OFFICIAL STATEMENT

New Issue – Bank Qualified
Book-Entry Only

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

In the opinion of Bond Counsel, under existing federal law and assuming compliance by the District with applicable requirements of the Internal Revenue Code of 1986, as amended, that must be satisfied subsequent to the issue date of the Bonds, interest on the Bonds is excluded from gross income for federal income tax purposes under existing federal law and is not an item of tax preference for purposes of the alternative minimum tax applicable to individuals. However, while interest on the Bonds also is not an item of tax preference for purposes of the alternative minimum tax applicable to corporations, interest on the Bonds received by corporations is taken into account in the computation of adjusted current earnings for purposes of the alternative minimum tax applicable to corporations, interest on the Bonds received by certain S corporations may be subject to tax, and interest on the Bonds received by foreign corporations with United States branches may be subject to a foreign branch profits tax. Receipt of interest on the Bonds may have other federal tax consequences for certain tax payers. See "TAX MATTERS."

$8,050,000
Whidbey Island Public Hospital District
Island County, Washington
(Whidbey General Hospital)
Limited Tax General Obligation Bonds, 2012

Dated: Date of Initial Delivery (Estimated to be February 28, 2012) **Due: December 1 (as shown on the Inside Cover)**

The above-captioned bonds (the "Bonds") will be issued by Whidbey Island Public Hospital District, Island County, Washington (the "District") (doing business as Whidbey General Hospital), as fully registered bonds and, when issued, will be registered in the name of Cede & Co., as bond owner and nominee for The Depository Trust Company ("DTC"). DTC will act as securities depository for the Bonds. The Bonds will be issued initially in book-entry form only in the denominations of $5,000 or any integral multiple thereof within a single maturity. Purchasers of the Bonds (the "Beneficial Owners") will not receive certificates representing their beneficial ownership interests in the Bonds purchased.

Interest on the Bonds will be paid semiannually on each June 1 and December 1, commencing June 1, 2012, to the maturity or prior redemption of the Bonds. The Bonds will mature on the dates and in the amounts and bear interest at the rates set forth on the inside cover. Principal of and interest on the Bonds are payable by the fiscal agent of the State of Washington (currently The Bank of New York Mellon in New York, New York) (the "Bond Registrar"), which is obligated in turn to remit such principal and interest to the Beneficial Owners. See "THE BONDS-Registration and Bond Registrar-Book-Entry System" and Appendix E – "DTC AND ITS BOOK-ENTRY SYSTEM."

The Bonds are subject to redemption prior to their stated maturity dates. See "THE BONDS-Redemption of the Bonds."

The Bonds are being issued to finance the costs of (1) acquiring and implementing an electronic medical record system, (2) improving data network infrastructure, (3) funding capital expenditures for hospital equipment, (4) retiring outstanding debt of the District, and (5) paying the costs of issuance of the Bonds. See "PURPOSE AND USE OF BOND PROCEEDS."

The Bonds are general obligations of the District. The full faith, credit and resources of the District are pledged irrevocably for the annual levy and collection of property taxes within the constitutional and statutory limitations provided by law without a vote of the electors, upon all property in the District subject to taxation in an amount sufficient, together with other money legally available, to pay principal of and interest on the Bonds. See "SOURCES OF PAYMENT AND SECURITY."

THE BONDS DO NOT CONSTITUTE A DEBT OR INDEBTEDNESS OF THE STATE OF WASHINGTON, ISLAND COUNTY OR ANY OTHER POLITICAL SUBDIVISION THEREOF OTHER THAN THE DISTRICT.

The District has designated the Bonds as "qualified tax-exempt obligations" within the meaning of Section 265(b)(3) of the Internal Revenue Code of 1986, as amended. See "TAX MATTERS – Certain Other Federal Tax Consequences."

The Bonds are offered by the Underwriter when, as and if issued, subject to the approving legal opinion of Foster Pepper PLLC of Seattle, Washington, Bond Counsel. It is anticipated that the Bonds will be ready for delivery in New York, New York, through the facilities of DTC or to the Bond Registrar on behalf of DTC by Fast Automated Securities Transfer on or about February 28, 2012 (the "Date of Initial Delivery").

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

PiperJaffray®

Dated: February 15, 2012

Maturity Schedule

$8,050,000
Whidbey Island Public Hospital District
Island County, Washington
(Whidbey General Hospital)
Limited Tax General Obligation Bonds, 2012

Due (December 1)	Principal Amounts*	Interest Rates	Yields	CUSIP[1]
2013	$ 30,000	2.000%	0.580%	963286 JP5
2014	65,000	2.000	0.840	963286 JQ3
2015	65,000	3.000	1.100	963286 JR1
2016	75,000	3.000	1.300	963286 JS9
2017	90,000	3.000	1.510	963286 JT7
2018	105,000	3.000	1.790	963286 JU4
2019	125,000	3.000	2.090	963286 JV2
2020	135,000	2.125	2.390	963286 JW0
2021	150,000	2.250	2.610	963286 JX8
2022	165,000	4.000	2.680[2]	963286 JY6
2023	180,000	4.000	2.790[2]	963286 JZ3
2024	195,000	2.750	3.020	963286 KA6
2025	215,000	2.875	3.110	963286 KB4
2026	230,000	3.000	3.270	963286 KC2
2027	250,000	3.125	3.360	963286 KD0
2028	280,000	3.250	3.450	963286 KE8
2029	320,000	3.375	3.590	963286 KF5
2030	340,000	3.500	3.690	963286 KG3
2031	365,000	3.625	3.780	963286 KH1
2032	390,000	3.750	3.880	963286 KJ7

$4,280,000 4.000% Term Bonds due December 1, 2037 – Priced to Yield 4.150%
CUSIP No. 963286 KK4

[1] CUSIP® is a registered trademark of the American Bankers Association. The CUSIP data herein is provided by the CUSIP Global Services, managed on behalf of the American Bankers Association by Standard and Poor's. The CUSIP numbers are not intended to create a database and do not serve in any way as a substitute for CUSIP service. CUSIP numbers have been assigned by an independent company not affiliated with the District and are provided solely for convenience and reference. The CUSIP numbers for a specific maturity are subject to change after the issuance of the Bonds. Neither the District nor the Underwriter takes responsibility for the accuracy of the CUSIP numbers.

[2] Priced to the December 1, 2021, par call date.

Whidbey Island Public Hospital District
Island County, Washington
(Whidbey General Hospital)

www.whidbeygen.org*

101 N. Main Street
Coupeville, WA 98239
(360) 678-5151

Commission

Grethe Cammermeyer, Ph.D.
Roger Case, M.D.
Anne Tarrant
Ron Wallin
Paul A. Zaveruha, M.D.

Administration

Tom Tomasino	Superintendent and Chief Executive Officer
Joe Vessey	Chief Financial Officer
Linda Gipson, R.N.	Chief Nursing Officer

Bond Counsel

Foster Pepper PLLC
Seattle, Washington

Paying Agent

The Bank of New York Mellon
New York, New York

Underwriter

Piper Jaffray & Co.
Seattle, Washington

* The District's website is not part of this Official Statement and investors should not rely on information presented in the District's website in determining whether to purchase the Bonds. This inactive textual reference to the District's website is not a hyperlink and does not incorporate the District's website by reference.

The information set forth herein has been obtained from the District and other sources that the District believes to be current and reliable. However, the District makes no representation regarding the accuracy or completeness of the information provided in Appendix D – "DTC AND ITS BOOK-ENTRY SYSTEM," which was obtained from DTC's website. The information and expressions of opinion herein are subject to change without notice, and neither the delivery of this Official Statement nor any sale made hereunder shall, under any circumstances, create any implication that there has been no change in the affairs of the District or any other parties described herein since the date as of which such information is presented.

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

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

In connection with this offering, the Underwriter may over-allot or effect transactions that stabilize or maintain the market price of the Bonds offered by this Official Statement at levels above those which otherwise might prevail in the open market. Such stabilizing, if commenced, may be discontinued or recommenced at any time without prior notice to any person.

The Bonds have not been registered under the Securities Act of 1933, as amended, and the Bond Resolution has not been qualified under the Trust Indenture Act of 1939, as amended, in reliance upon exemptions contained in such acts. The Bonds have not been recommended by any federal or state securities commission or regulatory authority. Furthermore, the foregoing authorities have not confirmed the accuracy or determined the adequacy of this document. Any representation to the contrary is a criminal offense.

Certain statements contained in this Official Statement do not reflect historical facts, but rather are forecasts and "forward-looking statements." No assurance can be given that the future results discussed herein will be achieved, and actual results may differ materially from the forecasts described herein. In this respect, the words "estimate," "forecast," "project," "anticipate," "expect," "intend," "believe" and other similar expressions are intended to identify forward-looking statements. The forward-looking statements in this Official Statement are subject to risks and uncertainties that could cause actual results to differ materially from those expressed in or implied by such statements. All estimates, projections, forecasts, assumptions and other forward-looking statements are expressly qualified in their entirety by the cautionary statements set forth in this Official Statement. These forward-looking statements speak only as of the date they were prepared. The District specifically disclaims any obligation to update any forward-looking statements to reflect occurrences or unanticipated events or circumstances after the date of this Official Statement, except as otherwise expressly provided in "CONTINUING DISCLOSURE."

Information on website addresses set forth in this Official Statement is not included in or incorporated into this Official Statement and cannot be relied upon to be accurate as of the date of this Official Statement, nor can it be relied upon in making investment decisions regarding the Bonds.

The order and placement of materials in this Official Statement, including the Appendices, are not to be deemed to be a determination of relevance, materiality or importance, and this Official Statement, including the Appendices, must be considered in its entirety. The offering of the Bonds is made only by means of this entire Official Statement.

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OFFICIAL STATEMENT

$8,050,000
Whidbey Island Public Hospital District
Island County, Washington
(Whidbey General Hospital)
Limited Tax General Obligation Bonds, 2012

INTRODUCTION

Whidbey Island Public Hospital District, Island County, Washington (doing business as Whidbey General Hospital) (the "District"), a Washington municipal corporation, furnishes this Official Statement in connection with the offering of $8,050,000 aggregate principal amount of its Limited Tax General Obligation Bonds, 2012 (the "Bonds").

This Official Statement provides information concerning the District and the Bonds. The information contained herein has been obtained from District officers, employees, records, and other sources believed to be reliable. This Official Statement is not to be construed as a contract or agreement between the District and the purchasers or owners of any of the Bonds.

Quotations, summaries and explanations of constitutional provisions, statutes, judicial decisions, administrative regulations, resolutions, ordinances, and other documents in this Official Statement do not purport to be complete and are qualified by reference to the complete text of such documents. A complete copy of the Bond Resolution (described below) may be obtained from the District at 101 N. main Street, Coupeville, Washington 98239.

Appendix A provides certain information concerning the District. Appendix B provides the audited financial statements of the District as of December 31, 2010 and 2009. Appendix C is the form of approving legal opinion of Foster Pepper PLLC, Seattle, Washington ("Bond Counsel"). Appendix D provides a description of DTC procedures with respect to book-entry bonds.

THE DISTRICT

The District is a public hospital district and a municipal corporation formed under the provisions of Chapter 70.44 of the Revised Code of Washington ("RCW"). The District is located within Island County, Washington (the "County"), and includes western Island County. The District is governed by a board of five publicly-elected commissioners.

The District owns and operates Whidbey General Hospital, an acute-care inpatient facility with 51 licensed beds and 25 beds currently in operation (the "Hospital"), and other health care facilities, all of which are located in the County (collectively, the "District Facilities"). See Appendix A-"CERTAIN INFORMATION CONCERNING THE DISTRICT – The District."

THE BONDS

AUTHORIZATION

The Bonds are issued pursuant to the authority of Chapter 39.46 RCW and RCW 70.44.110. The Bonds are authorized under the provisions of Resolution No. 320 (the "Bond Resolution"), to be adopted by the Commission of the District (the "Commission"), on February 13, 2012.

DESCRIPTION

The Bonds will be issued in the aggregate principal amount of $8,050,000, and will be dated and bear interest from the date of their initial delivery. The Bonds bear interest at the rates set forth on the inside

cover of this Official Statement, payable semiannually on June 1 and December 1, beginning on June 1, 2012), to the maturity or earlier redemption of the Bonds. Interest will be calculated on the basis of a 360-day year consisting of twelve 30-day months. The Bonds will mature on December 1 in the years and amounts set forth on the inside cover of this Official Statement, subject to earlier redemption as described under the heading "THE BONDS – Redemption of the Bonds."

REGISTRATION AND BOND REGISTRAR

Book-Entry System. The Bonds will be issued as fully registered bonds and, when issued, will be registered in the name of Cede & Co. as registered owner and nominee of The Depository Trust Company, New York, New York ("DTC"). DTC will act as securities depository for the Bonds. Individual purchases and sales of the Bonds will be made in book-entry form only in minimum denominations of $5,000 or integral multiples thereof within a single maturity. Purchasers will not receive certificates representing their interest in the Bonds. So long as Cede & Co. is the registered owner of the Bonds, as nominee of DTC, references herein to the registered owners or Bond owners will mean Cede & Co. and will not mean the "Beneficial Owners" of the Bonds. In this Official Statement, the term "Beneficial Owner" will mean the person for which a DTC Participant acquires an interest in the Bonds. See Appendix D—"DTC AND ITS BOOK-ENTRY SYSTEM." The District makes no representation as to the accuracy or completeness of the information in Appendix D provided by DTC. Purchasers of the Bonds should confirm this information with DTC or its Participants.

Bond Registrar. Principal of and interest on the Bonds will be payable by the fiscal agent of the State of Washington (the "State"), currently The Bank of New York Mellon in New York, New York (the "Bond Registrar") (or such other fiscal agency or agencies as the State may from time to time designate). So long as Cede & Co. is the registered owner of the Bonds, principal of and interest on the Bonds are payable by wire transfer by the Bond Registrar to DTC, which, in turn, is obligated to remit such principal and interest to the DTC Participants for subsequent disbursement to the Beneficial Owners of the Bonds, as further described herein in Appendix D—"DTC AND ITS BOOK-ENTRY SYSTEM."

Termination of Book-Entry System. If DTC resigns as the securities depository and the District is unable to retain a qualified successor to DTC, or the District has determined that the Bonds are to be in certificated form, the District will execute, authenticate and deliver at no cost to the Beneficial Owners of the Bonds or their nominees, Bonds in fully registered form, in the denomination of $5,000 or any integral multiple thereof within a maturity. Thereafter, the principal of the Bonds will be payable upon due presentment and surrender thereof to the Bond Registrar; interest on the Bonds will be payable by check or draft of the Bond Registrar mailed on the interest payment date to the persons in whose names such Bonds are registered, at the address appearing upon the registration books at the close of business on the 15th day of the month preceding the interest payment date or if requested in writing by a registered owner of Bonds prior to the applicable record date, by electronic transfer on the interest payment date. The Bonds will be transferable as provided in the Bond Resolution.

REDEMPTION OF THE BONDS

Optional Redemption. The District has reserved the right and option to redeem the Bonds maturing on or after December 1, 2022, prior to their stated maturity dates at any time on or after December 1, 2021, as a whole or in part within one or more maturities selected by the District, at a price of par plus accrued interest to the date fixed for redemption.

So long as the Bonds are registered in the name of Cede & Co., as nominee of DTC, selection of Bonds for redemption will be in accordance with the Letter of Representations between the District and DTC.

Mandatory Redemption. The Bonds maturing in 2037 are Term Bonds and, If not redeemed under the optional redemption provisions described above or purchased in the open market under the provisions set forth below, will be called will be called for redemption at par, plus accrued interest, on December 1 in the years and amounts as follows:

2037 Term Bond

Mandatory Redemption Years	Mandatory Redemption Amounts
2033	$ 420,000
2034	445,000
2035	1,075,000
2036	1,140,000
2037 (1)	1,200,000

(1) Maturity

If the District redeems under the optional redemption provisions, purchases in the open market or defeases Term Bonds, the par amount of the Term Bonds so redeemed, purchased or defeased (irrespective of their actual redemption or purchase prices) will be credited against one or more scheduled mandatory redemption amount for those Term Bonds. The District will determine the manner in which the credit is to be allocated and will notify the Bond Registrar in writing of its allocation prior to the earliest mandatory redemption date for that maturity of Term Bonds for which notice of redemption has not already been given.

Partial Redemption. Portions of the principal amount of any Bond, in installments of $5,000 or any integral multiple thereof, may be redeemed. If less than the entire principal amount of any Bond is redeemed, upon surrender of that Bond to the Bond Registrar, there shall be issued to the registered owner, without charge therefor, a new Bond (or Bonds, at the option of the registered owner) of the same maturity and interest rate in any of the denominations authorized by the Bond Resolution in the aggregate principal amount remaining unredeemed.

Selection of Bonds for Redemption. If fewer than all of the outstanding Bonds within a maturity are to be redeemed prior to maturity, the Bonds will be selected for redemption randomly within a maturity in such manner as the Bond Registrar shall determine. Notwithstanding the foregoing, so long as the Bonds are registered in the name of Cede and Co., as nominee of DTC, selection of Bonds for redemption will be made in accordance with the Letter of Representations.

Notice of Redemption. While the Bonds are registered in the name of DTC or its nominee, any notice of redemption will be given, and Bonds will be selected for redemption, only as set forth in the Letter of Representations given by the District to DTC.

If the Bonds cease to be in book-entry only form, the District will cause notice of any intended redemption of Bonds to be given not less than 20 nor more than 60 days before the date fixed for redemption by first class mail, postage prepaid, to the registered owner of any Bond to be redeemed at the address appearing on the Bond Register at the time the Bond Registrar prepares the notice as provided in the Bond Resolution. The actual receipt by the owner of any Bond of such notice of redemption is not a condition precedent to redemption.

Conditional Notice of Redemption. In the case of an optional redemption, the District reserves the right to rescind any redemption notice and the related optional redemption of Bonds by giving a notice of rescission to the affected registered owners at any time prior to the scheduled optional redemption date. Any notice of optional redemption that is so rescinded will be of no effect, and the Bonds for which the notice of optional redemption has been rescinded will remain outstanding.

Effect of Call for Redemption. Interest on the Bonds called for redemption will cease to accrue on the date fixed for redemption, except in the case of a rescinded optional redemption as described above or unless payment of that Bond is not made or provided for in full on the date fixed for redemption.

Open Market Purchase. The District reserves the right and option to purchase any or all of the Bonds in the open market at any time at any price.

FAILURE TO REDEEM BONDS

If any Bond is not redeemed when properly presented at its maturity or date set for redemption, the District will be obligated to pay interest on that Bond at the same rate provided in the Bond from and after its maturity or date set for redemption until that Bond, both principal and interest, is paid in full or until

sufficient money for its payment in full is on deposit in the District's Limited Tax General Obligation Bond Fund, 2012 (the "Bond Fund") and the Bond has been called for payment by giving notice of that call to the registered owner of the unpaid Bond.

REFUNDING OR DEFEASANCE

The District may issue refunding bonds pursuant to the laws of the State or use money available from any other lawful source to pay when due the principal of and interest on the Bonds, or any portion thereof included in a refunding or defeasance plan, and to redeem and retire, refund or defease all such then-outstanding Bonds (hereinafter collectively called the "defeased Bonds") and to pay the costs of the refunding or defeasance. If money and/or "government obligations" (as defined in chapter 39.53 RCW, as now or hereafter amended) maturing at a time or times and bearing interest in amounts (together with money, if necessary) sufficient to redeem and retire, refund or defease the defeased Bonds in accordance with their terms are set aside in a special trust fund irrevocably pledged to that redemption, retirement or defeasance of defeased Bonds (hereinafter called the "trust account"), then all rights and interest of the owners of the defeased Bonds in the covenants of the Bond Resolution and in the funds and accounts obligated to the payment of the defeased Bonds will cease and become void. The owners of defeased Bonds will have the right to receive payment of the principal of and interest on the defeased Bonds from the trust account. The District will include in the refunding or defeasance plan such provisions as the District deems necessary for the random selection of any defeased Bonds that constitute less than all of a particular maturity of the Bonds, for notice of the defeasance to be given to the owners of the defeased Bonds and to such other persons as the District will determine, and for any required replacement of Bond certificates for defeased Bonds. The defeased Bonds will be deemed no longer outstanding, and the District may apply any money in any other fund or account established for the payment or redemption of the defeased Bonds to any lawful purposes as it will determine.

As defined in chapter 39.53 RCW, "Government Obligations" means (a) direct obligations of or obligations the principal and interest on which are unconditionally guaranteed by the United States of America and bank certificates of deposit secured by such obligations; (b) bonds, debentures, notes, participation certificates or other obligations issued by the Banks for Cooperatives, the Federal Intermediate Credit Bank, the Federal Home Loan Bank System, the Export-import Bank of the United States, federal land banks or the Federal National Mortgage Association; (c) public housing bonds and project notes fully secured by contracts with the United States; and (d) obligations of financial institutions insured by the Federal Deposit Insurance Corporation or the federal savings and loan insurance corporation, to the extent insured or guaranteed as permitted under any other provision of State law.

PURPOSE AND USE OF BOND PROCEEDS

PURPOSE

The proceeds of the Bonds will be used to finance the costs of (1) acquiring and implementing an electronic medical record system, (2) improving data network infrastructure, (3) funding capital expenditures for hospital equipment, (4) retiring outstanding debt of the District, and (5) paying the costs of issuance of the Bonds. The foregoing acquisitions, improvements and reimbursement are hereafter known as the "Projects."

SOURCES AND USES OF PROCEEDS

The following table sets forth the estimated sources and uses of the Bond proceeds:

Sources of Funds	
Par Amount of Bonds	$ 8,050,000
Less Net Original Issue Discount	(100,266)
Total Sources of Funds	$ 7,949,734
Uses of Funds	
Deposit to Project Fund	$ 6,617,748
Retire Outstanding Debt	1,191,486
Issuance Expenses[(1)]	140,500
Total Uses of Funds	$ 7,949,734

[(1)] *Includes underwriter's discount, bond counsel fees, rating agency fees, contingency, and other costs associated with the issuance of the Bonds.*

SOURCES OF PAYMENT AND SECURITY

PROPERTY TAX PLEDGE

The Bonds are limited tax general obligations of the District. The District has pledged irrevocably to levy taxes annually within the constitutional and statutory tax limitations provided by law *without a vote of the electors of the District* on all taxable property within the District, in an amount sufficient, together with other revenues of the District legally available therefor, to pay the principal of and interest on the Bonds when due. The full faith, credit and resources of the District are pledged irrevocably for the prompt payment of that principal and interest.

The Bonds are not secured by or payable from excess property taxes levied by the District (i.e., those tax levies that the District is authorized by its voters to make without regard to rate or amount). The taxes pledged to the payment of the Bonds are the District's regular property taxes. The District's ability to levy and collect the regular property taxes is subject to certain limitations. See Appendix A - "PROPERTY TAX INFORMATION." Certain risk factors could also affect future financial condition of the District, and thereby, reduce available taxes and other revenue for the payment of the Bonds. See the heading "BONDOWNERS' RISKS" herein.

The District may issue revenue bonds with a lien on District revenue prior and superior to the lien of the Bonds. Revenue bonds are not general obligations of the District and are not payable from regular property taxes.

The Bonds do not constitute a debt or indebtedness of the County, the State or any political subdivision thereof other than the District.

DISSOLUTION

The dissolution of special purpose districts, such as public hospital districts, is governed by chapter 53.48 RCW. No dissolution may occur without the approval of the governing body of the special purpose district and the superior court of the county in which the district is located. The dissolution may be approved by the court only if the indebtedness of the district has been settled or paid and the court finds that the best interests of all persons concerned will be served by the dissolution. If the proceeds of the sale of the property of the district together with its available cash are insufficient to retire the district's indebtedness, the court is authorized to order the district's governing body to levy assessments against property in the district in amounts sufficient to retire the indebtedness regardless of whether the district continues to operate health care facilities or provide health care services.

INITIATIVES AND REFERENDA

Under the State constitution, the voters of the State have the ability to initiate legislation and to modify existing statutes through the powers of initiative and referendum. Initiatives and referenda are submitted to the voters upon receipt of a petition signed by at least 8% (initiatives) and 4% (referenda) of the number of voters registered and voting for the office of Governor at the preceding regular gubernatorial election. Any law approved in this manner by a majority of the voters may not be amended or repealed by the legislature within a period of two years following enactment, except by a vote of two-thirds of all the members elected to each house of the Legislature, but thereafter is subject to amendment or repeal by the legislature in the same manner as other laws.

Qualifying initiatives to the voters and qualifying referenda are submitted at the next State general election and must be approved by a majority of voters to be enacted into law. Qualifying initiatives to the State Legislature must be submitted to the State Legislature at its regular session each January. Once submitted, the State Legislature must either adopt the initiative as proposed, reject the proposed initiative (in which case the initiative must be placed on the ballot at the next state general election) or approve an amended version of the proposed initiative (in which case both the amended version and the original proposal must be placed on the next state general election ballot).

Any initiative approved by a majority of voters may not be amended or repealed by the State Legislature within a period of two years following enactment, except by a vote of two–thirds of all the members elected to each house of the State Legislature; after two years, the law is subject to amendment or repeal by the State Legislature in the same manner as other laws.

The voters of the State have limited the authority of State and local governments to levy taxes and increase revenues through the power of initiative and referendum. Some of these measures have been upheld by the State's courts and others have not. The District cannot predict whether any valid future initiative or referendum measure may have an adverse impact on its finances or operations.

BONDOWNERS' RISKS

The purchase of the Bonds involves certain investment risks that are discussed throughout this Official Statement. Accordingly, each prospective purchaser of the Bonds should make an independent evaluation of all of the information presented in this Official Statement and the Appendices hereto to make an informed investment decision. Certain of these risks are described below.

GENERAL

The Bonds are payable from certain tax receipts and from other revenue of the District, as described under the heading "SOURCES OF PAYMENT AND SECURITY" herein. The District's ability to collect regular property taxes could be adversely affected if the assessed valuation of the District declines in future years or if one or more of the regular property tax limitations described under the heading "PROPERTY TAX INFORMATION" in Appendix A causes a reduction in the rate or amount of taxes the District can levy.

The future financial condition of the District – and thus the District's ability to generate revenue – could be adversely affected by, among other things, legislation, regulatory actions, increased competition from other health care providers, demand for health care services, the impact of technological and demographic changes on the ability of the District to provide the services required by patients, confidence of physicians and the public in the District, economic developments in the service area, malpractice claims and other litigation, and changes in the rates, timing and methods of payment for the hospital services of health care providers. Such factors may also consequently affect payment by the District of principal of, premium, if any, and interest on the Bonds. There can be no assurance that the financial condition of the District will not be adversely affected by those factors. Certain of the factors that could affect the Bonds and the future financial condition of the District are set forth in more detail below.

For recent financial information relating to the operations and condition of the District, see Appendix A – "THE DISTRICT - Summary of Financial and Operating Data" and Appendix B – "AUDITED FINANCIAL STATEMENTS."

RISKS RELATED TO PATIENT SERVICES REVENUE

General

A substantial portion of the District's net patient service revenues is derived from third-party payors that pay for the services provided to patients covered by third parties for services. These third-party payors include the federal Medicare program, state Medicaid program and private health plans and insurers, including health maintenance organizations ("HMOs"). Many of those programs make payments to the District in amounts that may not reflect the District's direct and indirect costs of providing services to patients.

