NEW ISSUE – FULL BOOK-ENTRY

INSURED RATING: S&P: "AA-"
NO UNDERLYING RATING
See "RATING"

In the opinion of Norton Rose Fulbright US LLP, Los Angeles, California, Bond Counsel, under existing statutes, regulations, rulings and court decisions, and subject to the matters described in "TAX MATTERS" herein, interest on the Bonds is excluded pursuant to section 103(a) of the Internal Revenue Code of 1986 from the gross income for the owners thereof for federal income tax purposes and is not included in the federal alternative minimum tax for individuals or, except as described herein, corporations. It is also the opinion of Bond Counsel that under existing law interest on the Bonds is exempt from personal income taxes of the State of California. See "TAX MATTERS" herein, including a discussion of the federal alternative minimum tax consequences for corporations.

$4,125,000
MENDOCINO COAST HEALTH CARE DISTRICT
(Mendocino County, California)
ELECTION OF 2000 GENERAL OBLIGATION
REFUNDING BONDS, SERIES 2016

Dated: Date of Delivery **Due: August 1, as shown on inside cover**

The Mendocino Coast Health Care District (the "District") is issuing $4,125,000 aggregate principal amount of its Election of 2000 General Obligation Refunding Bonds, Series 2016 (the "Bonds"). The Bonds are being issued in fully registered form and, when delivered, will be 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 described herein under the caption "THE BONDS — Book-Entry Only System."

The Bonds will be issued pursuant to the terms of Articles 9 and 11 of Chapter 3 of Part 1 of Division 2 of Title 5 of the California Government Code and the provisions of a resolution of the Board of Directors of the District adopted on November 3, 2016 (the "Resolution"). The Bonds are being issued in order to effect the refunding of certain maturities of the District's Election of 2000 General Obligation Bonds, which were issued by the District on May 9, 2001 (the "Refunded Bonds"), and to pay the costs of issuance of the Bonds. The Bonds are payable as to both principal and interest from the proceeds of the levy of *ad valorem* taxes on all property subject to such taxes in the District, which taxes are unlimited as to rate or amount. The District voters approved the authorization of the Refunded Bonds by more than two-thirds of the votes cast by eligible voters within the District on November 7, 2000.

The Bonds will mature on the dates and in the amounts and bear interest at the rates shown on the inside cover hereof. Interest on the Bonds is payable each February 1 and August 1, commencing on February 1, 2017. See "THE BONDS" herein.

The Bonds are subject to optional and mandatory sinking fund redemption prior to maturity as described herein. See "THE BONDS — Redemption" herein.

The scheduled payment of principal of and interest on the Bonds when due will be guaranteed under a municipal bond insurance policy to be issued concurrently with the issuance of the Bonds by National Public Finance Guarantee Corporation. See "BOND INSURANCE" herein.

MATURITY SCHEDULE
(see inside cover)

This cover page contains certain information for quick 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 decision respecting purchase of the Bonds.

The Bonds are offered when, as and if issued and accepted by the Underwriter, subject to the approval as to legality by Norton Rose Fulbright US LLP, Los Angeles, California, Bond Counsel. Certain legal matters will be passed upon for the District by Norton Rose Fulbright US LLP, as Disclosure Counsel, and by John J. Ruprecht, as counsel to the District. Certain legal matters will be passed upon for the Underwriter by its counsel Nossaman LLP, Irvine, California. It is expected that the Bonds in definitive form will be available for delivery through the book-entry facilities of DTC in New York, New York, on or about December 15, 2016.

William Blair

Dated: November 18, 2016

MATURITY SCHEDULE

$3,835,000 Serial Bonds

Maturity (August 1)	Principal Amount	Interest Rate	Yield	Price	CUSIP No. (586580)†
2023	$235,000	2.500%	2.600%	99.393	BG6
2024	400,000	2.500	2.800	97.950	BH4
2025	435,000	2.750	2.980	98.259	BJ0
2026	465,000	3.000	3.090	99.253	BK7
2027	505,000	5.000	3.200	114.809(c)	BL5
2028	550,000	3.375	3.580	98.061	BM3
2029	600,000	3.625	3.750	98.748	BN1
2030	645,000	3.750	3.900	98.422	BP6

$290,000 2.375% Term Bonds due August 1, 2022 – Yield 2.400%; Price 99.867; CUSIP † 586580BF8

(C) Priced to the first optional redemption date of August 1, 2026.

† CUSIP is a registered trademark of the American Bankers Association. CUSIP data herein is provided by CUSIP Global Services, managed by Standard & Poor's Financial Services LLC on behalf of The American Bankers Association. This data is not intended to create a database and does not serve in any way as a substitute for the CUSIP Services. CUSIP numbers have been assigned by an independent company not affiliated with the District and are included solely for the convenience of investors. Neither the District nor the Underwriter is responsible for the selection or uses of these CUSIP numbers, and no representation is made as to their correctness on the Bonds or as included herein. The CUSIP number for a specific maturity is subject to being changed after the issuance of the Bonds as a result of various subsequent actions including, as a result of the procurement of secondary market portfolio insurance or other similar enhancement by investors that is applicable to all or a portion of certain maturities of the Bonds.

MENDOCINO COAST HEALTH CARE DISTRICT

BOARD MEMBERS

Name	Position
Tom Birdsell[(1)]	Chair
Kitty Bruning	Vice Chair
Peter Glusker, M.D.	Secretary
Sean Hogan[(1)]	Treasurer
Steve Lund[(1)]	Member

DISTRICT STAFF

Bob Edwards, Chief Executive Officer
Wade Sturgeon, Chief Financial Officer

DISTRICT COUNSEL
John J. Ruprecht, Esq.

PROFESSIONAL SERVICES

Bond and Disclosure Counsel

Norton Rose Fulbright US LLP
Los Angeles, California

Underwriter

William Blair & Company, LLC
Los Angeles, California

Financial Advisor

Eastshore Consulting, LLC
Oakland, California

Paying Agent

The Bank of New York Mellon Trust Company, N.A.
San Francisco, California

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(1) As of the date of this Official Statement, pursuant to the results of the November 8, 2016 election, which have not yet been certified by the Elections Division of the Office of the Assessor-County Clerk-Recorder of the County of Mendocino, Tom Birdsell and Sean Hogan's terms will expire in December 2016 as well as the temporary appointment of Steve Lund. Lucas W. Campos, M.D., and Steve Lund were elected to four-year terms commencing in December 2016. Kevin B. Miller, M.D., was elected to a two-year term also commencing in December 2016.

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No dealer, salesman or any other person has been authorized by the Mendocino Coast Health Care District (the "District") to give any information or to make any representations, other than those contained in this Official Statement, and, if given or made, such other information or representations must not be relied upon as having been authorized by the District.

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. This Official Statement is not to be construed as a contract with the purchasers of the Bonds. Neither the delivery of this Official Statement nor the sale of any of the Bonds implies that the information herein is correct as of any time subsequent to the date hereof. 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, create the implication that there has been no change in the matters described herein since the date hereof. This Official Statement is submitted in connection with the sale of securities referred to herein and may not be reproduced or be used, as a whole or in part, for any other purpose.

The information set forth herein has been obtained from the District and other sources believed to be reliable. The information and expressions of opinions herein are subject to change without notice and neither delivery of the Official Statement nor any sale made hereunder shall, under any circumstances, create any implication that there has been no change in the affairs of the District since the date hereof. All summaries contained herein of the Resolution (as defined herein) or other documents are made subject to the provisions of such documents and do not purport to be complete statements of any or all of such provisions. All statements made herein are made as of the date of this document by the District except statistical information or other statements where some other date is indicated in the text.

The Underwriter has provided the following sentence for inclusion in this Official Statement. The Underwriter has reviewed the information in this Official Statement in accordance with, and as part of, its responsibilities to investors under the federal securities laws as applied to the facts and circumstances of this transaction, but the Underwriter does not guarantee the accuracy or completeness of such information.

In connection with the offering of the Bonds, the Underwriter in connection with any reoffering may over-allot or effect transactions which stabilize or maintain the market price of the Bonds at a level above that which might otherwise prevail in the open market. Such stabilizing, if commenced, may be discontinued at any time. The Underwriter in connection with any reoffering may offer and sell the Bonds to certain dealers, institutional investors and others at prices lower than the public offering prices stated on the inside cover page hereof and such public offering prices may be changed from time to time by the Underwriter.

National Public Finance Guarantee Corporation ("National") makes no representation regarding the Bonds or the advisability of investing in the Bonds. In addition, National has not independently verified, makes no representation regarding, and does not accept any responsibility for the accuracy or completeness of this Official Statement or any information or disclosure contained herein, or omitted herefrom, other than with respect to the accuracy of the information regarding National supplied by National and presented under the heading "BOND INSURANCE" and "APPENDIX G – SPECIMEN FINANCIAL GUARANTY INSURANCE POLICY."

A wide variety of other information, including financial information, concerning the District is available from publications and websites of the District and others. Any such information that is inconsistent with the information set forth in this Official Statement should be disregarded. No such information is a part of or incorporated into this Official Statement, except as expressly noted herein

FORWARD-LOOKING STATEMENTS

Certain statements included or incorporated by reference in this Official Statement constitute forward-looking statements. Such statements are generally identifiable by the terminology used such as "plan," "expect," "estimate," "project," "budget" or other similar words. The achievement of certain results or other expectations contained in such forward-looking statements involve known and unknown risks, uncertainties and other factors which may cause actual results, performance or achievements described to be materially different from any future results, performance or achievements expressed or implied by such forward-looking statements. No assurance is given that actual results will meet the forecasts of the District in any way, regardless of the level of optimism communicated in the information. The District is not obligated to issue any updates or revisions to the forward-looking statements if or when its expectations, or events, conditions or circumstances on which such statements are based occur.

THE DISTRICT DOES NOT PLAN TO ISSUE ANY UPDATES OR REVISIONS TO THOSE FORWARD-LOOKING STATEMENTS IF OR WHEN ANY OF ITS EXPECTATIONS, OR EVENTS, CONDITIONS OR CIRCUMSTANCES ON WHICH SUCH STATEMENTS ARE BASED DO OR DO NOT OCCUR, OTHER THAN AS DESCRIBED UNDER THE CAPTION "CONTINUING DISCLOSURE" HEREIN.

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OFFICIAL STATEMENT

$4,125,000
MENDOCINO COAST HEALTH CARE DISTRICT
(Mendocino County, California)
ELECTION OF 2000 GENERAL OBLIGATION REFUNDING BONDS, SERIES 2016

INTRODUCTION

The following introductory statement is subject in all respects to more complete information contained elsewhere in this Official Statement. The order and placement of materials in this Official Statement, including the Appendices, are not to be deemed to be a determination of relevance, materiality or relative importance, and this Official Statement, including the cover page, inside cover page and Appendices, must be considered in its entirety. All capitalized terms used in this Official Statement that are not otherwise defined herein shall have the meanings ascribed to them in the Resolution.

Purpose of the Official Statement

The purpose of this Official Statement, including the cover page and inside cover page hereof and the Appendices hereto, is to furnish certain information relating to: (i) the Mendocino Coast Health Care District (the "District"), (ii) $4,125,000 aggregate principal of the District's Election of 2000 General Obligation Refunding Bonds, Series 2016 (the "Bonds"), and (iii) the current refunding of certain maturities of the District's Election of 2000 General Obligation Bonds, which were issued by the District on May 9, 2001, and are currently outstanding in the principal amount of $4,447,741.05 (the "2001 Bonds").

The District is a California local health care district organized pursuant to Division 23 of the Health and Safety Code of the State of California (the "Health and Safety Code").

The Bonds

The Bonds will be issued pursuant to Articles 9 and 11 of Chapter 3 of Part 1 of Division 2 of Title 5 of the California Government Code (the "Act") and the provisions of a resolution of the Board of Directors of the District (the "Board") adopted on November 3, 2016 (the "Resolution"). The District voters approved the issuance of general obligation bonds of the District in an amount not to exceed $5,500,000 by more than two-thirds of the votes cast by eligible voters within the District on November 7, 2000 (the "Authorization"), pursuant to which the 2001 Bonds were issued. All general obligation bonds of the District are issued on parity with one another and with the Bonds.

A description of the Bonds is contained in this Official Statement under "THE BONDS." All references to the Bonds are qualified in their entirety by the definitive forms thereof and the provisions with respect thereto included in the Resolution. A description of the refunding plan and a description of the estimated sources and uses of funds are contained in this Official Statement under "PLAN OF REFUNDING" and "ESTIMATED SOURCES AND USES OF FUNDS" herein, respectively.

Security for the Bonds

The Bonds are general obligations of the District. The Board of Supervisors of Mendocino County (the "County") has the power and is obligated to annually levy *ad valorem* taxes upon all property subject to taxation by the District, without limitation as to rate or amount (except certain personal property, which is taxable at limited rates), for the payment of principal of and interest on the Bonds (except certain personal property which is taxable at limited rates). See "SECURITY AND SOURCE OF PAYMENT FOR THE BONDS" and "APPENDIX C – INFORMATION CONCERNING MENDOCINO COAST HEALTH CARE DISTRICT."

Financial Statements

The District's audited financial statements for the fiscal years ended June 30, 2016 and 2015, are included in APPENDIX B to this Official Statement. The audited financial statements have been audited by Dingus, Zarecor & Associates, PLLC, independent certified public accountants, to the extent and for the periods indicated in their report, which is also included in APPENDIX B.

Other Information

This Official Statement speaks only as of its date, and the information contained herein is subject to change.

All references herein to the specified documents are qualified in their entirety by reference to the definitive forms of those documents, copies of which will be provided during the offering period to any prospective purchaser requesting the same from the Underwriter, upon payment by such prospective purchaser of the cost of complying with such request.

THE BONDS

Authority for Issuance

The 2001 Bonds were authorized by the Authorization. Pursuant to the Act, the District is empowered to issue general obligation bonds to refund any of its voter-approved debt, including the 2001 Bonds. The Board adopted the Resolution at a meeting of the Board held on November 3, 2016.

General

The Bonds will be issued in denominations of $5,000 or any integral multiple thereof and will mature on the dates and in the amounts and bear interest at the rates per annum, all as set forth on the inside cover page of this Official Statement.

Interest on the Bonds will be payable on February 1 and August 1 of each year (the "Bond Payment Dates"), commencing February 1, 2017. Interest on the Bonds will be computed on the basis of a 360-day year consisting of twelve 30-day months. Each Bond will bear interest from the Bond Payment Date next preceding the date of authentication thereof unless such date of authentication is a day during the period from the sixteenth day of the month next preceding any Bond Payment Date to such Bond Payment Date, inclusive, in which event it shall bear interest from such Bond Payment Date, or unless such date of authentication is on or prior to January 15, 2017, in which event it shall bear interest from the delivery date of the Bonds, provided, however, that if as of the date of authentication of any Bond, interest is in default thereon, such Bond shall bear interest from the Bond Payment Date to which interest has previously been paid or made available for payment thereon.

The principal or redemption price of the Bonds will be payable at the maturity or earlier redemption upon presentation and surrender of the Bonds at the corporate trust office of The Bank of New York Mellon Trust Company, N.A., as paying agent (the "Paying Agent"), and interest on the Bonds will be payable by check, mailed on the Bond Payment Date to each Owner of the Bonds as of the close of business on the fifteenth day of the month immediately preceding a Bond Payment Date, or by wire transfer to an account in the United States at the request of the Owner of at least $1,000,000 in aggregate principal amount of outstanding Bonds filed with the Paying Agent no later than the fifteenth day of the month next preceding such Bond Payment Date.

Redemption

Optional Redemption. The Bonds maturing on or before August 1, 2026 are not subject to redemption prior to their fixed maturity dates. The Bonds maturing on and after August 1, 2027 may be redeemed before maturity, at the option of the Authority, from any source of available funds, on any date on or after August 1, 2026, as a whole or in part, at par together with interest accrued thereon to the date of redemption.

Mandatory Sinking Fund Redemption. The Bonds maturing on August 1, 2022 are subject to mandatory redemption in part by lot, on August 1 in each year commencing August 1, 2017, and on each August 1 thereafter up to and including August 1, 2022, from mandatory sinking payments made by the District, at a redemption price equal to the principal amount thereof to be redeemed, without premium, plus accrued interest thereon to the date of redemption, in the following principal amounts:

Sinking Fund Payment Date	Principal Amount
August 1, 2017	$35,000
August 1, 2018	50,000
August 1, 2019	50,000
August 1, 2020	50,000
August 1, 2021	50,000
August 1, 2022[(1)]	55,000

[(1)] Maturity.

Selection of Bonds for Redemption

Whenever provision is made for the redemption of less than all of the Bonds, the Paying Agent, upon written instruction from the District given at least 30 days but not more than 60 days prior to the Bond Payment Date designated for such redemption, shall select Bonds for redemption in such order as the District may direct or, in the absence of such direction, in inverse order of maturity. Within a maturity, the Paying Agent shall select Bonds for redemption by lot. Redemption by lot shall be in such manner as the District shall determine; provided, however, that in the event the District shall fail to so determine, then in inverse order of maturity and by lot within a maturity; and that the portion of any Bond to be redeemed in part shall be in the principal amount of $5,000 or any integral multiple thereof. For purposes of such selection, all Bonds shall be deemed to be comprised of separate $5,000 Authorized Denominations and such separate Authorized Denominations shall be treated as separate Bonds which may be separately redeemed.

Notice of Redemption

Notice of redemption shall be mailed by the Paying Agent, by first class mail, postage prepaid, to the respective Owners of any Bonds designated for redemption at their addresses appearing on the

Registration Books and to the Securities Depositories and the Information Services at least 20 days but not more than 60 days prior to the redemption date. Neither the failure to receive such notice nor any defect in the notice so mailed will affect the sufficiency of the proceedings for redemption of such Bonds or the cessation of accrual of interest on the redemption date. Each notice of redemption shall state the redemption date, the place or places of redemption, the CUSIP numbers and the Bond numbers of the Bonds to be redeemed, and in the case of Bonds to be redeemed in part only, the respective Authorized Denominations of the principal amount thereof to be redeemed. Each such notice shall also state that on said date there will become due and payable on each of said Bonds the principal amount relating thereto or of said specified portion of the principal thereof in the case of a Bond to be redeemed in part only, plus accrued interest, if any, and through which date such interest will accrue, and that from and after such date interest thereon shall cease to accrue and shall require that such Bonds be then surrendered at the principal office of the Paying Agent. Neither the failure of any Owner to receive any notice so mailed nor any defect therein shall affect the sufficiency of the proceedings for redemption of any Bonds nor the cessation of accrual of interest thereon.

The Paying Agent shall, at the direction of the District, issue a notice of redemption on the foregoing terms that is conditioned upon the delivery of proceeds of refunding bonds or other funds lawfully available to pay the redemption price of the Bonds. Such a conditional notice of redemption, if given, may be rescinded by the Paying Agent at the direction of the District at any time prior to the scheduled redemption date, whereupon the notice of redemption shall: (A) be deemed null and void, (B) the District shall not be required to redeem such Bonds, (C) the redemption shall not be made and (D) the Paying Agent shall within a reasonable time thereafter give notice to the persons in the manner in which the conditional notice of redemption was given, that such condition or conditions were not met and that the redemption was cancelled.

Notice of redemption of Bonds shall be given by the Paying Agent, at the expense of the District.

Partial Redemption of Bonds

Upon surrender of any Bonds redeemed in part only, the District shall execute and the Paying Agent shall authenticate and deliver to the Owner thereof, at the expense of the District, a new Bond or Bonds of Authorized Denominations equal in aggregate principal amount or maturity amount, as applicable, representing the unredeemed portion of the Bond or Bonds surrendered.

Effect of Notice of Redemption

Notice having been given as aforesaid, and moneys for the redemption (including the interest to the applicable date of redemption and including any applicable premium), having been set aside in the in accordance with the Resolution, the Bonds shall become due and payable on said date of redemption.

If, on said date of redemption, moneys for the redemption of the Bonds to be redeemed, together with interest to said date of redemption, shall be held by or on behalf of the Paying Agent so as to be available therefor on such date of redemption, and, if notice of redemption thereof shall have been given as aforesaid and not cancelled, then, from and after said date of redemption, interest represented by such Bonds shall cease to accrue and become payable. All moneys held by or on behalf of the Paying Agent for the redemption of Bonds shall be held in trust for the account of the Owners of the Bonds so to be redeemed.

All Bonds paid at maturity or redeemed prior to maturity shall be cancelled upon surrender thereof and destroyed.

Defeasance

If all Outstanding Bonds shall be paid and discharged in any one or more of the following ways:

(a) by well and truly paying or causing to be paid the principal and interest on all Bonds Outstanding, and when the same become due and payable;

(b) by depositing with the Paying Agent, in trust, at or before maturity, cash which together with amounts then on deposit in the Debt Service Fund (as defined herein) together with the interest to accrue thereon, is fully sufficient to pay all Bonds Outstanding at maturity thereof or on any redemption date prior thereto, including any premium and all interest thereon, notwithstanding that any Bonds shall not have been surrendered for payment; or

(c) by depositing with an institution that meets the requirements for serving as a Paying Agent pursuant to the Resolution, in trust, lawful moneys, or obligations issued by the United States Treasury (including State and Local Government Series Obligations) or obligations which are unconditionally guaranteed by the United States of America and permitted under Section 149(b) of the Code and Regulations which, in the opinion of Bond Counsel, will not impair the exclusion of gross income for federal income tax purposes of interest on the Bonds, in such amount as will, in the opinion of an independent certified public accountant, together with the interest to accrue thereon, be fully sufficient to pay and discharge all Bonds Outstanding at maturity thereof or on any redemption date prior thereto, including any premium and all interest thereon, notwithstanding that any Bonds shall not have been surrendered for payment;

then all obligations of the District under the Resolution with respect to all Outstanding Bonds shall cease and terminate, except only the obligation of the Paying Agent to pay or cause to be paid from funds to the Owners of the Bonds all sums due thereon.

Transfer and Exchange

Any Bond may, in accordance with its terms, be transferred in the books required to be kept pursuant to the provisions of the Resolution by the person in whose name it is registered, in person or by their duly authorized attorney, upon surrender of such Bond for cancellation accompanied by delivery of a duly executed written instrument of transfer in a form acceptable to the Paying Agent. Whenever any Bond or Bonds are surrendered for transfer, the District will execute and the Paying Agent will authenticate and deliver to the transferee a new Bond or Bonds of the same maturity and tenor for a like aggregate principal amount or Maturity Amount. The Paying Agent will require the payment by the Owner requesting such transfer of any tax or other governmental charge required to be paid with respect to such transfer as a condition precedent to the exercise of such privilege.

The Paying Agent will not be required to issue, register the transfer of or exchange any Bonds during the period established by the Paying Agent for selection of Bonds for redemption or to register the transfer or exchange of any Bonds which have been selected for redemption in whole or in part.

Bonds may be exchanged at the corporate trust office of the Paying Agent for a like aggregate principal amount of Bonds of the same maturity and tenor of other authorized denominations. The Paying Agent will require the payment by the Owner requesting such exchange of any tax or other governmental charge required to be paid with respect to such exchange as a condition precedent to the exercise of such privilege.

CUSIP Numbers

It is anticipated that CUSIP identification numbers will be printed on the Bonds, but neither the failure to print such numbers on any Bonds, nor any error in the printing of such numbers, shall constitute cause for a failure or refusal by the purchaser thereof to accept delivery of and pay for any Bonds.

Book-Entry Only System

The Depository Trust Company ("DTC") will act as securities depository for the Bonds. The Bonds will be executed and delivered as fully registered securities registered in the name of Cede & Co. (DTC's partnership nominee). One fully registered bond will be issued for the Bonds of each maturity, in the initial aggregate principal amount of such maturity, and will be deposited with DTC or its authorized agent. See "APPENDIX F – BOOK-ENTRY ONLY SYSTEM" for further information regarding DTC.

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 tenor and in the same aggregate Principal amount or Maturity Amount. All of such exchanges shall be made as provided in the Resolution, or in such manner and upon such reasonable terms as may from time to time be determined and prescribed by the District.

PLAN OF REFUNDING

The Bonds are being issued in order to effect the refunding of certain maturities of the 2001 Bonds and to pay the costs of issuance of the Bonds. The District will enter into an Escrow Deposit and Trust Agreement, dated as of December 1, 2016 (the "Escrow Agreement"), with The Bank of New York Mellon Trust Company, N.A., in its capacity as Escrow Agent (the "Escrow Agent"), under which an Escrow Fund (the "Escrow Fund") will be established to secure the payment and redemption of the Refunded Bonds (as hereinafter defined) on December 19, 2016. The net proceeds of sale of the Bonds will be deposited into the Escrow Fund and held as uninvested cash.

The 2001 Bonds to be refunded (the "Refunded Bonds") are identified in the table below.

Maturity Date (August 1)	Principal Amount	Interest Rate	CUSIP (586580)
2023	$ 200,000	5.100%	AL6
2024	385,000	5.125	AM4
2025	430,000	5.200	AN2
2026	475,000	5.200	AP7
2029[1]	1,750,000	5.250	AQ5
2030	700,000	5.250	AR3

[1] Term Bond Maturing August 1, 2029.

ESTIMATED SOURCES AND USES OF FUNDS

The estimated sources and uses of funds in connection with the financing are as follows:

Sources:	
Bond Proceeds	$4,125,000.00
Net Original Issue Premium	25,371.80
Total Sources:	$4,150,371.80
Uses:	
Deposit to Escrow Fund	$3,946,853.88
Costs of Issuance Fund[1]	203,517.92
Total Uses:	$4,150,371.80

[1] Includes the Underwriter's discount, initial fees and expenses of the Paying Agent, printing costs, fees and expenses of Bond Counsel, Disclosure Counsel, the Escrow Agent and the Financial Advisor, premium for municipal bond insurance, and other miscellaneous costs of issuance.

DEBT SERVICE SCHEDULE

The following table displays the debt service schedule of the District for the Bonds and the Bonds, assuming no optional redemptions.

Bond Year Ending August 1	2001 Bonds Debt Service[(1)]	The Bonds		Aggregate Debt Service
		Principal	Interest	
2017	$245,000.00	$35,000.00	$86,900.14	$366,900.14
2018	265,000.00	50,000.00	137,593.76	452,593.76
2019	275,000.00	50,000.00	136,406.26	461,406.26
2020	300,000.00	50,000.00	135,218.76	485,218.76
2021	315,000.00	50,000.00	134,031.26	499,031.26
2022	335,000.00	55,000.00	132,843.76	522,843.76
2023	160,000.00	235,000.00	131,537.50	526,537.50
2024	--	400,000.00	125,662.50	525,662.50
2025	--	435,000.00	115,662.50	550,662.50
2026	--	465,000.00	103,700.00	568,700.00
2027	--	505,000.00	89,750.00	594,750.00
2028	--	550,000.00	64,500.00	614,500.00
2029	--	600,000.00	45,937.50	645,937.50
2030	--	645,000.00	24,187.50	669,187.50
Total	$1,895,000.00	$4,125,000.00	$1,463,931.44	$7,483,931.44

(1) Excludes debt service on Refunded Bonds.

BOND INSURANCE

The following information has been furnished by National Public Finance Guarantee Corporation ("National") for use in this Official Statement.

National does not accept any responsibility for the accuracy or completeness of any information or disclosure contained herein, or omitted herefrom, other than with respect to the accuracy of the information regarding National and the Financial Guaranty Insurance Policy issued by National (the "Policy"). Additionally, National makes no representation regarding the Bonds or the advisability of investing in the Bonds. A specimen of the Policy is attached hereto as Appendix G.

The Policy unconditionally and irrevocably guarantees the full and complete payment required to be made by or on behalf of the District to the Paying Agent or its successor of an amount equal to (i) the principal of (either at the stated maturity or by an advancement of maturity pursuant to a mandatory sinking fund payment) and interest on, the Bonds as such payments shall become due but shall not be so paid (except that in the event of any acceleration of the due date of such principal by reason of mandatory or optional redemption or acceleration resulting from default or otherwise, other than any advancement of maturity pursuant to a mandatory sinking fund payment, the payments guaranteed by the Policy shall be made in such amounts and at such times as such payments of principal would have been due had there not been any such acceleration, unless National elects in its sole discretion, to pay in whole or in part any principal due by reason of such acceleration); and (ii) the reimbursement of any such payment which is subsequently recovered from any Owner of the Bonds pursuant to a final judgment by a court of

competent jurisdiction that such payment constitutes an avoidable preference to such Owner within the meaning of any applicable bankruptcy law (a "Preference").

The Policy does not insure against loss of any prepayment premium which may at any time be payable with respect to any Bonds. The Policy does not, under any circumstance, insure against loss relating to: (i) optional or mandatory redemptions (other than mandatory sinking fund redemptions); (ii) any payments to be made on an accelerated basis; (iii) payments of the purchase price of Bonds upon tender by an owner thereof; or (iv) any Preference relating to (i) through (iii) above. The Policy also does not insure against nonpayment of principal of or interest on the Bonds resulting from the insolvency, negligence or any other act or omission of the Paying Agent or any other paying agent for the Bonds.

National Public Finance Guarantee Corporation

National is an operating subsidiary of MBIA Inc., a New York Stock Exchange listed company. MBIA Inc. is not obligated to pay the debts of or claims against National. National is domiciled in the State of New York and is licensed to do business in and subject to regulation under the laws of all 50 states, the District of Columbia, the Commonwealth of Puerto Rico, the Territory of Guam and the U.S. Virgin Islands.

The principal executive offices of National are located at 1 Manhattanville Road, Suite 301, Purchase, New York 10577 and the main telephone number at that address is (914) 765-3333.

Regulation

As a financial guaranty insurance company licensed to do business in the State of New York, National is also subject to the New York Insurance Law which, among other things, prescribes minimum capital requirements and contingency reserves against liabilities for National, limits the classes and concentrations of investments that are made by National and requires the approval of policy rates and forms that are employed by National. State law also regulates the amount of both the aggregate and individual risks that may be insured by National, the payment of dividends by National, changes in control with respect to National and transactions among National and its affiliates.

The National Insurance Policy is not covered by the Property/Casualty Insurance Security Fund specified in Article 76 of the New York Insurance Law.

Financial Strength Ratings of National

National's current financial strength ratings from the major rating agencies are summarized below:

Agency	Ratings	Outlook
S&P	AA-	Stable
Moody's	A3	Negative
KBRA	AA+	Stable

Each rating of National should be evaluated independently. The ratings reflect the respective rating agency's current assessment of the creditworthiness of National and its ability to pay claims on its policies of insurance. Any further explanation as to the significance of the above ratings may be obtained only from the applicable rating agency.

The above ratings are not recommendations to buy, sell or hold the Bonds, and such ratings may be subject to revision or withdrawal at any time by the rating agencies. Any downward revision or withdrawal of any of the above ratings may have an adverse effect on the market price of the Bonds. National does not guaranty the market price of the Bonds nor does it guaranty that the ratings on the Bonds will not be revised or withdrawn.

Recent Litigation

In the normal course of operating its business, National may be involved in various legal proceedings. Additionally, MBIA Inc. may be involved in various legal proceedings that directly or indirectly impact National. For additional information concerning material litigation involving National and MBIA Inc., see MBIA Inc.'s Annual Report on Form 10-K for the year ended December 31, 2015 and Quarterly Report on Form 10-Q for the quarter ended September 30, 2016, which is hereby incorporated by reference into this Official Statement and shall be deemed to be a part hereof, as well as the information posted on MBIA Inc.'s web site at http://www.mbia.com.

MBIA Inc. and National are defending against/pursuing the aforementioned actions and expect ultimately to prevail on the merits. There is no assurance, however, that they will prevail in these actions. Adverse rulings in these actions could have a material adverse effect on National's ability to implement its strategy and on its business, results of operations and financial condition.

Other than as described above and referenced herein, there are no other material lawsuits pending or, to the knowledge of National, threatened, to which National is a party.

National Financial Information

Based upon statutory financials, as of September 30, 2016, National had total net admitted assets of $4.5 billion (unaudited), total liabilities of $1.8 billion (unaudited), and total surplus of $2.7 billion (unaudited) determined in accordance with statutory accounting practices prescribed or permitted by insurance regulatory authorities.

For further information concerning National, see the financial statements of MBIA Inc. and its subsidiaries as of December 31, 2015, prepared in accordance with generally accepted accounting principles, included in the Annual Report on Form 10-K of MBIA Inc. for the year ended December 31, 2015, which are hereby incorporated by reference into this Official Statement and shall be deemed to be a part hereof.

Incorporation of Certain Documents by Reference

The following documents filed by MBIA Inc. with the Securities and Exchange Commission (the "SEC") are incorporated by reference into this Official Statement:

MBIA Inc.'s Annual Report on Form 10-K for the year ended December 31, 2015;

MBIA Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2016.

Any documents, including any financial statements of National that are included therein or attached as exhibits thereto, or any Form 8-K, filed by MBIA Inc. pursuant to Sections 13(a), 13(c), 14 or 15(d) of the Exchange Act after the date of MBIA Inc.'s most recent Quarterly Report on Form 10-Q or Annual Report on Form 10-K, and prior to the termination of the offering of the [Bonds/Obligations] offered hereby shall be deemed to be incorporated by reference in this Official Statement and to be a part hereof from the respective dates of filing such documents.

Any statement contained in a document incorporated or deemed to be incorporated by reference herein, or contained in this Official Statement, shall be deemed to be modified or superseded for purposes of this Official Statement to the extent that a statement contained herein or in any other subsequently filed document which also is or is deemed to be incorporated by reference herein modifies or supersedes such statement. Any such statement so modified or superseded shall not be deemed, except as so modified or superseded, to constitute a part of this Official Statement.

MBIA Inc., files annual, quarterly and special reports, information statements and other information with the SEC under File No. 1-9583. Copies of MBIA Inc.'s SEC filings (MBIA Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2016 and MBIA Inc.'s Annual Report on Form 10-K for the year ended December 31, 2015) are available (i) over the Internet at the SEC's web site at http://www.sec.gov; (ii) at the SEC's public reference room in Washington D.C.; (iii) over the Internet at MBIA Inc.'s web site at http://www.mbia.com; and (iv) at no cost, upon request to National at its principal executive offices.

In the event the Insurer were to become insolvent, any claims arising under a policy of financial guaranty insurance are excluded from coverage by the California Insurance Guaranty Association, established pursuant to Article 14.2 (commencing with Section 1063) of Chapter 1 of Part 2 of Division 1 of the California Insurance Code.

THE DISTRICT

The District is a public entity under the laws of the State of California (the "State") formed by a vote of the District's constituents on January 17, 1967, and is operated as a local health care district pursuant to Health & Safety Code Section 3200, et seq. The District is exempt from federal taxation under Section 115 of the Internal Revenue Code of 1986, as amended (the "Code"). The District owns and operates the Mendocino Coast District Hospital (the "Hospital"), a 25-bed acute care facility licensed by the State of California Department of Public Health. The Hospital has been designated as a critical access hospital (a "CAH"). The Hospital is located at 700 River Drive, in the City of Fort Bragg (the "City"), which is approximately 165 miles north of San Francisco and approximately a fifty minute drive from the next closest hospital. For information about the District, see "APPENDIX C – THE DISTRICT AND THE HOSPITAL." and "APPENDIX B – AUDITED FINANCIAL STATEMENTS OF THE DISTRICT FOR THE FISCAL YEARS ENDED JUNE 30, 2016 AND 2015."

The District encompasses approximately 680 square miles and extends approximately 70 miles south from the Humboldt/Mendocino County line. The District is bordered on the west by the Pacific Ocean and includes the City and the communities of Westport, Mendocino, Albion and Elk. The estimated population of the District is approximately 25,000.

SECURITY AND SOURCE OF PAYMENT FOR THE BONDS

General

The Bonds are general obligations of the District, and the Board of Supervisors of the County has the power and is obligated to cause to be levied and collected annual *ad valorem* taxes for payment of the Bonds and the interest thereon upon all property within the District subject to taxation by the District without limitation as to rate or amount. Such taxes will be levied annually in addition to all other taxes during the period that the Bonds are Outstanding in an amount sufficient to pay the principal of and interest on the Bonds when due. Such taxes, when collected, will be deposited into the Mendocino Coast Healthcare District Debt Service Fund (the "Debt Service Fund"), which is required to be applied for the payment of principal of and interest on the Bonds when due.

