Document No. 6 - Appendix A to Preliminary Official Statement

Information Concerning Palomar Pomerado Health

APPENDIX A

INFORMATION CONCERNING PALOMAR POMERADO HEALTH

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As discussed under "SECURITY AND SOURCE OF PAYMENT OF THE BONDS," in the front part of this Official Statement, the Bonds are payable from ad valorem taxes. The Board of Supervisors of the County of San Diego has the power and is obligated to annually levy ad valorem taxes upon all property subject to taxation within the boundaries of Palomar Pomerado Health as a political subdivision, without limitation as to rate or amount, for the payment of principal of and interest on the Bonds (except certain personal property which is taxable at limited rates). Palomar Pomerado Health anticipates that ad valorem taxes will be sufficient to pay principal of and interest on the Bonds, the 2005 GO Bonds and any additional general obligation bonds authorized by Measure BB. However, pursuant to Section 32127 of the Local Health Care District Law, the Palomar Pomerado Health is required to use moneys in its maintenance and operation fund whenever ad valorem taxes are insufficient to pay such principal and interest.

The information contained in this APPENDIX A has been obtained from Palomar Pomerado Health

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BACKGROUND AND HISTORY

Palomar Pomerado Health - Introduction

Palomar Pomerado Health (the "District") is a local health care district formed by a vote of the District's electorate in 1948, and is a political subdivision in the State of California organized pursuant to Division 23 of the Health and Safety Code of the State of California. Originally known as the Northern San Diego County Hospital District, the District has been known as Palomar Pomerado Health since 2001. The District is located inland in the northern portion of San Diego County (the "County") and is the largest California local health care district in terms of geographical area, covering approximately 800 square miles. The 2006 population within the District's boundaries was estimated, by Claritas, to be approximately 480,220. Included within those boundaries are all or a portion of the cities and communities of Escondido, Poway, Ramona, Rancho Bernardo, Rancho Penasquitos, San Marcos, Valley Center, Pauma Valley, Santa Ysabel and Julian.

The District owns and operates two acute care hospital facilities, the 324-bed Palomar Medical Center ("PMC") in Escondido that opened in 1950, and the 107-bed Pomerado Hospital ("Pomerado") in Poway that opened in 1977. The District also owns and operates: two skilled nursing facilities, the 96-bed Palomar Continuing Care Center in Escondido and the 129-bed Villa Pomerado in Poway; an ambulatory care center in San Marcos; and home health services. The District also: operates the Escondido Surgery Center, an outpatient surgery center in Escondido; and provides imaging services at the Gateway and Parkway Outpatient Radiology Centers, and Pomerado Imaging (a joint venture), which are managed by a hospital-based radiology group.

The PMC campus is located in downtown Escondido, and is a full-service tertiary and acute care facility. PMC is the only designated trauma center in the northern portion of the County and has a trauma service area of approximately 1,400 square miles (the size of Rhode Island). Pomerado is located in Poway and is a full-service community hospital.

Facilities Master Plan

To improve the District's ability to meet current demands for additional health care services, to respond to expected growth in demand within the cities and communities of the District and to comply with State mandated seismic building regulations, the District has developed a Facilities Master Plan (defined herein). The Facilities Master Plan provides for the repair, replacement and expansion of acute care hospital facilities and the development of satellite ambulatory care facilities in several communities in the District's boundaries to improve access to local health care services. The projects comprising the Facilities Master Plan are expected to be completed in several phases with the initial phase to be substantially completed prior to the end of fiscal year 2014. The Facilities Master Plan seeks to provide to the District's residents access to quality medical and emergency care in facilities that will integrate the future advances in medical technology and information technology and provide family-centered, healing environments for patients, visitors, staff and medical staff. See "FACILITIES MASTER PLAN, SERVICE AREA AND COMPETITION – Facilities Master Plan" herein.

ORGANIZATIONAL STRUCTURE

Organization

The District is a political subdivision that operates several facilities in multiple locations within the District's boundaries, as shown in chart below:

Facility	Type of Service	Location
Palomar Medical Center ("PMC")	Acute Care Hospital	Escondido
Pomerado Hospital ("Pomerado")	Acute Care Hospital	Poway
Palomar Continuing Care Center	Skilled Nursing Facility	Escondido
Villa Pomerado	Skilled Nursing Facility	Poway
Palomar Pomerado Home Care	Home Health	Escondido
San Marcos Ambulatory Care Center	Medical Office Building	San Marcos
Escondido Surgery Center	Outpatient Surgery Center	Escondido
Parkway Radiology	Outpatient Radiology	Escondido
Gateway Radiology	Outpatient Radiology	Poway
Pomerado Imaging*	Outpatient Radiology	Poway

* Joint Venture, which is described under "-Related Entities" below.

Services

The following describes inpatient, outpatient and other services provided at the District's facilities.

Palomar Medical Center. PMC began providing services in 1950 in downtown Escondido. PMC is a full-service 324-bed tertiary and acute care facility. The County of San Diego has designated six hospitals to provide trauma services within designated areas of the County. PMC has been designated as the only trauma center for the northern portion of the County. The PMC's trauma center has a service area of approximately 1,400 square miles from the San Diego/Riverside County line to the north, to the coast on the west, to the Anza Borrego desert on the east and south to Mira Mesa.

Pomerado Hospital. Pomerado began providing services in 1977 in Poway and is a full-service 107-bed community hospital.

Through its acute care facilities, the District provides the following programs and specialist services:

- 24-hour emergency and trauma services
- Peripheral angiograph and cardiac catheterization
- Open-heart surgery
- Neurosurgery

- Radiation therapy
- Family birthing center
- Level II neonatal intensive care
- Comprehensive wound care and hyperbaric oxygen treatment
- Outpatient surgery
- General medical/surgical services

Other Services Provided

Palomar Continuing Care Center is a 96-bed skilled nursing facility. Villa Pomerado is a 129-bed skilled nursing facility, including a 20-bed subacute center. San Marcos Ambulatory Care Center is an approximately 43,000 square foot medical office building. Its primary tenants include OB/GYN and family practice physicians, and the California State University San Marcos School of Nursing. Palomar Pomerado Home care provides home health services. Parkway Radiology and Gateway Radiology provide outpatient radiology services.

Related Entities

Described below are certain entities which are related to the District.

Palomar Pomerado Health Foundation. Palomar Pomerado Health Foundation (the "Foundation") is a California nonprofit public benefit corporation organized and operated to solicit and provide financial support for the District. The Foundation is a separately governed organization, is not controlled by the District, and its financial results are not included in the financial statements of the District. The Foundation funds various programs on behalf of the District, which totaled $498,209 and $556,209 in the fiscal years ended June 30, 2007 and 2006, respectively.

In 2006, update, as needed the District entered into a restructured management service agreement with the Foundation under which the District lends up to $3 million of working capital to the Foundation under a line of credit agreement and provides administrative support services to the Foundation, the costs of which the Foundation is obligated to repay. Under this agreement, the District selects, hires, and supervises the employees that operate the Foundation, and selects and employs the executive director of the Foundation, subject to the approval of the board of directors of the Foundation. The purpose of this restructuring was to create the organizational structure of the Foundation to formulate and execute the capital fund drive to raise a portion of the cost of implementing the Facilities Master Plan. The District provided administrative services to the Foundation totaling $1.6 million and $1.1 million in the fiscal years ended June 30, 2007 and 2006, respectively.

Palomar Pomerado North County Health Development, Inc. Palomar Pomerado North County Health Development, Inc. ("PPNCHD") is a California nonprofit public benefit corporation organized and operated to seek grants to support research and other programs at the

District's facilities. As the sole member of PPNCHD, the District appoints all of PPNCHD's board of directors. Currently, the District provides all administrative personnel and working capital for PPNCHD under a line of credit arrangement. During fiscal years 2005 through 2007, PPNCHD obtained a total of $6,933,071 million in grants for the District. The financial results of PPNCHD are included in the consolidated financial statements of the District.

Escondido Surgery Center. Formerly, Escondido Ambulatory Surgical Center Investors, L.P. ("ESC") was a for profit California limited liability partnership, in which the District was its general partner and the limited partners were surgeons on the District's medical staff. ESC operated an outpatient surgery facility located in Escondido. The District has acquired 100% ownership in ESC and is in the process of formally transferring title of ESC's assets to the District and formally dissolving ESC. The District is also in the process of re-licensing the facility as hospital based. The District will operate the facility as a hospital based entity and will provide outpatient infusion services and surgical services in ophthalmology, orthopedic, ear/nose/throat, gastrointestinal, gynecology, plastic surgery, general surgery, and podiatry. The formal transition and re-licensing is expected to be completed by December 31, 2007. The financial results of ESC are included in the consolidated financial statements of the District. See Notes to Financial Statements in APPENDIX B—"Audited Financial Statements Of Palomar Pomerado Health."

Pomerado Imaging. Pomerado Imaging ("PI") is a for profit California limited partnership in which the District is the limited partner and Valley Radiology Consultants is the general partner. PI provides diagnostic imaging in the form of multidetector computed tomography and magnetic resonance imaging. Under the limited partnership agreement, the District has no obligation to contribute any additional funding to PI.

FACILITIES MASTER PLAN, SERVICE AREA AND COMPETITION

Facilities Master Plan

In 2004, in order to meet expanding community needs and mandated State standards for earthquake safety, the Board of Directors of the District (the "District Board") approved a facilities master plan (the "Facilities Master Plan"). Major components of the Facilities Master Plan include: construction of a new second PMC campus in Escondido, which will replace 75% of the bed capacity at the existing PMC campus which bed capacity is currently located in seismically non-conforming structures; expansion of existing hospital facilities at Pomerado; renovation of the existing PMC campus; and construction of outpatient facilities at several locations. Such construction, expansion and renovation activities have been planned and designed to enable the District to: increase trauma and emergency treatment capacity; increase critical care capacity; increase operating room, related diagnostic and treatment and outpatient service capacity; and comply with current State standards for earthquake safety. The Facilities Master Plan is anticipated to be completed in phases, with the initial phase currently expected to be substantially completed by June 30, 2014.

The initial phase currently includes: (i) construction of the new PMC campus in Escondido, which will allow current health care services to remain fully available and accessible at the existing PMC campus in Escondido during the construction process, which is planned to commence in 2008 and be completed in 2011; (ii) expansion at Pomerado, which is planned to

commence in 2008 and be completed in 2011; and (iii) subsequent to commencement of operations at the new PMC campus, essential repair, replacement and remodel construction at the existing PMC campus in Escondido

Each of the campuses are sized for bed needs in 2020, as identified by the District during development of the Facilities Master Plan and construction will include shell space for anticipated future bed and service needs. Upon completion of the initial phase, the District currently anticipates that its bed capacity will increase to 573. The District contemplates further increases in bed capacity to 729 during subsequent phases, which are to be implemented as funding is available and additional services are needed.

The table below summarizes current estimated project costs for each of the major components of the Facilities Master Plan, in escalated dollars, throughout the construction period of the initial phase, which is currently expected to be substantially completed by June 30, 2014.

Initial Phase of Facilities Master Plan - Components	Estimated Costs (in thousands)
Palomar Medical Center (Escondido) – New Campus	$773,700
Palomar Medical Center (Escondido) – Existing Campus Renovations	$20,800
Pomerado Hospital (Poway) – Expansions	$176,000
Outpatient Facilities (Various Community Locations)	$12,500
Total	$983,000

Funding sources for the Facilities Master Plan currently include: (i) general obligation bonds authorized by Measure BB (herein referred to collectively as "GO Bonds"); (ii) obligations secured by operating revenues of the District (herein referred to as "Revenue Obligations"), including revenue bonds and certificates of participation; (iii) cash reserves; and (iv) a philanthropic capital campaign.

As of the date of this Official Statement, the District has issued $80 million of GO Bonds (herein referred to as the "2005 GO Bonds"), of which $68,360,000 remain outstanding, to finance portions of the Facilities Master Plan. In addition, certain certificates of participation (herein referred to as the "2006 Certificates") were executed and delivered for the benefit of the District in 2006, a portion of which are to be applied to finance portions of the Facilities Master Plan. See "MANAGEMENT'S DISCUSSION OF FINANCIAL PERFORMANCE—Outstanding Long-Term Debt".

With respect to the philanthropic capital campaign, the Foundation completed a campaign feasibility study in May 2007, which validated a $55 million campaign based on a review of identified and projected major lead gifts. The targeted net proceeds to be applied to finance the Facilities Master Plan from the capital campaign are $45 million in net contributions. Ketchum, a fundraising firm with 88 years of experience in helping non-profit institutions raise more than $13 billion in the aggregate, has been engaged by the Foundation to serve as its campaign advisor. The philanthropic capital campaign is currently in the planning and organization phase and will be conducted by the Foundation over the next four years.

Upon adoption of the Facilities Master Plan in 2004, the District estimated that the costs of implementation of the Facilities Master Plan would be approximately $753 million.

Subsequently and primarily as a result of increases in construction costs (including the cost of materials and labor) and not as a result of changes in the scope of the projects, the District revised the estimate to approximately $983 million in 2006. In order to manage continued increases in construction costs and remain within the current budgeted amount, District management has revised the plan of finance, altered certain plans and adjusted finished bed capacity to meet demand, but has retained a requisite amount of shelled capacity needed to accommodate projected increases in patient volumes and finished beds in future years. The current budgeted amount of $983 million is estimated to be sufficient for completion of the initial phase of the Facilities Master Plan as described herein. As the District moves forward with the implementation of the Facilities Master Plan, District management anticipates continuing to revise its plans, adjust its finished bed capacity and update its plan of finance based on availability of funding and need for additional services.

To manage costs of the Facilities Master Plan, District management is using a number of accepted industry techniques and strategies including construction management, phasing, schedule acceleration, value engineering, project segmentation and early procurement. Construction projects are subject to a variety of risks, including delays and increase in costs. See "RISKS RELATED TO DISTRICT OPERATIONS – Construction Risks" herein.

The four tables below summarize the current and planned bed complement by function included in the initial phase of the Facilities Master Plan, for the District as a whole and a table for each of the three hospital campuses. For each campus, a portion of patient care units will be shelled upon initial completion of the initial phase of the new facilities until such time as patient volume dictates completion of the shelled space and funding is available.

District Total-Key Bed Type/Services/Function

		June 30, 2014 Bed Complement	
Key Bed Type/Services/Function	**Existing**	**Finished**	**Shelled**
Acuity Assignable[1]	0	136	104
Intensive/Coronary Care Beds[1]	47	12	0
Medical/Surgical Beds	235	246	36
Labor & Delivery/Antepartum	37	37	0
Postpartum/GYN	23	47	0
Pediatric	23	23	0
Neonatal Intensive Care Beds	10	16	0
Acute Psychiatric	38	38	0
Acute Rehabilitation	18	18	0
Total Beds	**431**	**573**	**140**
Surgery Suites[2]	18	35	0
Cath Lab/Interventional Radiology	4	7	0
ED/Trauma/Observation Stations	66	82	0

Source: The District.

[1] Acute assignable beds are built to intensive/coronary care bed standards and can be used as either intensive care unit or general medical/surgical beds.

[2] Includes four outpatient surgery suites at Escondido Surgery Center.

Palomar Medical Center - New Campus

Key Bed Type/Services/Function	June 30, 2014 Bed Complement	
	Finished	Shelled
Acuity Assignable[1]	120	48
Intensive/Coronary Care Beds[1]	0	0
Medical/Surgical Beds	168	24
Labor & Delivery/Antepartum	0	0
Postpartum	0	0
Pediatric	0	0
Neonatal Intensive Care	0	0
Acute Psychiatric	0	0
Acute Rehabilitation	0	0
Total Beds	**288**	**72**
Surgery Suites[2]	17	0
Cath Lab/Interventional Radiology	5	0
ED/Trauma/Observation Stations	56	0

Source: The District.

[1] Acute Assignable beds are built to intensive/coronary care bed standards and can be used as either ICU or general medical/surgical beds.

[2] Includes four surgery suites at the Escondido Surgery Center.

Pomerado Campus

Key Bed Type/Services/Function	Existing	June 30, 2014 Bed Complement	
		Finished	Shelled
Acuity Assignable[1]	0	16	56
Intensive Care Beds[1]	12	12	0
Medical/Surgical Beds	68[2]	78[2]	12
Labor & Delivery/Antepartum	11	11	0
Postpartum/GYN	0	24	0
Neonatal Intensive Care Beds	4	4	0
Acute Psychiatric	12	12	0
Total Beds	**107**	**157**	**68**
Surgery Suites[3]	4	8	0
Cath Lab/Interventional Radiology	1	2	0
ED/Trauma/Observation Stations	22	26	0

Source: The District.

[1] Acuity Assignable beds are built to intensive/coronary bed standards and can be used as either intensive care or general medical/surgical beds.

[2] Eighteen of the Medical/Surgical beds are Intermediate Care Beds.

[3] Includes outpatient surgery centers at Pomerado campus.

Palomar Medical Center – Existing Campus

Bed Type/Services/Function	Existing Campus	June 30, 2014 Bed Complement	
		Finished	Shelled
Acuity Assignable	0	0	0
Intensive/Coronary Care Beds	35	0	0
Medical/Surgical Beds	167	0	0
Labor & Delivery/Antepartum	26	26	0
Postpartum	23	23	0
Pediatric	23	23	0
Neonatal Intensive Care	6	12	0
Acute Psychiatric	26	26	0
Acute Rehabilitation	18	18	0
Total Beds	**324**	**128**	**0**
Surgery Suites	10	10	0
Cath Lab/Interventional Radiology	2	0	0
ED/Trauma/Observation Stations	44	0	0

Source: The District.

The projects included in the Facilities Master Plan will require approvals from several governmental entities and must comply with several regulatory codes including: the Office of Statewide Health Planning and Development ("OSHPD") for all inpatient hospital buildings; local city permits for grading, site zoning and adherence to city specific plans; compliance with the California Environmental Quality Act; and State seismic requirements. The District has received an extension until 2013 to comply with the State's seismic requirements. See "OTHER INFORMATION - Seismic Compliance" herein. The District has obtained all approvals and permits currently necessary for implementation of the initial phase of the District's Facilities Master Plan and does not anticipate any difficulty in obtaining additional approvals and permits when required.

Service Area

The District's boundaries as a political subdivision cover an approximately 800-square mile area located inland in the northern portion of the County, as shown on map below. Management of the District considers this geographical area to be the District's service area. As shown on the map on the following page, the District's boundaries encompasses all or portions of the following cities and communities: Escondido, Poway, Ramona, Rancho Bernardo, Rancho Penasquitos, San Marcos, Valley Center, Pauma Valley, Santa Ysabel and Julian.

