFFECTING NEXT YEAR

2011 was an exciting and challenging year for the health system. We are once again very pleased with the number of significant achievements this year that continue to set our health system apart from our peer group.

Among the many accomplishments of FY 2011, we continue to enjoy a closer working relationship with UC Davis Health System. Our Rural PRIME teaching partnership continues to receive excellent feedback and is again a top rotation choice for UC Davis medical students. Our cancer program expansion is a very exciting outcome of our work with both the UC Davis Cancer Care Network and our local Cancer Advisory Council. Both organizations have provided our community with opportunities to broaden our cancer care programming which has led to an increasingly broader number of patients seeking care in our cancer center this year. Our Tahoe Institute for Rural Health Research has captured the imagination of our UC Davis affiliated research partners. The Institute will finish the year actively pursuing technology development opportunities in only its second year of existence.

We enjoyed another financially productive year. We completed the long awaited merger of the Truckee Surgery Center, formed the new Truckee Surgery Center LLC, and we were successful in restoring a major portion of the cash investment in the surgery center by aggressively managing our balance sheet through the year. We began the arduous process of evaluating how to best organize and govern the transformation of our information technology systems to a new enterprise system platform while focusing our strategic positioning to optimize the potential of leveraging an informatics platform to guide future planning.

Tahoe Forest Hospital reached a pinnacle of success in our service excellence program in the latter half of FY 2011 by outperforming all individual mountain area hospitals in our mountain community hospital cohort in two major service excellence categories as reported through Press Ganey. This has truly set our hospital apart from our peer group as one of the best mountain community hospitals in the nation. In addition, Tahoe Forest Health System was honored by the California Council for Excellence as a Gold Level CAPE Award recipient. The Gold Level is the highest rated performance tier among any hospitals and health systems in the state of California in 2011.

The health system expanded services by adding a dedicated breast MRI service as an extension of the Briner Center and our cancer program which improves diagnostic treatment for high risk breast cancer patients. The health system replaced the failing "Children's Cabinet Clinic" by opening the Incline Village Family Health Clinic. Management was also successful in recruiting a new general surgeon, a second cardiologist/internist, and a fourth pediatrician to the community. All three physicians will join our health system in July of the new fiscal year.

The new year will look much like 2011. Our strategic focus will continue to be narrowed to improve service and quality outcomes using the Baldrige Performance Excellence Criteria as our framework for performance excellence. We will continue to work our way through the process of building consensus around the selection of a new enterprise EMR and business systems as we work toward meeting the newly established meaningful use requirements for critical access hospitals under health reform.

In FY 2012, we will explore the potential of attracting federal, state, and third party grant funding to advance our strategic application of informatics to the design of new health delivery/preventive health concepts, and begin planning to improve programming in line with the findings in our 2011 needs assessment. The greatest collaboration of 2012 will be with one another as we begin the process of migrating new clinical information systems and creating more binding partnerships for improving our care delivery models.

The pace and uncertainty of health reform, the changing health insurance and consumer driven market environment combined with the absolute scope of unfunded, yet mandated financial investments, will require our health system to continually evaluate our capital structure, our service level pricing, closely scrutinize sources and uses of capital, redesign care delivery to improve efficiency, and optimize program revenues while we seek to drive collaborative innovation in 2012. Our financial assumptions focus on continued retention of the 80% range inpatient market share that we have enjoyed over the past few years, while growing outpatient revenues, mainly in the cancer market. Outpatient markets will continue to shift with new approaches to insurance benefit design, and we expect to continue to see declines in commercial payor levels and increases in Medicare and MediCal business. It is essential that we continue to invest in programs that have growth markets like the cancer program and continue to talk with local employers to assure them that we will partner with them as they reform their health care budgets.

As the health care delivery landscape continues to change at unprecedented levels, our health system will complete the new cancer center in the later part of 2012 and begin a new phase in service with the addition of radiation oncology in 2013. The health system will be adding depth to our management team in the cancer center as we prepare to grow its program scope and revenue for future years. Philanthropy and fund raising activities will continue to be a priority as we embark on a major endowment campaign for the cancer center and the completion of the first floor renovation of Incline Village Community Hospital. Measure C projects will continue to be developed based on the Board approved Facility Development Plan for Tahoe Forest Hospital.

Our budget assumptions for 2012 have been carefully constructed to balance key investments with a conservative approach to the maintenance of our strong, yet fragile capital structure. To complement this approach, management will continue to take an aggressive and proactive position on managing controllable expenses in FY 2012 to assure that we are able to balance our budget in this dynamic era of health reform. Balance sheet management and organization redesign will continue to be dominant themes as we lead our health system through these challenging times.

FINANCIAL SECTION

June 30	2011	2010
ASSETS		
CURRENT ASSETS		
Cash and cash equivalents	$ 16,018,750	$ 16,324,072
Patient accounts receivable - less allowance for uncollectible accounts of $12,313,805 and $11,634,835, respectively	15,289,062	12,974,920
Other receivables	1,203,036	807,768
Assets limited as to use	1,368,215	1,980,653
Inventories	2,229,673	2,136,807
Prepaid expenses and deposits	801,337	890,458
Estimated third-party payor settlements	1,902,281	388,942
Total Current Assets	38,812,354	35,503,620
ASSETS LIMITED AS TO USE		
Assets limited as to use	88,825,744	65,300,271
Less: Amount required to meet current obligations	(1,368,215)	(1,980,653)
Assets Limited as to Use - Net	87,457,529	63,319,618
NONCURRENT ASSETS AND INVESTMENTS		
Investment in joint venture	4,392,580	-
Bond issuance cost - net	1,386,009	1,266,764
Other receivables	192,644	27,589
Other noncurrent assets	1,238,671	1,255,338
Deferred outflow of resources	1,364,506	1,665,329
Total Noncurrent Assets and Investments	8,574,410	4,215,020
CAPITAL ASSETS - NET	89,938,926	75,142,948
Total Assets	$ 224,783,219	$ 178,181,206

The accompanying notes are an integral part of these financial statements.

June 30	2011	2010
LIABILITIES AND NET ASSETS		
CURRENT LIABILITIES		
Current maturities of long-term debt and capital lease obligations	$ 1,390,991	$ 1,731,117
Accounts payable	6,250,057	4,940,341
Accrued payroll and related expenses	6,920,901	6,490,966
Estimated claims incurred but not reported	3,851,676	3,593,327
Estimated third-party payor settlements	209,924	563,524
Accrued interest	2,170,180	1,551,672
Total Current Liabilities	20,793,729	18,870,947
NONCURRENT LIABILITIES		
Long-term debt and capital lease obligations - net of current maturities	109,170,583	70,757,239
Derivative instrument liability	1,364,506	1,665,329
Total Liabilities	131,328,818	91,293,515
NET ASSETS		
Invested in capital assets - net of related debt	29,284,259	28,931,324
Restricted	227,196	214,533
Unrestricted	63,942,946	57,741,834
Total Net Assets	93,454,401	86,887,691
Total Liabilities and Net Assets	$ 224,783,219	$ 178,181,206

The accompanying notes are an integral part of these financial statements.