Pursuant to Section 32127 of the Health and Safety Code, in the event that the amount on deposit in the District's Debt Service Fund is insufficient to pay the debt service coming due on the Bonds on any Bond Payment Date, an amount sufficient to make such debt service payment shall be transferred from the maintenance and operation fund of the District to the Debt Service Fund and used to pay debt service on the Bonds. The District has never had to transfer any amounts from its maintenance and operation fund to make any payments of debt service on any of its outstanding general obligation bonds.

The moneys in the Debt Service Fund, to the extent necessary to pay the principal of, premium, if any, and interest on the Bonds as the same becomes due and payable, shall be transferred by the County to the Paying Agent and by the Paying Agent, to DTC for remittance of such principal, premium, if any, and interest to its Participants (as defined herein) for subsequent disbursement to the Beneficial Owners of the Bonds.

The amount of the annual *ad valorem* tax levied to repay the Bonds will be determined by the relationship between the assessed valuation of taxable property in the District and the amount of debt service due on the Bonds. Fluctuations in the annual debt service on the Bonds and the assessed value of taxable property in the District may cause the annual tax rate to fluctuate. Economic and other factors beyond the District's control, such as economic recession, deflation of land values, a relocation out of the District or financial difficulty or bankruptcy by one or more major property taxpayers, or the complete or partial destruction of taxable property caused by, among other eventualities, earthquake, flood or other natural disaster, could cause a reduction in the assessed value within the District and necessitate a corresponding increase in the annual tax rate.

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 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 property are entered separately on the assessment roll maintained by the county assessor. The method of collecting delinquent taxes is substantially different for the two classifications of property.

Property taxes on the secured roll are due in two installments, on November 1 and February 1 of each fiscal 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 of the fiscal year. 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 tax collector.

Historically, 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. A bill enacted in 1983, SB 813 (Statutes of 1983, Chapter 498), however, provided for the supplemental assessment and taxation of property as of the occurrence of a change of ownership or completion of new construction. Thus, this legislation eliminated delays in the realization of increased property taxes from new assessments. As amended, SB 813 provided increased revenue to taxing jurisdictions to the extent that supplemental assessments of new construction or changes of ownership occur subsequent to the March 1 lien date.

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 for 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. 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.

Assessed Valuation of Property Within the District

All property (real, personal and intangible) is taxable unless an exemption is granted by the California Constitution or United States law. Under the State Constitution, exempt classes of property include household and personal effects, intangible personal property (such as bank accounts, stocks and bonds), business inventories, and property used for religious, hospital, scientific and charitable purposes. The State Legislature may create additional exemptions for personal property, but not for real property. Most taxable property is assessed by the assessor of the county in which the property is located. Some special classes of property are assessed by the State Board of Equalization, as described below.

Taxes are levied for each fiscal year on taxable real and personal property assessed as of the preceding January 1, at which time the lien attaches. The assessed value is required to be adjusted during the course of the year when property changes ownership or new construction is completed. State law also affords an appeal procedure to taxpayers who disagree with the assessed value of any property. When necessitated by changes in assessed value during the course of a year, a supplemental assessment is prepared so that taxes can be levied on the new assessed value before the next regular assessment roll is completed. See *"–Appeals of Assessed Valuation; Blanket Reductions of Assessed Values"* below.

Under the State Constitution, the State Board of Equalization assesses property of State-regulated transportation and communications utilities, including railways, telephone and telegraph companies, and companies transmitting or selling gas or electricity. The Board of Equalization also is required to assess pipelines, flumes, canals and aqueducts lying within two or more counties. The value of property assessed by the Board of Equalization is allocated by a formula to local jurisdictions in the county,

including school districts, and taxed by the local county tax officials in the same manner as for locally assessed property. Taxes on privately owned railway cars, however, are levied and collected directly by the Board of Equalization. Property used in the generation of electricity by a company that does not also transmit or sell that electricity is taxed locally instead of by the Board of Equalization. Thus, the reorganization of regulated utilities and the transfer of electricity-generating property to non-utility companies, as often occurred under electric power deregulation in California, affects how those assets are assessed, and which local agencies benefit from the property taxes derived. In general, the transfer of State-assessed property located in the District to non-utility companies will increase the assessed value of property in the District, since the property's value will no longer be divided among all taxing jurisdictions in the applicable county. The transfer of property located and taxed in the District to a State-assessed utility will have the opposite effect: generally reducing the assessed value in the District, as the value is shared among the other jurisdictions in the applicable county. The District is unable to predict future transfers of State-assessed property in the District and the counties, the impact of such transfers on its utility property tax revenues, or whether future legislation or litigation may affect ownership of utility assets, the State's methods of assessing utility property, or the method by which tax revenues of utility property is allocated to local taxing agencies, including the District.

Locally taxed property is classified either as "secured" or "unsecured," and is listed accordingly on separate parts of the assessment roll. The "secured roll" is that part of the assessment roll containing State-assessed property and property (real or personal) for which there is a lien on real property sufficient, in the opinion of the county assessor, to secure payment of the taxes. All other property is "unsecured," and is assessed on the "unsecured roll." Secured property assessed by the State Board of Equalization is commonly identified for taxation purposes as "utility" property.

The District's 2016-17 total assessed valuation is $3,172,124,408. The summary below shows a five-year history of the total secured and unsecured assessed property valuations of property within the District.

MENDOCINO COAST HEALTH CARE DISTRICT
Assessed Valuations
2012-13 Through 2016-17

Fiscal Year	Local Secured	Utility	Unsecured	Total
2012-13	$2,852,291,149	$542,898	$62,486,922	$2,915,320,969
2013-14	2,883,812,977	542,898	62,144,982	2,946,500,857
2014-15	2,913,429,461	542,898	62,266,527	2,976,238,886
2015-16	2,999,768,078	542,898	61,693,915	3,062,004,891
2016-17	3,111,087,822	340,398	60,696,188	3,172,124,408

Source: California Municipal Statistics, Inc.

Assessments may be adjusted during the course of the year when real property changes ownership or new construction is completed. Assessments may also be appealed by taxpayers seeking a reduction as a result of economic and other factors beyond the District's control, such as a general market decline in land values, reclassification of property to a class exempt from taxation, whether by ownership or use (such as exemptions for property owned by State and local agencies and property used for qualified educational, hospital, charitable or religious purposes), or the complete or partial destruction of taxable property caused by natural or manmade disaster, such as earthquake, flood, fire, toxic dumping, etc. When necessitated by changes in assessed value in the course of a year, taxes are pro-rated for each

portion of the tax year. See also *"–Appeals of Assessed Valuation; Blanket Reductions of Assessed Values"* below.

Drought. On January 17, 2014, the State Governor (the "Governor") declared a state-wide Drought State of Emergency. As of such date, the State faced water shortfalls due to the driest year in recorded State history; the State's rivers and reservoirs were below their record low levels, and manual and electronic readings recorded the water content of snowpack at the highest elevations in the State (chiefly in the Sierra Nevada mountain range) at about 20% of normal average for the winter season. As part of his State of Emergency declaration, the Governor directed State officials to assist agricultural producers and communities that may be economically impacted by dry conditions. Following the Governor's declaration, the California State Water Resources Control Board (the "Water Board") issued a statewide notice of water shortages and potential future curtailment of water right diversions. On April 1, 2015, the Governor issued an executive order mandating certain temporary conservation measures, which were implemented by means of an emergency regulation adopted by the Water Board on May 5, 2015.

The temporary conservation measures have been extended and amended by subsequent executive orders of the Governor and Water Board regulations. Most recently, on May 9, 2016, the Governor issued an executive order ordering the Department of Water Resources, the Water Board and the California Public Utilities Commission to update and extend temporary water restrictions through the end of January 2017, and to take actions to transition to permanent, long-term improvements in water use. Following the Governor's executive order, on May 18, 2016, the Water Board adopted a localized "stress test" approach of water conservation, under which local urban water agencies are required to ensure a three-year supply of water assuming three years of drought conditions. Agencies that project a water shortage at the end of the three-year period under the stress test are required to implement conservation measures through January 2017 equal to the percentage of water shortage projected.

The District cannot make any representation regarding the effects that the current drought has had, or, if it should continue, may have on the value of taxable property within the District, or to what extent the drought could cause disruptions to economic activity within the boundaries of the District.

Appeals of Assessed Valuation; Blanket Reductions of Assessed Values. There are two basic types of property tax assessment appeals provided for under State law. The first type of appeal, commonly referred to as a base year assessment appeal, involves a dispute on the valuation assigned by the assessor immediately subsequent to an instance of a change in ownership or completion of new construction. If the base year value assigned by the assessor is reduced, the valuation of the property cannot increase in subsequent years more than 2% annually unless and until another change in ownership and/or additional new construction or reconstruction activity occurs.

The second type of appeal, commonly referred to as a Proposition 8 appeal (which Proposition 8 was approved by the voters in 1978), can result if factors occur causing a decline in the market value of the property to a level below the property's then current taxable value (escalated base year value). Pursuant to State law, a property owner may apply for a Proposition 8 reduction of the property tax assessment for such owner's property by filing a written application, in the form prescribed by the State Board of Equalization, with the appropriate county board of equalization or assessment appeals board. A property owner desiring a Proposition 8 reduction of the assessed value of such owner's property in any one year must submit an application to the county assessment appeals board (the "Appeals Board"). Following a review of the application by the county assessor's office, the county assessor may offer to the property owner the opportunity to stipulate to a reduced assessment, or may confirm the assessment. If no stipulation is agreed to, and the applicant elects to pursue the appeal, the matter is brought before the Appeals Board (or, in some cases, a hearing examiner) for a hearing and decision. The Appeals Board generally is required to determine the outcome of appeals within two years of each appeal's filing date.

Any reduction in the assessment ultimately granted applies only to the year for which application is made and during which the written application is filed. The assessed value increases to its pre-reduction level (escalated to the inflation rate of no more than 2%) following the year for which the reduction application is filed. However, the county assessor has the power to grant a reduction not only for the year for which application was originally made, but also for the then current year and any intervening years as well. In practice, such a reduced assessment may and often does remain in effect beyond the year in which it is granted.

In addition, Article XIIIA of the State Constitution provides that the full cash value base of real property used in determining taxable value may be adjusted from year to year to reflect the inflationary rate, not to exceed a 2% increase for any given year, or may be reduced to reflect a reduction in the consumer price index or comparable local data. This measure is computed on a calendar year basis. Counties have in the past ordered blanket reductions of assessed property values and corresponding property tax bills on single-family residential properties when the value of the property has declined below the current assessed value.

No assurance can be given that property tax appeals and/or blanket reductions of assessed property values will not significantly reduce the assessed valuation of property within the District in the future.

California law exempts from taxation $7,000 of the assessed valuation of an owner-occupied dwelling. Effective with the 1980-81 fiscal year, State law has also exempted 100 percent of the value of business inventories from taxation, rather than 50 percent as in prior years. 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 in the 1979-80 fiscal year, 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.

Assessed Valuation and Parcels by Land Use

The following table sets forth the assessed valuation and parcels by land use in the District.

MENDOCINO COAST HEALTH CARE DISTRICT
Assessed Valuation and Parcels by Land Use

	2016-17 Assessed Valuation[(1)]	% of Total	No. of Parcels	% of Total
Non-Residential:				
Agricultural/Timber	$226,540,670	7.28%	2,623	19.16%
Commercial	381,704,336	12.27	620	4.53
Vacant Commercial	15,600,167	0.50	100	0.73
Industrial	32,711,330	1.05	60	0.44
Vacant Industrial	8,203,958	0.26	11	0.08
Recreational	12,029,671	0.39	29	0.21
Government/Social/Institutional	7,209,586	0.23	133	0.97
Miscellaneous	6,646,022	0.21	269	1.96
Subtotal Non-Residential	$690,645,740	22.20%	3,845	28.08%
Residential:				
Single Family Residence	$2,136,736,052	68.68%	7,214	52.69%
Mobile Home	82,766,024	2.66	703	5.13
Mobile Home Park	14,731,355	0.47	18	0.13
2-4 Residential Units	79,784,967	2.56	777	5.68
Vacant Residential	106,423,684	3.42	1,134	8.28
Subtotal Residential	$2,420,442,082	77.80%	9,846	71.92%
Total	$3,111,087,822	100.00%	13,691	100.00%

(1) Local Secured Assessed Valuation; excluding tax-exempt property.
Source: California Municipal Statistics, Inc.

Teeter Plan

The County has adopted the alternative method of secured property tax apportionment available under Chapter 3, Part 8, Division 1 (commencing with Section 4701) of the Revenue and Taxation Code of the State (also known as the "Teeter Plan"). This alternative method provides for funding each taxing entity included in the Teeter Plan with its total secured property taxes during the year the taxes are levied, including any amount uncollected at fiscal year-end. Under the Teeter Plan, the County assumes an obligation under a debenture or similar demand obligation to advance funds to cover expected delinquencies, and, by such financing, its general fund receives the full amount of secured property taxes levied each year and, therefore, no longer experiences delinquent taxes. In addition, the County's general fund benefits from future collections of penalties and interest on all delinquent taxes collected on behalf of participants in this alternative method of apportionment.

Upon adopting the Teeter Plan, the County was required to distribute to participating local agencies, 95% of the then-accumulated, secured roll property tax delinquencies and to place the remain 5% in a tax losses reserve fund. Taxing entities that maintain funds in the County Treasury are all included in the Teeter Plan; other taxing entities may elect to be included in the Teeter Plan. Taxing

entities that do not elect to participate in the Teeter Plan will be paid as taxes are collected. Since the District maintains funds in the County Treasury, the District is included in the Teeter Plan.

The Teeter Plan is to remain in effect unless the Board of Supervisors orders its discontinuance or unless, prior to the commencement of any fiscal year of the County (which commences on July 1), the Board of Supervisors shall receive a petition for its discontinuance joined in by resolutions adopted by two-thirds of the participating revenue districts in the County, in which event the Board of Supervisors would be required to order discontinuance of the Teeter Plan effective at the commencement of the subsequent fiscal year. In the event that the Teeter Plan were terminated, receipt of revenue of *ad valorem* taxes in the District would depend upon actual collections of the *ad valorem* property taxes and delinquency rates experienced with respect to the parcels within the District.

Tax Levies and Delinquencies

Taxes will be collected by the Mendocino County Tax Collector 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 on March 1 and become delinquent the following August 31. The following table lists the secured tax charges and delinquencies for the District for Fiscal Years 2011-12 through 2014-15. Information for Fiscal Year 2015-16 is not currently available.

MENDOCINO COAST HEALTH CARE DISTRICT
Secured Tax Charges and Delinquencies

Fiscal Year	Secured Tax Charge[(1)]	Amount Del. June 30	% Del. June 30
2011-12	$31,888,830.31	$1,144,215.55	3.59%
2012-13	32,075,525.51	1,021,521.17	3.18
2013-14	32,411,991.78	729,918.67	2.25
2014-15	32,791,599.82	590,606.99	1.80

(1) All taxes collected by the County within the District.
Source: California Municipal Statistics, Inc.

Tax Rates

The table below summarizes the total *ad valorem* tax rates levied by all taxing entities in a typical TRA within the District from Fiscal Year 2012-13 to Fiscal Year 2016-17.

MENDOCINO COAST HEALTH CARE DISTRICT
Typical Total Tax Rates (TRA 104-004)

	2012-13	2013-14	2014-15	2015-16	2016-17
General	1.000%	1.000%	1.000%	1.000%	1.000%
Redwoods Joint Community College District	.012	.011	.060	.010	.008
Mendocino Coast District Hospital	.013	.013	.013	.015	.010
Mendocino Unified School District	.080	.081	.080	.091	.085
Total	1.105	1.105	1.153	1.116	1.103

Source: California Municipal Statistics, Inc.

Largest Taxpayers

The twenty largest taxpayers in the District as shown on the Fiscal Year 2016-17 secured tax roll and the approximate amounts of their aggregate level for all taxing jurisdictions within the District are shown below. These twenty largest taxpayers have a 2016-17 local secured assessed valuation of $189,118,068, or 6.08% of the District's Fiscal Year 2016-17 local secured assessed value.

MENDOCINO COAST HEALTH CARE DISTRICT
Largest 2016-17 Local Secured Taxpayers

	Property Owner	Primary Land Use	2016-17 Assessed Valuation	% of Total [(1)]
1.	Georgia Pacific Corporation	Timber/Re-Use Development	$ 31,818,250	1.02%
2.	Mendocino Redwood Company LLC	Timber	20,412,122	0.66
3.	Lyme Redwood Timberlands LLC	Timber	15,922,348	0.51
4.	Rap Investors LP	Hotel	10,905,804	0.35
5.	Van L. Phillips Trust	Residential	10,605,196	0.34
6.	Heritage House LP	Hotel	10,389,883	0.33
7.	The Boatyard Associates Phase II	Shopping Center	9,854,606	0.32
8.	Stephen A. Ricks Trust	Residential	7,403,125	0.24
9.	Jeanette Colombi Trust	Hotel	6,987,248	0.22
10.	Safeway Inc.	Supermarket	6,955,640	0.22
11.	Jedediah D. and Megan Ayres, Trustees	Hotel	6,805,017	0.22
12.	Michael A. and Maribelle Anderson, Trustees	Industrial	6,395,337	0.21
13.	Judith L. Brown Trust	Hotel	6,230,636	0.20
14.	Siamex Investment Corp.	Rural Property	6,176,229	0.20
15.	Jeff and Joan Stanford, Trustees	Hotel	5,533,369	0.18
16.	Jason S. Hurst	Hotel	5,407,532	0.17
17.	Little River Inn Inc.	Hotel	5,382,239	0.17
18.	Jackson Grube Family Inc.	Hotel	5,317,921	0.17
19.	Pounce Holdings LLC	Residential	5,311,014	0.17
20.	Tanti Family II LLC	Hotel	5,304,552	0.17

[(1)] 2016-17 Local Secured Assessed Valuation: $3,111,087,822.
Source: California Municipal Statistics, Inc.

Direct and Overlapping Bonded Debt

Set forth below is a direct and overlapping debt report (the "Debt Report") prepared by California Municipal Statistics, Inc. as of December 1, 2016. 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 representation 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 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.

The contents of the Debt Report are as follows: (1) the first column indicates the public agencies which have outstanding debt as of the date of the Debt Report and whose territory overlaps the District; (2) the second column shows the respective percentage of the assessed valuation of the overlapping public agencies identified in column 1 which is represented by property located in the District; and (3) the third

column is an apportionment of the dollar amount of each public agency's outstanding debt (which amount is not shown in the table) to property in the District, as determined by multiplying the total outstanding debt of each agency by the percentage of the District's assessed valuation represented in column 2.

MENDOCINO COAST HEALTH CARE DISTRICT
Direct and Overlapping Bonded Debt

2016-17 Assessed Valuation: $3,172,124,408

DIRECT AND OVERLAPPING TAX AND ASSESSMENT DEBT:	% Applicable	12/1/16
Redwoods Joint Community College District	18.240%	$ 5,431,083
Fort Bragg Unified School District	100.000	31,881,854
Mendocino Unified School District	100.000	13,795,829
Mendocino Coast District Hospital	**100.000**	**4,447,742**[1]
TOTAL DIRECT AND OVERLAPPING TAX AND ASSESSMENT DEBT		$ 55,556,508
OVERLAPPING GENERAL FUND DEBT:		
Mendocino County General Fund Obligations	28.998%	$ 5,938,846
Mendocino County Pension Obligation Bonds	28.998	17,330,817
TOTAL OVERLAPPING GENERAL FUND DEBT		$ 23,269,663
OVERLAPPING TAX INCREMENT DEBT (Successor Agency):		$ 3,800,000
COMBINED TOTAL DEBT		$ 82,626,171[2]

(1) Includes the Refunded Bonds. Excludes the Bonds to be issued and sold.
(2) Excludes tax and revenue anticipation notes, revenue, mortgage revenue and non-bonded capital lease obligations.

Ratios to 2016-17 Assessed Valuation:
Direct Debt ($4,447,742)..... 0.14%
Total Direct and Overlapping Tax and Assessment Debt..... 1.75%
Combined Total Debt 2.48%

Ratio to Redevelopment Incremental Valuation ($199,543,581):
Total Overlapping Tax Increment Debt..... 1.90%

Source: California Municipal Statistics, Inc.

STATE CONSTITUTIONAL AND STATUTORY PROVISIONS AFFECTING DISTRICT REVENUES

Principal of and interest on the Bonds are payable from the proceeds of an *ad valorem* tax levied by the District for the payment thereof. (See "SECURITY AND SOURCE OF PAYMENT FOR THE BONDS" herein.) Articles XIIIA and XIIIB of the Constitution, Propositions 8 and 218 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, collect and spend taxes for payment of the general obligation bonds. The tax to be levied by the District for payment of the general obligation bonds was approved by the District's voters in compliance with Article XIIIA, XIIIB and all applicable laws.

The District, like other California public agencies, is subject to the following Constitutional limits on its ability to raise and expend revenues.

Article XIIIA

Article XIIIA of the California Constitution limits the amount of any *ad valorem* tax on real property, to one percent of the full cash value thereof, except that additional *ad valorem* taxes may be levied to pay debt service on indebtedness approved by the voters prior to July 1, 1978 and on bonded indebtedness for the acquisition or improvement of real property which has been approved on or after July 1, 1978 by two-thirds of the voters on such indebtedness. Article XIIIA defines full cash value to mean "the county assessor's valuation of real property as shown on the 1975-76 tax bill under "full cash value," or thereafter, the appraised value of real property when purchased, newly constructed, or a change in ownership have occurred after the 1975 assessment." The full cash value may be increased at a rate not to exceed two percent per year to account for inflation.

Article XIIIA has subsequently been amended to permit reduction of the "full cash value" base in the event of declining property values caused by damage, destruction or other factors, to provide that there would be no increase in the "full cash value" base in the event of reconstruction of property damaged or destroyed in a disaster and in other minor or technical ways.

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 one percent property tax is automatically levied by the 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 1989.

Increases of assessed valuation resulting from reappraisals of property due to new construction, change in ownership or from the two percent annual adjustment 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.

All taxable property is shown at full market value on the tax rolls, with tax rates expressed as $1 per $100 of taxable value. All taxable property value included in this Official Statement is shown at 100% of market value (unless noted differently) and all tax rates reflect the $1 per $100 of taxable value.

Article XIIIB of the California Constitution

Under Article XIIIB of the California State Constitution state and local government entities have an annual "appropriations limit" and are not permitted to spend certain moneys which are called "appropriations subject to limitation" (consisting of tax revenues, state subventions and certain other funds) in an amount higher than the "appropriations limit." Article XIIIB does not affect the appropriations of moneys which are excluded from the definition of "appropriations subject to limitation," including debt service on indebtedness existing or authorized as of January 1, 1979, or bonded indebtedness subsequently approved by the voters. In general terms, the "appropriations limit" is to be based on certain 1978-79 expenditures, and is to be adjusted annually to reflect changes in consumer prices, populations, and services provided by these entities. Among other provisions of Article XIIIB, if these entities' revenues in any year exceed the amounts permitted to be spent, the excess would have to be returned by revising tax rates or fee schedules over the subsequent two years.

Proposition 8

Property owners are entitled to an assessment based on the lower of the fair market value of their property as of the lien date (January 1), or the assessed value as determined at the time of purchase or construction, and increased by no more than two percent annually. The assessor may also adjust independently, without taxpayer appeal. See "SECURITY AND SOURCE OF PAYMENT FOR THE BONDS – Assessed Valuation of Property Within the District."

Unitary Property

AB 454 (Chapter 921, Statutes of 1986) ("AB 454") provides that revenues derived from most utility property assessed by the State Board of Equalization ("Unitary Property"), commencing with the 1988-89 fiscal year, will be allocated as follows: (1) each jurisdiction will receive up to 102% of its prior year State-assessed revenue; and (2) if county-wide revenues generated from Unitary Property are less than the previous year's revenues or greater than 102% of the previous year's revenues, each jurisdiction will share the burden of the shortfall or excess revenues by a specified formula. This provision applies to all Unitary Property except railroads, whose valuation will continue to be allocated to individual tax rate areas.

The provisions of AB 454 do not constitute an elimination of the assessment of any State-assessed properties nor a revision of the methods of assessing utilities by the State Board of Equalization. Generally, AB 454 allows valuation growth or decline of Unitary Property to be shared by all jurisdictions in a county

Proposition 218

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, which contain a number of provisions affecting the ability of local agencies, including healthcare districts, 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 healthcare 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 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 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, however, receive a portion of the basic 1% *ad valorem* property tax levied and collected by the County pursuant to Article XIIIA of the California Constitution.

Future Initiatives

Article XIIIA, Article XIIIB, Proposition 218 and Proposition 8 were each adopted as measures that qualified for the ballot pursuant to the State's initiative process. From time to time other initiative measures could be adopted, further affecting the District's revenues or the District's ability to expend revenues.

LEGAL MATTERS

Possible Limitations on Remedies; Bankruptcy

General. Following is a discussion of certain considerations in the event that the District should become a debtor in a bankruptcy proceeding. It is not an exhaustive discussion of the potential application of bankruptcy law to the District. The District filed for bankruptcy in 2013 and emerged from bankruptcy in March 2015. See "DISTRICT BANKRUPTCY" herein. While in bankruptcy, the District did not fail to make a payment on the 2001 Bonds.

Under Chapter 9 of the United States Bankruptcy Code (the "Bankruptcy Code"), no involuntary petitions for bankruptcy relief are permitted. However, California health care districts may petition for bankruptcy relief under Chapter 9 of the Bankruptcy Code.

Bankruptcy courts are courts of equity and as such have broad discretionary powers. If the District were to become the debtor in a proceeding under Chapter 9 of the Bankruptcy Code, the parties to the proceedings may be prohibited from taking any action to collect any amount from the District (including *ad valorem* tax revenues) or to enforce any obligation of the District, without the bankruptcy court's permission. In such a proceeding, as part of its plan of adjustment in bankruptcy, the District may be able to alter the priority, interest rate, principal amount, payment terms, collateral, maturity dates, payment sources, covenants (including tax-related covenants), and other terms or provisions of the Bonds and other transaction documents related to the Bonds, including the obligation of the County and the District to raise taxes if necessary to pay the Bonds, if the bankruptcy court determines that the plan is fair, equitable, not unfairly discriminatory and is in the best interests of creditors and otherwise complies with the Bankruptcy Code. There also may be other possible effects of a bankruptcy of the District that could result in delays or reductions in payments on the Bonds. Regardless of any specific adverse determinations in any District bankruptcy proceeding, the fact of a District bankruptcy proceeding could have an adverse effect on the liquidity and market price of the Bonds.

Limitations on Plans of Adjustments. Chapter 9 of the Bankruptcy Code provides that it does not limit or impair the power of a state to control, by legislation or otherwise, a political subdivision of the state in the exercise of its political or governmental powers, including expenditures for the exercise. In addition, Chapter 9 provides that a bankruptcy court may not interfere with the political or governmental powers of a political subdivision debtor, unless the political subdivision approves a plan of adjustment to that effect or consents to that action. State law provides that *ad valorem* taxes may be levied to pay the principal of and interest on the Bonds and other voted general obligation bonds of the District in an unlimited amount, and that proceeds of such a levy must be used for the payment of principal of and interest on the District's general obligation bonds, including the Bonds, and for no other purpose. Under State law, the District's share of the 1% limited tax imposed by the County is the only *ad valorem* tax revenue that may be raised and expended to pay liabilities and expenses of the District other than its voter-approved debt, such as its general obligation bonds. If the District should become a debtor in a Chapter 9 proceeding, then it must propose a plan of adjustment of its debts. The plan may not become effective until confirmed by the bankruptcy court. The court may not approve a plan unless it finds, among other conditions, that the District is not prohibited by law from taking any action necessary to carry out the plan and that the plan is in the best interests of creditors and is feasible. If the State law restriction on the levy and expenditure of *ad valorem* taxes is respected in a bankruptcy case, then *ad valorem* tax revenue in excess of the District's share of the 1% limited County tax could not be used by the District for any purpose under its plan other than to make payments on the Bonds and its other voted general obligation bonds. It is possible, however, that a bankruptcy court could conclude that the restriction should not be respected.

Statutory Lien. Pursuant to Senate Bill 222 (2015) ("SB 222") that became effective on January 1, 2016, all general obligation bonds issued by local agencies, including the Bonds, will be secured by a statutory lien on all revenues received pursuant to the levy and collection of the *ad valorem* taxes. SB 222 provides that the lien will automatically arise, without the need for any action or authorization by the local agency or its governing board, and will be valid and binding from the time the bonds are executed and delivered. As a result, the lien on debt service taxes will continue to be valid with respect to post-petition receipts of debt service taxes, should the District become the subject of bankruptcy proceedings. However, the automatic stay provisions of the Bankruptcy Code would apply, preventing bondholders from enforcing their rights to payment from such taxes, so payments that become due and owing on the Bonds during the pendency of the Chapter 9 proceeding could be delayed. It is also possible that the bankruptcy court could approve an alternate use of such taxes, if the bondholders are afforded adequate protection.

Possession of Tax Revenues; Remedies. If the County or the District goes into bankruptcy and has possession of tax revenues (whether collected before or after commencement of the bankruptcy), and if the County or the District, as applicable, does not voluntarily pay such tax revenues to the owners of the Bonds, it is not clear what procedures the owners of the Bonds would have to follow to attempt to obtain possession of such tax revenues, how much time it would take for such procedures to be completed, or whether such procedures would ultimately be successful.

TAX MATTERS

The delivery of the Bonds is subject to delivery of the opinion of Bond Counsel, to the effect that interest on the Bonds for federal income tax purposes under existing statutes, regulations, published rulings, and court decisions (1) will be excludable from the gross income, as defined in section 61 of the Internal Revenue Code of 1986, as amended to the date of initial delivery of the Bonds (the "Code"), of the owners thereof pursuant to section 103 of the Code, and (2) will not be included in computing the alternative minimum taxable income of the owners thereof who are individuals or, except as hereinafter described, corporations. The delivery of the Bonds is also subject to the delivery of the opinion of Bond

Counsel, based upon existing provisions of the laws of the State of California that interest on the Bonds is exempt from personal income taxes of the State of California. The form of Bond Counsel's anticipated opinion is included as Appendix A. The statutes, regulations, rulings, and court decisions on which such opinions will be based are subject to change.

Interest on the Bonds owned by a corporation will be included in such corporation's adjusted current earnings for purposes of calculating the alternative minimum taxable income of such corporation, other than an S corporation, a qualified mutual fund, a real estate investment trust, a real estate mortgage investment conduit, or a financial asset securitization investment trust ("FASIT"). A corporation's alternative minimum taxable income is the basis on which the alternative minimum tax imposed by Section 55 of the Code will be computed.

In rendering the foregoing opinions, Bond Counsel will rely upon the representations and certifications of the District made in a certificate of even date with the initial delivery of the Bonds pertaining to the use, expenditure, and investment of the proceeds of the Bonds and will assume continuing compliance with the provisions of the Resolution by the District subsequent to the issuance of the Bonds. The Resolution contains covenants by the District with respect to, among other matters, the use of the proceeds of the Bonds and the facilities and equipment financed or refinanced therewith by persons other than state or local governmental units, the manner in which the proceeds of the Bonds are to be invested, the calculation and payment to the United States Treasury of any "arbitrage profits" and the reporting of certain information to the United States Treasury. Failure to comply with any of these covenants may cause interest on the Bonds to be includable in the gross income of the owners thereof from the date of the issuance of the Bonds.

Except as described above, Bond Counsel will express no other opinion with respect to any other federal, State or local tax consequences under present law, or proposed legislation, resulting from the receipt or accrual of interest on, or the acquisition or disposition of, the Bonds. Prospective purchasers of the Bonds should be aware that the ownership of tax exempt obligations such as the Bonds may result in collateral federal tax consequences to, among others, financial institutions, life insurance companies, property and casualty insurance companies, S corporations with subchapter C earnings and profits, certain foreign corporations doing business in the United States, individual recipients of Social Security or Railroad Retirement benefits, individuals otherwise qualifying for the earned income tax credit, owners of an interest in a FASIT, and taxpayers who may be deemed to have incurred or continued indebtedness to purchase or carry, or who have paid or incurred certain expenses allocable to, tax-exempt obligations. Prospective purchasers should consult their own tax advisors as to the applicability of these consequences to their particular circumstances.

Bond Counsel's opinion is not a guarantee of a result, but represents its legal judgment based upon its review of existing statutes, regulations, published rulings and court decisions and the representations and covenants of the District described above. No ruling has been sought from the Internal Revenue Service (the "Service") or the State of California with respect to the matters addressed in the opinion of Bond Counsel, and Bond Counsel's opinion is not binding on the Service or the State of California. The Service has an ongoing program of auditing the tax-exempt status of the interest on municipal obligations. If an audit of the Bonds is commenced, under current procedures, the Service is likely to treat the District as the "taxpayer," and the Owners of the Bonds would have no right to participate in the audit process. In responding to or defending an audit of the tax-exempt status of the interest on the Bonds, the District may have different or conflicting interests from the Owners of the Bonds. Public awareness of any future audit of the Bonds could adversely affect the value and liquidity of the Bonds during the pendency of the audit, regardless of its ultimate outcome.

Existing law may change to reduce or eliminate the benefit to Bondholders of the exclusion of interest on the Bonds from gross income for federal income tax purposes. Any proposed legislation or administrative action, whether or not taken, could also affect the value and marketability of the Bonds. Prospective purchasers of the Bonds should consult with their own tax advisors with respect to any proposed or future changes in tax law.

Tax Accounting Treatment of Discount and Premium on Certain Bonds

The initial public offering price of certain Bonds (the "Discount Bonds") may be less than the amount payable on such Bonds at maturity. An amount equal to the difference between the initial public offering price of a Discount Bond (assuming that a substantial amount of the Discount Bonds of that maturity are sold to the public at such price) and the amount payable at maturity constitutes original issue discount to the initial purchaser of such Discount Bond. A portion of such original issue discount allocable to the holding period of such Discount Bond by the initial purchaser will, upon the disposition of such Discount Bond (including by reason of its payment at maturity), be treated as interest excludable from gross income, rather than as taxable gain, for federal income tax purposes, on the same terms and conditions as those for other interest on the Bonds described above. Such interest is considered to be accrued actuarially in accordance with the constant interest method over the life of a Discount Bond, taking into account the semiannual compounding of accrued interest, at the yield to maturity on such Discount Bond and generally will be allocated to an initial purchaser in a different amount from the amount of the payment denominated as interest actually received by the initial purchaser during the tax year.

However, such interest may be required to be taken into account in determining the alternative minimum taxable income of a corporation, for purposes of calculating a corporation's alternative minimum tax imposed by Section 55 of the Code, and the amount of the branch profits tax applicable to certain foreign corporations doing business in the United States, even though there will not be a corresponding cash payment. In addition, the accrual of such interest may result in certain other collateral federal income tax consequences to, among others, financial institutions, life insurance companies, property and casualty insurance companies, S corporations with subchapter C earnings and profits, individual recipients of Social Security or Railroad Retirement benefits, individuals otherwise qualifying for the earned income tax credit, owners of an interest in a FASIT, and taxpayers who may be deemed to have incurred or continued indebtedness to purchase or carry, or who have paid or incurred certain expenses allocable to, tax-exempt obligations. Moreover, in the event of the redemption, sale or other taxable disposition of a Discount Bond by the initial owner prior to maturity, the amount realized by such owner in excess of the basis of such Discount Bond in the hands of such owner (adjusted upward by the portion of the original issue discount allocable to the period for which such Discount Bond was held) is includable in gross income.

Owners of Discount Bonds should consult with their own tax advisors with respect to the determination of accrued original issue discount on Discount Bonds for federal income tax purposes and with respect to the state and local tax consequences of owning and disposing of Discount Bonds. It is possible that, under applicable provisions governing determination of state and local income taxes, accrued interest on Discount Bonds may be deemed to be received in the year of accrual even though there will not be a corresponding cash payment.

The initial offering price of certain Bonds (the "Premium Bonds") may be greater than the amount payable on such Bonds at maturity. An amount equal to the difference between the initial public offering price of a Premium Bond (assuming that a substantial amount of the Premium Bonds of that maturity are sold to the public at such price) and the amount payable at maturity constitutes premium to the initial purchaser of such Premium Bonds. The basis for federal income tax purposes of a Premium

Bond in the hands of such initial purchaser must be reduced each year by the amortizable bond premium, although no federal income tax deduction is allowed as a result of such reduction in basis for amortizable bond premium. Such reduction in basis will increase the amount of any gain (or decrease the amount of any loss) to be recognized for federal income tax purposes upon a sale or other taxable disposition of a Premium Bond. The amount of premium which is amortizable each year by an initial purchaser is determined by using such purchaser's yield to maturity. Purchasers of the Premium Bonds should consult with their own tax advisors with respect to the determination of amortizable bond premium with respect to the Premium Bonds for federal income purposes and with respect to the state and local tax consequences of owning and disposing of Premium Bonds.