[Printer to Insert Map – Provided to Working Group as a Separate Document]

The 2006 population within the District's service area was estimated by Claritas to be approximately 480,220.

Service Area Population

2000	2006	2011[1]	% growth 2000-2011[2]	2020[2]	% growth 2011-2020[2]
435,330	480,220	523,046	20.1%	610,000	16.6%

Source: Claritas.
[1] Estimated.
[2] Projected.

The District's service area had approximately 163,000 households in 2006 with an average household income of $84,937, and 29.1% of the households had an income of $100,000 or greater, according to Claritas.

Other characteristics of the District's service area shown in the tables below.

District Service Area
Population Distribution by Age Group – 2006

Age Group	Population	% of Total
0-14	110,980	23.1%
15-17	22,800	4.7%
18-24	43,147	9.0%
25-34	56,903	11.8%
35-54	140,851	29.3%
55-64	46,555	9.7%
65+	58,984	12.3%
Total	**480,220**	**100%**

Source: Claritas.
Note: Totals may not add correctly due to rounding.

District Service Area
Households by Income Group – 2006

Income	Households	% of Total
<$15K	10,981	6.7%
$15-25K	12,515	7.7%
$25-50K	35,904	22.0%
$50-75K	32,070	19.7%
$75-100K	24,054	14.8%
Over $100K	47,380	29.1%
Total	**162,904**	**100%**

Source: Claritas.
Note: Totals may not add correctly due to rounding.

The District's service area has a diverse mix of employers and industries.

District Service Area
Top 25 Employers by Industry - 2005

Manufacturing	38%
Education	26%
Health Services	11%
Finance	9%
Mining & Construction	8%
Government	4%
Services (Other)	2%
Transportation	2%
Total	100%

Source: Cities of Poway, Escondido, San Marcos, North County Chamber of Commerce.

Utilization

The table below presents selected combined utilization statistics for the District for its fiscal years ended June 30, 2004, 2005, 2006 and 2007.

	Fiscal Year Ended June 30,			
	2004	2005	2006	2007
Acute Beds				
Licensed/Available Beds	424	431	431	431
Patient Days	108,452	108,987	112,445	112,372
Discharges	27,247	27,801	28,216	28,969
Average Length of Stay (in days)	3.98	3.92	3.99	3.88
Occupancy Rate	70%	69%	71%	71%
Emergency Room Visits	62,025	62,228	64,449	68,693
Home Health Visits	33,667	30,643	28,997	31,297
Surgeries - Inpatient	7,732	8,356	7,908	7,569
Surgeries - Outpatient	2,994	3,266	3,690	4,146
Deliveries	5,417	5,612	5,363	5,386
Skilled Nursing Beds				
Licensed/Available Beds	225	225	225	225
Patient Days	75,851	74,875	75,846	76,840
Occupancy Rate	92%	91%	92%	94%

Source: The District.

Market Environment

There are no other hospitals located within the District's service area. However, outpatient facilities of hospitals which compete with the District for patients and offices of physicians who are on the medical staff of competing hospitals are located within the District's service area. In addition, there are other hospitals on the periphery of the District's services area, as shown on the map on the next page.

[Printer to Insert Map – Provided to Working Group as a Separate Document]

The table below shows acute and intensive care patient discharges in the District's service area for calendar years 2004, 2005 and 2006, the latest full year available. Included in the table are the number of discharged patients who reside in the District's service area and the hospitals from which such patients are discharged.

District Service Area – Acute Care Hospital Discharges
For Calendar Years 2004, 2005 and 2006

Hospital	Miles from Closest District Hospital	2004 Discharges	2004 Market Share	2005 Discharges	2005 Market Share	2006 Discharges	2006 Market Share
Palomar Medical Center	N/A	19,320	42.7%	19,356	41.3%	19,896	41.4%
Pomerado Hospital	N/A	6,355	14.0%	6,694	14.3%	6,507	13.5%
Scripps Memorial Hospital – La Jolla	18	2,918	6.5%	3,090	6.6%	3,372	7.0%
Kaiser Hospital – San Diego	18	2,558	5.7%	2,480	5.3%	2,534	5.3%
Tri-City Medical Center	16	2,046	4.5%	2,098	4.5%	2,194	4.6%
Scripps Green Hospital	18	1,864	4.1%	2,129	4.5%	2,278	4.7%
Children's Hospital – San Diego	22	1,748	3.9%	1,929	4.1%	1,946	4.0%
Sharp Mary Birch Hospital For Women	22	1,712	3.8%	1,842	3.9%	1,898	3.9%
Sharp Memorial Hospital	22	1,594	3.5%	1,559	3.3%	1,412	2.9%
UCSD (Hillcrest & Thornton)	21 & 28	1,575	3.5%	1,454	3.1%	1,639	3.4%
Scripps Memorial Hospital – Encinitas	21	781	1.7%	875	1.9%	915	1.9%
Scripps Mercy Hospital	20	560	1.2%	551	1.2%	539	1.1%
All Other Hospitals*		2,224	4.9%	2,843	6.0%	2,944	6.1%
TOTAL DISCHARGES		**45,255**	**100.0%**	**46,900**	**100.0%**	**48,074**	**100.0%**

Source: Office of Statewide Health Planning and Development Discharge Data Set.
*Each hospital in the "All Other" category has less than 1% market share.
Note: Columns may not total correctly due to rounding.

Managed care is dominant in the County and a significant portion of patient admissions at the District and other hospitals in the County are based upon relationships and contracts between various managed care networks and the hospitals. Approximately 40.1% of patient revenues of the District during its fiscal year 2007 were derived from managed care networks, including premium revenue under capitated managed care contracts. District management believes these managed care networks in the County have been relatively stable over time.

Relationship With Kaiser

The District has entered into a Hospital Service Agreement ("Kaiser Agreement") with Kaiser Foundation Hospitals ("Kaiser"). Kaiser is a nonprofit California public benefit corporation that provides hospital services to, or arranges the provision of hospital services for, members of the Kaiser Foundation Health Plan, Inc. ("Health Plan"). Under the Kaiser Agreement, the District is obligated to provide inpatient and outpatient hospital services, primarily at the new PMC hospital, to Kaiser for members of the Health Plan in exchange for

fees based upon a schedule the parties have negotiated including a fee for services rendered per diem and a fixed payment for bed availability guarantees.

The term of the Kaiser Agreement is through September 30, 2020. However, after October 1, 2015, the term is a rolling five-year term that is extended from four to five years each September 30, unless one of the parties has given at least five years' prior written notice of non-renewal. Kaiser can terminate the Kaiser Agreement earlier in certain circumstances. After the District completes and opens the new Palomar Medical Center Campus, the District will be required to provide Kaiser a guaranteed hospital bed capacity. If the District fails to provide the guaranteed hospital beds to Kaiser as needed, the District must provide alternative hospitalization at the Pomerado Hospital or at its own expense, or Kaiser may terminate the Kaiser Agreement and/or seek to revisit its terms. After the opening of the new PMC hospital, Kaiser will be required to make certain fixed payments to the District.

Through September 30, 2017 (unless either party has given notice of termination for cause or it is during the last five years before effectiveness of a non-renewal notice), the District has a right of first opportunity to negotiate with Kaiser to develop or participate with Kaiser in developing (at Kaiser's election) any general acute care hospital Kaiser proposes to develop in the District's service area.

HISTORIC FINANCIAL INFORMATION

Summary of Historical Financial Data

The summary of financial data for the District for the fiscal years ended June 30, 2004, 2005, 2006 and 2007 as shown in the two tables on the following pages, has been derived from the audited consolidated financial statements of the District and its affiliates. This summary should be read in conjunction with the audited consolidated financial statements of the District, together with the related notes and other financial information, appearing in APPENDIX B—"AUDITED FINANCIAL STATEMENTS OF PALOMAR POMERADO HEALTH."

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Condensed Consolidated Schedule of Revenue, Expenses and Changes in Net Assets

For the Years Ended June 30, 2004, 2005, 2006, and 2007
(shown in thousands)

	Fiscal Year Ended June 30,			
	2004	2005	2006	2007
Revenue				
Net patient service revenue	$271,430	$292,453	$312,329	$336,292
Net premium revenue	32,950	40,187	41,953	40,405
Other revenue	12,338	10,853	9,835	9,298
Total operating revenue	316,718	343,493	364,117	385,995
Expenses				
Operating expenses	291,487	318,671	345,383	365,903
Depreciation and amortization	14,547	16,395	18,737	19,453
Total operating expenses	306,034	335,066	364,120	385,356
Income (loss) from operations	10,684	8,427	(3)	639
Non-Operating Income (Expenses)				
Investment income	1,312	3,575	4,088	7,275
Unrealized gain on interest rate swap				4,373
Interest expense[1]	(5,581)	(5,272)	(4,406)	(3,337)
Property tax revenue[2]	9,206	10,218	11,495	12,562
Property tax revenue–GO Bonds[3]			9,423	11,016
Other	432	104	384	468
Total non-operating income-net	5,369	8,625	20,984	32,357
Excess of Revenue Over Expenses	16,053	17,052	20,981	32,996
Other changes in net assets	54	8	21	193
Increase in Net Assets	$16,107	$17,060	$21,002	$33,189

(1) Interest cost related to the 2006 Certificates and the 2005 GO Bonds is being capitalized to construction in progress and, therefore, is not reported as interest expense in the Condensed Consolidated Schedule of Revenue, Expenses and Changes in Net Assets.

(2) These "property tax revenues" are unrestricted and may be used by the District to fund ongoing operations and capital requisitions, as discussed under "-Unrestricted Property Tax Revenues" below.

(3) "Property tax revenue-GO Bonds" are restricted revenues and are pledged solely to and may be used only for the repayment of the Bonds, the 2005 GO Bonds and any additional series of GO Bonds.

Condensed Consolidated Schedule of Balance Sheet Data
As of June 30, 2004, 2005, 2006 and 2007
(shown in thousands)

	Fiscal Year Ended June 30,			
	2004	2005	2006 [1]	2007
ASSETS				
Current assets	$202,891	$197,693	$202,131	$225,888
Current assets –GO Bonds			12,160	11,060
Assets whose use is limited	34,769	29,904	29,933	137,036
Assets whose use is limited – GO Bonds			29,134	4,889
Capital assets	120,470	147,017	208,739	272,211
Other assets	8,086	9,762	6,248	23,227
TOTAL ASSETS	$366,216	$384,376	$488,345	$674,311
LIABILITIES AND NET ASSETS				
Current liabilities	$44,844	$47,831	$53,844	$63,885
Current portion of long-term debt	6,015	6,125	6,560	7,765
Current portion of GO Bonds			6,185	5,455
Workers' Compensation	3,900	7,334	5,696	5,024
Long-term debt – GO Bonds - Net of current portion			77,556	71,888
Long-term debt – Net of current portion	85,252	79,820	73,791	222,836
Total Liabilities	140,011	141,110	223,632	376,853
Minority Interest			444	-0-
NET ASSETS				
Invested in capital assets – net of related debt	31,102	63,384	86,995	104,900
Restricted for repayment of debt	11,127	11,317	12,361	29,698
Restricted for capital acquisitions & other purposes	278	282	13,403	14,043
Unrestricted	183,698	168,283	151,510	148,817
Total net assets	226,205	243,266	264,269	297,458
TOTAL LIABILITIES & NET ASSETS	$366,216	$384,376	$488,345	$674,311

[1] Restated. For further explanation, see footnote number 13 in APPENDIX B – "AUDITED FINANCIAL STATEMENTS OF PALOMAR POMERADO HEALTH".

Sources of Patient Revenue

The following is a summary of gross patient revenue of the District by payor source for each of its fiscal years ended June 30, 2004, 2005, 2006 and 2007.

	Fiscal Year Ended June 30,			
	2004	2005	2006	2007
MEDICARE				
Medicare Traditional	28.4%	27.2%	27.5%	27.6%
Medicare Managed Care	6.8%	6.3%	6.7%	7.7%
Medicare Capitation – Risk	11.1%	10.8%	10.7%	9.0%
MEDI-CAL (Medicaid)				
Medi-Cal Traditional	11.8%	13.3%	13.1%	13.8%
Medi-Cal Managed Care	2.5%	2.6%	2.6%	2.7%
County Medical Services ("CMS")	3.0%	1.7%	1.8%	2.1%
COMMERCIAL				
Managed Care	26.4%	20.3%	17.4%	17.6%
Managed Cared Capitation – Risk	3.2%	3.4%	3.1%	8.1%
Indemnity	0.6%	7.6%	10.6%	10.7%
OTHER	6.2%	6.8%	6.5%	5.7%
Total	100.0%	100.0%	100.0%	100.00

Source: The District.
Note: Columns may not total exactly due to rounding.

Payments on behalf of certain patients are made to the District by the federal government under the Medicare program, by the federal government and the State under the Medicaid program, known as Medi-Cal in California, by managed care entities and other contracted rate payors (including health maintenance organization and preferred provider organizations), by commercial insurance carriers, and by self-paying patients. The District has entered into noncapitated contracts with more than 20 managed care entities. Differing methods for the reimbursement of hospital services are utilized by third-party payors. Most negotiated contracts are on a capitation, case rate, per diem or discount from charges basis. The District currently contracts with Pacificare and Secured Horizons, along with four physician medical groups on a shared risk capitated basis, which contracts resulted in gross capitation premium revenue of $69.1 million and net patient capitation revenue (after expenses for treatment of members) of approximately $40.4 million in fiscal year ended June 30, 2007. See "RISKS RELATED TO DISTRICT OPERATIONS—Patient Service Revenues" herein for a discussion of Medicare, Medi-Cal and other managed care programs that contract with the District.

Unrestricted Property Tax Revenues

The District derives certain unrestricted property tax revenues (the "Unrestricted Property Tax Revenues") from a share of property taxes levied by County of San Diego on the assessed value of real property in the District's boundaries as a political subdivision. These property taxes levied by the County are subject to the provisions of Article XIIIA of the California Constitution, are apportioned according to State statutes and may be used by the District to fund ongoing

operations as well as capital acquisitions. Assessed value of property within the District's boundaries has grown at an average of 10.5% per year during the last five years. The aggregate of Unrestricted Property Tax Revenues collected during fiscal years 2006 and 2007 was $12.6 million and $11.5 million, respectively, and District management projects that during fiscal year 2008, $13.5 million will be collected. See the "Condensed Consolidated Schedule of Revenue, Expenses and Net Assets" shown above.

These Unrestricted Property Tax Revenues are in addition to, and are separate from, the ad valorem tax revenues resulting from the separate tax levy that is pledged solely to the payment of principal and interest on the Bonds, the 2005 GO Bonds and any additional series of GO Bonds issued by the District.

MANAGEMENT'S DISCUSSION OF FINANCIAL PERFORMANCE

Critical Accounting Policies and Estimates

Proprietary Fund Accounting

The District is a local health care district (a governmental entity) and therefore, follows accounting and financial reporting standards applicable to governmental health care entities. Such standards are governed by the Governmental Accounting Standards Board ("GASB") and the American Institute of Certified Public Accountants ("AICPA") Audit and Accounting Guide for Health Care Organizations. The District utilizes the proprietary fund (enterprise fund) method of accounting whereby revenue and expenses are recognized on the accrual basis. Substantially all revenue and expenses are subject to accrual. Pursuant to GASB Statement No. 20, *Accounting and Financial Reporting for Proprietary Funds and Other Governmental Entities That Use Proprietary Fund Accounting*, the District has elected to apply the provisions of all relevant pronouncements of the Financial Accounting Standards Board, including those issued after November 30, 1989, that do not conflict with or contradict GASB pronouncements.

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 the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates. Significant items subject to such estimates and assumptions include: the carrying amounts of property, plant and equipment, contractual and bad debt allowances for receivables, cost report settlements, and liabilities for claims incurred but not reported under capitation agreements and self-insured programs.

Revenues and Accounts Receivable

Healthcare delivery revenue consists primarily of: (1) revenue from patient services provided under contracts with various government-sponsored health care programs (Medicare and Medi-Cal), insurance companies, and other third parties; (2) capitation premium revenue

received under contracts with managed care payors; and (3) self-pay patients including co-insurance payments.

The District has agreements with third-party payors that provide for payments to the District at amounts different from its established rates and are recognized on an accrual basis. Payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges, and per diem payments. Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods, as final settlements are determined.

The District has agreements with various third-party payors to provide medical services to subscribing participants. Under these agreements, the District receives monthly capitation payments based on the number of each payor's participants, regardless of services actually performed by the District. Capitation premium revenue is recognized during the period enrollees are entitled to receive services.

The District provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Amounts determined to qualify as charity care are excluded from net patient revenue in the financial statements.

The District's property tax revenues are recorded in the year in which such taxes are due and received from the taxpayers and are included in non-operating income on the statement of revenue, expenses, and changes in net assets.

GO Bonds and Revenue Obligations

GO Bonds, including the Bonds, the 2005 GO Bonds and any additional series of GO Bonds, and any Revenue Obligations of the District, are reported as an obligation of the District on its balance sheet. Proceeds from the issuance of general obligation bonds are recorded as assets whose use is limited until such proceeds are expended on construction. As construction occurs, the bond proceeds are used to pay for such costs, resulting in a reduction of assets whose use is limited and an increase in fixed assets (construction in progress).

Interest costs related to tax-exempt debt, including the Bonds and the 2005 GO Bonds and the 2006 Certificates, are recorded on the accrual basis and are capitalized to the related construction in progress from the date of borrowing until the constructed assets are ready for their intended use. Thereafter, in the absence of other qualifying construction expenditures on which interest cost may be capitalized, capitalization of interest costs ceases and interest costs are expensed and are included as non-operating expenses in the statement of revenue, expenses, and changes in net assets. In addition, investment income on unexpended tax-exempt bond proceeds is recorded on the accrual basis as an offset to interest costs capitalized during the interest capitalization period. Thereafter, investment income on unspent bond proceeds is recorded as non-operating income.

Interest Rate Swaps

The District has entered into certain variable-to-fixed interest rate swaps which will be reflected at fair value in its balance sheet. The fair value of the interest rate swaps will fluctuate, generally based on changes in market rates of interest. Any unrealized gains or losses resulting from changes in fair value are reported as non-operating gains or losses in the statement of revenue, expenses, and changes in net assets. Interest cost on variable interest rate debt is recorded based on the fixed interest rate paid by the District under its interest rate swaps. See "—Outstanding Swap Transactions" below.