Years Ended June 30	2011	2010
OPERATING REVENUES		
Net patient service revenue - net of provision for bad debts of $5,606,618 in 2011 and $6,337,717 in 2010	$ 94,323,305	$ 92,422,631
Other revenue	6,596,181	6,334,876
Total Operating Revenues	100,919,486	98,757,507
OPERATING EXPENSES		
Salaries and wages	33,897,436	33,519,147
Employee benefits	19,357,692	17,351,530
Professional fees	12,685,630	12,225,924
Supplies	13,878,072	12,948,757
Purchased services	7,106,518	6,740,755
Depreciation and amortization	5,372,255	5,303,545
Insurance	750,382	387,962
Other	5,158,864	5,200,515
Total Operating Expenses	98,206,849	93,678,135
Operating Income	2,712,637	5,079,372
NONOPERATING INCOME (EXPENSE)		
District tax revenue	4,906,170	4,633,377
District tax revenue - general obligation bonds	2,917,548	1,589,924
Equity interest in joint venture	30,747	-
Interest income	279,847	854,686
Rental income - net	7,363	8,889
Donations	567,047	664,279
Gain (Loss) on disposal of assets	(145,663)	31,773
Interest expense	(4,867,445)	(3,356,535)
Total Nonoperating Income (Expense)	3,695,614	4,426,393
Excess of Revenues Over Expenses Before Capital Contributions	6,408,251	9,505,765
Capital contributions	158,459	131,426
Changes in Net Assets	6,566,710	9,637,191
NET ASSETS		
Net Assets - Beginning of Year	86,887,691	77,250,500
Net Assets - End of Year	$ 93,454,401	$ 86,887,691

The accompanying notes are an integral part of these financial statements.

STATEMENTS OF CASH FLOWS

Years Ended June 30	2011	2010
CASH FLOWS FROM OPERATING ACTIVITIES		
Receipts from and on behalf of patients	$ 90,142,224	$ 96,690,497
Payments to suppliers and contractors	(38,345,949)	(37,795,933)
Payments to and on behalf of employees	(52,566,844)	(50,986,555)
Other receipts and payments - net	6,146,474	6,737,200
Net Cash Provided by Operating Activities	5,375,905	14,645,209
CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES		
District tax revenue received for operations	4,917,464	4,730,711
Donations	567,047	664,279
Net Cash Provided by Noncapital Financing Activities	5,484,511	5,394,990
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES		
Capital contributions	158,459	131,426
Acquisition of property and equipment	(20,374,061)	(12,293,253)
Proceeds from sale of assets	-	34,884
Proceeds from issuance of bonds	42,851,494	-
Change in assets held by trustee	(23,630,175)	8,372,876
District tax revenue received for debt service on general obligation bonds	2,877,280	1,623,465
Payments on long-term debt and capital leases	(4,971,084)	(2,537,869)
Interest paid on long-term debt and capital leases	(4,259,970)	(3,360,392)
Net Cash Used by Capital and Related Financing Activities	(7,348,057)	(8,028,863)
CASH FLOWS FROM INVESTING ACTIVITIES		
Interest received	287,326	913,346
Net cash received for rental activities	152,124	155,283
Net change in board-designated assets	104,702	(15,335,078)
Investment in joint venture	(4,361,833)	-
Net Cash Used by Investing Activities	(3,817,681)	(14,266,449)
Net Decrease in Cash and Cash Equivalents	(305,322)	(2,255,113)
Cash and Cash Equivalents - Beginning of Year	16,324,072	18,579,185
Cash and Cash Equivalents - End of Year	$ 16,018,750	$ 16,324,072

The accompanying notes are an integral part of these financial statements.

Years Ended June 30	2011	2010
RECONCILIATION OF OPERATING INCOME TO NET CASH PROVIDED BY OPERATING ACTIVITIES		
Operating income	$ 2,712,637	$ 5,079,372
Adjustments to reconcile operating income to net cash provided by operating activities:		
Depreciation and amortization	5,372,255	5,303,545
Provision for bad debts	5,606,618	6,337,717
Changes in:		
Patient accounts receivable	(7,920,760)	(4,446,829)
Inventories	(92,866)	(204,569)
Prepaid expenses	89,121	(149,515)
Estimated third-party payor settlements	(1,866,939)	2,376,978
Accounts payable and accrued expenses	1,998,000	(219,995)
Other	(522,161)	568,505
Net Cash Provided by Operating Activities	$ 5,375,905	$ 14,645,209
NONCASH INVESTING AND FINANCING ACTIVITIES		
ISSUANCE OF GENERAL OBLIGATION BONDS 2008, SERIES B		
Par amount of 2008, Series B bonds	$ 43,000,000	$ -
Payments for bond issuance costs	(148,506)	-
Net Proceeds	$ 42,851,494	$ -
Capital Lease Obligation Incurred for the Use of Equipment	$ 44,302	$ -

The accompanying notes are an integral part of these financial statements.

1. DESCRIPTION OF ORGANIZATION AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Reporting Entity Tahoe Forest Hospital District (the District), is a political subdivision of the State of California. The District was established in 1949 under the provisions of Local Health Care District Law as set forth in the Health and Safety Code of the State of California. The District operates Tahoe Forest Hospital in Truckee, California, and Incline Village Community Hospital in Incline Village, Nevada, which provide health care services to residents of the surrounding communities and visitors to the area.

The District maintains its financial records in conformity with guidelines set forth by Local Health Care District Law and the Office of Statewide Health Planning and Development of the State of California.

Basis of Presentation The District uses enterprise fund accounting. Revenues and expenses are recognized on the accrual basis using the economic resources measurement focus. Pursuant to Governmental Accounting Standards Board (GASB) Statement No. 20, *Accounting and Financial Reporting for Proprietary Funds and Other Governmental Entities That Use Proprietary Fund Accounting*, the District has elected to apply the provisions of all relevant pronouncements of the Financial Accounting Standards Board (FASB), including those issued after November 30, 1989, that do not conflict with or contradict GASB pronouncements.

GASB Statement No. 39, *Determining Whether Certain Organizations are Component Units,* requires organizations that are "closely related to, or financially integrated with, the primary government" be reported as component units by the primary government. Tahoe Forest Health System Foundation and Incline Village Community Hospital Foundation, (the Foundations) are component units of the District. The Foundations issue separate audited financial statements for their fiscal year ends. Accounting principles generally accepted in the United States of America require the financial data for the component units to be reported with the financial data of the District unless the District also issues financial statements for the financial reporting entity that includes the financial data of is component units. The District has not issued such reporting entity financial statements. Summarized financial information for the Foundations is disclosed in note 12.

Use of Estimates The preparation of financial statements in conformity with generally accepted accounting principles 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 amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Cash and Cash Equivalents The District considers highly liquid investments, such as money market accounts, certificates of deposit, and pooled investment funds, as "cash equivalents." The District is authorized to deposit cash and invest excess funds by *California Government Code,* Section No. 53648 et seq.

Inventories Inventories are stated at the lower of cost or market. Cost is determined by the weighted-average, first-in, first-out method.

Assets Limited as to Use Assets limited as to use consist of assets held by trustees under indenture agreements and Board designated assets. Assets held by the trustees under indenture agreements are used by the trustees to make principal, interest, and insurance payments related to bonds, to maintain reserve funds as required by bond agreements, and to fund future approved capital acquisitions. Board designated assets have been set aside by the District's Board of Directors for property and equipment replacement and to satisfy future liabilities. The Board retains control over Board designated assets and may at its discretion subsequently use them for other purposes. Purchases and sales of underlying investments are reported net in the statements of cash flows.

Investment in Joint Venture In December 2010, the District purchased a 51% equity interest in the Truckee Surgery Center, LLC (the Center), an ambulatory surgery center. However, under the terms of the Center's operating agreement, the District is unable to unilaterally impose its will on the Center. Accordingly, the District accounts for its investment in the Center under the equity method. The District shares in the operating results of the Center, and reports its share of the operating results in nonoperating income. The Center has not issued audited financial statements.

