

1. SOURCES OF REVENUES FOR PATIENT SERVICES

In the space below, please provide the past three fiscal year's payor and service mix for each category as a percentage of gross patient revenues. Also provide the current YTD payor and service mix statistics.

<u>Payor</u>	Most Recent YTD As of _____	Fiscal Year 200__	Fiscal Year _____	Fiscal Year _____
<u>Medicare</u>				
(Traditional)	_____	_____	_____	_____
(Managed Care)	_____	_____	_____	_____
<u>Medicaid</u>				
(Traditional)	_____	_____	_____	_____
(Managed Care)	_____	_____	_____	_____
<u>Commercial Insurance</u>	_____	_____	_____	_____
<u>Self Pay & Other</u>	_____	_____	_____	_____
<u>Managed Care Entities</u>				
(PPO)	_____	_____	_____	_____
(HMO)	_____	_____	_____	_____
Net Outpatient Revenue as a % of <u>Total Net Operating Revenues</u>	_____	_____	_____	_____

2. UTILIZATION STATISTICS

3-year statistics. In the space below, please provide the utilization statistics for the Institution for the three most recent fiscal years and comparative interim statistics for the most recent period available.

	FY 200__	FY _____	FY _____	Most Recent YTD As of _____	YTD for Preceding <u>Year</u>
Approved / Staffed Beds	_____ / _____	_____ / _____	_____ / _____	_____ / _____	_____ / _____
Admissions (excluding newborns)	_____	_____	_____	_____	_____
Patient Days (excluding newborns)	_____	_____	_____	_____	_____
Occupancy (%)	_____	_____	_____	_____	_____
Average Length of Stay (days)	_____	_____	_____	_____	_____
Outpatient Visits	_____	_____	_____	_____	_____
Emergency Care Visits	_____	_____	_____	_____	_____
Observation Stays	_____	_____	_____	_____	_____
Average Days in Accounts Receivable	_____	_____	_____	_____	_____

3. LABOR RELATIONS

Please provide a brief description of labor relations at the Institution. Detail any union activity present at the Institution by noting the number of unionized employees, who represents them, the term of the current contract(s) and a history of any work stoppages which may have occurred.

(Please attach description as Exhibit 1)

4. DESCRIPTION OF MEDICAL STAFF

a) In the space below, please provide the requested statistics concerning the medical staff of the Institution for the three most recent fiscal years.

	FY 200____	FY _____	FY _____
# of Admitting Physicians	_____	_____	_____
# of Active Physicians	_____	_____	_____
# of Board Certified Active Physicians	_____	_____	_____
Average Age of Physicians on Active Staff	_____	_____	_____

b) In the space below, please provide the specialty and the percent of total inpatient discharges for each of the Institution's top five admitting physicians in the most recent fiscal year. Indicate the age of each such physician.

<u>Specialty</u>	<u>Percentage of Total Inpatient Discharges</u>	<u>Age</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
TOTAL	_____	AVERAGE

c) Please explain your physician-recruiting program. Do you own physician practices? Provide P & L on physician practices owned by the Institution. Explain where in financials these numbers reside. *(Please attach as Exhibit 2)*

5. SERVICE AREA

a) In the space provided, describe the service area of the Institution, including the name of the county or counties in which the service area is situated and the population of the service area in 2000 and estimated today.

<u>County</u>	<u>2000 Census Population</u>	<u>Estimated Population Today</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

b) For each county listed above provide a listing of the five largest employers including name, location, product or services provided, and number of local employees. *(Please attach as Exhibit 3)*

c) Unemployment statistics. Please list the indicated unemployment statistics.

	<u>Current</u>	<u>Year End – Last Year</u>	<u>Year End – 2 years ago</u>
Primary Service Area	_____	_____	_____
Secondary Service Area	_____	_____	_____

d) Provide any other pertinent information on the service area. *(Please attach as Exhibit 3b)*

6. OTHER COMPETITORS IN SERVICE AREA

a) In the space below, please provide information concerning other providers, which compete for patients in the service area of the Institution.

<u>Name of Competitor</u>	<u>Location</u>	<u>Distance in Miles from Institution</u>	<u>FY 2003 Staffed Beds</u>	<u>FY 2002 Admissions / Occupancy</u>
_____	_____	_____	_____	_____/_____ /
_____	_____	_____	_____	_____/_____ /
_____	_____	_____	_____	_____/_____ /
_____	_____	_____	_____	_____/_____ /
_____	_____	_____	_____	_____/_____ /

7. MANAGEMENT

Please provide (*as Exhibit 4*) resumes or biographies of the Institution's management team.

8. CREDIT RATING

If the Institution has currently outstanding rated debt, please provide the names of the rating agencies, the rating given, the debt issue the rating is associated with and the date the rating was given. (*Please attach as Exhibit 5*)

9. CAPITAL EXPANSION PROGRAMS

Describe briefly any major capital acquisition or expansion plans to be undertaken by the Institution within the next three years which have been approved or are under consideration by the Institution or a committee thereof (include description of costs, additional beds and services, method of financing, and year(s) in which program will be undertaken).

(*Please attach as Exhibit 6*)

10. INSURANCE

Please indicate the levels of insurance coverage maintained by the Institution with respect to the following categories of insurance. Please indicate if any of the insurance listed is maintained on a self-insured basis.

	<u>Coverage Amount</u>	<u>Self-Insurance</u>	
		<u>Yes</u>	<u>No</u>
Fire & Hazard	_____	_____	_____
General Liability	_____	_____	_____
Medical Malpractice	_____	_____	_____
Worker's Compensation	_____	_____	_____
Business Interruption	_____	_____	_____
Special Disaster (flood, etc.)	_____	_____	_____

11. LITIGATION

Is there any litigation, threatened or pending, in which the Institution is or may be a defendant and in which the Institution's potential liability, either individually or collectively, could exceed the Institution's insurance coverage with respect to such liability or liabilities?

Yes_____ No_____

If the answer is "yes", please attach a brief explanation to this application. (*as Exhibit 7*)

12. SECURITY

Has the Institution granted a security interest against any of its Properties, Gross Revenues or Patient Accounts Receivable? Yes_____ No_____

If yes, please describe. (*and attach as Exhibit 8*)

13. DOCUMENTS & INFORMATION TO BE ATTACHED TO APPLICATION

The following documents and information are to be attached to this application and submitted to WHEFA.

- a) Complete audited financial statements of the Institution for the past three fiscal years.
- b) The Institution's most recent year-to-date unaudited financial statements. These should include Balance Sheets and Income Statements along with comparative results for the preceding year.
- c) If the Institution has a currently outstanding bond issue, please enclose a copy of the Official Statement or Private Placement Memorandum.
- d) Photograph of Institution's facility.
- e) If the Institution is affiliated with other entities, please provide a corporate organizational chart or a listing of such affiliates.
- f) Board of Directors of Institution (include occupation)
- g) Institution's Mission Statement
- h) Most recent Accreditation Letter and Report (if applicable)
- i) Organization Bylaws
- j) Organization's Corporate Charter
- k) IRS Notification of Tax Status
- l) Institution literature including -
Annual Report
Newsletter
Program Brochures
Fundraising Literature