Impairment of Capital Assets

Capital assets, such as property, plant, and equipment, are reviewed for impairment when events or changes in circumstances suggest that the service utility of the capital asset may have significantly and unexpectedly declined. Capital assets are considered impaired if both the decline in service utility of the capital asset is large in magnitude and the event or change in circumstance is outside the normal life cycle of the capital asset. Such events or changes in circumstances that may be indicative of impairment include evidence of physical damage, enactment or approval of laws or regulations or other changes in environmental factors, technological changes or evidence of obsolescence, changes in the manner or duration of use of a capital asset, and construction stoppage. The determination of the impairment loss is dependent upon the event or circumstance in which the impairment occurred. Impairment losses are recorded in the statement of revenue, expenses, and changes in net assets.

Management's Discussion and Analysis of Current Performance

For the quarter ended September 30, 2007, the District recorded Income from Operations of $2.2 million (all figures in this paragraph have been rounded) and Excess of Revenues Over Expenses (excluding Property tax revenue–GO Bonds) of $7.2 million in comparison to $3.4 million and $7.9 million, respectively, for the quarter ended September 30, 2006. The Excess of Revenues Over Expenses negative variance of $700,000 was attributable to a change made in the first quarter ended September 30, 2007 in the recognition of reserves relating to capitated managed care contracts at discharge date versus recognition during the first quarter ended September 30, 2006 at the billing date ($1.5 million) and is expected by management to normalize throughout the current fiscal year. The first quarter performance was $23,000 positive to budget for Income from Operations and $1.47 million positive to budget for Excess of Revenues Over Expenses (excluding Property tax revenue-GO Bonds). The District has budgeted Excess of Revenues Over Expenses of $25.1 million for the entire fiscal year ending June 30, 2008 (excluding Property tax revenue–GO Bonds), which would reflect a 14% increase over comparable Excess of Revenues Over Expenses for the fiscal year ended June 30, 2007.

Management's Discussion and Analysis of Historical Performance

This ***Management's Discussion and Analysis of Historical Performance*** should be read in conjunction with the Management's Discussion and Analysis accompanying the audited consolidated financial statements of the District appearing in APPENDIX B—"AUDITED FINANCIAL STATEMENTS OF PALOMAR POMERADO HEALTH." All of the figures discussed in this subsection have been rounded.

For the fiscal year ended June 30, 2007, the District reported net patient service revenue totaling $336.3 million in comparison to $312.3 million for fiscal year 2006 and $292.5 million for fiscal year 2005. The $24.0 million (7.7%) growth from fiscal year 2006 to fiscal year 2007 is the result of payor contract and government payor rate increases, case management initiatives and volume growth (2.1% acute admissions, 1.3% skilled inpatient days and 6.6% emergency visits). Similarly, the growth from fiscal year 2005 to fiscal year 2006 was attributable to rate increases and volume growth (3.2% acute inpatient days and 3.6% emergency visits). Over the past three fiscal periods, the District has continued to improve managed care payor agreements. Effective November 2006, the District renewed its contract relationship with Blue Cross for a 32 month period. Additionally, consistency in volumes, market share and payor mix has contributed to these increases. Uncompensated care approximates 5% of revenues. As noted in the table under the heading "HISTORICAL FINANCIAL INFORMATION—Sources of Patient Revenue" set forth above, payor mix has remained relatively consistent over the three fiscal year periods.

For the fiscal year ended June 30, 2007, the District reported revenue earned on capitated contracts of $40.4 million in comparison to $42.0 million for fiscal year 2006 and $40.2 million for fiscal year 2005. Capitated contracts are concentrated with the Pacificare commercial plan (20,600 lives) and the Secured Horizons senior plan (11,900 lives), which involve four medical groups in the District's service area, with the fourth group added in fiscal year 2005.

Inpatient activity remains strong, as evidenced by the consistently strong inpatient acute occupancy rates of 69%, 71% and 71% for fiscal years 2005, 2006 and 2007. Since 2004, skilled nursing care inpatient occupancy has been constant at approximately 91-93%. Outpatient revenue cumulative growth has been 32% for fiscal years 2005 through 2007. Successful outreach strategies and investment in key outpatient technologies and programs have contributed to this growth.

The District receives a share of Unrestricted Property Tax Revenues levied by the County of San Diego, as discussed under "HISTORIC FINANCIAL INFORMATION – Unrestricted Property Tax Revenues." Growth of such revenues reflects continued population growth and increasing assessed valuation. Unrestricted Property Tax Revenues are separate and apart from the ad valorem property taxes collected from the separate tax levy that is pledged solely to the repayment of the Bonds and 2005 GO Bonds and any additional series of GO Bonds. Unrestricted Property Tax Revenues have been $10.2 million, $11.5 million and $12.6 million for fiscal years 2005, 2006 and 2007, respectively.

Salaries, wages and benefits for the fiscal years ended June 30, 2007, totaled $228.4 million, a 7.7% increase over 2006, at $212.0 million. Fiscal year 2005 was $199.2 million. Salaries, wages and benefits have approximated 57-60% of total operating revenues over the past three fiscal years. During fiscal years 2004 through 2007, the District experienced wage pressure related to the ongoing nursing and clinical staff shortages, with the majority of the increases attributed to wage inflation. The District staffs to the State-mandated nurse-staffing ratios. Costs related to registry (temporary agency for nurses) were $14.7 million, $12.6 million, and $8.5 million for fiscal years 2005, 2006, and 2007 respectively. The significant reduction in registry for fiscal year 2007 is attributable to enhanced recruitment and retention strategies. Despite the strong labor shortages in California, the District's overall employee vacancy rate

over the past 12 months is approximately 5.6%, compared with the California Healthcare Association average of 7.0%, and registered nurse vacancy is approximately 7.3%, compared with the California Healthcare Association average of 8.5% over the same time period. Unionized employees represent approximately two thirds of the District's total workforce. Registered nurses have been represented by California Nurses Associated (CNA) since June 2003 while the other portion of the unionized work force have been represented by California Healthcare Employees Union. Both labor contracts were successfully negotiated at the end of June 2006, each for additional three year terms.

Management expects that competitive and supply-driven labor shortages will continue to stress labor budgets and staffing plans. The successful negotiation of new labor agreements and maintaining comprehensive market competitive employee benefits have helped alleviate some workforce shortage concerns. Additionally in 2006, the District was recognized by San Diego Magazine as the third best place to work in San Diego County, among large employers in all industries, and by the San Diego Society for Human Resource Management as the best place to work in San Diego County, among large employers in all industries.

The District has a 6% defined contribution pension plan. The plan is fully funded and investments are individually managed by the employee based upon the plan options. Health and welfare benefits, consisting of POS and HMO options, are acquired from third party insurers.

Supplies expense for the fiscal year ended June 30, 2007, totaled $60.7 million. This represents a 4.6% decrease from fiscal year 2006 ($63.6 million). Effective supply chain management strategies, including physician preference items, forms, office products, and pharmaceuticals, resulted in the reduction on a volume and dollar savings basis. Fiscal year 2006 supplies expense was $63.6 million, representing a 9.8% increase over fiscal year 2005 ($57.9 million). Advancements in certain technology and treatment modalities, particularly in cardiac care, along with pharmaceutical advancements have contributed to increased supply expenditures challenging the management of year on year cost increases. The District remains committed to supporting advancements in technologies and treatment protocols in collaboration with its medical staffs.

Purchased Services for the fiscal year ended June 30, 2007, totaled $29.2 million, as compared to $28.1 million for fiscal year 2006 and $25.9 million for fiscal year 2005. Increases have been the result of license and maintenance fees for the replacement of all financial and clinical information technology systems during fiscal year 2004 to fiscal year 2007.

Professional fees represent the District's commitment to addressing community access to comprehensive health care, including specialty care such as trauma. The District has invested in medical directorships and in certain physician coverage programs including Emergency Department specialty call coverage, 24-hour Trauma coverage, hospitalists, and OB night call coverage. For the fiscal year ended June 30, 2007, the District reported professional fees of $24.2 million, as compared to $20.9 million for fiscal year 2006 and $18.6 for fiscal year 2005. The fiscal year increase of 15.8% over fiscal year 2006 was attributable to increased call coverage, hospitalist coverage, and information technology services. The District believes it has mitigated future costs of certain Emergency Department and Trauma call coverage through negotiating a contract with a primary vendor who secures 24/7 coverage for the various coverage

needs. This contract provides for an initial term of March 1, 2006 through June 20, 2011 and then automatically renews for one-year terms unless and until either party provides notice of intent not to renew. Future cost increases are inflation-adjusted, which provide certainty of costs.

For the fiscal year ended June 30, 2007, depreciation expense totaled $19.5 million, as compared to $18.7 million for fiscal year 2006 and $16.4 million for fiscal year 2005. Continued investment in capital assets and technology (notably information technology, imaging modalities, and warehouse facilities) has contributed to the ongoing increase in depreciation expense.

The provision for uncompensated care (bad debt, charity, and undocumented), which is netted in patient service revenue, for fiscal year 2007 totaled $64.4 million, as compared to $47.5 million for fiscal year 2006 and $45.1 million for fiscal year 2005. Historically, total uncompensated care, including bad debt, charity care and undocumented care, approximates 4% to 5% of gross revenues on an annual basis.

Interest expense attributable to the Series 1999 Bonds (described herein under "—Outstanding Long-Term Debt" below) and the 2006 Certificates totaled $3.3 million for fiscal year 2007, $4.4 million for fiscal year 2006 and $5.3 million for fiscal year 2005. Interest expense related to the new money portion of the 2006 Certificates is capitalized as part of project costs. For fiscal year 2007, unrealized gain on interest rate swap of $4.4 million was recognized compared to $0 for fiscal years 2006 and 2005. See "—Outstanding Swap Transactions" below.

Investment income for the fiscal year ended June 30, 2007 totaled $7.3 million, in comparison to $4.1 million for the year prior. Fiscal year 2005 totaled $3.6 million. The fluctuation in periods is primarily due to changes in market interest rate conditions. The District's investment policies and practices have remained consistent and are subject to State statutory restrictions regarding no equity investments and maturities less than five years. Investment income reported in the Consolidated Schedule of Revenue, Expenses and Changes in Net Assets represents the net result of realized and unrealized gains and losses on investment activity.

Income from operations, inclusive of Unrestricted Property Tax Revenues and exclusive of depreciation ("EBIDA"), is as follows for fiscal years ended June 30, 2005, 2006 and 2007:

	Fiscal year Ended June 30, (dollars in thousands)		
	2005	**2006**	**2007**
Income (loss) from operations	$8,427	$(3)	639
Add: depreciation expense	16,395	18,737	19,453
Add: Unrestricted Property Tax Revenues	10,218	11,495	12,562
EBIDA	$35,040	$30,229	$32,654

The District presents the above non-GAAP financial measure because it believes that it is a useful indicator of its operating performance. The District believes that EBIDA is useful to investors because it is frequently used by securities analysts, investors and other interested parties to measure a company's operating performance without regard to items such as interest expense and depreciation and amortization, which can vary substantially from company to company.

The District's improvement in EBIDA between fiscal year 2007 and fiscal year 2006 is the result of improved payor contracts and labor productivity management while maintaining a strong commitment and investment in its human resources, technology (supply and information technology). Productivity was 100% of benchmarked labor standards for fiscal year 2007.

Overall, the District's operations have remained financially strong through improved payor rate negotiations, implementation of certain cost containment strategies, focus on recruitment and retention to minimize premium pay, including registry, re-negotiation of its three year labor agreements with labor unions representing approximately 2/3 of the total work force, commitment to technology advancements and maintaining market share in its service area while addressing inpatient capacity constraints.

Although continued pressure is expected from payors and employers on reimbursement rates, the District has successfully negotiated ongoing payor rate increases reflective of its status as an essential provider in the North San Diego County market place.

Outstanding Long-Term Debt

The District has previously issued and has outstanding: (i) the Palomar Pomerado Health System Insured Refunding Revenue Bonds, Series 1999 (the "Series 1999 Bonds"); (ii) the Palomar Pomerado Health General Obligation Bonds, Election of 2004, Series 2005A (the "2005 GO Bonds"); and (iii) the Certificates of Participation Evidencing Proportionate Interests of the Holders Thereof in Installment Payments to be Paid by Palomar Pomerado Health executed and delivered in 2006 (the "2006 Certificates").

The Series 1999 Bonds and the 2006 Certificates are payable from gross operating revenues of the District and are not secured by any ad valorem taxes. The voters of the District approved $496 million of general obligation bonds (collectively, the "GO Bonds") at a November 2, 2004 election. The Bonds, the 2005 GO Bonds and any subsequent series of GO Bonds are payable from, and secured by a pledge of, ad valorem tax required to be levied by the County of San Diego, without limitation as to rate or amount, upon all property subject to taxation by the District (except certain personal property, which is taxable at limited rates) for the payment of principal of and interest on such GO Bonds.

The following table sets forth the original and outstanding aggregate principal amount of the District's long-term debt prior to the issuance of the Bonds:

	Original Aggregate Principal Amount	Outstanding Aggregate Principal Amount
Revenue Obligations		
Series 1999 Bonds	$ 66,700,000	$47,320,000
2006 Certificates	180,000,000	177,775,000
Total Revenue Obligations	**$246,700,000**	**$225,095,000**
GO Bonds		
2005 GO Bonds	$ 80,000,000	$ 68,360,000
Total Long-Term Debt	**$326,700,000**	**$293,445,000**

Outstanding Swap Transactions

In connection with the execution and delivery of the 2006 Certificates, the District entered into an interest rate swap agreement with respect to each of the three series of 2006 Certificates (each, a "Swap" and collectively, the "Swaps"), each with Citibank, N.A., New York, which became effective on December 28, 2006. The terms of the Swaps are substantially identical to one another and are payable from the revenues of the District. The notional amount of each Swap equals the aggregate principal amount of the related series of 2006 Certificates and will be reduced by an amount equal to the principal amount of the related series of 2006 Certificates that are redeemed. Under each Swap, the District pays a fixed rate of 3.218% per annum and receives a variable rate equal to 56% of the 1-month London Interbank Offered Rate plus 23 basis points. Net payments are made on a same-day basis. See "—Investment and Swap Policies" below and "RISKS RELATED TO DISTRICT OPERATIONS—Other Operational Risk Factors—*Risks Related to Outstanding Variable Rate Obligations and Interest Rate Swap Transactions*" herein.

Liquidity and Capital Resources

The District's unrestricted liquidity position as of June 30, 2007 was $109.1 million, including $1.4 million in operating cash and $107.8 million in unrestricted investments stated at fair market value. The available liquidity of $109.2 million represents a 2.5% decrease over the $112.0 million in available liquidity as of June 30, 2006, and equaled 47.3% of total outstanding debt as of June 30, 2007 (excluding the 2005 GO Bonds which are paid from ad valorem property taxes), as compared to available liquidity representing 103.9% of total outstanding debt as of June 30, 2006.

The District's primary need for capital resources is the necessary facility construction, repairs and expansions contemplated in its Facilities Master Plan. See "FACILITIES MASTER PLAN, SERVICE AREA AND COMPETITION—Facilities Master Plan" herein for a discussion of the anticipated funding sources for the Facilities Master Plan.

Capitalization

The following table sets forth the actual and pro forma capitalization of the District as of June 30, 2007. As more fully described in the front portion of this Official Statement under the caption "SECURITY AND SOURCE OF PAYMENT OF THE BONDS," all GO Bonds, including the Bonds and the 2005 GO Bonds, are payable from, and secured by, a pledge of ad valorem taxes. The District expects that the Bonds, the 2005 GO Bonds and any additional GO Bonds issued by the District pursuant to Measure BB will be repaid from such pledged ad valorem taxes. However, pursuant to Section 32127 of the Local Health Care District Law, the District is required to apply amounts on deposit in its maintenance and operations fund whenever ad valorem taxes are insufficient to make such payments. Therefore, actual and pro forma capitalization are presented both including and excluding the Bonds and the 2005 GO Bonds.

	With GO Bonds[1]		Without GO Bonds[1]	
	Actual	**Proforma**	**Actual**	**Proforma**
Bonds[1]	-	$250,000	-	-
2006 Certificates	$179,176	179,176	179,176	179,176
2005 GO Bonds[1]	77,343	77,343	-	-
Series 1999 Bonds	51,425	51,425	51,425	51,425
Total Long-Term Debt	$307,944	$557,944	$230,601	$230,601
Less: Current Portion of Long-Term Debt	13,220	13,220	7,765	7,765
Long-Term Debt, Net of Current Portion	$294,724	$544,724	$222,836	$222,836
Total Net Assets	297,457	297,457	297,457	297,457
Total Capitalization	$592,181	$842,181	$520,293	$520,293
Percentage of Long-Term Debt, Net of Current Portion, to Total Capitalization	49.77%	64.68%	42.83%	42.83%

Source: The District.

(1) The District is authorized to issue up to $496,000,000 principal amount of its GO Bonds to pay costs of the Facilities Master Plan.

Debt Service Coverage of Revenue Obligations

The table below sets forth the maximum annual debt service* requirement and the maximum annual debt service coverage ratio on the 2006 Certificates and the Series 1999 Bonds for fiscal years ended June 30, 2006 and 2007. The table below excludes the Bonds and the 2005 GO Bonds because such GO Bonds are payable from, and secured by a pledge of, ad valorem taxes to be levied and collected by the County of San Diego on taxable property within the District's boundaries and such GO Bonds are not secured by any pledge of gross operating revenue that are pledged to pay the 2006 Certificates and the Series 1999 Bonds. Although the District is legally required to repay the GO Bonds if such pledged ad valorem taxes are insufficient, management of the District expects that the GO Bonds will be paid from such pledged ad valorem taxes.

	Fiscal Year Ended June 30, (dollars in thousands)	
	2006	2007
Excess of revenue over expenses	$20,981	32,997
Less: Property tax revenue – GO Bonds	(9,423)	(11,016)
Plus: Depreciation and amortization	18,737	19,453
Plus: Interest expense	4,406	3,337
Income Available for Debt Service	$34,701	44,771
Maximum annual debt service requirement[(*)(1)]	$14,237	$14,237
Maximum annual debt service coverage ratio[(1)]	2.44x	3.14x

Source: The District.