Capital Assets Capital assets are recorded at cost or, in the case of donated items, at 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 is computed using the straight-line method over the estimated useful lives of the assets. Equipment under capital lease obligations is amortized on the straight-line method over the shorter period of the lease term or the estimated useful life of the equipment. Such amortization is included in depreciation expense in the financial statements. Useful lives are 2 to 40 years for land improvements, 5 to 40 years for buildings and improvements, and 5 to 20 years for equipment.

Costs of Borrowing Interest cost on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets. The District's interest cost capitalized was approximately $485,000 and $245,000 at June 30, 2011 and 2010, respectively.

Bond Issuance Costs Bond issue costs are deferred and amortized using the effective interest method over the life of the bonds. Bond issuance costs included original cost of $1,541,774 and $1,594,373, and accumulated amortization of $155,765 and $327,609, at June 30, 2011 and 2010, respectively. Amortization expense for the years ended June 30, 2011 and 2010, amounted to $64,204 and $62,594, respectively, and is estimated to be $64,504 for the next five years.

Net Assets The District's net assets are classified into three components, as follows:

1. Restricted net assets consists of net assets that must be used for a particular purpose, as specified by creditors, grantors, or contributors external to the District, or by laws or regulations.

2. Invested in capital assets net of related debt consists of capital assets net of accumulated depreciation, reduced by the current balances of any outstanding borrowings used to finance the purchase or construction of those assets, plus assets held by the bond trustee for debt service payments.

3. Unrestricted net assets consist of the remaining net assets balance that does not meet the other criteria.

Operating Income and Expenses The statements of revenues, expenses, and changes in net assets distinguishes between operating and nonoperating income and expenses. Operating revenues result from exchange transactions associated with providing health care services. Nonexchange revenues, including District tax revenues, grants, and contributions received for purposes other than capital asset acquisition, are reported as nonoperating income. Operating expenses are all expenses incurred to provide health care services, other than financing costs.

Net Patient Service Revenue Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors and net of charity care. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined.

Charity Care The District provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Because the District does not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue. Charges excluded from revenue under the District's charity care policy were $4,611,615 and $4,892,141 for 2011 and 2010, respectively.

Contributions Contributions received may be designated by the donor for restricted purposes or may be without restriction as to their use. Contributions restricted by donors as to use or time period are recorded as restricted net assets until used in the manner designated or upon expiration of the time period. When there are no legally imposed restrictions on contributions or on income earned from restricted contributions, they are recorded as nonoperating revenues.

Risk Management The District 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; medical malpractice; natural disasters; and employee health, dental, and accident benefits. Commercial insurance coverage is purchased for claims arising from such matters.

The District participates in a risk management authority for comprehensive liability self-insurance. The District is also partially self-insured for employee health insurance and workers' compensation insurance, up to certain stop-loss limits. The District estimates liabilities for claims incurred but not reported based on historical claims activity. Paid claims, estimated losses, and changes in reserves are expensed in the current period. These self-insurance programs are more fully described in note 10.

District Tax Secured property taxes attach as an enforceable lien on property as of January 1. Taxes are payable in two installments on November 1 and February 1 and become delinquent if paid after December 10 and April 10. Property taxes are levied by Nevada and Placer County Assessors on the District's behalf. They are intended to support general maintenance and operations of the District, including charity care and uncompensated care programs, and to service the debt on the 2008 Series A and Series B general obligation bonds. The amount of property tax received is dependent upon the assessed real property valuation, as determined by Nevada and Placer County Assessors. The District received approximately 7% and 6% of its financial support from property taxes in 2011 and 2010, respectively.

Reclassifications Various reclassifications have been made to the 2010 financial statements in order to reflect the presentation adopted with the 2011 financial statements.

Impact of Recently Issued Accounting Standards In August 2010, FASB issued Accounting Standards Update (ASU) 2010-23, *Measuring Charity Care for Disclosure*, with required implementation for the District during the 2011-12 fiscal year. ASU 2010-23 requires management to disclose their policy for providing charity care, as well as the level of charity care provided. The disclosure shall be measured based on the District's direct and indirect costs of providing charity care services. Management may estimate the costs of those services using reasonable techniques. Management has not yet determined the effect, if any, of the implementation of ASU 2010-23 on the District's financial statements.

In August 2010, FASB issued ASU 2010-24, *Presentation of Insurance Claims and Related Insurance Recoveries,* which clarifies that a health care entity should not net insurance recoveries against a related claim liability. The guidance provided in ASU 2010-24 is effective for the District during the 2011-12 fiscal year. The adoption of this standard is not expected to have any impact on the District's financial condition, results of operations, or cash flows.

In December 2010, GASB issued Statement No. 62, *Codification of Accounting and Financial Reporting Guidance Contained in Pre-November 30, 1989 FASB and AICPA Pronouncements.* The object of this statement is to incorporate into the GASB's authoritative literature certain accounting and financial reporting guidance that is included in the following pronouncements issued on or before November 30, 1989, which does not conflict with GASB pronouncements: 1) FASB Statements and Interpretations; 2) Accounting Principles Board (APB) Opinions; and 3) Accounting Research Bulletins (ARB) of the American Institute of Certified Public Accountants' (AICPA) Committee on Accounting Procedure. The provisions of GASB Statement No. 62 are effective for the District's 2012-13 fiscal year. The District has not yet determined the effect this Statement will have on its financial statements.

In June 2011, GASB issued GASB Statement No. 63, *Financial Reporting of Deferred Outflows of Resources, Deferred Inflows of Resources, and Net Position*, with required implementation for the District during the 2012-13 fiscal year. The statement establishes standards for reporting deferred outflows of resources, deferred inflows of resources, and net position for all state and local governments. Management does not expect the implementation of GASB No. 63 to have a material effect on the District's financial statements.

Date of Management Evaluation Management has evaluated subsequent events through October 7, 2011, the date on which the financial statements were available to be issued.

2. NET PATIENT SERVICE REVENUE

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

Medicare Tahoe Forest Hospital and Incline Village Community Hospital are each designated as a "critical access hospital" under the Medicare program. Accordingly, inpatient acute and outpatient services rendered to Medicare program beneficiaries are reimbursed under a cost reimbursement methodology pursuant to the facilities' designation as "critical access hospitals." Costs incurred are reimbursed at tentative rates with final settlement determined after submission of annual cost reports and audits thereof by the Medicare fiscal intermediary. The District's classification of patients under the Medicare program and the appropriateness of their admission are subject to an independent review by a peer review organization under contract with the District. The District's Medicare cost reports have been audited by the Medicare fiscal intermediary through June 30, 2009, and final settlements have been received through that date.

Medi-Cal Inpatient services rendered to Medi-Cal program beneficiaries are reimbursed under a cost reimbursement methodology. Reimbursement is at tentative rates with final settlement determined after submission of annual cost reports and audits thereof by the Medi-Cal fiscal intermediary. Medi-Cal cost reports have been audited by the Medi-Cal fiscal intermediary through June 30, 2009, and final settlements have been received through that date. Outpatient services related to Medi-Cal beneficiaries are paid at prospectively determined rates per procedure.

Revenue from the Medicare and Medi-Cal programs accounted for approximately 32% and 10% of gross patient service revenue in 2011 and approximately 30% and 9% of gross patient revenue in 2010, respectively. Net patient service revenue is reported at estimated realizable amounts, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. 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. Net patient service revenue increased by approximately $1,900,000 in 2011 and approximately $810,000 in 2010, due to changes in prior-year retroactive adjustments compared with amounts previously estimated. The District believes it is in compliance with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing. While no such regulatory inquiries have been made, compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory actions.