A copy of the proposed form of opinion of Bond Counsel is attached hereto as Appendix A.

APPROVAL OF LEGAL PROCEEDINGS

The validity of the Bonds and certain other legal matters are subject to the approving opinion of Norton Rose Fulbright US LLP, Bond Counsel to the District. A complete copy of the proposed form of opinion of Bond Counsel is attached as Appendix A hereto. Bond Counsel undertakes no responsibility for the accuracy, completeness or fairness of this Official Statement. Certain legal matters will be passed upon for the District by Norton Rose Fulbright US LLP, as Disclosure Counsel, and by John J. Ruprecht, as counsel to the District. Certain legal matters will be passed upon for the Underwriter by Nossaman LLP, Irvine, California. The District has retained Eastshore Consulting, LLC as financial advisor in connection with the issuance of the Bonds (the "Financial Advisor"). Compensation paid to Bond Counsel, Disclosure Counsel, the Financial Advisor and Underwriter's Counsel is contingent on the successful issuance of the Bonds.

DISTRICT BANKRUPTCY

During the fiscal year ended June 30, 2013, the District filed for bankruptcy under Chapter 9 of Title 11 of the United States Bankruptcy Code in United States Bankruptcy Court - Northern District of California. The District's plan for adjustment was confirmed by the bankruptcy court on October 31, 2014 and on March 31, 2015, the District emerged from bankruptcy under Chapter 9 of the Bankruptcy Code. The purpose of the District's plan of reorganization was to restructure certain classifications of the District's debt and provide for their payment in whole or in part. The ultimate success of the plan will depended primarily on the ability of the District's management to operate at a level of increased cash flow and thereby coupled with District property taxes, meet its obligations in the normal course of operations.

ABSENCE OF MATERIAL LITIGATION

No litigation is pending or threatened concerning the validity of the Bonds, and a certificate to that effect will be furnished to purchasers at the time of the original delivery of the Bonds. The District is not aware of any litigation pending or threatened questioning the political existence of the District or contesting the District's ability to receive *ad valorem* taxes or to collect other revenues or contesting the District's ability to issue and retire the Bonds. As with virtually all health care providers, the District experiences medical malpractice claims related to the provision of services. These claims are covered by insurance. See "APPENDIX A – Information Concerning Mendocino Coast Health Care District – ADDITIONAL INFORMATION –Insurance and Litigation."

UNDERWRITING

The Bonds are being purchased by the Underwriter at a purchase price of $4,109,121.80, which is the par amount of the Bonds of $4,125,000.00, less an Underwriter's discount of $41,250.00 and plus a net premium of $25,371.80. The Bond Purchase Agreement for the Bonds provides that the Underwriter will purchase all of Bonds, if any are purchased, and contains the agreement of the District to indemnify the Underwriter against certain liabilities to the extent permitted by law. The obligation of the Underwriter to make such purchase is subject to certain terms and conditions set forth in the Bond Purchase Agreement.

The Underwriter may offer and sell the Bonds to certain dealers and others at prices or yields different from the prices or yields stated on the cover page of this Official Statement. The offering prices or yields may be changed from time to time without notice by the Underwriter.

FINANCIAL STATEMENTS

The financial statements of the District for the fiscal years ended June 30, 2016 and 2015 are included in APPENDIX B to this Official Statement have been audited by Dingus, Zarecor & Associates, PLLC, Spokane Valley, Washington. Except for the financial statements of the District contained in APPENDIX B, Dingus, Zarecor & Associates, PLLC has not reviewed or audited any financial information of the District contained in this Official Statement or contained in APPENDIX C to this Official Statement.

RATING

S&P Global Ratings, a business unit of Standard & Poor's Financial Services LLC ("S&P"), is expected to assign a rating of "AA-" to the Bonds with the understanding that upon delivery of the Bonds, a municipal bond insurance policy insuring the payment of the principal of and interest on the Bonds when due will be issued by National. Such rating reflects only the views of such rating agency, and an explanation of the significance of the rating may be obtained from S&P at: S&P, 55 Water Street, New York, NY 10041. There is no assurance that such rating will continue for any given period of time or that it will not be revised downward or withdrawn entirely by the rating agency, if in the judgment of such rating agency circumstances so warrant. Any such downward revision or withdrawal of such ratings may have an adverse effect on the market price of the Bonds.

The District has not applied, and does not anticipate applying, for an underlying rating on the Bonds. Prospective purchasers of the Bonds are required to make independent determinations as to the underlying credit quality of the Bonds and their appropriateness as an investment.

CONTINUING DISCLOSURE

The District has covenanted for the benefit of owners of the Bonds to provide certain financial information and operating data relating to the District on an annual basis and to provide notices of the occurrence of certain enumerated events. These covenants have been made in order to assist the Underwriter in complying with United States Securities Exchange Commission Rule 15c2-12 (the "Rule"). The specific nature of the information to be provided by the District and notices of enumerated events is set forth in the form of Continuing Disclosure Certificate attached hereto in "APPENDIX D – FORM OF CONTINUING DISCLOSURE CERTIFICATE."

The District has previously entered into previous undertakings under the Rule in connection with the issuance of other long-term obligations. In the previous five years, the District has failed to timely file

its audited financial statements in connection with the Series 1996 Revenue Bonds, Series 2009 Revenue Bonds and Series 2010 Revenue Bonds. No audited financial statements were linked to the 2001 Bonds. The District also failed to file the required operational or financial information in the past five years as required by its undertakings. In addition, the District did not file any quarterly reports, as required by the undertakings with respect to the Series 2009 Revenue Bonds and the Series 2010 Revenue Bonds. Further, while some event notices were filed in connection with the District's 2013 bankruptcy, the District has not filed notices of other enumerated events or rating changes with respect to any bond issue of the District. The District has retained Willdan Financial Services ("Willdan") to cure outstanding filing lapses, Willdan has made reparative filings on the District's behalf, and Willdan will assist the District in complying with each of its undertakings, including as set forth in the Disclosure Certificate, in the future.

MISCELLANEOUS

All quotations from and summaries and explanations of the Act, the Resolution and other statutes and documents contained herein and in the Appendices hereto do not purport to be complete, and reference is made to said documents and statutes for full and complete statements of their provisions. Copies in reasonable quantity of the Resolution may be obtained upon request directed to the District during the offering period for the Bonds or to the District.

The agreements of the District with the Owners of the Bonds are fully set forth in the Resolution, and neither any advertisement of the Bonds nor this Official Statement is to be construed as constituting an agreement with the purchasers of the Bonds. Statements made in this Official Statement involving estimates, projections or matters of opinion, whether or not expressly so stated, are intended merely as such and not as representations of fact.

The execution and delivery of this Official Statement have been duly authorized by the District.

MENDOCINO COAST HEALTH CARE DISTRICT

By: /s/ Bob Edwards
Chief Executive Officer

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APPENDIX A

PROPOSED FORM OF OPINION OF BOND COUNSEL

[date of delivery]

Mendocino Coast Health Care District
700 River Drive
Fort Bragg, California 95437

Re: $4,125,000 Mendocino Coast Health Care District (Mendocino County, California) Election of 2000 General Obligation Refunding Bonds, Series 2016

Ladies and Gentlemen:

We have acted as bond counsel for the Mendocino Coast Health Care District (the "District"), in connection with the issuance by the District of $4,125,000 aggregate principal or denominational amount of the District's Election of 2000 General Obligation Refunding Bonds, Series 2016 (the "Bonds"). The Bonds are issued pursuant to Articles 9 and 11 of Chapter 3 of Part 1 of Division 2 of Title 5 of the California Government Code and a resolution adopted by the Board of Directors of the District on November 3, 2016 (the "Resolution"). All terms used herein and not otherwise defined shall have the meanings given to them in the Resolution.

As bond counsel, we have examined copies certified to us as being true and complete copies of the proceedings of the District for the authorization and issuance of the Bonds, including the Resolution and the Tax Exemption Certificate of the District dated the date hereof (the "Tax Certificate"). Our services as such bond counsel were limited to an examination of such proceedings and to the rendering of the opinions set forth below. In this connection we have also examined such certificates of public officials and officers of the District as we have considered necessary for the purposes of this opinion.

Certain agreements, requirements and procedures contained or referred to in the Resolution, the Tax Certificate and other relevant documents may be changed and certain actions (including, without limitation, the defeasance of the Bonds) may be taken or omitted under the circumstances and subject to the terms and conditions set forth in such documents. No opinion is expressed herein as to any Bond or the interest thereon if any such change occurs or action is taken or omitted upon the advice or approval of counsel other than ourselves.

The opinions expressed herein are based on an analysis of existing laws, regulations, rulings and court decisions and cover certain matters not directly addressed by such authorities. Such opinions may be affected by actions taken or omitted or events occurring after the date hereof. We have not undertaken to determine, or to inform any person, whether any such actions or events are taken or do occur. Our engagement with respect to the Bonds has concluded with their issuance, and we disclaim any obligation to update this letter. We have assumed the genuineness of all documents and signatures presented to us (whether as originals or as copies) and the due and legal execution and delivery thereof by any parties

other than the District. We have not undertaken to verify independently, and have assumed, the accuracy of the factual matters represented, warranted or certified in the documents referred to in the second paragraph hereof. Furthermore, we have assumed compliance with all covenants and agreements contained in the Resolution and the Tax Certificate, including (without limitation) covenants and agreements compliance with which is necessary to assure that future actions, omissions or events will not cause interest on the Bonds to be included in gross income for federal income tax purposes. We call attention to the fact that the rights and obligations under the Bonds, the Resolution and the Tax Certificate may be subject to bankruptcy, insolvency, reorganization, arrangement, fraudulent conveyance, moratorium and other laws relating to or affecting creditors' rights, to the application of equitable principles, to the exercise of judicial discretion in appropriate cases and to the limitations on legal remedies against public entities in the State of California. We express no opinion with respect to any indemnification, contribution, choice of law, choice of forum or waiver provisions contained in the foregoing documents. We express no opinion and make no comment with respect to the sufficiency of the security or the marketability of the Bonds. Finally, we undertake no responsibility for the accuracy, completeness or fairness of the Official Statement or other offering material relating to the Bonds and express no opinion with respect thereto.

Based on and subject to the foregoing and in reliance thereon, as of the date hereof, we are of the following opinions:

1. The Bonds constitute valid and binding obligations of the District, payable as to principal and interest from the proceeds of a levy of *ad valorem* taxes on all property subject to such taxes in the District, which taxes are unlimited as to rate or amount.

2. The Resolution has been duly adopted and constitutes a valid and binding obligation of the District.

3. It is further our opinion, based upon the foregoing, that pursuant to section 103 of the Internal Revenue Code of 1986, as amended and in effect on the date hereof (the "Code"), and existing regulations, published rulings, and court decisions thereunder, and assuming continuing compliance with the provisions of the Resolution and the Tax Certificate and representations and certifications of the District made in the Tax Certificate of even date herewith pertaining to the use, expenditure, and investment of the proceeds of the Bonds, when the Bonds are delivered to and paid for by the initial purchasers thereof, interest on the Bonds for federal income tax purposes (1) will be excludable from the gross income, as defined in section 61 of the Code, of the owners thereof, and (2) will not be included in computing the alternative minimum taxable income of the owners thereof who are individuals or, except as hereinafter described, corporations. Interest on the Bonds owned by a corporation will be included in such corporation's adjusted current earnings for purposes of calculating the alternative minimum taxable income of such corporation, other than an S corporation, a qualified mutual fund, a real estate mortgage investment conduit, a real estate investment trust, or a financial asset securitization investment trust ("FASIT"). A corporation's alternative minimum taxable income is the basis on which the alternative minimum tax imposed by section 55 of the Code will be computed.

In our opinion, under existing law, interest on the Bonds is exempt from personal income taxes of the State of California.

We express no other opinion with respect to any other federal, state, or local tax consequences under present law or any proposed legislation resulting from the receipt or accrual of interest on, or the acquisition or disposition of, the Bonds. Ownership of tax-exempt obligations such as the Bonds may result in collateral federal tax consequences to, among others, financial institutions, life insurance companies, property and casualty insurance companies, certain S corporations with subchapter C earnings

and profits, certain foreign corporations doing business in the United States, owners of an interest in a FASIT, individuals otherwise qualifying for the earned income tax credit, 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, or who have paid or incurred certain expenses allocable to, tax-exempt obligations.

Our opinions are based on existing law, which is subject to change. Such opinions are further based on our knowledge of facts as of the date hereof. We assume no duty to update or supplement our opinions to reflect any facts or circumstances that may thereafter come to our attention or to reflect any changes in any law that may thereafter occur or become effective. Moreover, our opinions are not a guarantee of result and are not binding on the Internal Revenue Service; rather, such opinions represent our legal judgment based upon our review of existing law that we deem relevant to such opinions and in reliance upon the representations and covenants referenced above.

Respectfully submitted,

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APPENDIX B

AUDITED FINANCIAL STATEMENTS FOR THE DISTRICT FOR THE FISCAL YEARS ENDED 2016 AND 2015

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Mendocino Coast Health Care District
doing business as
Mendocino Coast District Hospital

Basic Financial Statements and
Independent Auditors' Report

June 30, 2016 and 2015

DINGUS | ZARECOR & ASSOCIATES PLLC
Certified Public Accountants

Mendocino Coast Health Care District
doing business as Mendocino Coast District Hospital
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DINGUS | ZARECOR & ASSOCIATES PLLC
Certified Public Accountants

INDEPENDENT AUDITORS' REPORT

Board of Directors
Mendocino Coast Health Care District
doing business as Mendocino Coast District Hospital
Fort Bragg, California

Report on the Financial Statements

We have audited the accompanying financial statements of Mendocino Coast Health Care District doing business as Mendocino Coast District Hospital (the District) as of and for the year ended June 30, 2016, and the related notes to the financial statements, which collectively comprise the District's basic financial statements as listed in the table of contents.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditors consider internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

12015 East Main Avenue | Spokane Valley, WA 99206 | 509.242.0874 | www.dzacpa.com

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the District as of June 30, 2016, and the changes in its financial position and cash flows for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matters

Prior Year (June 30, 2015) Auditors' Report

The financial statements of the District as of and for the year ended June 30, 2015, were audited by JWT & Associates, LLP, and whose report dated February 25, 2016, expressed an unmodified opinion on those financial statements.

Required Supplementary Information

Management has omitted the management's discussion and analysis that accounting principles generally accepted in the United States of America require to be presented to supplement the basic financial statements. Such missing 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. Our opinion on the basic financial statements is not affected by this missing information.

Dingus, Zarecor & Associates PLLC

Spokane Valley, Washington
October 27, 2016

Mendocino Coast Health Care District
doing business as Mendocino Coast District Hospital
Statements of Net Position
June 30, 2016 and 2015

ASSETS	2016	2015
Current assets		
Cash and cash equivalents	**$ 2,679,733**	$ 1,370,370
Cash and cash equivalents restricted or limited as to use	**804,031**	837,082
Receivables:		
Patient accounts, net of estimated uncollectibles of $1,309,418 and $1,269,239, respectively	**5,425,781**	3,515,481
Estimated third-party payor settlements	**815,873**	945,541
Supplemental Medicaid funding	**725,219**	1,270,032
California Department of Health and Human Services	**1,114,594**	-
Medicare electronic health records incentive	**604,956**	10,874
Other	**114,962**	123,569
Taxes	**60,639**	58,117
Inventories	**800,371**	783,107
Prepaid expenses	**616,306**	706,453
Total current assets	**13,762,465**	9,620,626
Noncurrent assets		
Investments limited as to use in local agency investment fund	**3,998,601**	3,984,172
Cash and cash equivalents restricted or limited as to use, less current portion	**976,884**	976,515
Capital assets, net	**15,388,339**	17,568,736
Total noncurrent assets	**20,363,824**	22,529,423
Total assets	**$ 34,126,289**	$ 32,150,049

See accompanying notes to basic financial statements.

Mendocino Coast Health Care District
doing business as Mendocino Coast District Hospital
Statements of Net Position (Continued)
June 30, 2016 and 2015

LIABILITIES AND NET POSITION	2016	2015
Current liabilities		
Accounts payable	**$ 3,569,419**	$ 3,696,194
Accrued compensation and related liabilities	**3,031,950**	2,909,993
Estimated third-party payor settlements	**2,024,936**	1,787,115
Accrued interest	**1,327,592**	1,343,407
Current maturities of long-term debt	**1,294,110**	1,447,868
Total current liabilities	**11,248,007**	11,184,577
Noncurrent liabilities		
Long-term debt, less current maturities	**13,350,618**	14,795,106
Total liabilities	**24,598,625**	25,979,683
Net position		
Net investment in capital assets	**2,623,300**	3,646,793
Unrestricted	**6,904,364**	2,523,573
Total net position	**9,527,664**	6,170,366
Total liabilities and net position	**$ 34,126,289**	$ 32,150,049

See accompanying notes to basic financial statements

Mendocino Coast Health Care District
doing business as Mendocino Coast District Hospital
Statements of Revenues, Expenses, and Changes in Net Position
Years Ended June 30, 2016 and 2015

	2016	2015
Operating revenues		
Net patient service revenue, net of provision for bad debts of $783,715 and $971,317, respectively	**$ 52,426,560**	$ 46,415,770
Medicare electronic health records incentive	**594,082**	-
Other revenue	**835,729**	1,239,481
Total operating revenues	**53,856,371**	47,655,251
Operating expenses		
Salaries and wages	**17,519,350**	17,032,880
Employee benefits	**7,148,814**	6,994,678
Professional fees	**6,920,688**	7,512,962
Purchased services	**1,280,664**	1,597,297
Registry	**3,490,381**	2,473,334
Supplies	**8,222,292**	7,750,258
Depreciation and amortization	**2,451,836**	2,511,842
Repairs and maintenance	**1,134,240**	1,025,549
Utilities	**895,689**	864,691
Leases and rentals	**594,937**	632,405
Insurance	**486,516**	594,097
Other	**1,595,393**	2,026,125
Total operating expenses	**51,740,800**	51,016,118
Operating income (loss)	**2,115,571**	(3,360,867)
Nonoperating revenues (expenses)		
Taxation for debt service	**1,228,283**	1,116,211
Interest expense	**(888,393)**	(812,756)
Contributions	**340,300**	298,305
Gain (loss) on disposal of capital assets	**(12,207)**	2,683
Total nonoperating revenues (expenses), net	**667,983**	604,443
Excess of revenues (expenses) before gain on extinguishment of debt	**2,783,554**	(2,756,424)
Gain on extinguishment of debt	**573,744**	947,789
Change in net position	**3,357,298**	(1,808,635)
Net position, beginning of year	**6,170,366**	7,979,001
Net position, end of year	**$ 9,527,664**	$ 6,170,366

See accompanying notes to basic financial statements.

Mendocino Coast Health Care District
doing business as Mendocino Coast District Hospital
Statements of Cash Flows
Years Ended June 30, 2016 and 2015

	2016	2015
Increase (Decrease) in Cash and Cash Equivalents		
Cash flows from operating activities		
Receipts from and on behalf of patients	**$ 50,313,968**	$ 45,623,011
Other receipts	**844,336**	2,319,466
Medicare electronic health records incentive	**-**	102,000
Payments to and on behalf of employees	**(24,546,207)**	(23,596,900)
Payments to suppliers and contractors	**(24,100,948)**	(23,905,298)
Net cash provided by operating activities	**2,511,149**	542,279
Cash flows from noncapital financing activities		
District tax revenue for maintenance and operations	**768,870**	714,487
Principal payments on long-term debt	**(277,372)**	(210,000)
Proceeds from issuance of long-term debt	**-**	193,675
Interest paid	**(69,292)**	(10,160)
Contributions	**340,300**	298,305
Net cash provided by noncapital financing activities	**762,506**	986,307
Cash flows from capital and related financing activities		
District tax revenue for bond principal and interest	**456,891**	396,089
Principal payments on long-term debt	**(1,320,874)**	(1,162,452)
Proceeds from issuance of long-term debt	**-**	-
Interest paid	**(834,916)**	(901,901)
Purchase of capital assets	**(283,646)**	(1,220,637)
Net cash used in capital and related financing activities	**(1,982,545)**	(2,888,901)
Cash flows from investing activities		
Purchase of investments in local agency investment fund	**(14,429)**	-
Sale of investments in local agency investment fund	**-**	1,284,401
Net cash provided by (used in) investing activities	**(14,429)**	1,284,401
Net increase (decrease) in cash and cash equivalents	**1,276,681**	(75,914)
Cash and cash equivalents, beginning of year	**3,183,967**	3,259,881
Cash and cash equivalents, end of year	**$ 4,460,648**	$ 3,183,967

See accompanying notes to basic financial statements.

Mendocino Coast Health Care District
doing business as Mendocino Coast District Hospital
Statements of Cash Flows (Continued)
Years Ended June 30, 2016 and 2015

		2016		2015
Reconciliation of Cash and Cash Equivalents to the Statements of Net Position				
Cash and cash equivalents	**$**	**2,679,733**	$	1,370,370
Cash and cash equivalents restricted or limited as to use, current		**804,031**		837,082
Cash and cash equivalents restricted or limited as to use, long-term		**976,884**		976,515
Total cash and cash equivalents	**$**	**4,460,648**	$	3,183,967
Reconciliation of Operating Income (Loss) to Net Cash Provided by Operating Activities				
Operating income (loss)	**$**	**2,115,571**	$	(3,360,867)
Adjustments to reconcile operating income (loss) to net cash provided by operating activities				
Depreciation and amortization		**2,451,836**		2,511,842
Provision for bad debts		**783,715**		971,317
Decrease (increase) in assets:				
Receivables:				
Patient accounts		**(2,694,015)**		(1,518,303)
Estimated third-party payor settlements		**129,668**		(485,715)
Supplemental Medicaid payments due from State		**544,813**		(1,270,032)
California Department of Health and Human Services		**(1,114,594)**		-
Medicare electronic health records incentive		**(594,082)**		102,000
Other		**8,607**		1,079,985
Inventories		**(17,264)**		(131,123)
Prepaid expenses		**90,147**		285,832
Increase (decrease) in liabilities:				
Accounts payable		**446,969**		416,711
Accrued compensation and related liabilities		**121,957**		430,658
Estimated third-party payor settlements		**237,821**		1,509,974
Net cash provided by operating activities	**$**	**2,511,149**	$	542,279

See accompanying notes to basic financial statements.

1. Reporting Entity and Summary of Significant Accounting Policies:

a. Reporting Entity

Mendocino Coast Health Care District doing business as Mendocino Coast District Hospital (the District) is comprised of two separate divisions, a hospital division and a home health/hospice division, both of which are wholly owned by the District, a public entity organized under Local Hospital District Law as set fourth in the Health and Safety Code of the State of California. The District is a political subdivision of the State of California and is generally not subject to federal or state income taxes. The District is governed by a five-member Board of Directors, elected from within the district to specified terms of office. The District is located in Fort Bragg, California.

The District is a critical access hospital with 25 set-up acute-care beds. Services offered by the District include medical, swing bed, surgical, labor/delivery and nursery care, 24-hour emergency, laboratory, imaging services, orthopedics, oncology, physical therapy, home health, cardiac rehabilitation, and clinics. Members of the medical staff include specialist in emergency medicine, family practice, general surgery, radiology, and inpatient hospitalization.

b. Summary of Significant Accounting Policies

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

Enterprise fund accounting – The District's accounting policies conform to accounting principles generally accepted in the United States of America as applicable to proprietary funds of governments. The District uses enterprise fund accounting. Revenues and expenses are recognized on the accrual basis using the economic resources measurement focus.

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; natural disasters; and medical malpractice. Commercial insurance coverage is purchased for claims arising from such matters.

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

Inventories – Inventories are stated at cost on the first-in, first-out method. Inventories consist of pharmaceutical, medical, surgical, and other supplies used in the operation of the District.

Prepaid expenses – Prepaid expenses are expenses paid during the year relating to expenses incurred in future periods. Prepaid expenses are amortized over the expected benefit period of the related expense.

1. **Reporting Entity and Summary of Significant Accounting Policies (continued):**

   b. **Summary of Significant Accounting Policies (continued)**

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

   Accrued compensated absences – The District's employees earn paid time off (PTO) for vacation, holidays, and short term illnesses based upon years of service. The related liability is accrued during the period in which it is earned. The District's policy is to permit employees to accumulate up to 496 hours of accrued compensated absences. The District may pay accrued vacation absences upon termination if proper notice and termination procedures are followed. As of June 30, 2016 and 2015, the District has an accrued compensated absence liability of $1,452,903 and $1,377,926, respectively.

   Net position – Net position of the District is classified into three components. *Net investment in capital assets* consists of capital assets net of accumulated depreciation and is reduced by the current balances of any outstanding borrowings used to finance the purchase or construction of those assets. *Restricted net position* is noncapital net position that must be used for a particular purpose, as specified by creditors, grantors, or contributors external to the District. *Unrestricted net position* is remaining net position that does not meet the definition of *net investment in capital assets* or *restricted net position*.

   Operating Revenues and Expenses – The District's statements of revenues, expenses, and changes in net position distinguish between operating and nonoperating revenues and expenses. Operating revenues result from exchange transactions associated with providing healthcare services, which is the District's principal activity. Operating expenses are all expenses incurred to provide healthcare services, other than financing costs. Nonoperating revenues and expenses are those transactions not considered directly linked to providing healthcare services.

   Restricted resources – When the District has both restricted and unrestricted resources available to finance a particular program, it is the District's policy to use restricted resources before unrestricted resources.

   Grants and contributions – From time to time, the District receives grants from the state of California and others as well as contributions from individuals and private organizations. Revenues from grants and contributions (including contributions of capital assets) are recognized when all eligibility requirements are met. Grants and contributions may be restricted for specific operating purposes or for capital purposes. Amounts that are restricted to specific capital acquisitions are reported after nonoperating revenues and expenses. Grants that are for specific projects or purposes related to the District's operating activities are reported as operating revenue. Grants that are used to subsidize operating deficits are reported as nonoperating revenue. Contributions, except for capital contributions, are reported as nonoperating revenue.

   Reclassifications – Certain amounts have been reclassified in the 2015 financial statements in order to be consistent with the 2016 financial statements. These reclassifications had no effect on the previously reported change in net position.

1. Reporting Entity and Summary of Significant Accounting Policies (continued):

b. Summary of Significant Accounting Policies (continued)

Subsequent Events – The District's management evaluated the effect of subsequent events on the financial statements through October 27, 2016, the date the financial statements are issued, and determined that there are no material subsequent events that have not been disclosed.

2. Bank Deposits and Investments:

As of June 30, 2016 and 2015, the District had amounts on deposit in various financial institutions in the form of operating cash and cash equivalents which amounted to $2,297,786, and $1,501,663, respectively. All of these funds were collateralized in accordance with the California Government Code (CGC), except for $250,000 per account that is federally insured.

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

3. Investments:

The District's investment balances and average maturities were as follows:

	2016			
		Investment Maturities in Years		Investment
	Fair Value	Less than 1	1 to 5	Over 5	Ratings
Investment in Local Agency Investment Funds	$ 3,998,601	$ 3,998,601	$ -	$ -	Not applicable
Total investments	$ 3,998,601	$ 3,998,601	$ -	$ -	

	2015			
		Investment Maturities in Years		Investment
	Fair Value	Less than 1	1 to 5	Over 5	Ratings
Investment in Local Agency Investment Funds	$ 3,984,172	$ 3,984,172	$ -	$ -	Not applicable
Total investments	$ 3,984,172	$ 3,984,172	$ -	$ -	

The District categorizes its fair value measurements within the fair value hierarchy established by generally accepted accounting principles. The hierarchy is based on the valuation inputs used to measure the fair value of the asset. Level 1 inputs are quoted prices in active markets for identical assets; Level 2 inputs are significant other observable inputs; Level 3 inputs are significant unobservable inputs. The District had no investments subject to fair value measurements at June 30, 2016 or 2015.

The policy identifies certain provisions which address interest rate risk, credit risk, and concentration of credit risk.

3. Investments (continued):

Interest Rate Risk – Interest rate risk is the risk that changes in market interest rates will adversely affect the fair value of an investment. Generally, the longer the maturity of an investment the greater the sensitivity of its fair value to changes in market interest rates. The District's exposure to interest rate risk is minimal as 100% of their investments have a maturity of less than one year. Information about the sensitivity of the fair values of the District's investments to market interest rate fluctuations is provided by the preceding schedules that show the distribution of the District's investments by maturity.

Credit Risk – Credit risk is the risk that the issuer of an investment will not fulfill its obligation to the holder of the investment. This is measured by the assignment of a rating by a nationally recognized statistical rating organization, such as Moody's Investor Service, Inc. The District's investments in are in government investment funds which are not rated. The District believes that there is minimal credit risk with its investments at this time.

Custodial Credit Risk – Custodial credit risk is the risk that, in the event of the failure of the counterparty (e.g. broker-dealer), the District will not be able to recover the value of its investment or collateral securities that are in the possession of another party. The District's investments are generally held by banks or government agencies. The District believes that there is minimal custodial credit risk with their investments at this time. District management monitors the entities which hold the various investments to ensure they remain in good standing.

Concentration of Credit Risk – Concentration of credit risk is the risk of loss attributed to the magnitude of the District's investment in a single issuer. The District believes that there is minimal concentration of credit risk at this time.

Assets limited as to use – Assets limited as to use as of June 30, 2016 and 2015, were comprised of cash and cash equivalents held by the County of Mendocino under a General Obligation bond agreement, held by a trustee under bond indenture agreements, and designated by the board for investment in Local Agency Investment Fund for board determined use. Interest income, dividends, and both realized and unrealized gains and losses on investments are recorded as investment income. Total investment income includes both income from operating cash and cash equivalents and cash and cash equivalents related to assets limited as to use. Debt securities, when present, are recorded at market price or the fair market value as of the date of each statement of net position.

Assets limited as to use as of June 30, 2016 and 2015, were comprised of the following:

		2016		2015
Board designated for investment in Local Agency Investment Fund	**$**	**3,998,601**	$	3,984,172
Board designated for repayment of long-term debt		**804,031**		837,082
Bond restricted for payment of long-term debt		**976,884**		976,515
Total assets limited as to use	**$**	**5,779,516**	$	5,797,769

4. Patient Accounts Receivable:

Patient accounts receivable are reduced by an allowance for uncollectible accounts. In evaluating the collectibility of accounts receivable, the District analyzes its past history and identifies trends for each of its major payor sources of revenue to estimate the appropriate allowance for uncollectible accounts and provision for bad debts. Management regularly reviews data about these major payor sources of revenue in evaluating the sufficiency of the allowance for uncollectible accounts. For receivables associated with services provided to patients who have third-party coverage, the District analyzes contractually due amounts and provides an allowance for uncollectible accounts and a provision for bad debts, if necessary (for example, for expected uncollectible deductibles and copayments on accounts for which the third-party payor has not yet paid, or for payors who are known to be having financial difficulties that make the realization of amounts due unlikely). For receivables associated with self-pay patients (which include both patients without insurance and patients with deductible and copayment balances due for which third-party coverage exists for part of the bill), the District records a significant provision for bad debts in the period of service on the basis of its past experience, which indicates that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The difference between the standard rates (or the discounted rates if negotiated) and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for uncollectible accounts.

The District's allowance for uncollectible accounts for self-pay patients did not change significantly from the prior year. The District does not maintain a material allowance for uncollectible accounts from third-party payors, nor did it have significant writeoffs from third-party payors.

Patient accounts receivable reported as current assets consisted of these amounts:

		2016		2015
Receivable from patients and their insurance carriers	**$**	**3,325,020**	$	2,351,420
Receivable from Medicare		**2,348,370**		1,364,563
Receivable from Medi-Cal		**1,061,809**		1,068,737
Total patient accounts receivable		**6,735,199**		4,784,720
Less allowance for uncollectible accounts		**(1,309,418)**		(1,269,239)
Patient accounts receivable, net	**$**	**5,425,781**	$	3,515,481

5. District Tax Revenues:

The Mendocino County Treasurer acts as an agent to collect property taxes levied in the County for all taxing authorities. Taxes are levied annually and are due in equal installments on October 31 and February 1. Property taxes are recorded as revenue when levied. Since state law allows for sale of property for failure to pay taxes, no estimate of uncollectible taxes is made.

6. Medicare Electronic Health Records Incentive:

The District recognized Medicare electronic health records (EHR) incentive revenue during the year ended June 30, 2016. The EHR incentive payments are provided to incent hospitals to become meaningful users of EHR technology, not to reimburse providers for the cost of acquiring EHR assets. EHR incentive payments are therefore reported as operating revenue.

The District recognizes the Medicare incentive payment on the date that the District has successfully complied with meaningful use criteria during the entire EHR reporting period. The District obtained hardship exemptions from complying with meaningful use criteria in 2016 and 2015. The Districts Medicare EHR reporting period is through December 31 of each year.

The Medicare incentive payment recognized is an estimate and subject to audit by Centers for Medicare and Medicaid services (CMS). The Medicare EHR incentive payment is based on the patient days reported in the prior cost report and the undepreciated cost of the EHR equipment submitted to CMS. Medicare incentive payments of approximately $600,000 related to meaningful use equipment claimed on the 2013 Medicare cost report were recorded as revenue in 2016. No Medicare incentive payments were recorded as revenue in 2015.

7. Capital Assets:

The District capitalizes assets whose costs exceed $5,000 and have an estimated useful life of at least two years. Major expenses for capital assets, including repairs that increase the useful lives, are capitalized. Maintenance, repairs, and minor renewals are accounted for as expenses as incurred. Capital assets are reported at historical cost or their estimated fair value at the date of donation. Depreciation is provided over the estimated useful life of each class of depreciable asset and computed using the straight-line method.

Useful lives are estimated as follows:

	Years
Buildings and improvements	5-40
Equipment	3-20

Capital asset activity follows:

	Balance June 30, 2015	Additions	Retirements	Transfers	Balance June 30, 2016
Capital assets not being depreciated					
Land	$ 117,490	$ -	$ -	$ -	**$ 117,490**
Construction in progress	238,379	85,293	-	(64,155)	**259,517**
Total capital assets not being depreciated	355,869	85,293	-	(64,155)	**377,007**
Building and improvements	25,215,842	-	-	-	**25,215,842**
Equipment	22,345,822	198,353	(1,191,346)	64,155	**21,416,984**
Total capital assets being depreciated	47,561,664	198,353	(1,191,346)	64,155	**46,632,826**
Less accumulated depreciation for					
Building and improvements	(12,476,283)	(849,517)	-	-	**(13,325,800)**
Equipment	(17,872,514)	(1,602,319)	1,179,139	-	**(18,295,694)**
Total accumulated depreciation	(30,348,797)	(2,451,836)	1,179,139	-	**(31,621,494)**
Total capital assets being depreciated, net	17,212,867	(2,253,483)	(12,207)	64,155	**15,011,332**
Capital assets, net of accumulated depreciation	$ 17,568,736	$ (2,168,190)	$ (12,207)	$ -	**$ 15,388,339**

7. Capital Assets (continued):

	Balance June, 30 2014	Additions	Retirements	Transfers	Balance June 30, 2015
Capital assets not being depreciated					
Land	$ 117,490	$ -	$ -	$ -	**$ 117,490**
Construction in progress	1,489,120	-	-	(1,250,741)	**238,379**
Total capital assets not being depreciated	1,606,610	-	-	(1,250,741)	**355,869**
Capital assets being depreciated					
Building and improvements	23,432,245	532,856	-	1,250,741	**25,215,842**
Equipment	21,672,216	690,088	(16,482)	-	**22,345,822**
Total capital assets being depreciated	45,104,461	1,222,944	(16,482)	1,250,741	**47,561,664**
Less accumulated depreciation for					
Building and improvements	(11,671,895)	(804,388)	-	-	**(12,476,283)**
Equipment	(16,181,542)	(1,707,454)	16,482	-	**(17,872,514)**
Total accumulated depreciation	(27,853,437)	(2,511,842)	16,482	-	**(30,348,797)**
Total capital assets being depreciated, net	17,251,024	(1,288,898)	-	1,250,741	**17,212,867**
Capital assets, net of accumulated depreciation	$ 18,857,634	$ (1,288,898)	$ -	$ -	**$ 17,568,736**

Construction in Progress – As of June 30, 2016, the District had construction in progress (CIP) representing cost capitalized for a nurse-call system and an auto transfer switch replacement. The projects in CIP are all expected to be completed in 2017 with minimal expected costs to complete.