(*) Maximum annual debt service is assumed to be the maximum debt service payable in any fiscal year based upon actual principal and interest payments scheduled for the Series 1999 Bonds and the fixed rate on the Swaps related to the 2006 Certificates.

(1) Assumes the 2006 Certificates pay an interest rate of 3.21%, which is the fixed swap rate to be paid by the District under the Swaps. See "—Outstanding Swap Transactions" above.

Investment and Swap Policies

The District may invest in investments permitted under the California Government Code, which include: U.S. Treasuries, U.S. Agency Debt, State of California obligations, LAIF, Bankers Acceptances, Commercial Paper, Certificates of Deposit, Repurchase Agreements, Reverse Repurchase Agreements and Money Market Mutual Funds, all with a five year or less maturity. The District's investment program is overseen by professional outside investment advisors, who have been retained to manage specific classes of permitted investments.

The District Board has adopted a Debt and Swap Policy ("Policy") to establish guidelines for the execution and management of the District's use of variable rate debt and interest rate swaps, caps, options, basis swaps, rate locks, total return swaps and other similar products (collectively, "Swap Products"). The Policy sets forth the parameters under which the District may enter into transactions involving Swap Products. The District may integrate Swap Products into its overall debt and investment management programs only in a manner in accordance with the parameters set forth in the Policy. The Policy sets forth the criteria for financial and risk management practices related to debt and Swap Products. The District Board plans to review the Policy periodically.

GOVERNANCE AND MANAGEMENT

District Board

The District is governed by a seven-member board elected by the eligible voters residing within the boundaries of the District. District Board members are elected to four-year terms with no term limitations. If a vacancy occurs mid-term, the District Board appoints, by majority vote, a replacement to fill the position until the next election, and the person elected serves the then-remaining term of office. Tenure of current District Board members ranges from less than one to more than ten years. As of October 2007, one District Board seat was vacated as a result of the

former District Board member moving out of state. It is expected that the remaining District Board members will appoint a new member at the December 2007 District Board meeting, such appointed member's term to expire in November 2008.

District Board Members	Position	Year First Elected	Term Expiration
Marcelo Rivera, M.D.	Chair	2000	2008
Nancy Bassett, R.N., MBA	Vice-Chair	2000	2008
Ted Kleiter	Treasurer	1996	2010
Linda Greer, R.N.	Secretary	2004	2008
Alan Larson, M.D.	Director and Past Chair	1998	2010
Bruce Krider, M.A.[1]	Director	2003	2010

[1] Board appointed in 2003 and elected in 2004 for balance of term. Elected to full term in November 2006.

The standing committees of the Board include, among others, the following:

Audit and Compliance	Governance
Community Relations	Human Resources
Facility and Grounds	Quality
Finance	Strategic Planning

Administratively, the District is structured as a matrix organization. All executive management team ("EMT") members and many directors have responsibilities for operations throughout all the District facilities. This structure encourages the transfer of best practices and supports a single standard of care. Board Committees are generally aligned with the responsibilities of a specific EMT member, providing a close working relationship that facilitates policy and budget decisions, as well as regulatory compliance.

Executive Management Team

MICHAEL H. COVERT, President and Chief Executive Officer. Michael H. Covert, F.A.C.H.E., came to the District as President and Chief Executive Officer in January 2003, bringing more than 35 years experience in health care administration. His previous positions include President and CEO of Sarasota Memorial Health Care System from 1992 to 2000; acting Director of the Public Health Department, Wichita, Kansas; Executive Director of the Ohio State University of Hospitals, Columbus, Ohio; Chief Operating Officer at St. Francis Regional Medical Center, Wichita, Kansas; and Senior Vice President of Physicians Corporation of America, Wichita, Kansas. From 2000 to 2002, Mr. Covert served as President and Chief Executive Officer of the Washington Hospital Medical Center in Washington, D.C., one of the 10 busiest hospitals in the United States and the largest in the DC/Maryland area. Mr. Covert received both a bachelor's degree in business administration and a master's degree in health administration from Washington University School of Medicine in St. Louis, Missouri and is a Fellow in the American College of Health Care Executives.

GERALD E. BRACHT, Chief Administrative Officer, PMC. Gerald E. Bracht has been the Chief Administrative Officer for PMC since 2002. He has over 20 years of experience in the health care industry. Mr. Bracht received a Bachelor of Science in Business Administration and a Masters in Business Administration from University of San Diego.

Mr. Bracht has held positions in materials management, support services, and administration. His positions have included Vice President/Administrator of Scripps Memorial Hospital and Ocean View Convalescent Hospital; Vice President, System Development at Scripps Health; and Vice President, Business Development and Operations Southwest Region for Cove HealthCare. Mr. Bracht has also provided independent consulting to hospitals and medical groups.

SHEILA BROWN, Chief Clinical Outreach Officer. Sheila D. Brown is the Chief Clinical Outreach Officer for the District and has been with the District since 1992 having fulfilled increasingly responsible management positions. She oversees the strategic planning, operations, business plan development and financial management for the following: Home Health, Behavioral Health, Ambulatory Care Surgical Center, Rehabilitation, Wound Care Center, Diabetes Health, Employee Health, Skilled Nursing Facilities, and Comprehensive Occupational Medicine. She has over 20 years experience in the health care industry. Ms. Brown received her Bachelors of Science in Nursing from St. Louis University. Ms. Brown then served on the management team for BJC Health System in St. Louis until her move to San Diego. Ms. Brown obtained her Master's degree in Business Administration from University of Phoenix in 1996 and is an Associate of the American College of Health Care Executives. She is also a fellow alumnus of the California Health Leadership College.

DUANE M. BURINGRUD, M.D., Chief Quality Medical Officer. Dr. Buringrud is a board certified OB/GYN physician who has been in private practice in Escondido, California for 25 years. Dr. Buringrud became the Chief Quality Medical Officer in 2005, which responsibility for facilitating processes with the medical staff to achieve the full implementation of national best practice clinical standards throughout the District health system continuum. He completed his Medical Degree from Texas Tech University, and internship and residency in OB/GYN at Naval Regional Medical Center, Oakland, California. Dr. Buringrud is a Diplomat of the National Board of Medical Examiners as well as a Diplomat of the American Board of Obstetrics and Gynecology. Dr. Buringrud has held numerous physician leadership positions, including, Chief of Staff, Co-Chair - Quality Council, Chairman – Medical Staff Credentials Committee, and Chairman – Department of OB/GYN.

GUSTAVO FRIEDERICHSEN, Chief Marketing & Communications Officer. Gustavo Friederichsen joined the executive management team January 2004. He came to the District from Sharp Healthcare, where he served as the Vice President of Communications, Public Relations and International Business. He also served as Director of Corporate Communications and Multicultural Services for Sharp from 1998 to January 2003, and Director of Strategic Communications for Tenet Healthcare Corporation in Santa Barbara, California. Offering a comprehensive background in communications, Mr. Friederichsen served as Senior Policy Advisor to Supervisor Ron Roberts from 1996 to 1997, Public and Government Relations Manager for Scripps Health in San Diego from 1991 to 1996 and Deputy Director for Communications with the U.S. Department of Health & Human Services in Washington, D.C. from 1990 to 1991. Mr. Friederichsen has a bachelor's degree in Journalism from San Diego State University, attended the Executive Management program at the University of Notre Dame Mendoza School of Business and Executive Education at the Wharton School of Business.

WALTER L GEORGE, Chief Human Resource Officer. Wallie George joined the executive management team at the District in September 2005. He is responsible for clinical

education, organizational development, compensation and benefits, workers' compensation, recruitment, employee relations, and HR information systems. Mr. George has over 30 years experience in Human Resource leadership. Prior to joining the District, he served as Interim Vice President and Riverside Methodist Hospital in Columbus, Ohio. He was Senior Vice President of Human Resources at Mercy Health Partners for five years, and prior to that was Vice President of Human Resources as Sarasota Memorial Hospital in Florida for five years. Mr. George was also Vice President of Human Resources Presbyterian St. Luke's Medical Center in Denver, Colorado and worked at the Federal Aviation Administration as Chief of the Labor Relations Branch. Mr. George received his Bachelors in Business Administration at Eastern Illinois University and his Masters in Management at Regis University in Denver, Colorado.

STEVE GOLD, Interim Chief Administrative Officer. Steve Gold was appointed the District's Interim Chief Administrative Officer in 2007. In addition, he is the Administrator for Skilled Nursing Services for Palomar Pomerado Health. He has over 30 years of experience in the healthcare industry, having worked for non-profit health systems, long-term care facilities, long-term care physician group practices, managed care products and community-based health care systems. Mr. Gold received his BS in Business Administration from the State University of New York at Buffalo, and his MHA from the State University of New York at Stony Brook. He is a Certified Fellow of the American College of Health Care Administrators, a member of ACHE, a Licensed Nursing Home Administrator. He serves on the Boards of the Poway Chamber of Commerce and the California Hospital Association's Hospital Services for Continuing Care. Previously, he served as Chairman of the American Hospital Association Rehab & Long-Term Care Governing Council, as well as a Governor's Appointee to the Virginia Health Services Cost Review Council

ROBERT HEMKER, Chief Financial Officer. Robert Hemker was appointed CFO of the District in May 2001 and served as the District's Interim President and CEO from May 2002 through January 2003. A 25-year veteran of the health care industry, Mr. Hemker has extensive experience managing the financial and operational aspects of health care organizations, working closely with community, physician, and board representatives. His career includes Chief Financial Officer, Chief Operating Officer and Chief Executive Officer responsibilities in for-profit, not-for-profit, and governmental acute care hospitals in Southern California and Hawaii, as well as consulting experiences to various health care sectors. Mr. Hemker holds a Master's in Healthcare Administration from the University of LaVerne and a BS in Accounting from San Diego State University. Currently, he serves as Chair for the HFMA National CFO Forum Peer Council, Chair of the VHA West Coast CFO/COO Forum, Treasurer of the worker compensation captive, Alpha Fund, a member of the ACHD Finance Committee and a member of the Beta Alliance Insurance Group Board of Directors. He is a frequent speaker on various topics to the Healthcare Industry.

MARCIA JACKSON, Chief Planning Officer. Marcia Jackson joined the District in April 2000. Ms. Jackson is responsible for the developing and overseeing the implementation of the annual and long-term strategic planning, physician relations and recruitment and development of business plans. Ms. Jackson has over 18 years experience in healthcare planning, marketing and business development, including the construction of a 100,000 square foot maternity center. She has an MBA from the University of California, Riverside.

Ms. Jackson serves as the Chair of the Board of Directors of Partners for Community Access and serves on the Meals on Wheels Board of Directors. Marcia is a Fellow of the Health Forum's Creating Healthier Communities Fellowship Program.

OPAL REINBOLD, Chief Quality Officer. Opal Reinbold joined the District in May 2005, with responsibility for the performance improvement/patient safety and resource utilization programs for the health system, working closely with the designated physician leaders for the health system. Ms. Reinbold's prior work experience includes Vice President for Performance Improvement at Sharp Healthcare. She was the Principal of West Coast Division of the Accreditation and Assessment practice of Premier Inc., System-wide Director of Quality Resource Management for Scripps Health in San Diego, Vice President with Holy Cross Health System, and Director of Accreditation Services with the National Healthcare Advisory Services practice of BDO Seidman, LLP. Ms. Reinbold has a BA degree from Boise State University.

JANINE SARTI, General Counsel. Janine Sarti is a member of the executive management team and joined the District in June 2007. She is responsible for the delivery of legal services throughout the entire organization. Ms. Sarti has over 25 years experience in General Counsel leadership for healthcare organizations. Prior to joining the District, she was Regional Vice President and General Counsel for St. Luke's Health System in Boise, Idaho, and prior to that was Regional Vice President, General Counsel, Legal, Risk, and Mission for Catholic Health Initiatives. Her experience includes representing not for profit, for profit, and governmental acute care hospitals, as well as other types of healthcare organizations. Ms. Sarti received her Bachelor's in Business Administration and Political Science from Linfield College, and her Juris Doctor from Gonzaga University School of Law.

LORIE SHOEMAKER, Chief Nurse Executive. Lorie Shoemaker was appointed Chief Nurse Executive in March 2004. She oversees the nursing divisions for the District. She has 20 years experience with the District, having fulfilled progressive management positions since 1992. Ms. Shoemaker received her Registered Nursing degree from the College of the Desert in Palm Desert, CA in 1974. She obtained her Bachelor of Science in Nursing degree from National University in 1997 and Master of Science in Nursing degree from the University of Phoenix in 2000. Ms. Shoemaker is an alumnus of the 2004 Johnson & Johnson/Wharton Fellows Program in Management for Nurse Executives and in 2005 obtained certification in Advanced Nursing Administration (CNAA-BC) from the American Nurses Credentialing Center.

STEVEN TANAKA, Chief Information Officer. Steve Tanaka has been serving as the Chief Information Officer since 2005. Mr. Tanaka is responsible for the IS Division of the District. He has overall responsibility for the IS and Telecommunications operations and strategic planning. Mr. Tanaka has over 20 years experience in Information Technology leadership roles. Prior to being appointed to his current position, Mr. Tanaka served as the Project Manager and Director of Application Services at the District from 2003 to 2004. He also served as Director of Information Technology at Scripps Health. Mr. Tanaka has a BS degree in Microbiology from San Diego State University and is a graduate of the UCSD Healthcare Executive Leadership Certificate Program.

BENJAMIN KANTER, Chief Medical Information Officer. Benjamin Kanter MD FCCP has served the District as CMIO with responsibilities for the development of clinical information systems since September 2006. Dr. Kanter is Board Certified in Internal Medicine

and Pulmonary Disease, and received special certification in Critical Care in 1990. He has been in private practice in Escondido, California for 19 years. Dr. Kanter graduated from the University of Michigan with Distinction and Honors, after which he received his Medical degree and Internal Medicine training at Northwestern University in Chicago. He completed his post-doctoral studies in both Pulmonary Disease and Critical Care Medicine at the U.C.S.D. Medical center. Dr. Kanter continued to teach at U.C.S.D. as an associate clinical professor of medicine after going into private practice. He has served in numerous leadership roles within the District including chairing the departments of Medicine at both PMC and Pomerado Hospital, directed Respiratory and Critical Care services at Pomerado Hospital, and founded and maintains his directorship over the Palomar Medical Center Sleep Disorders Laboratory. He received certification training in electronic health records and hospital information systems in 2006. Dr. Kanter currently serves as the Chief of Staff at Pomerado Hospital and chairs their medical executive committee.

Foundation Management

DANA DAWSON, President & Chief Development Officer, Palomar Pomerado Health Foundation. Dana Dawson was appointed to this position in September 2006. Mr. Dawson has more than 23 years of fundraising experience, helping raise $148.5 million in his career. Mr. Dawson is a Certified Fund Raising Executive (CFRE). Mr. Dawson experience includes, Development PLUS Fundraising Counsel Inc., West Park Health Care Centre Foundation, North York General Hospital Foundation, and Ketchum Co. of Canada. He has led a number of successful campaigns, and has served as a director for several foundations in areas of health care, education, non-profit and performing arts. Mr. Dawson's previous fundraising campaigns include; Alzheimer's Society of Peterborough and Lindsay, Ontario, Hotel Dieu Hospital Foundation, Toronto Association for Community Living, The Queen Elizabeth Hospital Foundation, Sault Area Hospital Foundation, Ross Memorial Hospital Foundation, The Wellesley Hospital Foundation, Ryerson Polytechnic University, University of Toronto Schools, Holland College and the University of Calgary.

OTHER INFORMATION

Medical Staff

As of October 2007, the District had a total of 650 physicians on the separate medical staffs of the PMC (608) and of Pomerado (430). Approximately 85% are board-certified in their respective specialties within approximately 42 specialties. Both hospitals' Medical Staff Bylaws require board certification as a condition for medical staff privileges. The exceptions are: physicians who have been grandfathered in if they were on the medical staff prior to this requirement; and physicians newly out of residency programs are given a specified number of years to achieve board certification. The medical staffs include: primary care physicians – PMC (195) and Pomerado (86); surgeons – PMC (148) and Pomerado (104); and medical specialists – PMC (101) and Pomerado (84). Based on an analysis of the age distribution of the physicians, with the average age being 48 and with only 11% of the physicians age 63 or older, District management does not expect to experience decrease in admissions due to retirement in the near future.

In accordance with legal requirements, the District has a formalized physician recruitment program that has been in place for approximately five years, under which income

guarantees may be provided to physicians who move to the District's service area to establish a medical practice to meet community need. When possible, these recruitments are undertaken in conjunction with a physician or medical group already practicing in the service area, who either want to expand their capacity to care for additional patients or who are recruiting to fill a vacancy due to retirement or a physician relocating. The District has been involved in recruitment of 12 physicians to its medical staffs, all of whom are still practicing in the District's service area.

Accreditations, Certifications and Memberships

The District is subject to regulatory oversight by the Centers for Medicare and Medicaid Services, The Joint Commission, the California Department of Health Services, among others. In 2004, the District received three year accreditation from JCAHO. Management of the District anticipates that it will have its next accreditation survey during the first quarter of calendar year 2008. As a result of its performance on The Joint Commission surveys, the District was selected in 2005 as one of 25 health care organizations nationwide to participate in a The Joint Commission pilot study to further improve the accreditation process. The District has voluntarily initiated accreditation/certification for specific programs such as the Acute Rehabilitation Unit from the Commission on Accreditation of Rehabilitation Facilities (CARF) and Clinical Laboratory from College of American Pathologists.

Generally, hospitals in the County are experiencing nursing shortages. To address the nursing shortage, the District is collaborating with local colleges to expand the supply of nurses. Early in calendar year 2006, the District expended $2.5 million for improvements in the District's San Marcos Ambulatory Care Center, which improvements are provided without charge to California State University at San Marcos, Palomar College and Mira Costa College for nursing education programs. The District's goal is to increase the pool of nursing graduates available to the District. The District is implementing several other initiatives to meet nursing needs, including: formal in-house training programs for nurses to train for hard-to-fill nursing positions such as critical care; collaborating with key nursing publications for print and web-based recruitment; system-wide employee referral program for nursing and other allied health care professions; tuition reimbursement programs; and a nursing student loan forgiveness program. In the shorter term, the District anticipates that the demand for nurses will continue to outweigh supply and the District will continue to use registry (temporary agencies for nurses). During the fiscal years ended June 30, 2006 and 2007, the District spent approximately $12.6 million and $8.5 million, respectively, on registry in nursing and other patient care services areas. See "MANAGEMENT'S DISCUSSION OF FINANCIAL PERFORMANCE – Management's Discussion and Analysis of Historical Performance" set forth above.