Other Arrangements The District has entered into payment agreements with certain commercial insurance carriers and preferred provider organizations. The payments to the District under these agreements may be based on discounts from established charges.

3. DEPOSITS AND INVESTMENTS

The District has adopted and uses California Health and Safety Code Section 32127 (the Code) as its policy for limitation on investment instruments. The Code authorizes investments in obligations of the U.S. Treasury, commercial paper, bankers' acceptances, repurchase agreements, and the State of California Local Agency Investment Fund (LAIF), which is a pooled investment fund held at the State of California Treasurer's office, among other investments.

The LAIF pool includes structured notes and asset-backed securities which total 5.01% of the total portfolio as of June 30, 2011. These structured notes and asset-backed securities are subject to market risk as to change in interest rates. The fair value of the District's investment in LAIF is the same as the carrying value of the pool shares. The fair value of LAIF is 100.16% of the carrying value and is deemed to not represent a material difference as of June 30, 2011. There are no LAIF funds invested in derivatives as of June 30, 2011. LAIF has oversight by the Local Investment Advisory Board (LIAB), which consists of five members as designated by statute. The Chairman of the LIAB is the State Treasurer or his designated representative. The District is considered to be a voluntary participant in the LAIF investment pool.

California Government Code, Section 53635 places the following concentration limits on the State investment pool, which is unrated:

> No more than 40% may be invested in eligible commercial paper, no more than 10% may be invested in the outstanding commercial paper of any single issuer, and no more than 10% of the outstanding commercial paper of any single issuer may be purchased.

Deposits and investments at carrying value consisted of the following:

	2011	2010
DEPOSITS		
Cash in banks	$ 16,099,587	$ 16,706,188
INVESTMENTS		
LAIF	38,838,000	38,641,423
ASSETS HELD BY TRUSTEES		
Cash	43,901,992	15,987,800
Money market funds	2,464,434	4,312,762
LAIF	2,640,102	2,626,740
Certificates of deposit	-	2,200,000
Government bonds	900,379	900,379
Bayerische Landesbank - commercial paper	-	249,051
Total Assets Held by Trustees	49,906,907	26,276,732
Total Deposits and Investments	$104,844,494	$ 81,624,343

Deposits and investments are reflected on the accompanying balance sheets under the following captions:

	2011	2010
Cash and cash equivalents	$ 16,018,750	$ 16,324,072
Assets limited as to use	88,825,744	65,300,271
Total Deposits and Investments	$104,844,494	$ 81,624,343

Custodial credit risk is the risk that in the event of a bank failure, the District's deposits might not be recovered. The bank balance of cash in banks at June 30, 2011, amounted to $16,018,750. Deposits up to $250,000 are covered by depository insurance and the total balances are subject to collateralization agreements. The total uninsured balance for all banks was $15,575,382 at June 30, 2011.

The deposits in LAIF are pooled investment funds, which are not evidenced by securities. A "security" is transferable financial instrument that evidences ownership or creditorship, whether in physical or book-entry form. Investments that are not securities do not have custodial credit risk because they do not involve a transferable financial instrument. Thus, the District's LAIF investment is not categorized into custodial credit risk categories.

Interest rate risk is the risk that changes in market interest rates which could affect the fair value of an investment. The District's investments held by the trustee are of short-term durations.

The commercial paper issued by Bayerische Landesbank did not have a credit rating.

4. ASSETS LIMITED AS TO USE

The composition of assets limited as to use is set forth in the following table:

	2011	2010
BOARD DESIGNATED ASSETS		
Cash	$ 564,723	$ 925,487
LAIF	38,354,114	38,098,052
Subtotal	38,918,837	39,023,539
ASSETS HELD BY TRUSTEES		
Cash	43,901,992	15,987,800
Money market funds	2,464,434	4,312,762
LAIF	2,640,102	2,626,740
Certificates of deposit	-	2,200,000
Government bonds	900,379	900,379
Bayerische Landesbank - commercial paper	-	249,051
Subtotal	49,906,907	26,276,732
Total Assets Limited as to Use	$ 88,825,744	$ 65,300,271

5. PATIENT ACCOUNTS RECEIVABLE

The District grants credit without collateral to its patients, most of who are local residents and are insured under third-party payor agreements. The mix of receivables from patients and third-party payors at June 30, 2011 and 2010, was as follows:

Years Ended June 30	2011	2010
Medicare	23%	24%
Medi-Cal	14%	13%
Patients	27%	33%
Commercial insurance and others	36%	30%
Total	100%	100%

6. CAPITAL ASSETS

A summary of changes in capital assets is as follows:

	Balance June 30, 2010	Additions	Retirements/ Transfers	Balance June 30, 2011
Land and improvements	$ 6,052,219	$ 198,559	$ -	$ 6,250,778
Buildings and improvements	73,711,175	3,129,223	904,433	75,935,965
Equipment	48,112,456	3,736,881	472,702	51,376,635
Subtotal	127,875,850	7,064,663	1,377,135	133,563,378
Less: Accumulated depreciation	(67,397,752)	(5,476,722)	(1,231,472)	(71,643,002)
Property held for future expansion	836,353	-	-	836,353
Construction in progress	13,828,497	18,563,112	5,209,412	27,182,197
Capital Assets - Net	$ 75,142,948	$ 20,151,053	$ 5,355,075	$ 89,938,926

	Balance June 30, 2009	Additions	Retirements/ Transfers	Balance June 30, 2010
Land and improvements	$ 6,052,219	$ -	$ -	$ 6,052,219
Buildings and improvements	70,351,632	3,362,654	3,111	73,711,175
Equipment	45,591,395	2,521,061	-	48,112,456
Subtotal	121,995,246	5,883,715	3,111	127,875,850
Less: Accumulated depreciation	(61,987,791)	(5,409,961)	-	(67,397,752)
Property held for future expansion	836,353	-	-	836,353
Construction in progress	7,418,959	9,954,296	3,544,758	13,828,497
Capital Assets - Net	$ 68,262,767	$ 10,428,050	$ 3,547,869	$ 75,142,948

7. LONG-TERM DEBT AND CAPITAL LEASE OBLIGATIONS

Long-term debt and capital lease obligations consisted of the following:

	Balance June 30, 2010	Additions	Reductions	Balance June 30, 2011	Amounts Due Within One Year
Series 2006 Revenue Bonds	$ 26,630,000	$ -	$ 625,000	$ 26,005,000	$ 650,000
Series 2002 Variable Rate Demand Revenue Bonds	10,940,000	-	250,000	10,690,000	260,000
Series 1999 Revenue Bonds	3,040,000	-	3,040,000	-	-
Series A (2008) General Obligation Bonds	29,400,000	-	-	29,400,000	-
Series B (2010) General Obligation Bonds	-	43,000,000	-	43,000,000	-
Note payable to West America Bank in monthly installments of $3,310, including interest at 5.50% per annum, paid off in 2011.	86,506	-	86,506	-	-
Note payable to West America Bank in quarterly installments of $9,158, including interest at 5.80% per annum, paid off in 2011.	52,267	-	52,267	-	-
Lease agreement with Bank of America payable in monthly installments of $22,886, including interest at 3.55%, paid off in 2011.	465,325	-	465,325	-	-
Lease agreement with US Bank payable in monthly installments of $4,809, including interest at 4.62%, through July 2014. The lease is collateralized by equipment.	210,408	-	49,025	161,383	51,336
Lease agreement with Bank of America payable in monthly installments of $38,350, including interest at 4.06% through May 2014. The lease is collateralized by equipment.	1,663,850	-	400,037	1,263,813	416,584
Lease agreement with US Bank payable in monthly installments of $773, including interest at 6.71%, through June 2014. The lease is collateralized by equipment.	-	27,637	2,494	25,143	7,827
Lease agreement with Great America Leasing payable in monthly installments of $473, including interest at 2.60%, through June 2014. The lease is collateralized by equipment.	-	16,665	430	16,235	5,244
Total Long-Term Debt and Capital Lease Obligations	$ 72,488,356	$ 43,044,302	$ 4,971,084	$ 110,561,574	$ 1,390,991