The District's financial performance has been and could be in the future adversely affected by the financial position or the insolvency or bankruptcy of or other delay in receipt of payments from third-party payors that provide coverage for services to their patients.

Medicare and Medicaid Programs

General. Approximately 45% and 8% of the District's gross patient service revenues for the fiscal year ended December 31, 2010, were derived from the Medicare and Medicaid programs, respectively. Medicare and Medicaid are the commonly used names for reimbursement or payment programs governed by certain provisions of the federal Social Security Act. Medicare is an exclusively federal program and Medicaid is a combined federal and state program. Medicare provides certain health care benefits to beneficiaries who are 65 years of age or older, blind, disabled or qualify for the End Stage Renal Disease Program. Medicare Part A covers inpatient hospital services, skilled nursing care and some home health care. Medicare Part B covers physician services and some supplies. Medicaid is designed to pay providers for care given to the medically indigent and others who receive federal aid. Medicaid is funded by federal and state appropriations and administered by the various states.

Medicare. Medicare is the federal governmental health insurance system under which physicians, hospitals and other health care providers are reimbursed or paid directly for services provided to eligible elderly and disabled persons. Medicare is administered by the Centers for Medicare & Medicaid Services ("CMS") of the federal Department of Health and Human Services. In order to achieve and maintain Medicare certification, a health care provider must meet CMS's "Conditions of Participation" on an ongoing basis, as determined by the state in which the provider is located and/or The Joint Commission.

Health care providers have been and continue to be affected significantly by changes made in the last several years in federal and state health care laws and regulations, particularly those pertaining to Medicare and Medicaid. The purpose of much of the recent statutory and regulatory activity has been to reduce the rate of increase in health care costs, particularly costs paid under the Medicare and Medicaid programs. Diverse and complex mechanisms to limit the amount of money paid to health care providers under both the Medicare and Medicaid programs have been enacted, some of which have been implemented and some of which will be or may be implemented in the future.

The Washington State Medicaid Program. In order to receive federal grants, a state's Medicaid program must cover persons receiving assistance from Temporary Assistance for Needy Families (previously known as Aid to Families With Dependent Children) or the federal Supplemental Social Security ("SSI") program and certain categories of children and pregnant women. The design and operation of the Medicaid program falls to each state, however, and there are significant variations in virtually all aspects of the Medicaid program across states. State-specific variations arise because the Medicaid statute allows for optional benefits and categories of beneficiaries, as well as waivers of certain statutory requirements to implement specific programs or demonstration projects. The Medicaid statute also allows each state some latitude in defining the methods and standards that the state uses to reimburse facilities for items and services that it provides to Medicaid beneficiaries.

CMS, the federal agency that oversees the Medicaid program, approved the request of the State of Washington (the "State") for a waiver under Section 1115 of the Federal Social Security Act, which has allowed the State to implement a statewide Medicaid managed care delivery system as a demonstration project. The Medicaid health care delivery system, entitled "Healthy Options," provides payment for health care services through managed care provider networks. The District contracts with managed care providers who participate in Healthy Options.

The District participates in the State's Medicaid program and accordingly provides inpatient hospital services to eligible Medicaid beneficiaries. The District's Medicaid revenues could be materially affected by changes at the state or federal level, including reductions in Medicaid coverage (of persons or benefits), reductions in funding or payments, or termination or reduction in scope of the Healthy Options or Medicaid programs generally. Coverage of persons could be reduced by eliminating groups of currently eligible State residents or by changing the poverty level threshold required for eligibility. Either of these changes would increase the number of uninsured persons treated by health care providers and increase the risk of unreimbursed expenses. In addition, reductions in provider reimbursement from Medicaid could have a significant negative impact on the District's revenues.

The Washington State budget for the 2011-1013 biennium drastically reduced coverage for many Medicaid programs and also reduces coverage for certain hospital services. These reductions in coverage are beyond the deep cuts made in the previous biennium. The budget reduces coverage for the Basic Health Plan, dropping enrollment by 10,000 people during the biennium, which reduces payments to for hospital and physician services by over $200 million. Medicaid coverage for certain emergency room visits and other hospital services has also been reduced resulting in a reduction in hospital payments of over $80 million over the biennium. The budget also eliminates a number of the disproportionate share payments and other special payment programs. These reductions in Medicaid coverage and payment may adversely affect the District's revenue.

Medicare Reimbursement of Critical Access Hospitals. The District owns and operates the Hospital, which is an acute care inpatient facility. The Hospital is designated as a critical access hospital ("CAH"). Under applicable federal law, a CAH is limited to operating no more than 25 inpatient beds, which may be operated as "swing beds" with state approval, meaning that they may be used to provide acute or skilled nursing level beds, is either located in a rural area or has been designated by the state as a "necessary provider," and must have an average length of stay of 96 hours or less. As a CAH, the Hospital is paid by Medicare based on its costs and is generally exempt from the prospective payment system that is otherwise used to pay for most services under the Medicare program. Medicare pays for most CAH inpatient and outpatient services on the basis of 101% of the Hospital's allowable and reasonable costs. CAHs are paid an interim rate throughout the year based on a specified amount per inpatient day for inpatient stays and a percentage of the Hospital's charges for outpatient services. After the end of each fiscal year, the Hospital files a cost report with CMS, which settles the difference between the interim rates and the costs (including allocated overhead) in each Hospital department. The Hospital is paid for routine or daily charges at a calculated amount per day while outpatient and inpatient ancillary charges are paid on a ratio of cost-to-charges for each ancillary department. Not all costs are considered to be "allowable" for cost report purposes and are not, therefore, reimbursed by Medicare.

The Hospital has elected the "optional" payment method ("Method II Billing") for its services to Medicare patients, which permits the Hospital to bill the Medicare Fiscal Intermediary ("FI") for both the facility services and professional services provided to its outpatients. If a physician or other practitioner reassigns his or her billing rights and agrees to be included under a hospital's Method II Billing, Medicare pays for the physician's professional services at a rate equal to 115% of the otherwise allowable amount, after applicable deductions, under the Medicare Physician Fee Schedule ("MPFS"). The additional 15% incremental payment applies only to the amount paid by Medicare, not amounts paid by the beneficiary as a copayment. Professional charges billed for an inpatient are not covered under the Method II Billing and are paid at the regular rate under the MPFS.

If the Hospital were to lose its CAH designation, it would be paid for inpatient and outpatient services under the prospective payment system and it would not qualify for Method II Billing for professional services. Such a change could reduce the Hospital's payments from Medicare and Medicaid and could have a material adverse impact on the future operations and financial condition of the Hospital.

Medicaid Reimbursement of Critical Access Hospitals. Payment for most inpatient and outpatient services rendered to Medicaid program beneficiaries by CAHs is made on a cost basis as defined by the State. The Hospital is reimbursed for cost-reimbursable items at a tentative rate with final settlement determined after submission of annual cost reports by the Hospital and review by the Washington State Department of Social and Health Services. For Medicaid beneficiaries who have elected to enroll in the Medicaid Healthy Options program, the Hospital is reimbursed a percentage of charges based on the

direct Medicaid interim rate and there is no settlement process. Physician services are paid based on a Medicaid fee schedule.

Reimbursement for Physician Services. The Medicare program pays for physician services on the basis of a resource-based relative value scale fee schedule. The fee schedule uses three types of relative value units ("RVUs") to determine the amount of payment for a particular physician service: (1) physician work; (2) practice expense; and (3) malpractice expense. The RVUs are adjusted by a geographic adjustment factor, then multiplied by a national conversion factor. The conversion factor is adjusted annually by (1) an inflation factor (as measured by a Medicare Economic Index ("MEI")) and (2) a target factor (as measured by a Sustainable Growth Rate ("SGR")). The target factor specifies a desired rate of growth in Medicare expenditures on physician services in a given fiscal year. The 2012 Proposed Medicare Physician Fee Schedule contains an SGR adjustment that will result in a 29.5% reduction in physician payment rates for 2012. While in recent years Congress has enacted legislation to reduce the severity of the SGR adjustment, given the scope of the federal budget deficit, there may be a substantial reduction in physician payment rates for 2012.

Medicare Trust Funds. Two trust funds are maintained as part of the Medicare Program. Hospital Insurance ("HI"), or Medicare Part A, helps to pay for hospital, home health, skilled nursing facility and hospice care for the aged and disabled (including certain individuals with end stage renal disease) and is financed primarily by payroll taxes paid by workers and employers. Supplementary Medical Insurance ("SMI") consists of Medicare Part B and Part D. Part B helps pay for physician, outpatient and other services for the aged and disabled who have voluntarily enrolled. Part D initially provided access to prescription drug discount cards and transitional assistance to low-income beneficiaries. In 2006 and later, Part D provides subsidized access to drug insurance coverage on a voluntary basis for beneficiaries.

The Board of Trustees of the Medicare trust funds delivered its most recent annual report (the "Annual Report") to Congress on May 13, 2011. The Annual Report indicated that the Part A Trust Fund is not adequately financed and based upon its intermediate estimate is projected to be exhausted in 2024, five years later than projected in 2010. The trustees project that total Medicare expenditures and scheduled tax income are significantly out of balance and substantial increases in tax revenues and/or reductions in expenditures are required to stabilize the HI Trust Fund. The Part B and Part D accounts in the SMI Trust Fund are adequately financed over the next ten years because premiums and general revenue income are reset each year to match expected costs. Such financing, however, would have to increase rapidly to match expected expenditure growth and to rebuild the Part B assets to an appropriate level. The trustees express the need for timely action to address Medicare's financial challenges and promote consideration of reforms for the program in the near future. Accordingly, it is likely that additional statutory and regulatory reforms to contain increases in Medicare costs will continue in the future. The effect of such future initiatives on the District cannot be predicted.

Medicare and Medicaid Conditions of Participation. Health care facilities must comply with standards called "Conditions of Participation" in order to be eligible for Medicare and Medicaid reimbursement. CMS is responsible for ensuring that hospitals meet these regulatory Conditions of Participation. Under the Medicare rules, providers such as the District that are accredited by The Joint Commission are deemed to meet the Conditions of Participation. However, CMS may request that the state agency responsible for licensing hospitals on behalf of CMS conduct a "sample validation survey" of a hospital to determine whether it is complying with the Medicare or Medicaid Conditions of Participation. Failure to maintain The Joint Commission accreditation or otherwise to comply with the Conditions of Participation could have a material adverse effect on the District's financial condition.

Audits and Withholds. The District receives payments for various services provided to Medicare and Medicaid patients based upon charges or other reimbursement methodologies that are then reconciled annually based upon the preparation and submission of annual cost reports. Estimates for the annual cost reports are reflected as amounts due to/from third-party payors and represent several years of open cost reports due to time delays in audits by the fiscal intermediaries and the basic complexity of billing and reimbursement regulations. These estimates are adjusted periodically based upon correspondence received from the fiscal intermediary. Medicare and Medicaid regulations also provide for withholding of payment in certain circumstances if it is determined that an overpayment has been made. In addition,

under certain circumstances, payments may be determined to have been made as a consequence of improper claims subject to the Federal False Claims Act or other federal statutes, subjecting the District to civil or criminal sanctions. The District is not aware of any situation whereby a material Medicare or Medicaid payment is being withheld.

Private Health Plans and Insurers

Certain private insurance companies contract with hospitals and other providers on an "exclusive" or a "preferred" provider basis and have introduced plans known as "preferred provider organization plans" ("PPOs"). Under such PPOs, there generally are financial incentives for enrollees to use those contracted providers. Under HMO plans, private payers may direct patients away from participating providers by limiting coverage for services provided by them.

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.

Often, payer 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 payer is able to pay the hospital. Hospitals from time to time have disputes with payers 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. Thus, managed care poses significant business risks (and opportunities) for hospitals.

Federal and State Anti-Fraud and Abuse Laws

Federal and state governments have enacted health care fraud and abuse laws to regulate both the provision of services to government program beneficiaries and the methods and requirements for submitting claims for services rendered to those beneficiaries. These laws penalize individuals and organizations for submitting claims for services that: (i) they did not provide; (ii) were not medically necessary; (iii) were provided by an improper person; (iv) involved an illegal inducement to utilize or refrain from utilizing a service or product; or (v) were billed in a manner that does not comply with applicable government requirements. The scope of certain federal and state fraud and abuse laws has been expanded to include non-governmental private health care plans.

Federal and state governments have a range of criminal, civil and administrative sanctions available to penalize and remediate health care fraud and abuse, including imposing civil money penalties, suspending payments and excluding the provider from participating in the federal and state health care programs. One or more government entities and/or private individuals can prosecute fraud and abuse cases, and courts and/or regulators can impose more than one of the available penalties for each violation.

Laws governing fraud and abuse apply to virtually all individuals and entities with which a hospital does business, including other hospitals, home health agencies, long-term care entities, infusion providers, pharmaceutical providers, insurers, HMOs, PPOs, third-party administrators, physicians, physician groups and physician practice management companies. Fraud and abuse prosecutions can have a catastrophic effect on any of these entities, which can result in a material adverse impact on the financial condition of other entities in the same health care delivery system.

Federal Anti-Fraud and Abuse Law. In recent years, both the federal and state governments have increased enforcement of laws designed to combat health care fraud and practices that the governments regard as abusive, and additional anti-fraud legislation has been adopted at both federal and state levels. Under the federal Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977 to the Social Security Act, as amended (the "Anti-Kickback Law"), it is a felony to knowingly and willfully offer, pay, solicit or receive any remuneration (including any kickback, bribe or rebate) directly or indirectly, overtly or covertly,

in cash or in kind in order to induce business for which reimbursement is provided, in whole or in part, under a federal health care program, including Medicare and Medicaid. Penalties for each violation of the Anti-Kickback Law include criminal fines and civil monetary penalties. Moreover, a violation of the Anti-Kickback Law may form the basis for a Federal False Claims Act suit (see discussion below). The statute does include some exceptions and federal regulations establish numerous "safe harbors." Arrangements that meet the safe harbor requirements are deemed not to be violations of the Anti-Kickback Law. Failure to comply with the safe harbors, however, does not mean that the activity violates the law. Arrangements that fail to qualify for safe harbor protection may or may not violate the Anti-Kickback Law depending on the facts and the intent of the parties.

The scope of the Anti-Kickback Law prohibition is, however, broadly drafted and liberally interpreted by some federal regulators and enforcement authorities. Thus, the Anti-Kickback Law may create liability in connection with a wide range of economic arrangements involving managed care entities, hospitals, physicians and other health care providers, including joint ventures, space and equipment rentals, purchases of physician practices, managed care arrangements, and management and personal services contracts. While the District believes its arrangements currently comply with the Anti-Kickback Law, the ambiguity and breadth of the law mean that there can be no assurance that enforcement authorities or courts of law would agree.

In the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Congress established a fraud and abuse control program to coordinate federal, state and local health care fraud and abuse activities. HIPAA also created several new federal health care crimes, many of which are broadly worded and potentially applicable to a wide range of conduct. For example, HIPAA created a general prohibition on knowingly and willfully executing or attempting to execute schemes to defraud any public or private health care benefit program or making any false or fraudulent representations in any matter involving any private or public health care program.

Several federal statutes, including the Social Security Act, the Program Fraud Civil Remedies Act of 1986 and the Federal False Claims Act (which is discussed in more detail below), also provide for imposition of civil monetary penalties for knowingly making false or improper claims to federal health care programs. Penalties under these statutes can be severe, ranging up to $25,000 per claim plus up to three times the amount of damages sustained by the government.

Penalties for noncompliance with the above-referenced statutes can be substantial and could include criminal or civil liability and/or exclusion from participation in Medicare, Medicaid and other health programs. Based on its internal processes, the District believes that it is in compliance with the above-referenced statutes; however, there can be no assurance that enforcement authorities would agree.

State Anti-Fraud and Abuse Law. In addition to the federal laws prohibiting kickbacks and other types of exchanges of remuneration for referrals of patients, Washington law also prohibits such conduct. Subject to certain exceptions, RCW 19.68.010 provides criminal and civil penalties for licensed facilities and individuals who make or receive payments for referrals of patients for health care services. Entities and individuals found to have violated this provision are subject to loss of licensure, fines and/or imprisonment. The statute contains several ambiguities, has been sparsely reviewed or interpreted, and the exact scope and extent of its prohibition are still subject to interpretation. Based on its internal processes, the District believes that it is in compliance with RCW 19.68; however, there can be no assurance that enforcement authorities or courts of law would agree.

Federal and State Self-Referrals Prohibition. The Ethics in Patient Referrals Act of 1989 ("STARK I"), as amended in the Omnibus Budget Reconciliation Act of 1993 ("STARK II") (collectively, the "Stark Law"), prohibits a physician from referring Medicare patients for specified "designated health services" to entities with which the physician or an immediate family member of the physician has a financial relationship unless an exception applies. The Stark Law also prohibits the entity receiving the tainted referral from billing for such services. "Designated health services" ("DHS") include, but are not limited to, clinical laboratory services, physical and occupational therapy, radiology and certain other diagnostic services, radiation therapy, home health services, and inpatient and outpatient hospital services. A "financial relationship" is defined to include any ownership or investment interest in the entity or any compensation arrangement between the entity and the physician. The Stark Law contains a number of exceptions. For example, space and equipment rental arrangements, bona fide employment relationships, personal

service arrangements, arrangements unrelated to the provision of designated health services and physician recruitment arrangements that meet specified requirements are excepted from the referral prohibition.

New Stark regulations effective December 4, 2007 and the CMS comments preceding them have made the Stark statute more difficult to understand; this increases the possibility that inadvertent violations may occur. In addition, CMS continues to revise, supplement and update the Stark law. On August 19, 2008, CMS published final regulations relating to the Stark Law in the 2009 IPPS Rule that further restrict the type of financial arrangements that facilities and physicians may enter into, including additional restrictions on certain leases, percentage compensation arrangements and agreements under which a hospital purchases services.

Penalties for violation of the Stark Law include denial of payment, recoupment, refunds of amounts paid in violation of the law, exclusion from the Medicare or Medicaid program, and substantial civil monetary penalties (up to $15,000 per service, $100,000 for each arrangement or scheme intended to circumvent or to violate the statute, or $10,000 per day for false reporting or failure to report certain information required under the law). Violation of the Stark Law may also provide the basis for a claim under the False Claims Act (see discussion below).

The Stark Law applies to state Medicaid programs indirectly. Section 1903(s) of the Social Security Act denies federal financial participation to state Medicaid programs for services furnished to Medicaid patients pursuant to a physician referral prohibited by the Stark Law. In 1995, the State Legislature enacted a state physician self-referral prohibition patterned after the Stark Law. This statute, RCW 74.09.240(3), explicitly provides that the physician referral prohibition shall not apply in any case covered by a general exception in the Stark Law. Although the scope of the State self-referral statute remains ambiguous, a letter issued by the Washington State Attorney General dated September 30, 1998, indicates that the State statute should be interpreted in a manner consistent with its federal counterpart. The State self-referral law prohibits certain physician referrals, but does not directly prohibit billing for services provided pursuant to a prohibited referral. The State statute does not identify what, if any, penalties apply in the event of a violation.

The District has and may have in the future relationships with physicians that may be characterized as financial arrangements under the Stark Law and/or the State self-referral statute. The statutes and interpretive regulations contain numerous ambiguities and are subject to interpretation. Under these circumstances, it is not possible to ascertain with certainty the effect that the Stark Law or the State self-referral statute may have on the District's operations or financial results. Based upon its review, however, the District's management does not believe that any attempted enforcement action under the Stark Law or the State self-referral statute would have a material adverse impact on the District's financial condition.

The False Claims Act. Under federal law, a "whistleblower" may bring a lawsuit in the name of the federal government against an entity that is alleged to have submitted false claims for payments to the federal government. The federal False Claims Act ("FCA") provides for potentially severe penalties: treble damages, attorneys' fees and civil fines of $5,000 to $10,000 per claim. Whistleblowers can be awarded a significant portion of any damages or penalties recovered by the government. The government may either join in a civil False Claims Act action filed by a whistleblower or allow the whistleblower to proceed without the government's direct involvement. The cases are filed under seal and the federal government is given the option to pursue the lawsuit. If the federal government declines, then the whistleblower may proceed with the lawsuit.

In order to prevail, the government or the whistleblower must establish that the false claims were submitted "knowingly." Under the False Claims Act, a claim may be submitted knowingly if it is submitted in "deliberate ignorance" or "reckless disregard" of the truth or falsity of the information contained in the claim, in addition to claims actually known to be false. Some regulators and whistleblowers have asserted that claims submitted to governmental payers that do not comply fully with regulations or guidelines come within the scope of the False Claims Act.

Management of the District is not aware that any False Claims Act lawsuits have been filed against it. Because such lawsuits are filed under seal, however, there can be no guarantee that one or more lawsuits have not been filed or will not be filed in the future.

Federal Civil Monetary Penalty Law. The federal Civil Monetary Penalty 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 under Medicare, Medicaid or the Child Health Services Block Grant programs. A hospital that participates in a "gainsharing" arrangement that is found to constitute a payment to physicians to limit or reduce services to Medicare fee-for-service beneficiaries also would be subject to CMPL penalties. The CMPL authorizes imposition of civil money penalty of up to $10,000 for each item or service improperly claimed. Health care providers may be found liable under the CMPL even when they 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 and ignorance of the Medicare regulations is no defense.

The Health Insurance Portability and Accountability Act of 1996. The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") established 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, securities, premiums, credits, property, or other assets of a health care benefit program. A health care provider convicted of health care fraud would be subject to mandatory exclusion from the Medicare program.

The HITECH Act. Provisions in the 2008 Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), enacted as part of the economic stimulus legislation, increase the maximum civil monetary penalties for violations of HIPAA and grant enforcement authority of HIPAA to state attorneys general. The HITECH Act also (i) extends the reach of HIPAA beyond "covered entities," (ii) imposes a breach notification requirement on HIPAA-covered entities, (iii) limits certain uses and disclosures of individually identifiable health information and (iv) restricts covered entities' marketing communications. Management anticipates that compliance with the HITECH Act will not have a material adverse effect on the District's operations.

Exclusions from Medicare or Medicaid Participation. The government may exclude from Medicare/ Medicaid program participation a hospital 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, fraud against any federal, state or locally financed health care program or an offense relating to the illegal manufacture, distribution, prescription, or dispensing of a controlled substance. The government also may exclude individuals or entities under certain other circumstances, such as an unrelated conviction of fraud or other financial misconduct relating either to the delivery of health care in general or to participation in a federal, state or local government program. Exclusion from the Medicare/Medicaid program means that a hospital would be decertified and no program payments could be made. Any hospital exclusion could be a materially adverse event, even within a large hospital system.

Enforcement. Enforcement activity against health care providers has increased and enforcement authorities have adopted aggressive approaches. In the current regulatory climate, it is anticipated that many health care providers will be subject to investigation, audit or inquiry regarding the health care fraud laws mentioned above. As with other health care providers, the District may be the subject of Office of the Inspector General, U.S. Attorney General and/or Justice Department investigations, audits or inquiries in the future. Because of the complexity of these laws, the instances in which an alleged violation may arise to trigger such investigations, audits or inquiries is increasing and could result in enforcement action against the District.

Enforcement authorities are in a position to compel settlement by providers charged with kickback, referral, billing practice or false claims violations by imposing or threatening to withhold Medicare, Medicaid and/or similar payments and/or exclusion and/or criminal action. In addition, the cost of defending such investigations or litigation, the time and management attention consumed thereby and the facts of a particular case may dictate settlement. Therefore, regardless of the merits of a particular case or cases, the District could experience materially adverse settlement and/or litigation costs. Prolonged and publicized investigations could be damaging to the reputation, business and credit of the District, regardless of the outcome, and could have material adverse consequences on the financial condition of

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

Voluntary Corporate Compliance. The District has adopted and implemented a voluntary corporate compliance program called the Voluntary Corporate Integrity Program ("Compliance Plan"), designed in light of the applicable compliance guidance offered by the Office of the Inspector General. The purpose of the Compliance Plan is to detect and deter violations of law. One of the major goals of such a plan is to identify and address issues involving the submission of claims to governmental payers such as Medicare and Medicaid and whether those claims comply with statutes, regulations and other guidance provided by the programs. Integral components of the Compliance Plan include a code of conduct, adoption of written standards, education, policies and procedures, auditing and monitoring, remediation of identified issues, and encouraging employees to identify potential issues.

It is possible that the Compliance Plan may bring to the District's attention issues with respect to prior practices and payments. Depending upon the nature of the issue and whether an overpayment has occurred, such a discovery may result in either voluntary or involuntary refunds to governmental payers. Enforcement authorities take into account the existence and efficacy of a provider's voluntary compliance efforts in assessing the application and severity of penalties for a violation of federal or state rules governing reimbursement to or business relationships among providers of medical services; however, the decision of whether and how much weight to attach to voluntary compliance efforts is solely within the enforcement authorities' discretion.

Voluntary Disclosures and Refunds. The District strives to be a good corporate citizen, including full compliance with all laws and regulations. If the District learns that it has submitted claims that do not comply with statutes, regulations or other guidance provided by governmental programs, then one of its options is the voluntary disclosure to the affected program of the issue and a voluntary repayment. As a result of its Compliance Plan, the District may identify in the future instances where payments may have been received in error and may disclose such instances to the affected governmental programs and voluntarily submit a refund. There can be no assurance, however, that the affected governmental program will not seek to impose sanctions on the District for practices that were voluntarily disclosed, and this could have a material adverse effect on the District.

HIPAA – Administrative Simplification. In addition to provisions governing the portability of health insurance and health care fraud, HIPAA includes administrative simplification provisions ("AS Provisions") intended to reduce costs and administrative burdens in the health care industry by standardizing the electronic transmission of many administrative and financial transactions that currently are carried out manually on paper or in many different electronic formats. The AS Provisions also impose privacy and security requirements on entities covered by HIPAA ("Covered Entities") as well as mandate other standards such as national identifiers. Covered Entities are health plans, health care clearinghouses, and health care providers such as the District, that engage in covered transactions. Additionally, Covered Entities must enter into contracts with their business associates with whom they share protected health information to assure that such information is appropriately safeguarded and that other HIPAA requirements are met.

Under the final transaction and code set regulations promulgated by HHS, Covered Entities must use the prescribed standards for designated electronic transactions. The final HIPAA privacy regulations impose requirements on the use and disclosure of protected health information, create individual rights, and mandate certain administrative requirements for Covered Entities. Covered Entities are expected to be in compliance with the privacy regulations. Additionally, security regulations require Covered Entities to assess risks and develop and implement appropriate security measures to protect individually identifiable health information, with particular focus on administrative procedures, physical safeguards, technical security services, and technical security mechanisms. Covered Entities such as the District must comply with the security regulations.

Penalties for noncompliance with the AS Provisions include civil monetary penalties of up to $100 for any violation not to exceed $25,000 in any calendar year for identical violations. Criminal penalties include up to $50,000 in fines and/or one year imprisonment for wrongful disclosure of individually identifiable health information; $100,000 and/or imprisonment of not more than five years for wrongful disclosure under false

pretenses; and up to $250,000 and/or ten years of imprisonment for wrongful disclosure with the intent to sell, transfer or use individually identifiable health information for commercial advantage, personal gain, or malicious harm.