8. Long-term Debt and Capital Lease Obligations:

A schedule of changes in the District's long-term debt and capital lease obligations follows:

Bonds and Notes Payable	Balance June 30, 2015	Additions	Reductions	Balance June 30, 2016	Amounts Due Within One Year
LTGO bonds series 2000	$ 3,940,000	$ -	$ -	$ 3,940,000	$ -
LTGO bonds series 2000 - capital appreciation	661,474	-	(75,971)	585,503	77,762
1996 revenue bonds	1,330,000	-	(235,000)	1,095,000	250,000
2009 revenue bonds	4,045,000	-	(210,000)	3,835,000	220,000
2010 revenue bonds	2,260,000	-	(120,000)	2,140,000	125,000
United Healthcare note	1,890,000	-	(210,000)	1,680,000	210,000
CMS note	193,675	-	(67,372)	126,303	76,564
OSHPD CAL Mortgage	1,005,805	-	(25,000)	980,805	100,000
Bankruptcy payables	604,248	-	(180,154)	424,094	234,784
Premiums and discounts	(188,599)	-	26,622	(161,977)	-
Total bonds and notes payable	15,741,603	-	(1,096,875)	14,644,728	1,294,110
Capital Lease Obligations					
Toshiba Medical	469,891	-	(469,891)	-	-
Bausch & Lomb - Surgery System	9,766	-	(9,766)	-	-
Bausch & Lomb	21,714	-	(21,714)	-	-
Total capital lease obligations	501,371	-	(501,371)	-	-
Total long-term debt and capital lease obligations	$ 16,242,974	$ -	$ (1,598,246)	$ 14,644,728	$ 1,294,110

Bonds and Notes Payable	Balance June 30, 2014	Additions	Reductions	Balance June 30, 2015	Amounts Due Within One Year
LTGO bonds series 2000	$ 3,940,000	$ -	$ -	$ 3,940,000	$ -
LTGO bonds series 2000 - capital appreciation	736,975	-	(75,501)	661,474	75,971
1996 revenue bonds	1,555,000	-	(225,000)	1,330,000	235,000
2009 revenue bonds	4,250,000	-	(205,000)	4,045,000	210,000
2010 revenue bonds	2,380,000	-	(120,000)	2,260,000	120,000
United Healthcare note	2,100,000	-	(210,000)	1,890,000	210,000
CMS note	-	193,675	-	193,675	77,954
OSHPD CAL Mortgage	1,005,805	-	-	1,005,805	25,000
Bankruptcy payables	604,248	-	-	604,248	180,154
Premiums and discounts	(215,221)	-	26,622	(188,599)	-
Total bonds and notes payable	16,356,807	193,675	(808,879)	15,741,603	1,134,079
Capital Lease Obligations					
Toshiba Medical	1,001,984	-	(532,093)	469,891	282,309
Bausch & Lomb - Surgery System	19,532	-	(9,766)	9,766	9,766
Bausch & Lomb	43,428	-	(21,714)	21,714	21,714
Total capital lease obligations	1,064,944	-	(563,573)	501,371	313,789
Total long-term debt and capital lease obligations	$ 17,421,751	$ 193,675	$ (1,372,452)	$ 16,242,974	$ 1,447,868

8. Long-term Debt and Capital Lease Obligations (continued):

Aggregate annual principal and interest payments over the terms of long-term debt and capital lease obligations follow:

Years Ending June 30,	Long-term Debt		
	Principal	Interest	Total
2017	$ 1,294,110	$ 815,627	$ 2,109,737
2018	1,283,761	790,051	2,073,812
2019	1,144,659	761,751	1,906,410
2020	1,178,463	722,896	1,901,359
2021	901,356	693,892	1,595,248
2022-2026	4,360,099	2,472,668	6,832,767
2027-2029	4,644,257	673,185	5,317,442
	$ 14,806,705	**$ 6,930,070**	**$ 21,736,775**

Refunding Revenue Bonds, Series 1996 – Interest is payable semiannually at an interest rate of 5.875%. Principal maturities on the serial bonds range from $250,000 to $300,000 and are due annually on February 1 of each year. The term bonds aggregating $1,330,000 mature in 2020. Mandatory sinking fund deposits to retire the term bonds ranging from $200,000 to $300,000 are due annually on February 1, 2015 through 2020.

The bonds are secured by a pledge of gross revenues, a first deed of trust on the District's facilities and a deposit control agreement covering substantially all the District's operating bank accounts. Repayment of the bonds is insured pursuant to a Contract of Insurance and a Regulatory Agreement (Agreement) through the California Health Facility Construction Loan Insurance Program administered by the Office of Statewide Health Planning and Development of the State of California (OSHPD). The District is required to maintain certain financial ratios and to make monthly deposits to a trustee for bond sinking fund payments and insurance payments becoming due and payable within the next 12 months, and for interest payments becoming due and payable within the next six months.

The Agreement with OSHPD sets out certain business covenants of the District, including maintenance, operation and management of facilities and limitations on encumbrances, assignment and transfer of any part of the facilities and other matters. The Agreement also provides for the rights and obligations of the parties in the event of a default. Under the Agreement, the District has agreed to fix, charge and collect such rates, fees, and charges which, together with all other receipts and revenues of the District, will produce a debt coverage ratio of at least 1.25 times the District's aggregate debt service for a fiscal year.

8. Long-term Debt and Capital Lease Obligations (continued):

General Obligation Bonds, Series 2000 – Upon voter approval in November 2000, the District issued $5,500,000 principal amount of general obligation bonds, $4,615,000 of current interest bonds and $884,638 of capital appreciation bonds. Interest on the current interest bonds is payable semiannually at rates ranging from 5.25% to 7.125% and principal maturities ranging from $200,000 in 2023 to $700,000 in 2030 are due annually on August 1 of each year. Interest rates ranging from 5.7% to 7.1% and principal maturities ranging from $34,667 to $79,905 are due annually on August 1 and are payable through 2023.

Bonds maturing on or after August 1, 2012, may be redeemed prior to maturity at the District's option. The redemption price is 100%. The Bonds are general obligations of the District payable from ad valorem taxes. Payment of principal, interest and maturity value of the Bonds, when due, are insured by a municipal bond insurance policy.

Refunding Revenue Bonds, Series 2009 – In October 2009, the District issued the Mendocino Coast Health Care District (Mendocino County, California) Insured Health Facility Revenue Bonds, Series 2009 in the amount of $5,000,000. Interest is payable semiannually at rates ranging from 4.05% to 5.3%. Principal maturities on the serial bonds range from $220,000 to $390,000, and are due annually on February 1. The term bonds mature in 2029. Bonds maturing on February 1, 2019, and thereafter may be called by the District at a redemption price of 100%.

The bonds are secured by a pledge of gross revenues, a first deed of trust on the District's facilities and a deposit control agreement covering substantially all the District's operating bank accounts. Repayment of the bonds is insured pursuant to a Contract of Insurance and a Regulatory Agreement (Agreement) through the California Health Facility Construction Loan Insurance Program administered by the Office of Statewide Health Planning and Development of the State of California (OSHPD). The District is required to maintain certain financial ratios and to make monthly deposits to a trustee for bond sinking fund payments and insurance payments becoming due and payable within the next 12 months, and for interest payments becoming due and payable within the next six months.

The Agreement with OSHPD sets out certain business covenants of the District, including maintenance, operation and management of facilities and limitations on encumbrances, assignment and transfer of any part of the facilities and other matters. The Agreement also provides for the rights and obligations of the parties in the event of a default. Under the Agreement, the District has agreed to fix, charge, and collect such rates, fees, and charges which, together with all other receipts and revenues of the District, will produce a debt coverage ratio of at least 1.25 times the District's aggregate debt service for a fiscal year.

8. Long-term Debt and Capital Lease Obligations (continued):

Revenue Bonds, Series 2010 – In July 2010, the District issued the Mendocino Coast Health Care District (Mendocino County, California) Insured Health Facility Revenue Bonds, Series 2010 in the amount of $2,875,000. The bond principal is payable yearly at various amounts from $120,000 to $215,000. Bond interest is payable semiannually at various rates from 3.8% to 4.85%. The bonds mature in 2024 and are secured by a pledge of gross revenues, a deed of trust on the District's facilities and a deposit control agreement covering substantially all the District's operating bank accounts. Repayment of the bonds is insured pursuant to a Contract of Insurance and a Regulatory Agreement through the California Health Facility Construction Loan Insurance Program administered by the Office of Statewide Health Planning and Development of the State of California (OSHPD). The District is required to maintain certain financial ratios and to make monthly deposits to a trustee for bond sinking fund payments and insurance payments becoming due and payable within the next 12 months, and for interest payments becoming due and payable within the next six months.

The Agreement with OSHPD sets out certain business covenants of the District, including maintenance, operation and management of facilities and limitations on encumbrances, assignment and transfer of any part of the facilities, and other matters. The Agreement also provides for the rights and obligations of the parties in the event of a default. Under the Agreement, the District has agreed to fix, charge, and collect such rates, fees, and charges which, together with all other receipts and revenues of the District, will produce a debt coverage ratio of at least 1.25 times the District's aggregate debt service for a fiscal year.

United Healthcare Note – The District borrowed funds in the amount of $2,100,000 in April 2014 from United Healthcare (UHC) under a program established to finance certain electronic medical records (EMR) conversion and installation required by CMS. The note carries an interest rate of 4.0% and principal payments of $210,000 are due annually in April through 2024.

Cal Mortgage – The District borrowed a total of $1,005,806 from Cal Mortgage to replace a line of credit with a bank in the amount of $1,000,000 during fiscal year ended June 30, 2013. This was done to help facilitate the District's bankruptcy filing. The note carries varying interest rates and payments including principal and interest ranging from $11,726 to $27,252 are due monthly through March 2022.

CMS Payable – The District has a note payable to CMS related to a settlement for a self-reported Stark Law violation. The settlement was for $210,000, and carries interest at 5.0%, with payments including interest of $81,271 and $56,645 in 2017 and 2018, respectively.

9. Net Patient Service Revenues:

The District recognizes patient service revenue associated with services provided to patients who have third-party payor coverage on the basis of contractual rates for the services rendered. For uninsured patients that do not qualify for charity care, the District recognizes revenue on the basis of its standard rates for services provided (or on the basis of discounted rates, if negotiated or provided by policy). On the basis of historical experience, a significant portion of the District's uninsured patients will be unable or unwilling to pay for the services provided. Thus, the District records a significant provision for bad debts related to uninsured patients in the period the services are provided. The District's provisions for bad debts and writeoffs have not changed significantly from the prior year. The District has not changed its charity care or uninsured discount policies during 2016. Patient service revenue, net of contractual adjustments and discounts (but before the provision for bad debts), recognized in the period from these major payor sources, is as follows:

	2016	2015
Patient service revenue (net of contractual adjustments and discounts):		
Medicare	**$ 31,135,745**	$ 28,777,947
Medi-Cal	**7,887,427**	6,333,494
Other third-party payors	**13,221,130**	11,281,979
Patients	**1,085,240**	1,094,620
	53,329,542	47,488,040
Less:		
Charity care	**119,267**	100,953
Provision for bad debts	**783,715**	971,317
Net patient service revenue	**$ 52,426,560**	$ 46,415,770

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** – The District has been designated a critical access hospital by Medicare and is reimbursed for inpatient and outpatient services and rural health clinic visits on a cost basis as defined and limited by the Medicare program. Physician services outside the rural health clinic are paid on a fee schedule. Home health and hospice services are reimbursed on a prospective rate per episode of care. The District is reimbursed for cost reimbursable items at a tentative rate with final settlement determined after submission of annual cost reports by the District and audits thereof by the Medicare administrative contractor.

- **Medi-Cal** – Services to Medi-Cal beneficiaries are paid at prospectively determined rates per procedure or discharge. The RHC is paid a prospective rate per encounter and updated annually for inflation.

The District also has entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payment to the District under these agreements includes prospectively determined rates per discharge, discounts from established charges, and prospectively determined daily rates.

9. Net Patient Service Revenues (continued):

Laws and regulations governing Medicare, Med-Cal, and other 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 $1,500,000 in 2016, due to differences between original estimates and final settlements or revised estimates.

The District provides charity care to patients who are financially unable to pay for the healthcare services they receive. The District's policy is not to pursue collection of amounts determined to qualify as charity care. Accordingly, the District does not report these amounts in net operating revenues or in the allowance for uncollectible accounts. The District determines the costs associated with providing charity care by aggregating the applicable direct and indirect costs, including salaries and wages, benefits, supplies, and other operating expenses, based on data from its costing system. The costs of caring for charity care patients for the years ended June 30, 2016 and 2015, were approximately $60,000 and $52,000, respectively. The District did not receive any gifts or grants to subsidize charity services during 2016 and 2015.

10. Employees' Retirement Plans:

The District has a noncontributory, defined contribution pension plan which covers substantially all employees, the Mendocino Coast District Hospital Money Purchase Pension Plan (the Plan) which is administered by Transamerica. The District has the authority to amend the Plan. Assets of the plan consist of a group of annuity contracts. The annual contribution made by the District is equal to approximately 6% of eligible employee salaries. Total pension costs for the years ended June 30, 2016 and 2015, were $1,009,396 and $938,651, respectively. For the year ended June 30, 2016, actual annual contributions by the District credited to the pension plan totaled $999,866. The amount the District was required to actually pay was reduced by accumulated plan account forfeitures in the amount of $9,530 and $244,686, respectively, in the years ended June 30, 2016 and 2015.

The District has a 403(b) salary savings plan which is available to substantially all employees. The 403(b) plan is wholly employee funded through regular deductions from wages and salaries. There is no provision for any matching or other such contributions by the District. Employee contributions to the plan for the years ended June 30, 2016 and 2015, were $468,596 and $798,626, respectively.

11. Risk Management and Contingencies:

Medical malpractice claims – The District purchases malpractice liability insurance through Beta Healthcare Group. Beta offers the District a professional and general liability policy on a "claims made" basis with primary limits of $10,000,000 per claim and an annual aggregate of $20,000,000. The policy has a $1,000 deductible per claim.

No liability has been accrued for future coverage of acts, if any, occurring in this or prior years. Also, it is possible that claims may exceed coverage available in any given year.

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; natural disasters; and employee health, dental, and accident benefits. Commercial insurance coverage is purchased for claims arising from such matters. Settled claims have not exceeded this commercial coverage in any of the three preceding years.

11. Risk Management and Contingencies (continued):

Industry regulations – The healthcare industry is subject to numerous laws and regulations of federal, state, and local governments. Recently, government activity has increased with respect to investigations and allegations concerning possible violations of various statutes and regulations by healthcare providers. Compliance with such laws and regulations can be subject to future government review and interpretation as well as regulatory actions unknown or unasserted at this time. Management believes the District is in compliance with fraud and abuse as well as other applicable government laws and regulations. If the District is found in violation of these laws, the District could be subject to substantial monetary fines, civil and criminal penalties, and exclusion from participation in the Medicare and Medicaid programs.

12. Mendocino Coast District Foundation:

The Mendocino Coast District Foundation (the Foundation) has been established as a nonprofit public benefit corporation to solicit contributions on behalf of the community in the Mendocino County coastal area. Funds raised, except for funds required for operation of the Foundation, are distributed to the District or held for the benefit of the District and other healthcare functions within the community. The Foundation's funds, which represent the Foundation's unrestricted resources, are donated to the District in amounts and in periods determined by the Foundation's Board of Trustees, who may also restrict the use of such funds for District property or equipment replacement, expansion, or other specific purposes.

The District received contributions from the Foundation in the amount of $259,020 and $278,578 during the years ended June 30, 2016 and 2015, respectively. The District provides office space to the Foundation at no charge and the Foundation's directors and computer equipment are covered under the District's general liability, directors and officers, and property insurance.

13. Concentrations of Credit Risk:

Patient accounts receivable – The District grants credit without collateral to its patients and residents, most of whom are local residents and are insured under third-party payor agreements. The majority of these patients are geographically concentrated in and around Mendocino County.

The mix of receivables from patients was as follows:

	2016	**2015**
Medicare	**42 %**	39 %
Medicaid	**18**	22
Other third-party payors	**28**	26
Patients	**12**	13
	100 %	100 %

Physicians – The District is dependent on local physicians practicing in its service area to provide admissions and utilize District services on an outpatient basis. A decrease in the number of physicians providing these services or change in their utilization patterns may have an adverse effect on District operations.

13. Concentrations of Credit Risk (continued):

Collective Bargaining Unit – Effective July 1, 2011, the District renewed its contract with United Food & Commercial Workers Union 8-Golden State. The contract was effective through June 30, 2014, and has been renewed on an annual basis.

As of June 30, 2016 and 2015, 81.1% and 82.6%, respectively, of the Districts' employees were represented by the union under the collective bargaining agreement with United Food & Commercial Workers Union 8-Golden State.

14. Chapter 9 Bankruptcy:

During the year ended June 30, 2013, the District filed for Bankruptcy under Chapter 9 of Title 11 of the United States Bankruptcy Code in the United States Bankruptcy Court – Northern District of California. The District is represented by legal counsel in this reorganization under Chapter 9. The purpose of the District's plan of reorganization was to restructure certain classifications of the District's debt and provide for their payment in whole or in part. The District's bankruptcy filing and related reorganization plan was approved by the courts in early 2015. Certain debt was restructured, reduced, discharged, or rendered unenforceable. The ultimate success of this plan will depend primarily on the ability of the District's management to operate at a level of increased cash flows, coupled with District property taxes, to meet their obligations in the normal course of operations going forward. District management is continuing a program of cost reductions and revenue enhancement which it believes will result in improved cash flows.

During the years ended June 30, 2016 and 2015, the District received forgiveness of debt related to settlement and approval of its bankruptcy filing. The District reported a net gain of $573,744 for the year ended June 30, 2016, and $947,789 for the year ended June 30, 2015.

15. Compliance Issue:

Through its compliance program, the District identified certain situations that raised potential issues with respect to compliance with the strict requirements of the Stark Law (42 U.S.C.§1395nn) and the corresponding regulations (42 CFR §411.351 et seq). The issues included missing signatures on agreements, operating under agreements after their stated expiration, and other technical issues. The District's investigation showed little or no benefit to physicians and no inappropriate costs to any governmental entity as a result of these technical violations. The District self-disclosed these issues to CMS in 2013, utilizing the Self-Referral Disclosure Protocol issued by CMS in September 2010. As required by the Self-Referral Disclosure Protocol, the District informed CMS that the estimated value of the physician referrals potentially affected by the matters identified in the self-disclosure is approximately $11,555,000. Because there is little precedence with CMS's settlement of matters disclosed by Districts under the Self-Referral Disclosure Protocol, the ultimate outcome was difficult to estimate. However, District management negotiated aggressively with CMS and was able to reach a settlement in early 2015. CMS imposed a $210,000 fine for the self-disclosed noncompliance issues.

16. Subsequent Events:

Bond Issuance – The District issued revenue bonds dated July 20, 2016, in the original amount of $5,745,000 in order to refinance the 1996, 2009, and 2010 Revenue Bonds. The 2016 Revenue Bonds are due in varying principal installments from $305,000 to $535,000, plus semiannual interest at varying rates from 3.0% to 5.0% through June 2029.

Mendocino Coast Health Care District
doing business as
Mendocino Coast Hospital District

Financial Indicators

June 30, 2016

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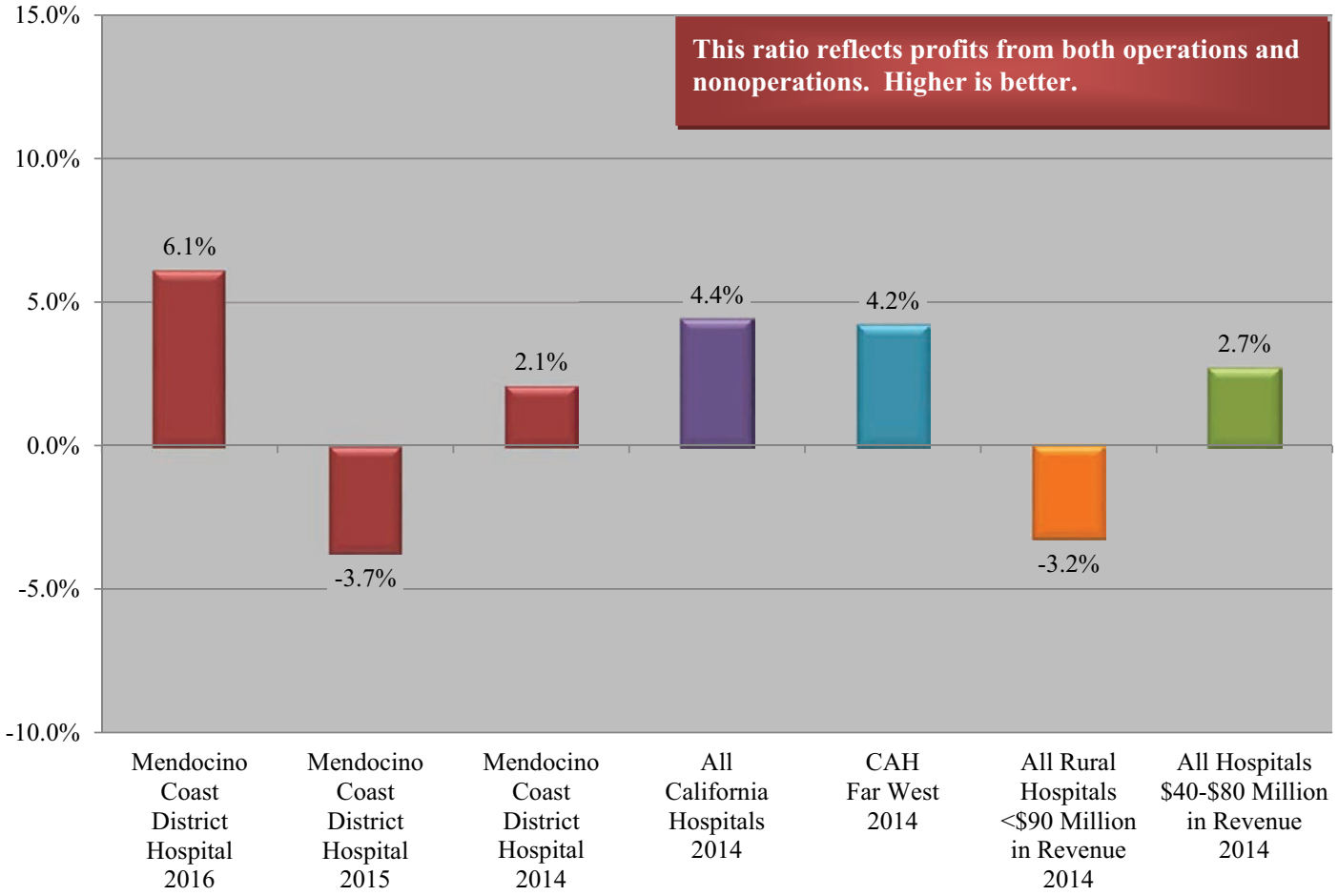
Mendocino Coast Health Care District
doing business as
Mendocino Coast Hospital District

Total Margin

Change in Net Position
Total Revenues



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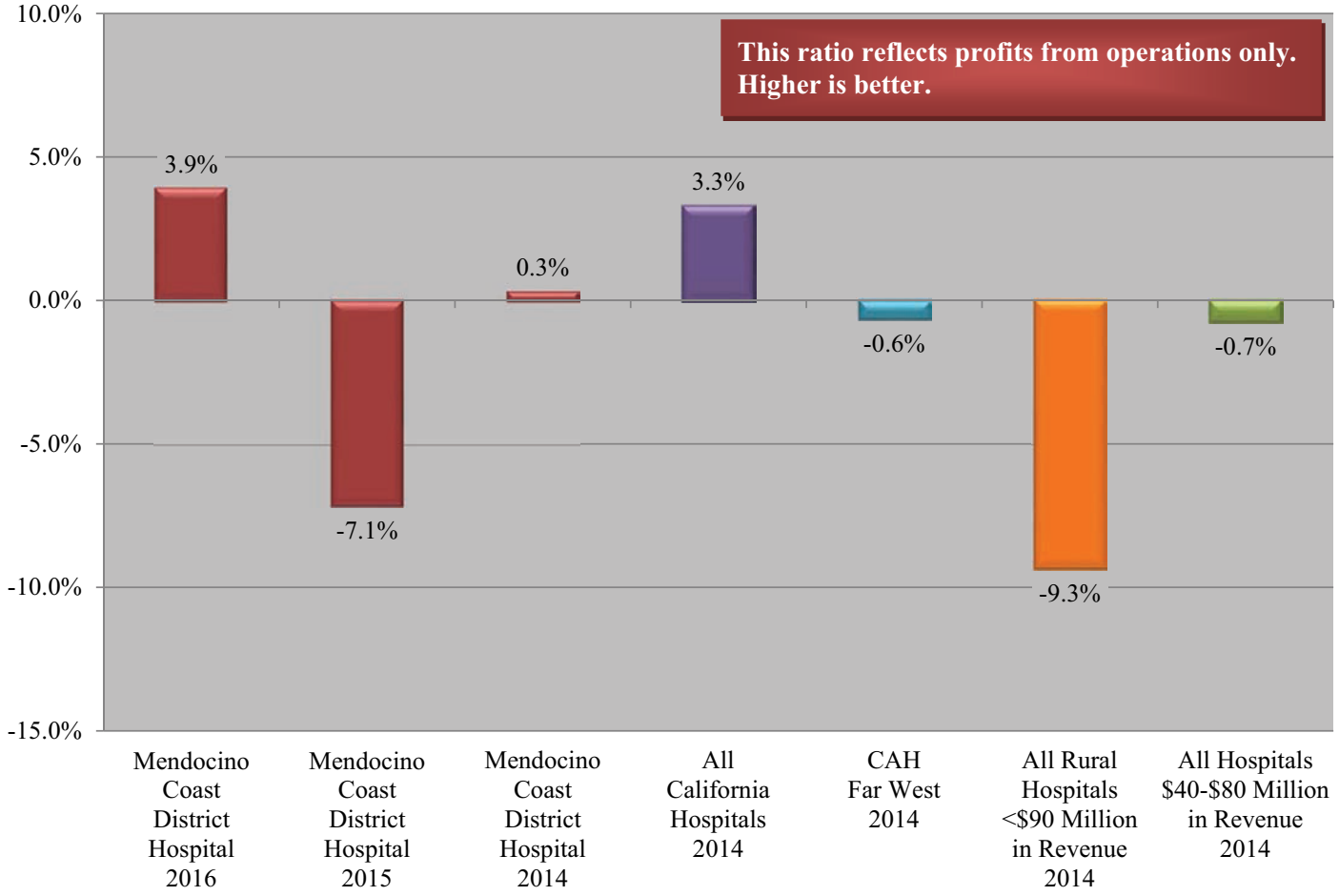
Mendocino Coast Health Care District
doing business as
Mendocino Coast Hospital District

Operating Margin

Operating Income (Loss)
Total Operating Revenues



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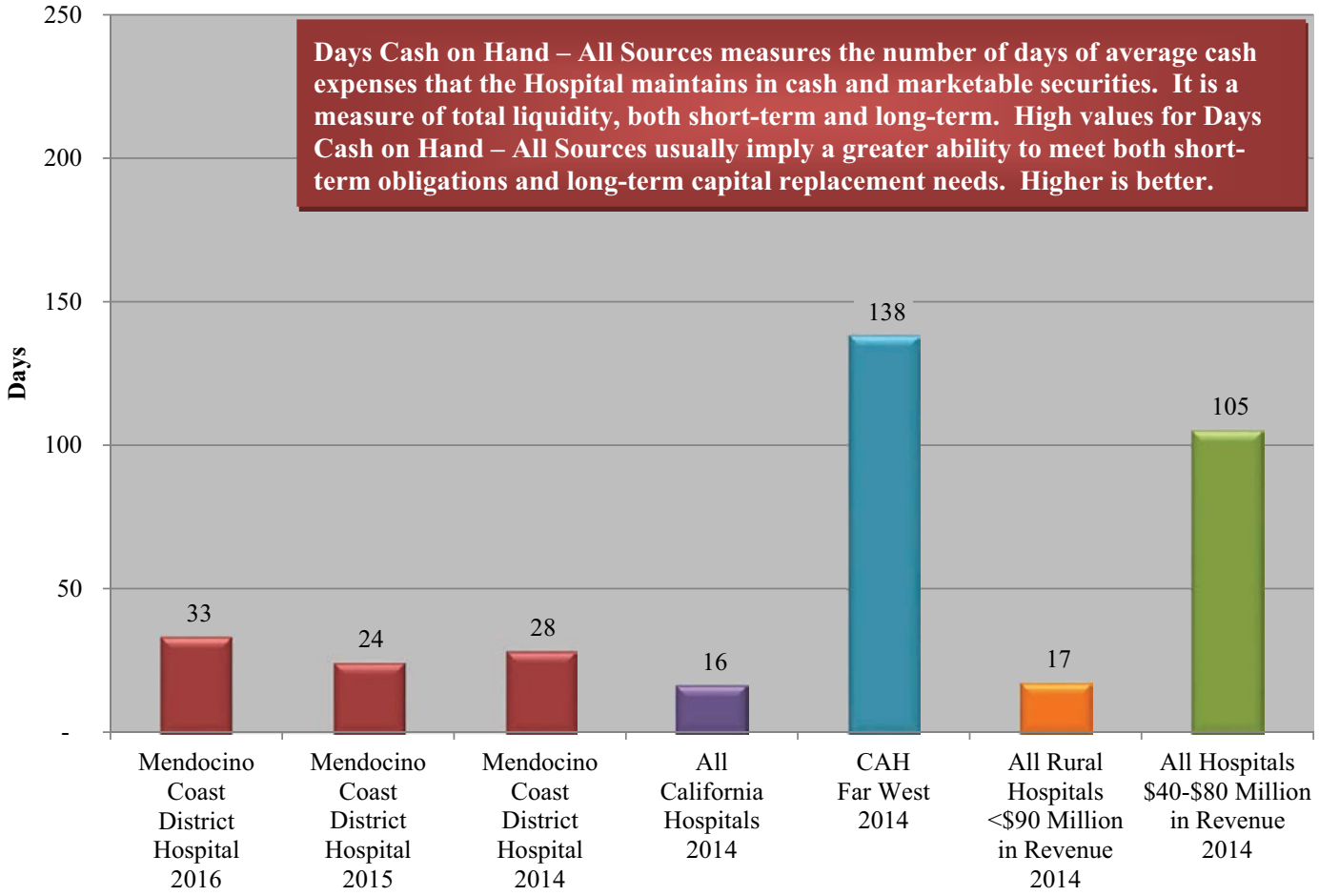
Mendocino Coast Health Care District
doing business as
Mendocino Coast Hospital District

Days Cash on Hand – All Sources

$$\frac{\text{Cash + Short-Term Investments + Unrestricted Long-Term Investments}}{\text{(Total Expenses - Depreciation) / 365}}$$



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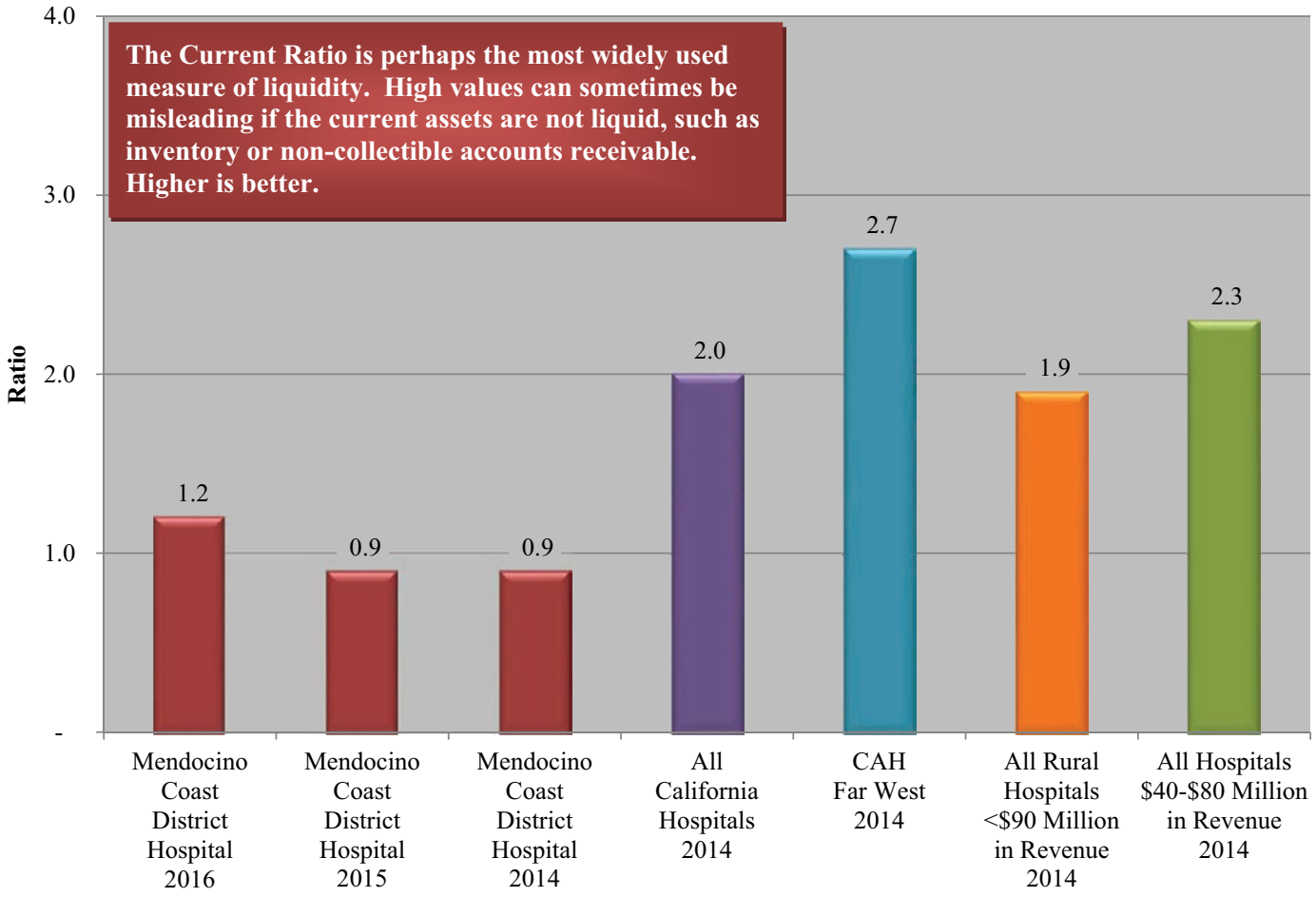
Mendocino Coast Health Care District
doing business as
Mendocino Coast Hospital District