	Balance June 30, 2009	Additions	Reductions	Balance June 30, 2010	Amounts Due Within One Year
Series 2006 Revenue Bonds	$ 26,945,000	$ -	$ 315,000	$ 26,630,000	$ 625,000
Series 2002 Variable Rate Demand Revenue Bonds	11,175,000	-	235,000	10,940,000	250,000
Series 1999 Revenue Bonds	3,740,000	-	700,000	3,040,000	75,000
Series A (2008) General Obligation Bonds	29,400,000	-	-	29,400,000	-
Note payable to West America Bank in monthly installments of $3,310, including interest at 5.50% per annum, through January 2013. The note is secured by real property.	120,107	-	33,601	86,506	35,353
Note payable to West America Bank in quarterly installments of $9,158, including interest at 5.80% per annum, through November 2011. The note is secured by real property.	84,685	-	32,418	52,267	34,341
Lease agreement with Bank of America payable in semi-annual installments of $274,823, including interest at 2.99%, through February 2010. The lease is collateralized by equipment.	537,562	-	537,562	-	-
Lease agreement with Bank of America payable in monthly installments of $22,886, including interest at 3.55%, through March 2012. The lease is collateralized by equipment.	718,548	-	253,223	465,325	262,360
Lease agreement with US Bank payable in monthly installments of $4,809, including interest at 4.62%, through July 2014. The lease is collateralized by equipment.	257,225	-	46,817	210,408	49,025
Lease agreement with Bank of America payable in monthly installments of $38,350, including interest at 4.06% through May 2014. The lease is collateralized by equipment.	2,048,098	-	384,248	1,663,850	400,038
Total Long-Term Debt and Capital Lease Obligations	$ 75,026,225	$ -	$ 2,537,869	$ 72,488,356	$ 1,731,117

Scheduled principal and interest repayments on long-term debt and payments on capital lease obligations are as follows:

	Long-Term Debt		Capital Lease Obligations	
	Principal Amount	Interest Amount	Principal Amount	Interest Amount
2012	$ 910,000	$ 5,249,244	$ 480,991	$ 51,869
2013	955,000	5,224,022	501,353	31,508
2014	995,000	5,184,267	484,230	10,281
2015	1,095,000	5,141,864	-	-
2016	1,410,000	5,094,642	-	-
2017 to 2021	9,840,000	24,404,918	-	-
2022 to 2026	15,775,000	21,690,490	-	-
2027 to 2031	23,610,000	17,072,853	-	-
2032 to 2036	27,915,000	10,947,118	-	-
2037 to 2041	26,590,000	3,600,250	-	-
Total	$109,095,000	$103,609,668	$ 1,466,574	$ 93,658

Following is a summary of equipment under capital leases:

	2011	2010
Cost of equipment	$ 7,233,532	$ 7,216,867
Less: Accumulated depreciation	6,598,989	6,004,035
Capital Lease Equipment - Net	$ 634,543	$ 1,212,832

The District issued the $43,000,000 General Obligation Bonds, Election of 2007, Series B (the 2010 G.O. Bonds) to fund the construction and equipping of additions and improvements to the District's health facilities, refinance $3,500,000 in outstanding debt (including the Series 1999 A Bonds), and to pay costs incident thereto.

Interest on the 2010 G.O. Bonds is payable semiannually on February 1 and August 1 at rates ranging from 4.00% and 5.50%. Principal maturities on 2010 G.O. Bonds are due annually commencing August 2015 through August 2040 in amounts ranging from $215,000 to $3,965,000.

The District issued the $29,400,000 General Obligation Bonds, Election of 2007, Series A (the 2008 G.O. Bonds) for the purpose of financing and refinancing the expansion, improvement, acquisition, construction, equipping and renovation of health facilities of the District, and to pay costs incident thereto.

The balance of the Series 1999 bonds were fully refunded in 2011. The costs of refunding in 2011 along with the balance of the unamortized refunding costs from the prior 1999 Series A refunding resulted in a deferred charge amounting to $769,304. The deferred charge is being amortized as a component of interest expense over a period of 20 years ending in June 2030.

Interest on the Series 2008 G.O. Bonds is payable semiannually on February 1 and August 1 at rates ranging from 4.00% to 5.13%. Principal maturities on the 2008 G.O. Serial Bonds, totaling $27,140,000, are due annually commencing August 2013 through August 2038 in amounts ranging from $5,000 to $3,060,000. Mandatory sinking fund deposits to retire the 2008 G.O. Term Bonds totaling $2,260,000 on the August 2025 maturity date are due annually commencing August 2023 through August 2025 in amounts ranging from $655,000 to $855,000.

All of the G.O. Bonds represent the general obligation of the District. The District has the power and is obligated to cause to be levied and collected by both Nevada and Placer Counties annual ad valorem taxes on all property within the District's boundaries subject to taxation by the District for payment when due of the principal and interest on the bonds. However, the District is legally required to repay the 2010 and the 2008 G.O. Bonds if ad valorem taxes are insufficient.

The District issued the $27,385,000 Hospital Revenue Bonds, Series 2006 (the Series 2006 Bonds) to construct and equip the western addition expansion project, to renovate and equip portions of the existing facility, and to advance refund $11,790,000 of 1999 Series A Bonds outstanding. The Series 2006 Bonds are secured by a pledge of gross revenues.

Interest on the Series 2006 Bonds is payable semiannually on January 1 and July 1 at rates ranging from 3.70% to 5.00%. Principal maturities on the Series 2006 Serial Bonds, totaling $10,335,000, are due annually commencing July 2007 through July 2021 in amounts ranging from $135,000 to $1,010,000. Mandatory sinking fund deposits to retire the Series 2006 Term Bonds totaling $5,855,000 and $11,195,000 on the July 2026 and 2036 maturity dates, respectively, are due annually commencing July 2022 through July 2036 in amounts ranging from $690,000 to $2,780,000.

The District issued the $12,000,000 Variable Rate Demand Revenue Bonds, Series 2002 (the Series 2002 Bonds) to finance the costs of constructing and equipping new health care facilities and remodeling certain existing facilities.

Interest on the Series 2002 Bonds is payable semiannually on January 1 and July 1 at a variable interest rate. The variable interest rate on the Series 2002 Bonds has been effectively changed to a fixed rate of 3.54% through an interest rate swap agreement (see note 8). The Series 2002 Bonds mature on July 1, 2033. Mandatory sinking fund deposits to retire the bonds on their maturity date are due annually through July 2033 in amounts ranging from $225,000 to $805,000. The Series 2002 Bonds are secured by a pledge of gross revenues and by a direct-pay letter of credit issued by U.S. Bank National Association.

The District is required to maintain a debt service coverage ratio of at least 1.75 to 1.00 and at least 60 days cash on hand. The District is also limited in the incurrence of future indebtedness and encumbrances.

In connection with the Series 2006 bond agreement, the District is required to make monthly deposits to the trustee for the term bond sinking fund payments, serial bond principal payments, and insurance premiums becoming due and payable within the next 12 months, and for interest payments becoming due and payable within the next six months. Aggregate future monthly deposits required are approximately $159,500 at June 30, 2011.