The District has made a concerted effort to comply with all of the AS Provisions and continues to work with fiscal intermediaries, electronic claim submission clearinghouses and insurance carriers to ensure that all financial transaction data sets are compliant with the new regulations. The District's information resources management team worked closely with its software vendors to make sure that all outgoing data sets were compliant with the new AS Provisions. The District expected that there would be some delay in claims submission and electronic processing of information as the claim submission clearinghouses and insurance carriers updated the software necessary to receive and process the new transaction formats provided under the AS Provisions. The District is currently submitting claims in an AS-compliant format to all carriers that can process claims in that format. Management cannot predict if additional regulations, amendments or interpretations might increase the District's costs or impair timely collections from Covered Entities.

Health Care Reform

On March 23, 2010, the President signed into law comprehensive health reform through the Patient Protection and Affordable Health Care Act (Pub. L. 111-148) and signed a budget reconciliation bill that included amendments (Pub. L. 111-152). These laws in combination form the "Health Care Reform Act."

Some of the provisions of the Health Care Reform Act took effect immediately, while others will take effect later or will be phased in over time, ranging from a few months following approval to ten years. Because of the complexity of the Health Care Reform Act generally, additional legislation is likely to be considered and enacted over time. The Health Care Reform Act will also require the promulgation of substantial regulations with significant effect on the health care industry and third-party payers. In response, third-party payers and suppliers and vendors of goods and services to health care providers are expected to impose new and additional contractual terms and conditions. Thus, the health care industry will be subjected to significant new statutory and regulatory requirements and contractual terms and conditions, and consequently to structural and operational changes and challenges.

The ramifications of the Health Care Reform Act may become apparent only through or following regulatory and judicial interpretations or additional legislation. All or portions of the Act may be limited or nullified as a result of legal challenges or amendments. Multiple cases challenging the individual mandate provision of the Health Care Reform Act are pending and while two federal district courts have upheld its constitutionality, two other federal district courts have held it to be unconstitutional under the Commerce Clause. The most recent of the two declared the Health Care Reform Act void in its entirety, finding that the individual mandate is not severable from the Act as a whole. Some or all of these decisions will likely be appealed to the courts of appeals and the U.S. Supreme Court. Efforts are also underway in Congress to repeal all or portions of the Health Care Reform Act. On January 19, 2011, the U.S. House of Representatives approved a bill to repeal the Health Care Reform Act. A similar bill in the U.S. Senate was rejected.

District management is analyzing the Health Care Reform Act and will continue to assess the effects of the legislation and evolving regulations and judicial interpretations on current and projected operations, financial performance and financial condition. At this time, management cannot predict with any reasonable degree of certainty or reliability any interim or ultimate effects of the legislation. As enacted, the Health Care Reform Act impacts CAHs such as the Hospital differently than other hospitals in certain respects. For example, certain provisions linking payment to quality of care do not apply to CAHs. Some of the specific provisions of the Health Care Reform Act that may affect hospital operations, financial performance or financial conditions, including those of the District, are described below. This summary is not intended to be nor should it be considered by the reader as comprehensive.

The Health Care Reform Act will significantly change the methods by which consumers pay for health care for themselves and their families and by which employers procure health insurance for their employees and dependents. One of the primary objectives of the Health Care Reform Act is to cause the extension of health care insurance to millions of currently uninsured (or underinsured) consumers. The Health Care Reform Act proposes to accomplish that objective through various provisions, summarized

as follows: (i) the creation of active markets (referred to as exchanges) in which individuals and small employers can purchase health care insurance for themselves and their families or their employees and dependents; (ii) providing subsidies for premium costs to individuals and families based upon their income relative to federal poverty levels; (iii) mandating that individual consumers obtain and certain employers provide a minimum level of health care insurance and providing for penalties or taxes on consumers and employers that do not comply with these mandates; (iv) expansion of private commercial insurance coverage generally through such reforms as prohibitions on denials of coverage for pre-existing conditions and elimination of lifetime or annual cost caps; and (v) expansion of existing public programs, including Medicaid, for individuals and families. The Congressional Budget Office (the "CBO") has estimated that in federal fiscal year 2015, 19 million consumers who are currently uninsured will become insured, followed by an additional 11 million consumers in federal fiscal year 2016. To the extent that all or any of those provisions produce the expected result, an increase in utilization of health care services by those who are currently avoiding or rationing their health care can be expected and bad debt expenses may be reduced. Associated with increased utilization will be increased variable and fixed costs of providing health care services, which may or may not be offset by increased revenues.

The delivery system changes in the reform legislation, among other things, increasingly link provider payments to quality and coordination of care. Hospitals will be subject to Medicare payment withholds or bonuses based on performance scores under a new value-based purchasing program. CAHs are exempt from this program although pilot programs involving CAHs will be established. Hospitals with excess readmissions will face payment reductions. CAHs such as the Hospital are exempt from the value-based purchasing and payment reductions although pilot programs including CAHs will be established. Under both Medicare and Medicaid, hospitals will not receive payment for certain hospital-acquired conditions and hospitals with the highest rates of hospital-acquired conditions will be subject to Medicare payment penalties on all discharges. The Health Care Reform Act also imposes quality-related requirements on health insurers. Health care insurers will be required to include quality improvement covenants in their contracts with hospital providers and will be required to report their progress on such actions to the Secretary of Health and Human Services (HHS). Health care insurers participating in the health insurance exchanges will be allowed to contract only with hospitals that have implemented programs designed to ensure patient safety and enhance quality of care. The effect of these provisions upon the process of negotiating contracts with insurers or the costs of implementing such programs cannot be predicted.

Several provisions included to fund the cost of health care reform could have an adverse impact on provider payment rates. These provisions will have a limited impact on CAHs such as the Hospital, at least initially, because CAHs are generally reimbursed based on cost. These provisions include: (i) reductions in Medicare market basket updates to inpatient and outpatient hospital payment rates and further reductions to these market basket updates to account for economy-wide productivity gains; (ii) reductions in payments under the "Medicare Advantage" programs (Medicare managed care), which may result in increased premiums or out-of-pocket costs to Medicare beneficiaries enrolled in Medicare Advantage plans; and (iii) reductions in Medicare disproportionate share hospital (DSH) payments (although it is not possible to determine the specific impact on the District until CMS calculates the funding to be redistributed to hospitals based on their relative uncompensated care costs, and until CMS determines the allocation of cuts to each state and the State determines the allocation of remaining funds among providers).

There will be a new Independent Payment Advisory Board that provides to Congress and the President annual recommendations on curtailing Medicare cost growth and non-binding recommendations on constraining costs and improving quality in the private sector. Starting in 2020, the Medicare proposals related to inpatient and outpatient hospitals will be automatically implemented unless Congress passes an alternative package that meets the same savings targets.

The Health Care Reform Act also implements significant changes to health care fraud and abuse laws that will intensify the risks and consequences of enforcement actions. These include expansion of the False Claims Act by: (i) narrowing the public disclosure bar; (ii) explicitly stating that violations of the anti-kickback statute trigger false claims liability; and (iii) applying the False Claims Act to payments under the new exchanges to the extent the payments are made with federal funds. In addition, health care reform lessens the intent requirements under the anti-kickback statute to provide that a person may violate the

statute without knowledge or specific intent. The health care reform legislation also provides new funding and expanded powers to investigate fraud, including through expansion of the Medicare Recovery Audit Contractor ("RAC") program to Medicare Parts C and D and Medicaid. Finally, the legislation creates enhanced penalties for noncompliance, including increased criminal penalties and expansion of administrative penalties under Medicare and Medicaid. Also of potential cost to the District, all hospitals must establish and maintain compliance programs that satisfy certain federal requirements as a condition of enrollment in Medicare, Medicaid and the Children's Health Insurance Program ("CHIP").

The Health Care Reform Act creates a Center for Medicare and Medicaid Innovation to test innovative payment and service delivery models and to implement various demonstration programs and pilot projects to test, evaluate, encourage and expand new payment structures and methodologies to reduce health care expenditures while maintaining or improving quality of care, including bundled payments under Medicare and Medicaid, and comparative effectiveness research programs that compare the clinical effectiveness of medical treatments and develop recommendations concerning practice guidelines and coverage determinations. Other provisions encourage the creation of new health care delivery programs, such as accountable care organizations or combinations of provider organizations, that voluntarily meet quality thresholds to share in the cost savings they achieve for the Medicare program. The outcomes of these projects and programs, including their effect on payments to providers and financial performance, cannot be predicted.

OTHER FEDERAL, STATE AND LOCAL LEGISLATION

General. The District is subject to a wide variety of federal, state and local regulatory actions and legislative and policy changes that could have a significant impact on the District. Federal, state and local legislative bodies have broad discretion in altering or eliminating programs that contribute significantly to the revenues of the District, including the Medicare and Medicaid programs. In addition, such entities may enact legislation that imposes significant new burdens on the operations of the District. There can be no assurance that such legislative bodies will not make legislative policy changes (or direct governmental agencies to promulgate regulatory changes) that have adverse effects upon the ability of the District to generate revenues or upon the favorable utilization of their facilities.

Certificate of Need. The State employs a certificate of need program whereby health care facilities are required to obtain approval from the State before undertaking certain projects, including constructing or developing a new health care facility, selling, purchasing or leasing part or all of any existing hospital, changing bed capacity in a manner which increases the total number of licensed beds or redistributes beds, and/or offering a new tertiary health service. No certificate of need is required for the project to be funded with the proceeds of the Bonds.

Business and Occupation Taxes. Hospitals in the State are subject to a 1.5% business and occupation tax on gross receipts, which is used to fund a health plan for people otherwise uninsured. Any hospital owned by a municipal corporation is allowed to deduct revenues received from Medicare, Medicaid and other governmental programs in calculating the tax. The District meets the definition and is currently deducting such revenues. The amount of the tax and the continued ability to deduct governmental revenues is subject to change by the State Legislature.

Licensing and Accreditation. Health facilities, including those of the District, are subject to numerous legal, regulatory, professional and private licensing, certification and accreditation requirements. Management of the District currently anticipates no difficulty in renewing or maintaining currently held licenses, certifications or accreditation, and does not anticipate a reduction in third-party payments that would materially adversely affect the operations or financial conditions of the District due to licensing, certification or accreditation difficulties. Nevertheless, actions in any of these areas could result in a reduction in utilization or revenues or both, or the loss of the District's ability to operate all or a portion of its health facilities and, consequently, could have a material adverse effect on the District's financial condition.

Environmental Laws Affecting Health Care Facilities. Hospitals and other health care facilities are subject to a wide variety of federal, state and local environmental and occupational health and safety laws and regulations that address, among other things, hospital operations or facilities and properties owned or operated by hospitals. Among the types of regulatory requirements faced by hospitals are: air and water

quality control requirements; waste management requirements; specific regulatory requirements applicable to asbestos, hospital, medical and infectious waste, polychlorinated biphenyls, and radioactive substances; requirements for providing notice to employees and members of the public about hazardous materials handled by or located at the hospital; requirements for worker safety and training employees in the proper handling and management of hazardous materials and waste. In their role as owners and operators of properties or facilities, hospitals may be subject to liability for investigating and remedying any hazardous substances that have come to be located on the property, including any such substances that may have migrated off the property. Typical health care operations include, in various combinations, the handling, use, storage, transportation, disposal and discharge of infectious, toxic, radioactive, flammable and other hazardous materials, wastes, pollutants or contaminants. For this reason, health care facility operations are particularly susceptible to the practical financial and legal risks associated with compliance with such laws and regulations. Such risks may result in damage to individuals, property or the environment, may interrupt operations or increase their costs or both, may result in legal liability, damages, injunctions or fines, or may trigger investigations, administrative proceedings, penalties or other government agency actions. There can be no assurance that the District will not encounter such risks in the future and such risks could have a material adverse effect on the District's financial condition.

Antitrust. Enforcement of antitrust laws against health care providers is becoming more common and antitrust liability may arise in a wide variety of circumstances, including medical staff privilege disputes, third-party contracting, physician relations, joint venture, merger, virtual merger, formation of provider networks, diversification of hospitals into non-traditional hospital services and affiliation and acquisition activities. At various times health care providers may be subject to an investigation by a governmental agency charged with the enforcement of antitrust laws or may be subject to administrative or judicial action by a federal or state agency or a private party. The Department of Justice may bring criminal and civil actions to enforce the antitrust laws. Private litigants may bring actions for treble damages.

From time to time, the District is or will be involved in a variety of activities that could receive scrutiny under antitrust laws and it cannot be predicted when or to what extent liability may arise. With respect to payer contracting, the District may, from time to time, be involved in joint contracting activity with other hospitals or providers. The precise degree to which this or similar joint contracting activities may expose the participants to antitrust risk from governmental or private sources is dependent on factual matters that may change from time to time.

Some court decisions have held hospitals liable for abusing their local market power by steering business to ancillary health care businesses in which they have an interest. Such activities may result in monetary liability for the participating hospitals under certain circumstances where a competitor suffers damage.

Furthermore, hospitals, including the District, regularly have disputes regarding credentialing and peer review and may be subject to liability in this area. In addition, hospitals occasionally indemnify medical staff members who are involved in such credentialing or peer review activities and may also be liable with respect to such indemnity.

The ability to consummate mergers, acquisitions or affiliations may also be impaired by the antitrust laws, potentially limiting the ability of health care providers to fulfill their strategic plans. Liability in any of these or other antitrust areas may be substantial, depending on the facts and circumstances of each case.

OTHER RISK FACTORS GENERALLY AFFECTING HEALTH CARE FACILITIES

Hospital Pricing. Recently, focus has increased on the provision of charity care by nonprofit health care institutions and their pricing policies and billing and collection practices involving the underinsured and uninsured. This increased focus has resulted in congressional hearings, governmental inquiries and private class-action litigation against a number of nonprofit health care institutions generally alleging the overcharging of underinsured and uninsured patients. Inflation in hospital costs may evoke action by legislatures, payors or consumers. It is possible that legislative action at the state or national level may be taken with regard to the pricing of health care services. Major purchasers of hospital services could also take action to restrain hospital charges or charge increases.

As a result of increased public scrutiny, it is 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 hospital revenues may be negatively impacted.

The District has not been served with a complaint relating to litigation regarding pricing policies and billing and collection practices. There can be no assurance, however, that such a claim will not be asserted against the District in the future.

Technology and Services. Scientific and technological advances, new procedures, drugs and appliances, 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 costly equipment and services for diagnosis and treatment. The increased cost of technology is not immediately reflected in the prospective payment system (PPS) rates established by the Medicare and Medicaid programs, nor under private health plan-negotiated contract rates. The acquisition and operation of certain equipment or 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 or specialists, governmental approval or the ability to finance such acquisitions or operations.

Employment and Labor Issues. The District is a major local employer and its work force combines a complex mix of professional, quasi-professional, technical, clerical, housekeeping, maintenance, dietary and other types of workers in a single operation. As with all large employers, the District bears a wide variety of risks in connection with its employees including strikes and other related work actions, contract disputes, difficulties in recruitment, discrimination claims, personal tort actions, work-related injuries, exposure to hazardous materials, interpersonal torts, risks related to its benefit plans and other risks that may flow from the relationships between employer and employee or between physicians, patients and employees. Many of these risks are not covered by insurance and certain of them cannot be anticipated or prevented. The District believes that its retirement plans are in material compliance with the Employee Retirement Income Security Act of 1974, as amended, and other applicable laws. The District is subject to all of the risks listed above and such risks, alone or in combination, could have material adverse consequences to the financial condition or operations of the District. At the present time the District is not a party to any collective bargaining agreements, see "EMPLOYEES AND RETIREMENT PLAN" in Appendix A.

Wage and Hour Class Actions and Litigation. Federal law and many states, including Washington, impose standards related to worker classification, eligibility and payment for overtime, liability for providing rest periods and similar requirements. Large employers with complex workforces, such as the District, are susceptible to actual and alleged violations of these standards. In recent years there has been an increase in lawsuits regarding such "wage and hour" issues, often in the form of large class-actions, sometimes multi-state. For large employers such as hospitals, such class actions can involve multi-million dollar claims, judgments and/or settlements. A major class action decided or settled adversely to the District could have a material adverse impact on the District's financial condition.

Health 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 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 Service (the "IRS") has established criteria for determining whether a worker is an employee or an independent for tax purposes. If the IRS were to reclassify a significant number of hospital independent contractors (e.g., physician medical directors) as employees, back taxes and penalties could be material.

Physician, Nursing and Staff Shortages. In recent years, the health care industry has suffered from a scarcity of physician specialists and sub-specialists, 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 the District.

Competition. Increased competition from a wide variety of sources, including specialty hospitals, other hospitals and health care systems, HMOs, inpatient and outpatient health care facilities, long-term care

and skilled nursing services facilities, clinics, physicians and others, may adversely affect the utilization and 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.

Additionally, scientific and technological advances, new procedures, drugs and appliances, preventive medicine and outpatient health care delivery may reduce utilization and revenues of the hospitals in the future or otherwise lead 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.

Professional Liability Claims and 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 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 District if determined or settled adversely.

At times many hospitals and health care providers experience difficulty renewing or obtaining all types of commercial insurance, including insurance against malpractice and general liability claims, at reasonable cost. Insurers exert pressure to mandate lower amounts of coverage, require greater deductibles, and charge more in premium. Policies issued may not be renewed or renewable. While the insurance market is currently favorable for the District, the ability of, and the cost to, the District to continue to insure or otherwise protect itself against various claims is unknown.

Cost Increases. Cost increases without corresponding increases in revenue could result from, among other factors, increases in the salaries, wages and fringe benefits of employees, increases in costs associated with advances in medical technology or with inflation and future legislation which would prevent or limit the ability of the District to increase revenues from operating its physical plants.

Epidemics, Pandemics and Natural Disasters. The occurrence of an epidemic, pandemic or natural disaster, including floods, volcanoes and earthquakes, may damage part or all of the facilities of the District, interrupt utility service to part or all of the facilities of the District or otherwise impair the operation of part or all of the facilities of the District, result in abnormally high demand for health care services, or otherwise interrupt the generation of revenues from part or all of the facilities of the District beyond existing insurance coverages.

Construction Costs. The development and construction of new 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.

The anticipated costs and construction period for projects are based upon budgets, conceptual design documents and construction schedule estimates prepared by the District in consultation with its 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 the projects may be delayed until adequate funding is available. The completion date of the projects could also differ significantly from expectations for construction-related or other reasons. Assurances cannot be given that projects will be completed, if at all, on time or within

established budgets, or that projects will result in increased earnings. Significant delays, cost overruns or failure of projects to provide the benefits expected could have a material adverse effect on the District's business, financial condition and results of operations.

The failure to complete projects as planned, on schedule, within budget or in a manner that generates anticipated profits, could have an adverse effect on the District's business, financial condition and results of operations. In addition, although hospital construction is generally planned to have minimal impact on ongoing operations, no assurances can be given that the construction will not disrupt the District's ongoing operations or that it will be implemented as planned. Therefore, the construction of the new facilities may adversely impact the business, operations and revenues of the District.

Impact of Economic Turmoil. The domestic and international economic turmoil of the last several years has had, and is expected to continue to have, negative repercussions upon the national and global economies, including a scarcity of credit, lack of confidence in the financial sector, extreme volatility in the financial markets, increase in interest rates, reduced business activity, increased unemployment rates, increased consumer and business bankruptcies, and increased bank failures. In addition, as investor confidence has waned, investments previously recognized as stable, such as tax-exempt money market funds (which are one of the largest purchasers of tax-exempt bonds), have experienced significant withdrawals. If the current economic turmoil continues and the economy further weakens, hospitals could be materially and adversely impacted in a number of ways, including through reduced investment income, reduced access to the credit markets and increased borrowing costs.

RISKS RELATED TO HOSPITAL MANAGEMENT DISCRETION

Affiliation, Merger, Acquisition and Divestiture. As part of its ongoing planning process, the District has considered and will continue to consider the potential acquisition of operations or properties which may become affiliated with or become part of the District in the future, as well as the potential disposition of certain existing operations or properties. As a result, it is possible that the organizations and assets owned by or affiliated with the District may change from time to time.

Integrated Delivery Systems. Many health care providers are exploring ways to further develop their integrated systems for the delivery of health care services within their geographic service areas. Integrated health care delivery systems involve the coordinated delivery of services by hospitals, physician groups, other health care professionals and payer organizations. This coordination may be achieved through formal corporate affiliations such as the merger of existing corporate entities or through contractual agreements to implement and coordinate services or some combination of both. Examples of such integrated delivery systems include management service organizations which provide physician and physician groups with a combination of financial and contracting services, and hospital-based clinics or medical practice foundations which purchase and operate physician practices and provide administrative services to physicians. The development of these integrated delivery systems may require that assets be transferred out of the District or that new entities be brought into the District. Although any such transfer or entry would require compliance with the applicable provisions of the Bond Resolution, such action could nevertheless result in a reduction in the net income available for debt service of the District. Further, such integrated delivery systems also, in some instances, depending on the structure and operation of such systems, may raise certain legal or regulatory risks, including questions relating to compliance with the antitrust laws, Medicare/Medicaid anti-self-referral laws, and anti-kickback laws and federal or state tax-exemption issues. No prediction can be made as to the potential impact of such risks on the District.

LIMITATIONS ON REMEDIES

Any remedies available to the owners of the Bonds upon the occurrence of a default in payment of principal of or interest on the Bonds are in many respects dependent upon judicial actions that in turn are often subject to discretion and delay and could be both expensive and time-consuming to obtain. If the District fails to comply with its covenants under the Bond Resolution or to pay principal of or interest on the Bonds, there can be no assurance that available remedies will be adequate to fully protect the interests of the owners of the Bonds.

In addition to the limitations on remedies contained in the Bond Resolution, the rights and obligations under the Bonds and the Bond Resolution may be limited by and are subject to bankruptcy, insolvency,

reorganization, fraudulent conveyance, moratorium and other laws relating to or affecting creditors' rights, to the application of equitable principles and to the exercise of judicial discretion in appropriate cases. The opinion to be delivered by Foster Pepper PLLC, as Bond Counsel, concurrently with the issuance of the Bonds, will be subject to limitations regarding bankruptcy, insolvency and other laws relating to or affecting creditors' rights. The proposed form of opinion of Bond Counsel is set forth in Appendix C to this Official Statement.

RISKS RELATED TO TAX-EXEMPT STATUS OF BONDS

The Code imposes a number of requirements that must be satisfied for interest on state and local obligations, such as the Bonds, to be excludable from gross income for federal income tax purposes. These requirements include limitations on the use of proceeds of the Bonds, limitations on the investment earnings of proceeds of the Bonds prior to expenditure, a requirement that certain investment earnings on proceeds of the Bonds be paid periodically to the United States, and a requirement that the District file an information report with the IRS. The District has covenanted in the Bond Resolution that it will comply with such requirements. Future failure by the District to comply with the requirements stated in the Code and related regulations, rulings and policies may result in the treatment of interest on the Bonds as taxable, retroactively to the date of issuance. In such event, the Bond Resolution does not contain any specific provision for mandatory acceleration of the Bonds nor does it provide that any additional interest will be paid to the holders of the Bonds.

Future legislation, if enacted into law, or clarification of the Code may cause interest on the Bonds to be subject, directly or indirectly, to federal income taxation, or otherwise prevent Beneficial Owners from realizing the full current benefit of the tax status of such interest. The introduction or enactment of any such future legislation or clarification of the Code may also affect the market price for, or marketability of, the Bonds. Prospective purchasers of the Bonds should consult their own tax advisers regarding any pending or proposed federal tax legislation.

The opinion of Bond Counsel with respect to the Bonds is based on current legal authority, covers certain matters not directly addressed by such authorities, and represents Bond Counsel's judgment as to the proper treatment of interest on the Bonds for federal income tax purposes. The District has not sought to obtain a private letter ruling from the IRS with respect to the Bonds, and the opinion of Bond Counsel is not binding on the IRS or the courts. Furthermore, Bond Counsel cannot give and has not given any opinion or assurance about the future activities of the District or about the effect of future changes in the Code, the applicable regulations, the interpretation thereof or the enforcement thereof by the IRS.

The Bonds may from time to time be subject to audits by the IRS. Bond Counsel's engagement with the District in connection with the Bonds ends with the issuance of the Bonds and, unless separately engaged, Bond Counsel is not obligated to defend the District or the Beneficial Owners regarding the tax-exempt status of the Bonds in the event of an audit examination by the IRS. Under current procedures, parties other than the District and its appointed counsel, including the Beneficial Owners, would have little if any right to participate in the audit examination process. Moreover, because achieving judicial review in connection with an audit examination of tax-exempt bonds is difficult, obtaining an independent review of IRS positions with which the District legitimately disagrees, may not be practicable. Any action of the IRS, including but not limited to selection of the Bonds for audit or the course or result of such audit, or an audit of bonds presenting similar tax issues may affect the market price for, or the marketability of, the Bonds, and may cause the District or the Beneficial Owners to incur significant expense.

See "TAX MATTERS."

TAX MATTERS

TAX EXEMPTION

Exclusion from Gross Income. In the opinion of Bond Counsel, under existing federal law and assuming compliance by the District with applicable requirements of the Code, that must be satisfied subsequent to the issue date of the Bonds, interest on the Bonds is excluded from gross income for federal income tax purposes and is not an item of tax preference for purposes of the alternative minimum tax applicable to individuals.

Continuing Requirements. The District is required to comply with certain requirements of the Code after the date of issuance of the Bonds in order to maintain the exclusion of the interest on the Bonds from gross income for federal income tax purposes, including, without limitation, requirements concerning the qualified use of Bond proceeds and the facilities financed or refinanced with Bond proceeds, limitations on investing gross proceeds of the Bonds in higher yielding investments in certain circumstances, and the requirement to comply with the arbitrage rebate requirements to the extent applicable to the Bonds. The District has covenanted in the Bond Resolution to comply with those requirements, but if the District fails to comply with those requirements, interest on the Bonds could become taxable retroactive to the date of issuance of the Bonds. Bond Counsel has not undertaken and does not undertake to monitor the District's compliance with such requirements.

Corporate Alternative Minimum Tax. While interest on the Bonds also is not an item of tax preference for purposes of the alternative minimum tax applicable to corporations, under Section 55 of the Code, tax-exempt interest, including interest on the Bonds, received by corporations is taken into account in the computation of adjusted current earnings for purposes of the alternative minimum tax applicable to corporations (as defined for federal income tax purposes). Under the Code, alternative minimum taxable income of a corporation will be increased by 75% of the excess of the corporation's adjusted current earnings (including any tax-exempt interest) over the corporation's alternative minimum taxable income determined without regard to such increase. A corporation's alternative minimum taxable income, so computed, that is in excess of an exemption of $40,000, which exemption will be reduced (but not below zero) by 25% of the amount by which the corporation's alternative minimum taxable income exceeds $150,000, is then subject to a 20% minimum tax.

A small business corporation is exempt from the corporate alternative minimum tax for any taxable year beginning after December 31, 1997, if its average gross receipts during the three-taxable-year period beginning after December 31, 1993, did not exceed $5,000,000, and its average annual gross receipts during each successive three-taxable-year period thereafter ending before the relevant taxable year did not exceed $7,500,000.

Tax on Certain Passive Investment Income of S Corporations. Under Section 1375 of the Code, certain excess net passive investment income, including interest on the Bonds, received by an S corporation (a corporation treated as a partnership for most federal tax purposes) that has Subchapter C earnings and profits at the close of the taxable year may be subject to federal income taxation at the highest rate applicable to corporations if more than 2% of the gross receipts of such S corporation is passive investment income.