Employees and Labor Relations

As of June 30, 2007, the District employed approximately 2,700 productive full-time equivalent employees. Approximately 2,260 employees are full-time and 1,230 are part-time and per diem. Approximately 68% have been represented by the California Nursing Association and California Healthcare Employees Union since June 2003. The District and these Unions completed successful negotiations and entered into new three year employment agreements effective June 30, 2006. The District and the unions have a collaborative working relationship and there have been no work stoppages or strikes.

Pension and Deferred Compensation Plans

Since July, 1980, the District has provided a defined contribution retirement plan for employees, under which benefits are limited to amounts accumulated from total contributions by the District and capital appreciation of the invested amounts as directed by the individual employee. Contributions under the plan by the District equal 6% of covered employees' basic compensation after one year of employment and are funded as incurred. Total District contributions expensed for its fiscal years ended June 30, 2007 and 2006 were $9.5 million and $7.5 million, respectively.

Effective July 2006, the District began providing an employer match to the employee deferred compensation plan. Under the plan, the District matches up to 2% of the employee's contribution, based on a variety of factors including length of employment. Prior to July 2006, contributions to the deferred compensation plan were made only by employees who chose to participate. During fiscal year 2007, the District made matching payments of $1.2 million.

Regulatory and Ethics Compliance Programs

The District has a corporate compliance officer and maintains a corporate compliance program intended to be consistent with laws and government guidance relating to compliance programs for health care entities. The program includes education of employees and managers about certain significant legal and regulatory requirements applicable to the District and includes steps to monitor and promote compliance with these requirements. All employees are provided a copy of the District's Code of Conduct Policy.

With the goal to develop a "best practices" ethics compliance program, the District's Board has implemented standards for ethics, business practices and codes based on the State's ethics standards, has formed Board Audit and Compliance Committee, and has identified standards of behavior that are consistent with the values of the organization. The District's Board and all staff members are required to undergo mandatory ethics and compliance training. New staff undergo background checks and must sign Compliance Attestation forms upon initial hiring. Physicians are required to sign conflict of interest statements and are also subject to background checks upon initial and re-credentialing. Additionally, all leadership must attest that they are aware of no unreported wrong-doing. Although not required, the District has implemented formal Compliance and Internal Audit Programs. The programs have reporting responsibility to the CEO and direct access to the Board of Directors through the Board Audit and Compliance Committee. Promoted by senior leadership, every employee is entitled to direct anonymous access to the District's Compliance Officer and an accompanying anonymous compliance hotline exists for employees, patients, and physicians to report perceived breaches in legal and ethical behavior.

Although not required, the District has implemented formal Compliance and Internal Audit Programs. The programs have reporting responsibility to the CEO and direct access to the Board of Directors through the Board Audit and Compliance Committee.

Insurance and Risk Management

The District is insured through Program BETA for hospital professional and general liability risks for the first $5 million of loss per occurrence and excess coverage of the next $15

million of loss per occurrence on a claims made basis. Program BETA has a Best rating of "A-" (excellent). Deductible is $50,000 per claim with no annual aggregate. The District is insured by Alpha Fund for workers compensation risk. Alpha Fund is a workers compensation captive program of the Association of California Healthcare Districts. Losses in excess of this amount are insured through reinsurance policies of Alpha Fund. Effective July 1, 2007, the District went to a guaranteed loss level of coverage with Alpha Fund.

The District is insured through commercial insurance companies for all risk property losses, excluding earthquake, up to $1 billion. The primary layer $10 million with various amounts of excess coverage up to the stated limit. Maximum deductible, depending on loss type, per occurrence is $50,000.

Seismic Compliance

A significant earthquake could have a material adverse effect on the District and could result in material damage and temporary or permanent cessation of operations at its facilities. Earthquakes affecting California hospitals have prompted the State to impose new hospital seismic safety standards, commonly known as S.B. 1953. Hospital acute care buildings are required by S.B. 1955 to meet more stringent seismic guidelines generally by 2008.

In 2005, the District requested and received an extension of time until January 1, 2013 to comply with S.B. 1953 requirements. Completion of the initial phase of the District's Facilities Master Plan will enable the District to comply with S.B. 1953 requirements.

RISKS RELATED TO DISTRICT OPERATIONS

This section discusses risks related to District operations and focuses primarily on the general risks associated with the operations and activities of hospitals and health care systems; whereas other portions of this APPENDIX A describes the District specifically and APPENDIX B contains financial statements of the District. These should be read together. This discussion is not intended to be comprehensive or definitive, but rather is intended to summarize certain risks related to District operations.

General

The Bonds are payable from ad valorem taxes, as discussed under "SECURITY AND SOUCE OF PAYMENT OF THE BONDS" in the front part of this Official Statement. The Board of Supervisors of the County has the power and authority and is obligated to annually levy ad valorem taxes upon all property subject to taxation in the District, without limitation as to rate or amount, for the payment of principal of and interest on the Bonds (except certain personal property which is taxable at limited rates). The District anticipates that ad valorem taxes collected by the County for the District will be sufficient to pay all of the District's GO Bonds when due. However, in the event that the County fails to levy and collect sufficient ad valorem taxes, Section 3217 of the Local Health Care District Law requires the District to use moneys in its maintenance and operation fund to pay principal of and interest on its GO Bonds whenever ad valorem taxes are insufficient to pay such principal and interest.

Any of the operational risk factors described in this APPENDIX A may affect the District's operations, and there can be no assurance that the financial condition or operations of the District will not be adversely affected by any of these or other factors.

The District is a local health care district and political subdivision of the State and as such its powers and the methods of exercising its powers are governed by the laws of the State, which can be, and have been, amended by the State legislature from time to time. The District and its affiliates are subject to a wide variety of federal and State regulatory actions and legislative and policy changes by those governmental agencies and private entities that administer the Medicare and Medi-Cal (Medicaid) programs and by private entities that administer other payment arrangements. The District and its affiliates are subject to actions by, among others, the Centers for Medicare and Medicaid Services (or CMS), the U.S. Department of Health and Human Services (or DHHS), the National Labor Relations Board, The Joint Commission, and other federal, state and local governmental agencies.

The future financial condition of the District and its affiliates could be adversely affected by, among other things: changes in the method and amount of payments to the District and its affiliates by governmental payors, nongovernmental payors, the financial viability of these payors, increased competition from other health care entities, the costs associated with responding to governmental inquiries and investigations, demand for health and medical care, changes in the methods by which employers purchase health care for employees, capability of management, future changes in the economy, demographic changes, availability of physicians and nurses, malpractice claims and other litigation, and changes in the State laws governing local health care districts, hospital operations (including nursing ratios) and licensure, among other factors. These factors and others may adversely affect the financial condition or results of operations of the District.

Set forth below is a limited discussion of certain of the risks affecting the District. The discussion below does not discuss all such risks. In particular, payment provisions and regulations and restrictions on hospitals change frequently and that additional material payment limitations and regulations or restrictions may be created, implemented or expanded.

Significant Operational Risk Areas Highlighted

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

Reliance on Government Payors. Hospitals and health care systems rely to a high degree on revenues from Medicare and Medicaid. Medicare and Medicaid are the commonly used names for reimbursement or payment programs governed by certain provisions of the federal Social Security Act. Future changes in the underlying law and regulations, as well as in payment policy and timing, creates uncertainty and could have a material adverse impact on hospitals' payments from Medicare and Medicaid. With health care and hospital spending reported to be increasing faster than the rate of general inflation, Congress and/or CMS may take action in the future to decrease or restrain Medicare and Medicaid outlays for hospitals.

Managed Care Exposure. Certain hospital markets, including the communities served by the District, are strongly impacted by managed care. In these areas, managed care companies have significant bargaining power over hospital rates, utilization and competition. Rate pressure imposed by managed care payors may have a material adverse impact on hospitals, particularly if employer groups and other major purchasers put increasing pressure on payors to restrain rate increases.

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 of California may require that many hospital facilities be substantially modified, replaced or closed. Nearly all hospitals in California are affected. Estimated construction costs are substantial and actual costs of construction may exceed estimates. Total capital needs may exceed capital capacity.

Construction Risks. Construction projects are subject to a variety of risks, including but not limited to delays in issuance of required building permits or other necessary approvals or permits, including environmental approvals, strikes, shortages of materials and adverse weather conditions. Such events could delay occupancy. Cost overruns may occur due to change orders, delays in the construction schedule, scarcity of skilled trade labor, scarcity of building materials and other factors. Cost overruns could cause the costs to exceed available funds. See "FACILITIES MASTER PLAN, SERVICE AREA AND COMPETITION – Facilities Master Plan" herein.

The District's Status as Local Health Care District. As a local health care district and political subdivision of the State, the powers of the District and the method of exercising its powers are governed by the laws of the State, which have been, and may in the future be, amended by the State legislature and interpreted by State courts. Such amendments and interpretations could be adverse to the District. There can often be a tension between the law and rules designed to regulate governmental entities, such as the District, and the day-to-day operations of a complex health care organization. In addition, as a local health care district, the District is subject to laws that non-governmental competitors are not, including restrictions on the use of public funds, the Brown Act (which generally requires the District Board of Directors to take action only at public meetings), local health care district law (which has been interpreted as, among other things, prohibiting local health care districts from granting indemnities in certain circumstances), and various laws prohibiting conflicts of interest. These laws impose additional operational burdens on hospitals run by local health care districts that do not apply to other hospitals, and may result in prosecution or other sanctions, if violated.

General Economic Conditions; Bad Debt and Indigent Care. Economic downturns and lower funding of the Medicare and Medi-Cal programs may increase the number of patients treated by hospitals who are uninsured or otherwise unable to pay for some or all of their care. These conditions may give rise to increased bad debt and higher indigent care utilization. These factors may have a material adverse impact on hospitals.

Government "Fraud" Enforcement. "Fraud" in government funded health care programs is a significant concern of DHHS, CMS and many states 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 complex and technical requirements intended to prevent over-utilization based on economic inducements, misallocation of expenses, overcharging and other forms of "fraud" in the Medicare and Medicaid programs, as well as other state and federally-funded health care programs. This body of regulation impacts a broad spectrum of hospital 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. The government periodically conducts widespread investigations covering categories of services or certain accounting or billing practices.

The government and/or private "whistleblowers" often pursue aggressive investigative and enforcement actions. The government may impose a wide array of civil, criminal and monetary penalties, including withholding essential hospital 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 settlements, payment of fines and prospective restrictions that may have a materially adverse impact on hospital operations, financial condition and reputation. Multi-million dollar fines and settlements are common. These risks are generally uninsured. Government enforcement and private whistleblower suits may increase in the hospital sector.

Personnel Shortage. Currently, a shortage of physicians and nursing and other technical personnel exists which may have its primary impact on hospitals. Various studies have predicted that this shortage will become more acute over time and grow to significant proportions. In California, State regulation of nurse staff ratios will likely intensify the shortage of nursing personnel. Hospital operations, patient and physician satisfaction, financial condition and future growth could be negatively affected by physician and nursing and other technical personnel shortages, resulting in material adverse impact to hospitals.

Labor Costs and Disruption. Hospitals are labor intensive. Labor costs, including salary, benefits and other liabilities associated with the workforce, have significant impact on hospital operations and financial condition. Hospital 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 and reputation.

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.

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 are increasing, bringing with it operational limitations, enforcement and liability risks, and significant and sometimes unanticipated cost impacts.

Proliferation of Competition. Hospitals increasingly face competition from specialty providers of care and free-standing outpatient facilities, such as diagnostic imaging centers and ambulatory surgery centers. This may cause hospitals to lose essential inpatient or outpatient market share. Competition may be focused on services or payor classifications where hospitals realize their highest margins, thus negatively affecting programs that are economically important to hospitals. These new sources of competition may have 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 competitor facilities. The growing consumer movement for pricing transparency may also adversely impact hospitals' charging structure.

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. 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 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.

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

Health Care Reform. Federal and state officials have proposed various health care reform plans that, if enacted, would make significant changes in the way health care services are delivered and reimbursed. It is anticipated that more health care reform proposals will be forthcoming. Some proposals are sweeping and would require conforming and complex changes to both federal and state laws addressing many aspects of hospital operations, health care delivery and reimbursement. These changes could result in lower hospital reimbursement, utilization changes, increased government enforcement and other impacts.

Patient Service Revenues

The Medicare Program. Medicare is the federal health insurance system under which hospitals and other health care providers are paid for services provided to eligible elderly and disabled persons. Medicare is administered by the Center for Medicare and Medicaid Services ("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. Compliance is determined by the

state, but hospitals with accredited by The Joint Commission are deemed compliant. 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 to address such changing requirements.

The District's hospitals are Medicare-certified and for the fiscal years ended June 30, 2007 and June 30, 2006, Medicare, inclusive of regular Medicare, Medicare Managed Care and Senior Capitation, represented approximately 44.3% and 44.9%, respectively, of the District's gross patient service revenue for such year. See "HISTORIC FINANCIAL INFORMATION - Sources of Patient Revenue" herein.

In December of 2003, the Medicare Prescription Drug, Improvement and Modernization Act of 2003 ("MPDIM") was enacted. MPDIM significant changes include, without limitation, the expansion of outpatient prescription drug coverage through the creation of a voluntary prescription drug benefit, the replacement of the current Medicare Plus Choice managed care program with a new program, Medicare Advantage, that offers additional health plan options, modifications to coverage and payment for various providers under traditional fee-for-service Medicare, changes to combat waste, fraud and abuse, and reforms to regulatory procedures.

Hospital Inpatient Payments. Hospitals are generally paid a pre-determined payment amount for inpatient services provided to Medicare beneficiaries based on diagnosis-related groups ("DRGs"). The principal diagnosis and principal procedure determine DRG assignment. The DRG rate covers all care provided to a beneficiary during an inpatient stay. The actual cost of providing care, including capital costs, may be more or less than the DRG reimbursement rate. DRG rates are subject to adjustments by CMS 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.

The individual or collective impact of these changes cannot be determined at this time. Additional actions by the federal government in future years affecting Medicare coverage and payment may occur.

Hospital Outpatient and Other Services. Hospitals are also paid a pre-determined payment amount for most outpatient services based upon ambulatory payment classification ("APC") groups. An APC group includes various services and procedures determined to be similar. The APC payment, which bases payment on APC groups rather than on individual services, may not be sufficient to cover the actual costs of the outpatient services. Medicare payment for skilled nursing services, psychiatric services, inpatient rehabilitation services, and home health services are based on regulatory formulas or pre-determined rates.

Part D Drug Benefit. Beginning January 1, 2006, the Medicare Modernization Act of December 2003 ("MMA") implemented a major expansion of the Medicare program through the introduction of a prescription drug benefit under new Medicare Part D. Medicare beneficiaries, who elect Part D coverage and are dual eligible, will be enrolled automatically in Part D and will have their outpatient prescription drug costs covered by this new Medicare benefit, subject to certain limitations. Accordingly, Medicaid will no longer be a significant payor for the prescription pharmacy services provided to these residents. Medicaid will continue as a significant payor for over-the-counter medications.

Ambulatory Surgery Centers ("ASC"). An ASC is a distinct entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients. There are two elements in the total charge for a covered surgical procedure – a charge for the "facility" services (such as use of an operating room) and a charge for the physician's professional services for performing the procedure. Each ASC covered service is assigned to one of the payment groups. ASC facilities are paid according to the rates established in list of covered ASC services. Each covered service is assigned to a "group." Each group has a specified payment rate that applies to all services assigned to that group. These rates, as they may change from time to time, may not be adequate to cover the actual cost of providing these services to Medicare patients.

Inpatient Rehabilitation Facilities ("IRFs"). IRFs are free standing rehabilitation hospitals and rehabilitation units in acute care hospitals. They provide an intensive rehabilitation program and patients who are admitted must be able to tolerate three hours of intense rehabilitation services per day. These facilities are exempt from the Medicare Hospital PPS and are paid under the IRF Prospective Payment System ("IRF PPS"). In order to be paid under the IRF PPS, the facility must submit the IRF-PAI (patient assessment instrument). 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.

Skilled Nursing Facilities ("SNFs"). Medicare reimburses SNFs for long-term care services at a predetermined rate, based on the anticipated costs of treating patients. Under this system, reimbursement rates are determined by classifying each patient into a resource utilization group ("RUG"), a category that is based upon each patient's acuity level.

Medi-Cal, the state-administered medical assistance program for the indigent reimburses SNFs for long-term care services for individuals who are Medicaid eligible and qualify for institutional care. Medi-Cal reimbursement rates are generally lower than reimbursement provided by Medicare. 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. Given that Medi-Cal outlays are a significant component of state budgets, we expect continuing cost containment pressures on Medicaid outlays for SNF services.

Medicare Advantage. The MMA renamed the Medicare Plus choice program "Medicare Advantage" ("MA") and created new regional PPOs, "special needs plans" for dual eligibles, the institutionalized, or those with severe and disabling conditions, and new private drug plans that went into effect in January 2006. MA plans are generally required to provide all Medicare-covered benefits. Plans with costs below their Medicare payments must distribute savings to beneficiaries as lower plan premiums and co-payments, additional benefits, or a reduction in Part B premiums; or plans can contribute to a reserve fund.

Medi-Cal Program. Medicaid is the joint state-federal assistance program for certain qualifying individuals and their dependants operated by individual states with the financial participation of the federal Government. Medi-Cal is the California Medicaid program. The federal government provides substantial funding to the Medi-Cal program, so long as it meets federal standards. Attempts to balance or reduce the federal budget and/or California's budget will likely negatively impact Medi-Cal spending.

For the fiscal years ended June 30, 2007 and June 30, 2006, the District received approximately 16.5% and 15.7%, respectively, of gross patient service revenues from Medi-Cal programs for such year. See "HISTORIC FINANCIAL INFORMATION-Sources of Patient Revenue" herein.

Under a five-year federal Medicaid waiver most recently approved by CMS in 2005, the State selectively contracts with hospitals to provide acute 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 disproportionate share hospitals and an individual hospital's ability to control costs.

Generally, such selective inpatient contracting is made on a negotiated per diem payment basis, and such payment rates historically have not increased in direct relation to inflation or provider costs. Medi-Cal payments for inpatient hospital services are also subject to an aggregate statewide upper payment limit, under which aggregate payments to non-public hospitals may not exceed the aggregate amount which would have been paid if Medicare payment principles were utilized. Additionally, the total Medi-Cal payments to an individual hospital for inpatient hospital services for any fiscal period may not exceed that hospital's customary charges for the services. Medi-Cal payments for outpatient hospital services are based on fee schedules set by the State.