8. INTEREST RATE SWAP AGREEMENT

Objective of the Interest Rate Swap In May 2005, as a means to lower its borrowing costs when compared against fixed-rate bonds, the District entered into an interest rate swap in connection with its Series 2002 Variable-Rate Revenue Bonds. The intention of the swap was to effectively change the District's variable interest rate on the Bonds to a synthetic fixed rate of 3.54%.

Terms The Series 2002 Bonds and the related swap agreement mature on July 1, 2033, and the swap's original notional amount of $11.8 million matched the variable-rate bonds at the agreement date. The swap was entered into three years after the Bonds were issued (July 2002). Starting in fiscal year 2005, the notional value of the swap and the principal amount of the associated debt will decline with each principal payment made by the District. Under the swap, the District pays the counterparty a fixed payment of 3.54% and receives a variable payment computed as 70% of the London Interbank Offered Rate (LIBOR) one month rate.

Fair Value Because interest rates have declined since execution of the swap, the swap had negative fair values of $1,364,506 and $1,665,329 as of June 30, 2011 and 2010, respectively. The swap's negative fair value may be countered by a reduction in total interest payments required under the variable-rate bonds, creating a lower synthetic interest rate. Because the coupons on the District's variable-rate bonds adjust to changing interest rates, the bonds do not have a corresponding fair value increase. The fair value was estimated using mathematical approximations of market values derived from proprietary models. These valuations are calculated on a mid-market basis and do not include bid/offer spread that would be reflected in an actual price quotation. It should be assumed that the actual price quotations for unwinding the transactions would be different. In connection with the fair value determination of the interest rate swap, the District has recorded a derivative instrument liability in the amount of $1,364,506 and $1,665,329 at June 30, 2011 and 2010, respectively, and a corresponding deferred outflow of resources (asset).

Credit Risk As of June 30, 2011, the District was not exposed to credit risk because the swap had a negative fair value. However, should interest rates change and the fair value of the swap become positive, the District would be exposed to credit risk in the amount of the derivative's fair value. The swap counterparty was rated A2/A/A as of June 30, 2011. To mitigate the potential for credit risk, if the counterparty's credit quality falls below AA/Aa, the fair value of the swap will be fully collateralized by the counterparty with U.S. government securities. Collateral would be posted with a third-party custodian.

Termination Risk The District or the counterparty may terminate the swap if the other party fails to perform under the terms of the contract. The swap may be terminated by the District if the counterparty's credit quality rating falls below A3/A-/A-. If the swap is terminated, the variable-rate bond would no longer carry a synthetic interest rate. If at the time of termination the swap has a negative fair value, the District would also be liable to the counterparty for a payment equal to the swap's fair value.

9. BENEFIT PROGRAMS

The District contributes to the Tahoe Forest Hospital District Employee Money Purchase Pension Plan, a defined contribution pension plan administered by the District. The money purchase pension plan covers employees who complete 1,000 hours of service in a calendar year. The District is required to make annual contributions to the money purchase pension plan equal to 3% of each eligible employee's annual compensation, plus 3% of an eligible employee's annual compensation in excess of the social security tax wage base. Employee contributions are voluntary and are limited to 10% of an employee's annual compensation.

The District provides a deferred compensation plan created in accordance with Internal Revenue Code, Section 457. The deferred compensation plan allows employees to defer a portion of their current compensation until future years. The District matches participant deferrals from 3% to 7% of compensation. Employee contributions are limited to 100% of total employee compensation or $16,500, whichever is less. The employer matching contributions under this deferred compensation plan are deposited into employee accounts in the money purchase pension plan.

Total employer contributions under the above benefit programs were $2,223,650 and $2,394,604 in 2011 and 2010, respectively.

10. RISK MANAGEMENT

Joint Powers Agreement

The District participates in a joint powers agreement (JPA) with the Program BETA Risk Management Authority (the Program).

The Program was formed for the purpose of operating a comprehensive liability self-insurance program for certain hospital districts of the Association of California Healthcare Districts, Inc. (ACHD). The Program operates as a separate JPA established as a public agency separate and distinct from ACHD. Each member hospital pays a premium commensurate with the level of coverage requested and shares surpluses and deficits proportionate to its participation in the Program. The District maintains coverage on a claims-made basis.

Condensed financial information of BETA Health Care Group (which includes the Program BETA JPA) for the year ended December 31, 2010, follows:

	BETA Healthcare Group
Total assets	$ 486,285,361
Total liabilities	311,380,578
Fund Balance as Reported	$ 174,904,783
Total revenues	$ 92,211,333
Total expenses	(44,263,210)
Member surplus funds contributed	1,000
Change in unrealized gains on investments	(223,045)
Member dividends	(23,845,000)
Net Increase in Fund Balance	$ 23,881,078

Coverage under a claims-made policy could expose the District to a gap in coverage if the District were to terminate coverage with the Program. In order to mitigate this potential gap in coverage, the District has accrued an estimated premium to purchase an unlimited extended reporting amendment (tail coverage) in the amount of $1,044,000 at June 30, 2011.

Employee Health Insurance

The District is self-insured to provide group medical, dental, and vision coverage. A third party administers these coverages for the District. The District funds its losses based on actual claims. A stop-loss insurance contract executed with an insurance carrier provides a specific stop-loss deductible per claim of $150,000 with an aggregate specific annual deductible of $75,000. There were no significant changes in insurance coverage from the prior year.

The liability for unpaid claims is estimated using an industry average that is based on actual claims paid. The estimated liability for claims pending and incurred but not reported at June 30, 2011 and 2010, has been included in the accompanying balance sheets under estimated claims incurred but not reported. Changes in the claims liability are as follows:

	2011	2010
Estimated claims incurred but not reported - beginning of year	$ 1,017,359	$ 1,294,000
Incurred claims and claims adjustment expense	7,918,198	5,875,587
Claim payments	(7,659,846)	(6,152,228)
Estimated Claims Incurred But Not Reported - End of Year	$ 1,275,711	$ 1,017,359

Workers' Compensation Insurance

The District is self-insured for workers' compensation losses. A third party administers this coverage for the District. The District funds its losses based on future claims projections developed by the third-party administrator. A stop-loss insurance contract executed with an insurance carrier covers individual claims in excess of $400,000 per plan year with an aggregate limit of $1,000,000. There were no significant changes in insurance coverage from the prior year.

The liability for unpaid claims is estimated using development factors including actual claims paid, industry standards, and actuarial factors. The estimated liability for claims pending and incurred but not reported at June 30, 2011 and 2010, has been included in the accompanying balance sheets under estimated claims incurred but not reported. Changes in the claims liability are as follows:

	2011	2010
Estimated claims incurred but not reported - beginning of year	$ 1,532,207	$ 1,736,405
Incurred claims and claims adjustment expense	756,190	515,127
Claim payments	(756,190)	(719,325)
Estimated Claims Incurred But Not Reported - End of Year	$ 1,532,207	$ 1,532,207

11. COMMITMENTS AND CONTINGENCIES

Operating Leases

The District leases certain facilities and equipment under noncancelable operating leases. Total lease expense was $2,216,806 and $1,989,447 for 2011 and 2010, respectively. Future minimum payments under these agreements at June 30, 2011, were as follows:

Years Ending June 30	
2012	$ 1,281,873
2013	867,993
2014	673,669
2015	415,507
2016	58,656
Total Minimum Payments	$ 3,297,698

Litigation

The District is involved in claims and other litigation arising in the course of business. After consultation with legal counsel, management estimates that these matters will be resolved without material adverse effect on the District's future financial position or results from operations.

