Washington State Department of Health
Certificate of Need Program
P.O. Box 47852
Olympia, Washington 98502-7852

**Official Use Only-Date Received:**

# Application for Certificate of Need
# Purchase of Part or All of a Hospital

(Do Not Use this form for any other type of hospital project)

To be accepted Certificate of Need applications must include the appropriate fee (WAC 246-310-990.)

This is an application for a Certificate of Need under state law and rules. (RCW Chapter 70.38 and WAC 246-310). I hereby certify that the statements in this application are correct to the best of my knowledge and belief. I understand that any misrepresentation, misleading statements, evasion, or suppression of material fact in this application may be used to take actions identified in WAC 246-310-500.

**My signature authorizes the Department of Health to verify any responses provided. The department will use such information as appropriate to further program purposes. The department may disclose this information when requested by a third party to the extent allowed by law.**

## Applicants(s)

| **Seller (Owner):** | **Purchaser (Operator):** |
|---|---|
| Legal Name of Seller: | Legal Name of Purchaser: |
| Address of Seller: | Address of Purchaser: |
| Name and Title of Responsible Officer: (**Print)** | Name and Title of Responsible Officer: (**Print)** |
| Signature of Responsible Officer | Signature of Responsible Officer |
| Date: | Date: |
| Telephone: | Telephone: |

**Current Ownership Type:**

- ☐ District
- ☐ Private Non-Profit
- ☐ Proprietary - Corporation
- ☐ Proprietary - Individual
- ☐ Proprietary - Partnership
- ☐ State or County

**Purchaser Type:**

- ☐ District
- ☐ Private Non-Profit
- ☐ Proprietary - Corporation
- ☐ Proprietary - Individual
- ☐ Proprietary - Partnership
- ☐ State or County

**Project Description Summary:**

_____
_____
_____
_____
_____

Estimated Capital Expenditure as defined in WAC 246-310-010(10): _____

Intended Project Start Date: _____ Intended Project Completion Date: _____

**Application Contacts:**

**Primary:**

Name: _____
Title: _____
Address: _____
_____
_____
Phone: _____

**Financial Projections/Statements**

Name: _____
Title: _____
Address: _____
_____
_____
Phone: _____

**Other:**

Role: _____
Name: _____
Title: _____
Address: _____
_____
_____
Phone: _____

# Application Instructions
# Purchase of Part or All of a Hospital

The department will use the information in your application to determine if your project meets the applicable review criteria. These criteria are included in state law and rules. (RCW 78.38.115, WAC 246-310-210, WAC 246-310-220, WAC 246-310-230, and WAC 246-310-240.)

**General Instructions:**

- Include a table of contents for major application sections and appendices
- Number **all** pages consecutively
- **Do not** bind or 3-hole punch the application
- Make the narrative information complete and to the point
- Cite all data sources
- Provide copies of articles, studies, etc., cited in the application
- Place extensive supporting data in an appendix
- Provide detailed descriptions of assumptions used for **all** projections
- Use **non-inflated** dollars for **all** cost projections
- **Do not** include a general inflation rate for these dollar amounts.
- **Do** include current contract cost increases such as union contract staff salary increases. You must identify each contractual increase in the description of assumptions in the application
- **Do not** include a capital expenditure contingency

**Application Submission:**

**Number of Copies:**

- Submit an **original, one copy, and an electronic (pdf) version**
- All subsequent submissions associated with this application must be submitted with an **original, one copy and an electronic (pdf) version**.

**To be accepted, the application must include:**

- A completed and signed Certificate of Need application face sheet
- The review fee of **$40,470**. Make check payable to ***Department of Health***

Send application to:

**Mailing Address:**

Department of Health
Certificate of Need Program
P O Box 47852
Olympia, Washington 98504-7852

**Physical Address:**

Department of Health
Certificate of Need Program
111 Israel Road SE
Tumwater, Washington 98501

**If you have questions, call (360) 236-2955**

## I. Applicant Description

**"Applicant" means:**

**a. Any person proposing to engage in any undertaking subject to review under chapter 70.38 RCW**

**OR**

**b. Any person or individual with a 10 percent or greater financial interest in a partnership or corporation or other comparable legal entity engaging in any undertaking subject to review under provisions of RCW 70.38.**