Generally, the State or the contracting hospitals may terminate Medi-Cal contracts upon 120 days' prior written notice. The State also may terminate these contracts without notice under certain circumstances and is obligated to make contractual payments only to the extent the State legislature appropriates adequate funding therefor.

Disproportionate Share Payments. The federal Medicare and the California Medi-Cal programs provide additional payment for hospitals that serve a disproportionate share of certain low income patients. The District does qualify as a disproportionate share hospital under the Medicare program, but does not qualify as a disproportionate share hospital under the Medicaid program and does not expect to qualify in future years.

State Budget. The State of California faces severe financial challenges that have resulted in a shortfall between revenue and spending demands. The financial challenges facing the State of California may negatively affect hospitals in a number of ways, including, but not limited to, a greater number of indigent patients who are unable to pay for their care and a greater number of individuals who qualify for Medi-Cal and/or reductions in Medi-Cal payment rates.

California Universal Health Care Proposal. Recently, several proposals have emerged that would, if enacted, expand health care coverage for individuals in California. Early in 2007, Governor Schwarzenegger proposed a plan that would expand health care coverage through various methods, including a mandate that all California residents maintain health coverage and that employers with 10 or more employees offer coverage or contribute 4% of payroll toward the cost of employees' coverage. This plan would be financed through increased federal funding, a 2% fee on physician revenue, a 4% fee on hospital revenue and a sliding scale individual/family contributions of between 3% and 6% of income. Late in 2006, Assembly Speaker Nunez introduced Assembly Bill 8 ("AB 8") that would expand health care coverage through various

methods, including expansion of eligibility for the State's Medi-Cal and Healthy Family Programs, creation of a statewide health care purchasing program and modification to the rules governing private individual and group health insurance. AB 8 would be financed through employer and employee contributions and new federal matching dollars associated with public program expansion. As of September 2007, the Assembly and Senate passed AB 8. Governor Schwarzenegger announced his intent to veto AB 8 and called a special legislative session to continue negotiations related to the expansion of health care coverage. One or more proposals for financing a compromise measure may be submitted to voters as a ballot measure in 2008.

It is not clear whether, or in what form, legislation will be enacted, nor what impact the legislation would have on the healthcare industry or the District. If legislation similar to that summarized in the above paragraph is enacted, California hospitals may potentially receive higher reimbursement from Medi-Cal and for indigent care but any net revenue increases may be offset by potentially significant "taxes" on revenues, employers' fees and increased cost of complying with additional regulatory requirements. It is not possible to gauge at this time whether the overall impact would be positive or negative to the District, but the effects could be material.

Health Plans and Managed Care. Most private health insurance coverage is provided by various types of "managed care" plans, including health maintenance organizations, or HMOs, and preferred provider organizations, or PPOs. To control costs, managed care plans typically contract with hospitals and other providers for discounted prices, review medical services for medical necessity, require members to pay co-payments and deductibles, and channel patients to contracted providers of health care services. Medicare and Medi-Cal also purchase hospital care using managed care options. Payments to hospitals from managed care plans typically are lower than those received from traditional indemnity or commercial insurers.

For the fiscal years ended June 30, 2007 and June 30, 2006, commercial managed care constituted approximately 20.7% and 20.5%, respectively, of gross patient service revenues of the District. See "HISTORIC FINANCIAL INFORMATION - Sources of Patient Revenue" herein.

In California, managed care plans have replaced indemnity insurance as the prime source of non-governmental payment for hospital services, and hospitals must be capable of attracting and maintaining managed care business. Many HMOs and PPOs currently pay providers on a negotiated fee-for-service basis or, for institutional care, on a fixed rate per day of care, which, in each case, usually is discounted from the typical charges for the care provided. As a result, the discounts offered to HMOs and PPOs may result in payment to a provider that is less than its actual cost. Additionally, the volume of patients directed to a provider may vary significantly from projections, and/or changes in the utilization may be dramatic and unexpected, thus jeopardizing the provider's ability to manage this component of revenue and cost.

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

For the fiscal years ended June 30, 2007 and June 30, 2006, capitated payments constituted approximately 12.1% and 13.8%, respectively, of gross patient service revenues of the District. See "HISTORIC FINANCIAL INFORMATION - Sources of Patient Revenue" herein.

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 a hospital. Hospitals from time to time have disputes with managed care payors concerning payment and contract interpretation issues.

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.

Actions by Purchasers of Hospital Services and Consumers. Major purchasers of hospital services also could take action to restrain hospital charges or charge increases. In California, the California Public Employees' Retirement System, the nation's third largest purchaser of employee health benefits, has pledged to take action to restrain the rate of growth of hospital charges and has excluded certain California hospitals from serving its covered members. As a result of increased public scrutiny, it is also possible that the pricing strategies of hospitals may be perceived negatively by consumers, and hospitals may be forced to reduce fees for their services. Decreased utilization could result, and hospitals' revenues may be negatively impacted.

Negative Rankings Based on Clinical Outcomes and Other Performance Measures

Health plans, Medicare, Medi-Cal, 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 physicians. Published rankings such as "score cards", tiered hospital networks with higher co-payments and deductibles for non-emergent use of lower-ranked providers, "pay for performance" and other financial and non-financial incentive programs are being introduced to affect the reputation and revenue of hospitals and the members of their medical staffs and to influence the behavior of consumers and providers such as the District. Prevalent currently 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 negatively may adversely affect its reputation and financial condition.

Regulatory Environment

"Fraud" and "False Claims." Health care "fraud and abuse" laws have been enacted at the federal and state levels to broadly regulate the provision of services to government program beneficiaries and the methods and requirements for submitting claims for services rendered to the beneficiaries. Under these laws, hospitals and other health care providers 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 an illegal inducement to utilize or refrain from utilizing a service or product.

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

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

Criminal Fraud and Abuse Liability. Both individuals and organizations are subject to prosecution under the criminal fraud and abuse statutes. Criminal conviction for an offense may result in substantial fines and/or the provider's exclusion and debarment from all government programs.

Criminal False Claims Act. The criminal False Claims Act or Criminal FCA prohibits anyone from knowingly submitting a false, fictitious or fraudulent claim to the federal government. There are numerous specific rules that a health care provider must follow with respect to the submission of claims. Violation of the Criminal FCA can result in imprisonment of five years and a fine of up to $250,000 for an individual or $500,000 for an organization.

Anti-Kickback Law. The federal "Anti-Kickback Law" is a criminal statute that 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 may be paid by any federal or state health care program. The Anti-Kickback Law applies to many common health care transactions between persons and entities with which a hospital or health care system does business, including hospital-physician joint ventures, hospital-physician integration vehicles (such as a medical foundation), medical director agreements, physician recruitment agreements, physician office leases, purchases from vendors, and other transactions.

Violation or alleged violation of the Anti-Kickback Law can result in settlements that require multi-million dollar payments and compliance agreements. The Anti-Kickback Law can be prosecuted either criminally or civilly. Each violation is 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 Medi-Cal programs. This fine may be increased to $250,000 for individuals and $500,000 for organizations. In addition, civil monetary penalties of $10,000 per item or service in noncompliance (which may be each item or each bill sent to a federal program) or an "assessment" of three times the amount claimed may be imposed.

Civil Fraud and Abuse Liability. Unlike criminal statutes, which require the government to prove that the health care provider intended to violate the law, civil statutes may be violated simply by the provider's participation in a prohibited financial arrangement or the provider having knowledge that its claims procedures are not in full compliance with the law.

Civil False Claims Act. The civil False Claims Act, or Civil FCA makes it illegal to submit or present a false, fictitious or fraudulent claim to the federal government, and may include claims that are simply erroneous. Civil FCA investigations and cases have become common in the health care field and may cover a range of activity from intentionally inflated billings, to highly technical billing infractions, to allegations of inadequate care. Violation or alleged violation of the Civil FCA can result in settlements that require multi-million dollar payments and compliance agreements. The Civil FCA also permits individuals to initiate civil actions on behalf of the government in lawsuits called "qui tam" actions. Qui tam plaintiffs, or "whistleblowers," can share in the damages recovered by the government or recover independently if the government does not participate. The Civil FCA has become one of the government's primary weapons against health care fraud. Civil FCA violations or alleged violations could lead to settlements, fines, exclusion or reputation damage that could have a material adverse impact on a hospital or other health care provider.

Stark Referral Law. [Under Review by Latham & Watkins] The federal "Stark" statute prohibits the referral by a physician of Medicare and Medi-Cal patients for certain designated health services (including inpatient and outpatient hospital services, clinical laboratory services, and various diagnostic imaging services) to entities with which the referring physician has a financial relationship. It also prohibits a hospital or other health care provider 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. Many ordinary business practices and economically desirable arrangements between physicians and hospitals or other health care providers arguably constitute "financial relationships" within the meaning of the Stark statute. The prohibition on referrals and billing would be triggered by the financial relationship unless the relationship fully complied with one of several exceptions. Most providers of the designated health services with physician relationships have some exposure to liability under the Stark statute.

Medicare may deny payment for all services related to a prohibited referral and a hospital or other health care provider 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, a hospital could be obligated to repay CMS for the payments received from Medicare for all of the heart surgeries performed by all of the physicians in the group for the duration of the lease; a potentially significant amount. The government may also seek substantial civil monetary penalties, and in some cases, a hospital or other health care provider may be liable for fines up to three times the amount of any monetary penalty, and/or be excluded from the Medicare and Medi-Cal programs. Potential repayments to CMS, settlements, fines or exclusion for a Stark violation or alleged violation could have a material adverse impact on a hospital or other health care provider.

Civil Monetary Penalties Law. The federal Civil Monetary Penalties Law ("CMPL") 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 CMPL if it knowingly presents, or causes to be presented, improper claims for reimbursement to a federal or state agency, such as those that administer the Medicare and Medicaid programs. A hospital that participates in arrangements known as "gainsharing," through which the hospital pays physicians to limit or reduce services to Medicare fee-for-service beneficiaries also may be subject to substantial civil monetary penalties.

A health care provider may be found liable under the CMPL even if it did not have actual knowledge of the impropriety of the claim. It is sufficient that the provider "should have known" that the claim was false. Ignorance of the Medicare regulations is no defense. The Secretary of DHHS, acting through the OIG, also has both mandatory and permissive authority to exclude individuals and entities from participation in federal health care programs pursuant to this statute.

HIPAA. The Health Insurance Portability and Accountability Act of 1996, or HIPAA, adds additional criminal sanctions for health care fraud and applies to all health care benefit programs, whether public or private. HIPAA also provides for punishment of a health care provider for knowingly and willfully embezzling, stealing, converting or intentionally misapplying any money, funds or other assets of a health care benefit program. A health care provider convicted of health care fraud could be excluded from Medicare. In addition, HIPAA includes administrative simplification provisions that require standardization of electronic transactions, specific security protections for medical information and processes, privacy protections for patient medical records, and establishment of national employer and provider identifiers. DHHS and CMS have promulgated rules related to electronic transactions, national employer identifiers, national provider identifiers, security, and medical records privacy. Rules regarding national health plan identifiers, claims attachments standards and first report of injury standards have been published in proposed form or are under development.

Exclusions from Medicare or Medi-Cal Participation. The government may exclude a hospital or other health care provider from Medicare/Medi-Cal program participation that 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, felony fraud against any federal, state or locally financed health care program or a felony 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/Medi-Cal program means that a hospital or other health care provider would be terminated from participation and no program payments can be made. Any hospital exclusion could be a materially adverse event, even within a large hospital system.

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

Enforcement Activity. Enforcement activity against hospitals and health care providers has increased and enforcement authorities have adopted aggressive approaches. Hospitals and other health care providers are frequently subject to audits, investigations or other enforcement actions regarding the health care fraud laws mentioned above. In addition, enforcement agencies increasingly pursue sanctions for violations of health care fraud and abuse laws through civil administrative actions. 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.

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, Medi-Cal and/or similar payments and/or by instituting criminal action. In addition, the cost of defending such an action, the time and management attention consumed, and the facts of a case may dictate settlement. Therefore, regardless of the merits of a particular case, a hospital or other health care provider 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 or other health care provider, regardless of outcome. The U.S. Attorney's office for the Southern District of California in particular has shown an aggressive approach to enforcement activity against hospitals and health care providers. In U.S. v. Weinbaum, the federal prosecutors alleged that Tenet Healthsystem, Alvarado Hospital Medical Center ("Alvarado") and former Alvarado CEO Barry Weinbaum paid more than $100 million in illegal kickbacks to physicians through relocation agreements in exchange for patient referrals. While two trials ended in mistrials, in May 2006, the OIG announced plans to exclude Alvarado from participation in Medicare, Medicaid and other federal health care programs. Tenet Healthcare eventually resolved the matter by agreeing to sell or close Alvarado and pay $21 million in civil damages.

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 can be compounded. Generally these risks are not covered by insurance. Enforcement actions may involve multiple hospitals or health care providers in a health system, as the government often extends enforcement actions regarding health care fraud to other hospitals or health care providers in the same organization. Therefore, Medicare fraud related risks identified as being materially adverse as to a hospital or other health care provider could have materially adverse consequences to a health system taken as a whole.

Liability Under State "Fraud" and "False Claims" Laws. Hospitals and other health care providers in California also are subject to state laws related to false claims, anti-kickback, and physician referrals, which pose the possibility of material adverse impact for the same reasons as the federal statutes. In addition, in contrast to federal laws which typically apply only to services rendered to beneficiaries covered under federal or state health care financing programs, these state laws typically apply to services rendered to any patients, regardless of the source of payment for such services.

EMTALA. The Emergency Medical Treatment and Active Labor Act, or EMTALA, is a federal civil statute that requires hospitals to conduct a medical screening for emergency conditions and to stabilize a patient's emergency medical condition before releasing, discharging

or transferring the patient. Over the last few years, the federal government has increased its enforcement of EMTALA. A hospital that violates EMTALA is subject to civil penalties of up to $50,000 per offense and exclusion from Medicare and Medi-Cal programs. In addition, a hospital may be liable for any claim by an individual who has suffered harm as a result of a violation of EMTALA.

Licensing, Surveys, Investigations and Audits. Health facilities are subject to numerous legal, regulatory, professional and private licensing, certification and accreditation requirements. These include, but are not limited to, requirements of state licensing agencies and The Joint Commission. Renewal and continuation of certain of these licenses, certifications and accreditations are based on inspections or other reviews generally conducted in the normal course of business of health facilities. Loss of, or limitations imposed on, hospital licenses, certifications or accreditations could reduce hospital utilization or revenues, or a hospital's ability to operate all or a portion of its facilities.

Renewal and continuance 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 action or response by the District. These activities generally are conducted in the normal course of business of health facilities. Nevertheless, an adverse result could result in a loss or reduction in the District's scope of licensure, certification or accreditation, or could reduce the payment received or require repayment of amounts previously remitted.

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

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

Business Relationships and Other Business Matters

Integrated Physician Groups. Hospitals and health care systems often own, control or have affiliations with relatively large physician groups. Generally, the sponsoring hospital or health care system will be the primary capital and funding source for such alliances and may have an ongoing financial commitment to provide growth capital and support operating deficits.

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. These goals may not be achieved, however, and an unsuccessful alliance may be costly and counterproductive to all of the above-stated goals.

Integrated delivery systems carry with them the potential for legal or regulatory risks in varying degrees. The ability of hospitals or health care 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 their independence for a variety of reasons, thus putting a hospital or health care system's investment at risk, and potentially reducing its managed care leverage and/or overall utilization.

Indigent Care, Underinsured and Uninsured Patients. The District may be susceptible to economic and political changes that could increase the number of indigents or their responsibility for caring for this population. General economic conditions that affect the number of employed individuals who have health coverage affects the ability of patients to pay for their care. Similarly, changes in governmental policy, which may result in coverage exclusions under local, state and federal health care programs (including Medicare and Medi-Cal) may increase the frequency and severity of indigent treatment by such hospitals and other providers. It also is possible that future legislation could require that hospital districts and other providers maintain minimum levels of indigent care.

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

An emerging area of potential risk for all hospitals surrounds the appropriate management of physician conflicts of interest with hospitals that grant practice privileges. Described as "economic credentialing" by physicians who oppose efforts of hospitals to manage the presence of direct competitors within the leadership or boardroom, the issue requires all hospitals to thoughtfully manage these potential conflicts to maintain a healthy, collegial and professional relationship required with the independent medical staff, while ensuring the organization is not suffering irreversible harm from a competitor gaining specific or specialized information not available to the public regarding the District's plans. In the worst circumstances, such efforts have led to litigation and potentially material impacts on the practice patterns of physicians at a specific facility. It is not possible to predict the course of such decisions or make any assurances that the District will be successful in managing such conflicts without causing some changes in physician practice patterns, which could have a material effect on the District.

Competition Among Health Care Providers. Increased competition from a wide variety of sources, including specialty hospitals, other hospitals and health care systems, inpatient and outpatient health care facilities, long-term care and skilled nursing services facilities, clinics, physicians and others, may adversely affect the utilization and 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.

Specialty hospital developments that attract away an important segment of an existing hospital's admitting specialists may be particularly damaging. For example, some large hospitals may have significant dependence on cardiovascular and/or orthopedic surgery programs, as revenue streams from those programs may cover significant fixed overhead costs. If a significant component of such a hospital's cardiovascular or orthopedic surgeons develop their own specialty hospital (alone or in conjunction with a growing number of specialty hospital operators and promoters) taking with them their patient base, a hospital could experience a rapid and dramatic decline in net revenues that is not proportionate to the number of patient admissions or patient days lost. It is also possible that the competing specialty hospital, as a for-profit venture, would not accept indigent patients or other payors and government programs, leaving low-pay patient populations in the full-service hospital. In certain cases, such an event could be materially adverse to a hospital.

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

Additionally, scientific and technological advances, new procedures, drugs and devices, preventive medicine and outpatient health care delivery may reduce utilization and revenues of a hospital 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.

Private Health Care Plans and Managed Care. The District contracts with several third party payors. For the fiscal year ended June 30, 2007 and June 30, 2006, non-governmental payors, including non-senior capitated managed care, managed care, insurance, and workers' compensation, accounted for approximately 31.5% and 32.4%, respectively, of the total gross patient service revenue of the District.] See "HISTORIC FINANCIAL INFORMATION – Sources of Patient Revenue" herein.