Foreign Branch Profits Tax. Interest on the Bonds may be subject to the foreign branch profits tax imposed by Section 884 of the Code when the Bonds are owned by, and effectively connected with a trade or business of, a United States branch of a foreign corporation.

Possible Consequences of Tax Compliance Audit. The IRS has established a general audit program to determine whether issuers of tax-exempt obligations, such as the Bonds, are in compliance with requirements of the Code that must be satisfied in order for interest on those obligations to be, and continue to be, excluded from gross income for federal income tax purposes. Bond Counsel cannot predict whether the IRS would commence an audit of the Bonds. Depending on all the facts and circumstances and the type of audit involved, it is possible that commencement of an audit of the Bonds could adversely affect the market value and liquidity of the Bonds until the audit is concluded, regardless of its ultimate outcome.

See "BONDOWNERS' RISKS – Risks Related to Tax-Exempt Status of Bonds."

CERTAIN OTHER FEDERAL TAX CONSEQUENCES

Bonds "Qualified Tax-Exempt Obligations" for Financial Institutions. Section 265 of the Code provides that 100% of any interest expense incurred by banks and other financial institutions for interest allocable to tax-exempt obligations acquired after August 7, 1986, will be disallowed as a tax deduction. However, if the tax-exempt obligations are obligations other than private activity bonds, are issued by a governmental unit that, together with all entities subordinate to it, does not reasonably anticipate issuing more than $10,000,000 of tax-exempt obligations (other than private activity bonds and other obligations not required to be included in such calculation) in the current calendar year, and are designated by the

governmental unit as "qualified tax-exempt obligations," only 20% of any interest expense deduction allocable to those obligations will be disallowed.

The District is a governmental unit that, together with all subordinate entities, reasonably anticipates issuing less than $10,000,000 of tax-exempt obligations (other than private activity bonds and other obligations not required to be included in such calculation) during the current calendar year and has designated the Bonds as "qualified tax exempt obligations" for purposes of the 80% financial institution interest expense deduction. Therefore, only 20% of the interest expense deduction of a financial institution allocable to the Bonds will be disallowed for federal income tax purposes.

Reduction of Loss Reserve Deductions for Property and Casualty Insurance Companies. Under Section 832 of the Code, interest on the Bonds received by property and casualty insurance companies will reduce tax deductions for loss reserves otherwise available to such companies by an amount equal to 15% of tax-exempt interest received during the taxable year.

Effect on Certain Social Security and Retirement Benefits. Section 86 of the Code requires recipients of certain Social Security and certain Railroad Retirement benefits to take receipts or accruals of interest on the Bonds into account in determining gross income.

Other Possible Federal Tax Consequences. Receipt of interest on the Bonds may have other federal tax consequences as to which prospective purchasers of the Bonds may wish to consult their own tax advisors.

Potential Future Federal Tax Law Changes. From time to time, there are legislative proposals in Congress which, if enacted, could require changes in the description of federal tax matters relating to the Bonds set forth above or adversely affect the market value of the Bonds. It cannot be predicted whether future legislation may be proposed or enacted that would affect the federal tax treatment of interest received on the Bonds. Prospective purchasers of the Bonds should consult with their own tax advisors regarding any proposed or pending legislation that would change the federal tax treatment of interest on the Bonds.

Original Issue Discount. The Bonds maturing in 2020, 2021, 2024 through 2032, and 2037 have been sold at prices reflecting original issue discount ("Discount Bonds"). Under existing law, the original issue discount in the selling price of each Discount Bond, to the extent properly allocable to each owner of such Discount Bond, is excluded from gross income for federal income tax purposes with respect to such owner. The original issue discount is the excess of the stated redemption price at maturity of such Discount Bond over the initial offering price to the public, excluding underwriters and other intermediaries, at which price a substantial amount of the Discount Bonds of such maturity were sold.

Under Section 1288 of the Code, original issue discount on tax-exempt bonds accrues on a compound basis. The amount of original issue discount that accrues to an owner of a Discount Bond during any accrual period generally equals (i) the issue price of such Discount Bond plus the amount of original issue discount accrued in all prior accrual periods, multiplied by (ii) the yield to maturity of such Discount Bond (determined on the basis of compounding at the close of each accrual period and properly adjusted for the length of the accrual period), less (iii) any interest payable on such Discount Bond during such accrual period. The amount of original issue discount so accrued in a particular accrual period will be considered to be received ratably on each day of the accrual period, will be excluded from gross income for federal income tax purposes, and will increase the owner's tax basis in such Discount Bond. Any gain realized by an owner from a sale, exchange, payment or redemption of a Discount Bond will be treated as gain from the sale or exchange of such Discount Bond.

The portion of original issue discount that accrues in each year to an owner of a Discount Bond may result in certain collateral federal income tax consequences. The accrual of such portion of the original issue discount will be included in the calculation of alternative minimum tax liability as described above, and may result in an alternative minimum tax liability even though the owner of such Discount Bond will not receive a corresponding cash payment until a later year.

Owners who purchase Discount Bonds in the initial public offering but at a price different from the first offering price at which a substantial amount of those Discount Bonds were sold to the public, or who do not purchase Discount Bonds in the initial public offering, should consult their own tax advisors with

respect to the tax consequences of the ownership of such Discount Bonds. Owners of Discount Bonds who sell or otherwise dispose of such Discount Bonds prior to maturity should consult their own tax advisors with respect to the amount of original issue discount accrued over the period such Discount Bonds have been held and the amount of taxable gain or loss to be recognized upon that sale or other disposition of Discount Bonds. Owners of Discount Bonds also should consult their own tax advisors with respect to state and local tax consequences of owning such Discount Bonds.

Original Issue Premium. The Bonds maturing in 2013 through 2019, 2022 and 2023 have been sold at prices reflecting original issue premium ("Premium Bonds"). An amount equal to the excess of the purchase price of a Premium Bond over its stated redemption price at maturity constitutes premium on such Premium Bond. A purchaser of a Premium Bond must amortize any premium over such Premium Bond's term using constant yield principles, based on the purchaser's yield to maturity. The amount of amortizable premium allocable to an interest accrual period for a Premium Bond will offset a like amount of qualified stated interest on such Premium Bond allocable to that accrual period, and may affect the calculation of alternative minimum tax liability described above. As premium is amortized, the purchaser's basis in such Premium Bond is reduced by a corresponding amount, resulting in an increase in the gain (or decrease in the loss) to be recognized for federal income tax purposes upon a sale or disposition of such Premium Bond prior to its maturity. Even though the purchaser's basis is reduced, no federal income tax deduction is allowed. Purchasers of Premium Bonds, whether at the time of initial issuance or subsequent thereto, should consult with their own tax advisors with respect to the determination and treatment of premium for federal income tax purposes and with respect to state and local tax consequences of owning such Premium Bonds.

CONTINUING DISCLOSURE

Basic Undertaking to Provide Annual Financial Information and Notice of Material Event. To meet the requirements of United States Securities and Exchange Commission ("SEC") Rule 15c2-12(b)(5) (the "Rule"), as applicable to a participating underwriter for the Bonds, the District will undertake (the "Undertaking") for the benefit of holders of the Bonds to provide or cause to be provided, either directly or through a designated agent, to the Municipal Securities Rulemaking Board ("MSRB"), in an electronic format as prescribed by the MSRB, accompanied by identifying information as prescribed by the MSRB: (a) annual financial information and operating data of the type include in this Official Statement as generally described below ("annual financial information") and (b) to the MSRB timely notice (not in excess of ten business days after the occurrence of the event) of the occurrence of any of the following events with respect to the Bonds: (1) principal and interest payment delinquencies; (2) non-payment related defaults, if material; (3) unscheduled draws on debt service reserves reflecting financial difficulties; (4) unscheduled draws on credit enhancements reflecting financial difficulties; (5) substitution of credit or liquidity providers, or their failure to perform; (6) adverse tax opinions, the issuance by the Internal Revenue Service of proposed or final determinations of taxability, Notice of Proposed Issue (IRS Form 5701 – TEB) or other material notices or determinations with respect to the tax status of the Bonds; (7) modifications to rights of holders of the Bonds, if material; (8) Bond calls (other than scheduled mandatory redemptions of Term Bonds), if material, and tender offers; (9) defeasances; (10) release, substitution, or sale of property securing repayment of the Bonds, if material; (11) rating changes; (12) bankruptcy, insolvency, receivership or similar event of the District as such "Bankruptcy Events" are defined in Rule 15c2-12; (13) the consummation of a merger, consolidation, or acquisition involving the District or the sale of all or substantially all of the assets of the District, other than in the ordinary course of business, the entry into a definitive agreement to undertake such an action or the termination of a definitive agreement relating to any such actions, other than pursuant to its terms, if material; and (14) appointment of a successor or additional trustee or the change of name of a trustee, if material. The District also will provide to the MSRB timely notice of a failure by the District to provide required annual financial information on or before the date specified below.

Type of Annual Financial Information Undertaken to be Provided. The annual financial information that the District undertakes to provide will consist of (1) annual financial statements prepared (except as noted in the financial statements) in accordance with applicable generally accepted accounting principles applicable to Washington State local governmental units, as such principles may be changed from time to time, which will not be audited, except that if and when audited financial statements are otherwise

prepared and available to the District they will be provided; and (2) financial information and operating data with respect to the District and its Facilities of the type included in Appendix A hereto under the heading "DEBT INFORMATION. The annual financial information will be provided to the MSRB not later than the last day of the sixth month after the end of each fiscal year of the District (currently, a fiscal year ending December 31), as such fiscal year may be changed as required or permitted by State law, commencing with the District's fiscal year ending December 31, 2011.

The annual financial information may be provided in a single or multiple documents, and may be incorporated by specific reference to documents available to the public on the Internet website of the MSRB or filed with the SEC.

Amendment of Undertaking. The Undertaking is subject to amendment after the primary offering of the Bonds without the consent of any holder of any Bond, or of any broker, dealer, municipal securities dealer, participating underwriter, rating agency or the MSRB, under the circumstances and in the manner permitted by the Rule.

The District will give notice to the MSRB of the substance (or provide a copy) of any amendment to the Undertaking and a brief statement of the reasons for the amendment. If the amendment changes the type of annual financial information to be provided, the annual financial information containing the amended financial information will include a narrative explanation of the effect of that change on the type of information to be provided.

Termination of Undertaking. The District's obligations under the Undertaking shall terminate upon the legal defeasance of all of the Bonds. In addition, the District's obligations under the Undertaking shall terminate if those provisions of the Rule which require the District to comply with the Undertaking become legally inapplicable in respect of the Bonds for any reason, as confirmed by an opinion of nationally recognized bond counsel or other counsel familiar with federal securities laws delivered to the District, and the District provides timely notice of such termination to the MSRB.

Remedy for Failure to Comply with Undertaking. If the District or any other obligated person fails to comply with the Undertaking, the District will proceed with due diligence to cause such noncompliance to be corrected as soon as practicable after the District learns of that failure. No failure by the District or other obligated person to comply with the Undertaking will constitute a default in respect of the Bonds. The sole remedy of any holder of a Bond will be to take such actions as that holder deems necessary, including seeking an order of specific performance from an appropriate court, to compel the District or other obligated person to comply with the Undertaking.

Prior Compliance with Continuing Disclosure Undertakings. The District has entered into previous undertakings under the Rule with respect to its obligations issued after July 3, 1995, and is in compliance with those undertakings.

LITIGATION

There is no controversy or litigation of any nature now pending against the District or, to the knowledge of its officers, threatened, restraining or enjoining the issuance of the Bonds or in any way contesting or affecting (i) the validity of the Bonds, or (ii) any proceedings of the District taken concerning the issuance or sale thereof or the collection of taxes pledged under the Bond Resolution.

As with most health care providers, the District is subject to certain legal actions that, in whole or in part, are not or may not be covered by insurance because of the type of action or amount or types of damages requested (e.g., punitive damages), because of a reservation of rights by an insurance carrier, or because the action has not proceeded to a stage that permits full evaluation. In addition to the matters described above, there are certain legal actions currently pending against the District known to management for which insurance coverage is uncertain for the above reasons. Management does not anticipate that any such suits will ultimately result in punitive damage awards or judgments in excess of applicable insurance limits, or if such awards or judgments were to be entered, that they would have a material adverse impact on the financial condition of the District.

Other than as described above, there is no litigation of any nature now pending against the District or, to the knowledge of its officers, threatened, which, if successful, would materially adversely affect the operations or financial condition of the District.

APPROVAL OF COUNSEL

Legal matters incident to the authorization, issuance and sale of the Bonds by the District are subject to the approving legal opinion of Foster Pepper PLLC, Seattle, Washington, Bond Counsel. The form of the opinion of Bond Counsel with respect to the Bonds is attached as Appendix C. The opinion of Bond Counsel is given based on factual representations made to Bond Counsel, and under existing law, as of the date of initial delivery of the Bonds, and Bond Counsel assumes no obligation to revise or supplement its opinion to reflect any facts or circumstances that may thereafter come to its attention, or any changes in law that may thereafter occur. The opinion of Bond Counsel is an expression of its professional judgment on the matters expressly addressed in its opinion and does not constitute a guarantee of result. Bond Counsel will be compensated only upon the issuance and sale of the Bonds.

CONFLICTS OF INTEREST

All or a portion of the fees of the Underwriter and Bond Counsel are contingent upon the issuance and sale of the Bonds. In addition, Bond Counsel from time to time serves as counsel to the Underwriter with respect to bonds issued by issuers other than the District. None of the Commissioners or other officers of the District have any conflict of interest in the issuance of the Bonds that is prohibited by applicable law.

UNDERWRITING

The Bonds are being purchased by Piper Jaffray & Co., the Underwriter. The purchase contract provides that the Underwriter will purchase all of the Bonds, if any are purchased, at a price of $7,869,234.40, representing the principal amount of the Bonds less a net original issue discount of $100,265.60, and less an Underwriter's discount of $80,500.00. The obligation of the Underwriter to accept delivery of the Bonds is subject to various conditions contained in the purchase contract. The Underwriter may offer and sell the Bonds to certain dealers (including dealers depositing Bonds into unit investment trusts) and others at prices lower than the public offering prices reflected on the inside cover page hereof. The initial public offering prices may be changed from time to time by the Underwriter.

Piper Jaffray & Co. and Pershing LLC, a subsidiary of The Bank of New York Mellon Corporation, entered into an agreement (the "Agreement") which enables Pershing LLC to distribute certain new issue municipal securities underwritten by or allocated to Piper Jaffray & Co., including the Bonds. Under the Agreement, Piper Jaffray & Co. will share with Pershing LLC a portion of the fee or commission paid to Piper.

RATING

The District has received a rating for the Bonds of "A2" from Moody's Investors Service. This rating reflects only the view of the rating agency and an explanation of the significance of the rating may be obtained from the rating agency. No application was made to any other rating agency for the purpose of obtaining an additional rating on the Bonds. There is no assurance that the ratings will be retained for any given period of time or that the ratings will not be revised downward or withdrawn entirely by the rating agencies if, in their judgment, circumstances so warrant. Any such downward revision or withdrawal of the rating will be likely to have an adverse effect on the market price of the Bonds.

INDEPENDENT AUDITORS

Moss Adams LLP, the District's independent auditor, current audits the District's financial statements. The District's audited financial statements for the years ended December 31, 2010 and 2009, are included in Appendix B. Moss Adams LLP has not been engaged to perform and has not performed,

since the day of its report included herein, any procedures on the financial statements addressed in that report. Moss Adams LLP also has not performed any procedures relating to this Official Statement.

State law requires that the State auditor examine the financial affairs of all taxing districts at least once every three years. The most recent State audit of the District was for the year ended December 31, 2009.

MISCELLANEOUS

All forecasts, estimates and other statements in this Official Statement involving matters of opinion, whether or not expressly so stated, are intended as such and not as representations of fact. This Official Statement is not intended to be construed as a contract or agreement between the District and the purchasers or holders of any of the Bonds. The information contained in this Official Statement is presented for the guidance of prospective purchasers of the Bonds described therein. The information has been compiled from official sources and, while not guaranteed by the District, is believed to be correct.

ADDITIONAL INFORMATION

The descriptions in this Official Statement of the Bonds, the Bond Resolution and other documents do not purport to be definitive or comprehensive, and all references to those documents are qualified in their entirety by reference to the approved forms of those documents, copies of which are available at the offices of the District and, during the period of the offering of the Bonds, at the office of the Underwriter.

OFFICIAL STATEMENT CERTIFICATE

At the time of delivery of the Bonds, one or more officials of the District will furnish a Certificate stating that (1) the Official Statement of the District relating to the Bonds does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements contained therein, in light of the circumstances in which they were made, not misleading, except that no representation is made about information in the Official Statement ascribed to sources other than the District, although the District has no reason to believe, and does not believe, that such information is materially inaccurate or misleading, and (2) the execution and delivery of this Official Statement and its use by the Underwriter in the offering and sale of the Bonds have been duly authorized by the Commission of the District.

WHIDBEY ISLAND PUBLIC HOSPITAL DISTRICT
ISLAND COUNTY, WASHINGTON

/s/ Anne Tarrant
President of the Commission

APPENDIX A

Certain Information Concerning

Whidbey Island Public Hospital District
Island County, Washington
(Whidbey General Hospital)

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THE DISTRICT

INTRODUCTION

The District is a public hospital district and a municipal corporation formed under the provisions of Chapter 70.44 of the Revised Code of Washington ("RCW"). The District is located within Island County, Washington (the "County"), and includes western Island County. The District is governed by a board of five publicly-elected commissioners.

The District owns and operates Whidbey General Hospital, a 25-bed acute-care inpatient facility (the "Hospital"), and other health care facilities, all of which are located in Island County, Washington (collectively, the "District Facilities").

The Hospital is located on a campus of approximately 15 acres in the Town of Coupeville, Washington, approximately 65 miles north of Seattle. The Hospital is currently licensed as a 51-bed hospital. In 2005, the Hospital was designated by the State of Washington and certified by CMS as a critical access hospital ("CAH"). As a CAH, the Hospital is not permitted to operate more than 25 acute care beds. In addition to the Hospital, the District operates satellite clinics in the City of Oak Harbor, Washington, and the unincorporated community of Clinton, Washington, and an emergency medical service, including ambulances.

FACILITIES

The Hospital. The Hospital is a licensed 51-bed facility providing a wide variety of inpatient and outpatient services to over 40,000 people per year. As a CAH, the Hospital operates 25 inpatient beds and 26 observation stretchers where patients may be observed for up to 48 hours.

Over 60 physicians representing 16 specialties work with nurses and support staff to provide health care at the Hospital. A fully-equipped 13-bed emergency room is staffed twenty-four hours a day by physicians and nurses skilled in emergency care.

The Hospital opened in 1970 and has undergone several expansion and renovation projects over the last 40 years. Beginning in 1986, the District remodeled and renovated nearly all patient care areas and upgraded space for support services. In 2001 and 2002, the Hospital completed a $5 million renovation and capital improvement project which improved its general facilities for cancer treatment, emergency services, cardiac rehabilitation, physical therapy, diagnostic imaging, medical records, gift shop and waiting areas.

The Hospital is currently licensed to operate 51 beds, as detailed in the following table.

Hospital Bed Complement
(As of December 31, 2011)

Type of Bed	Number of Licensed Beds	Number of Set-Up Beds	License Category
Critical Care	7	5	Acute
Obstetrics/LDRP	6	3	Acute/Newborn
Medical/Surgical/Pediatrics	38	17	Acute
Total Beds	**51**	**25**	

Source: District Administration

Satellite Clinics. Whidbey General North is a satellite clinic located in the City of Oak Harbor, approximately 10 miles north of the Hospital. Whidbey General North is licensed as a rural health clinic and receives enhanced reimbursement to meet the community needs for primary care for low- to moderate-income patients. Whidbey General North includes physical, occupational and speech therapies, x-ray services, digital mammography and outpatient laboratory services. Whidbey General North is also home to the District's sleep disorder center.

Whidbey General South is a satellite clinic located in Clinton, approximately 25 miles south of the Hospital. Whidbey General South is a licensed rural health clinic and receives enhanced reimbursement in order to meet the community needs for primary care for low- to moderate-income patients. Whidbey General South also includes outpatient cancer care, x-ray, digital mammography, and outpatient laboratory services.

Other District Services. The Hospital offers full scope imaging services including multi-slice CT, digital x-ray, digital fluoroscopy, digital mammography, MRI, echocardiography, ultrasound, nuclear medicine, bone densitometry and Picture Archiving Communication System (PACS). PACS allows referring physicians to view an imaging study from their office or home immediately after the study is completed at the Hospital. A table summarizing the Hospital's outpatient services is shown below. In addition to hospital outpatient services, the District owns and operates the only certified ground ambulance service within the geographic boundaries of the District that is staffed by paramedics 24-hours a day, seven days a week. The ambulance service operates twelve ambulances from three locations within the District. The District also owns and operates the only Medicare Certified Home Health Agency within the geographic boundaries of the District. The Agency also has state licensure for hospice services. The Agency provides skilled nursing care, physical therapy, occupational therapy, speech therapy, medical social work, spiritual care, counseling and bereavement for patients in their homes.

Outpatient Services
Emergency Room
Outpatient Surgery
Diagnostic and Clinical Laboratory
Accredited Sleep Center
X-Ray
Ultrasound
CT Scan
Mammography
Bone Density
Respiratory Therapy
Nuclear Medicine
Physical, Occupational and Speech Therapies
Diabetic Education
Wound Care
Medical Oncology

PROJECT

The proceeds of the District's Limited Tax General Obligation Bonds, 2012 (the "Bonds") will be used to (1) acquire and implement an electronic medical record system, (2) improve data network infrastructure, (3) fund capital expenditures for hospital equipment, (4) retire capital leases for the acquisition of equipment and other property, and (5) pay the costs related to the sale, issuance and delivery of the Bonds.

LOCATION

The District's boundaries are coterminous with Whidbey Island. The following maps depict Whidbey Island, as well as its position off the coast.


Deception Pass Bridge
Cornet Bay
Deception Pass State Park
Cranberry Lk.
Ala Spit
Rosario Strait
Troxell Rd.
Jones Rd.
Naval Air Station Whidbey Island (Ault Field)
Dugualla Bay
Joseph Whidbey State Park
Strait of Juan de Fuca
Whidbey Island
Oak Harbor
Marina
Crescent Harbor
Ft. Ebey State Park
Oak Harbor Airport (Wes Lupien)
Grasser's Lagoon
Penn Cove
Coupeville
Wharf
Perego's Lk.
Ebey's Landing National Historic Reserve
Kettle's Trail
Ft. Casey State Park
Crockett Lk.
Admiralty Head Lighthouse
Keystone Underwater State Park
Keystone Ferry
Admiralty Bay
Saratoga
Hancock Nature Preserve
Greenbank Farm
Beach Park
Greenbank
Meerkerk Rhododendron Gardens
Admiralty Inlet
South Whidbey State Park
Bush Point
Holmes Harbor
Saratoga Woods
Lone Lk.
Marina
Langley
Freeland
Mutiny Bay
S. Whidbey Air Park
Bayview
Double Bluff Park
Useless Bay
Puget Sound
Deer Lk.
Clinton
Dave Mackie Park
Mukilteo Ferry from I-5 exit 189
Cultus Bay
Possession Point Park
Utsalady Bay & Vista Point Park
Maple Grove Beach Park (Boat Ramp)
English Boom Historical Park
Camano Island
Terry's Corner
Reinig Airport
Skagit Bay
To I-5 Exit 212
Stanwood
C. Center Park
Iverson Spit Preserve
Stillaguamish Delta
Livingston Bay
Triangle Cove
Cavalero Beach (Boat Ramp)
Cama Beach State Park
Camano State Park
Camano Head/ Point Allen


TO VICTORIA FERRY
Anacortes
Sedro Woolley
Burlington
FIDALGO ISLAND
Mt. Vernon
La Conner
Conway
Oak Harbor
Utsalady
Stanwood
Coupeville
Camano
Keystone
TO SEATTLE
PORT TOWNSEND FERRY
Greenbank
Langley
Freeland
CLINTON FERRY
Everett
Clinton
TO VANCOUVER
Whidbey Island

SUMMARY OF FINANCIAL INFORMATION AND OPERATING DATA

The following tables present selected operating data and financial information for the District.

Utilization Statistics. Historical patient utilization data of the District's facilities is shown in the following table:

Historical Utilization
Years ended December 31

Utilization Statistics	2008	2009	2010	2011
Admissions	1,968	1,848	1,908	1,656
Patient Days	6,188	5,486	6,069	5,428
Average Length of Stay	2.9	2.8	3.0	3.0
Average Daily Census	16.9	15.0	16.6	14.9
Ambulance Runs	6,189	6,396	6,773	6,775
Deliveries	204	170	184	182
Emergency Room Visits	18,756	18,914	18,528	17,993
Outpatient Visits	183,191	199,221	191,853	217,566
Surgical Procedures	3,086	2,933	3,161	3,081
Home Health Visits	9,621	10,049	9,104	8,621
Rural Health Clinic Visits	16,925	17,381	17,014	15,464

Source: District Administration

Summary of Revenues and Expenses. The following table shows selected historical financial data derived from the District's audited financial statements:

Summary of Revenues and Expenses
Years ended December 31
(in $s)

	2008	2009	2010	Unaudited 2010 through November	Unaudited 2011 through November
Operating Revenues:					
Net patient service revenue	67,144,762	69,467,775	75,191,111	67,715,130	69,333,837
Other revenue	6,854,936	6,889,037	5,498,517	5,040,307	5,451,254
Total operating revenues	73,999,698	76,356,812	80,689,628	72,215,437	74,785,091
Operating Expenses:					
Salaries and benefits	41,202,958	44,236,810	47,589,653	43,458,806	47,065,397
Professional fees	4,858,627	6,606,095	6,253,801	5,787,614	5,819,926
Supplies	9,294,951	9,141,192	9,860,919	9,063,273	8,776,068
Purchased services	9,766,346	10,479,163	11,741,752	10,658,531	10,636,433
Other expenses	3,009,205	3,211,528	3,557,113	3,244,360	3,276,840
Interest expense	141,200	126,733	114,526	104,982	98,122
Depreciation and amortization	2,041,409	2,072,725	2,292,430	2,048,965	1,872,876
Total operating expenses	70,314,696	75,874,246	81,410,194	74,366,531	77,545,662
Income (loss) from operations	3,685,002	482,566	(720,566)[(1)]	(2,151,094)	(2,760,571)
Total Non-Operating Revenues, net[(2)]	1,195,107	340,154	2,158,527	1,978,650	1,291,698
Excess of Revenues over Expenses	4,880,109	822,720	1,437,961	172,444	(1,468,873)
Capital Contributions and Grants	487,820	207,428	240,767	193,356	91,622
Change in Net Assets	5,367,929	1,030,148	1,678,728	365,800	(1,377,251)

(1) The reduction in loss from operations for the period ended December 31, 2010, by comparison to the period ended November 30, 2010, reflects a $1,170,000 positive estimated adjustment in Medicare revenue for the period ended December 31, 2010, based on the preparation of the final Medicare cost report for that period.

(2) Total Non-Operating Revenue includes property tax and other miscellaneous tax revenue received by the District.

Source: District Administration

Management Discussion. See Management Discussion and Analysis on pages 2 to 8 of the District's financial statement for the fiscal years ended December 31, 2010 and 2009 attached as Appendix B.