Seismic Compliance

California Senate Bill 1953 (SB 1953) requires hospital acute care buildings to meet more stringent seismic guidelines by 2008. In fiscal 2005, the District received approval of a time extension from the Office of Statewide Health Planning and Development for compliance with SB 1953 until January 1, 2013. The Board of Directors has approved a $98.5 million expansion plan, which includes expanding and enhancing the emergency room to ensure access to lifesaving care; maintaining critical medical services including pediatrics, maternity, long-term care for seniors and cancer care; and upgrading facilities that are outdated or do not meet state-mandated earthquake safety standards. This plan will enable the District to comply with SB 1953 seismic guidelines. The financing for this expansion plan has multiple parts, including $72.4 million of general obligation bonds to be repaid through ad valorem property taxes of the residents of the District (see note 7).

12. FOUNDATIONS

Tahoe Forest Health System Foundation

The Tahoe Forest Health System Foundation (TFHSF) is a legally separate nonprofit organization, exempt from federal tax, formed to assist in developing and increasing the facilities of the District. TFHSF's activities are governed by a separate board of directors. TFHSF's financial activity is not included in the District's financial statements, but is a component unit of the District. During the years ended June 30, 2011 and 2010, TFHSF distributed approximately $910,000 and $570,000, respectively, to the District. TFHSF has issued separate financial statements for the year ended June 30, 2011. A copy of the TFHSF's financial statements can be obtained through the District.

A summary of the TFHSF's financial information is as follows:

	2011	2010
Total assets	$ 525,000	$ 336,000
Total liabilities	186,000	93,000
Net Assets	$ 339,000	$ 243,000
Total Revenue	$ 1,639,000	$ 1,277,000
Total Expenses	$ 1,544,000	$ 1,044,000

Incline Village Community Hospital Foundation

The Incline Village Community Hospital Foundation (IVCHF) is a legally separate nonprofit organization, exempt from federal tax, formed to assist in developing and increasing the facilities of the District. IVCHF's activities are governed by a separate board of directors. IVCHF's financial activity is not included in the District's financial statements, but is a component unit of the District. During the years ended June 30, 2011 and 2010, IVCHF distributed approximately $169,000 and $220,000, respectively, to the District. IVCHF has issued separate financial statements for the year ended June 30, 2011. A copy of IVCHF's financial statements can be obtained through the District.

A summary of IVCHF's financial information is as follows:

	2011	2010
Total assets	$ 744,000	$ 667,000
Total liabilities	-	-
Net Assets	$ 744,000	$ 667,000
Total Revenue	$ 381,000	$ 314,000
Total Expenses	$ 305,000	$ 403,000

13. INVESTMENT IN JOINT VENTURE

The District owns 51% of Truckee Surgery Center, LLC (the Center). Summarized financial information for the Center as of June 30, 2011, and for the seven months then ended is as follows:

Total Assets	$ 5,130,820
Total Liabilities	$ 274,195
Net Income	$ 60,288

APPENDIX C

CONTINUING DISCLOSURE CERTIFICATE

This Continuing Disclosure Certificate (the "Disclosure Certificate") is executed and delivered by the TAHOE FOREST HOSPITAL DISTRICT (the "District") in connection with the issuance by the District of $26,100,000 Tahoe Forest Hospital District (Placer and Nevada Counties, California) General Obligation Bonds, Election of 2007, Series C (2012) (the "Bonds"). The Bonds are being issued pursuant to a resolution adopted by the Board of Directors of the District on June 26, 2012 (the "Resolution"). The District covenants and agrees as follows:

Section 1. Definitions. In addition to the definitions set forth in the Indenture, 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:

"*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 which (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 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) 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 any of the original underwriters of the Bonds required to comply with the Rule in connection with offering of the Bonds.

"*Rule*" shall mean Rule 15c2-12(b)(5) adopted by the Securities and Exchange Authority 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 holders and beneficial owners of the Bonds and in order to assist the Participating Underwriter in complying with S.E.C. Rule 15c2-12(b)(5).

Section 3. Provision of Annual Reports.

(a) *Delivery of Annual Report to MSRB*. 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 2011-12 Fiscal Year, which is due not later than April 1, 2013, provide to the Participating Underwriter and to file with EMMA, in a 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 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(d).

(c) *Delivery of Annual Report to Dissemination Agent*. Not later than fifteen (15) Business Days prior to the date specified in subsection (a) 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 unable to provide an Annual Report by the date required in subsection (a), the Dissemination Agent shall send a notice to EMMA in substantially the form attached 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 provided pursuant to this Disclosure Certificate, stating the date it was provided.

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 with the laws of the State and including all statements and information prescribed for inclusion therein by the Controller of the State. 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 statement of the District, the Annual Report shall also include 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;
(ii) The Placer County portion of property tax levies, collections and delinquencies for the District, for the most recent completed fiscal year; and
(iii) The Nevada County portion of 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 the MSRB's Internet web site or filed with the Securities and Exchange Commission. 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 Significant 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 Bonds, or other material events affecting the tax status of the Bonds.

(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 Bond holders.

(3) Bond calls.

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

(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.* 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 any 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 Indenture.

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.

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. The initial Dissemination Agent shall be 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 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, Holders 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.

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 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), 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; and

(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 Indenture for amendments to the Indenture 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(d), 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 the District agrees, to the extent permitted by law, 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 obligations of the District under this Section shall survive resignation or removal of the Dissemination Agent and payment of the Bonds. 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 any reports, notices or disclosures provided to it under this Agreement, and has no liability to any person, including any Bondholder, with respect to any such reports, notices or disclosures.

The Dissemination Agent agrees to accept and act upon instructions or directions pursuant to this Disclosure Certificate sent by unsecured e-mail, facsimile transmission or other similar unsecured electronic methods; provided, however, that the Dissemination Agent shall have received an incumbency certificate listing persons designated to give such instructions or directions and containing specimen signatures of such designated persons, which such incumbency certificate shall be amended and replaced whenever a person is to be added or deleted from the listing. If the District elects to give the Dissemination Agent e-mail or facsimile instructions (or instructions by a similar electronic method) and the Dissemination Agent in its discretion elects to act upon such instructions, the Dissemination Agent's understanding of such instructions shall be deemed controlling. The Dissemination Agent shall not be liable for any losses, costs or expenses arising directly or indirectly from the Dissemination Agent's reliance upon and compliance with such instructions notwithstanding such instructions conflict or are inconsistent with a subsequent written instruction. The District agrees to assume all risks arising out of the use of such electronic methods to submit instructions and directions to the Dissemination Agent, including without limitation the risk of the Dissemination Agent acting on unauthorized instructions, and the risk of interception and misuse by third parties.

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

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 have been submitted to the Securities and Exchange Commission. If the document included by reference is a final official statement, it must be available from the Municipal Securities Rulemaking Board. The District shall clearly identify each such other document so included by reference.

Date: [Closing Date]

TAHOE FOREST HOSPITAL DISTRICT

By _____
Authorized Officer

ACKNOWLEDGED:

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

By _____
Authorized Officer

EXHIBIT A

NOTICE TO MUNICIPAL SECURITIES RULEMAKING BOARD
OF FAILURE TO FILE ANNUAL REPORT

Name of Issuer: Tahoe Forest Hospital District

Name of Issue: $26,100,000 Tahoe Forest Hospital District (Placer and Nevada Counties, California) General Obligation Bonds, Election of 2007, Series C (2012)

Date of Issuance: [Closing Date]

NOTICE IS HEREBY GIVEN that the Tahoe Forest Hospital District (the "Issuer") has not provided an Annual Report with respect to the above-named Bonds as required by the Continuing Disclosure Certificate dated [Closing Date], furnished by the District 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: Trustee

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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 Trustee 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 Trustee 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 UNDERWRITERS, 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 capability of management of the District, the ability of the District to provide the services required or requested by patients, physicians' confidence in the Health Facilities and management, economic developments in the service area served by the Health Facilities, employee relations and unionization, shortages of healthcare professionals, 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 Health Facilities will not decrease.