Growth of E-Commerce. The growth of e-commerce also may result in a shift in the way that health care is delivered. Persons residing in the District's service areas may be able to receive certain health services from remote providers. For example, physicians will be able to

provide certain services over the internet (e.g., teleradiology and second opinions). Pharmaceuticals and other health services may also now be ordered on-line. Additionally, other service providers in competition with the District may now compete through this new medium by advertising their services and providing easy registration for competing services over the internet. Also, alternative forms of health care payment including managed care organizations and consumer-driven care, as well as expanded preventive medicine and outpatient treatment, could affect the District's ability to maintain their market share at current levels.

Technology. Scientific and technological advances, new procedures, drugs and devices, preventive medicine, occupational health and safety, and outpatient health care delivery may reduce utilization and revenues of the District in the future. Technological advances in recent years have accelerated the trend toward the use by hospitals of sophisticated and costly equipment and services, and hospitals may have to incur significant costs to acquire the equipment needed to maintain or enhance their competitive position. Recently, President Bush called for the establishment of a nationwide electronic medical records system over the next 10 years and created a national health information technology office within DHHS to lead the effort. The costs to acquire and implement an electronic medical records system are significant but it is widely believed that such systems will lead to greater efficiencies in the provision of patient care and improved quality of care. The acquisition and operation of certain equipment and services may continue to be a significant factor in hospital utilization, but the ability of the District to offer such equipment or services may be subject to the availability of equipment and specialists, governmental approval and the ability to finance such acquisitions and operations.

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, and anticompetitive business conduct or practices. 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 for hospitals and other health care providers are joint action among providers with respect to payor contracting, medical staff credentialing disputes and anticompetitive business conduct or practices by hospitals and other health care providers with sufficiently large market share.

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. Moreover, successful private or governmental litigants may obtain injunctive relief that can affect the defendant's ability to conduct or continue certain business practices or activities.

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. Approximately two thirds of employees of the

District currently are covered by collective bargaining agreements. See "OTHER INFORMATION – Employees and Labor Relations."

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 Internal Revenue Services (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., physicians) 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 technicians. 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 employees, coupled with increased recruiting and retention costs will increase hospital operating costs, possibly significantly, and growth may be constrained. This trend could have a material adverse impact on hospitals.

Effective January 1, 2004, California implemented mandatory nurse staffing ratios for all patient care areas. The impact on California hospitals varies by facility. The required staffing, in aggregate, has proven more costly than prior staffing patterns. The mandatory nurse staffing ratios have been, and continue to be, the subject of legislative actions and judicial challenges seeking to alter the proscribed ratios.

Professional Liability Claims and General Liability Insurance. In recent years, the number of professional and general liability suits and the dollar amounts of damage recoveries have increased in health care nationwide, resulting in substantial increases in malpractice insurance premiums, higher deductibles and generally less coverage. Professional liability and other actions alleging wrongful conduct and seeking punitive damages are often filed against hospitals and other health care providers. Insurance does not provide coverage for judgments for 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 hospital or other health care provider if determined or settled adversely.

There is no assurance that the District 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 the District or that such coverage will be available at a reasonable cost in the future. For a description of insurance coverage maintained by the District, see "OTHER INFORMATION– Insurance and Risk Management" herein.

Construction Risks

The development and construction of new or renovated hospital facilities are susceptible to various risks and uncertainties, such as:

- inflation of construction costs;
- general construction risks, including cost overruns, change orders and plan or specification modification, shortages of equipment, materials or skilled labor, labor disputes, unforeseen environmental, engineering or geological problems, work stoppages, fire and other natural disasters, construction scheduling problems and weather interferences;
- changes and concessions required by governmental or regulatory authorities;
- delays in obtaining, or inability to obtain, all licenses, permits and authorizations required to complete and/or operate the project; and
- disruption of existing operations and facilities.

Hospitals and health systems in California are experiencing significant escalation in the estimated costs of hospital facility construction and costs. The anticipated costs and construction period for projects comprising the District's Facilities Master Plan are based upon budgets, some conceptual design documents and construction schedule estimates prepared by the District in consultation with the District's architects and contractors. The cost of any project may vary significantly from initial expectations, and there may be a limited amount of capital resources to fund cost overruns. If cost overruns cannot be financed on a timely basis, the completion of one or more projects may be delayed until adequate funding is available. The completion dates of any of the projects could also differ significantly from expectations for construction-related or other reasons. Assurances cannot be given that any project will be completed, if at all, on time or within established budgets, or that any project will result in increased earnings. Significant delays, cost overruns, or failures of the construction or renovation projects to achieve market acceptance could have a material adverse effect on the hospitals' business, financial condition and results of operations. Furthermore, the projects, including the projects funded by the GO Bonds, may not help the District compete with new or increased competition. See "FACILITIES MASTER PLAN, SERVICE AREA AND COMPETITION - Facilities Master Plan" herein.

Certain permits, licenses and approvals necessary for some of the District's current or anticipated projects have not yet been obtained. The scope of the approvals required for expansion, development or renovation projects can be extensive and may include state and local land-use permits and building and zoning permits. Unexpected changes or concessions required by local, state or federal regulatory authorities could involve significant additional costs and delay the scheduled openings of the facilities. The District may not receive the necessary permits, licenses and approvals or obtain the necessary permits, licenses and approvals within the anticipated time frame.

The failure to complete any construction or renovation project as planned, on schedule, within budget or in a manner that generates anticipated profits, could have an adverse effect on

the hospitals' business, financial condition and results of operations. Further, the magnitude and scope of construction and renovation projects, and the management of multiple construction and renovation projects at the same time, may divert management resources from ongoing operations and/or construction and/or opening of any one project. Management's inability to devote sufficient time and attention to ongoing operations and/or any one project may have an adverse affect on the ongoing operations of the hospitals or delay the construction or opening of any or all of the projects. Any delay caused by such circumstances could have a negative effect on business and operations.

In addition, although hospital construction and renovation is generally planned to have minimal impact on ongoing operations, no assurances can be given that the construction and renovation at the District's hospital facilities will not disrupt the ongoing operations of its hospitals or that it will be implemented as planned. Therefore, the construction and renovation of hospital facilities may adversely impact the business, operations and revenues of the District.

Other Operational Risk Factors

Earthquakes. Many hospitals in California are in close proximity to active earthquake faults. A significant earthquake in southern California could destroy or disable the hospitals of the District or otherwise severely disrupt their operations and the regional economy.

California requires each acute care hospital in the state to either comply with new hospital seismic safety standards or cease acute care operations by January 1, 2008. Delays in compliance with the January 1, 2008 deadline will be permitted if a hospital shows that capacity lost in the closure of a facility cannot be provided by another facility in the area or if a hospital agrees that, on or before January 1, 2013, designated services will be provided by moving into an existing conforming building, relocating to a newly built building or continuing in the building as retrofitted to comply with the standards. The 2013 deadline may be extended up to two years to January 1, 2015 if the hospital demonstrates certain requirements, including that it is under construction at the time of the request for the extension, it has made reasonable progress in meeting the deadline, but it cannot meet the deadline due to reasons beyond its control. Management of the District believes that their facilities that are subject to the seismic requirements will be in compliance with such seismic requirements within the prescribed guidelines; however, no assurance can be given at this time that the deadline will be met. See OTHER INFORMATION – Seismic Compliance" herein.

Investments. The District has significant holdings in a broad range of investments. Market fluctuations may affect the value of those investments and those fluctuations may be and historically have been at times material. For a discussion of the District's investments, see "HISTORIC FINANCIAL INFORMATION - Liquidity and Capital Resources" herein.

Risks Related to Outstanding Variable Rate Obligations and Interest Rate Swap Transactions. The 2006 Certificates are variable rate obligations, the interest rates on which could rise. Such interest rates vary on a periodic basis and may be converted to a fixed interest rate. However, conversion is a limited protection against rising interest rates because the District would be required to continue to pay interest at the variable rate until it is able to convert the 2006 Certificates to a fixed rate and would be subject to the fixed interest rates then available in the market for credit similar to the District.

The District has entered into the Swaps relating to the 2006 Certificates, as described herein under "MANAGEMENT'S DISCUSSION OF FINANCIAL PERFORMANCE—Outstanding Swap Transactions." The Swaps are subject to periodic "mark-to-market" valuations and at any time may have a negative value to the District. The Swap counterparty may terminate a Swap upon the occurrence of certain "termination events" or "events of default." The District may terminate a Swap at any time upon the satisfaction of certain conditions. If either the counterparty to a Swap or the District terminates such Swap during a negative value situation, the District may be required to make a termination payment to such Swap counterparty, and such payment could be material.

Pursuant to the Swaps, the counterparty is obligated to make payments to the District based on a floating rate index and the applicable notional amount, which payments may be more or less than the variable rates the District is required to pay with respect to a comparable principal amount of the related series of 2006 Certificates, as the case may be. No determination can be made at this time as to the potential exposure to the District relating to the difference in variable rate payments.

Other Future Risks. In the future, the following factors, among others, may adversely affect the operations of hospitals and other health care providers, including the District, to an extent that cannot be determined at this time.

(a) Adoption of legislation that would establish a national or statewide single-payor health program or that would establish national, statewide or otherwise regulated rates applicable to hospitals and other health care providers.

(b) Bankruptcy of an indemnity/commercial insurer, managed care plan or other payor.

(c) Efforts by insurers and governmental agencies to limit the cost of hospital services, to reduce the number of beds and to reduce the utilization of hospital facilities by such means as preventive medicine, improved occupational health and safety and outpatient care, or comparable regulations or attempts by third-party payors to control or restrict the operations of certain health care facilities.

(d) The occurrence of a pandemic or a natural or man-made disaster that could damage the District's facilities, interrupt utility service to the facilities, result in an abnormally high demand for health care services or workforce loss or otherwise impair the District's operations and the generation of revenues from the facilities.

(e) Limitations on the availability of, and increased compensation necessary to secure and retain, nursing, technical and other professional personnel.

(f) Reduced demand for District services that might result from decreases in population.

Document No. 7 - Appendix C to Preliminary Official Statement

Economic and Demographic Profile of San Diego County

APPENDIX C

Economic and Demographic Profile of San Diego County

The following information about the County of San Diego (the "County") is presented as general background information because the District is located in the northern part of the County. As discussed under "SECURITY AND SOURCE OF PAYMENT OF THE BONDS," the Bonds are payable from ad valorem taxes, and are not a debt of, nor payable by, the County.

General

The County is the southernmost major metropolitan area in the State of California. The County covers 4,255 square miles, extending 70 miles along the Pacific Coast from the Mexican border to Orange County, and inland 75 miles to Imperial County. Riverside and Orange counties form the northern boundary. The County is approximately the size of the State of Connecticut.

Topography of the County varies from broad coastal plains and fertile inland valleys to mountain ranges in the east which rise to an elevation of 6,500 feet. Eastern slopes of these mountains form the rim of the Anza-Borrego Desert and the Imperial Valley. The Cleveland National Forest occupies much of the interior portion of the County. The climate is equable in the coastal and valley regions where most of the population and resources are located. The average annual rainfall in the coastal areas is approximately 10 inches.

The County possesses a diverse economic base consisting of a significant manufacturing presence in the fields of electronics and shipbuilding, a large tourist industry attracted by the favorable climate of the region, and a considerable defense-related presence which contributes approximately $10 billion annually to the retail and service businesses of the area.

The County is also growing as a major center for culture and education Over 30 recognized art organizations, including the San Diego Opera, the Old Globe Theatre productions, the La Jolla Chamber Orchestra, as well as museums and art galleries, are located in the County. Higher education is provided through five two-year colleges and six four-year colleges and universities.

In addition to the City of San Diego, other principal cities in the County include Carlsbad, Chula Vista, Oceanside, El Cajon, Escondido, La Mesa and National City. Most County residents live within 20 miles of the coast. Farther inland are agricultural areas, principally planted in avocados and tomatoes, while the easternmost portion of the County has a dry, desert-like topography.

Population

There are 18 incorporated cities in the County, and a number of unincorporated communities. For many years the population of the County has grown at a greater rate than that of either California or the nation. The County population as of January 2006 was estimated to be approximately 3,084,634, making it the third largest County by population in California and the sixteenth largest Metropolitan Statistical Area in the United States. The 2006 population increased approximately 7.9% from 2001. As of January 2006, the unincorporated population of the County was 465,553.

The following table shows changes in the population in the County, the State and the United States for the years 1995 to 2006.

POPULATION ESTIMATES[1]
(In Thousands)

Year	San Diego County	Percent Change	State of California	Percent Change	United States	Percent Change
1996	2,621	0.31	31,837	0.70	265,229	0.91
1997	2,653	1.23	32,207	1.16	267,784	0.95
1998	2,703	1.86	32,657	1.40	270,248	0.91
1999	2,751	1.78	33,140	1.48	272,691	0.90
2000	2,806	2.00	33,753	1.85	282,178	3.48
2001	2,860	1.92	34,385	1.87	285,094	1.03
2002	2,909	1.71	35,000	1.79	287,974	1.01
2003	2,976	2.30	35,612	1.75	290,810	0.98
2004	3,017	1.38	36,144	1.49	293,700	1.00
2005	3,058	1.36	36,154	0.03	296,507	0.96
2006	3,085	0.88	36,458	0.84	299,398	0.98

Sources: U.S. Bureau of the Census
[1] As of July 1 of the year shown.

Employment

The County's total labor force, the number of persons who work or are available for work, averaged approximately 1,518,000 in 2006. The number of employed workers in the labor force averaged approximately 1,457,500. The following table sets forth information regarding the size of the labor force, employment and unemployment rates for the County, the State and the United States for the years 2000 through 2006.

LABOR FORCE – EMPLOYMENT AND UNEMPLOYMENT*
ANNUAL AVERAGES 2000-2006
By Place of Residence
(In Thousands)

	2002	2003	2004	2005	2006
County of San Diego					
Labor Force	1,451	1,470	1,492	1,508	1,518
Employment	1,376	1,393	1,422	1,443	1,458
Unemployment Rate	5.2%	5.2%	4.7%	4.3%	4.0%
State of California					
Labor Force	17344	17,419	17,539	17,740	17,902
Employment	16,181	16,227	16,445	16,782	17,089
Unemployment Rate	6.7%	6.8%	6.2%	5.4%	4.9%
United States					
Labor Force	144,863	146,510	147,700	149,300	151,400
Employment	136,485	137,736	139,200	141,700	144,400
Unemployment Rate	5.8%	6.0%	5.5%	5.1%	4.6%

Sources: State Data - California Employment Development Department; National Data – U.S. Department of Labor, Bureau of Labor Statistics.
* Data not seasonally adjusted.

The following table sets forth the annual average employment within the County, by employment sector for the Fiscal Years 2000 through 2006. The service sector constitutes the largest non-farm employment sector in the County, representing approximately 51% of all non-farm employment.

SAN DIEGO COUNTY
NON-AGRICULTURAL LABOR FORCE AND INDUSTRY EMPLOYMENT
ANNUAL AVERAGES
2000-2006
(In Thousands)

Employment Sector	2000	2001	2002	2003	2004	2005	2006
Mining	0.3	0.3	0.3	0.3	0.3	0.3	0.3
Construction	69.7	75.1	76.4	80.2	87.7	90.8	92.6
Manufacturing	122.6	119.0	112.3	105.3	104.3	104.5	103.6
Wholesale and Retail Trade	172.9	177.1	179.3	182.4	186.8	191.0	192.7
Transportation, Warehousing and Utilities	29.8	32.0	29.3	27.3	28.4	28.4	28.3
Services							
Information	39.2	38.8	37.7	36.9	36.6	37.4	37.2
Financial Activities	71.2	72.0	75.0	79.9	81.9	83.2	83.7
Professional and Business Services	195.2	198.2	201.7	201.2	204.5	210.4	213.8
Educational and Health Services	115.3	116.0	119.7	121.8	121.7	122.5	124.7
Leisure and Hospitality	129.0	131.4	133.8	140.7	145.7	149.6	156.2
Other Services	42.2	44.9	45.6	46.8	47.9	48.8	48.9
Government	206.6	213.8	219.7	217.3	214.3	215.1	217.7
Total, All Non- Farm Industries	**1,193.8**	**1,218.4**	**1,230.7**	**1,240.1**	**1,260.3**	**1,282.1**	**1,299.9**

Source: California Employment Development Department.

Regional Economy

In recent years the County has enjoyed economic stability, out pacing the State economy despite a general recession in the State. Much of this strength was evidenced by and due to employment gains, population growth, personal income increases, and commercial and industrial development.

The Gross Regional Product ("GRP") for 2005 rose to $146.2 billion from $138.2 billion in 2004, and it has been forecasted that when the data for 2006 is compiled, it will show that the GRP for 2006 rose to $149.9 billion. The GRP is an estimate of the value for all goods and services produced in the region. The following table presents the County's GRP from 1996 through 2006.

COUNTY OF SAN DIEGO
GROSS REGIONAL PRODUCT
1996-2006

Year	Gross Regional Product (In Billions)	Annual Percent Change Current Dollars San Diego
1996	$ 79.6	5.9%
1997	86.1	8.2
1998	94.4	9.7
1999	103.1	9.2
2000	112.4	9.0
2001	112.4	0.0
2002	120.2	6.9
2003	126.8	5.5
2004	138.2	9.0
2005	146.3	5.9
2006[(1)]	149.9	2.5

Sources: Bureau of Economic Analysis; Economic Research Bureau of the Greater San Diego Chamber of Commerce.
[(1)] Forecast.

Economic activity and population growth in the local economy are closely related. Helping to sustain the County's economy is the performance of three basic industries of the region, which consist of manufacturing, the military, and tourism. The U.S. Department of Defense contributes about $10 billion annually to the local economy, through wages paid to the uniformed military and civilian personnel, and for equipment and services purchased from local businesses. San Diego's military presence is anticipated to remain relatively stable and may even increase due to the consolidation of military operations and facilities from elsewhere in California, the West, and throughout the United States. The Department of Defense closed and vacated the Naval Training Center in 1997. However, three procurement agencies have recently relocated to San Diego, including the Naval Space and Warfare Systems Command, the Naval Aviation Engineering Servicing Unit, which hires private contractors to service jets, and the Naval Aviation Technical Service Facility, which stores approximately 10 million jet blueprints.