Fiscal year 2011 was the sixth year that the Hospital was licensed as a critical access hospital. This designation provides cost reimbursement under Medicare and Medicaid programs. During 2011, the hospital experienced a decrease in operating margin as compared with 2010. This decline is attributed to deteriorating utilization of inpatient and surgical services and increased uncompensated care, as a result of the national and regional economic conditions. Cash reserves also declined during 2011 as a result of operations, working capital investments in Primary Care Associates (the District's wholly owned subsidiary), and resolution of the District's Stark Self Disclosure penalty with the Office of Inspector General. See Note 14 on page 32 of the District's financial statement for the fiscal years ended December 31, 2010 and 2009 attached as Appendix B.

Sources of Patient Revenue. The District derives a substantial portion of its operating revenues from federal and state programs and insurance plans that pay for all or a portion of the health-care services provided to a patient. As a consequence, the District's operating revenues depend to a great extent on the availability and level of reimbursement or payment under those programs and plans. See the heading "BONDOWNERS' RISKS – Medicare and Medicaid Programs."

The following table sets forth historical percentages of the District's gross patient revenues applicable to various programs and plans.

Percent of Gross Patient Revenue
Years ended December 31

	2008	2009	2010	2011
Medicare	47%	45	45	44
Medicaid	7	8	8	8
Commercial Insurance	30	29	29	31
CHAMPUS	10	11	11	9
Private Pay	6	7	7	8
Total	**100%**	**100%**	**100%**	**100%**

Source: District Administration

Medicare. Payments for inpatient and outpatient acute care services rendered to Medicare program beneficiaries are paid under the CAH program, which reimburses the District for its portion of allowed Medicare costs. Under this methodology, the District is paid at interim rates during the year and then at the end of each year, a final settlement is determined after submission of the annual cost report and related audit thereof by the Medicare fiscal intermediary. Medicare has audited and settled cost reports for the District for all years through 2009.

Medicaid. The District is paid for services at an interim rate with final settlement determined after submission of annual cost report thereof by the Department of Social and Health Services. Medicaid has audited and settled cost reports for the District through 2008.

Other Payers. The District also has entered into payment agreements with certain commercial insurance carriers, preferred provider organizations and health maintenance organizations. The basis for payments to the Hospital are generally of two types: percent discount off billed charges or fixed per diem reimbursement. Contracts with per diem-based reimbursement include provisions for high cost outlier cases in order to minimize any payment risk to the Hospital.

EMPLOYEES

As of December 31, 2011, the District employed 510 full-time equivalent employees. The District contracts with five separate collective bargaining units as described below

The District enters into written bargaining agreements with each of the bargaining organizations. The agreements contain provisions on such matters as salaries, vacation, sick leave, medical and dental insurance, working conditions, and grievance procedures. The District strives to complete agreements with all groups in a timely manner, consistent with all applicable state law, to ensure equity in contract provisions, and promote labor relation policies mutually beneficial to management and employees. In the past decade, there have been no labor strikes.

Collective Bargaining Unit

Name	Group Representative	Contract Expires
UFCW Local 21	EMS	March 31, 2014
UFCW Local 21	LPN	February 28, 2013
UFCW Local 21	Professional/Technical	February 28, 2013
UFCW Local 21	Support Services	June 30, 2012
WSNA	RN	March 31, 2012

MEDICAL STAFF

The Hospital currently has an active medical staff of 50 practitioners and a courtesy medical staff of 101 practitioners. 92% of the active staff is board certified. The average age of the Hospital's active medical staff is 52 years. The following table provides the Hospital's number of physicians by specialty.

Active Medical Staff
as of December 31, 2011

Specialty	Number of Physicians
Anesthesia	2
Emergency Services	9
Family Practice	11
General Surgery	3
Internal Medicine	9
OB/GYN	2
Ophthalmology	2
Orthopedics	3
Pathology	1
Pediatrics	4
Podiatry	1
Radiology	2
Urology	1
Total	**50**

Source: District Administration

The following table summarizes admissions by the Hospital's top ten admitters for 2011.

Top Ten Hospital Admitters
for 2011

Service Physician	Percent of Admissions	Percent of Gross Revenue
OB/GYN	11	3
OB/GYN	10	3
Hospitalist	10	10
Hospitalist	7	9
Hospitalist	5	6
Hospitalist	5	6
Hospitalist	4	5
Hospitalist	4	4
Orthopedics	4	12
Hospitalist	4	4

Source: District Administration

GOVERNANCE

The District is governed by a five-member board of commissioners elected by the District's voters. Each commissioner serves for a term of three years and the expiration dates of the commissioners' terms are staggered. The present commissioners, their positions and terms of office are shown in the following table.

Name	Position	Expiration
Grethe Cammermeyer, Ph.D.	Commissioner	2017
Roger Case, M.D.	Commissioner	2013
Anne Tarrant	President and Commissioner	2017
Ron Wallin	Secretary and Commissioner	2013
Paul A. Zaveruha, M.D.	Commissioner	2015

MANAGEMENT

Tom Tomasino, Superintendent and Chief Executive Officer. Mr. Tomasino has been the Chief Executive Officer of the District since 2008. He previously served as the Chief Operating Officer and Chief Information Officer of the District since 2002. Mr. Tomasino has over 25 years experience in information technology and systems science leadership, development, and training. He holds a Bachelors of Science degree from Chapman University.

Joe Vessey, CPA, MBA, Chief Financial Officer. Mr. Vessey has been the Chief Financial Officer of the District since 2008. He previously served as the Chief Financial Officer of Northern Idaho Advanced Care Hospital for over two years and has over twelve years of experience in finance. He holds a Bachelors of Arts degree in Accounting and Management Information Systems and Masters of Business Administration from Eastern Washington University.

Linda Gipson, MSN, MBA, RN, NEA-BC, CLNC, Chief Nursing Officer –Dr. Gipson brings 35 years of experience as a health care executive, advanced practice nurse, educator, consultant and speaker. She holds a Bachelor's degree from the University of Maryland, Master's degrees in nursing from Duke University, MBA from Cleveland State University and the PhD in Public Health with a focus in Health Policy and Management. She is board certified in healthcare legal consulting and health care executive practice and is board eligible in healthcare risk management and quality. Dr. Gipson previously served as the System Vice President and Chief Nursing Officer for the NCH Healthcare System, Chief Operating Officer for the Nebraska Heart Institute, Chief Operations Officer for Baptist Health in the UAB System and Vice President for Operations at University Hospitals of Cleveland where she also held joint faculty appointments at their affiliated universities.

Teresa Fulton, RN, Chief Quality Officer. Ms. Fulton is a registered nurse who obtained her Masters Degree in Nursing from Webster University in St Louis, Missouri. She has practiced quality improvement, patient safety and infection control in acute care, long term critical care, skilled nursing facilities, home health and hospice.

Hank Hanigan, MBA, FACHE, Chief Operating Officer. Mr. Hanigan has recently joined Whidbey General Hospital as its Chief Operations Officer. He has served in a variety of hospital roles over the past 15 years including Chief Financial Officer and Director of Surgical and Physical Rehabilitation Service Lines. Mr. Hanigan holds a Masters of Business Administration degree from Washington State University and a Bachelors of Business Administration degree from Gonzaga University.

Carolyn Pape, Chief Human Resource Officer – Ms. Pape joined Whibey General Hospital in November 1998 and has seen many changes over the last decade including the focus on providing a patient centered experience to our community through the introduction of Patients First in 2001. She is the current Chief Human Resources Officer and brings over 20 years experience in Human Resources in a broad range of industries, including healthcare, technology and finance. Ms. Pape holds a Bachelors of Administration in Political Science from the University of California at San Diego and has received her certification as a Senior Professional in Human Services ("SPHR").

ACCREDITATION AND MEMBERSHIP

The Hospital is licensed by the Washington State Department of Health as a hospital through December 2013. The Hospital is certified as a CAH by the Centers for Medicare and Medicaid Services. The Hospital is designated as a Trauma Level III by the Washington State Department of Health. The Hospital is the only CAH in the State of Washington to be awarded a Trauma Level III designation. The Whidbey Island Sleep Center is accredited by the American Academy of Sleep Medicine.

PROFESSIONAL LIABILITY INSURANCE

The District maintains liability insurance through Washington Casualty Company ("WCC") on a claims made basis in the amount of $1 million per occurrence with a $5 million annual aggregate. WCC also provides excess coverage in the amount of $10 million per occurrence with a $10 million annual aggregate on a claims made basis.

AUTHORIZED INVESTMENTS

Chapter 35.39 RCW limits the investment by municipalities, including public hospital districts, of inactive funds or other funds in excess of current needs to the following authorized investments: United States bonds, United States certificates of indebtedness, bonds or warrants of the State and any local government in the State, its own bonds or warrants of a local improvement district which are within the protection of the local improvement guaranty fund law and any other investment authorized by law for any other taxing district or the State Treasurer. Under chapter 43.84 RCW, the State Treasurer may invest in non-negotiable certificates of deposit in designated qualified public depositories; in obligations of the U.S. government, its agencies and wholly owned corporations; in bankers' acceptances; in commercial paper; in the obligations of the federal home loan bank, federal national mortgage association and other government corporations subject to statutory provisions and may enter into repurchase agreements. Utility revenue bonds and warrants of any city and bonds or warrants of a local improvement district are also eligible investments (RCW 35.39.030). The District currently invests its funds in shares of money market funds with portfolios of securities authorized by law for investment by local governments.

Authorized Investments for Bond Proceeds. In addition to the eligible investments discussed above, bond proceeds may also be invested in mutual funds with portfolios consisting of U.S. government and guaranteed agency securities with average maturities of less than four years; municipal securities rated in one of the four highest categories; and money market funds consisting of the same, so long as municipal securities held in the fund(s) are in one of the two highest rating categories of a nationally recognized rating agency. Bond proceeds may also be invested in shares of money market funds with portfolios of securities otherwise authorized by law for investment by local governments (RCW 39.59.030).

RETIREMENT PLANS

Whidbey General Hospital Retirement Plan. The District has a retirement plan established in accordance with Internal Revenue Code Section 401(a) covering substantially all qualifying employees. Qualifying participants contribute a portion of their wages to the Deferred Compensation Plan described below and the District contributes an amount equal to 6% of an employee's compensation and 0.1% of their compensation multiplied by the full years of service as a plan participant, subject to a maximum of five years.

Deferred Compensation Plan. The District has a deferred compensation plan established in accordance with Internal Revenue Code Section 457(b) covering substantially all qualifying employees. Qualifying participants can contribute up to the maximum specified by the Code into the plan. The employee contributions are matched by the District as described above with a contribution to the Whidbey General Hospital Retirement Plan. The District makes no contributions to the deferred compensation plan.

SERVICE AREA AND COMPETITION

SERVICE AREA

The District is located north of Seattle, Washington, and encompasses all of Whidbey Island, which includes about 80% of the population of the County. The District serves residents across Whidbey Island, including the City of Oak Harbor, the City of Langley, the Town of Coupeville and the unincorporated communities of Clinton, Freeland, Bayview and Greenbank (the "Service Area").

COMPETITION

There are no other hospitals located within the District's Service Area. The Hospital's two primary competitors are Providence Everett Medical Center and Island Hospital. Providence Everett Medical

Center is a 468-bed regional medical center located in Everett, Washington. Everett is accessible from Coupeville by driving 28 miles to the Clinton–Mukilteo Ferry, which is a 20-minute ferry crossing, and a remaining seven-mile drive from Mukilteo to Everett. Everett is also accessible from Coupeville by driving across the Deception Pass Bridge on the north end of Whidbey Island, resulting in a 75-mile drive. Island Hospital is a 43-bed hospital located in Anacortes, Washington, 30 miles from Coupeville.

PROPERTY TAX INFORMATION

DISTRICT PROPERTY TAX REVENUE

The District is authorized by statute to levy "excess," "regular" and "emergency medical services" property taxes. The Bonds are secured by a pledge of regular property taxes.

EXCESS PROPERTY TAXES

The District may impose "excess" property taxes, which are not subject to limitation, when authorized by a 60% majority popular vote, as provided in Article VII, Section 2, of the State Constitution and RCW 84.52.052. To be valid, such popular vote must have a minimum voter turnout of 40% of the number of those who voted at the last state general election, except that one-year excess tax levies also are valid if the turnout is less than 40% and the measure receives a number of affirmative votes equal to or greater than 24% of the number who voted at the last state general election. Excess levies also may be imposed without a popular vote when necessary to prevent the impairment of the obligation of contracts.

REGULAR PROPERTY TAXES

The District may impose regular property taxes for general corporate purposes, including the payment of debt service on limited tax general obligation bonds. Subject to a number of statutory and constitutional limitations, the District may levy regular property taxes, without voter approval, up to a maximum statutory amount of $0.75/$1,000 of assessed value. The statutory and constitutional limitations include (i) a constitutional requirement that property taxes be levied at a uniform rate upon the same class of property within the territorial limits of a taxing district; (ii) constitutional and statutory requirements that limit aggregate regular property tax levies by the State and all taxing districts, except port districts and public utility districts, to 1% of the true and fair value of property; (iii) a statutory limitation that restricts the aggregate rate of regular levies by all overlapping taxing districts, other than the State, public utility districts and port districts, to a maximum of $5.90/$1,000 of the assessed valuation; and (iv) a statutory restriction on the amount of increase in an individual taxing district's regular levy from one year to the next (the "Levy Lid Law"). The Levy Lid Law limits a taxing district's regular levy, without voter approval, to an amount equal to 100% of the district's highest levy amount certified in the past three years, multiplied by a "limit factor," plus a full value adjustment for new construction, improvements to existing property and State-assessed property. Substantively, this means that the taxing district must set its regular levy so that the property taxes payable in a given year (excluding new construction, improvements and State-assessed property) will not exceed the amount levied by the taxing district in the highest of the three most recent years multiplied by the limit factor. Revenue attributable to new construction, improvements to existing property and State-assessed property is not subject to the levy limit. See "Property Tax Limitations – The 101% Regular Tax Increase Limitation" below.

The District's current and historical regular property tax levy amounts and rates are shown in the table below under the heading "District Property Tax Levies."

EMERGENCY MEDICAL SERVICES PROPERTY TAXES

The District may impose additional regular property tax levies for emergency medical services in an amount equal to 50 cents or less per thousand dollars of the assessed value of property in the District in each year for six consecutive years, each year for ten consecutive years or permanently when specifically authorized so to do by majority of at least 60% of the electors thereof approving a proposition authorizing the levies submitted at a general or special election, at which election the number of persons voting "yes" on the proposition constitutes 60% of a number equal to 40% of the total votes cast in the District at the last preceding general election when the number of electors voting on the proposition does not exceed 40% of the total votes cast in the District in the last preceding general election; or by majority of at least

60% of the electors thereof voting on a proposition when the number of electors voting on the proposition exceeds 40% of the total votes cast in the District in the last preceding general election.

The total dollar amount of an emergency medical services levy by an individual taxing district is limited to the amount of such taxes levied in the highest of the three most recent years multiplied by a "limit factor," plus adjustments for new construction, improvements to existing property and State assessed property. For taxing districts with a population greater than 10,000, such as the District, the limit factor is defined as (i) the lesser of 101% or 100% plus inflation (measured by the implicit price deflator or IPD), or (ii) up to 101%, regardless of inflation, if approved by the legislative authority of the taxing district upon a finding of substantial need.

In 2006, the District's voters approved a six-year emergency medical services levy in the amount of $0.50/$1,000 of the assessed value of property within the District, beginning in tax collection year 2007. The levy expires as of December 31, 2012, and no taxes received by the District on account of this levy will be pledged to the repayment of the Bonds.

TIMBER EXCISE TAXES

The District also receives timber excise taxes. In Washington State, standing timber is exempted from *ad valorem* taxes, but is subject to an excise tax at the time it is harvested, as calculated and collected by the State Department of Revenue. The State imposes a 1% tax, while counties may impose up to 4%, to be distributed to local governments, such as hospital districts. The timber assessed value ("TAV") for a county equals the stumpage value of timber harvested from privately-owned land multiplied by the ratio of the county's timber excise tax rate to its property tax rate on forestlands. The TAV for an individual taxing district equals the county TAV multiplied by the percentage of county forestland within that district. Timber excise taxes are distributed to districts in the following order, with any excess placed in reserve for use the following year:

(1) Taxing districts with an excess levy or a capital levy. The amount is the district's TAV multiplied by that levy rate.

(2) School districts with a maintenance and operations levy. The amount is half the district's TAV multiplied by that levy rate.

(3) Taxing districts with a regular property tax levy. The amount is the district's TAV multiplied by that levy rate.

DISTRICT PROPERTY TAX LEVIES

The following table shows the District's emergency medical services, regular and excess levy rates and dollar amounts levied since 2007.

District Tax Levy
(Per $1,000 of Assessed Value)

	Levy Rates (%)			Levy Amounts ($) [1]		
Collection Year	EMS	Regular	Excess	EMS	Regular	Excess
2011	0.50000	0.08767	0.13677	4,852,529	850,937	1,310,919
2010	0.46827	0.07742	0.12081	5,116,420	845,893	1,306,352
2009	0.46123	0.08225	0.12036	5,134,239	915,559	1,327,631
2008	0.45347	0.07485	0.12359	4,808,241	793,618	1,300,000
2007	0.50000	0.08260	0.14029	4,643,557	767,127	1,292,751

(1) Excludes timber, excise and other miscellaneous taxes collected by treasurer. Differences in Levy Amounts and Levy Rate times Assessed Value due to error corrections or refunds during those years

Source: Island County Assessor's Office.

PROPERTY TAX LIMITATIONS

Regular property taxes are subject to rate and amount limitations, as described below, and to the uniformity requirement of Article VII, Section 1, of the State Constitution, which specifies that a taxing

district must levy the same rate on similarly classified property throughout a district. Aggregate property taxes vary because of various combinations of overlapping taxing districts. Properties that are subject to the same combination of taxing districts and thus have the same aggregate levy rate are in the same "levy code."

Maximum Regular Tax Levy Rates. Subject to the limitations described below, public hospital districts and other taxing districts in the State may levy regular, nonvoted property taxes at the following rates subject to the limitations provided by chapter 84.55 RCW.

Maximum Regular Tax Levy Rates
(per $1,000 of Assessed Value)

Taxing District	Levy Rate	Taxing District	Levy Rate
Hospital Districts	$0.75	Metropolitan Park Districts	$0.75
Counties[(1)]	1.80	Park and Recreation Districts	0.60
County Roads (Unincorp)	2.25	Cities and Towns[(2)]	3.60
Library Districts	0.50	State Schools[(3)]	3.60
Fire Districts	1.50	Cemetery Districts	0.1125
Port Districts	0.45		

(1) Pursuant to RCW 84.52.043(1), a county may increase its levy from $1.80/$1,000 to $2.475/$1,000 if (i) the total levies for the county and any road district in the county do not exceed $4.05/$1,000 and (ii) no taxing district has its levy reduced as a result of the increased county levy.

(2) Up to $.225/$1,000 of this amount may be levied for pension funding purposes under RCW 41.16.060. Also, the maximum regular levy for any city annexed to a library district or a fire protection district is limited to $3.60/$1,000 less any regular levy made by the library or fire protection district, pursuant to RCW 27.12.390 and 52.04.081.

(3) The $3.60/$1,000 maximum is adjusted for a county by the ratio of assessed value to market value.

There are three other regular levies that certain taxing districts may impose that are outside the above statutory rate limits: (1) a conservation futures levy, which can be imposed by a county without voter approval at a maximum rate of $0.0625 per $1,000 assessed value; (2) an emergency medical services levy, which can be imposed with voter approval at a maximum rate of $0.50 per $1,000 assessed value; and (3) an affordable housing levy, which can be imposed by a city or a county, with voter approval, at a maximum rate of $0.50 per $1,000 assessed value.

ALTHOUGH THE DISTRICT MAY LEVY REGULAR TAXES AT THE MAXIMUM LEVY RATES DESCRIBED UNDER THIS SUBHEADING, THE DISTRICT'S ABILITY TO DO SO IS LIMITED BY: (I) STATUTES THAT RESTRICT THE DISTRICT'S ABILITY TO INCREASE THE DOLLAR AMOUNT OF ITS REGULAR TAX LEVY IN ANY GIVEN YEAR (SEE "THE 101% REGULAR PROPERTY TAX INCREASE LIMITATION" BELOW); (II) STATUTES THAT LIMIT THE AGGREGATE REGULAR TAX LEVY RATE OF CERTAIN TAXING DISTRICTS AND REQUIRE ADJUSTMENT OF THOSE LEVY RATES UNDER CERTAIN CIRCUMSTANCES (SEE "THE $5.90/$1,000 AGGREGATE REGULAR LEVY RATE LIMITATION" BELOW); AND (III) A CONSTITUTIONAL AND STATUTORY LIMIT ON THE MAXIMUM AMOUNT OF ALL REGULAR TAXES LEVIED ON PROPERTY (SEE "CONSTITUTIONAL 1% AGGREGATE REGULAR PROPERTY LEVY RATE LIMITATION" BELOW). FURTHER, VARIOUS INITIATIVES AND REFERENDA HAVE BEEN SUBMITTED TO THE STATE'S VOTERS IN RECENT YEARS THAT HAVE ATTEMPTED TO FURTHER LIMIT THE DISTRICT'S ABILITY TO LEVY REGULAR TAXES. SOME OF THESE HAVE BEEN APPROVED BY THE VOTERS. THE DISTRICT ANTICIPATES THAT ADDITIONAL INITIATIVES AND REFERENDA REGARDING TAXES WILL BE SUBMITTED IN THE FUTURE. SEE "INITIATIVES AND REFERENDA"

Constitutional Uniformity Requirement. Article VII, Section 1, of the State Constitution requires that a taxing district must levy the same rate on similarly classified property throughout a district. It is possible that the overlapping of taxing districts in different areas of the District could cause the maximum aggregate levy to vary within the District. To comply with the uniformity requirement, if either the Constitutional 1% limitation or the $5.90 limitation is exceeded, county assessors must reduce or eliminate levies according to a detailed prioritized list, beginning with the junior taxing districts. See "Junior Taxing Districts" below.

Constitutional 1% Aggregate Regular Levy Rate Limitation. Article VII, Section 2 of the State Constitution limits aggregate regular property tax levies by the State and all taxing districts, except port districts and public utility districts, to 1% of the true and fair value of property. RCW 84.52.050 provides the same limitation by statute.

The 101% Regular Property Tax Increase Limitation. Chapter 84.55 RCW limits the total dollar amount of regular property taxes levied by an individual taxing district to the amount of such taxes levied in the highest of the three most recent years multiplied by a "limit factor," plus adjustments for new construction, improvements to existing property and State-assessed property. For taxing districts with a population greater than 10,000, such as the District, the limit factor is defined as (i) the lesser of 101% or 100% plus inflation (measured by the implicit price deflator or IPD), or (ii) up to 101%, regardless of inflation, if approved by the legislative authority of the taxing district upon a finding of substantial need. Since the regular tax increase limitation applies to the total dollar amount levied rather than to levy rates, any increases in property values exceeding the limit factor result in decreased levy rates, unless voters authorize a higher levy.

RCW 84.55.092 allows the property tax levy to be set at the amount that would be allowed if the tax levy since 1986 had been set at the full amount allowed under chapter 84.55 RCW. Also, a newly created taxing district can initiate its levy at the maximum permitted statutory levy rate, unless that rate would exceed the limitations described below.

With a majority vote, RCW 84.55.050 allows a taxing district to levy a greater amount than would otherwise be allowed under the levy lid, either indefinitely or for a limited period or purpose. This is known as a "levy lid lift." A levy lid lift does not permit the taxing district to exceed any applicable levy rate limitations. The District has not received an increase to the levy lid in the past several years.

The $5.90/$1,000 Aggregate Regular Levy Rate Limitation. Aggregate regular property tax levies imposed by all taxing districts, except the State, port districts and public utility districts, are limited to $5.90/$1,000 (0.59%) of assessed value, per RCW 84.52.043(2). This limit excludes the regular levies for conservation futures, emergency medical services and affordable housing as discussed above under the subheading "Maximum Regular Tax Levy Rate."

Junior Taxing Districts. The District is a "junior" taxing district relative to the $5.90/$1,000 limit. Junior taxing districts are defined by RCW 84.52.043 as all taxing districts other than the State, counties, cities, towns, road districts, port districts and public utility districts. Under RCW 84.52.010, junior taxing district levies are reduced or eliminated in the following order until the consolidated levy is within the $5.90 limitation:

(1) Levies by park and recreation districts; park and recreation service areas; and recreation service districts; city transportation authorities; and cultural arts, stadium and convention districts are reduced on a *pro rata* basis or eliminated..

(2) The levies of flood control zone districts are reduced on a *pro rata* basis or eliminated.

(3) The levy rates of all other junior taxing districts (<u>except</u> fire protection districts, regional fire protection service authorities, library districts, and the first $0.50/$1,000 levied by a public hospital district or a metropolitan park district) are reduced on a *pro rata* basis or eliminated.

(4) For new metropolitan park districts, the $0.50/$1,000 protected under (3), above, is reduced or eliminated.

(5) Levies by fire protection districts and regional fire protection service authorities are reduced on a *pro rata* basis until only the first $0.50/$1,000 remains.

(6) The remaining levies (i.e., library districts, and the remaining $0.50/$1,000 levied by older metropolitan park districts, public hospital districts, fire protection districts and regional fire protection service authorities) are all reduced on a *pro rata* basis or eliminated.

In addition, RCW 84.52.125 provides that, beginning with levies collected in 2006, fire protection districts may protect up to $0.25/$1,000 from proration under the steps outlined above, regardless of the aggregate levy limitation. However, if the Constitutional 1% aggregate rate limitation (see above) is exceeded, this $0.25/$1,000 is the first levy to be reduced or eliminated in accordance with RCW 84.52.010.

Finally, chapter 39.67 RCW allows taxing districts to contract with one another to avoid a loss of revenues associated with a reduction of levy rates. Typically under these contracts, a geographically smaller taxing

district agrees to impose a lower levy rate in order to avoid proration. In return, that district receives payments from a geographically larger taxing district so that the total revenues received by the small district are approximately equal to what they would have received had it not agreed to lower its levy.

Representative Levy Rates. The following table shows that (i) if all taxing districts in the incorporated areas of the District levied regular property taxes at the maximum allowable rates, the $5.90/$1,000 limit would be exceeded by $0.25 per $1,000 assessed value; and (ii) if all taxing districts in the unincorporated areas of the District levied regular property taxes at the maximum allowable rates, the $5.90/$1,000 limit would be exceeded by $1.6125 per $1,000 assessed value.

Maximum Regular Levy Rates
Subject to $5.90/$1,000 Limit
(Per $1,000 of Assessed Value)

Incorporated Areas		Unincorporated Areas	
Senior Districts:		Senior Districts:	
Island County	$1.8000	Island County	$1.8000
Cities[1]	3.6000	County Roads	2.2500
Total Senior Districts:	$5.4000	Total Senior Districts:	$4.0500
Junior Districts:		Junior Districts:	
The District	$0.7500	Fire Districts	$1.5000
		The District[2]	0.7500
		Park and Recreation Districts	0.6000
		Library Districts	0.5000
		Cemetery Districts	0.1125
Total Junior Districts:	$0.7500	Total Junior Districts:	$3.4625
Maximum Aggregate Rate:	$6.1500	Maximum Aggregate Rate:	$7.5125
Amount in Excess of Limit	$0.2500	Amount in Excess of Limit	$1.6125

(1) The maximum regular levy for any city annexed to a library district or a cemetery district is limited to $3.60/$1,000 less any regular levy made by the library.