With respect to the financial condition of the District, see the audited financial statements of the District attached hereto 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. Further, it is unclear how efforts to repeal the legislation will be resolved. 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 precarious 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 from the current federal budget baseline for federal fiscal years 2011 and 2012. Medicare, Social Security, Medicaid and other entitlement programs will not be 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 requires automatic spending reductions of $1.2 trillion for fiscal years 2013 through 2021, minus any deficit reductions enacted by Congress and debt service costs. However, the percentage reduction for Medicare may not be more than 2% for a fiscal year, with a uniform percentage reduction across all Medicare programs.

The BCA also provides for a 27.4% reduction in Medicare's sustainable growth rate ("SGR") formula for physician reimbursement, which would become effective in 2013, absent additional congressional action prior to year end to repeal or modify that SGR formula. The Middle Class Tax Relief and Job Creation Act of 2012, enacted in February 2012, freezes physician payment rates at 2011 levels only until December 31, 2012.

The District is unable to predict how these reductions will be structured, what other deficit reduction initiatives may be proposed by Congress or whether Congress will attempt to suspend or restructure the automatic budget cuts. However, if effective, these reductions could have a material adverse effect on the financial condition of the District. Further, 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.

Healthcare Reform

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 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 he 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 expansion requirements was nullified as a result of a recent United States Supreme Court decision. The balance of the ACA was upheld by that decision. However, continuing legislative challenges to the ACA are anticipated by Republicans in Congress. In addition, the uncertainties regarding the implementation of or changes to 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 32% of the revenues of the District (for fiscal year ended June 30, 2011) were from Medicare spending, the reductions may have a material 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 provide 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. During the past decade, State legislators have frequently introduced proposals to reform the healthcare delivery system and insurance market, including proposals to create a statewide single-payor system. Legislation or regulation concerning healthcare reform could have a material adverse effect on the District.

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, 2011, Medicare payments represented approximately 32%, 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. Beginning in federal fiscal year 2013, Medicare inpatient payments to each hospital will be reduced based on the dollar value of that hospital's percentage of preventable Medicare readmissions for certain medical conditions.

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"

Hospital inpatient Reimbursement. Generally, hospitals are 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. Because Tahoe Forest Hospital is a "critical access hospital," services rendered to Medicare beneficiaries under a cost reimbursement methodology. There is no guarantee that Tahoe Forest Hospital will retain this favorable designation or that reimbursement to critical access hospitals will not be less favorable in the future.

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 Health Facilities 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.

Sustainable Growth Rate Formula. The BCA provides for a 27.4% reduction in Medicare's SGR formula for physician reimbursement, which would become effective in 2013, absent additional congressional action prior to year end to repeal or modify that SGR formula. Health systems that have large physician practices could be negatively affected. The Middle Class Tax Relief and Job Creation Act of 2012, enacted in February 2012, freezes physician payment rates at 2011 levels only until December 31, 2012.

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. 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.

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.

While most California hospitals are reimbursed for inpatient Medi-Cal services based on contracts between the hospital and Medi-Cal, the District does not hold such a contract and is a critical access hospital and, therefore, is reimbursed on a cost basis for inpatient services furnished to certain Medi-Cal beneficiaries.

The ACA makes changes to Medicaid funding and potentially increases the number of Medicaid beneficiaries. Management of the Health Facilities 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) are exempt from paying the fee but have received supplemental payments. For the initial 21-month period of this program, the District received approximately $146,000 in supplemental payments.

Since then the District as a public entity has not participated in this program although the program has continued for non-profit hospitals.

For the fiscal year ended June 30, 2011, the District received approximately 10% of its gross patient service revenues from services covered by Medi-Cal programs.

Recent legislation has mandated that the California Department of Health Services develop a DRG payment system to be implemented by January 2013. The system is currently under development and would only apply to those Medi-Cal fee-for-service aid categories and beneficiaries not already enrolled in a Medi-Cal managed care program. While the effect on Medi-Cal reimbursement cannot yet be predicted with certainty, total Medi-Cal fee-for-service revenues are expected to reduce significantly. However, under the State's proposed model, the transition from fee-for-service to a DRG-based prospective payment system would be phased in over a three-year period and would limit a hospital's reimbursement reduction to 5% in the first year, an additional 5% in the second year, and then full reduction in the third year. However, the California Governor's recently-released "May Revise" of the State's proposed fiscal year 2013 budget now proposes 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 proposed CPE model for district and municipal hospitals. While the District may be materially and adversely affected by this proposed CPE model, it is possible that the availability of federal supplemental funds may mitigate some or substantially all of the loss in State funding.

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. Tahoe

Forest Hospital does not qualify as a disproportionate share hospital due to its critical access hospital status and does not expect to qualify in future years as long as it remains a critical access hospital.

California State Budget. California faces significant financial challenges, including erosion of general fund tax revenues, falling or stalled real estate values, slowing economic growth and higher unemployment, each of which may continue or worsen over the coming years. Shortfalls between State revenues and spending have in the past and may in the future result in cutbacks to 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.

California faces a continuing significant gap between the expected level of tax revenues and projected expenditures for the current and future fiscal years. The State's budget for the 2011-2012 fiscal year includes approximately $2.6 billion in spending reductions from State health programs, including funding cuts of approximately $2.0 billion from Medi-Cal. Also, funding cuts that will be triggered if the State does not achieve budgeted revenue levels could cause further reductions. The Governor's proposed budget for the 2012-2013 fiscal year, issued in January 2012, included approximately $840 million in additional expenditure reductions to the Medi-Cal program. The actual amount is subject to change depending on changes in projections of the total deficit and determinations of the California Legislature. It is impossible to predict what actions will be taken in future years by the California Legislature, the Governor or citizen initiative actions to address California's significant financial problems. It is possible that additional cuts in the levels and timing of healthcare provider reimbursement, including that to hospitals under Medi-Cal, could materially adversely affect the District.

The financial challenges facing California may negatively affect healthcare organizations in a number of ways. California, may enact legislation designed to reduce its Medi-Cal expenditures through eligibility restrictions, (causing a greater number of indigent, uninsured or underinsured patients) and reductions in Medi-Cal payment rates. In October 2011, CMS approved California's request for 10% reductions in Medi-Cal payments for certain outpatient services and for long-term care. The ACA provides for potential significant expansions to the Medicaid program, and the BCA may shift further funding responsibility from the federal government to state governments, exacerbating the California's financial challenges.

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 PPOs and HMOs for commercially-insured patients constituted approximately 58% 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 Health Facilities. 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.

Tahoe Forest Hospital typically receives average scores from published scoring of health care outcomes, but typically receives high ratings from patient satisfaction surveys.

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 recent "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.

Currently, clinical trials are not conducted at the Health Facilities.

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. Health facilities 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 health facilities. 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 Health Facilities. 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.

Currently, most of the District's employees are covered by collective bargaining agreements.

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 District currently meets the new seismic safety standards required by 2013, except for the facilities that are used to provide obstetric services. Before such services are moved in 2014 to a structure which fully complies with the 2013 seismic requirements obstetric services will be provided in facilities which receive a temporary waiver of the 2013 seismic requirements.

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 at one or more of the Health Facilities. The geographic area in which the Health Facilities are located has not been earthquake prone in the past. The Health Facilities are not 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, 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.

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