Current Ratio

$$\frac{\text{Current Assets}}{\text{Current Liabilities}}$$



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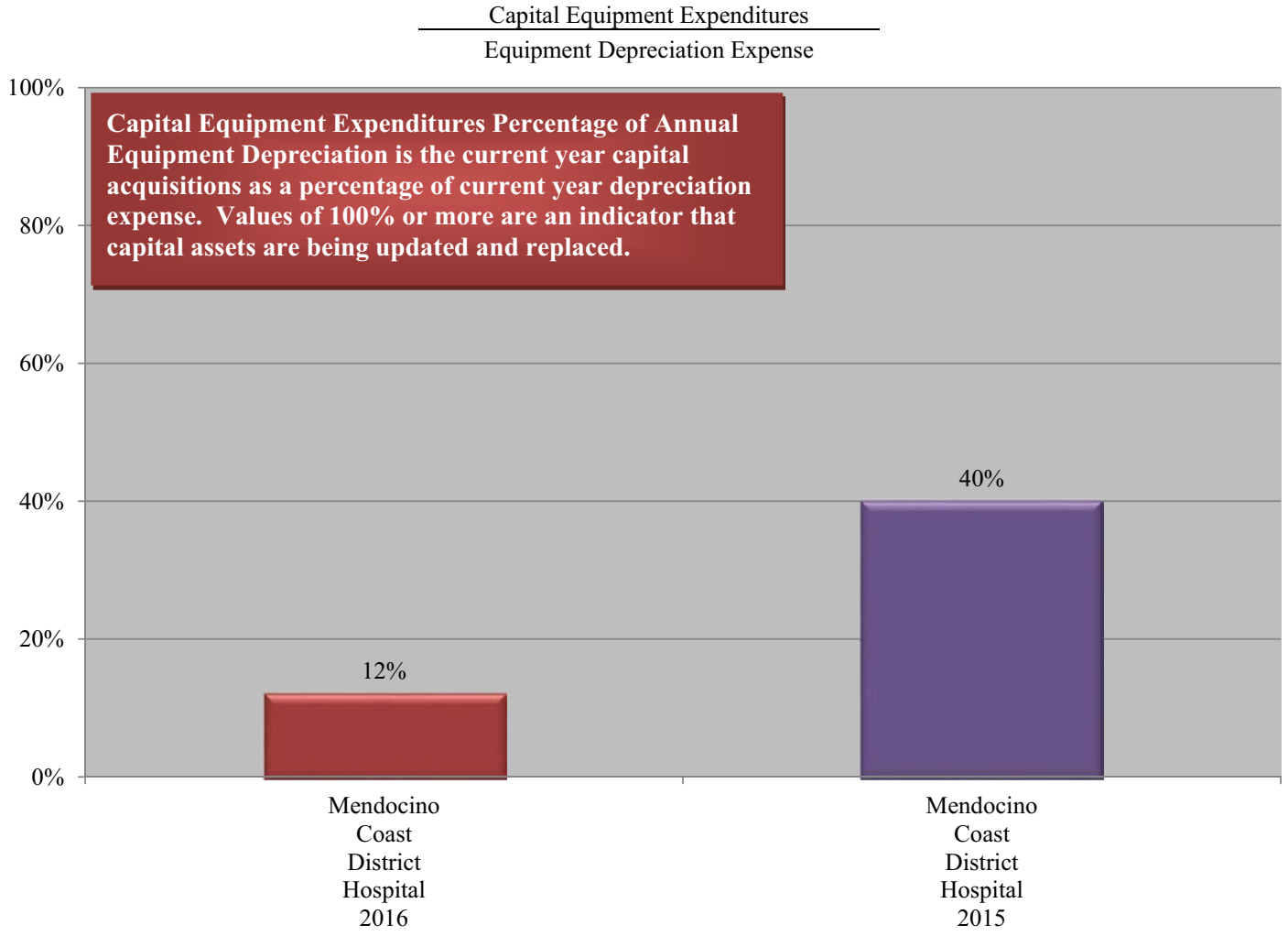
Mendocino Coast Health Care District
doing business as
Mendocino Coast Hospital District

Capital Equipment Expenditures Percentage of Annual Equipment Depreciation



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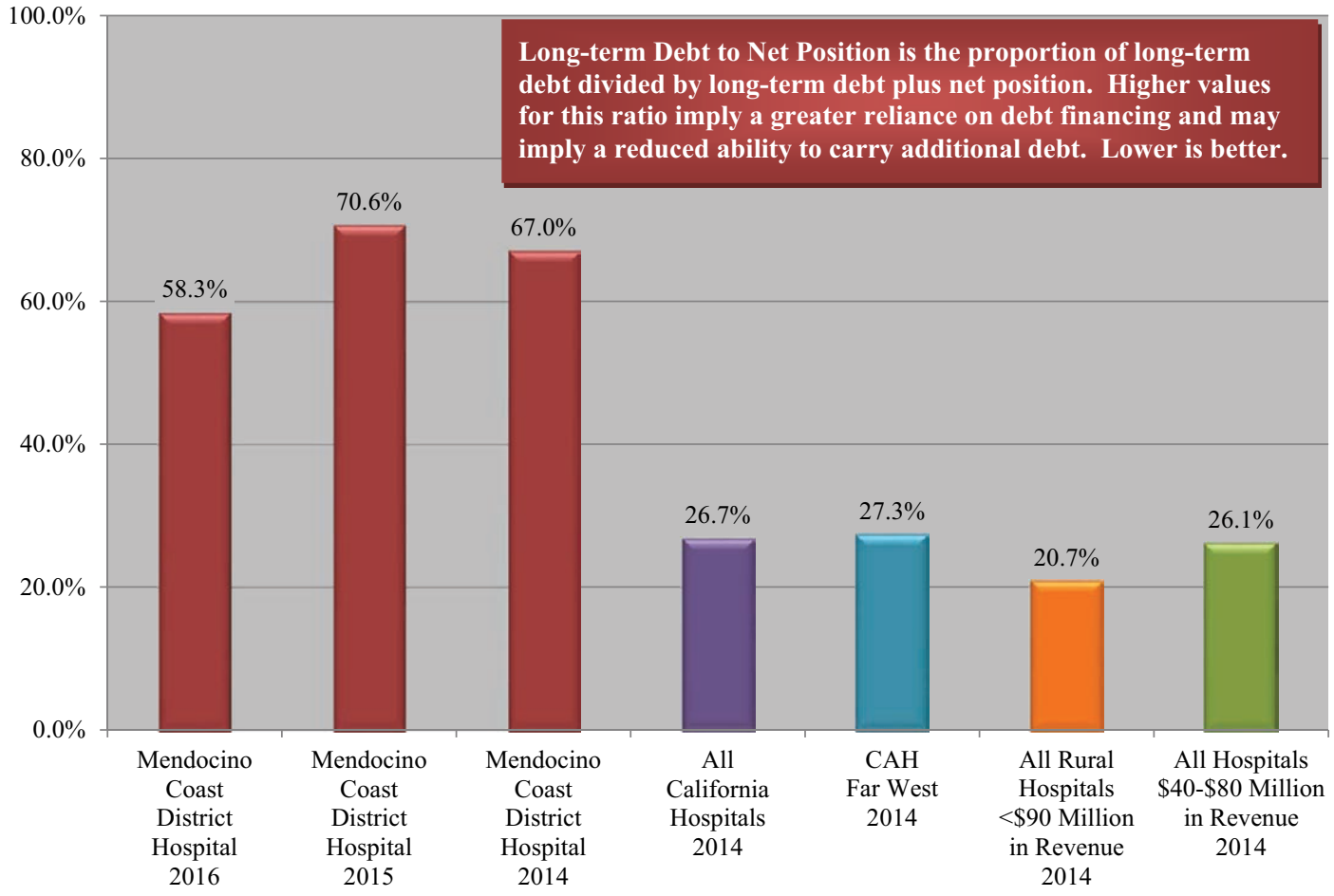
Mendocino Coast Health Care District
doing business as
Mendocino Coast Hospital District

Long-term Debt to Net Position

$$\frac{\text{Long-term Debt}}{\text{Long-term Debt + Net Position}}$$



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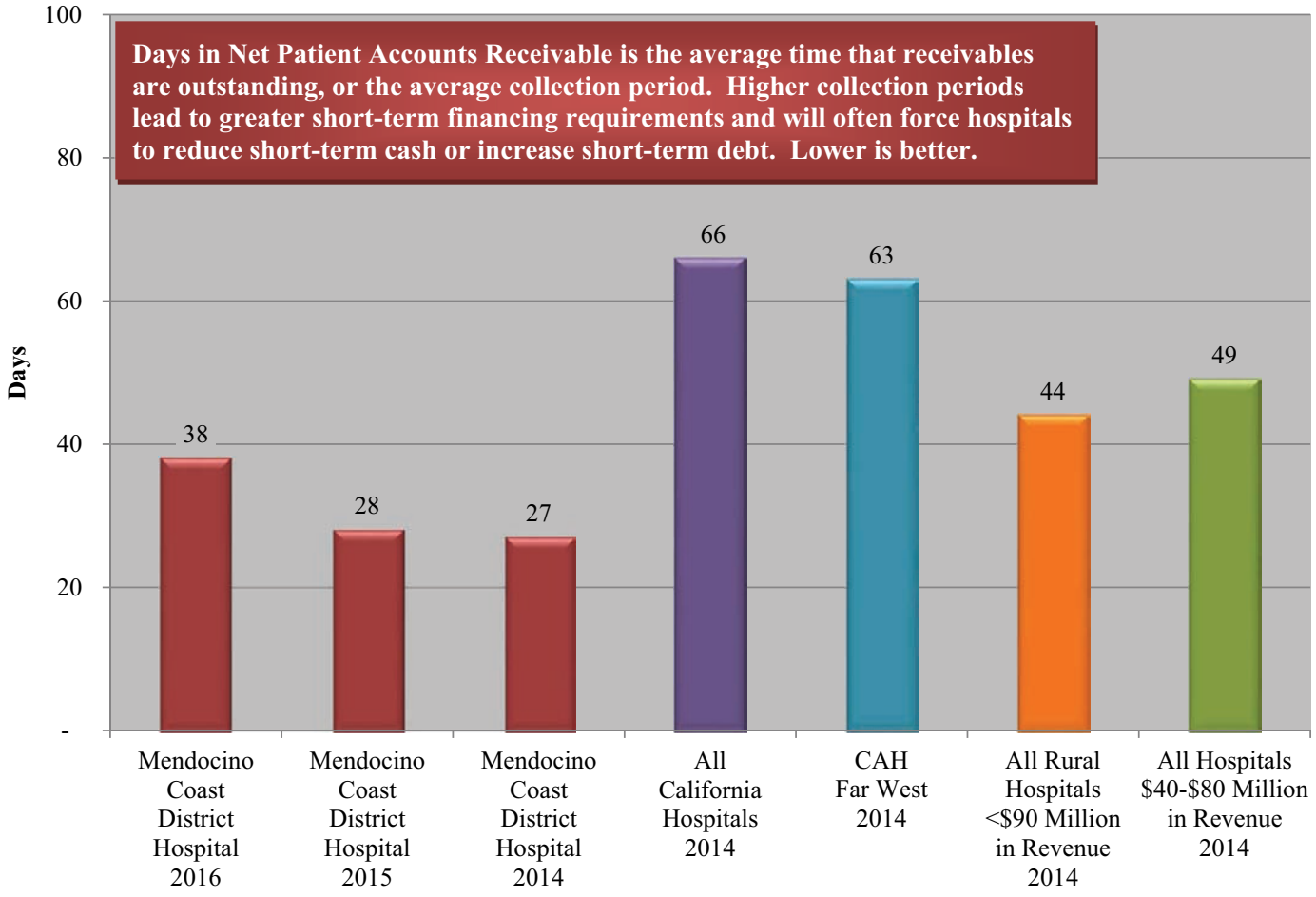
Mendocino Coast Health Care District
doing business as
Mendocino Coast Hospital District

Days in Net Patient Accounts Receivable

$$\frac{\text{Net Patient Accounts Receivable}}{\text{Net Patient Service Revenue / 365}}$$



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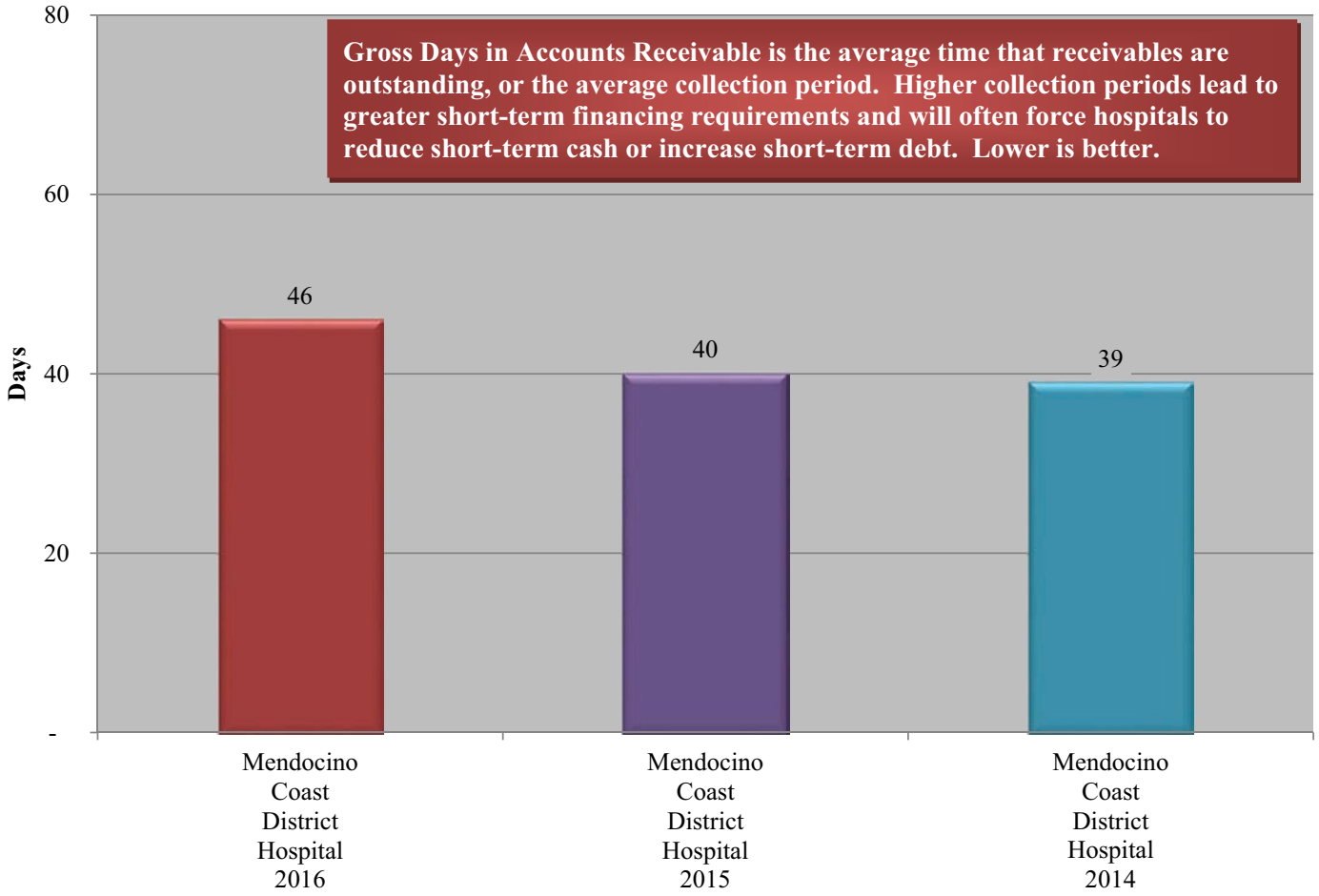
Mendocino Coast Health Care District
doing business as
Mendocino Coast Hospital District

Gross Days in Accounts Receivable

Gross Patient Revenues
Average Daily Hospital Revenue (Revenue/365)



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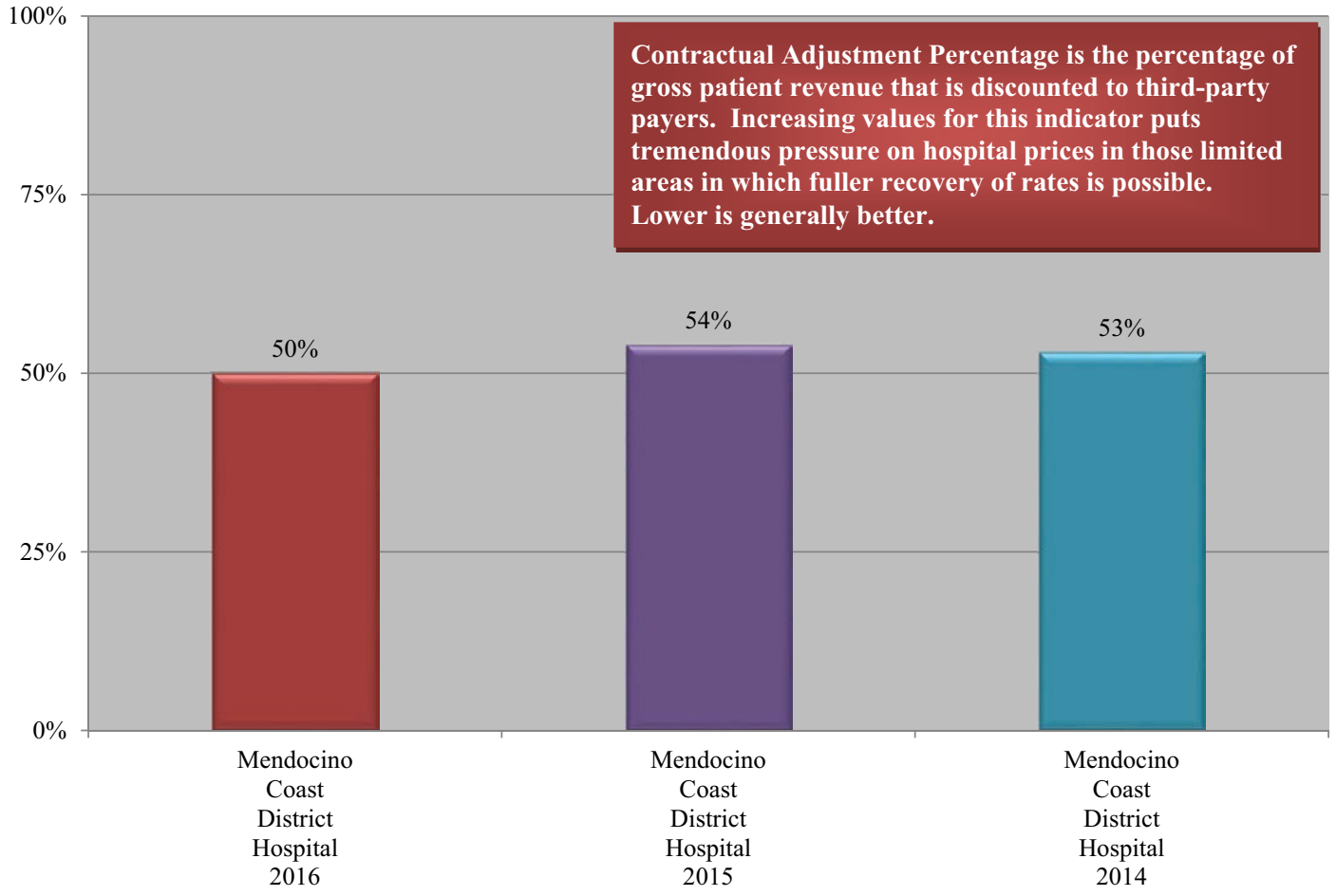
Mendocino Coast Health Care District
doing business as
Mendocino Coast Hospital District

Contractual Adjustment Percentage

Contractual Adjustments
Gross Patient Revenues



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doing business as
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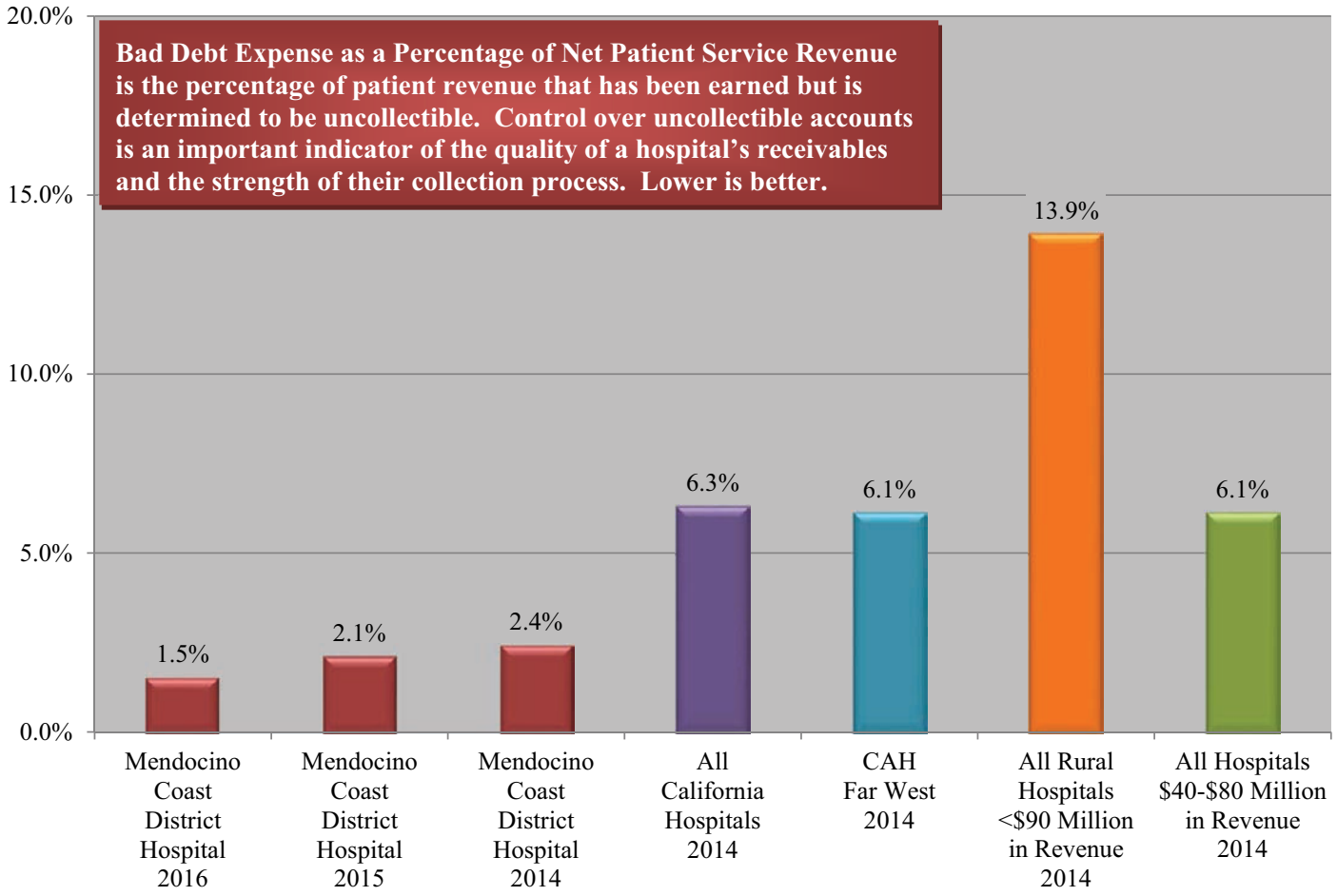
Bad Debt Expense as a Percentage of Net Patient Service Revenue

Provision for Bad Debt
Net Patient Service Revenues



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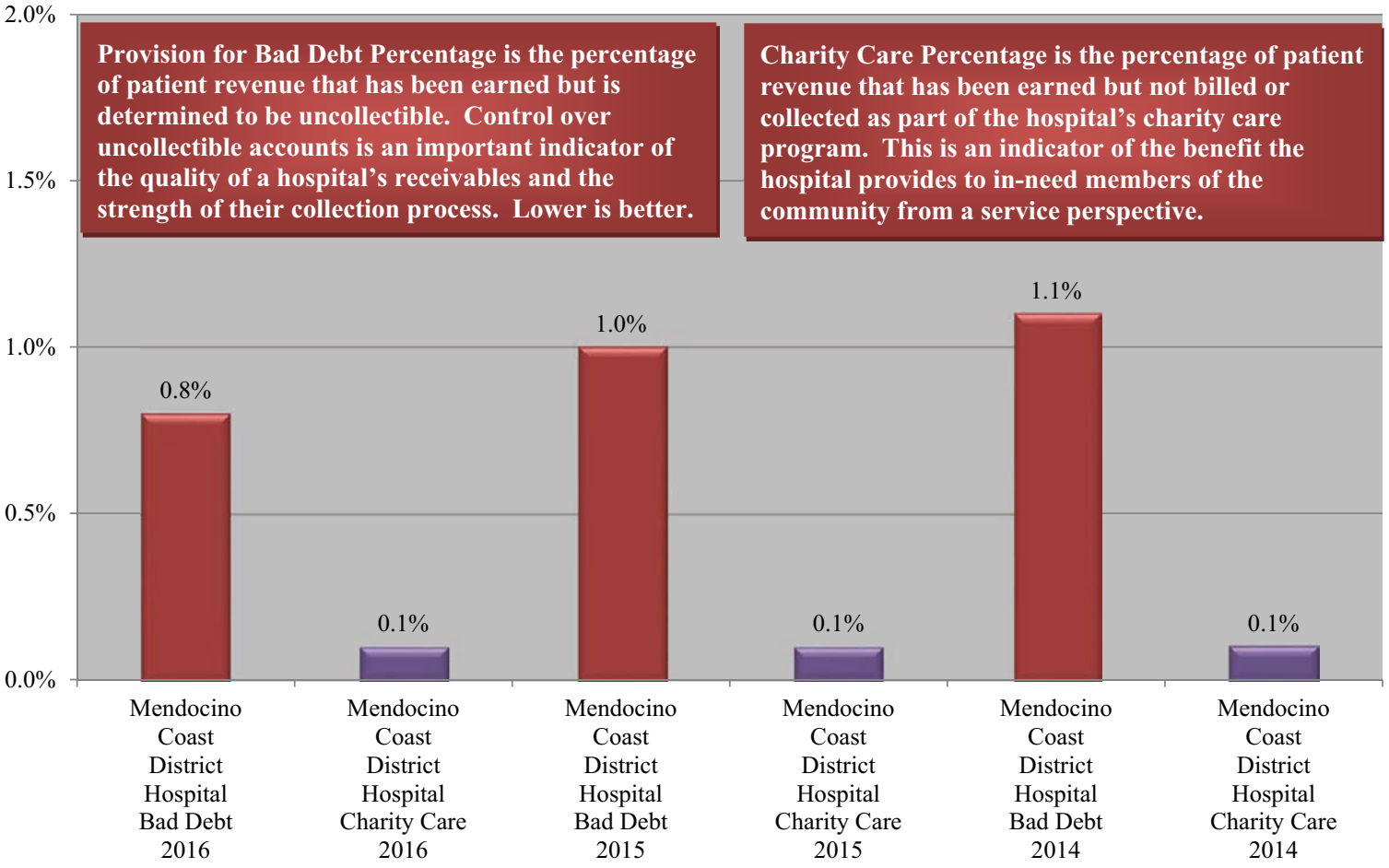
Bad Debt and Charity Care Percentage

Provision for Bad Debt & Charity Care
Gross Patient Service Revenues



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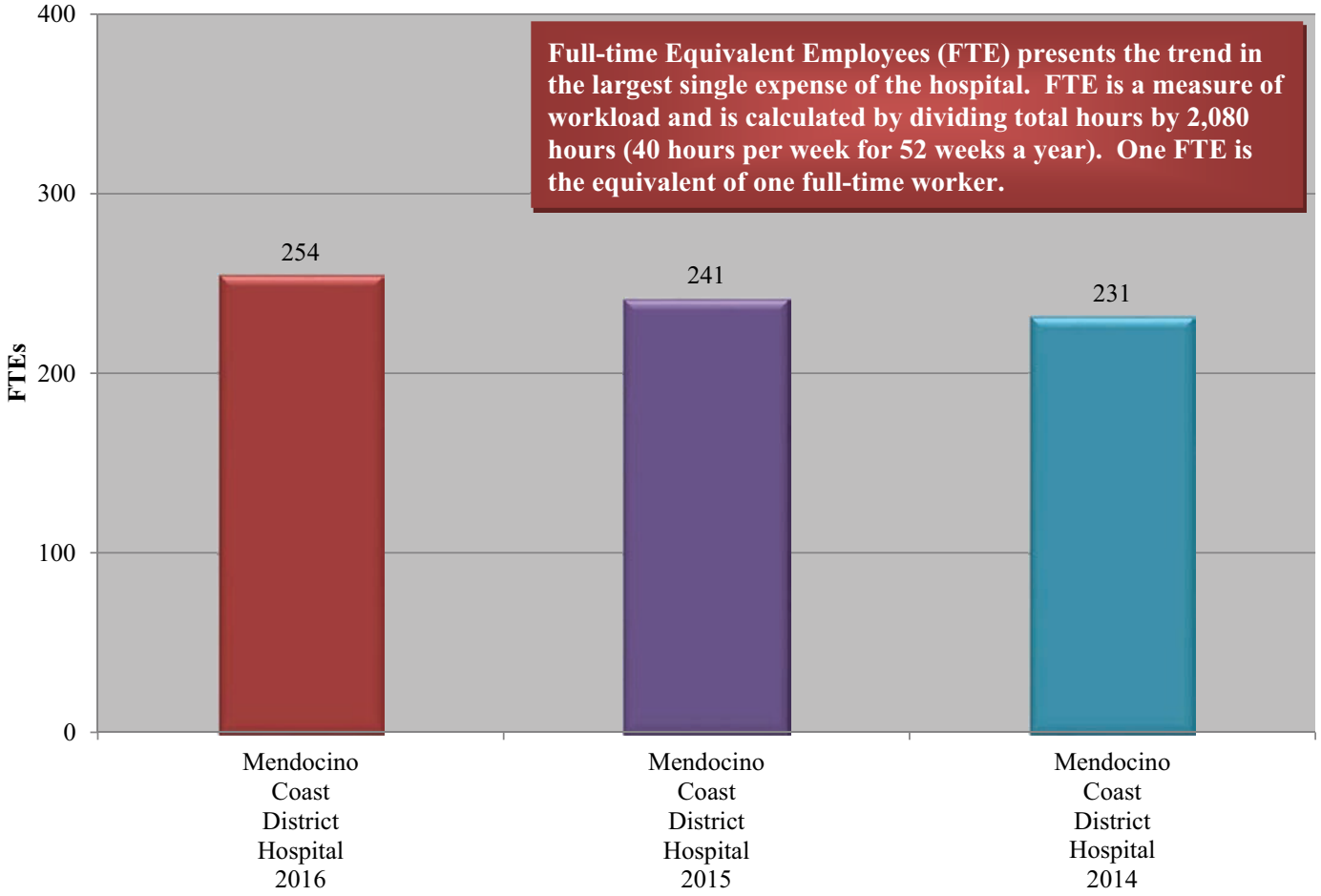
Mendocino Coast Health Care District
doing business as
Mendocino Coast Hospital District

Full-time Equivalent Employees (FTE)



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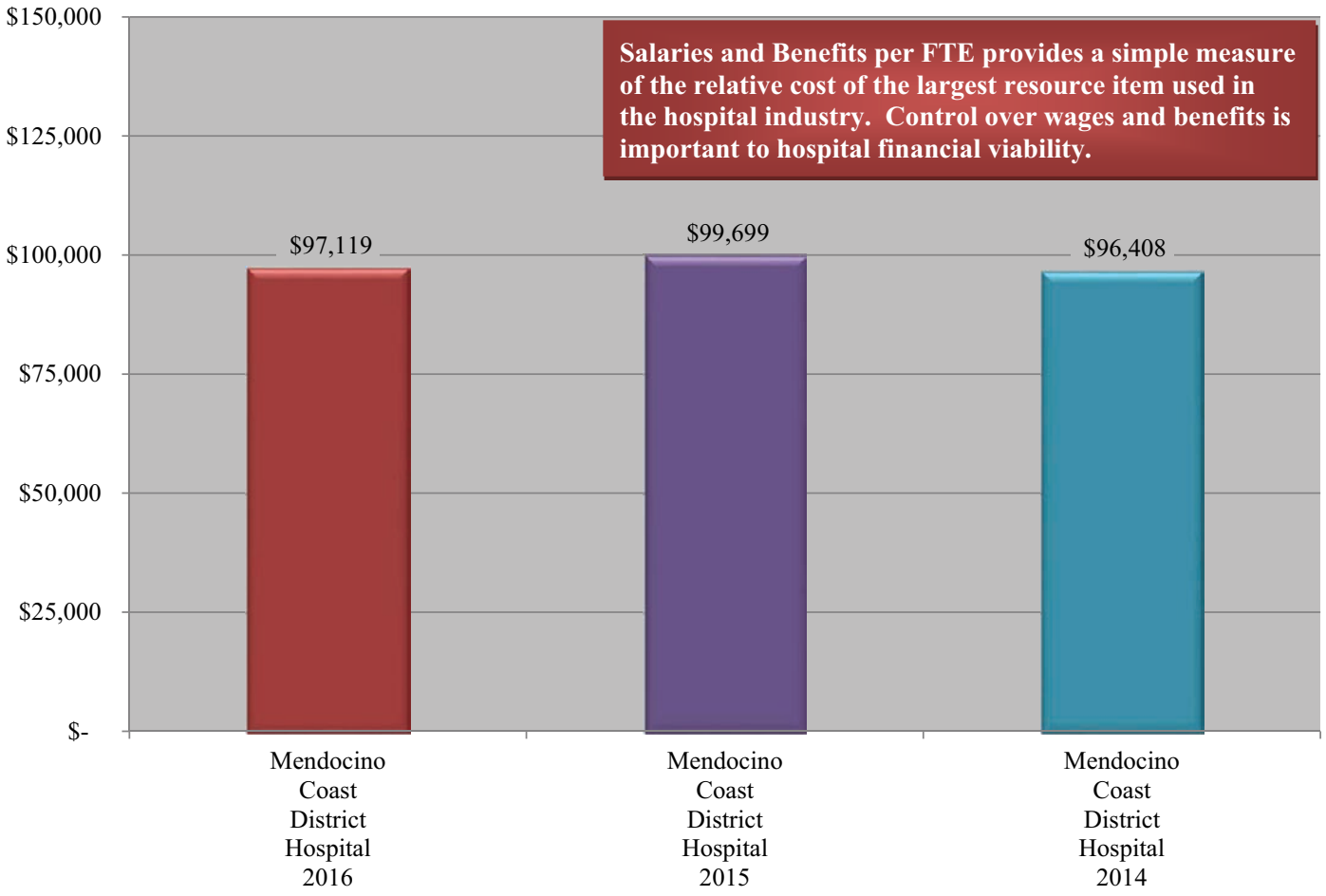
Mendocino Coast Health Care District
doing business as
Mendocino Coast Hospital District

Salaries and Benefits per FTE

$$\frac{\text{Total Salaries + Total Benefits}}{\text{FTEs}}$$



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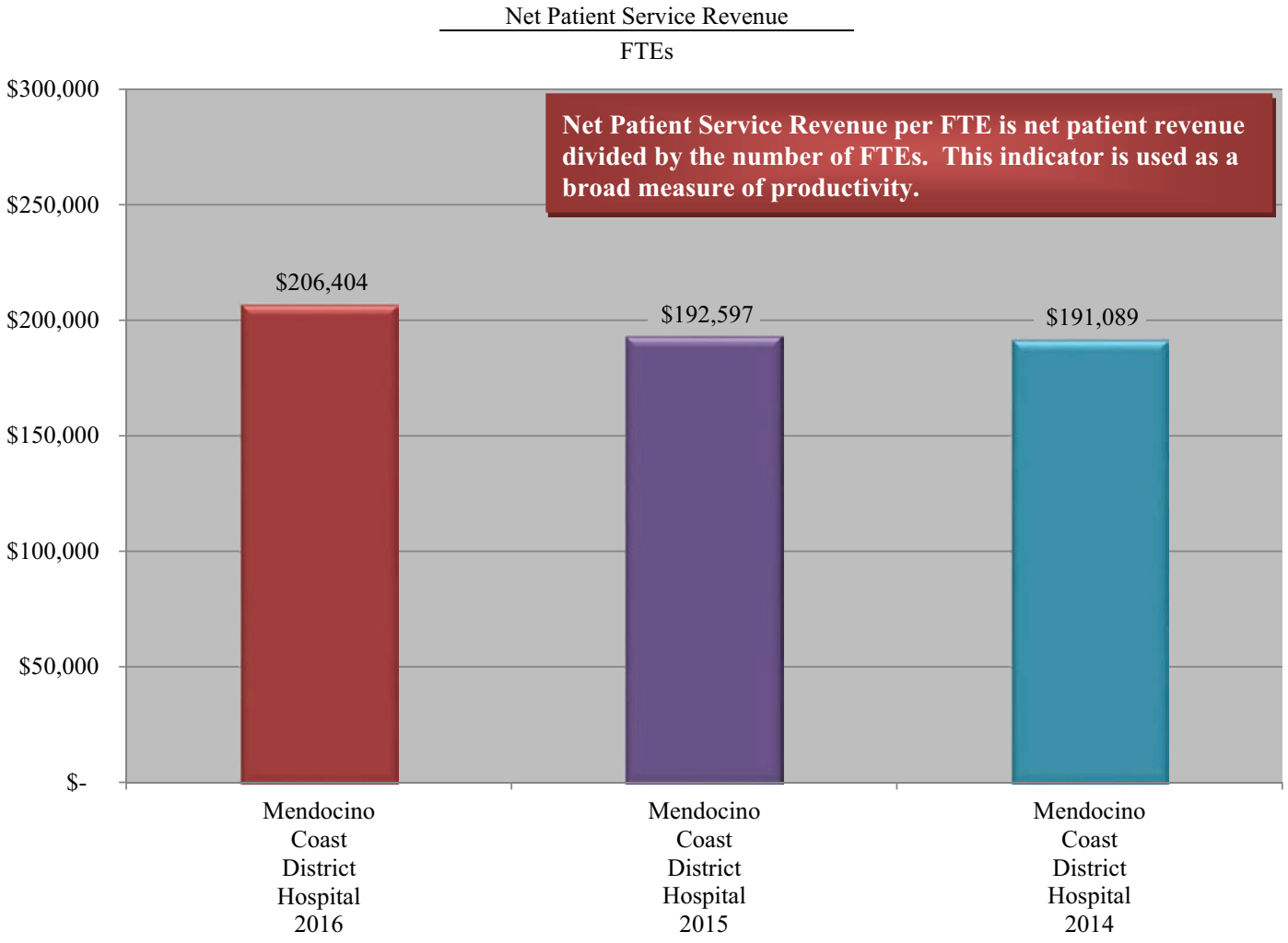
Mendocino Coast Health Care District
doing business as
Mendocino Coast Hospital District

Net Patient Service Revenue per FTE



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APPENDIX C

INFORMATION CONCERNING MENDOCINO COAST HEALTH CARE DISTRICT

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MENDOCINO COAST HEALTH CARE DISTRICT

THE DISTRICT

Mendocino Coast Health Care District (the "District"), a local healthcare district formed in 1967, is a public entity under the laws of the State of California (the "State") organized pursuant to the State's Local Health Care District Law (formerly the Local Hospital District Law) as set forth in the State's Health and Safety Code. The District encompasses approximately 680 square miles and extends approximately 70 miles south from the Humboldt/Mendocino County line. The District is bordered on the west by the Pacific Ocean and includes the City of Fort Bragg and the communities of Westport, Mendocino, Albion and Elk. The District also provides healthcare services to people living outside the District, the majority of which live within an area extending from Elk south along the coast to the Mendocino/Sonoma county line and visitors to the area.