(2) In the unincorporated area $0.50 of the District's levy is essentially protected. A park and recreation district levy would be reduced first, then the cemetery district levy and the first $0.25/$1,000 of the District's levy, followed by the first $1.00 of a fire district levy, if necessary.

The following table shows the 2011 regular tax levy rates for the Tax Code Area ("TCA") in the incorporated and unincorporated areas of the District with the highest overall regular tax levy rates.

Highest Regular 2011 Levy Rates
Subject to $5.90/$1,000 Limit
(Per $1,000 of Assessed Value)

Incorporated Areas [1]		Unincorporated Areas [2]	
Senior Districts:		Senior Districts:	
Island County	$0.5815	Island County	$0.5815
City of Oak Harbor	2.2853	County Roads	0.7322
Total Senior Districts:	$2.8668	Total Senior Districts:	$1.3137
Junior Districts		Junior Districts	
Sno-Isle Regional Library District	$0.4506	Fire Protection District No. 5	$0.9749
N. Whidbey Park & Rec. District	0.1542	Sno-Isle Regional Library District	0.4506
The District	0.0876	The District	0.0876
Cemetery District No. 1	0.0076	Cemetery District No. 2	0.0147
Total Junior Districts	$0.7000	Total Junior Districts	$1.5278
Aggregate Rate	$3.5668	Aggregate Rate	$2.8415
Amount Below Limit	$2.3332	Amount Below Limit	$3.0585

(1) TCA 100 in the City of Oak Harbor.

(2) TCA 310 in unincorporated Island County

Source: Island County Assessor's Office

ASSESSED VALUE

Real and Personal Property. The County Assessor determines the value of taxable real and personal property in the County (including the District), except certain utility properties that are valued by the State Department of Revenue. The County Assessor is an elected official whose duties and methods of determining value are prescribed and controlled by statute and detailed regulations of the State Department of Revenue. For tax purposes, the assessed value of property is 100% of its actual value. In the County real property is revalued annually and is subject to on-site inspection every six years. The County Assessor's determinations are subject to revision by the County Board of Equalization and, for certain property, by the State Board of Equalization.

The following table sets forth historical regular taxable assessed values for the District, the Town of Coupeville and the County.

Historical Regular Taxable Assessed Values

Year	The District	Town of Coupeville	Island County
2012	$ 9,487,011,645	$262,499,029	$12,746,639,465
2011	9,705,059,868	263,362,160	13,049,490,027
2010	10,926,216,699	285,804,461	14,629,093,831
2009	11,131,635,262	283,819,449	14,914,591,763
2008	10,603,223,256	271,719,100	14,222,491,479
2007	9,287,113,791	242,962,850	12,452,312,810

Source: Island County Assessor

TAX COLLECTIONS

The County Assessor delivers the tax roll (showing the total amount of *ad valorem* taxes to be collected in each taxing district) to the County Treasurer, who creates an account for each taxpayer and collects the taxes. Taxes are due by April 30, but if the amount due from a taxpayer exceeds $50, one-half may be paid then and the balance paid by October 31. Interest must be paid on delinquent taxes. The method of

giving tax notices, collecting the taxes, accounting for the money collected, and distributing taxes among taxing districts are all covered by detailed state statutes. The lien on property taxes is prior to all other liens or encumbrances of any kind on real or personal property subject to taxation. By law, the County Treasurer may not commence foreclosure of a tax lien until three years have passed since delinquency.

Washington State courts have not made a determination whether or not the homestead law (chapter 6.13 RCW) gives the occupying homeowner a right to retain the first $125,000 proceeds of forced sale of a family residence for delinquent general property taxes. In *Algona vs. Sharp, 30 Wn. App. 837, 638 P. 2d 627 (1982*), the State Court of Appeals held the homestead right superior to liens for local improvement district assessments but was silent regarding liens for property taxes. The U.S. Bankruptcy Court for the Western District of Washington has held that the Homestead Exemption applies to the liens for property taxes, while the State Attorney General has taken the position that it does not.

Historic District Tax Collections
EMS Property Taxes

		Collected in the year of the Levy		Collection as of December 31, 2011	
Collection Year	**Property Tax Levy ($)**	**Amount**	**Percent**	**Amount**	**Percent**
2011	4,852,530	4,687,761	96.61	4,687,761	96.61
2010	5,116,420	4,906,031	95.89	5,048,740	98.68
2009	5,134,239	5,001,461	97.41	5,103,520	99.40
2008	4,808,221	4,717,546	98.11	4,803,163	99.90
2007	4,643,568	4,558,854	98.18	4,643,296	99.99

Source: Island County Treasurer

Historic District Tax Collections
Regular Property Taxes

		Collected in the year of the Levy		Collection as of December 31, 2011	
Collection Year	**Property Tax Levy ($)**	**Amount**	**Percent**	**Amount**	**Percent**
2011	850,937	822,043	96.60	822,043	96.60
2010	845,893	811,109	95.89	834,703	98.68
2009	915,559	891,883	97.41	910,081	99.40
2008	793,616	778,650	98.11	792,781	99.90
2007	767,127	753,132	98.18	767,082	99.99

Source: Island County Treasurer

MAJOR TAXPAYERS

The following table lists the top ten major taxpayers within the District ranked according to their assessed value for the 2011 tax collection year.

2011 Major Taxpayers

Taxpayer	2011 Regular Taxable Assessed Value	Percent of District's 2011 Regular Taxable Assessed Value
Puget Sound Energy	$ 31,070,742	0.33
Whidbey Telephone Company	17,605,030	0.18
Frontier Communications NW	17,220,459	0.18
Oak Harbor Retirement Comm LLC	14,268,629	0.15
Freund Trustee, Carl R.	9,093,216	0.10
Harbor Town Center LLC	8,477,450	0.09
Hennyc Co Trustee, Marion Fay	8,415,000	0.09
Anne E. Gittinger	8,259,280	0.09
Isle West Properties LLC	7,887,240	0.08
BC Partners II LLC	7,762,215	0.08
Subtotal	$ 130,059,261	1.37%
All other Taxpayers	9,356,952,384	98.63
Total Taxpayers	$9,487,011,645	100.00%

Source: Island County Assessor's Office.

DEBT INFORMATION

OUTSTANDING GENERAL OBLIGATION INDEBTEDNESS

The District will have the following general obligations outstanding after issuance of the Bonds:

Outstanding General Obligations
(After Issuance of the Bonds)

Type	Amount Outstanding	Final Maturity
Non-Voted Debt		
Bank Notes		
For Bame Land	65,000	2018
For Bame Land and Building	318,000	2028
Capital Lease	66,000	2013
LTGO Bonds, 2009	7,885,000	12/01/2034
The Bonds	8,050,000	12/01/2037
Total Non-Voted Debt:	$ 16,384,000	
Voted Debt		
UTGO Bonds[(1)]	0	
Total Voted Debt:	$ 0	

(1) All of the District's outstanding voted bonds matured as of December 1, 2011.

REVENUE BONDS

The District has no tax-exempt revenue bonds outstanding.

DEBT PAYMENT RECORD

The District has promptly met all debt service payments on outstanding obligations. No refunding bonds have been issued to prevent an impending default.

FUTURE BORROWING

The District has no plans to issue additional general obligation debt in the next twelve months, other than the Bonds.

GENERAL OBLIGATION DEBT CAPACITY

Non-Voted Debt Capacity. The District may have non-voted general obligation debt outstanding of up to three-quarters of one percent (0.75%) of assessed value of taxable property within the District. This includes any limited tax general obligation ("LTGO") bonds, conditional sales contracts and capital leases. The principal of and interest on such non-voted debt is payable from its "regular levy" (subject to the limitations described herein under "Property Tax Information") or from other available revenues.

Total (Voted and Non-Voted) Debt Capacity. The District may have total (voted and non-voted) general obligation debt outstanding of up to two and one-half percent (2.50%) of the assessed value of taxable property within the District. Pursuant RCW 39.36.020, unlimited tax general obligation ("UTGO") bonds, may be issued with the approval of 60% of voters at an election at which the total number of persons voting is at least 40% of the total number of persons voting at the last state general election. Principal of and interest on such voted debt is payable from an "excess levy," without limitation as to rate or amount.

General Obligation Debt Capacity
(After Issuance of the Bonds)

2012 Regular Taxable Assessed Value	$9,487,011,645
Non-Voted Debt Capacity	
Maximum: 0.75% of Assessed Value	$ 71,152,587
Less: Outstanding Non-Voted Debt	(8,334,000)
Less: The Bonds	(8,050,000)
Remaining Non-Voted Debt Capacity	$ 54,768,587
Total Debt Capacity	
Maximum: 2.50% of Assessed Value	$ 237,175,291
Less: Outstanding Voted Debt	0
Less: Outstanding Non-Voted Debt	(8,334,000)
Less: The Bonds	(8,050,000)
Remaining Total Debt Capacity	$ 220,791,291

OVERLAPPING DEBT

Overlapping taxing districts are those local governments whose boundaries overlap all or a portion of the District's boundaries. The District encompasses all of Whidbey Island and 32 of its 35 overlapping taxing districts are located entirely within the District. The following table presents information regarding the overlapping taxing districts with outstanding general obligation debt and the estimated portion of overlapping debt allocable to the District. The overlapping debt information was provided by the Island County Assessor's and Treasurer's offices and individual taxing districts. While such information is believed by the District to be reliable, the District does not guarantee the accuracy of the debt information provided by other taxing districts.

Estimated Overlapping Debt

Taxing District	2012 Regular Taxable Assessed Value	Overlap (Percentage)	Outstanding GO Debt	Estimated Overlapping Debt
Oak Harbor, City of	$ 1,619,266,260	100.00	2,495,413	2,495,413
Langley, City of	249,975,127	100.00	110,000	110,000
Coupeville, Town of	262,499,029	100.00	1,594,717	1,594,717
School District No. 201 (Oak Harbor)	3,398,555,408	100.00	60,433,154	60,433,154
School District No. 204 (Coupeville)	2,008,621,643	100.00	17,375,000	17,375,000
S. Whidbey Park and Recreation District	4,012,089,824	100.00	2,222,215	2,222,215
Sno-Isle Library Capital Facilities Improvement Area	2,008,621,643	100.00	2,245,000	2,245,000
Island County	12,746,639,465	73.47	9,710,000	7,133,937
		Total:	96,185,499	93,609,436

Source: Island County Assessor and Treasurer; individual taxing districts.

BONDED DEBT RATIOS

The following ratios provide an indication of the debt burden on District residents, after issuance of the Bonds.

Bonded Debt Ratios
(After Issuance of the Bonds)

2012 Regular Taxable Assessed Value	$9,487,011,645
District Estimated Population	62,845
Debt Information	
Direct Debt [(1)]	$ 16,384,000
Estimated Overlapping Debt	93,609,436
Total Direct and Overlapping Debt	$109,993,436
Ratios	
Direct Debt to 2012 Regular Taxable Assessed Value	0.17%
Direct and Overlapping Debt to 2012 Regular Taxable Assessed Value	1.16%
Per Capita 2012 Regular Taxable Assessed Value	$150,959
Per Capita Direct Debt	$261
Per Capita Direct and Overlapping Debt	$1,750

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(1) Includes Non-Voted Debt and the Bonds of the District. See "Outstanding General Obligation Indebtedness" herein.

ESTIMATED DEBT SERVICE REQUIREMENTS

The following table shows the District's estimated non-voted debt service requirements.

Estimated Annual LTGO Debt Service Requirements
(Years Ending December 31)

Year	Outstanding Debt[1]	The Bonds		Total Debt Service
		Principal	Interest	
2012	$ 1,702,435	-	$ 222,083	$ 1,924,518
2013	549,601	$ 30,000	292,856	872,458
2014	530,230	65,000	292,256	887,486
2015	545,155	65,000	290,956	901,111
2016	549,380	75,000	289,006	913,386
2017	552,380	90,000	286,756	929,136
2018	555,182	105,000	284,056	944,239
2019	549,784	125,000	280,906	955,690
2020	555,859	135,000	277,156	968,015
2021	561,015	150,000	274,288	985,302
2022	564,015	165,000	270,913	999,927
2023	571,265	180,000	264,313	1,015,577
2024	577,515	195,000	257,113	1,029,627
2025	577,765	215,000	251,750	1,044,515
2026	586,490	230,000	245,569	1,062,059
2027	588,902	250,000	238,669	1,077,571
2028	582,595	280,000	230,856	1,093,451
2029	566,044	320,000	221,756	1,107,800
2030	574,781	340,000	210,956	1,125,738
2031	580,313	365,000	199,056	1,144,369
2032	584,156	390,000	185,825	1,159,981
2033	586,313	420,000	171,200	1,177,513
2034	596,781	445,000	154,400	1,196,181
2035	-	1,075,000	136,600	1,211,600
2036	-	1,140,000	93,600	1,233,600
2037	-	1,200,000	48,000	1,248,000
Total[2]	$14,187,956	$8,050,000	$5,970,895	$28,208,852

(1) Outstanding Non-Voted Debt.

(2) Totals may not foot due to rounding.

DEMOGRAPHIC AND ECONOMIC INFORMATION

Located northwest of Seattle and just west of Everett, the County lies off the coast of Snohomish and Skagit counties. The County includes Whidbey Island and Camano Island, as well as three small islands. The three incorporated communities on Whidbey Island are the City of Oak Harbor, the City of Langley and the Town of Coupeville. Historic population for the District, the County, the Cities of Oak Harbor and Langley and the Town of Coupeville is set forth in the table below.

Historical Population[(1)]

Year	The County	City of Oak Harbor	City of Langley	Town of Coupeville
2011	78,800	22,200	1,045	1,855
2010	78,506	22,075	1,035	1,831
2009	80,300	23,360	1,100	1,910
2008	79,300	22,980	1,080	1,915
2007	78,400	22,690	1,060	1,855
2006	77,200	22,290	1,055	1,820
2000	71,558	19,795	959	1,723

(1) 2000 and 2010 are U.S. Census statistics; remaining years are State Office of Financial Management estimates as of April 1 of each year.

Source: Washington State Office of Financial Management.

ECONOMIC INDICATORS

Following are selected economic indicators.

Island County
Residential Building Permits

	New Single Family Units		New Multi Family Units		Total
Year	Number	Valuation	Number	Valuation	Valuation
2010	219	$40,307,786	0	0	$40,307,786
2009	198	39,337,416	0	0	39,337,416
2008	329	87,552,555	0	0	87,552,555
2007	232	45,189,078	10	$4,872,608	50,061,686
2006	125	22,477,786	2	1,166,820	23,644,606

Source: U.S. Census Bureau

Taxable Retail Sales

Year	The City of Oak Harbor	The Town of Coupeville	The County [(1)]
2011 [(2)]	$144,437,044	$30,030,958	$329,629,329
2010	306,115,055	39,529,668	705,367,671
2009	334,812,793	36,925,612	745,578,288
2008	327,451,400	37,954,941	790,870,084
2007	348,954,522	49,241,580	884,268,864
2006	336,995,780	44,791,375	829,841,269

(1) Includes the Cities of Oak Harbor and Coupeville.
(2) First two quarters of 2011

Source: Washington State Department of Revenue

Island County and State of Washington
Total Personal and Per Capita Income

	Island County		State of Washington	
Year	Total Personal Income (in thousands)	Per Capita Income	Total Personal Income (in thousands)	Per Capita Income
2009	$2,941,708	$36,293	$285,696,255	$42,870
2008	3,064,485	37,905	287,010,560	43,711
2007	2,979,047	36,842	272,624,864	42,169
2006	2,802,549	34,553	252,091,288	39,561
2005	2,541,382	31,869	230,057,261	36,743

Source: U.S. Department of Commerce, Bureau of Economic Analysis, Regional Economic Accounts

Island County Major Employers

Company	Product or Service	Employees (1)
NAS, Whidbey Island	Military	10,000
The District	Health Care	700
Oak Harbor School District	Education	534
Whidbey Island Bank	Financial Services	400
The County	Local Government	393
Navy Exchange	Retail	299
Nichols Brothers Boat Builders	Manufacturing-Boats	220
Skagit Valley Community College-Whidbey Campus	Higher Education	220
Wal-Mart	Retail	210
South Whidbey School District	Education	155

(1) Includes part-time employees

Source: Economic Development Council of Island County(July 2010)

INDUSTRY AND EMPLOYMENT

Employment within the County is described in the following tables.

Resident Civilian Labor Force – Island County

	Annual Average					
	2006	2007	2008	2009	2010	2011(1)
Civilian Labor Force	32,150	32,690	32,990	32,950	32,870	36,930
Total Employment	30,500	31,090	31,190	30,020	29,790	33,650
Total Unemployment	1,650	1,600	1,800	2,930	3,080	3,280
Percent of Labor Force	5.1%	4.9%	5.4%	8.9%	9.4%	8.9%

(1) Average through October, 2011.

Source: Washington State Employment Security Department.

Employment (Non-Agriculture) – Island County

	Annual Average					
NAICS Industry	**2006**	**2007**	**2008**	**2009**	**2010**	**2011[(1)]**
Total Non-farm	16,500	16,580	16,360	15,560	15,270	15,040
Natural Resources, Mining and Construction	1,530	1,630	1,440	1,060	880	760
Manufacturing	740	660	610	610	640	660
Trade, Transportation and Utilities	2,980	2,990	2,890	2,690	2,580	2,520
Wholesale Trade	190	180	190	160	140	150
Retail Trade	2,520	2,530	2,430	2,250	2,140	2,080
Transportation, Warehousing and Utilities	280	270	280	280	300	280
Information and Financial Activities	960	970	900	840	790	780
Government	4,630	4,640	4,670	4,570	4,660	4,550
Total Private	11,880	11,940	11,680	10,990	10,610	10,490

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(1) Average through October, 2011.

Source: Washington State Employment Security Department.

[51186112]

APPENDIX B

AUDITED FINANCIAL STATEMENTS
FOR THE YEARS ENDING DECEMBER 31, 2010 AND 2009

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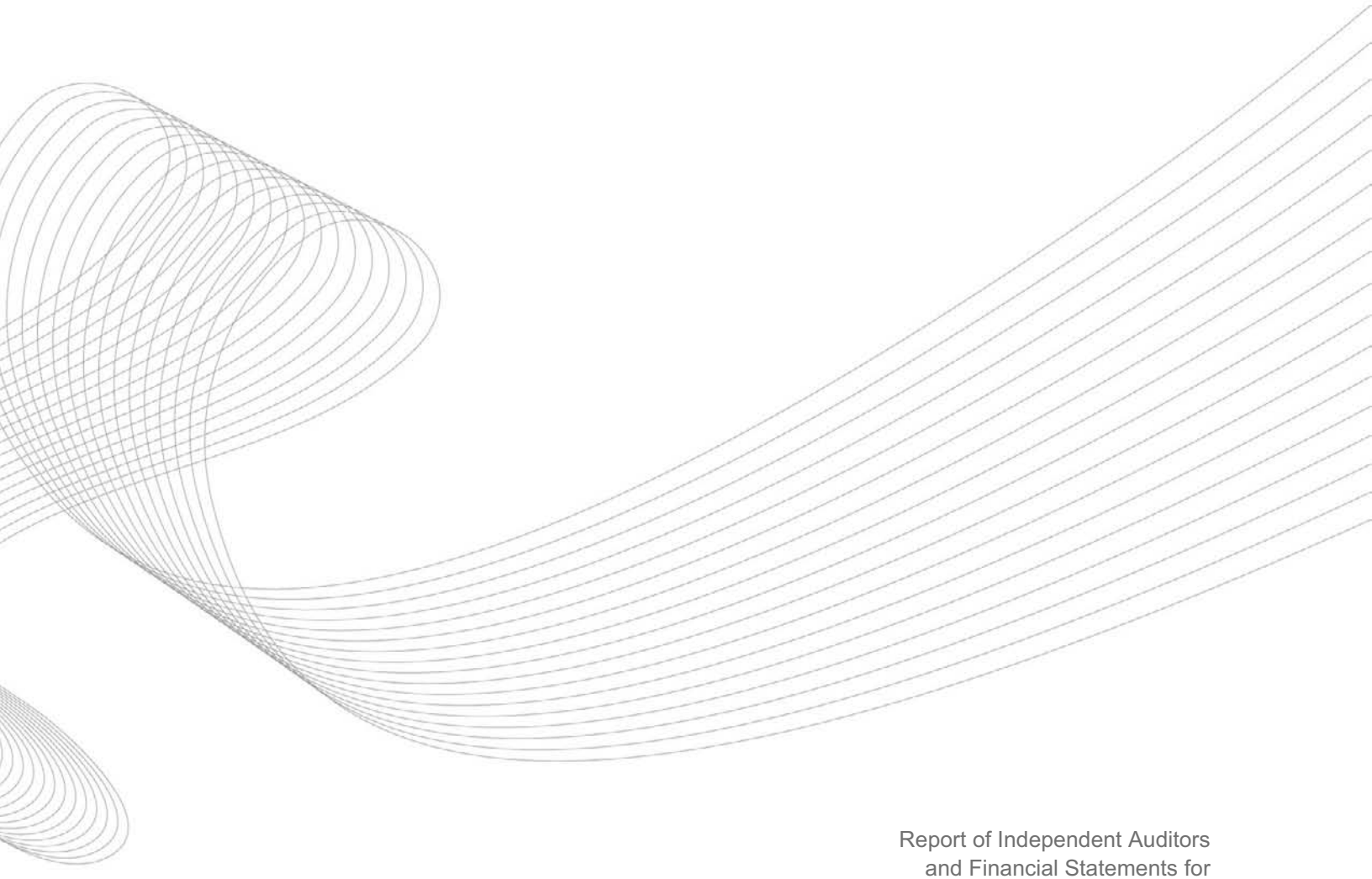

Report of Independent Auditors
and Financial Statements for

Whidbey Island Public Hospital District, Island County, Washington dba Whidbey General Hospital

December 31, 2010 and 2009

MOSS-ADAMS LLP

Certified Public Accountants | Business Consultants

Acumen. Agility. Answers.

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MOSS-ADAMS LLP
Certified Public Accountants | Business Consultants

REPORT OF INDEPENDENT AUDITORS

To the Board of Commissioners
Whidbey Island Public Hospital District,
Island County, Washington
dba Whidbey General Hospital

We have audited the balance sheet of Whidbey Island Public Hospital District, Island County, Washington (a municipal corporation), dba Whidbey General Hospital, as of December 31, 2010 and 2009, and the related statements of revenues, expenses, and changes in net assets and cash flows for the years then ended. These financial statements are the responsibility of the District's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Organization's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Whidbey Island Public Hospital District, Island County, Washington, as of December 31, 2010 and 2009, and the changes in its financial position and its cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

The accompanying management's discussion and analysis on pages 2 through 6 is not a required part of the financial statements but is supplementary information required by the Governmental Accounting Standards Board. We have applied certain limited procedures, which consisted principally of inquiries of management regarding the methods of measurement and presentation of the required supplementary information. However, we did not audit the information and express no opinion on it.

Moss Adams LLP

Everett, Washington
May 23, 2011

Board of Commissioners

Roger Case, M.D.	Commissioner/President	Term - 12/2013
Grethe Cammermeyer, Ph.D.	Commissioner	Term - 12/2011
Anne Tarrant	Commissioner	Term - 12/2011
Ron Wallin	Commissioner	Term - 12/2013
Paul Zaveruha, M.D.	Commissioner	Term - 12/2015

Administrators

Tom Tomasino	Chief Executive Officer
Joe Vessey	Chief Financial Officer
John Bitting	Chief Nursing Officer
Hank Hanigan	Chief Operating Officer
Teresa Fulton	Chief Quality Officer
Carolyn Pape	Chief Human Resources Officer

Summary of Events Affecting Operations

Fiscal year 2010 was the fifth year that the Hospital was licensed as a critical access hospital. This designation provides cost reimbursement under Medicare and Medicaid programs. During 2010, the hospital experienced a decrease in operating margin as compared with 2009. This decline is attributed to weakening demand and increased uncompensated care, as a result of the national and regional economic conditions. While inpatient admissions and surgical volumes increased over 2009, this trend was partially mitigated by decreased volume in other outpatient areas, including emergency room, diagnostic imaging, physical therapy, and physician clinics.

Volumes and Statistics

Fiscal year 2010 inpatient days increased from 2009 by 3%. There was an 8% increase in the number of newborns in 2010 from 2009.

The percentage of government patient days remained high at 77% of total days as compared with 75% in 2009.

Average length of stay increased to 3.0 days in 2010 as compared with 2.8 in 2009.

Fiscal year 2010 outpatient volumes decreased 4% from 2009. The largest volume decreases were experienced in Outpatient Therapies (Physical Therapy, Occupational Therapy, and Speech Therapy) and Radiology.

Volumes and Statistics (continued)

The following are key statistics for December 31, 2010, 2009, and 2008:

	2010	2009	2008
Admissions	1,908	1,848	1,968
Patient days	6,069	5,486	6,188
Newborns	184	170	204
Surgery cases	3,161	2,933	3,086
ER visits	18,528	18,914	18,756
Rural health clinics visits	17,014	17,381	16,925
Home health visits	9,104	10,049	9,621
Outpatient visits	191,853	199,221	183,191
Ambulance runs	6,773	6,396	6,189

Using This Annual Report

The District's financial statements consist of three statements: a Balance Sheet; a Statement of Revenues, Expenses, and Changes in Net Assets; and a Statement of Cash Flows. These financial statements and related notes provide information about the activities of the District, including resources held by the District but restricted for specific purposes by contributors, grantors, or enabling legislation.

The Balance Sheet and Statement of Revenues, Expenses, and Changes in Net Assets

Our analysis of the District's finances begins on page 4. One of the most important questions asked about the District's finances is, "Is the District as a whole better or worse off as a result of the year's activities?" The Balance Sheet and the Statement of Revenues, Expenses, and Changes in Net Assets report information about the District's resources and its activities in a way that helps answer this question. These statements include all restricted and unrestricted assets and all liabilities using the accrual basis of accounting. All the current year's revenues and expenses are taken into account regardless of when the cash is received or paid. These two statements report the District's net assets and changes in them. You can think of the District's net assets—the difference between assets and liabilities—as one way to measure the District's financial health, or financial position. Over time, increases or decreases in the District's net assets are one indicator of whether its financial health is improving or deteriorating. You will need to consider other nonfinancial factors, however, such as changes in the District's patient base and measures of the quality of service it provides to the community, as well as the local economic factors to assess the overall health of the District.

The Statement of Cash Flows

The final required statement is the Statement of Cash Flows. The statement reports cash receipts, cash payments, and net changes in cash resulting from operations, investing, and financing activities. It provides answers to such questions as "Where did cash come from?" "What was cash used for?" and "What was the change in cash balance during the reporting period?"