**"Person" means an individual, a trust or estate, a partnership, a corporation (including associations, joint stock companies, and insurance companies), the state, or a political subdivision or instrumentality of the state, including a municipal corporation or a hospital district. WAC 246-310-010(42)**

**A. Applicant (Purchaser) Description**

1. Legal name(s) of purchaser(s)
2. Address of each purchaser(s)
3. Provide the following information about each owner
    a. Identify each person or individual with a **10 percent or greater financial interest** and the percent of financial interest.
    b. For out-of-state corporations or partnerships, provide proof of registration with Secretary of State, Corporations, Trademarks, and Limited Partnerships Division.
    c. Show relationship to any organization as described in 42 CFR 413.17.
    d. Provide a chart showing organizational relationship to any related organizations as described in 42 CFR 413.17.
4. Is the applicant currently reimbursed by Medicare for services?
5. If no to question 4, does the applicant propose to be reimbursed by Medicare for services?
6. Is the applicant currently reimbursed by Medicaid for services?
7. If no to question 6, does the applicant propose to be reimbursed for services by Medicaid?
8. List the following for each Washington and out-of-state health care facility owned or managed by the applicant or related party:
    a. Name
    b. Address
    c. Medicare provider number
    d. Medicaid provider number
    e. Specify whether facility is owned or managed.
9. For each out-of-state health care facility owned or managed by the applicant or related party, provide the following contact information for the state entity responsible for the licensing or certification of each facility.
    a. Entity Name
    b. Address
    c. Phone number
    d. Contact person
    e. Applicant or related party facility name
10. Provide a copy of the current Articles of Incorporation and Bylaws.
11. Provide a copy of the restated (draft) Articles of Incorporation and Bylaws.

## II. General Information

**A. Facility Information**

1. Name of Facility to be purchased: _____
   Address:
   _____
2. Medicare Provider Number:_____
3. Medicaid Provider Number: _____

**B. Capacity and Service Information**

1. Provide the following Bed Capacity information:

| | Current | Proposed |
|---|---|---|
| a. 24 hr. assigned and set-up (general Medical/Surgical) | _____ | _____ |
| b. 24 hr. assignable-not set-up (general Medical/Surgical). These are spaces that meet licensure standards and the hospital has ready access to required movable equipment. | _____ | _____ |
| c. Dedicated or PPS exempt Psychiatric | _____ | _____ |
| d. Dedicated or PPS exempt Rehabilitation | _____ | _____ |
| e. Long Term Care/Nursing Home Beds | _____ | _____ |
| f. Neonatal Intermediate Care Nursery Level II | _____ | _____ |
| g. Neonatal Intensive Care Nursery Level III | _____ | _____ |
| h. Neonatal Intensive Care Nursery Level IV | | |
| Total Licensed Beds (sum of above) | _____ | _____ |
| Banked LTC/Nursing Home Beds | _____ | _____ |
| Swing Beds (as defined by Medicare-may also be included in a above) | _____ | _____ |

4. Identify the primary geographic planning/service area currently served by this facility.
5. Provide the following Scope of Service information:

| **Obstetrical/Medical/Surgical Services** | Current | Proposed |
|---|---|---|
| Perinatal/Obstetrical Services | | |
| Cesarean Section | ☐ | ☐ |
| NICU Level II | ☐ | ☐ |
| LDRP | ☐ | ☐ |
| NICU Level III | ☐ | ☐ |
| NICU Level IV | ☐ | ☐ |
| Critical Care | ☐ | ☐ |
| Pediatric | ☐ | ☐ |
| Emergency | ☐ | ☐ |
| Dialysis | | |
| Acute | ☐ | ☐ |
| Diagnostic Services | | |
| Cardiac Cath Lab | ☐ | ☐ |
| Endoscopy | ☐ | ☐ |
| Imaging | ☐ | ☐ |
| Laboratory | ☐ | ☐ |
| Other (list) | ☐ | ☐ |
| Therapeutic Services | | |
| Cardiac Cath Lab | ☐ | ☐ |
| Endoscopy | ☐ | ☐ |
| Other (list) | ☐ | ☐ |
| Medical Services-Other (list) | ☐ | ☐ |

| **Obstetrical/Medical/Surgical Services** | Current | Proposed |
|---|---|---|
| Surgical Services | | |
| Inpatient | ☐ | ☐ |
| Outpatient | ☐ | ☐ |
| Contracted Services (list) | ☐ | ☐ |
| Outpatient Services (list) | ☐ | ☐ |
| Mobile Services (list) | ☐ | ☐ |
| **Other services** | | |
| Dialysis | | |
| Outpatient | ☐ | ☐ |
| Long Term Care/Nursing Home | ☐ | ☐ |
| Chemical Dependency | | |
| Inpatient | ☐ | ☐ |
| Outpatient | ☐ | ☐ |
| Psychiatric | ☐ | ☐ |
| Rehabilitation | ☐ | ☐ |