The 2016 estimated population for the City of Fort Bragg and Mendocino County was 7,672 and 88,378, respectively. Management of the District estimates that there are approximately 25,000 residents living within its boundaries. Projections made by the State Department of Finance estimates Mendocino County's population will reach approximately 92,203 by the year 2025. The District owns and operates the Hospital and operates a rural health clinic, both of which are located within the City of Fort Bragg, Mendocino County, California.

District's Mission and Vision

The District's stated mission is to make a positive difference in the health of the District's rural community.

The District's stated vision is to play a vital role in the overall health and well-being of the community and to be the key element in the healthcare system serving the needs of the community; to provide leadership to enhance the efficiency, coordination, quality and range of services provided within its rural healthcare system; to be the healthcare provider and employer of choice within the community and to continually address and keep up with technology and superior clinical skills.

The District is committed to providing excellent quality, patient centered, cost effective healthcare in a caring, safe and professional environment, and serving the community's healthcare needs with current technology and superior clinical skills. The District believes in the right to local access to a wide range of excellent quality healthcare services for its rural community. District management promotes patient safety and satisfaction, and consistently works toward a high level of care that results in its patients recommending the Hospital to others and in patients returning to the Hospital for needed healthcare.

GOVERNING BODY, DISTRICT MANAGEMENT AND STAFF

Board of Directors

The District is governed by a Board of Directors (the "Board"), which consists of five members, each elected to four-year alternating terms at elections held every two years. The Board has responsibility for the quality of patient care, District policies, strategic planning, as well as fiduciary responsibility for protecting and enhancing District assets. Members of the Board serve in a voluntary capacity and receive no compensation for their services. Current Board members and their Board positions, occupations and current terms are as follows:

Name	Position	Occupation	Term Expiration
Tom Birdsell[(1)]	Chair	Office Manager	12/5/2016
Kitty Bruning	Vice Chair	Retired	12/5/2018
Peter Glusker, M.D.	Secretary	Retired	12/5/2018
Sean Hogan[(1)]	Treasurer	Retired	12/5/2016
Steve Lund[(1)]	Member	Retired	12/5/2016

(1) As of the date of this Official Statement, pursuant to the results of the November 8, 2016 election, which have not yet been certified by the Elections Division of the Office of the Assessor-County Clerk-Recorder of the County of Mendocino, Tom Birdsell and Sean Hogan's terms will expire in December 2016 as well as the temporary appointment of Steve Lund. Lucas W. Campos, M.D., and Steve Lund were elected to four-year terms commencing in December 2016. Kevin B. Miller, M.D., was elected to a two-year term also commencing in December 2016.
Source: The District.

Board Committees and Relationships

There are five standing committees of the Board, each consisting of up to two Board members and as many as eight additional non-Board members. The Board's current standing committees include: finance, planning, legislative, audit and compensation. Standing committees to the Board serve solely in an advisory capacity and recommend action items to the Board for their approval. Special committees may be formed by appointment of the Board's President with full Board concurrence to investigate, study or review specific matters.

Members of the Board have various relationships with service or product providers who may, from time to time, provide services or products to the District, but these relationships are not considered to be material. The Board has established a conflict of interest policy to identify, approve and manage such relationships.

Management

The Board delegates day-to-day operations of the District and its health facilities to the executive managers of the District who are profiled below:

Chief Executive Officer. Bob S. Edwards, Jr. MBA FACHE, Chief Executive Officer. Mr. Edwards has been with Mendocino Coast Health Care District since April 15, 2015. He has 25 years of hospital CEO experience in small to medium size hospitals. Mr. Edwards has lead teams to achieve top 100 Critical Access Hospital status in two hospitals, there are over 1,300 Critical Access Hospitals in the United States. MBA, with specialty in Health Care Administration, City University, Bellevue, WA 1989; BS, Respiratory Therapy, University of Central Arkansas, Conway, AR 1977.

Chief Financial Officer. Wade Sturgeon, Chief Financial Officer. Mr. Sturgeon has been with Mendocino Coast Health Care District since September of 2015. He started his career in hospital finance in 1997 and worked at three other hospitals, all small/rural Critical Access Hospitals as CFO prior to moving to California. Mr. Sturgeon has worked in California since 2011 in the capacity of CEO, COO and CFO. Mr. Sturgeon has an Associate's Degree in Accountancy from the College of Southern Idaho along with his Bachelors of Business Administration in Accountancy from Boise State University. In 2014, he graduated from the California Health Leadership College. Mr. Sturgeon is a member of the Healthcare Financial Management Association as well as the American College of Healthcare Executives.

District Employees

As of June 21, 2016, the District employed 228 full-time, 29 part-time and 54 per-diem personnel (253 full-time equivalent employees). The District had a collective bargaining agreement with Local 588 of the United Food and Commercial Workers Union representing all hourly employees. The contract was extended beyond its June 30, 2016 expiration date to accommodate negotiations. A tentative agreement between Local 588 of the United Food and Commercial Workers Union and the District was executed on August 17, 2016.

FACILITIES AND SERVICES

District Facilities

The District owns and operates Mendocino Coast Hospital (the "Hospital"), a 49-bed acute care facility licensed by the State of California Department of Public Health. The Hospital is located at 700 River Drive, in the City of Fort Bragg, which lies approximately 165 miles north of the City of San Francisco and approximately a fifty minute drive from the next closest hospital located in Willits, California. The Hospital opened in June of 1971, and was financed by the issuance of $2,250,000 in general obligation bonds authorized at an election held in the District on December 5, 1967, and the receipt of a $637,934 federal Hill-Burton grant in 1969. Pursuant to a 1991 Health and Human Services audit, the District's Hill-Burton obligation has been deemed fulfilled. A 9,000 square foot addition to the Hospital was completed in 1994 and funded in part by revenue bonds issued in 1990 by the District. This addition contained a new emergency room and laboratory department. In 1996, the District issued revenue bonds to refund the 1990 revenue bonds and to finance radiology and surgery department improvements. In 2001, the District issued current interest general obligation bonds in the aggregate principal amount of $4,615,000 and capital appreciation general obligation bonds in the aggregate principal amount of $884,627.75 (collectively, the "Series 2001 General Obligation Bonds"). Proceeds of the Series 2001 General Obligation Bonds were used to finance the construction and equipping of the patient services building, which includes the rehabilitation department, patient registration, the hematology/oncology clinic, administrative offices for finance, and a conference room. In 2009, the District issued $5,000,000 in revenue bonds to construct and equip an 8,000 square foot diagnostic imaging facility. In 2010, he District issued $2,875,000 in revenue bonds to construct and equip a central plant for the Hospital and retrofit facilities for earthquake protection, among other capital improvement projects.

The Hospital was licensed for 52 acute beds until March 31, 2004, at which time the State Department of Public Health granted the Hospital a change in its licensed beds to 49 beds. Although the Hospital continues to be licensed for 49 beds (24 beds were placed in suspense), in October of 2006, the Hospital became a 25-bed Critical Access Hospital ("CAH"). A CAH is a hospital that is certified to receive cost-based reimbursement from Medicare. See "FACTORS AFFECTING HEALTH CARE DISTRICTS – Patient Services Revenues – Medicare Payments" in this appendix for a discussion of reimbursement from Medicare for Critical Access Hospitals.

The Hospital offers inpatient and outpatient services including respiratory care, ophthalmology, laboratory services, chemotherapy, oncology, radiology, cardiology, neurophysiology, obstetrics, physical therapy, outpatient surgery, nuclear medicine, CT scanning, home health, hospice care, ambulance service, and outpatient mobile magnetic resonance imaging. Fifteen of the Hospital's acute care Medical/Surgical beds are licensed by the State Department of Public Health for utilization as swing beds for use as either acute care beds or as skilled nursing beds, as the need demands.

In 2007, the District purchased a local physician group and converted the practice into a provider-based rural health clinic. The purchase of the North Coast Family Health Center permits the District to

maintain a continuity of care for primary care services in the community and provides an additional revenue source for the District. The North Coast Family Health Center is operated by the District as a department of the Hospital and offers primary care and specialty care services to the community.

The North Coast Family Health Center, a 95-210 rural health clinic, utilizes approximately 10,000 square feet of space available in the approximate 12,300 square foot Mendocino Coast Medical Plaza located on District property. The Mendocino Coast Medical Plaza is owned by a California Limited Liability Company formed for the purpose of constructing and managing the Mendocino Coast Medical Plaza building. Construction of the Mendocino Coast Medical Plaza building began in 2004 and was completed in 2005. The Hospital and the North Coast Family Health Center are herein referred to as the Health Facilities.

The Hospital also has an active auxiliary consisting of approximately 48 volunteers who provide supplemental services to patients and District staff. The auxiliary also assists in fundraising efforts and has contributed funds to the District for equipment acquisitions.

Bed Complement

The Hospital has a combined licensed capacity of 49 beds. The current bed count for the Hospital, however, classified by service type, is as follows:

Bed Service Type	Licensed Beds
General Acute Care[(1)(2)]	14
Intensive Care	4
Perinatal (Obstetrics)[(2)]	7
Total Licensed Beds	25

Source: State Department of Public Health license.

(1) Fifteen of the Hospital's general acute care beds are approved as swing beds for skilled nursing services. The swing bed designation allows the Hospital to utilize these fifteen beds for either acute care patients or skilled nursing patients, as demand requires.

(2) Twenty general acute care beds and four perinatal beds have been suspended by the District.

Licensure, Accreditations and Memberships

The Hospital is licensed by the State Department of Public Health and accredited by The Joint Commission. The Hospital is inspected by the State and surveyed by The Joint Commission. The most recent accreditation review by The Joint Commission was completed on February 16, 2016, and is valid for up to 36 months.

The District is an eligible provider under Medicare, Medi-Cal, Blue Cross and other commercial insurance programs. The District holds memberships in the California Hospital Association, the Association of California Healthcare Districts, the American Hospital Association, the Hospital Council of Northern and Central California, and other professional healthcare organizations. The Hospital is designated as a CAH, is located in a health professional shortage area and has sole community provider status. The Hospital is also designated as a rural hospital.

The District has also established affiliation programs for clinical site training with the following schools and programs: the nursing program at California State University, Chico; the nursing and paramedic programs at Mendocino College in Ukiah; the radiology program at Santa Rosa Junior College; and the phlebotomy and emergency medical technician program at Mendocino County Office of Education.

Services

Core medical services along with other inpatient and outpatient specialty services are provided by the District at the site of the Health Facilities. Core services delivered by the District include medical, pediatrics, emergency medicine, imaging (radiology), laboratory and physical therapy. Specialty services include inpatient and outpatient surgery, outpatient occupational and speech therapy, cardiac rehabilitation, obstetrics and an orthotics lab. Some of these services are described more fully below.

The Hospital provides primary care and certain secondary services, within the capability of its medical staff (family practice, general surgery and orthopedic surgery). Cases which require a medical specialty not represented by the Hospital's Medical Staff and cases that require technology not available at the Hospital are transferred to other health facilities located in Santa Rosa and San Francisco.

Emergency Department – The Emergency Department is staffed 24-hours a day by an experienced team of medical professionals. All Emergency Department physicians are certified in Advanced Cardiac Life Support ("ACLS"). Emergency Department registered nurses are assisted by Paramedics and Emergency Medical Technicians ("EMT"). Medical consultants are available on-call in various specialties such as gynecology, internal medicine, obstetrics, pathology, pediatrics, radiology, surgery, anesthesiology and ophthalmology.

ICU/CCU – The four-bed combination Intensive and Coronary Care Unit is designed to provide specialized care for critically ill or injured patients. The ICU/CCU Unit is staffed by registered nurses who have completed the specialized education and technical training required for the care of these patients. The unit is equipped with sophisticated life-support equipment, as well as current medical technology which allows physicians and nurses to monitor continuously all vital signs (blood pressure, temperature, heart rate, etc.). The unit also has telemetry services which enable Hospital staff to monitor cardiac functions for an additional four patients in the Medical/Surgical unit.

Obstetrics (perinatal) – The Hospital's Obstetrical Unit was one of the first in-house, family-centered maternity care programs in California. The Obstetrical Unit includes labor, delivery and recovery services, plus a four-bed nursery with facilities for immediate care, stabilization and transport for critically ill newborns.

Medical/Surgical – The Medical/Surgical Unit provides care for both medical patients and patients hospitalized under any of the specialty surgical services offered at the Hospital, such as general surgery and orthopedic surgery. In addition, a designated pediatric area is available to provide medical and surgical care to infants and children. The medical/surgical area is staffed by registered nurses, and certified nursing assistants.

Swing Bed Program – Fifteen of the Hospital's acute care beds are licensed by the State for utilization as skilled nursing beds. The Swing Bed Program allows patients whose medical condition has stabilized to remain in the Hospital if they still require skilled nursing services. Such services may include physical therapy, occupational therapy, speech therapy, respiratory therapy, IV therapy, and/or other skilled nursing services.

Inpatient and Outpatient Surgical Services – Surgery facilities at the Hospital consist of two operating rooms and a three-bed post anesthesia recovery unit. The Hospital offers a wide variety of surgical services and has the equipment and expertise to perform gynecological and general surgery via the laparoscope, and advanced orthopedic procedures via the arthroscope. The Hospital's Ambulatory Surgical Service allows patients to have surgery and return home on the same day. This service is located within the surgical suites of the Hospital, providing immediate access to support services such as radiology and laboratory.

Laboratory – The Laboratory Department provides clinical laboratory, medicine, pathology and transfusion services. Under the supervision of a physician pathologist, the Clinical and Pathology Laboratories allow for a wide variety of tests to assist doctors in diagnosis and treatment. Over 95% of requested tests are performed in-house, reducing delays in reporting results.

Outpatient Services – In addition to outpatient surgical services, the Hospital provides treatment for patients receiving chemotherapy, blood transfusions, diagnostic clinical studies including endoscopic exam and biopsy, and other specialized treatments or procedures.

Radiology X-Ray – The Radiology Department has the only fast high resolution CT scanning equipment on the Mendocino Coast between San Francisco and Eureka. The Hospital's State licensed mammography program provides a follow-up reminder and monitoring service. Other services provided by the department include ultrasonography, diagnostic X-ray, MRI, and nuclear medicine modalities. The tele-radiology system allows images to be transferred via telephone lines to other hospitals for consultation. Together these services eliminate the need to refer patients out of the area for anything other than specialized services provided by large medical centers.

Respiratory Care – The Respiratory Care Department has a pulmonary diagnostic lab and participates in all phases of respiratory therapy from the simplest aerosol treatment to continuous artificial ventilation.

Cardiology – In addition to standard cardiographic services, the Hospital's Cardiology Department has a cardiac stress lab and specializes in echocardiography for non-invasive cardiac evaluation, Holter monitoring and 24-hour blood pressure monitoring.

Physical Therapy – The Physical Therapy Department provides inpatient as well as outpatient treatment. In addition to all standard physical therapy treatments, such as neurological, orthopedic and sports rehabilitations, the Physical Therapy Department is equipped with all physical and electrical modalities.

Occupational Therapy – The Occupational Therapy Department provides services to both inpatients and outpatients who have a wide variety of neurological and orthopedic disorders. Treatment focuses on increasing independence in activities of daily living. In addition to all standard treatment modalities, home evaluations are provided to ease the transition between hospital and home by identifying equipment needs and addressing safety issues. In addition to rehabilitation services, a hand treatment program provides comprehensive treatment modalities including static and dynamic splinting of the injured hand.

Speech Pathology – The Speech Pathology Department, state licensed for inpatients and outpatients, provides assessment and treatment of speech, language, cognition and swallowing disorders. Therapists are certified by the American Speech, Language and Hearing Association. Specialized exercises and compensatory strategies assist patients in reaching their maximum potential for both rehabilitation or habilitation of a communication or swallowing disorder. Videofluoroscopic swallowing exams are used to assess specific swallowing disorders and define treatment strategies. Therapy is coordinated with rehabilitation team members enhancing a trans-disciplinary approach.

Hematology/Oncology – The Hospital based Hematology-Oncology-Infusion Clinic opened in the spring of 2006. The clinic specializes in hematology and oncology, treating patients with blood diseases and a wide variety of cancers. The professional team consists of registered nurses specially trained in cancer and infusion therapy as well as a physician who is board certified as a diplomat of the American Board of Internal Medicine, a fellow of the American Board of Hospital Physicians and certified by the American Board of Ethical Physicians.

Pharmacy – The Pharmacy Department serves both inpatients and outpatients. It provides medications to inpatients through a unit dose distribution system, automated dispensing cabinets and a centralized IV admixture program. The Hospital has instituted interim measures to achieve compliance with the requirements of USP 797 with respect to pharmaceutical compounding -- sterile preparations.

Outpatient services include the provision of chemotherapy, IV admixtures and clinical support in the Outpatient Surgery Department and the on-site Hematology-Oncology-Infusion Clinic. Pharmacists provide on-site and on-call support to nurses and physicians by providing drug information, drug selection and dosing calculation assistance, and patient monitoring through established protocols designed to provide patients with optimal drug therapy.

Nutrition Department – The District's Nutrition Department is dedicated to providing nutritious, tasteful and attractive meals to aid in the healing process of patients. A registered dietician provides inpatient nutrition counseling. Individual outpatient instruction is available with a physician's referral.

Home Health Care Program – Under the direction of a referring physician, the home care program provides skilled healthcare and social services to the patient and family in familiar and comfortable surroundings. The home care team promotes family integrity and independence by teaching families the skills they need to care for the home patient. The Home Health service area extends from Westport to Sea Ranch. All referrals and communications are received through the Fort Bragg Home Health office.

Hospice Program – Hospice care responds to the special needs of the terminally ill patient. Hospice is a coordinated program of palliative and supportive care (physical, psychological, social, and spiritual) for dying persons and their families. Services are provided by an interdisciplinary team of professionals and volunteers.

Ambulance Service – The Hospital is designated as a "base hospital." It monitors local and county-wide emergency radio channels and can dispatch two advanced life support ambulances to any location in the District.

Outpatient Clinic (North Coast Family Health Center) – The North Coast Family Health Center offers primary care and specialty care services to the community, including family practice, internal medicine, women's health, general medicine, endocrinology, orthopedics, osteopathy, podiatry, pediatrics, diabetes education, bone densitometry, pacemaker checks and spinal adjustments.

MEDICAL STAFF

The medical staff of the Hospital is comprised of physicians and allied health professionals. A Chief of Staff oversees the physicians at the Hospital and his biography is provided below.

John Kermen, D.O., Chief of Staff. Dr. Kermen is the Hospital's Medical Director of Anesthesiology Service. Dr. Kermen has practiced at the Hospital since October 1995 and has served as Chief of the Medical Staff for a cumulative ten years. Prior to practicing at the Hospital, Dr. Kermen practiced at a number of other hospitals, including the University of Arizona Medical Center, Cuyahoga Falls General Hospital, Michigan Capital Medical Center, Akron Children's Hospital and the Cleveland Clinic Foundation. Dr. Kermen received his Doctor of Osteopathy from Ohio University College of Osteopathic Medicine, where he also completed his residency in anesthesiology.

Hospital Medical Staff

As of June 21, 2016, the medical staff of the Hospital consisted of 77 physicians, including 41 active staff, 7 affiliate staff and 26 provisional staff. The average age and tenure of the active medical staff at the Hospital is 61 years and 16 years, respectively. Approximately 100% of the Hospital's active medical staff is board certified. The active staff, affiliate staff and provisional staff designations are described below.

Active Staff. Appointees to this category must have served on the medical staff for one year, be involved in 25 patient contacts, which is defined as an inpatient admission, consultation, outpatient surgical procedure, or have faithfully served on a medical staff committee at the Hospital for a two-year period. If an appointee to the active staff category does not meet the qualifications for reappointment to the active staff category, and if the appointee is otherwise abiding by all bylaws, rules, regulations and policies of the staff, the appointee may be appointed to the affiliate staff category. Appointees to this category may exercise such clinical privileges as are granted by the Board, vote on all matters presented by the medical staff and by the appropriate department and committee of which he or she is a member, and hold office and sit on or be the chairperson of any committee, unless otherwise specified in the District's bylaws. Appointees to this category must contribute to the organizational and administrative affairs of the medical staff; actively participate in recognized functions of the staff appointment including quality/performance improvement, risk management and monitoring activities, including monitoring of new appointees during the provisional period and in discharging other staff functions as may be required from time to time; and fulfill any meeting attendance requirements as established by the medical staff.

Affiliate Staff. The affiliate category is reserved for practitioners who do not meet the eligibility requirements for the active staff category or choose not to pursue active staff status. Practitioners assigned to this category must be involved in 25 patient contacts, which is defined as an inpatient admission, consultation, outpatient surgical procedure and/or an outpatient ancillary referral at the Hospital for a two-year period, except as expressly waived for practitioners with at least ten years of services in the affiliate category or for those practitioners who document their efforts to support the Hospital's patient care mission to the satisfaction of the Medical Executive Committee and the Board. Appointees to this category may exercise such clinical privileges as are granted by the Board and attend meetings of the staff and department of which he or she is an appointee and any staff or Hospital education programs. Appointees to this category must assist the Hospital in the fulfillment of its mission.

Provisional Staff. The provisional staff category consists of physicians newly appointed to the medical staff. Except as otherwise provided, the members of the provisional staff are entitled to admit patients and exercise certain clinical privileges and attend meetings of the medical staff and the department of which that person is a member, including open committee meetings and educational programs, but have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment. Members of the provisional staff are not eligible to hold office in the medical staff organization but may serve upon committees. All members of the provisional staff must undergo a period of observation.

Hospitalist Program

In November 2001, a contract between the District and a local medical group was approved to implement a hospitalist program at the Hospital. The hospitalist program is part of a well-established practice of using physician specialists for the care and treatment of patients in the Hospital. Hospitalists are hospital-based physicians with no outpatient office practice who specialize in treating inpatients. Each hospitalist works as a member of the patient care team to ensure patients receive a continuity of care and maintains communication with the primary care physician of each patient. The program was initially managed and staffed by a local medical group. In 2005, the District took over management of the

program and the District implemented a full-time hospitalist program in 2006. The program provides 24-hour coverage to patients admitted to the Hospital. These include unassigned patients, patients admitted through the Emergency Department and also admitted patients who have primary care and sub-specialty physicians in the area.

SERVICE AREA AND COMPETITION

Service Area

The Hospital serves an area that encompasses the coastal corridor from Elk to Westport in Mendocino County, California (the "County"). The Hospital is located on the north coast of the State, approximately 165 miles north of San Francisco. The District is the sole provider of hospital services for the region, providing emergency and primary care, and assisting with preventive and rehabilitative services.

Employment

The service area's economic base is changing. Tourism provides the highest percentage of employment of all other employment categories followed by retail, health services and construction. As of April 2016, the unemployment rate was 4% in Fort Bragg and 5.2% in Mendocino. (Source: State of California Employment Development Department.)

Competition

The closest competitor to the Hospital is approximately a fifty minute drive from the Hospital. Existing and potential competitors may not be subject to various regulations and restrictions applicable to the District; consequently, these competitors may be more flexible in their ability to adapt to competitive opportunities and risks. If these competitors and any future competitors not currently anticipated or prevalent are successful, some of the most profitable aspects of healthcare operations may be stripped away and/or overall utilization may decline.

OPERATION AND UTILIZATION DATA

Sources of Revenue

Payments on behalf of certain patients are made to the District by commercial insurance carriers, private payors, the federal government under the Medicare program, and by the State and federal government under the Medicaid program known as Medi-Cal in California. The following table shows the District's percentage of revenues for the District by source of payment for the fiscal years ended June 30, 2014, 2015 and 2016.

Payor	Fiscal Years Ended June 30, 2014	2015	2015
Medicare	$49,338,314	$52,803,069	$61,767,363
Medi-Cal	20,094,339	21,836,847	20,503,331
Commercial Insurance	16,335,95	16,983,125	19,684,716
Other	2,853,513	2,042,512	1,085,240
Total	$88,622,119	$93,665,552	$103,040,650
Medicare	55.67%	56.37%	59.94%
Medi-Cal	22.67	23.31	19.90
Commercial Insurance	18.43	18.13	19.10
Other	3.22	2.18	1.05

Source: Internal District Data.

Description of Medicare, Medicaid and Private Payor Reimbursement

Medicare

Prior to converting the Hospital to a CAH, inpatient services rendered by the District to Medicare program beneficiaries were paid at prospectively determined rates per discharge. These rates varied according to a patient classification system that was based on clinical, diagnostic and other factors. Outpatient services were paid based on prospectively determined fee-scale rates as defined and limited by the Medicare program.

In 2006, the Hospital was designated as a CAH. Currently, the District is reimbursed by Medicare for inpatient and most outpatient services provided to Medicare patients on a cost basis as defined and limited by the Medicare program. The Medicare program's administrative procedures allow final determination of amounts due to the District for such services three years after the District's cost reports are audited or otherwise reviewed and settled by the Medicare 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.

In July 2007, the District became the owner of the North Coast Family Health Center. North Coast Family Health Center is recognized by Medicare as a provider-based rural health clinic and is reimbursed on a cost-per-visit basis.

California Medicaid (Medi-Cal)

Payments for inpatient services rendered to Medi-Cal (non-managed care) patients were made based on reasonable costs through December 31, 2014. Effective January 1, 2015, the State of California's Medi-Cal program changed inpatient reimbursement to Diagnosis-Related Groups ("DRG"), similar to the Medicare inpatient payment methodology. Outpatient payments continue to be paid on pre-determined charge screens. The District is paid for cost-based inpatient services at an interim rate with final settlement determined after submission of annual cost reports and audits thereof by Medi-Cal. Medi-Cal rural health care clinic services are paid on a per patient services rate established by the State from a base-year cost report submitted by the District and audited by the State and are no longer subject to cost

reimbursement. Medi-Cal Home Health and managed care services are paid on pre-determined rates and are not subject to cost reimbursement.

Other Payors

The District has entered into payment agreements with certain commercial insurance carriers and preferred provider organizations, including Blue Cross, Blue Shield and United Health Care. The basis for payments to the District on these agreements is an average 30% discount off charges. The District has no HMO or risk-based contracts.

See "FACTORS AFFECTING HEALTH CARE DISTRICTS – Patient Services Revenues" in this Official Statement for a more detailed discussion of patient service revenues received from Medicare, Medicaid and other payors.

Health Facilities Utilization Statistics

The table below presents selected statistical indicators of inpatient and outpatient activity at the Hospital during the past three fiscal years ended June 30, 2014, 2015 and 2016.

	Fiscal Years Ended June 30,		
	2014	**2015**	**2016**
Licensed Beds*	49	49	49
Critical Access Licensed Beds	25	25	25
Admissions	1,188	1,278	1,065
Total Deliveries	141	126	99
Inpatient Days	4,494	4,790	4,507
Total Newborn Days	254	266	190
Average Length of Stay in Days	3.7	4.0	4.2
Emergency Visits	9,469	10,199	10,1530
OP Encounters	51,255	55,061	56,502
Clinic Visits	25,873	31,107	30,263
Home Health Visits	4,635	4,635	5,197

Source: The District.

* The Hospital is currently licensed for 49 beds but as a CM-1, uses only 25 licensed beds with 24 beds in suspense.

OUTSTANDING INDEBTEDNESS

As of the date hereof, the District has one general obligation bond issue and two revenue bond issues outstanding.

In 2001, the District issued current interest general obligation bonds in the aggregate principal amount of $4,615,000 and capital appreciation general obligation bonds in the aggregate principal amount of $884,627.75 (collectively, the "2001 Bonds"). Certain maturities of the 2001 Bonds are expected to be refunded with proceeds of the Bonds. See "PLAN OF REFUNDING" in the forepart of the Official Statement.

The District issued $5,000,000 in revenue bonds in 2009 (the "Series 2009 Bonds") that are insured by the Cal-Mortgage program and are currently outstanding in the aggregate principal amount of

$690,000. The final maturity of the Series 2009 Bonds is February 1, 2029. A portion of the Series 2009 Bonds was refunded and defeased with a portion of the proceeds of the Series 2016 Bonds, together with other available amounts.

The District issued $5,745,000 in revenue bonds in 2016 (the "Series 2016 Bonds") that are insured by the Cal-Mortgage program and are currently outstanding in the aggregate principal amount of $5,745,000. The final maturity of the Series 2016 Bonds is February 1, 2029.

The District expects to issue approximately $4.1 million of subordinate revenue bonds in January 2017.

The District borrowed funds in the amount of $2,100,000 from UHC of California, Inc. (the "UHC Note") secured by a deed of trust under a program established to finance certain EMR conversion and installation required by CMS. The note carries an interest rate of 4.0% and the principal payments are scheduled to coincide with both federal and State reimbursement payments to the District over the meaningful use program life.

In addition, the District borrowed a total of $1,005,806 from Cal-Mortgage to replace a line of credit with a bank in the amount of $1,000,000 during fiscal year ended June 30, 2013. This obligation is on a parity with the Series 2009 Bonds, the Series 2016 Subordinate Bonds and other Parity Debt that will remain outstanding after the issuance of the Series 2016 Subordinate Bonds. This was done to help facilitate the District's bankruptcy filing. The District has a note payable to CMS related to a settlement for a self-reported Stark Law violation. The settlement was for $400,000, carries interest at 5.0%, with principal and interest payments due monthly through 2018. The balance of the note payable to CMS was $126,303 at June 30, 2016.

FINANCIAL INFORMATION

The following is a summary of certain financial information of the District for each of the four fiscal years ended June 30, 2013, 2014, 2015 and 2016. This information has been derived from the audited financial statements of the District. These summaries should be read in conjunction with the audited financial statements for the fiscal years ended June 30, 2015 and 2016, and notes thereto included in Appendix B of this Official Statement.

The summaries of statements of revenue, expenses and changes in net assets 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.

Summary Statement of Revenue and Expenses

The following table sets forth a summary statement of revenues and expenses for the fiscal years indicated.

	Fiscal Years Ended June 30,		
	2013 (audited)	2014 (audited)	2015 (audited)
Operating Revenues:			
Net Patient Service Revenue	$42,937,651	$44,228,194	$45,353,121
Other Operating Revenue	801,241	382,780	1,927,929
Total Operating Revenues	$43,738,892	$44,610,974	$47,281,050
Operating Expenses:			
Salaries & Wages	$15,886,108	$14,346,253	$15,781,501
Employee Benefits	9,629,811	8,833,023	9,316,891
Registry	949,115	1,593,059	2,632,005
Professional Fees	6,111,179	6,150,027	7,289,015
Purchased Services	6,771,742	6,452,678	7,393,028
Supplies	1,378,305	1,424,145	1,498,363
Repairs & Maintenance	878,348	883,220	971,773
Utilities	650,951	758,496	740,714
Lease/Rental	977,799	490,845	632,403
Depreciation & Amortization	705,463	682,568	594,097
Insurance	1,836,350	2,458,665	2,535,214
Other Expense	1,177,467	897,719	1,932,544
Total Operating Expenses	$46,952,638	$44,970,698	$51,317,548
Operating Income (Loss)	(3,213,746)	(359,724)	(4,036,498)
Non-Operating Revenues:			
District Tax Revenues	1,136,279	1,121,434	1,116,211
Investment Income	15,830	11,111	11,599
Interest Expense	(844,742)	(897,002)	(789,383)
Grants and Contributions	361,277	668,287	298,207
Other Non-Operating Income (expenses		-	2,683
Total Non-Operating Revenue (expenses)	$ 668,644	$ 903,830	$ 639,317
Excess of Revenues (expenses)	-	544,106	(3,397,181)
Other increases in net position	(2,044,828)	476,801	1,588,546
Increase (decrease) in net position	(2,545,102)	1,020,907	(1,808,635)
Net position, beginning of the year	7,770,101	6,958,093	7,979,000
Net position, end of the year	$7,269,827	$7,979,000	$6,170,365

Source: Audited financial statements of the District for the fiscal years ended June 30, 2013, 2014 and 2015.

The following table sets forth a summary statement of revenues and expenses for Fiscal Year 2015-16. These figures are presented separately due to a change in the presentation of line items in the District's Fiscal Year 2015-16 audited financial statements.

	Fiscal Year Ended June 30, 2016 (audited)
Operating Revenues:	
Net Patient Service Revenue	$52,426,560
Medicare electronic health records incentive	594,082
Other Operating Revenue	835,729
Total Operating Revenues	$53,856,371
Operating Expenses:	
Salaries & Wages	$17,519,350
Employee Benefits	7,148,814
Professional Fees	6,920,688
Purchased Services	1,280,664
Registry	3,490,381
Supplies	8,222,292
Depreciation & Amortization	2,451,836
Repairs & Maintenance	1,134,240
Utilities	895,689
Lease/Rentals	594,937
Insurance	486,519
Other	1,595,393
Total Operating Expenses	$51,740,800
Operating Income (Loss)	2,115,571
Non-Operating Revenues:	
Taxation for debt service	1,228,283
Interest Expense	(888,393)
Contributions	340,300
Gain (loss) on disposal of capital assets	(12,207)
Total Non-Operating Revenue (expenses), net	$ 667,983
Excess of Revenues (expenses)	2,783,554
Gain on extinguishment of debt	573,744
Change in net position	3,357,298
Net position, beginning of the year	6,170,366
Net position, end of the year	$9,527,644

Source: Audited financial statements of the District for the fiscal year ended June 30, 2016.

Concentration of Credit Risk

The District grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of receivables from patient and third-party payors at June 30, 2013, 2014 and 2015, was as follows:

	Fiscal Years Ended June 30,		
	2013 audited	2014 (audited)	2015 (audited)
Medicare	$ 2,889,534	$ 3,174,192	$ 4,019,400
Medi-Cal	2,309,831	2,344,976	2,334,213
Commercial and Other Third-party Payors	3,104,932	3,444,343	2,916,943
Private Pay and Other	2,470,667	1,167,358	2,135,161
Total Gross Patient Accounts Receivable	$10,774,964	$10,130,869	$11,405,717
Less Allowances for contractual adjustments and bad debts	(7,420,000)	(6,875,000)	(7,568,248)
Net Patient Accounts Receivable	$3,354,964	$3,255,869	$3,837,469

Source: District's audited financial statements for the fiscal years ended June 30, 2013, 2014 and 2015.