Building Activity

Building permit valuation for residential construction in the County in 2006 decreased over 2005 levels by more than 30%. Building permit valuation for non-residential construction in the County in 2006 increased over 2005 levels by more than 17%.

Annual total building permit valuation and the annual unit total of new residential permits from 2003 through 2006 are shown in the following table.

COUNTY OF SAN DIEGO
BUILDING PERMIT ACTIVITY
2003-2006
(In Thousands)

	2002	2003	2004	2005	2006
Valuation:					
Residential	$3,008,209	$3,683,807	$3,875,359	$3,562,702	$2,470,685
Non-Residential	1,391,497	1,169,397	1,288,130	1,381,794	1,621,608
Total	**$4,399,706**	**$4,853,204**	**$5,163,489**	**$4,944,496**	**$4,092,293**
New Housing Units:					
Single Family	$ 9,167	$ 9,455	$ 9,555	$ 7,904	$ 4,753
Multiple Family	6,760	8,859	7,751	7,354	6,024
Total	**$15,927**	**$18,314**	**$17,306**	**$15,258**	**$10,777**

Source: Construction Industry Research Board.

Commercial Activity

Consumer spending for 2005 resulted in approximately $46,679,471 in taxable sales in the County. The table on the following page sets forth information regarding taxable sales in the County for the years 2000-2005.

County of San Diego
TAXABLE SALES
2000-2005
(In Thousands)

Type of Business	2000	2001	2002	2003	2004	2005*
Apparel Stores	$ 1,182,173	$1,274,552	$1,374,858	$1,466,233	$1,644,428	$1,798,104
General Merchandise	4,307,562	4,445,352	4,557,457	4,352,937	5,204,962	5,406,091
Specialty Stores	3,663,924	3,718,292	3,803,803	4,144,293	4,541,225	4,728,028
Food Stores	1,557,244	1,595,933	1,650,104	1,685,203	1,736,610	1,858,152
Home Furnishings/ Appliances	1,237,271	1,314,860	1,353,158	1,458,403	1,549,482	1,566,046
Eating and Drinking Establishments	3,211,306	3,366,463	3,505,859	3,757,136	4,047,726	4,267,302
Building Materials and Group	2,104,100	2,343,008	2,510,931	2,757,706	3,341,105	3,376,009
Automotive	6,955,856	7,426,582	7,862,366	8,563,690	9,318,277	9,736,136
All Other Retail Stores	733,653	778,296	803,063	855,601	961,645	1,045,927
Business and Personal Services	1,954,589	1,957,109	1,977,606	2,040,077	2,146,781	2,239,304
All Other Outlets	9,337,740	9,478,886	9,196,342	9,303,350	9,978,097	10,655,372
TOTAL ALL OUTLETS	$36,245,418	$37,699,333	$38,595,547	$40,863,978	$44,470,338	$46,679,471

Source: California State Board of Equalization, Taxable Sales in California.

* Data for 2005 is currently the most updated annual information available regarding taxable sales for the County of San Diego.

Personal Income

The following table summarizes the median household income for the County, the State, and the United States between 2001 and 2006.

MEDIAN HOUSEHOLD INCOME
2001 through 2006

	San Diego County	California	United States
2001	446,845	$47,262	$42,228
2002	50,384	47,437	42,409
2003	49,886	49,300	43,318
2004	51,939	49,222	44,344
2005	56,335	51,755	46,326
2006	59,591	55,319	48,201

Source: U.S. Bureau of the Census Bureau.

Transportation

Surface, sea and air transportation facilities serve County residents and businesses. Interstate 5 parallels the coast from Mexico to the Los Angeles area and points north. Interstate 15 runs inland, leading to Riverside-San Bernardino, Las Vegas, and Salt Lake City. Interstate 8 runs eastward through the southern United States.

San Diego's International Airport (Lindbergh Field) is located approximately one mile west of the downtown area at the edge of San Diego Bay. The facilities are owned and maintained by the San Diego County Regional Airport Authority and are leased to commercial airlines and other tenants. The airport is California's third most active commercial airport, served by 20 major airlines. In addition to San Diego International Airport there are two naval air stations and seven general aviation airports located in the County.

Public transit in the metropolitan area is provided by the Metropolitan Transit Development Board. The San Diego Trolley, developed by the Metropolitan Transit Development Board beginning in 1979, has been expanded. A total of 17.6 miles were added to the original 108 miles; construction was completed in 1990.

The County is the terminus of the Santa Fe Railway's main line from Los Angeles. Amtrak passenger service is available at San Diego, with stops at Solana Beach and Oceanside in the North County.

The County harbor is one of the world's largest natural harbors. The Port of San Diego is administered by the San Diego Unified Port District, which includes the cities of San Diego, National City, Chula Vista, Imperial Beach, and Coronado.

Visitor and Convention Activity

The climate, proximity to Mexico, multiple maritime facilities, and various visitors attractions, such as the San Diego Zoo and Wild Animal Park, Sea World, Cabrillo National Monument, and Palomar Observatory enable the County to attract a high level of visitor and convention business each year. Contributing to the growth of visitor business has been the development of the 4,600-acre Mission Bay Park at San Diego and the construction of meeting and convention facilities at the San Diego Community Concourse.

The County visitor industry is a major sector of the region's economy. Visitor revenues in the County reached approximately $7.7 billion in 2006, according to an estimate by the San Diego Convention and Visitors Bureau, an increase of approximately $495 million from the prior year. The County hosted 71 conventions and trade shows in 2006, attended by approximately 573,398 delegates.

Education

Forty-two independent school districts provide educational programs for the elementary and secondary public school children in the County. Each school system is governed by a locally elected board of education and administered by a superintendent or other chief administrative officer appointed by the board. In the County there are three types of school districts: elementary, union high and unified.

Elementary districts educate elementary students, union high districts educate for the most part secondary students, and unified districts educate both elementary and secondary students. There are currently 12 unified, 24 elementary and 6 union high school districts in the County.

Community colleges in California are locally operated and administered two-year institutions of higher education. They offer Associates in Arts and Associates in Science degrees and have extensive vocational curricula. There are five community college districts in the County with students at eleven campuses and numerous adult and community centers.

Among the institutions of higher education offering bachelors and graduate programs in metropolitan San Diego are San Diego State University, the University of California at San Diego, National University, the University of San Diego, Point Loma College, California State University - San Marcos, United States International University, and the University of Phoenix.

Document No. 8 - Continuing Disclosure Undertaking

Continuing Disclosure Undertaking

This Continuing Disclosure Undertaking (the "Disclosure Undertaking") is executed and delivered by Palomar Pomerado Health (the "District") in connection with the issuance of $[250,000,000] Palomar Pomerado Health General Obligation Bonds, Election of 2004, Series 2007A (the "Bonds"). The Bonds are being issued pursuant to a Resolution of the Board of Directors of the District adopted on [November 12], 2007 (the "Bond Resolution"). The District covenants and agrees as follows:

SECTION 1. Purpose of the Disclosure Undertaking. This Disclosure Undertaking is being executed and delivered by the District for the benefit of the Holders and Beneficial Owners of the Bonds and in order to assist the Participating Underwriter in complying with S.E.C. Rule 15c2-12(b)(5).

SECTION 2. Definitions. In addition to the definitions set forth in the Bond Resolution and that certain Paying Agent Agreement, dated as of June 1, 2005, as supplemented by the First Supplemental Paying Agent Agreement, dated as of December 1, 2007 (collectively, the "Paying Agent Agreement"), which apply to any capitalized term used in this Disclosure Undertaking unless otherwise defined in this Section, the following capitalized terms shall have the following meanings:

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

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

"Bond Counsel" shall mean a firm of attorneys of national reputation experienced in the field of municipal bonds whose opinions are generally accepted by purchasers of municipal bonds, which is selected by the District.

"Dissemination Agent" shall mean initially the District, or any successor Dissemination Agent designated in writing by the District (which may be the District) and which has filed with the District a written acceptance of such designation.

"Holders" shall mean registered owners of the Bonds.

"Listed Events" shall mean any of the events listed in Section 5(a) of this Disclosure Undertaking.

"National Repository" shall mean any Nationally Recognized Municipal Securities Information Repository for purposes of the Rule. The National Repositories currently approved by the Securities and Exchange Commission can be found at www.sec.gov/info/municipal/nrmsir.htm.

"Official Statement" shall mean the final Official Statement relating to the Bonds, dated December __, 2007.

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

"Repository" shall mean each National Repository and each State Repository.

"Rule" shall mean Rule 15c2-12(b)(5) adopted by the Securities and Exchange Commission under the Securities Exchange Act of 1934, as the same may be amended from time to time.

"State" shall mean the State of California.

"State Repository" shall mean any public or private repository or entity designated by the State as a state repository for the purpose of the Rule and recognized as such by the Securities and Exchange Commission. As of the date of this Undertaking, there is no State Repository.

SECTION 3. Provision of Annual Reports.

(a) The District shall, or shall cause the Dissemination Agent to, not later than 6 months after the end of the District's fiscal year (presently ending June 30), commencing with the report for the 2007-08 Fiscal Year, provide to each Repository an Annual Report which is consistent with the requirements of Section 4 of this Disclosure Undertaking. The Annual Report may be submitted as a single document or as separate documents comprising a package, and may cross-reference other information as provided in Section 4 of this Disclosure Undertaking; *provided* that the audited financial statements of the District may be submitted separately from the balance of the Annual Report and later than the date required above for the filing of the Annual Report if they are not available by that date. If the District's fiscal year changes, it shall give notice of such change in the same manner as for a Listed Event under Section 5(c).

(b) Not later than thirty (30) days (nor more that sixty (60) days) prior to said date the Dissemination Agent shall give notice to the District that the Annual Report shall be required to be filed in accordance with the terms of this Disclosure Undertaking. Not later than fifteen (15) Business Days prior to said date, the District shall provide the Annual Report in a format suitable for reporting to the Repositories to the Dissemination Agent (if other than the District). If the District is unable to provide to the Repositories an Annual Report by the date required in subsection (a), the District shall send a notice to each Repository in substantially the form attached as Exhibit A with a copy to the Dissemination Agent. The Dissemination Agent shall not be required to file a Notice to Repositories of Failure to File an Annual Report.

(c) The Dissemination Agent shall file a report with the District stating it has filed the Annual Report in accordance with its obligations hereunder, stating the date it was provided and listing all the Repositories to which it was provided.

SECTION 4. Content of Annual Reports. The District's Annual Report shall contain or include by reference the following:

1. The audited financial statements of the District for the prior fiscal year, prepared in accordance with generally accepted accounting principles as promulgated to apply to governmental entities from time to time by the Governmental Accounting Standards Board. If the District's audited financial statements are not available by the time the Annual Report is required to be filed pursuant to Section 3(a), the Annual Report shall contain unaudited financial statements in a format similar to the financial statements contained in the Official Statement, and the audited financial statements shall be filed in the same manner as the Annual Report when they become available.

2. Material financial information with respect to the District of the type included in the Official Statement in the following categories (to the extent not included in the District's audited financial statements):

(a) information on the aggregate assessed value of property and the delinquent property taxes, if available, within the District;

(b) outstanding District general obligation bonds; and

(c) receipts of ad valorem taxes pledged to the Bond(s); and

(d) the top ten local secured taxpayers in the District, if the aggregate of their assessed valuation exceeds 10% of the total assessed valuation of the District.

3. The financial information and operating data set forth in Appendix A to the Official Statement in the text and tables under the headings "MASTER FACILITIES PLAN, SERVICE AREA AND COMPETITION—Utilization" and "—District Service Area—Acute Care Hospital Discharges;" "HISTORICAL FINANCIAL INFORMATION—Summary of Historical Financial Data," "—Sources of Patient Revenue" and "—Unrestricted Property Tax Revenues;" and "MANAGEMENT'S DISCUSSION OF FINANCIAL PERFORMANCE—Outstanding Long-Term Debt," "—Outstanding Swap Transactions," "—Liquidity and Capital Resources," "—Capitalization" and "—Debt Service Coverage of Revenue Obligations".

Any or all of the items listed above may be included by specific reference to other documents, including official statements of debt issues of the District or related public entities, which have been submitted to each of the Repositories or the Securities and Exchange Commission. If the document included by reference is a final official statement, it must be available from the Municipal Securities Rulemaking Board. The District shall clearly identify each such other document so included by reference. The material required herein may be filed as part of, or concurrently with, any other continuing disclosure undertaking, provided such material is identified as also pertaining to the Bonds.

SECTION 5. Reporting of Significant Events.

(a) Pursuant to the provisions of this Section 5, the District shall give, or cause to be given, notice of the occurrence of any of the following events with respect to the Bonds, if material:

1. principal and interest payment delinquencies.

2. non-payment related defaults.

3. modifications to rights of Holders.

4. optional, contingent or unscheduled bond calls.

5. defeasances.

6. rating changes.

7. adverse tax opinions or events affecting the tax-exempt status of the Bonds.

8. unscheduled draws on the debt service reserves reflecting financial difficulties.

9. unscheduled draws on the credit enhancements reflecting financial difficulties.

10. substitution of the credit or liquidity providers or their failure to perform.

11. release, substitution or sale of property securing repayment of the Bonds.

(b) Whenever the District obtains knowledge of the occurrence of a Listed Event, the District shall as soon as possible determine if such event would be material under applicable federal securities laws.

(c) If the District determines that knowledge of the occurrence of a Listed Event would be material under applicable federal securities laws, the District shall promptly file a notice of such occurrence with the Repositories or provide notice of such reportable event to the Dissemination Agent in format suitable for filing with the Repositories. Notwithstanding the foregoing, notice of Listed Events described in subsections (a)(4) and (5) 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 Bond Resolution. The Dissemination Agent shall have no duty to independently prepare or file any report of Listed Events. The Dissemination Agent may conclusively rely on the District's determination of materiality pursuant to Section 5(b).

SECTION 6. Termination of Reporting Obligation. The District's obligations under this Disclosure Undertaking shall terminate upon the legal defeasance, prior redemption or payment in full of all of the Bonds. If such termination occurs prior to the final maturity of the Bonds, the District shall give notice of such termination in the same manner as for a Listed Event under Section 5(a).

SECTION 7. Dissemination Agent. The District may, from time to time, appoint or engage a Dissemination Agent (or substitute Dissemination Agent) to assist it in carrying out its obligations under this Disclosure Undertaking, and may discharge any such Agent, with or without appointing a successor Dissemination Agent. A Dissemination Agent which is not the District may resign upon fifteen (15) days written notice to the District. Upon such resignation, the District shall act as its own Dissemination Agent until it appoints a successor. The Dissemination Agent shall not be responsible in any manner for the content of any notice or report prepared by the District pursuant to this Disclosure Undertaking and shall not be responsible to verify the accuracy, completeness or materiality of any continuing disclosure information provided by the District. The District shall compensate the Dissemination Agent for its fees and expenses hereunder as agreed by the parties. Any entity succeeding to all or substantially all of the Dissemination Agent's corporate trust business shall be the successor Dissemination Agent without the execution or filing of any paper or further act.

SECTION 8. Alternate Means of Disclosure. Notwithstanding the provisions of Sections 3, 4 and 5 requiring that the District file its Annual Report, notice of any Material Event and notice of any failure to comply with this Undertaking with each of the National Repositories and any State Repository, the District may instead comply with the provisions of this Undertaking by filing the required information with an entity then recognized by the Securities and Exchange Commission as eligible to receive filings and submit such filings to such National Repositories and any State Repository for purposes of the Rule (a "Central Post Office"). As of the date of this Disclosure Undertaking, the Central Post Office that has been so recognized by the Securities and Exchange Commission is:

DisclosureUSA.org
P.O. Box 684667
Austin, Texas 78768-4667
Fax: (512) 476-6403
http://www.disclosureUSA.org

SECTION 9. Amendment; Waiver. Notwithstanding any other provision of this Disclosure Undertaking, the District may amend this Disclosure Undertaking, and any provision of this Disclosure

Undertaking may be waived, provided that the District first obtain an opinion of Counsel that such amendment or waiver is permitted under the Rule.

In the event of any amendment or waiver of a provision of this Disclosure Undertaking, the District shall describe such amendment in the next Annual Report.

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

SECTION 11. Default. In the event of a failure of the District to comply with any provision of this Disclosure Undertaking, the sole remedy hereunder of any Holder or Beneficial Owner of the Bonds shall be any actions as may be necessary and appropriate to compel performance, including seeking mandate or specific performance by court order, to cause the District to comply with its obligations under this Disclosure Undertaking. A default under this Disclosure Undertaking shall not be deemed an event of default under the Bonds or any agreement entered into by the District in connection with the Bonds.

SECTION 12. Duties, Immunities and Liabilities of Dissemination Agent. The Dissemination Agent shall have only such duties as are specifically set forth in this Disclosure Undertaking. The Dissemination Agent acts hereunder solely for the benefit of the District; this Disclosure Undertaking shall confer no duties on the Dissemination Agent to the Participating Underwriter, the Holders and the Beneficial Owners. The District agrees to indemnify and save the Dissemination Agent, its officers, directors, employees and agents, harmless against any loss, expense and liabilities which it may incur arising out of or in the exercise or performance of its powers and duties hereunder, including the costs and expenses (including attorneys fees) of defending against any claim of liability, but excluding liabilities due to the Dissemination Agent's gross negligence or willful misconduct. The obligations of the District under this Section shall survive resignation or removal of the Dissemination Agent and payment of the Bonds. The Dissemination Agent shall have no liability for the failure to report any event or any financial information as to which the District has not provided an information report in format suitable for filing with the Repositories. The Dissemination Agent shall not be required to monitor or enforce the District's duty to comply with its continuing disclosure requirements hereunder.

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

Date as of December __, 2007

PALOMAR POMERADO HEALTH

By:_____

Its:_____

EXHIBIT A TO

CONTINUING DISCLOSURE UNDERTAKING

FORM OF NOTICE TO REPOSITORIES OF FAILURE TO FILE ANNUAL REPORT

Name of Obligor: Palomar Pomerado Health

Name of Bonds: $[250,000,000] General Obligation Bonds, Election of 2004, Series 2007A

Date of Issuance: December ___, 2007

NOTICE IS HEREBY GIVEN that Palomar Pomerado Health (the "District") has not provided an Annual Report with respect to the above-named Bonds as required by Section 3 of the Continuing Disclosure Undertaking of the District, dated as of December 1, 2007. [The District anticipates that the Annual Report will be filed by _____.]

Dated:_____

_____,
on behalf of Palomar Pomerado Health