6. Provide the hospital's overall utilization for the last five years.

| | Year ____ | Year ____ | Year ____ | Year ____ | Year ____ |
|---|---|---|---|---|---|
| Inpatient Days | | | | | |
| Outpatient Visits | | | | | |

## III. General Project Description

1. Describe the proposed project.

2. Projected utilization for the first three years of operation following project completion:

| | Partial Year ____ | Year ____ | Year ____ | Year ____ |
|---|---|---|---|---|
| Inpatient Days | | | | |
| Outpatient Visits | | | | |

3. Percent of patient **revenue**, by payor source:

| Source of Revenue | Current Hospital Operations | Proposed Hospital Operations |
|---|---|---|
| Medicare | | |
| Medicaid | | |
| Private (no Insurance) | | |
| Insurance-Other | | |
| HMO | | |
| Other (Specify) | | |

4. Total estimated capital expenditures: $ _____.

5. Source of financing for capital costs: _____

6. Timetable for implementing the proposed project. This information is used to monitor an approved project as required by WAC 246-310-590 and may be used for actions stated in WAC 246-310-600.
   a. Month/Year 25% toward completion
   b. Month/Year 50% toward completion
   c. Month/Year 75% toward completion
   d. Month/Year project complete.

## IV. Project Specific Criteria

**Reminder: Follow application instructions on page 3 of this form**

### Need (WAC 246-310-210)

**A. Community Need**

1. Describe the benefits, if any, to the community that will result from this purchase. This description must include the following:
   a. Access to care
   b. Availability of services
   c. Costs
   d. Quality of Care
2. Describe the impact to the community if this project were to be denied.

**B. Service Changes**

1. Describe any anticipated changes in service during the first three years of the proposed purchase.
2. If anticipated changes include a reduction, relocation, or elimination of a service, document the following:
   a. Need the population presently has for the service.
   b. How the need will be adequately met by the proposed change
   c. Alternative arrangements designed to meet the identified need

**C. Access to Services**

1. Document the manner in which the hospital intends to assure access to services by:
   a. Low income persons
   b. Racial and ethnic minorities
   c. Women
   d. Disabled persons
   e. Other underserved groups
2. Provide the following for the **current** hospital operations:
   a. Copy of the hospital's admissions policy or policies
   b. Copy of the hospital's nondiscrimination policy
   c. Copy of the hospital's community health needs assessment, if applicable
   d. Copy of the hospital's charity care policy. If the hospital has more than one charity care policy based on type of service, provide a copy of all charity care policies.
   e. Copy of the hospital's end of life policy or policies
   f. Copy of the hospital's reproductive health policy or policies
   g. Other information as appropriate
3. Provide the following for the **post purchase** hospital operations:
   a. Copy of the hospital's admissions policy or policies
   b. Copy of the hospital's nondiscrimination policy
   c. Copy of the hospital's community health needs assessment, if applicable
   d. Copy of the hospital's charity care policy. If the hospital has more than one charity care policy based on type of service, provide a copy of all charity care policies.
   e. Copy of the hospital's end of life policy or policies
   f. Copy of the hospital's reproductive health policy or policies
   g. Other information as appropriate

4. Charity Care Levels: Seller's hospital operations:

| | Historical Year ____ | Historical Year ____ | Last full Year _____ |
|---|---|---|---|
| Dollar Amount | | | |
| % of total Revenue | | | |
| % of Adjusted Revenue | | | |

5. Charity Care Levels: Purchaser's current operations and project's projected:

| | Historical Year ____ | Historical Year ____ | Last full Year _____ | Projection Year 1 _____ | Projection Year 2 _____ | Projection Year 3 _____ |
|---|---|---|---|---|---|---|
| Dollar Amount | | | | | | |
| % of total Revenue | | | | | | |
| % of Adjusted Revenue | | | | | | |