The mix of receivables from patient and third-party payors at June 30, 2016, was as follows. These figures are presented separately due to a change in the presentation of line items in the District's June 30, 2016 audited financial statements.

	Fiscal Year Ended June 30, 2016 (audited)
Receivables from patients and their insurance carriers	$ 3,325,020
Receivables from Medicare	2,348,370
Receivables from Medi-Cal	1,061,809
Total Gross Patient Accounts Receivable	$ 6,735,199
Less allowance for uncollectible accounts	(1,309,418)
Patient Accounts Receivable, net	$5,425,781

Source: District's audited financial statements for the fiscal year ended June 30, 2016.

MISCELLANEOUS

Compliance Issues

Through its compliance program, the District identified certain situations that raised potential issues with respect to compliance with the strict requirements of the Stark Law and the corresponding regulations. The issues included missing signatures on agreements, operating under agreements after their stated expirations and other technical issues. The District's investigation showed little or no benefit to physicians and no inappropriate costs to any governmental entity as a result of these technical

violations. The District self-disclosed these issues to CMS in 2013, utilizing the Self-Referral Protocol issued by CMS in September 2010. As required by the Self-Referral Disclosure Protocol, the District informed CMS that the estimated value of the physician referrals potentially affected by the matters identified in the self-disclosure is approximately $11,555,000. Because there is little precedent with CMS's settlement of matters disclosed by hospitals under the Self-Referral Disclosure Protocol, the ultimate outcome was difficult to estimate. The District management negotiated aggressively with CMS and was able to reach a settlement in early 2015. CMS imposed a $210,000 fine for the self-disclosed non-compliance issues, payable in monthly installments through 2017 with interest at 5.0%. The amounts payable to CMS, including interest, in 2017 and 2018 are $81,271 and $56,645, respectively.

Insurance and Litigation

The District currently has property insurance through Alliant Insurance Services in the amount of $1,000,000,000 per occurrence, which includes certain specified coverage for structures (real property), contents (personal property) and business interruption. The District currently has general and professional liability insurance in the amount of $10,000,000 per claim and automobile liability insurance in the amount of $2,000,000 per accident through Beta Healthcare Group Risk Management Authority. The District also currently has a Flood Loss Limit policy in the amount of $15,000,000 per occurrence. The District also purchases policies covering directors' and officers' liability in amounts that the District believes to be customary for institutions of its size and character. The District has limited earthquake insurance. The insurance coverage the District currently has may change in the future.

It is not unusual for healthcare organizations to have multiple medical legal inquiries and claims in today's litigious environment. The District believes that it has ample insurance coverage that is appropriate for its size and scope of services. The District maintains a proactive risk management philosophy and vigorously defends itself against any medical legal claim.

At this time, the District has no pending or threatened litigation claims that are expected to be outside insurance coverage limits.

Investment Policies

The District's investments are made pursuant to a recently revised Board Investment Policy. The objective of the investment policy is to preserve investment principal, assure financial liquidity, and maximize investment income consistent with the need for safety of principal. The District invests only in fixed income securities of a quality that makes them readily liquid. Any securities transactions not specifically authorized by the Board Investment Policy are excluded, unless approved, in writing, by the Board. As of November 1, 2016, the District's cash on hand is invested in the Local Agency Investment Fund (LAIF), a money market fund established by the State of California, which allows local agencies to pool their investment resources. Pursuant to the Board Investment Policy, the District may also invest in U.S. Treasury Bills, U.S. Treasury Notes, U.S. Treasury Bonds, U.S. Government Agencies, certificates of deposit, mutual funds and money market mutual funds as expressly approved by the Board. Eligible investment alternatives for the District are also limited by California Government Code sections that allow only high-grade fixed income securities or fixed income securities collateralized up to 110% with government securities.

Charity Care

The District accepts all patients regardless of their ability to pay. A patient is classified as a charity patient by reference to certain established policies of the District. Essentially, these policies define charity services as those services for which no payment is anticipated. Because the District does not pursue collection of amounts determined to qualify as charity care, they are not reported as net patient

service revenues. Services provided are recorded as gross patient service revenues and then written off entirely as an adjustment to net patient service revenues.

FACTORS AFFECTING HEALTH CARE DISTRICTS

Certain factors which could have a material adverse effect on the financial condition and results of operations of the District are briefly summarized in general terms below, certain of which are explained in greater detail in subsequent sections. **However, prospective purchasers should note that the Bonds are general obligations of the District and payable from *ad valorem* taxes levied upon all property subject to taxation by the District, and are not obligations payable from the operating revenues of the District**.

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, Medi-Cal (the State's Medicaid program) and other payors and is subject to actions by, among others, the National Labor Relations Board, The Joint Commission, the Centers for Medicare & Medicaid Services ("CMS") of the U.S. Department of Health and Human Services ("DHHS"), 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 and amount of payments to the District by governmental and nongovernmental payors, the financial viability of these payors, increased competition from other health care entities, decreased demand for health care, changes in the methods by which employers purchase health care for employees, capability of management, changes in the structure of how health care is delivered and paid for, future changes in the economy, demographic changes, availability of physicians, nurses and other health care professionals, and malpractice claims and other litigation.

The District derives a significant portion of its revenues from Medicare, Medi-Cal and other third party payor programs. The District is subject to governmental regulations applicable to health care providers and the receipt of future revenues from the operation of the District's facilities is subject to, among other factors, federal and State policies affecting the health care industry and other conditions that are impossible to predict. Such conditions may include difficulties in increasing room charges and other fees while maintaining an appropriate amount and quality of health services, changes in reimbursement or prospective payment policies and unanticipated competition from other health care providers. The effect on the District of recently enacted laws and regulations and of future changes in federal and State laws and policies cannot be fully or accurately determined at this time.

For more than a decade, healthcare providers, including the District, have been under increasing economic pressure from various third party payors, both governmental (particularly Medicare and MediCal) and private (e.g., health maintenance organizations). Certain payors have pressured health care providers to accept "capitated" reimbursement, which has the effect of shifting the economic risk of providing healthcare from the payors to the health care providers. Shifts in third party payor policies and the need for providers to adapt to changing and complex payment arrangements have had and will continue to have a significant impact upon the economic performance of the District.

General Health Care Risk Factors

Certain of the primary risks associated with the operations of the health facilities are briefly summarized in general terms below, and are explained in greater detail in other sections of this Official Statement. The occurrence of one or more of these risks (or other risks not currently known to the District) could have a material adverse effect on the financial condition and results of operations of the District and, in turn, the ability of the District to make payments of principal of and interest on the Bonds.

Federal Health Care Reform and Deficit Reduction. The federal health care reform legislation has changed and will change how health care services are covered, delivered and reimbursed. These changes will result in lower hospital reimbursement from Medicare and Medi-Cal, utilization changes, increased government enforcement and the necessity for health care providers to assess, and potentially alter, their business strategies and practices, among other consequences. The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the "Affordable Care Act") dramatically altered the U.S. healthcare system and was intended to decrease the number of uninsured individuals and reduce the overall cost of healthcare. On November 8, 2016, Donald Trump was elected President of the United States. The Affordable Care Act continues to alter the U.S. healthcare system by decreasing the number of uninsured Americans and through its attempts to reduce the overall cost of healthcare. The Affordable Care Act attempts to achieve these goals by, among other things, requiring most Americans to obtain health insurance, providing additional funding for Medicaid in states that choose to expand their programs, reducing Medicare and Medicaid payments to providers, expanding the Medicare program's use of value-based purchasing programs, tying hospital payments to the satisfaction of certain quality criteria, bundling payments to hospitals and other providers, and instituting certain private health insurance reforms. The Affordable Care Act includes certain reductions in Medicare spending, such as negative adjustments to the hospital inpatient and outpatient prospective payment system market basket updates, the revision of annual inflation updates and other cost-containment measures, including planned payment reductions. While most providers will receive reduced payments for care, millions of previously uninsured Americans have gained, and will continue to gain, coverage. A number of the provisions of the Affordable Care Act that were originally scheduled to have already become effective, such as the employer mandate (for employers with 50 to 99 employees), the Small Business Health Option Program (for employers with 100 or fewer full-time employees), and the Cadillac Tax, were delayed until 2016 or later. Additional delays in the implementation of these or other provisions of the Affordable Care Act could be imposed in the future. The District is unable to predict with a high level of precision how providers, payors, employers and other market participants will continue to respond to the various reform provisions because certain provisions are scheduled for implementation over the coming years. Furthermore, several bills have been and may continue to be introduced in Congress to delay, defund or repeal implementation of or amend all significant provisions of the Affordable Care Act. In addition, efforts to reduce the federal deficit and balance the State budget will likely curb Medicare and Medi-Cal spending further to the detriment of providers. During his campaign, President-elect Donald Trump promised to repeal the Affordable Care Act. As a result of these factors and numerous other variables, including the law's complexity and the lack of complete implementing regulations and interpretive guidance, the District is unable to predict with any certainty the future net effect of the Affordable Care Act on its business, financial condition or results of operations or whether the Affordable Care Act may be repealed in whole or in part.

General Economic Conditions; Bad Debt, Indigent Care and Investment Losses. Health care 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 health care coverage or (3) private and public insurers seek to reduce payments to health care providers or curb utilization of health care services, health care 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 health care providers to increase free care. Furthermore, economic downturns and lower funding of 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 health care providers' uncollectible accounts, or "bad debt," uninsured, discounted and charity care 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 cause 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 health care providers. Philanthropic support may also decrease or be delayed.

Capital Needs vs. Capital Capacity. Hospital and other health care 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. 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 health care 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 health care choices based on such information.

Rate Pressure from Insurers and Major Purchasers. Certain health care 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 health care 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 health care 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 health care 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 health care 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 and abuse" in government funded health care programs is a significant concern of federal and state regulatory agencies overseeing health care 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, improper billing or coding, and other forms of "fraud" in the Medicare and Medicaid programs, as well as other state and federally-funded health care programs. This body of regulation impacts a broad spectrum of hospital and other health care 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 Carry Significant 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 health care 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 health care 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 and monitoring on health care providers. Such negotiated settlement terms may have a material adverse impact on hospital and other health care 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 health care industry. These risks are generally uninsured. Government enforcement and private whistleblower suits may increase in the hospital and health care sector. Many large hospital and other health care 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 health care reform is implemented, expanding Medicaid coverage to significant numbers of previously 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, any financial instability of the State may result in lower funding levels and/or payment delays. These could have a material adverse impact on California hospitals. See "Patient Service Revenues" below.

Professional Staff Shortages. From time to time, a shortage of certain physician specialties, nurses and medical technicians exists which may have a significant 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 health care practitioners to deliver care. Some studies predict that such shortages may be exacerbated in the future by decreased reimbursement

and inadequate support for medical education. In California regulation of nurse staffing ratios can intensify the potential shortage of nursing personnel. A new influx of patients with insurance coverage as a result of health care reform may also exacerbate personnel shortages. 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 on hospitals.

Labor Costs and Disruption. The delivery of health care services is labor intensive. Labor costs, including salary, benefits and other liabilities associated with the workforce, have significant impacts on hospital and health care provider operations and financial condition. Hospital and health care 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, employment recruitment efforts and reputation.

Pension and Benefit Funds. As large employers, hospitals 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. Hospitals may be affected by negative financial and liability impacts on physicians. Costs of insurance, including self-insurance, may increase dramatically.

Other 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 are highly dependent on the condition and functionality of their physical facilities. Damage from earthquakes, 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

The federal Bipartisan Budget Control Act of 2015 extends the 2 percent reduction in Medicare spending imposed by the federal Budget Control Act of 2011 ("BCA") through federal fiscal year 2025. It is possible that the U.S. Congress will take action to eliminate some or all of the reductions in the future and any Congressional action could be made retroactive to eliminate some or all of the cuts even to the extent they were imposed. However, there is no certainty that the U.S. Congress will take any action. Ultimately, these reductions or alternatives could have a disproportionate impact on hospital providers and could have a material adverse effect on the financial condition of the District.

It is possible that Congress will take action to eliminate some or all of the reductions in the future and any Congressional action could be made retroactive in order to eliminate some or all of the cuts even to the extent they were imposed. However, there is no certainty that Congress will take any action. Ultimately, these reductions or alternatives could have a disproportionate impact on hospital providers and could have a material adverse effect on the financial condition of the District.

Debt Limit Increase

The federal government has through legislation created a debt "ceiling" or limit on the amount of debt that may be issued by the United States Treasury. In the past several years, political disputes have arisen within the federal government in connection with discussions concerning the authorization for an increase in the federal debt ceiling. Any failure by Congress to increase the federal debt limit may impact the federal government's ability to incur additional debt, pay its existing debt instruments and to satisfy its obligations relating to the Medicare and Medicaid programs.

Management of the District is unable to determine at this time what impact any future failure to increase the federal debt limit may have on the operations and financial condition of the District, although such impact may be material. Additionally, the market price or marketability of the Bonds in the secondary market may be materially adversely impacted by any failure to increase the federal debt limit.

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, or those who qualify under the End Stage Renal Disease Program. 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. The District is certified to participate in the Medicare program.

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 Medicare program reimburses hospitals based on a fixed schedule of rates based on categories of treatments or conditions. These rates change over time and there is no assurance that these rates will cover the actual costs of providing services to Medicare patients. The Affordable Care Act institutes multiple mechanisms for reducing the rate of increase in the costs of the Medicare program, including the following:

Value-Based Purchasing Program. Beginning in federal fiscal year 2013, Medicare inpatient payments to hospitals have been determined, in part, based on a program under which value-based incentive payments are made in a fiscal year to hospitals that meet certain performance standards during that fiscal year. The program is funded through the reduction of hospital inpatient care payments by a specified percentage (progressing to 2% by federal fiscal year 2017) and then using the estimated total amount of those payment reductions to fund value-based incentive payments for hospitals that meet or exceed quality standards.

Market Basket Reductions. Generally, Medicare payment rates to hospitals are adjusted annually based on a "market basket" of estimated cost increases. In recent years, market basket adjustments for inpatient hospital care have averaged approximately two to four percent annually. The Affordable Care

Act calls for annual decreases in the "market basket" update amount reaching 0.2 percent in 2016 and progressing to 0.75 percent each year for federal fiscal years 2017 through 2019.

Market Productivity Adjustments. Beginning in federal fiscal year 2012 and thereafter, the Affordable Care Act provides for "market basket" adjustments based on overall national economic productivity statistics calculated by the Bureau of Labor Statistics. This adjustment is currently anticipated to result in an approximately one percent additional reduction to the "annual market basket" update.

Hospital Acquired Conditions Penalty. Beginning in federal fiscal year 2015, CMS began reducing payments by one percent for those Medicare inpatient payments to hospitals in the top quartile nationally for frequency of certain "hospital-acquired conditions".

Readmission Rate Penalty. Beginning in federal fiscal year 2013, Medicare inpatient payments to those hospitals with excess readmissions compared to the national average for three patient conditions (acute myocardial infarction, pneumonia and heart failure) are reduced based on the dollar value of that hospital's percentage of excess preventable Medicare readmissions within 30 days of discharge, for certain medical conditions. The maximum penalty was 1% in fiscal year 2013, increasing to 3% in fiscal year 2015 and for future years. In fiscal year 2015, CMS is expanding the patient conditions assessed for this penalty to include acute exacerbation of chronic obstructive pulmonary disease, elective total hip arthroplasty, and total knee arthroplasty.

Medicare/Medicaid DSH Payments. Beginning in federal fiscal year 2014, hospitals receiving supplemental disproportionate share or "DSH" payments from Medicare (i.e., those hospitals that care for a disproportionate share of low-income Medicare beneficiaries) began having their DSH payments reduced by 75 percent, although a portion of this reduction potentially can be offset by new, additional payments based on the volume of uninsured and uncompensated care provided by each such hospital. Separately, beginning in federal fiscal year 2017, Medicaid DSH allotments to each state will be reduced, based on a methodology to be determined by DHHS, accounting for statewide reductions in uninsured and uncompensated care.

Technological Capabilities. Components of the 2009 federal stimulus package, the American Recovery and Reinvestment Act ("ARRA"), provide for Medicare and Medicaid incentive payments that began in 2011 to hospital providers meeting designated deadlines for the installation and use of electronic health information systems. Hospitals were required to adopt and demonstrate "meaningful use" of electronic health information systems in order to maintain their existing Medicaid and Medicare reimbursement levels. The District has met the "meaningful use" requirements to date. If the District fails to meet the "meaningful use" requirements in future years, its Medicare reimbursements will be reduced. Future compliance will require continued investment in the District's information technology systems.

Physician Services. Physician services are reimbursed under the Medicare physician fee schedule. In April 2015, the President signed into law the Medicare Access and CHIP Reauthorization Act ("MACRA"), which provides for significant changes to how Medicare reimburses physician services. Among other things, MACRA repealed the longstanding Sustainable Growth Rate formula. In its place, MACRA provides that for services paid under the physician fee schedule and furnished during calendar years 2016 through 2019, Medicare's payment rates will increase by 0.5 percent per year over calendar year 2015. Beginning in 2019, amounts paid to physicians will be subject to adjustments through either the Merit-based Inceptive Payment System or the Advanced Alternative Payment Model track. Given the complexity of the law, that some implementing rules are still in development, and that the value-based payment mechanisms have yet to take effect, the District cannot determine the impact of MACRA at this time.

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

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

- the debt must be related to covered services and derived from deductible and coinsurance amounts;
- the provider must be able to establish that reasonable collection efforts were made;
- the debt was actually uncollectible when claimed as worthless; and
- sound business judgment established that there was no likelihood of recovery at any time in the future.

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

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 pre-determined 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 apportioned to Medicare patient use (including depreciation and interest) 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 District applicable to Medicare patient stays or will provide flexibility to meet changing capital needs.

Medicare Advantage. Hospitals also receive payments from private health plans under the Medicare Advantage program. The Affordable Care Act introduced significant changes to federal payments to Medicare Advantage plans. Payments to plans were frozen for fiscal year 2011, and thereafter have transitioned to benchmark payments tied to the level of fee-for-service spending in the applicable county. Over the long term, companies offering Medicare Advantage plans may respond to payment changes in different ways, some of which could adversely affect District.

Recovery Audit Contractor Program. CMS has implemented a Recovery Audit Contractor ("RAC") program on a nationwide basis pursuant to which CMS contracts with private contractors to conduct pre- and post-payment reviews to detect and correct improper payments in the fee-for-service Medicare program. The Affordable Care Act expanded 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. See "Medicare and Medicaid Audits" herein. Although the District has undergone RAC audits, and some of those audits have resulted in substantial adjustments, the District's management is not aware of a situation in which any future RAC audit, if conducted, and any resulting payments made by the District would materially adversely affect the financial condition of the District. However, in light of the complexity of the regulations relating to the Medicare program and the ongoing threat of audits, there can be no assurance that any audit would not affect the financial condition of the District.

The State selectively contracts with general acute care hospitals to provide inpatient services to Medi-Cal patients. The financial impact of selective contracting on a particular hospital depends upon a variety of factors such as the base contract rates, whether a hospital qualifies as a disproportionate share hospital, the availability of supplemental payments for private disproportionate share hospitals and an individual hospital's ability to control costs, Generally, such selective contracting is made on a negotiated per diem payment basis. Historically, such payment rates have not increased in direct relation to inflation, costs or other factors.

Hospital inpatient services are reimbursed based on All-Patient Refined Diagnosis Related Groups ("APR-DRGs"), which is a proprietary classification system for clinical conditions that is currently licensed and in use by many other state Medicaid programs. Under this payment method, the Department of Health Care Services ("DHCS") reimburses hospitals a fixed amount for each inpatient admission based on the APR-DRG for that admission, which DHCS assigns based on the diagnoses, procedures, patient age and discharge status submitted by the hospital on its claim form. The District is reimbursed by DHCS for inpatient care provided to traditional Medi-Cal beneficiaries (those not enrolled in Medi-Cal managed care plans).

Legislation enacted in 2010 directed DHCS to replace the prevailing reimbursement method for hospital inpatient services, which provided for per-diem payments, with reimbursement according to DRGs. Effective July 1, 2013, the DRG payment method replaced the prior reimbursement method. The DRG payment method is based on All-Patient Refined Diagnosis Related Groups ("APR-DRGs"), which is a proprietary classification system for clinical conditions that is currently licensed and in use by many other state Medicaid programs. Under the new payment method, DHCS will reimburse hospitals a fixed amount for each inpatient admission based on the APR-DRG for that admission, which DHCS will assign based on the diagnoses, procedures, patient age and discharge status submitted by the hospital on its claim form. As DHCS and hospitals gain experience with the new method, DHCS intends to make adjustment in certain circumstances. It is anticipated that some California hospitals will see decreases in Medi-Cal payments while other hospitals will receive increases.

The State is obligated to make contractual payments only to the extent the State legislature appropriates adequate funding. Except in areas of the State that have been excluded from contracting, a

general acute care hospital generally will not qualify for payment for non-emergency acute inpatient services rendered to a Medi-Cal beneficiary unless it is a contracting hospital. Typically, either party may terminate such contracts on 120 days' notice and the State may terminate without notice under certain circumstances. No assurances can be made that hospitals will be awarded Medi-Cal contracts or that any such contracts will reimburse hospitals for the cost of delivering services.

Significant Expansions to Medi-Cal following the Affordable Care Act. The State began implementation of its Section 1115 Medicaid Waiver Renewal demonstration project known as "Medi-Cal 2020" which is an extension of the demonstration project known as "California's Bridge to Reform." The extension allows California to extend its safety net care pool for five years in order to support the State's efforts towards the adoption of robust alternative payment methodologies and support better integration of care. Federal funding supports Medicaid program expansion. The federal government paid 100 percent of the costs for newly eligible adults through 2016 but gradually phases down to 90 percent by 2020.

By contrast, if the State or Federal government were to hereinafter reduce the scope of persons covered under the Medicaid program, by a reversal in the poverty level threshold required for eligibility or elimination of other groups of currently eligible California residents, such a contraction would increase the number of uninsured persons treated by health care providers and increase the risk of unreimbursed expenses.

Medicaid Payment Reductions. Payments made to health care providers under the Program are subject to change as a result of federal or state legislative and administrative actions, including changes in the methods for calculating payments, the amount of payments that will be made for covered services, the eligibility requirements for Medicaid coverage, and the types of services that will be covered under the program. Budget cuts and other federal or state legislation that reduce payments by government agencies could have an adverse effect on the District's financial position.

California Hospital Provider Fee. In 2009, the State legislature enacted the Medi-Cal Hospital Provider Rate Stabilization Act and the Quality Assurance Fee Act, which imposed a "quality assurance fee" (the ''Provider Fee") on California's general acute care hospitals, except for public hospitals and certain exempt hospitals. The Medi-Cal hospital provider fee is essentially a tax on hospitals to raise funds for provider payments. The proceeds are used to earn federal matching funds for Medi-Cal, and to increase Medi-Cal payments to hospitals. Under this program, some California hospitals receive more funding in increased Medi-Cal reimbursement than the quality assurance fees paid, while other California hospitals receive less money in Medi-Cal payments than the fees paid. The program is scheduled to end on January 1, 2018.

The District, as a non-designated public hospital in the State, is not subject to the Provider Fee according to the legislation, but does receive various supplemental funds through federal programs of matching funds administered by the State. In fiscal years 2015 and 2014, the District recognized net patient services revenues of approximately $250,000 and $175,000, respectively, in supplemental funding, including intergovernmental transfers and grants. The District cannot predict whether such payments will continue in the future. Any material reductions in these supplemental payments could have a material adverse effect on the District.

California State Budget. The State has in the past faced severe financial challenges, including erosion of general tax revenues, falling real estate values, slow economic growth and high unemployment. It is impossible to predict the impact of future financial challenges to the California economy, including threat of future recessions, historic drought problems, changes in federal spending policy and other events that could result in budget deficits. It is also impossible to predict what the State's budget will be in future years or the actions that the Governor, the State legislature or voters, via ballot initiative, will take in the

future. It is reasonable to expect, however, that the Governor and the State legislature will continue to pursue cost containment measures to keep the State's budget in balance, in part by aggressively managing the State's health care spending, which may have an adverse effect on the financial condition of the District.

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 utilization of or payment for health care services. Medicare and Medicaid also purchase health care using managed care options. Payments to health care 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 nongovernmental payment for hospital services. Hospitals 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 hospitals 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 on a fixed rate per day of care, or a fixed-rate per hospital stay, 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 could, in some cases, 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 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 hospitals are paid a predetermined periodic rate for each enrollee in the HMO who is "assigned" or otherwise directed to receive care from a particular hospital. The hospital may assume financial risk for the cost and scope of institutional care given. If payment is insufficient to meet the hospital's actual costs of care, or if utilization by such enrollees materially exceeds projections, the financial condition of the hospital could erode rapidly and significantly. In addition to this standard managed care risk sharing approach, private health insurance companies are increasingly adopting various additional risk sharing/cost containing measures, sometimes similar to those introduced by government payors. Providers may expect health care cost containment and its associated risk sharing to continue to increase in the coming years among all payors.

Often, HMO contracts are enforceable for a stated term, regardless of hospital losses and may require hospitals to care for enrollees for a certain time period, regardless of whether the HMO is able to pay the hospital. Hospitals 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 the District's market share and net patient services revenues. Conversely, participation may result in lower net income if participating hospitals 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 health care organizations face.

If health insurance premiums continue to increase, substantial numbers of employers may elect to discontinue employer-funded medical care for employees eligible for federal assistance in securing private insurance, and the employees could then choose health insurance under the health insurance exchanges. Individuals choosing their own coverage may be more highly price sensitive, which could increase the number of enrollees in HMO plans and increase the use of capitation, making price negotiations with HMO and other insurance plans more difficult.

For information concerning the managed care payments received by the District for the fiscal years ended June 30, 2014, 2015 and 2016, see "FINANCIAL INFORMATION – Sources of Patient Services Revenue" in this Appendix.

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"). The ICD-10 implementation deadline was October 1, 2015. 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. While the District has transitioned to ICD-10, the transition is not without risk as 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. There is a potential for revenue stream disruption for health care organizations and the magnitude of the transition within the industry may add pressure to health care organizations' cash flows. Health care 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.

Negative Rankings Based on Clinical Outcomes, Cost, Duality, 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 health care services provided by hospitals and providers. The Affordable Care Act shifts payments from paying for volume to paying for value, based on various health outcome measures. Published rankings such as the hospital Star Rating recently launched by CMS, "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 District. 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 a provider negatively may adversely affect its reputation and financial condition.

Increased 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 responsible 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. The District is occasionally the direct recipient of such awards, and the District receives payments for health care items and services under many of these grants as a subcontractor. The District is subject to complex and ambiguous coverage principles and rules governing billing for items or services it provides to patients participating in clinical trials funded by governmental agencies and private sponsors. The enforcement powers of agencies with oversight of clinical research range from substantial fines and penalties to exclusion of researchers and suspension or termination of entire research programs. Billing of the Medicare Program for experimental care provided to patients enrolled in clinical trials that is not eligible for Medicare reimbursement can subject the District to sanctions as well as repayment obligations.

Regulatory Environment

"Fraud" and "False Claims." Health care "fraud and abuse" laws at the federal and state levels broadly regulate providers of services to government program beneficiaries and the methods and requirements for submitting claims for services rendered. 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 including inaccurate billing information, billing for services deemed to be medically unnecessary, or billings accompanied by certain proscribed inducements 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 health care 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 or brought by private individuals, and more than one of the available sanctions may be, and often are, imposed for each violation. The Affordable Care Act 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.

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

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. A person may be charged with knowledge of the falsity of a claim based not only on actual knowledge but also based on deliberate ignorance or reckless disregard of the relevant facts. The FCA has become one of the federal government's primary weapons against health care fraud. Due to the broad range of conduct covered by the statute, FCA investigations and cases are common and may cover a range of activity from intentionally inflated billings, to highly technical billing infractions and to allegations of inadequate care. Damages under the FCA may include "treble damages" (i.e., damages up to three times the amount of the false claims) plus civil monetary penalties of up to $11,000 per false claim. As a result, violation or alleged violations of the FCA frequently result in settlements involving multi-million dollar payments and compliance 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. FCA violations or alleged violations could lead to settlements, fines, exclusion or reputation damage that could have a material adverse impact on hospitals and other health care providers.

Under the Affordable Care Act, the FCA has been expanded to include overpayments that are identified by a health care provider and not timely reported or refunded to the applicable federal health care program, even if the claims relating to the overpayment were initially submitted without any knowledge that they were false. This expansion of the FCA exposes hospitals and other health care providers to liability under the FCA for a considerably broader range of claims than in the past.

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 (or to induce a referral) for any item or service that is paid by any federal or state health care program. The Anti-Kickback Law potentially applies to many common health care transactions between persons and entities with which a hospital does business, including hospital-physician joint ventures, medical director arrangements, physician recruitments, physician office leases and other transactions with persons or entities in a position to provide federal health care program business to hospitals. The Affordable Care Act provides explicitly that a claim that includes items or services resulting from a violation of the Anti-Kickback Law constitutes a false or fraudulent claim for purposes of the FCA.

Violations or alleged violations of the Anti-Kickback Law may result in settlements that require multi-million dollar payments and onerous corporate integrity agreements. The Anti-Kickback Law can be prosecuted either criminally or civilly. A criminal violation may be prosecuted as a felony, subject to a fine of up to $25,000 for each act (which may be each item or each bill sent to a federal program), imprisonment and/or exclusion from the Medicare and Medicaid programs. In addition, civil monetary penalties of $10,000 per violation and an "assessment" of three times the amount claimed may be imposed. Violations of the Anti-Kickback Law are increasingly being prosecuted under the FCA, triggering the FCA penalties discussed above.

Stark Referral Law. The federal "Stark Law" 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 radiation therapy services, radiology and certain other imaging services) to entities with which the referring physician has a financial relationship unless that relationship fits within a Stark exception. It also prohibits a hospital furnishing the designated services from billing Medicare, or any other payor or individual 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 all technical requirements of an applicable exception are not satisfied, many ordinary business practices and economically desirable arrangements between hospitals and physicians, which constitute "financial relationships" within the meaning of the Stark Law, result in the prohibition on referrals and billing. Most providers of the designated health services with physician relationships have exposure to liability under the Stark Law.

Medicare may deny payment for all services performed based on 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 of the group for the duration of the lease; a potentially significant amount. As a result, even relatively minor, technical violations of the law may trigger substantial refund obligations. Moreover, if the violations of the Stark Law were knowing, the government may also seek civil monetary penalties of up to $15,000 per claim, and in some cases, a hospital may be excluded from the Medicare and Medicaid programs. In addition, violations of the Stark Law increasingly are being prosecuted under the FCA, triggering the FCA penalties discussed above. Potential repayments to CMS, settlements, fines or exclusion for a Stark violation or alleged violation could have a material adverse impact on a hospital.

CMS has established a voluntary self-disclosure program under which hospitals and other health care providers or suppliers may report potential Stark violations and seek a reduction in potential refund obligations. However, the program is relatively new and therefore it is difficult to determine at this point in time whether it will provide significant monetary relief to hospitals that discover inadvertent Stark Law violations. The District may make self-disclosures pursuant to this program as appropriate, and may make other disclosures from time to time.

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 the Stark Law). These prohibitions while similar in public policy and scope to the federal laws have not in all instances been avidly enforced to date. However, in the future they could pose the possibility of material adverse impact for the same reasons as the federal statutes. See discussion under the subheadings "– False Claims Act," "– Anti-Kickback Law" and "Stark Referral Law" above.

Civil Monetary Penalty Act. The federal Civil Monetary Penalty Act ("CMPA") provides for administrative sanctions against health care providers for a broad range of billing and other abuses. A health care provider is liable under the CMPA if it knowingly presents, or causes to be presented, improper claims for reimbursement under Medicare, Medicaid and other federal health care programs. A hospital that participates in arrangements known as "gainsharing" by paying a physician to limit or reduce services to Medicare fee-for-service beneficiaries also could be subject to CMPA penalties. A health care provider that provides benefits to Medicare or Medicaid beneficiaries that such provider knows or should know are likely to induce the beneficiaries to choose the provider for their care also could be subject to CMPA penalties. The CMPA authorizes imposition of a civil money penalty and treble damages. The Affordable Care Act also amended the CMPA laws to establish various new grounds for exclusion and civil monetary penalties, as well as increased penalty thresholds for existing civil monetary penalties.

Health care providers may be found liable under the CMPA even when they did not have actual knowledge of the impropriety of their action. Knowingly undertaking the action is sufficient. Ignorance of the Medicare regulations is no defense. The imposition of civil money penalties on a health care provider could have a material adverse impact on the provider's financial condition.

HIPAA, HITECH and Other Privacy and Security Requirements. The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act (the "HITECH ACT") addresses the confidentiality of individuals' health information. HIPAA requires the establishment of distinct privacy and security protections for individually identifiable health information maintained by health care providers, hospitals, health plans, health insurers and health care clearinghouses. Disclosure of certain broadly defined protected health information is prohibited unless expressly permitted under the provisions of HIPAA and related regulations or authorized by the patient. HIPAA's privacy and security provisions extend not only to patient medical records, but also to a wide variety of health care clinical and financial settings where patient privacy restrictions often impose new communication, operational, accounting and billing restrictions. Violations of the HIPAA privacy and security regulations may result in criminal penalties and a range of civil penalties of up to $50,000 per violation and a maximum civil penalty of $1.5 million for violations of the same requirement in a given calendar year. Increased enforcement efforts by the DHHS Office for Civil Rights is anticipated; Phase II of the Agency's HIPAA audit program is currently underway.

Additionally, certain provisions of the privacy and security regulations apply to business associates, which are entities that perform certain functions or activities on behalf of covered entities and pursuant to which require access to or the use or disclosure of protected health information. In certain

circumstances, a covered entity may he held liable for the actions of its business associate if DHHS determines an agency relationship exists between the covered entity and the business associate under federal law.

The District is also subject to California privacy laws. California medical privacy laws penalize unlawful access, use or disclosure of patient's medical information, as well as unauthorized access, which the laws define as the inappropriate viewing of patient medical information without the direct need for diagnosis, treatment or other lawful use. Administrative penalties may reach $250,000 per violation. Unlike HIPAA, the California Medical Privacy Act authorizes a private right of action and health care entities are exposed to the risk of individual or class action lawsuits from patients or other affected persons, in addition to government enforcement.

This framework of laws and regulations subjects the District to communication, operational, and accounting obligations that add costs and create potentially unanticipated sources of liability. 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 hospital's reputation and materially adversely affect business operations.

Audits, Compliance with Conditions of Participation and Exclusions from Medicare or Medicaid Participation. 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. Although required to identify both overpayments and underpayments, recovery audit contractors ("RACs") have in practice collected significantly more in overpayments from providers as compared to addressing underpayments to providers.

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.

The government may also exclude a hospital from Medicare/Medicaid program participation if it is convicted of a criminal offense relating to the delivery of any item or service reimbursed under Medicare or a state health care program, any criminal offense relating to patient neglect or abuse in connection with the delivery of health care, fraud against any federal, state or locally financed health care 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 health care in general or to participation in a federal, state or local government program. Exclusion from the Medicare/Medicaid program means that a hospital would be decertified from program participation and no program payments can be made. Any hospital exclusion could be a materially adverse event. In addition, exclusion of hospital employees under Medicare or Medicaid may be another source of potential liability for hospitals or health systems based on services provided by those excluded employees.

Business Associates. Under existing HIPAA regulations, covered entities must include certain required provisions in their contractual relationships with organizations that perform functions on their behalf which involve use or disclosure of protected health information. These organizations are called business associates, and have been indirectly regulated by HIPAA through those contractual obligations. The HITECH Act and the final rules promulgated thereunder provide that all of the HIPAA security administrative, physical, and technical safeguards, as well as security policies, procedures and documentation requirements now apply directly to all business associates, In addition, the HITECH Act makes certain privacy provisions directly applicable to business associates, These changes are significant because business associates will now be directly regulated by DHHS for those requirements, and as a result, will be subject to penalties imposed by DHHS and/or state attorneys general, Likewise, to the extent a business associate is deemed to be an agent of the covered entity under the Federal common law, the covered entity will be liable for the breaches of the business associate. Covered entities have had to review and amend their business associate agreements in recent years in order to comply with these changing rules, which can be costly and administratively burdensome.