Balance Sheet

The following is a presentation of certain financial information derived from the District's balance sheet (amounts in thousands):

	2010	2009	2008
Assets			
Total current assets	$ 25,231	$ 22,919	$ 16,481
Assets limited as to use			
Capital assets, net	23,840	25,374	21,260
Other assets	195	207	16
Total assets	$ 49,266	$ 48,500	$ 37,757
Liabilities and net assets			
Current liabilities	$ 11,622	$ 9,934	$ 7,412
Long-term liabilities	8,444	11,068	3,767
Estimated medical malpractice costs	183	160	270
Total liabilities	20,249	21,162	11,449
Net assets			
Invested in capital assets, net of related debt	12,772	11,777	15,893
Restricted for debt service	1,082	1,074	328
Restricted expendable net assets			
Unrestricted net assets	15,163	14,487	10,087
Total net assets	29,017	27,338	26,308
Total liabilities and net assets	$ 49,266	$ 48,500	$ 37,757

Current assets include cash, accounts receivable, supplies inventory, prepaid expenses, and other current assets. The net increase in current assets of $2,312,671 is due primarily to an increase in patient accounts receivable of $2,026,486. Days revenue in receivables increased to 44 from 37 at December 31, 2010 and 2009, respectively.

Current liabilities include accounts payable, accrued payroll and vacation, and other liabilities.

Long-term debt decreased in fiscal year 2010 by approximately $2,528,855 from fiscal year 2009 due to scheduled repayment.

Statement of Revenues, Expenses, and Changes in Net Assets

The following is a summary of 2010, 2009, and 2008 annual amounts (amounts in thousands):

	2010	2009	2008
Total operating revenues	$ 80,690	$ 76,357	$ 74,000
Operating expenses			
Wages and benefits	47,590	44,237	41,203
Supplies, insurance, and other	31,414	29,438	26,929
Depreciation and amortization	2,292	2,073	2,041
Interest expense	115	127	141
Total operating expenses	81,411	75,875	70,314
Operating income	(721)	482	3,686
Nonoperating income and capital contributions	2,399	548	1,682
Increase in net assets	$ 1,678	$ 1,030	$ 5,368
Ending net assets	$ 29,017	$ 27,338	$ 26,308

Total operating revenues increased by $4,332,816, or 6%, in 2010. The increase is due to a combination of rate and inpatient volume increases. The following is a summary of the District's gross revenue by payors:

Medicare	45%	45%	47%
Medicaid	8%	8%	7%
Other government	11%	11%	10%
Total government payors	64%	64%	64%
Commercial	29%	29%	30%
Private pay	7%	7%	6%
	100%	100%	100%

This results in a substantial increase in uncompensated care provided by the District in fiscal year 2010 as reflected below (amounts in thousands):

Charity care	$ 2,533	$ 1,812	$ 1,086
Bad debts	3,973	3,743	3,717
	$ 6,506	$ 5,555	$ 4,803

Statement of Revenues, Expenses, and Changes in Net Assets (continued)

Supplies increased by 8%, which is related largely to the increase in inpatient and surgery volumes in the past year. Insurance expense increased by 29% due to premium increase and tail insurance coverage for newly employed physicians, including OB/GYN.

The 2010 increase in net assets improved by $648,580 to $1,678,728 from $1,030,148 in 2009.

Statement of Cash Flows

The following is a summary of cash flow in 2010, 2009, and 2008 (amounts in thousands):

	2010	2009	2008
Net cash from operating activities	$ (3,492)	$ (867)	$ (988)
Net cash from noncapital financing activities	4,448	5,831	5,619
Net cash from capital financing activities	(1,103)	2,171	(4,772)
Net cash from investing activities	50	116	154
Net change in cash	$ (97)	$ 7,251	$ 13

Net cash from operating activities has decreased by $2,624,442 due to the increase in accounts receivable days.

Capital Assets

At the end of 2010, the District had $23,839,656 invested in capital assets, net of accumulated depreciation, as detailed in Note 6 to the financial statements. Approximately $759,000 in capital assets was added. Depreciation of $2,292,430 was expensed.

Long-Term Obligations

The District has long-term bond obligations, bank real estate loans, and capital leases outstanding, as detailed in Note 8 to the financial statements.

Contacting the Hospital's Financial Management

This financial report is designed to provide our patients, suppliers, taxpayers, and creditors with a general overview of the District's finances and to show the Hospital's accountability for the money it receives. If you have questions about this report or need additional financial information, contact the District's financial management at Whidbey General Hospital, 101 N. Main Street, Coupeville, Washington 98239.

WHIDBEY ISLAND PUBLIC HOSPITAL DISTRICT, ISLAND COUNTY, WASHINGTON
dba WHIDBEY GENERAL HOSPITAL
BALANCE SHEET
DECEMBER 31, 2010

ASSETS

	DECEMBER 31, 2010		
	Whidbey General Hospital	WGH Primary Care Associates	Total
CURRENT ASSETS			
Cash and cash equivalents	$ 5,814,887	$ 20,939	$ 5,835,826
Short-term investments	6,574,380		6,574,380
Patient accounts receivable, net of estimated uncollectibles of $3,552,000	8,871,933	200,806	9,072,739
Other accounts receivable	113,000	74,733	187,733
Assets limited as to use required for current liabilities	1,497,156		1,497,156
Supplies inventory	1,118,594		1,118,594
Prepaid expenses and other	911,347	33,763	945,110
Total current assets	24,901,297	330,241	25,231,538
CAPITAL ASSETS			
Land	4,194,220		4,194,220
Construction in progress	1,144,395		1,144,395
Depreciable capital assets, net of accumulated depreciation	18,394,331	106,710	18,501,041
Total capital assets, net of accumulated depreciation	23,732,946	106,710	23,839,656
DEFERRED FINANCING COSTS	195,063		195,063
Total assets	$ 48,829,306	$ 436,951	$ 49,266,257

WHIDBEY ISLAND PUBLIC HOSPITAL DISTRICT, ISLAND COUNTY, WASHINGTON
dba WHIDBEY GENERAL HOSPITAL
BALANCE SHEET
DECEMBER 31, 2010

LIABILITIES AND NET ASSETS

	DECEMBER 31, 2010		
	Whidbey General Hospital	WGH Primary Care Associates	Total
CURRENT LIABILITIES			
Accounts payable	$ 2,017,411	$ 62,276	$ 2,079,687
Accrued liabilities			
Compensation and benefits	4,701,382	70,270	4,771,652
Interest	38,986		38,986
Estimated third-party payor settlements	2,107,886		2,107,886
Current portion of long-term obligations	2,623,482		2,623,482
Total current liabilities	11,489,147	132,546	11,621,693
LONG-TERM OBLIGATIONS, net of current portion	8,444,301		8,444,301
ESTIMATED MEDICAL MALPRACTICE COSTS	183,238		183,238
Total liabilities	20,116,686	132,546	20,249,232
NET ASSETS			
Invested in capital assets net of related debt	12,665,163	106,710	12,771,873
Restricted expendable for debt service	1,081,680		1,081,680
Unrestricted net assets	14,965,777	197,695	15,163,472
Total net assets	28,712,620	304,405	29,017,025
Total liabilities and net assets	$ 48,829,306	$ 436,951	$ 49,266,257

See accompanying notes.

WHIDBEY ISLAND PUBLIC HOSPITAL DISTRICT, ISLAND COUNTY, WASHINGTON
dba WHIDBEY GENERAL HOSPITAL
BALANCE SHEET
DECEMBER 31, 2009

ASSETS

	DECEMBER 31, 2009		
	Whidbey General Hospital	WGH Primary Care Associates	Total
CURRENT ASSETS			
Cash and cash equivalents	$ 5,862,428	$ 74,253	$ 5,936,681
Short-term investments	6,525,203		6,525,203
Patient accounts receivable, net of estimated uncollectibles of $3,062,000	6,684,157	362,096	7,046,253
Other accounts receivable	120,000	74,733	194,733
Assets limited as to use required for current liabilities	1,314,086		1,314,086
Supplies inventory	979,648		979,648
Prepaid expenses and other	859,115	63,148	922,263
Total current assets	22,344,637	574,230	22,918,867
CAPITAL ASSETS			
Land	4,194,220		4,194,220
Construction in progress	1,140,520		1,140,520
Depreciable capital assets, net of accumulated depreciation	19,930,157	108,591	20,038,748
Total capital assets, net of accumulated depreciation	25,264,897	108,591	25,373,488
DEFERRED FINANCING COSTS	207,275		207,275
Total assets	$ 47,816,809	$ 682,821	$ 48,499,630

WHIDBEY ISLAND PUBLIC HOSPITAL DISTRICT, ISLAND COUNTY, WASHINGTON
dba WHIDBEY GENERAL HOSPITAL
BALANCE SHEET
DECEMBER 31, 2009

LIABILITIES AND NET ASSETS

	DECEMBER 31, 2009		
	Whidbey General Hospital	WGH Primary Care Associates	Total
CURRENT LIABILITIES			
Accounts payable	$ 1,658,654	$ 51,868	$ 1,710,522
Accrued liabilities			
Compensation and benefits	4,134,723	88,955	4,223,678
Interest	46,277		46,277
Estimated third-party payor settlements	1,424,785		1,424,785
Current portion of long-term obligations	2,529,199		2,529,199
Total current liabilities	9,793,638	140,823	9,934,461
LONG-TERM OBLIGATIONS, net of current portion	11,067,439		11,067,439
ESTIMATED MEDICAL MALPRACTICE COSTS	159,433		159,433
Total liabilities	21,020,510	140,823	21,161,333
NET ASSETS			
Invested in capital assets net of related debt	11,668,259	108,591	11,776,850
Restricted expendable for debt service	1,073,762		1,073,762
Unrestricted net assets	14,054,278	433,407	14,487,685
Total net assets	26,796,299	541,998	27,338,297
Total liabilities and net assets	$ 47,816,809	$ 682,821	$ 48,499,630

See accompanying notes.

WHIDBEY ISLAND PUBLIC HOSPITAL DISTRICT, ISLAND COUNTY, WASHINGTON
dba WHIDBEY GENERAL HOSPITAL
STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET ASSETS
YEAR ENDED DECEMBER 31, 2010

	YEAR ENDED DECEMBER 31, 2010		
	Whidbey General Hospital	WGH Primary Care Associates	Total
OPERATING REVENUES			
Net patient service revenue, net of provision for bad debts of $3,973,374	$ 70,644,480	$ 4,546,631	$ 75,191,111
Tax levies for maintenance and operations	461,998		461,998
Tax levies for emergency medical services	4,159,424		4,159,424
Cafeteria and other	877,095		877,095
Total operating revenues	76,142,997	4,546,631	80,689,628
OPERATING EXPENSES			
Salaries and wages	37,461,005	1,634,900	39,095,905
Employee benefits	8,262,418	231,330	8,493,748
Professional fees	6,253,801		6,253,801
Supplies	9,744,906	116,013	9,860,919
Purchased services, utilities	1,413,855		1,413,855
Purchased services, other	7,176,404	3,151,493	10,327,897
Insurance	752,962	87,154	840,116
Rent	265,085	346,559	611,644
Other	1,860,832	244,521	2,105,353
Depreciation and amortization	2,290,549	1,881	2,292,430
Interest expense	114,526		114,526
Total operating expenses	75,596,343	5,813,851	81,410,194
Operating income (loss)	546,654	(1,267,220)	(720,566)
NONOPERATING INCOME (EXPENSE)			
Tax levies for bonds	2,669,616		2,669,616
Interest income	101,041	2	101,043
Interest expense	(577,867)		(577,867)
Other	(34,265)		(34,265)
Nonoperating income, net	2,158,525	2	2,158,527
Excess (deficiency) of revenues over expenses before capital contributions	2,705,179	(1,267,218)	1,437,961
CAPITAL CONTRIBUTIONS	240,767		240,767
NET ASSET TRANSFERS	(1,029,625)	1,029,625	
INCREASE IN NET ASSETS	1,916,321	(237,593)	1,678,728
NET ASSETS, beginning of year	26,796,299	541,998	27,338,297
NET ASSETS, end of year	$ 28,712,620	$ 304,405	$ 29,017,025

See accompanying notes.

WHIDBEY ISLAND PUBLIC HOSPITAL DISTRICT, ISLAND COUNTY, WASHINGTON
dba WHIDBEY GENERAL HOSPITAL
STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET ASSETS
YEAR ENDED DECEMBER 31, 2009

	YEAR ENDED DECEMBER 31, 2009		
	Whidbey General Hospital	WGH Primary Care Associates	Total
OPERATING REVENUES			
Net patient service revenue, net of provision for bad debts of $3,743,171	$ 64,968,208	$ 4,499,567	$ 69,467,775
Tax levies for maintenance and operations	795,774		795,774
Tax levies for emergency medical services	5,101,317		5,101,317
Cafeteria and other	991,946		991,946
Total operating revenues	71,857,245	4,499,567	76,356,812
OPERATING EXPENSES			
Salaries and wages	34,421,915	1,769,045	36,190,960
Employee benefits	7,716,680	329,170	8,045,850
Professional fees	6,606,095		6,606,095
Supplies	9,141,192		9,141,192
Purchased services, utilities	1,359,677		1,359,677
Purchased services, other	6,089,911	3,029,575	9,119,486
Insurance	558,004	92,029	650,033
Rent	542,461	234,524	776,985
Other	1,629,179	155,331	1,784,510
Depreciation and amortization	2,070,844	1,881	2,072,725
Interest expense	126,733		126,733
Total operating expenses	70,262,691	5,611,555	75,874,246
Operating income (loss)	1,594,554	(1,111,988)	482,566
NONOPERATING INCOME (EXPENSE)			
Tax levies for bonds	1,467,238		1,467,238
Interest income	121,044	12	121,056
Interest expense	(376,408)		(376,408)
Other	(871,732)		(871,732)
Nonoperating income, net	340,142	12	340,154
Excess (deficiency) of revenues over expenses before capital contributions	1,934,696	(1,111,976)	822,720
CAPITAL CONTRIBUTIONS	207,428		207,428
NET ASSET TRANSFERS	(1,162,985)	1,162,985	
INCREASE IN NET ASSETS	979,139	51,009	1,030,148
NET ASSETS, beginning of year	25,817,160	490,989	26,308,149
NET ASSETS, end of year	$ 26,796,299	$ 541,998	$ 27,338,297

See accompanying notes.

WHIDBEY ISLAND PUBLIC HOSPITAL DISTRICT, ISLAND COUNTY, WASHINGTON
dba WHIDBEY GENERAL HOSPITAL
STATEMENT OF CASH FLOWS
YEAR ENDED DECEMBER 31, 2010

Increase (Decrease) in Cash

	YEAR ENDED DECEMBER 31, 2010		
	Whidbey General Hospital	WGH Primary Care Associates	Total
CASH FLOWS FROM OPERATING ACTIVITIES			
Receipts from and on behalf of patients	$ 69,139,805	$ 4,707,921	$ 73,847,726
Payments to suppliers and contractors	(27,276,461)	(3,905,947)	(31,182,408)
Payments to employees and vendors	(45,156,764)	(1,884,915)	(47,041,679)
Other receipts and payments, net	884,095		884,095
Net cash from operating activities	(2,409,325)	(1,082,941)	(3,492,266)
CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES			
Tax levies considered noncapital financing activity	4,447,657		4,447,657
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES			
Tax levies for repayment of long-term obligations	2,665,363		2,665,363
Repayment of long-term obligations	(2,529,624)		(2,529,624)
Interest payments	(686,703)		(686,703)
Purchase of buildings and equipment	(758,598)		(758,598)
Cash received from contributions	240,767		240,767
Other	(34,265)		(34,265)
Net cash from capital and related financing activities	(1,103,060)		(1,103,060)
CASH FLOWS FROM INVESTING ACTIVITIES			
Purchase of investments, net	(49,177)		(49,177)
Interest received	101,041	2	101,043
Net change in assets limited as to use	(1,387)		(1,387)
Cash transfers	(1,029,625)	1,029,625	
Net cash from investing activities	(979,148)	1,029,627	50,479
NET CHANGE IN CASH	(43,876)	(53,314)	(97,190)
CASH, beginning of year	6,889,455	74,253	6,963,708
CASH, end of year	$ 6,845,579	$ 20,939	$ 6,866,518
RECONCILIATION OF CASH TO THE BALANCE SHEET			
Cash and cash equivalents	$ 5,814,887	$ 20,939	$ 5,835,826
Cash in assets whose use is limited	1,030,692		1,030,692
	$ 6,845,579	$ 20,939	$ 6,866,518

WHIDBEY ISLAND PUBLIC HOSPITAL DISTRICT, ISLAND COUNTY, WASHINGTON
dba WHIDBEY GENERAL HOSPITAL
STATEMENT OF CASH FLOWS
YEAR ENDED DECEMBER 31, 2010

Increase (Decrease) in Cash

	YEAR ENDED DECEMBER 31, 2010		
	Whidbey General Hospital	WGH Primary Care Associates	Total
RECONCILIATION OF OPERATING INCOME (LOSS) TO NET CASH FROM OPERATING ACTIVITIES			
Operating income (loss)	$ 546,654	$ (1,267,220)	$ (720,566)
Revenue from tax levies considered noncapital financing activity	(4,621,422)		(4,621,422)
Interest expense considered capital financing activity	114,526		114,526
Noncash expenses included in operating income			
Depreciation and amortization	2,290,549	1,881	2,292,430
Provision for bad debts	3,963,374	10,000	3,973,374
Changes in assets and liabilities			
Accounts receivable	(6,144,150)	151,290	(5,992,860)
Supplies inventory, prepaid expenses, and other	(191,178)	29,385	(161,793)
Accounts payable	358,757	10,408	369,165
Accrued compensation and benefits	566,659	(18,685)	547,974
Estimated third-party payor settlements	683,101		683,101
Estimated medical malpractice costs	23,805		23,805
Net cash from operating activities	$ (2,409,325)	$ (1,082,941)	$ (3,492,266)

WHIDBEY ISLAND PUBLIC HOSPITAL DISTRICT, ISLAND COUNTY, WASHINGTON
dba WHIDBEY GENERAL HOSPITAL
STATEMENT OF CASH FLOWS
YEAR ENDED DECEMBER 31, 2009

Increase (Decrease) in Cash

	YEAR ENDED DECEMBER 31, 2009		
	Whidbey General Hospital	WGH Primary Care Associates	Total
CASH FLOWS FROM OPERATING ACTIVITIES			
Receipts from and on behalf of patients	$ 67,465,309	$ 4,384,252	$ 71,849,561
Payments to suppliers and contractors	(26,389,840)	(3,413,620)	(29,803,460)
Payments to employees and vendors	(41,800,030)	(2,084,953)	(43,884,983)
Other receipts and payments, net	971,059		971,059
Net cash from operating activities	246,498	(1,114,321)	(867,823)
CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES			
Tax levies considered noncapital financing activity	5,831,279		5,831,279
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES			
Tax levies for repayment of long-term obligations	1,455,258		1,455,258
Repayment of long-term obligations	(1,632,505)		(1,632,505)
Proceeds from issuance of bonds, net of discount	9,704,466		9,704,466
Cash paid for bond issuance	(199,075)		(199,075)
Interest payments	(466,858)		(466,858)
Purchase of buildings and equipment	(5,915,053)	(110,472)	(6,025,525)
Cash received from contributions	207,428		207,428
Other	(871,732)		(871,732)
Net cash from capital and related financing activities	2,281,929	(110,472)	2,171,457
CASH FLOWS FROM INVESTING ACTIVITIES			
Purchase of investments, net	(6,525,203)		
Interest received	121,044	12	121,056
Net change in assets limited as to use	(4,900)		(4,900)
Cash transfers	(1,162,985)	1,162,985	
Net cash from investing activities	(7,572,044)	1,162,997	116,156
NET CHANGE IN CASH	787,662	(61,796)	7,251,069
CASH, beginning of year	6,101,793	136,049	6,237,842
CASH, end of year	$ 6,889,455	$ 74,253	$ 13,488,911
RECONCILIATION OF CASH TO THE BALANCE SHEET			
Cash and cash equivalents	$ 5,862,428	$ 74,253	$ 5,936,681
Cash in assets whose use is limited	1,027,027		1,027,027
	$ 6,889,455	$ 74,253	$ 6,963,708

WHIDBEY ISLAND PUBLIC HOSPITAL DISTRICT, ISLAND COUNTY, WASHINGTON
dba WHIDBEY GENERAL HOSPITAL
STATEMENT OF CASH FLOWS
YEAR ENDED DECEMBER 31, 2009

Increase (Decrease) in Cash

	YEAR ENDED DECEMBER 31, 2009		
	Whidbey General Hospital	WGH Primary Care Associates	Total
RECONCILIATION OF OPERATING INCOME (LOSS) TO NET CASH FROM OPERATING ACTIVITIES			
Operating income (loss)	$ 1,594,554	$ (1,111,988)	$ 482,566
Revenue from tax levies considered noncapital financing activity	(5,897,091)		(5,897,091)
Interest expense considered capital financing activity	126,733		126,733
Noncash expenses included in operating income			
Depreciation and amortization	2,070,844	1,881	2,072,725
Provision for bad debts	3,672,552	70,619	3,743,171
Changes in assets and liabilities			
Accounts receivable	(2,535,256)	(185,934)	(2,721,190)
Supplies inventory, prepaid expenses, and other	(232,060)	106,545	(125,515)
Accounts payable	(120,846)	14,928	(105,918)
Accrued compensation and benefits	338,565	(10,372)	328,193
Estimated third-party payor settlements	1,338,918		1,338,918
Estimated medical malpractice costs	(110,415)		(110,415)
Net cash from operating activities	$ 246,498	$ (1,114,321)	$ (867,823)
SUPPLEMENTAL DISCLOSURES OF NONCASH TRANSACTIONS			
Capital assets financed with capital lease obligations	$ 161,038		$ 161,038

Note 1 - Organization

Whidbey Island Public Hospital District, Island County, Washington (the District), serving the residents of Whidbey Island, Washington, is organized as a municipal corporation pursuant to the laws of the state of Washington. The primary purpose of the District is to operate Whidbey General Hospital (the Hospital), which maintained 51 licensed beds through 2005. The Hospital converted to critical access hospital status under the Medicare program on December 31, 2005, at which time the number of beds in service dropped to 25. The District also operates several clinics and provides home health services and emergency medical services on Whidbey Island. The majority of the Hospital's patients are geographically concentrated on Whidbey Island.

On January 1, 2008, the District formed WGH Primary Care Associates, P.S. (PCA), a nonprofit professional service corporation formed under the laws of Washington State. PCA is a multi-provider primary care practice providing related medical services on Whidbey Island, Washington. The District is the sole member of PCA.

Note 2 - Summary of Significant Accounting Policies

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

Accrual basis - The accompanying financial statements have been prepared on the accrual basis of accounting using the economic resources measurement focus. Under this method of accounting, revenues are recognized when earned and expenses are recorded when liabilities are incurred without regard to receipt or disbursement of cash.

Financial statement presentation - PCA has been presented in the accompanying financial statements as a discretely presented component unit in accordance with GASB Statement No. 14, *The Financial Reporting Entity*.

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

Cash and cash equivalents - The District defines cash and cash equivalents to include demand and interest-bearing deposits, investments with an initial maturity of three months or less, and highly liquid deposits with a local government investment pool.

Note 2 - Summary of Significant Accounting Policies (continued)

Short-term investments - Short-term investments consist of certificates of deposits at banks and have original maturities greater than three months but less than one year. Short-term investments are measured at fair value in the financial statements.

Patient accounts receivable - Receivables arising from revenue for services to patients are reduced by an allowance for estimated uncollectible accounts based on past experience and other circumstances, which may affect the ability of patients to meet their obligations. Accounts deemed uncollectible are charged against this allowance.

Supplies inventory - Inventories of medicine, dietary, and hospital supplies are valued at the lower of cost, computed on the first-in, first-out basis, or net realizable value.

Assets limited as to use - Assets limited as to use include assets set aside by the District for future capital improvements, other uses over which the District retains control, and funds restricted for construction or bond debt service. Excess cash is invested in certificates of deposit or a local government investment pool. Cash and pooled investments are covered by the Federal Deposit Insurance Corporation or by collateral held in a multiple financial institution collateral pool administered by the Washington Public Deposit Protection Commission. Investments held as assets limited as to use are recorded at fair market value.

Capital assets - Capital asset acquisitions are recorded at cost. Donated assets are recorded at fair market value at the date of contribution, which is thereafter treated as cost. Expenditures for maintenance and repairs are charged to operations as incurred. Betterments and major renewals are capitalized. Depreciation is provided over the estimated useful lives of the assets on the straight-line method as follows:

Buildings	10 - 40 years
Fixed equipment	10 - 20 years
Movable equipment	3 - 20 years

Expenditures for maintenance and repairs are charged to operations as incurred. Betterments and major renewals are capitalized. Expenditures that materially increase value, change capacities, or extend useful lives of buildings and equipment are capitalized. The District's capitalization policy is $5,000 and a useful life of three years or greater.

Deferred financing costs - Costs incurred in financing are deferred and amortized over the period the obligation is outstanding using the effective interest method.

Estimated malpractice costs - The District has purchased claims-made liability insurance coverage, which covers only asserted malpractice claims. The District recognizes expenses associated with reported claims and estimated claims incurred, but not reported, in the period in which the incidents are estimated to have occurred, rather than when a claim is asserted. Expenses associated with these incidents are based on estimated settlement costs.

Note 2 - Summary of Significant Accounting Policies (continued)

Net assets - Net assets of the District are classified in three components. *Net assets invested in capital assets net of related debt* consist of capital assets net of accumulated depreciation and reduced by the current balances of any outstanding borrowings used to finance the purchase or construction of those assets. *Restricted expendable net assets* are noncapital net assets that must be used for a particular purpose, as specified by creditors, grantors, or contributors external to the District, including amounts deposited with the County Treasurer as required by bond indentures. *Unrestricted net assets* are remaining net assets that do not meet the definition of *invested in capital assets net of related debt* or *restricted expendable.*

Operating revenues and expenses - The District's statement of revenues, expenses, and changes in net assets distinguishes between operating and nonoperating revenues and expenses. Operating revenues result from exchange transactions associated with providing health care services—the District's principal activity. Nonexchange revenues, including grants and contributions received for purposes other than capital asset acquisition or taxes for uses other than repayment of long-term debt, are reported as other operating revenues. Operating expenses are all expenses incurred to provide health care services, other than financing costs paid by specific tax proceeds.

Net patient service revenue - Patient service revenue is recorded at established rates. Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered. Preliminary settlements under reimbursement agreements with third-party payors are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined.

Reimbursement received from certain third-party payors is subject to audit and retroactive adjustment. Provision for possible adjustment as a result of audits is recorded in the financial statements. When reimbursement settlements are received, or when information becomes available with respect to reimbursement changes, any variations from amounts previously accrued are accounted for in the period in which the settlements are received or the change in information becomes available.

Tax revenue for maintenance and operations and emergency medical services - Property taxes are levied by the County on the District's behalf and are intended to finance the District's activities of the same calendar year. Amounts levied are based on assessed property values.

Charity care - The District provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Because the District does not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue. Forgone revenue for charity care provided during 2010 and 2009, measured by the District's standard charges, was $2,533,151 and $1,811,849, respectively.

Note 2 - Summary of Significant Accounting Policies (continued)

Federal income tax - The District is a municipal corporation and is exempt from federal income tax. Accordingly, no provision for taxes has been made.

Reclassifications - Certain reclassifications have been made to the 2009 amounts to conform to the 2010 presentation.