## Financial Feasibility (WAC 246-310-220)

### A. Financial Statements

1. Provide a copy of the proposed sale agreement. Include all attachments, exhibits, and appendices.
2. Complete the financial statements in the format provided by the forms at the end of this application.
3. Number of admissions by payor source for past three fiscal years and estimate of current year.

| Payor | Historical Year____ | Historical Year____ | Historical Year____ | Current Year Est. |
|---|---|---|---|---|
| Medicare | | | | |
| Medicaid | | | | |
| Private (no Insurance) | | | | |
| Insurance-Other | | | | |
| HMO | | | | |
| Other (Specify) | | | | |

4. Patient days by payor source for past three fiscal years and estimate of current year.

| Payor | Historical Year____ | Historical Year____ | Historical Year____ | Current Year Est. |
|---|---|---|---|---|
| Medicare | | | | |
| Medicaid | | | | |
| Private (no Insurance) | | | | |
| Insurance-Other | | | | |
| HMO | | | | |
| Other (Specify) | | | | |

5. Total patient revenue by payor source for past three fiscal years and estimate of current year

| Payor | Historical Year____ | Historical Year____ | Historical Year____ | Current Year Est. |
|---|---|---|---|---|
| Medicare | | | | |
| Medicaid | | | | |
| Private (no Insurance) | | | | |
| Insurance-Other | | | | |
| HMO | | | | |
| Other (Specify) | | | | |

6. Projected number of admissions by payor source following purchase.

| Payor | Partial Year____ | Projected Year____ | Projected Year____ | Projected Year____ |
|---|---|---|---|---|
| Medicare | | | | |
| Medicaid | | | | |
| Private (no Insurance) | | | | |
| Insurance-Other | | | | |
| HMO | | | | |
| Other (Specify) | | | | |

7. Projected number of patient days by payor source following purchase.

| Payor | Partial Year____ | Projected Year____ | Projected Year____ | Projected Year____ |
|---|---|---|---|---|
| Medicare | | | | |
| Medicaid | | | | |
| Private (no Insurance) | | | | |
| Insurance-Other | | | | |
| HMO | | | | |
| Other (Specify) | | | | |

8. Projected Revenue by payor source following purchase.

| Payor | Partial Year____ | Projected Year____ | Projected Year____ | Projected Year____ |
|---|---|---|---|---|
| Medicare | | | | |
| Medicaid | | | | |
| Private (no Insurance) | | | | |
| Insurance-Other | | | | |
| HMO | | | | |
| Other (Specify) | | | | |

9. Identify source(s) and amounts of the initial working capital.

10. Estimated Start-up and Initial Operating Expenses
    a. Total Estimated Start-up costs (Expenses incurred prior to opening such as staff training, inventory, etc.) $_____
    b. Estimated Period of Time Necessary for Initial Start up: _____"months"
    c. Total Estimate initial operating deficits, if any (Operating deficits, occurring during operating period.) $_____
    d. Estimated initial operating breakeven point (Period of time from receipt of first patient until total revenues equal total expenses.) _____"months"

11. Provide the most recent audited financial statements for the hospital's current operation.

12. Provided the most recent audited financial statements for the purchaser's current operation.

## B. Project Financing

1. Identify the sources and amounts of project financing.

| Source of Financing | Amount |
|---|---|
| a. Public Campaign | $_____ |
| b. Bond Issue | $_____ |
| c. Commercial Loans | $_____ |
| d. Government Loans | $_____ |

e. Grants $_____
f. Bequests and Donations $_____
g. Private Foundations $_____
h. Accumulated Reserves $_____
i. Internal Loans $_____
j. Capital Allowance $_____
k. Other – specify $_____
l. **Total** (Should equal Total Project Cost) $_____

2. Describe if any related organizations are involved in the financing of this project. If yes, describe its relationship.
3. Describe all covenants related to the financing of the proposed purchase.
4. For projects to be totally or partially funded from capital allowance, identify the amount(s) of capital allowance and budget year(s) during which the funds would be used.
5. Evidence of Availability of Financing for the Project. Submit one of the following:
   a. Copies of letter(s) from lending institutions stating a willingness to finance the proposed project. The letter(s) should include:
      i. Status of loan application(s)
      ii. Purpose of the loan(s)
      iii. Proposed interest rate(s) (Fixed or Variable)
      iv. Proposed term (period) of the loan(s)
   b. Copies of Hospital Board minutes authorizing the proposed project.
6. Provide amortization schedule(s) for each financing arrangement including long-term and any short-term start-up or initial operating deficit loans. Identify the:
   a. Principal
   b. Term (number of payment periods) (long term loans may be annualized)
   c. Interest
   d. Outstanding balance at end of each payment period