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

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. Healthcare facilities, including those of the District, are subject to numerous legal, regulatory, professional and private licensing, certification and accreditation requirements. These include, but are not limited to, requirements relating to Medicare and Medi-Cal participation and payment, state licensing agencies and private payors. Renewal and continuation of certain of these licenses, certifications and accreditations are based on inspections, surveys, audits, investigations or other reviews, some of which may require or include affirmative activity or response by the District. These activities generally are conducted in the normal course of business of healthcare facilities. Nevertheless, an adverse result could cause a loss or reduction in the District's scope of licensure, certification or accreditation, could reduce the payment received, or could require repayment of amounts previously remitted to the provider.

Environmental Laws and Regulations. Health facilities 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.

Health care facilities 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 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 increase their cost; may

result in legal liability, damages, injunctions or fines; and may result in investigations, administrative proceedings, civil litigation, criminal prosecution, penalties or other governmental agency actions; and may not be covered by insurance.

Enforcement Activity. Enforcement activity against health care 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 health care 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 similar payments or to recover higher damages, assessments or penalties 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 hospital, regardless of outcome.

Certain acts or transactions may result in violation or alleged violation of a number of the federal health care fraud laws described above, and therefore penalties or settlement amounts often are compounded. Generally these risks are not covered by insurance. Enforcement actions may involve multiple hospitals or other facilities in a health system, as the government often extends enforcement actions regarding health care fraud to other entities in the same organization. Therefore, Medicare fraud related risks identified as being materially adverse as to a hospital could have materially adverse consequences for a health system taken as a whole.

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 health care is evolving, 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.

Business Relationships and Other Business Matters

Integrated Delivery Systems. Hospitals and health care systems often own, control or have affiliations with physician groups and independent practice associations. Generally, the sponsoring health facility or health system is 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 subsidies or other support from the related hospital or health system. 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 generally designed to respond to trends in the delivery of medicine to better integrate hospital and physician care, to increase physician availability to the community and/or to enhance the managed care capability of the affiliated hospitals and physicians. However, these goals may not be achieved, and an unsuccessful alliance may be costly and counterproductive to all of the above-stated goals.

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 health care delivery and reimbursement systems that are intended to restrain the rate of increases of health care costs, encourage coordinated care, promote collective provider accountability and improve clinical outcomes. The Affordable Care Act 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 health care providers to set standards, reduce costs and share savings, among other things. The ability of hospitals or health systems to conduct integrated physician operations may be altered or eliminated in the future by legal or regulatory interpretation or changes, or by health care fraud enforcement. In addition, participating physicians may seek to maintain their independence for a variety of reasons, thus putting the hospital or health system's investment at risk, and potentially reducing its managed care leverage and/or overall utilization. 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.

Health care providers, responding to health care reform and other industry pressures, are increasingly moving toward integrated delivery systems, managing the health of populations of individuals, patient-centered medical homes, bundled payments, and capitated insurance plans. These trends will require new competencies, including the appropriate mix of physician specialties, new administrative skills, close and aligned relationships between physicians and hospitals, insurance risk management, and new relationships between patients and providers. Providers may be unsuccessful in assembling successful integrated networks, fail to achieve savings sufficient to offset the substantial costs of creating and maintaining the necessary capabilities to support such developments, or otherwise could incur losses or damage reputations from assuming increased risk.

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 arc 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 and other health care facilities. CMS annually reviews overall physician reimbursement formulas for Medicare and Medicaid. Changes to physician compensation under these programs 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 and health systems may be required to invest additional resources in recruiting and retaining physicians, or may be compelled to affiliate with, and provide support to, physicians in order to continue serving the growing population base and maintain market share. The physician-to-population ratio in certain parts of the State is below the national average, and the shortage of physicians could become a significant issue for hospitals and health care systems in the State.

Competition Among Health Care Providers. Increased competition from a wide variety of sources, including specialty hospitals, other hospitals and health care systems, HMOs, inpatient and outpatient health care 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 away significant commercial outpatient services traditionally performed at hospitals. Commercial outpatient services, currently among the most profitable services 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 the significant reduction of profitable income. Competing ambulatory surgery centers, more likely for-profit businesses, 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 health care delivery may reduce utilization and revenues of the 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.

Action by Purchasers of Hospital Services and Consumers. Major purchasers of hospital services could take action to restrain hospital charges or charge increases. 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 health care providers to be transparent and provide information about cost and quality of services that may affect future consumer choices about where to receive health care services.

Employer Status. Hospitals are major employers with mixed technical and nontechnical workforces. Labor costs, including salary, benefits and other liabilities associated with a workforce, have significant impacts on hospital operations and financial condition. Developments affecting hospitals as major employers include: (i) imposing higher minimum or living wages; (ii) enhancing occupational health and safety standards; and (iii) 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, all of the District's employees are covered by collective bargaining agreements. See " GOVERNING BODY, DISTRICT MANAGEMENT AND STAFF – District Employees" in this Appendix.

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 class actions. For large employers such as hospitals, such class actions can involve multi-million dollar claims, judgments and settlements. Additionally, 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 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.

Health Care Worker Classification. Health care 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 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. In recent years, the health care industry has suffered from a scarcity of nursing personnel, respiratory therapists, pharmacists and other trained health care and information system technicians. In addition, aging medical staffs and difficulties in recruiting physicians are leading to 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. Competition for physicians and other health care professionals, coupled with increased recruiting and retention costs will increase hospital-operating costs, possibly significantly. This trend could have a material adverse impact on the financial condition and results of operations of hospitals and other health care facilities. This scarcity may further be intensified if utilization of health care services increases as a consequence of the Affordable Care Act's expansion of the number of insured consumers. As reimbursement amounts are

reduced to health care facilities and organizations that employ or contract with physicians, nurses and other health care professionals, pressure to control and possibly reduce wage and benefit costs may further strain the supply of those professionals.

California imposes mandatory nurse staffing ratios for all hospital patient care areas. The nurse to patient ratio standards increased as of January 1, 2008. It is possible that the State may take further action to regulate nurse to patient staffing and the impact on California hospitals will vary by department and facility, but the increased required staffing, in aggregate, could incur higher costs for hospitals.

Professional Liability Claims and General Liability Insurance. Professional and general liability suits and the dollar amounts of damage recoveries may have contributed to 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 health care providers. Insurance does not provide coverage for judgments of punitive damages; however, California District hospitals are not subject to punitive damages.

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 liability of the District 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 health care 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, HITECH and Other Privacy and Security Requirements" 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 health care 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 health care providers, which may increase the cost, complexity and risks of operations. All of these risks may have adverse consequences on hospitals and health care providers.

Access by Information Systems Vendors to Protected Health Information. The District relies on a number of outside vendors to supply applications and software used in its operations. Thus, in some instances, vendors have access to individually identifiable information that relates to the District's patients' past, present, or future physical or mental health, health care, or payment for health care, as defined at 45 CFR § 160.103 ("Protected Health Information"). Even though the District takes many precautions against the unauthorized use and disclosure of Protected Health Information by its vendors, including through the terms of its contracts and security requirements and through security audits and vulnerability assessments, it does not control the actions and practices of outside entities. In addition, despite the security measures the District has in place to ensure compliance with applicable laws and rules, its facilities and systems and those of its third-party service providers may be vulnerable to security breaches, acts of vandalism or theft, computer viruses, misplaced or lost data, programming and/or human errors or other similar events. Noncompliance with any privacy laws or any security breach involving the misappropriation, loss or other unauthorized use or disclosure of Protected Health Information or other personal information, whether by the District or by one of its vendors, could have a material adverse effect on the District's business, reputation and results of operations, and could result in any or all of the following: material fines and penalties; compensatory, special, punitive, and statutory damages; consent orders regarding privacy and security practices; and adverse actions against the District's licenses to do business.

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 and health systems involved. From a compliance standpoint, these types of financial relationships may raise federal and state "anti-kickback" and federal "Stark" issues (see "Regulatory Environment," above), as well as other legal and regulatory risks, and these could have a material adverse impact on hospitals.

Section 340B Drug Pricing Program. Hospitals that participate in the prescription drug discount program established under Section 340B of the federal Public Health Service Act (the "340B Program") are able to purchase certain outpatient drugs for their patients at reduced cost. The District currently participates in and receives discounts through the 340B Drug Discount Program.

The Health Resources and Services Administration ("HRSA") issued proposed 340B Program Omnibus Guidance on August 28, 2015 in the Federal Register (the "Proposed 340B Guidance"). The public comment period for the Proposed 340B Guidance ended on October 27, 2015. The Proposed 340B Guidance addresses key 340B policy issues, including eligibility and registration of hospitals and outpatient facilities, individuals eligible to receive 340B drugs, drugs eligible for purchase under the 340B Program, and prohibition of duplicate discounts. Over one year later, HRSA has yet to publish a final 340B Guidance document. If the Proposed 340B Guidance is implemented without change, it will likely materially decrease the discounts that the District will be able to receive under the 340B Program going forward, and may result in a material adverse effect.

Cybersecurity Risks. Despite the implementation of network security measures by the District, its information technology systems may be vulnerable to breaches, hacker attacks, computer viruses, physical or electronic break-ins and other similar events or issues. Such events or issues could lead to the inadvertent disclosure of protected health information or other confidential information or could have an adverse effect on the ability of the District to provide health care services.

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APPENDIX D

SERVICE AREA ECONOMY

The following information concerning the City of Fort Bragg (the "City") and Mendocino County (the "County") is included only for the purpose of supplying general information regarding the area of the City.

The City is located on the central coast of the County with a total area of approximately 2.8 square miles. The City was incorporated in 1889 and is governed by a five member City Council which provides governance over the City's services to a population of approximately 7,600 residents. Each Councilmember is elected at large and serves a four-year term. The Mayor is elected by the members of the City Council following the seating of new Councilmembers in even-numbered election years, and serves a two-year term.

The County was created in 1850 by the State Legislature and was one of the State's original 27 counties. The County spans an area of over 2 million acres and its coastline runs about 100 miles. The County is located on the north coast of the U.S. state of California. The County is legislatively governed by a board of five supervisions, each with a separate district. The County has nine Indian reservations lying within its borders, the fourth most of any county in the United States (after San Diego County, California; Sandoval County, New Mexico; and Riverside County, California).

Population

Population figures as reported by the State of California Department of Finance for the years 2012 through 2016 for the City, the County and the State are as follows:

	City of Fort Bragg	County of Mendocino	State of California
2012	7,367	87,436	37,881,357
2013	7,556	87,634	38,239,207
2014	7,564	88,177	38,567,459
2015	7,633	88,163	38,907,642
2016	7,672	88,378	39,255,883

(1) As of January 1 of each year.
Source: State of California, Department of Finance.

Industry and Employment

In 2015, the total civilian labor force for the County was 40,210. Unemployment for the same area averaged 5.9% while the State during the same period averaged 6.2%. The following summarizes civilian labor force data for the City, the County and the State for 2011 through 2015 (annual average):

CITY OF FORT BRAGG, COUNTY OF MENDOCINO AND STATE OF CALIFORNIA
Annual Average Civilian Labor Force, Civilian Employment, Civilian Unemployment, and Civilian Unemployment Rate

Years and Area	Labor Force	Employment	Unemployed	Unemployment Rate[1]
2011				
City of Fort Bragg	3,590	3,270	320	9.0
Mendocino County	40,950	36,280	4,670	11.4
California	18,415,102	16,258,100	2,157,000	11.7
2012				
City of Fort Bragg	3,610	3,320	280	7.9
Mendocino County	41,020	36,900	4,120	10.0
California	18,551,400	16,627,800	1,923,600	10.4
2013				
City of Fort Bragg	3,620	3,380	240	6.5
Mendocino County	40,940	37,320	3,420	8.4
California	18,670,100	17,001,000	1,669,000	8.9
2014				
City of Fort Bragg	3,600	3,410	200	7.9
Mendocino County	40,620	37,780	2,840	7.0
California	18,287,900	17,418,000	1,409,900	7.5
2015				
City of Fort Bragg	3,370	3,410	160	4.5
Mendocino County	40,210	37,850	2,350	5.9
California	18,981,800	17,798,600	1,183,200	6.2

[1] Unemployment rate is based on unrounded data. Not seasonally adjusted.
Sources: California State Employment Development Department.

The following tables show the annual average industry employment for the County between 2011 and 2015.

COUNTY OF MENDOCINO, CALIFORNIA
Annual Average Industry Employment
2011-2015[1]

Industry	2011	2012	2013	2014	2015
Agriculture	1,510	1,530	1,500	1,530	1,460
Mining and Logging	250	300	310	330	310
Construction	930	960	950	990	1,010
Manufacturing	2,230	2,330	2,420	2,490	2,520
Wholesale Trade	690	720	810	830	730
Retail Trade	4,310	4,360	4,350	4,380	4,620
Transportation, Warehousing and Utilities	580	610	650	650	680
Information	310	290	280	270	260
Financial Activities	1,080	1,040	1,060	1,050	1,040
Professional and Business Services	1,800	1,700	1,700	1,660	1,670
Educational and Health Services	4,640	5,060	5,690	5,570	5,490
Leisure and Hospitality	3,590	3,690	4,180	4,230	4,250
Other Services	730	750	760	770	780
Federal Government	290	290	330	260	270
State Government	500	520	540	560	590
Local Government	6,260	6,120	6,140	6,200	6,290
Total All Industries[1]	29,460	30,540	31,440	31,750	31,950

[1] Totals may not add due to independent rounding.
Source: California Employment Development Department

Major Employers

The following table sets forth the 25 major employers for in the County for 2015 in alphabetical order. The number of employees employed by each employer listed below is not readily available.

Employer's Name	Industry
City of Ukiah	Government Offices-City, Village & Twp.
Coyote Valley Casino	Casinos
Dharma Realm Buddhist Assn	Associations
Fetzer Vineyards	Wineries (mfrs.)
Forestry & Fire Protection	Government Offices-State
Frank R Howard Memorial Hosp.	Hospitals
Hopland Sho Ka Wah Casino	Casinos
Mendocino Coast District Hosp.	Hospitals
Mendocino College	Schools-Universities & Colleges Academic
Mendocino Community Health	Clinics
Mendocino County Food Stamps	Government Offices-County
Mendocino County Office-Edctn	Government Offices-County
Mendocino County Sheriff	Government Offices-County
Mendocino County Sheriff's Dept.	Government Offices-County
Mendocino County Social Svc	Government Offices-County
Mendocino Redwood Co LLC	Nonclassified Establishments
Raley's	Grocers-Retail
Redwood Empire Packing Inc.	Fruits & Vegetables-Growers & Shippers
Safeway	Grocers-Retail
Trinity Youth Svc	Religious Schools
Ukiah Campus	Schools-Universities & Colleges Academic
Ukiah City Civic Ctr.	Government Offices-City, Village & Twp.
Ukiah High School	Schools
Ukiah Valley Medical Ctr.	Hospitals
Walmart	Department Stores

Source: State of California, Employment Development Department

Commercial Activity

The table below sets forth taxable sales in the County for 2010 through 2014. Annual figures for 2015 are not available. Total taxable sales during calendar year 2014 in the County were reported to be $1,333,741, a 2.26% increase over the total taxable sales of $1,304,197 reported during calendar year 2013.

MENDOCINO COUNTY
Taxable Retail Sales
Number of Permits and Valuation of Taxable Transactions
(Dollars in Thousands)

	Retail Stores		Total All Outlets	
	Number of Permits	Taxable Transactions	Number of Permits	Taxable Transactions
2010	2,539	$824,000	3,705	$1,075,810
2011	2,468	882,347	3,616	1,158,893
2012	2,537	930,163	3,616	1,216,736
2013	2,583	976,583	3,674	1,304,197
2014	2,623	996,040	3,732	1,333,741

Source: State of Equalization. Taxable Sales in California (Sales & Use Tax)

Transportation

U.S. 101, which connects San Francisco and northern coastal points, traverses the County's inland valleys. Route I, designated a "scenic highway" by the State, follows the coastline through Point Arena and Fort Bragg. Routes 20 and 129 connect the coastal areas with interior points.

Rail service through the County is provided by Northern Pacific Railroad Company (Southern Pacific) and the California Western Railroad, which operates the “Skunk Train” from Fort Bragg to Willits. A tourist attraction, the train also carries milled timber.

Mendocino Transit Authority and Greyhound Bus Lines serve both inland and coastal communities. Greyhound operates scheduled passenger service and the city is also served by several major truck lines. Ukiah operates a Municipal Airport with a 5,000 foot runway that provides charter service, plane rentals and agricultural services. Noyo Harbor, near Fort Bragg, can accommodate vessels up to a nine-foot draft and is a center of both commercial and sport fishing.

Education

Mendocino College is a part of the California Community College System and provides a variety of curricula and programs, including academic preparation for the California State University and University of California systems, vocational education, community extension and numerous specialized professional preparation programs.

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APPENDIX E

FORM OF CONTINUING DISCLOSURE CERTIFICATE

This CONTINUING DISCLOSURE CERTIFICATE (this "Disclosure Certificate") is executed and delivered by the Mendocino Coast Health Care District (the "District") in connection with the issuance of $4,125,000 aggregate principal amount of the District's Election of 2000 General Obligation Refunding Bonds, Series 2016 (the "Bonds"). The Bonds are being issued pursuant to a Resolution adopted by the Board of Directors of the District on November 3, 2016 (the "Resolution"). Capitalized terms used but not defined herein shall have the meanings ascribed thereto in the Resolution.

In consideration of the execution and delivery of the Bonds by the District and the purchase of such Bonds by the Underwriter described below, the District hereby covenants and agrees as follows:

SECTION 1. Purpose of the Disclosure Certificate. This Disclosure Certificate is being executed and delivered by the District for the benefit of the Bondholders and in order to assist William Blair & Company, LLC (the "Underwriter") in complying with Rule 15c2-12 (the "Rule") adopted by the Securities and Exchange Commission under the Securities Exchange Act of 1934, as amended.

SECTION 2. Additional Definitions. In addition to the above definitions and the definitions set forth in the Resolution, 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 4 and 5 of this Disclosure Certificate.

"Annual Report Date" means the date that is not later than 270 days after the end of the District's fiscal year (which currently ends on June 30).

"Bondholder" or "Holder" means any holder of the Bonds or any beneficial owner of the Bonds so long as they are immobilized with DTC.

"Business Day" shall mean any day on which the District is not required or authorized to be closed.

"Designated Material Event" means any of the events listed in Section 6(a) of this Disclosure Certificate.

"Dissemination Agent" shall mean any Dissemination Agent, or any alternate or successor Dissemination Agent, designated in writing by the President and Chief Executive Officer (or otherwise by the District), which Agent has evidenced its acceptance in writing. Initially, the Dissemination Agent shall be Willdan Financial Services.

"EMMA System" shall mean the MSRB's Electronic Municipal Market Access system, which can be found at www.emma.msrb.org, or any other repository of disclosure information that may be designated by the Securities and Exchange Commission in the future.

"MSRB" shall mean the Municipal Securities Rulemaking Board.

"State" shall mean the State of California.

SECTION 3. CUSIP® Numbers and Final Official Statement. The CUSIP Numbers for the Bonds have been assigned. The Final Official Statement relating to the Bonds is dated November 18, 2016, 2016 ("Final Official Statement").

SECTION 4. Provision of Annual Reports.

(a) The District shall cause the Dissemination Agent, not later than the Annual Report Date, commencing with the report for the Fiscal Year ending June 30, 2016, to provide to the MSRB through the EMMA System an Annual Report which is consistent with the requirements of Section 5 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 5 of this Disclosure Certificate; provided that the audited financial statements of the District may be submitted, when and if available, separately from the balance of the relevant Annual Report.

(b) If the District is unable to provide to the MSRB through the EMMA System an Annual Report by the date required in paragraph (a) above, the District shall send a notice to the MSRB through the EMMA System in substantially the form attached as Exhibit A.

(c) The Dissemination Agent shall:

(i) determine each year prior to the Annual Report Date the electronic filing requirements of the MSRB for the Annual Reports; and

(ii) if the Dissemination Agent is other than the District or an official of the District, the Dissemination Agent shall 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 and confirming that it has been filed with the MSRB through the EMMA System.

SECTION 5. Content of Annual Report. The District's Annual Report shall contain or incorporate by reference the following:

(a) Financial information including the general purpose financial statements of the District for the preceding Fiscal Year, prepared in conformity with generally accepted accounting principles as prescribed by the Governmental Accounting Standards Board and the American Institute of Certified Public Accountants. If audited financial information is not available by the time the Annual Report is required to be filed pursuant to Section 4(a) hereof, the financial information included in the Annual Report may be unaudited, and the District will provide audited financial information to the EMMA System as soon as practical after it has been made available to the District.

(b) Operating data, including the following information with respect to the District's preceding Fiscal Year (to the extent not included in the audited financial statements described in paragraph (a) above):

(i) Outstanding indebtedness and lease obligations;

(ii) General fund budget and actual results;

(iii) Assessed valuations;

(iv) Tax levies and delinquencies; provided that information pertaining to delinquencies will only need to be provided if the County of Mendoncino discontinues the Teeter Plan; and

(v) Top twenty largest local secured taxpayers

(c) Any or all of the items listed above may be incorporated by reference from other documents, including official statements of debt issues of the District or related public entities, which have been submitted to the EMMA System or to the Securities and Exchange Commission. If the document incorporated by reference is a final official statement, it must be available from the MSRB. The District shall clearly identify each other document so incorporated by reference.

SECTION 6. Reporting of Significant Events.

(a) The District agrees to provide or cause to be provided to the MSRB notice of the occurrence of any of the following events with respect to the Bonds not later than ten (10) Business Days after the occurrence of the event:

(i) Principal and interest payment delinquencies;

(ii) Unscheduled draws on any debt service reserves reflecting financial difficulties;

(iii) Unscheduled draws on any credit enhancements reflecting financial difficulties;

(iv) Substitution of or failure to perform by any credit provider;

(v) Issuance by the Internal Revenue Service of an adverse tax opinion, a proposed or final determination of taxability or of a Notice of Proposed Issue (IRS Form 5701 TEB), or other material notices or determinations with respect to the tax status of the Bonds, or other events affecting the tax status of the Bonds;

(vi) Tender offers;

(vii) Defeasances;

(viii) Rating changes; and

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

For purposes of item (ix) above, the described event shall be deemed to occur when any of the following shall occur: the appointment of a receiver, fiscal agent or similar officer for the District in a proceeding under the United States Bankruptcy Code or in any other proceeding under state or federal law in which a court or governmental authority has assumed jurisdiction over substantially all of the assets or business of the District, or if such jurisdiction has been assumed by leaving the existing governing body and officials or officers in possession but subject to the supervision and orders of a court or other governmental authority, or the entry of an order confirming a plan of reorganization, arrangement or liquidation by a court or governmental authority have supervision or jurisdiction over substantially all of the assets or business of the District.

(b) 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, not later than ten (10) Business Days after the occurrence of the event:

(i) Modifications of rights to Bondholders;

(ii) Bond calls;

(iii) Release, substitution or sale of property securing repayment of the Bonds;

(iv) Non-payment related defaults;

(v) 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; or

(vi) Appointment of a successor or additional Paying Agent or the change of name of a Paying Agent.

(c) The District shall give, or cause to be given, in a timely manner, notice of a failure to provide the annual financial information on or before the date specified in Section 4 hereof, as provided in Section 4(b) hereof.

(d) Upon the occurrence of an event described in Section 6(a) hereof, or if the District determines that knowledge of an event described in Section 6(b) hereof would be material under applicable federal securities laws, the District shall within ten (10) Business Days of occurrence of such event file a notice of such occurrence with the MSRB in electronic format, accompanied by such identifying information as is prescribed by the MSRB. Notwithstanding the foregoing, notice of an event described in subsection (a)(vii) or an event described in subsection (b)(iii) need not be given under this subsection any earlier than the notice (if any) of the underlying event is given to Holders of affected Bonds pursuant to the Resolution.

SECTION 7. Termination of Reporting Obligation. The District's obligations under this Disclosure Certificate shall terminate when the District is no longer an obligated person with respect to the Bonds, as provided in the Rule, upon the defeasance, prior redemption or payment in full of all of the Bonds.

SECTION 8. Dissemination Agent. The District may, from time to time, appoint or engage an alternate or successor Dissemination Agent to assist in carrying out the District's obligations under this Disclosure Certificate, and may discharge any such Dissemination Agent, with or without appointing a successor Dissemination Agent.

The Dissemination Agent shall be entitled to the protections, limitations from liability, immunities and indemnities provided to the Paying Agent as set forth in the Resolution which are incorporated by reference herein. The Dissemination Agent agrees to perform only those duties of the Dissemination Agent specifically set forth in the Agreement, and no implied duties, covenants or obligations shall be read into this Agreement against the Dissemination Agent.

The Dissemination Agent shall have no duty or obligation to review the Annual Report nor shall the Dissemination Agent be responsible for filing any Annual Report not provided to it by the District in a timely manner in a form suitable for filing. In accepting the appointment under this Agreement, the Dissemination Agent is not acting in a fiduciary capacity to the registered holders or beneficial owners of the Bonds, the District, or any other party or person.

The Dissemination Agent may consult with counsel of its choice and shall be protected in any action taken or not taken by it in accordance with the advice or opinion of such counsel. No provision of this Agreement shall require the Dissemination Agent to risk or advance or expend its own funds or incur any financial liability. The Dissemination Agent shall have the right to resign from its duties as Dissemination Agent under this Agreement upon thirty days' written notice to the District. The Dissemination Agent shall be entitled to compensation for its services as Dissemination Agent and reimbursement for its out-of-pocket expenses, attorney's fees, costs and advances made or incurred in the performance of its duties under this Agreement in accordance with its written fee schedule provided to the District, as such fee schedule may be amended from time to time in writing. The District agrees to indemnify and hold the Dissemination Agent harmless from and against any cost, claim, expense, or liability related to or arising from the acceptance of and performance of the duties of the Dissemination Agent hereunder, provided the Dissemination Agent shall not be indemnified to the extent of its willful misconduct or negligence. The obligations of the District under this Section shall survive the termination or discharge of this Agreement and the Bonds.

SECTION 9. Amendment. Notwithstanding any other provision of this Disclosure Certificate, the District may amend this Disclosure Certificate under the following conditions, provided no amendment to this Agreement shall be made that affects the rights, duties or obligations of the Dissemination Agent without its written consent:

(a) The amendment may be made only 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 the obligated person, or type of business conducted;

(b) This Disclosure Certificate, as amended, would have complied with the requirements of the Rule at the time of the primary offering of the Bonds, after taking into account any amendments or interpretations of the Rule, as well as any change in circumstances; and

© The amendment does not materially impair the interests of Holders, as determined either by parties unaffiliated with the District or another obligated person (such as Bond Counsel) or by the written approval of the Bondholders; provided, that the Annual Report containing the amended operating data or financial information shall explain, in narrative form, the reasons for the amendment and the impact of the change in the type of operating data or financial information being provided.

SECTION 10. Additional Information. If the District chooses to include any information from any document or notice of occurrence of a Designated Material Event or a Material 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 to include it in any future disclosure or notice of occurrence of a Designated Material Event or Material Event.

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 Designated Material Event or Material Event, in addition to that which is required by this Disclosure Certificate.

SECTION 11. Default. The District shall give notice to the MSRB through the EMMA System of any failure to provide the Annual Report when the same is due hereunder, which notice shall be given prior to July 1 of that year. In the event of a failure of the District to comply with any provision of this Disclosure Certificate, any Bondholder 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. A default under this Disclosure Certificate shall not be deemed an event of default under the Resolution, and 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. Beneficiaries. This Disclosure Certificate shall inure solely to the benefit of the District, the Dissemination Agent, the Underwriter and Holders from time to time of the Bonds, and shall create no rights in any other person or entity.

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SECTION 13. Governing Law. This Disclosure Certificate shall be governed by the laws of the State, applicable to contracts made and performed in such State.

Dated: December 15, 2016

MENDOCINO COAST HEALTH CARE DISTRICT

By:_____
Chief Executive Officer

AGREED AND ACCEPTED:

WILLDAN FINANCIAL SERVICES,
as Dissemination Agent

By:_____
Authorized Officer

EXHIBIT A

NOTICE TO REPOSITORIES OF FAILURE TO FILE ANNUAL REPORT

Name of Issuer: Mendocino Coast Health Care District

Name of Issue: $4,125,000 Election of 2000 General Obligation Refunding Bonds, Series 2016

Date of Issuance: December 15, 2016

NOTICE IS HEREBY GIVEN that the above-named Issuer has not provided an Annual Report with respect to the above-named Bonds as required by Section 4(a) of the Continuing Disclosure Certificate dated December 15, 2016. The Issuer anticipates that the Annual Report will be filed by _____.

Dated: _____

ISSUER/DISSEMINATION AGENT

By: _____

APPENDIX F

BOOK ENTRY-ONLY SYSTEM

The information in this section concerning DTC and DTC's book-entry system has been obtained from sources that the District believes to be reliable, but the District takes no responsibility for the accuracy or completeness thereof. The District cannot and does not give any assurances that DTC, DTC Participants or Indirect Participants will distribute to the Beneficial Owners (a) payments of interest, principal or premium, if any, with respect to the Bonds, (b) Bonds representing ownership interest in or other confirmation or ownership interest in the Bonds, or (c) prepayment or other notices sent to DTC or Cede & Co., its nominee, as the registered owner of the Bonds, or that they will so do on a timely basis or that DTC, DTC Participants or DTC Indirect Participants will act in the manner described in this Official Statement. The current "Rules" applicable to DTC are on file with the Securities and Exchange Commission and the current "Procedure" of DTC to be followed in dealing with DTC Participants are on file with DTC.

General

The Depository Trust Company ("DTC"), New York, New York, will act as securities depository for the Bonds. The Bonds will be issued as fully-registered securities 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 of the Bonds, in the aggregate principal amount of such maturity, and will be deposited with DTC.

DTC, the world's largest securities 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 asset 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 certificates. 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 is rated "AA+" by Standard & Poor's. The DTC Rules applicable to its Participants are on file with the Securities and Exchange Commission. More information about DTC can be found at www.dtcc.com. The foregoing internet address is included for reference only, and the information on such internet site is not incorporated by reference herein.

Purchases of 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 and Indirect

Participants' records. Beneficial Owners will not receive written confirmation from DTC of their purchase. Beneficial Owners are, however, expected to receive written confirmations providing details of the transaction, as well as periodic statements of their holdings, from the Direct 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 Direct and Indirect Participants acting on behalf of Beneficial Owners. Beneficial Owners will not receive certificates representing their ownership interests in 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 Bonds with DTC and their registration in the name of Cede & Co. or such other DTC 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 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.

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

Neither DTC nor Cede & Co. (nor any other DTC nominee) will consent or vote with respect to Bonds unless authorized by a Direct Participant in accordance with DTC's MMI Procedures. Under its usual procedures, DTC mails an Omnibus Proxy to the District (or the Paying Agent on behalf thereof) 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 Bonds are credited on the Record Date (identified in a listing attached to the Omnibus Proxy).

Principal, Maturity Amount, premium, if any, and interest payments on 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 District or Paying Agent, on payable date in accordance with their respective holdings shown on DTC's records. Payments by 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 Participant and not of DTC nor its nominee, Paying Agent, or the District, subject to any statutory or regulatory requirements as may be in effect from time to time. Payment of principal, Maturity Amount, premium, if any, and interest payments to Cede & Co. (or such other nominee as may be requested by an authorized representative of DTC) is the responsibility of the District or Paying Agent, disbursement of such payments to Direct Participants will be the responsibility of DTC, and disbursement of such payments to the Beneficial Owners will be the responsibility of Direct and Indirect Participants.

DTC may discontinue providing its services as depository with respect to the Bonds at any time by giving reasonable notice to the District or Paying Agent. Under such circumstances, in the event that a successor depository is not obtained, 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).Discontinuance of use of the system of book-entry transfers through DTC may require the approval of DTC Participants under DTC's operational arrangements. In that event, printed certificates for the Bonds will be printed and delivered.

The information in this section concerning DTC and DTC's book-entry system has been obtained from sources that the District believes to be reliable, but the District takes no responsibility for the accuracy thereof.

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APPENDIX G

SPECIMEN FINANCIAL GUARANTY INSURANCE POLICY

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FINANCIAL GUARANTY INSURANCE POLICY
National Public Finance Guarantee Corporation
Purchase, New York 10577

Policy No. [POLICY #]

National Public Finance Guarantee Corporation (the "Insurer"), in consideration of the payment of the premium and subject to the terms of this policy, hereby unconditionally and irrevocably guarantees to any owner, as hereinafter defined, of the following described obligations, the full and complete payment required to be made by or on behalf of the Issuer to [PAYING AGENT], [PAYING AGENT CITY & STATE] or its successor (the "Paying Agent") of an amount equal to (i) the principal of (either at the stated maturity or by any advancement of maturity pursuant to a mandatory sinking fund payment) and interest on, the Obligations (as that term is defined below) as such payments shall become due but shall not be so paid (except that in the event of any acceleration of the due date of such principal by reason of mandatory or optional redemption or acceleration resulting from default or otherwise, other than any advancement of maturity pursuant to a mandatory sinking fund payment, the payments guaranteed hereby shall be made in such amounts and at such times as such payments of principal would have been due had there not been any such acceleration); and (ii) the reimbursement of any such payment which is subsequently recovered from any owner pursuant to a final judgment by a court of competent jurisdiction that such payment constitutes an avoidable preference to such owner within the meaning of any applicable bankruptcy law. The amounts referred to in clauses (i) and (ii) of the preceding sentence shall be referred to herein collectively as the "Insured Amounts." "Obligations" shall mean:

[PAR AMOUNT]
[FIRST LINE OF LEGAL TITLE]
[SECOND LINE OF LEGAL TITLE]
[THIRD LINE OF LEGAL TITLE]
[FOURTH LINE OF LEGAL TITLE]

Upon receipt of telephonic or telegraphic notice, such notice subsequently confirmed in writing by registered or certified mail, or upon receipt of written notice by registered or certified mail, by the Insurer from the Paying Agent or any owner of an Obligation the payment of an Insured Amount for which is then due, that such required payment has not been made, the Insurer on the due date of such payment or within one business day after receipt of notice of such nonpayment, whichever is later, will make a deposit of funds, in an account with U.S. Bank Trust National Association, in New York, New York, or its successor, sufficient for the payment of any such Insured Amounts which are then due. Upon presentment and surrender of such Obligations or presentment of such other proof of ownership of the Obligations, together with any appropriate instruments of assignment to evidence the assignment of the Insured Amounts due on the Obligations as are paid by the Insurer, and appropriate instruments to effect the appointment of the Insurer as agent for such owners of the Obligations in any legal proceeding related to payment of Insured Amounts on the Obligations, such instruments being in a form satisfactory to U.S. Bank Trust National Association, U.S. Bank Trust National Association shall disburse to such owners, or the Paying Agent payment of the Insured Amounts due on such Obligations, less any amount held by the Paying Agent for the payment of such Insured Amounts and legally available therefor. This policy does not insure against loss of any prepayment premium which may at any time be payable with respect to any Obligation.

As used herein, the term "owner" shall mean the registered owner of any Obligation as indicated in the books maintained by the Paying Agent, the Issuer, or any designee of the Issuer for such purpose. The term owner shall not include the Issuer or any party whose agreement with the Issuer constitutes the underlying security for the Obligations.

Any service of process on the Insurer may be made to the Insurer at its offices located at 1 Manhattanville Road, Suite 301, Purchase, New York 10577 and such service of process shall be valid and binding.

This policy is non-cancellable for any reason. The premium on this policy is not refundable for any reason including the payment prior to maturity of the Obligations.

In the event the Insurer were to become insolvent, any claims arising under a policy of financial guaranty insurance are excluded from coverage by the California Insurance Guaranty Association, established pursuant to Article 14.2 (commencing with Section 1063) of Chapter 1 of Part 2 of Division 1 of the California Insurance Code.

IN WITNESS WHEREOF, the Insurer has caused this policy to be executed in facsimile on its behalf by its duly authorized officers, this [DAY] day of [MONTH], [YEAR].

National Public Finance Guarantee Corporation

_____
President

Attest: _____
Secretary

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3/14

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