Subsequent events - Subsequent events are events or transactions that occur after the balance sheet date but before financial statements are available to be issued. The District recognizes in the financial statements the effects of all subsequent events that provide additional evidence about conditions that existed at the date of the balance sheet, including the estimates inherent in the process of preparing the financial statements. The District's financial statements do not recognize subsequent events that provide evidence about conditions that did not exist at the date of the balance sheet but arose after the balance sheet date and before the financial statements are available to be issued. Note 15 provides disclosure of certain subsequent events that did not result in recognition in the financial statements.

The District has evaluated subsequent events through May 23, 2011, which is the date the financial statements are available to be issued.

Note 3 - Patient Service Revenue

The following are the components of net patient service revenue for the years ended December 31:

	2010	2009
Gross patient service charges	$ 164,951,929	$ 152,035,787
Adjustments to patient service charges		
Contractual discounts	83,254,293	77,012,992
Provision for bad debts	3,973,374	3,743,171
Charity care	2,533,151	1,811,849
	89,760,818	82,568,012
Net patient service revenue	$ 75,191,111	$ 69,467,775

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

Note 3 - Patient Service Revenue (continued)

Medicare - The Hospital converted to critical access hospital status under the Medicare program on December 31, 2005, under which inpatient, swing-bed, and outpatient services are reimbursed on a cost basis. Inpatient acute, swing-bed, and outpatient care services rendered to Medicare program beneficiaries are paid on an interim basis at a tentative rate with final settlement determined after submission of annual cost reports by the Hospital and audits thereof by the Medicare fiscal intermediary. These interim payments will be subject to final settlement upon submission and audit of the cost report to the Medicare fiscal intermediary.

The Hospital's Medicare cost reports have been audited by the Medicare fiscal intermediary through 2007. The Hospital's classification of patients under the Medicare program and the appropriateness of their admission are subject to an independent review by a peer review organization. Reimbursement received from Medicare is subject to audit and retroactive adjustment.

Net revenue under the Medicare program totaled $32,167,000 and $26,176,000 for 2010 and 2009, respectively. Net unsecured patient accounts receivable due from Medicare were $248,000 and $1,872,000 at December 31, 2010 and 2009, respectively.

Medicaid - As a critical access hospital, inpatient and outpatient services rendered to Medicaid program beneficiaries are reimbursed on a cost reimbursement methodology. Under this methodology, the Hospital is reimbursed at a tentative rate with final settlement determined after audits by the Medicare fiscal intermediary of annual cost reports submitted by the Hospital.

Net revenue under the Medicaid program totaled $6,718,000 and $3,789,000 for 2010 and 2009, respectively. Net unsecured patient accounts receivable due from Medicaid were $657,000 and $378,000 at December 31, 2010 and 2009, respectively.

Other third-party payor arrangements - The District has entered into payment agreements with certain commercial insurance companies. Payment under these agreements includes prospectively determined rates and discounts from standard charges.

Patient accounts receivable, including amounts due from third-party payors, are unsecured and arise from services provided to individuals geographically concentrated on Whidbey Island.

Note 4 - Deposits and Investments

	2010	2009
Cash and cash equivalents		
Deposits in banks	$ 5,835,826	$ 5,936,681
Short-term investments		
Deposits in banks	$ 6,574,380	$ 6,525,203
Assets limited as to use		
Bond fund		
Deposits in banks	$ 1,030,692	$ 1,027,027
Taxes receivable	50,988	46,735
Taxes receivable	381,265	207,500
Trust accounts	34,211	32,824
	$ 1,497,156	$ 1,314,086

The District makes investments in accordance with Washington State law. Eligible investments include obligations secured by the U.S. Treasury, other obligations of the United States or its agencies, certificates of deposit with approved institutions, eligible bankers' acceptances, and repurchase agreements (up to 30 days).

As a political subdivision of the State, deposits and investments are categorized to give an indication of the risk assumed at year-end. Category 1 includes deposits and investments that are insured, registered, or held in the District's name. Category 2 includes uninsured and unregistered investments that are held by a broker's or dealer's trust department or agent in the District's name. Category 3 includes uninsured and unregistered deposits and investments for which the securities are held by the broker or dealer, or its trust department or agent, but not in the District's name. At December 31, 2010 and 2009, all deposits and investments of the District are categorized as Category 1.

At times, the District participates in the Washington State Local Government Investment Pool (LGIP). The Office of the State Treasurer of Washington (OST) manages and operates the LGIP. Participation by local governments is voluntary. The investment policies of the LGIP are the responsibility of the OST, and any proposed changes are reviewed by the LGIP Advisory Committee. The LGIP is comparable to a Rule 2a-7 money market fund recognized by the Securities and Exchange Commission (17 CFR 270.2a-7). Rule 2a-7 funds are limited to high-quality obligations with limited maximum and average maturities, the effect of which is to minimize both market and credit risk. The objectives of the State Treasurer's investment practices for the LGIP, in priority order, will be safety, liquidity, and return on investment. Separate financial statements for the LGIP are available from the OST. The LGIP is not subject to risk evaluation.

Note 4 - Deposits and Investments (continued)

Credit risk - Credit risk is the risk that an issuer or other counterparty to an investment will not fulfill its obligations. The District's investment policy limits the types of securities to those authorized by statute, and, therefore, credit risk is very limited.

Deposits - All of the District's deposits are either insured or collateralized. The District's insured deposits are covered by the Federal Deposit Insurance Corporation. Collateral protection is provided by the Washington Public Deposit Protection Commission.

Custodial credit risk - Custodial credit risk is the risk that, in the event of a failure of the counterparty, the District will not be able to recover the value of the investment or collateral securities that are in the possession of an outside party. The District is not exposed to custodial credit risk.

Concentration of credit risk - Concentration of credit risk is the risk of loss attributed to the magnitude of the District's investment in a single issuer. The District is not exposed to concentration of credit risk because all deposits and investments are insured or collateralized.

Interest rate risk - Interest rate risk is the risk that changes in interest rates of debt instruments will adversely affect the fair value of an investment. The District is not exposed to interest rate risk because all deposits and investments are extremely liquid.

Note 5 - Property Taxes

The County Treasurer acts as an agent to collect property taxes levied in the County for all taxing authorities. Taxes are levied annually, on January 1, on property values listed as of the prior May 31. Assessed values are established by the County Assessor at 100% of the fair market value. A revaluation of all property is required every four years. Taxes are due in two equal installments on April 30 and October 31. Collections are distributed monthly to the District by the County Treasurer.

The District is permitted by law to levy up to $0.75 per $1,000 of assessed valuation for general District purposes. The Washington State Constitution and Washington State law, RCW 84.55.010, limit the rate. The District may also levy taxes at a lower rate. Further amounts of tax need to be authorized by the vote of the people.

Note 5 - Property Taxes (continued)

For 2010 and 2009, the District's regular tax levy was $0.08, per $1,000 on a total assessed valuation of $10,926,216,700 and $11,131,635,262, respectively, for a total regular levy of $868,265 and $902,459, respectively. Of these amounts, $406,267 and $106,685 was pledged and used for payments on limited tax general obligation bonds for 2010 and 2009, respectively. There is a voter-approved tax levy for service of the unlimited tax general obligation bonds. For 2010 and 2009, the tax levy for bond service was $0.12 per $1,000 on a total assessed valuation for a total bond levy of $1,306,353 and $1,327,631, respectively. There is a voter-approved tax levy for emergency medical services (EMS). For 2010 and 2009, the District's EMS tax levy was $0.47 and $0.46, respectively, per $1,000 for a total EMS levy of $5,116,420 and $5,134,239, respectively. Of these amounts, $956,996 and $32,922 was pledged and used for payments on limited tax general obligation bonds.

Note 6 - Capital Assets

The schedule of capital asset activity for the years ended December 31, 2010 and 2009, was as follows:

	Beginning Balance January 1, 2010	Additions	Retirements	Account Transfers	Ending Balance December 31, 2010
NONDEPRECIABLE CAPITAL ASSETS					
Land	$ 4,194,220		$ -	$ -	$ 4,194,220
Construction in progress	1,140,520	$ 3,875			1,144,395
Total nondepreciable capital assets	5,334,740	3,875			5,338,615
DEPRECIABLE CAPITAL ASSETS					
Land improvements	1,314,511				1,314,511
Buildings	21,468,889	21,363			21,490,252
Fixed equipment	6,469,946	14,190			6,484,136
Movable equipment	20,427,675	719,170			21,146,845
LESS ACCUMULATED DEPRECIATION					
Land improvements	(661,695)	(61,212)			(722,907)
Buildings	(7,027,093)	(757,419)			(7,784,512)
Fixed equipment	(5,298,601)	(338,365)			(5,636,966)
Movable equipment	(16,654,884)	(1,135,434)			(17,790,318)
Depreciable capital assets, net	20,038,748	(1,537,707)			18,501,041
	$ 25,373,488	$ (1,533,832)	$ -	$ -	$ 23,839,656

Note 6 - Capital Assets (continued)

	Beginning Balance January 1, 2009	Additions	Retirements	Account Transfers	Ending Balance December 31, 2009
NONDEPRECIABLE CAPITAL ASSETS					
Land	$ 3,481,198	$ 713,022	$ -		$ 4,194,220
Construction in progress	1,500,197	1,722,590		$ (2,082,267)	1,140,520
Total nondepreciable capital assets	4,981,395	2,435,612		(2,082,267)	5,334,740
DEPRECIABLE CAPITAL ASSETS					
Land improvements	1,001,016			313,495	1,314,511
Buildings	16,846,086	2,854,031		1,768,772	21,468,889
Fixed equipment	6,348,570	121,376			6,469,946
Movable equipment	19,652,131	775,544			20,427,675
LESS ACCUMULATED DEPRECIATION					
Land improvements	(616,298)	(45,397)			(661,695)
Buildings	(6,501,868)	(525,225)			(7,027,093)
Fixed equipment	(4,959,848)	(338,753)			(5,298,601)
Movable equipment	(15,491,534)	(1,163,350)			(16,654,884)
Depreciable capital assets, net	16,278,255	1,678,226		2,082,267	20,038,748
	$ 21,259,650	$ 4,113,838	$ -	$ -	$ 25,373,488

Depreciation expense totaled $1,853,785 in 2010 and $1,501,294 in 2009.

Equipment under capital lease is included in movable equipment, above, at a total cost of $2,097,580 at December 31, 2010, and $2,415,516 at December 31, 2009, with accumulated amortization of $1,670,947 and $1,550,238 at December 31, 2010 and 2009, respectively. Amortization expense for this equipment was $438,645 in 2010 and $571,431 in 2009. Depreciation and amortization expense totaled $2,292,430 in 2010 and $2,072,725 in 2009.

Note 7 - Line of Credit

The Hospital had a line of credit with a bank for $3,000,000, which expired in March 2009. There were no borrowings against the line during 2009.

Note 8 - Long-Term Obligations

	2010	2009
Limited tax general obligation bonds, 2009, 3.00% to 5.625%, due serially on December 1, in amounts from $975,000 in 2011 to $565,000 in 2034, including bond discount of $80,687 in 2010 and $84,109 in 2009.	$ 8,779,835	$ 9,705,891
Unlimited tax general obligation bonds, 2000, 5.25%, due serially on December 1, in the amount of $1,190,000 in 2011, including bond premium of $0 in 2010 and $2,653 in 2009.	1,190,000	2,327,653
Notes payable to a bank in monthly installments of $2,837, including interest at the bank's 5-year long-term fixed rate plus 3.05% (7.75% at December 31, 2010) through July 2028. Collateralized by property.	327,603	336,068
Note payable to a bank in monthly installments of $999, including interest at the bank's 5-year long-term fixed rate plus 1.70% (6.40% at December 31, 2010) through July 2018. Collateralized by property.	73,170	80,446
Note payable to a bank in monthly installments of $5,672, including interest at 7.50% through February 2015. Collateralized by property.	231,067	279,804
Obligations under capital lease, stated at present value of future minimum lease payments.	466,380	866,776
	11,068,055	13,596,638
Less current portion	2,623,482	2,529,199
Long-term portion	$ 8,444,573	$ 11,067,439

Note 8 - Long-Term Obligations (continued)

A schedule of changes in the District's long-term obligations, net of any discounts or premiums, for the years ended December 31, 2010 and 2009, follows:

	Beginning Balance January 1, 2010	Additions	Reductions	Ending Balance December 31, 2010	Amounts Due Within One Year
Unlimited tax general obligation bonds 2000 series	$ 2,327,653	$ -	$ 1,137,653	$ 1,190,000	$ 1,190,000
Limited tax general obligation bonds 2009 series	9,705,891		845,891	8,779,563	975,000
Notes payable to a bank					
Land	336,068		8,465	327,603	9,072
Building	80,446		7,276	73,170	7,610
Land and building	279,804		48,737	231,067	52,560
Obligations under capital lease	866,776		400,396	466,380	389,240
Total long-term obligations	13,596,638		2,448,418	11,067,783	2,623,482
Estimated medical malpractice costs	159,433	23,805		183,238	
Total noncurrent liabilities	$ 13,756,071	$ 23,805	$ 2,448,418	$ 11,251,021	$ 2,623,482

Note 8 - Long-Term Obligations (continued)

	Beginning Balance January 1, 2009	Additions	Reductions	Ending Balance December 31, 2009	Amounts Due Within One Year
Unlimited tax general obligation bonds					
1993 series	$ 630,000		$ 630,000		
2000 series	2,776,745		449,092	$ 2,327,653	$ 1,135,000
Limited tax general obligation bonds					
2009 series		$ 9,704,466	(1,425)	9,705,891	930,000
Notes payable to a bank					
Land	343,997		7,929	336,068	8,397
Building	87,290		6,844	80,446	7,139
Land and building	325,027		45,223	279,804	48,773
Obligations under capital lease	1,203,247	161,038	497,509	866,776	399,890
Total long-term obligations	5,366,306	9,865,504	1,635,172	13,596,638	2,529,199
Estimated medical malpractice costs	269,848		110,415	159,433	
Total noncurrent liabilities	$ 5,636,154	$ 9,865,504	$ 1,745,587	$ 13,756,071	$ 2,529,199

Scheduled principal and interest repayments on bonds and notes payable are as follows:

	Principal	Interest
2011	$ 2,234,242	$ 512,706
2012	1,174,552	415,672
2013	225,270	376,952
2014	226,447	366,443
2015	187,179	357,548
2016-2020	1,103,258	1,658,461
2021-2025	1,490,301	1,360,164
2026-2030	1,990,760	907,148
2031-2034	2,050,081	297,563
	10,682,090	$ 6,252,657
Plus amounts representing net unamortized bond discount	(80,687)	
Bonds and notes payable	$ 10,601,403	

Note 8 - Long-Term Obligations (continued)

The District has pledged to levy taxes and set aside net revenue of the Hospital, if necessary, sufficient to make principal and interest payments on all bonds. Further, the bond fund (Note 4) collateralizes these obligations.

The Hospital acquired certain equipment under capital leases. Monthly payments total $53,375 and include interest at implicit rates ranging from 3.85% to 9.00% per annum. The leases are collateralized by the related equipment. Future minimum lease payments and the present value of net minimum lease payments are as follows:

	AMOUNT
2011	$ 401,504
2012	63,963
2013	14,706
Total minimum lease payments	480,173
Less amount representing interest	13,793
Present value of minimum lease payments	466,380
Less current portion	389,240
Long-term portion of capital leases	$ 77,140

Note 9 - Employee Benefit Plans

The District has a deferred compensation plan created in accordance with Internal Revenue Code Section 457. The plan is available to eligible employees and permits them to defer a portion of their salary until withdrawn in future years. The District contributes a percentage of certain employees' salaries through the 401(a) pension plan if certain criteria are met as discussed below. The deferred compensation is not available to employees until termination, retirement, death, or unforeseeable emergency. The District fully funds all compensation deferred under the plan agreement through deposits with an insurance company.

The District provides a 401(a) pension plan for all employees with at least one and one-half years of service and who contribute at least 5% of their salaries to the deferred compensation plan mentioned above. The District contributes 6% of employees' salaries from the prior calendar year, plus .1% of such pay, times years of service after joining the plan, up to a maximum of 6.5%. It is the District's policy to currently fund pension costs accrued.

Note 9 - Employee Benefit Plans (continued)

Plan provisions and contribution requirements are established by the District, and may be amended by the District's Board of Commissioners. The District's contributions to the employee benefit plans totaled $1,531,000 in 2010 and $1,396,000 in 2009. Contributions made by employees to the benefit plans totaled approximately $2,673,000 in 2010 and $2,552,000 in 2009. For more information on the plans, contact the District's human resources office.

Note 10 - Related Party Transactions

One of the individuals who sits on the Board of Commissioners contracts with Whidbey Island Medical Services Council to provide medical control for the District's emergency medical services program. This individual receives $1,500 per month for education and training, as well as a contracted service fee. Payments under these agreements totaled $85,500 for 2010 and 2009.

PCA contracts for management services to be provided by Whidbey Community Physicians, P.S. (WCP), which is partially owned by three of the physicians that PCA employs. Expense recorded under this agreement for the year ended December 31, 2010 and 2009, was $3,151,599 and $3,029,575, respectively.

Note 11 - Commitments and Contingencies

Operating leases - The District and PCA lease certain facilities and equipment under operating lease arrangements. The following is a schedule by year of future minimum lease payments as of December 31, 2010:

	AMOUNT
2011	$ 493,000
2012	439,000
2013	388,000
2014	385,000
2015	388,000
2016-2018	1,119,000
Total minimum lease payments	$ 3,212,000

Rent expense on operating leases for 2010 and 2009 was $611,644 and $776,985, respectively.

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

Note 11 - Commitments and Contingencies (continued)

Compliance with laws and regulations - The District is subject to many complex federal, state, and local laws and regulations. Compliance with these laws and regulations is subject to government review and interpretation and unknown or unasserted regulatory actions. Government activity with respect to investigations and allegations regarding possible violations of these laws and regulations by health care providers, including those related to medical necessity, coding, and billing for services, has increased significantly. Violations of these laws can result in large fines and penalties, sanctions on providing future services, and repayment of past patient service revenues. The District has implemented a voluntary corporate compliance program, which includes guidance for all District employees' adherence to applicable laws and regulations. Management believes any actions that may result from investigations of noncompliance with laws and regulations will not have a material effect on the District's future financial position or results of operations (Note 14).

Risk management - The District is exposed to various risks of loss from torts; theft of, damage to, and destruction of assets; business interruption; errors and omissions; employee injuries and illnesses; and natural disasters. Commercial insurance coverage is purchased for claims arising from such matters and no claims have exceeded such coverage during any of the preceding years.

Note 12 - Concentration of Credit Risk

The Hospital grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of receivables from patients and third-party payors at December 31, 2010 and 2009, was as follows:

	2010	2009
Medicare	43%	43%
Medicaid	9%	5%
Other third-party payors	31%	30%
Patients	17%	22%
	100%	100%

Note 13 - Collective Bargaining Units

At December 31, 2010, the District had a total of approximately 699 employees. Of this total, approximately 521 were covered by collective bargaining agreements. The EMS Bargaining Agreement, which covered 41 employees, will expire in 2011.

Note 14 - Contingent Liability

During 2008, the District discovered apparent instances of noncompliance with certain requirements of the Ethics in Patient Referrals Act of 1989 and subsequent laws and regulations promulgated pursuant to that Act (collectively, the Stark Law). In letters dated November 3, 2008, and April 30, 2009, the District self-disclosed the apparent instances of noncompliance to the Department of Health and Human Services' Office of the Inspector General (OIG) pursuant to the OIG's Provider Self-Disclosure Protocol. The District's subsequent investigation of the matters has identified an estimated $237,000 in "benefit conferred" on physicians as a result of the instances of noncompliance. Based on prior pronouncements by the OIG, it is expected that the final settlement amount to resolve the matters that are the subject of the District's self-disclosure will be based on a multiple of this or another calculation of the amount of benefit that has been conferred on physicians by the District as a result of the disclosed noncompliance. In June 2010, the District offered the government approximately $854,000 to resolve the discovered instances of noncompliance. The District has recorded a liability of $854,000 as of December 31, 2010 and 2009, to cover the eventual settlement cost. The final settlement amount in this matter cannot be reasonably estimated at this time but may exceed the amount that the District has accrued.

Note 15 - Subsequent Events

Effective May 1, 2011, PCA merged with WCP, with PCA being the surviving corporation. WCP was a nonprofit corporation and had provided management services to the PCA since February 2008 pursuant to a management services agreement between the parties. As a result of the merger, the separate corporate existence of WCP ceased, title to all property owned by WCP was transferred to PCA, and PCA assumed all the obligations and liabilities of WCP. Based upon the unaudited financial statements of WCP, the merger should not have a material effect upon the financial position of PCA or the Hospital.

During 2011, the Hospital entered into an agreement to upgrade its magnetic resonance imaging machine. The capital costs of the upgrade are approximately $1,086,943, including delivery, training, and taxes. The capital costs will be financed using a tax-exempt lease purchase with 60 monthly payments of approximately $16,583.

APPENDIX C

FORM OF LEGAL OPINION

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[FORM OF APPROVING LEGAL OPINION]

Whidbey Island Public Hospital District
Island County, Washington

Re: Whidbey Island Public Hospital District,
Island County, Washington, $8,050,000
Limited Tax General Obligation Bonds, 2011

We have served as bond counsel to Whidbey Island Public Hospital District, Island County, Washington (the "District"), in connection with the issuance of the above referenced bonds (the "Bonds"), and in that capacity have examined such law and such certified proceedings and other documents as we have deemed necessary to render this opinion. As to matters of fact material to this opinion, we have relied upon representations contained in the certified proceedings and other certifications of public officials furnished to us, without undertaking to verify the same by independent investigation.

The Bonds are issued by the District pursuant to Resolution No. 320 (the "Bond Resolution") for general District purposes to provide the funds to pay a portion of the costs of carrying out the project plan specified and adopted in the Bond Resolution and pay the costs of issuance and sale of the Bonds, all as set forth in the Bond Resolution.

Reference is made to the Bonds and the Bond Resolution for the definitions of capitalized terms used and not otherwise defined herein.

We express no opinion herein concerning the completeness or accuracy of any official statement, offering circular or other sales or disclosure material relating to the issuance of the Bonds or otherwise used in connection with the Bonds.

Under the Internal Revenue Code of 1986, as amended (the "Code"), the District is required to comply with certain requirements after the date of issuance of the Bonds in order to maintain the exclusion of the interest on the Bonds from gross income for federal income tax purposes, including, without limitation, requirements concerning the qualified use of Bond proceeds and the facilities financed or refinanced with Bond proceeds, limitations on investing gross proceeds of the Bonds in higher yielding investments in certain circumstances and the arbitrage rebate requirement to the extent applicable to the Bonds. The District has covenanted in the Bond Resolution to comply with those requirements, but if the District fails to comply with those requirements, interest on the Bonds could become taxable retroactive to the date of issuance of the Bonds. We have not undertaken and do not undertake to monitor the District's compliance with such requirements.

Based upon the foregoing, as of the date of initial delivery of the Bonds to the purchaser thereof and full payment therefor, it is our opinion that under existing law:

1. The District is a duly organized and legally existing municipal corporation under the laws of the State of Washington.

2. The Bonds have been duly authorized and executed by the District and are issued in full compliance with the provisions of the Constitution and laws of the State of Washington and the resolutions of the District relating thereto.

3. The Bonds constitute valid and binding general obligations of the District payable from annual *ad valorem* taxes to be levied within the constitutional and statutory tax limitations provided by law without a vote of the electors of the District on all of the taxable property within the District, except only to the extent that enforcement of payment may be limited by bankruptcy, insolvency or other laws affecting

creditors' rights and by the application of equitable principles and the exercise of judicial discretion in appropriate cases.

4. Assuming compliance by the District after the date of issuance of the Bonds with applicable requirements of the Code, the interest on the Bonds is excluded from gross income for federal income tax purposes and is not an item of tax preference for purposes of the alternative minimum tax applicable to individuals; however, while interest on the Bonds also is not an item of tax preference for purposes of the alternative minimum tax applicable to corporations, interest on the Bonds received by corporations is to be taken into account in the computation of adjusted current earnings for purposes of the alternative minimum tax applicable to corporations, interest on the Bonds received by certain S corporations may be subject to tax, and interest on the Bonds received by foreign corporations with United States branches may be subject to a foreign branch profits tax. We express no opinion regarding any other federal tax consequences of receipt of interest on the Bonds.

This opinion is given as of the date hereof, and we assume no obligation to revise or supplement this opinion to reflect any facts or circumstances that may hereafter come to our attention, or any changes in law that may hereafter occur.

We bring to your attention the fact that the foregoing opinions are expressions of our professional judgment on the matters expressly addressed and do not constitute guarantees of result.

Respectfully submitted,

APPENDIX D

DTC AND ITS BOOK-ENTRY SYSTEM

The following information has been provided by DTC. The District makes no representation as to the accuracy or completeness thereof. Beneficial Owners should confirm the following with DTC or the Participants (as hereinafter defined).

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

2. DTC, the world's largest depository, is a limited-purpose trust company organized under the New York Banking Law, a "banking organization" within the meaning of the New York Banking Law, a member of the Federal Reserve System, a "clearing corporation" within the meaning of the New York Uniform Commercial Code, and a "clearing agency" registered pursuant to the provisions of Section 17A of the Securities Exchange Act of 1934. DTC holds and provides asset servicing for over 3.5 million issues of U.S. and non-U.S. equity issues, corporate and municipal debt issues, and money market instruments (from over 100 countries) that DTC's participants ("Direct Participants") deposit with DTC. DTC also facilitates the post-trade settlement among Direct Participants of sales and other securities transactions in deposited securities, through electronic computerized book-entry transfers and pledges between Direct Participants' accounts. This eliminates the need for physical movement of securities certificates. Direct Participants include both U.S. and non-U.S. securities brokers and dealers, banks, trust companies, clearing corporations, and certain other organizations. DTC is a wholly-owned subsidiary of The Depository Trust & Clearing Corporation ("DTCC"). DTCC is the holding company for DTC, National Securities Clearing Corporation and Fixed Income Clearing Corporation, all of which are registered clearing agencies. DTCC is owned by the users of its regulated subsidiaries. Access to the DTC system is also available to others such as both U.S. and non-U.S. securities brokers and dealers, banks, trust companies, and clearing corporations that clear through or maintain a custodial relationship with a Direct Participant, either directly or indirectly ("Indirect Participants"). DTC has a Standard & Poor's rating of AA+. The DTC Rules applicable to its Participants are on file with the Securities and Exchange Commission. More information about DTC can be found at www.dtcc.com (which website is not incorporated by reference).

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

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

5. Conveyance of notices and other communications by DTC to Direct Participants, by Direct Participants to Indirect Participants, and by Direct Participants and Indirect Participants to Beneficial Owners will be governed by arrangements among them, subject to any statutory or regulatory requirements as may be in effect from time to time. [Beneficial Owners of Bonds may wish to take certain steps to augment the transmission to them of notices of significant events with respect to the Bonds, such as redemptions, tenders, defaults, and proposed amendments to the security documents. For example, Beneficial Owners of Bonds may wish to ascertain that the nominee holding the Bonds for their benefit has agreed to obtain and transmit notices to Beneficial Owners. In the alternative, Beneficial Owners may wish to provide their names and addresses to the registrar and request that copies of notices be provided directly to them.]

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

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

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

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

10. District may decide to discontinue use of the system of book-entry-only transfers through DTC (or a successor securities depository). In that event, Bond certificates will be printed and delivered.

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

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