## **Structure and Process-Quality of Care (**WAC 245-310-230)

### A. Staffing

1. Describe any anticipated changes in hospital staffing as a result of this proposed purchase.
2. Describe any anticipated changes in physician privileges, etc. as a result of this proposed purchase.
3. Describe any other anticipated changes not described in 1 or 2 above.

### B. Continuity of Care and Unwarranted Fragmentation of Services

1. Describe the working relationships of the hospital with other health facilities **in** the hospital's primary geographic service area.
2. Describe any new working relationships between the hospital and other facilities **in** the hospital's primary geographic service area that would be developed as a result of this project.
3. Describe the working relationships of the hospital with other health facilities that are **outside** the hospital's primary geographic service area.
4. Describe any new working relationships between the hospital and other facilities **outside** the hospital's primary geographic service area that would be developed as a result of this project.

**C. Compliance**

1. Identify if the Purchaser in this application has had any of the following in this state or other states:
   a. Decertification from Medicare
   b. Decertification from Medicaid
   c. Convictions related to the competency to practice medicine or own or operate a hospital
   d. Denial of a license
   e. Revocation of a license
   f. Voluntary withdrawal from Medicare or Medicaid while decertification processes were pending.
   g. Ongoing or completed investigations concerning the operation of any or all of its health care facilities.
2. If yes to any part of question 1, describe the incident and provide clear, sound, and convincing evidence that the occurrence is not likely to re-occur.

**Cost Containment** (WAC 246-310-240)

1. Identify each option considered before submitting the current application, including no action.
2. For each option identified in question 1, provide at least the following information:
   a. Advantages
   b. Disadvantages
   c. Impact on operating costs to the hospital
   d. Impact on staffing
   e. Impact on costs to the patient
   f. Impact on physical hospital space
   g. Legal restrictions
      i. If seller or purchaser is organizationally connected to a hospital district, provide a discussion of how the purchase transaction meets the requirements in RCW 70.44.
   h. Other-Specify
   i. Reason for rejecting each option
3. Identify the specific ways this project will promote staff efficiency and productivity.
4. Identify the specific ways this project will promote system efficiency.

# Financial Statement Forms

**Reminder: Follow application instructions on page 3 of this form**

Hospital Information

Comparison Statement of Revenue & Expense-Unrestricted Funds-**Hospital Aggregate**

| | Current YR _____ | Historical YR _____ | Historical YR _____ | Historical YR _____ |
|---|---|---|---|---|
| Operating Revenue: | | | | |
| Inpatient Revenue | | | | |
| Outpatient Revenue | | | | |
| **Total Patient Service Revenue** | | | | |
| Deductions From Revenue: | | | | |
| Provision for Bad Debt | | | | |
| Contractual Adjustments | | | | |
| Charity and Uncompensated Care | | | | |
| Other Adjustments and Allowances | | | | |
| **Total Deductions From Revenue** | | | | |
| **Net Patient Service Revenue** | | | | |
| Other Operating Revenue | | | | |
| Other Operating Revenue | | | | |
| Tax Revenues | | | | |
| **Total Other Operating Revenue** | | | | |
| **Total Operating Revenue** | | | | |
| Operating Expenses | | | | |
| Salaries and Wages | | | | |
| Employee Benefits | | | | |
| Professional Fees | | | | |
| Supplies | | | | |
| Purchased Services - Utilities | | | | |
| Purchased Services - Other | | | | |
| Depreciation | | | | |
| Rentals and Leases | | | | |
| Insurance | | | | |
| License and Taxes | | | | |
| Interest | | | | |
| Other Direct Expenses | | | | |
| Allocated Expenses | | | | |
| **Total Operating Expenses** | | | | |
| **Net Operating Revenue** | | | | |
| **Non-Operating Revenue-Net of Expenses** | | | | |
| **Net Revenue Before Items Listed Below** | | | | |
| Extraordinary Item | | | | |
| Federal Income Tax | | | | |
| **Net Revenue or (Expense)** | | | | |
| Explanation: | | | | |

Hospital Information

Deductions From Revenue-**Hospital Aggregate**

| Acct: | Item: | Current YR_____ | Historical YR _____ | Historical YR _____ | Historical YR _____ |
|---|---|---|---|---|---|
| 5800 | Provision For Bad Debts | | | | |
| | | | | | |
| | Contractual Adjustments | | | | |
| 5810 | Medicare | | | | |
| 5820 | Medicaid | | | | |
| 5830 | Workers Compensation | | | | |
| 5840 | Other Government Programs | | | | |
| 5850 | Negotiated Rates | | | | |
| 5860 | Other | | | | |
| | **Total Contractual Adjustments** | | | | |
| | | | | | |
| | Charity Care | | | | |
| 5900 | Inpatient | | | | |
| 5910 | Outpatient | | | | |
| | | | | | |
| | | | | | |
| | **Total Charity Care** | | | | |
| | | | | | |
| 5970 | Administrative Adjustments | | | | |
| | | | | | |
| 5980 | Other Deductions (Specify) | | | | |
| | **Total Deductions From Revenue** | | | | |

Explanation:

Hospital Information

Balance Sheet – Unrestricted Fund-Hospital **Aggregate**

| **Assets** | Current YR_____ | Historical YR _____ | Historical YR _____ | Historical YR _____ |
|---|---|---|---|---|
| Current Assets: | | | | |
| Cash | | | | |
| Marketable Securities | | | | |
| Accounts Receivable | | | | |
| Less-Estimated Uncollectable & Allowances | | | | |
| Receivables From Third Party Payors | | | | |
| Pledges And Other Receivables | | | | |
| Due From Restricted Funds | | | | |
| Inventory | | | | |
| Prepaid Expenses | | | | |
| Current Portion Of Funds Held In Trust | | | | |
| **Total Current Assets** | | | | |
| Board Designated Assets: | | | | |
| Cash | | | | |
| Marketable Securities | | | | |
| Other Assets | | | | |
| **Total Board Designated Assets** | | | | |
| Property, Plant and Equipment: | | | | |
| Land | | | | |
| Land Improvements | | | | |
| Buildings | | | | |
| Fixed Equipment - Building Service | | | | |
| Fixed Equipment - Other | | | | |
| Equipment | | | | |
| Leasehold Improvements | | | | |
| Construction In Progress | | | | |
| **Total Property, Plant & Equipment** | | | | |
| Less Accumulated Depreciation | | | | |
| **Net Property, Plant & Equipment** | | | | |
| Investments and Other Assets: | | | | |
| Investments In Property, Plant & Equipment | | | | |
| Less - Accumulated Depreciation | | | | |
| Other Investments | | | | |
| Other Assets | | | | |
| **Total Investments & Other Assets** | | | | |
| Intangibles Assets: | | | | |
| Goodwill | | | | |
| Unamortized Loan Costs | | | | |
| Preopening And Other Organization Costs | | | | |
| Other Intangible Assets | | | | |
| **Total Intangible Assets** | | | | |
| **Total Assets** | | | | |

Hospital Information

Balance Sheet - Unrestricted Fund-**Hospital Aggregate**

| **Liabilities and Fund Balances-Unrestricted** | Current YR_____ | Historical YR_____ | Historical YR_____ | Historical YR_____ |
|---|---|---|---|---|
| Current Liabilities: | | | | |
| Notes and Loans Payable | | | | |
| Accounts Payable | | | | |
| Accrued Compensation and Related Liabilities | | | | |
| Other Accrued Expenses | | | | |
| Advances from Third Party Payors | | | | |
| Payables to Third Party Payors | | | | |
| Due to Restricted Funds | | | | |
| Income Taxes Payable | | | | |
| Other Current Liabilities | | | | |
| Current Maturities of Long Term Debt | | | | |
| **Total Current Liabilities** | | | | |
| Deferred Credits: | | | | |
| Deferred Income Taxes | | | | |
| Deferred Third Party Revenue | | | | |
| Other Deferred Credits | | | | |
| **Total Deferred Credits** | | | | |
| Long Term Debt: | | | | |
| Mortgage Payable | | | | |
| Construction Loans - Interim Financing | | | | |
| Notes Payable | | | | |
| Capitalized Lease Obligations | | | | |
| Bonds Payable | | | | |
| Notes and Loans Payable to Parent | | | | |
| Noncurrent Liabilities | | | | |
| **Total t** | | | | |
| Less Current Maturities of Long Term Debt | | | | |
| **Total Long Term Debt** | | | | |
| **Unrestricted Fund Balance** | | | | |
| **Equity (Investor Owned)** | | | | |
| Preferred Stock | | | | |
| | | | | |
| Common Stock | | | | |
| | | | | |
| Additional Paid In Capital | | | | |
| | | | | |
| Retained Earnings (Capital Account for Partnership or Sole Proprietorship) | | | | |
| | | | | |
| Less Treasury Stock | | | | |
| **Total Equity** | | | | |
| **Total Liabilities and Fund Balance or Equity** | | | | |

Hospital Information

Comparison Statement of Revenue & Expense-Unrestricted Funds-**Hospital Aggregate**

| | Partial YR _____ | Projected YR _____ | Projected YR _____ | Projected YR _____ |
|---|---|---|---|---|
| Operating Revenue: | | | | |
| Inpatient Revenue | | | | |
| Outpatient Revenue | | | | |
| **Total Patient Service Revenue** | | | | |
| Deductions From Revenue: | | | | |
| Provision for Bad Debt | | | | |
| Contractual Adjustments | | | | |
| Charity and Uncompensated Care | | | | |
| Other Adjustments and Allowances | | | | |
| **Total Deductions From Revenue** | | | | |
| **Net Patient Service Revenue** | | | | |
| Other Operating Revenue | | | | |
| Other Operating Revenue | | | | |
| Tax Revenues | | | | |
| **Total Other Operating Revenue** | | | | |
| **Total Operating Revenue** | | | | |
| Operating Expenses | | | | |
| Salaries and Wages | | | | |
| Employee Benefits | | | | |
| Professional Fees | | | | |
| Supplies | | | | |
| Purchased Services - Utilities | | | | |
| Purchased Services - Other | | | | |
| Depreciation | | | | |
| Rentals and Leases | | | | |
| Insurance | | | | |
| License and Taxes | | | | |
| Interest | | | | |
| Other Direct Expenses | | | | |
| Allocated Expenses | | | | |
| **Total Operating Expenses** | | | | |
| **Net Operating Revenue** | | | | |
| **Non-Operating Revenue-Net of Expenses** | | | | |
| **Net Revenue Before Items Listed Below** | | | | |
| Extraordinary Item | | | | |
| Federal Income Tax | | | | |
| **Net Revenue or (Expense)** | | | | |
| Explanation: | | | | |

Hospital Information

Deductions From Revenue-**Hospital Aggregate**

| Acct: | Item: | Partial YR_____ | Projected YR _____ | Projected YR _____ | Projected YR _____ |
|---|---|---|---|---|---|
| 5800 | Provision For Bad Debts | | | | |
| | | | | | |
| | Contractual Adjustments | | | | |
| 5810 | Medicare | | | | |
| 5820 | Medicaid | | | | |
| 5830 | Workers Compensation | | | | |
| 5840 | Other Government Programs | | | | |
| 5850 | Negotiated Rates | | | | |
| 5860 | Other | | | | |
| | **Total Contractual Adjustments** | | | | |
| | | | | | |
| | Charity Care | | | | |
| 5900 | Inpatient | | | | |
| 5910 | Outpatient | | | | |
| | | | | | |
| | | | | | |
| | **Total Charity Care** | | | | |
| | | | | | |
| 5970 | Administrative Adjustments | | | | |
| | | | | | |
| 5980 | Other Deductions (Specify) | | | | |
| | **Total Deductions From Revenue** | | | | |

Explanation:

Hospital Information

Balance Sheet – Unrestricted Fund-Hospital **Aggregate**

| **Assets** | Partial YR_____ | Projected YR _____ | Projected YR _____ | Projected YR _____ |
|---|---|---|---|---|
| Current Assets: | | | | |
| Cash | | | | |
| Marketable Securities | | | | |
| Accounts Receivable | | | | |
| Less-Estimated Uncollectable & Allowances | | | | |
| Receivables From Third Party Payors | | | | |
| Pledges And Other Receivables | | | | |
| Due From Restricted Funds | | | | |
| Inventory | | | | |
| Prepaid Expenses | | | | |
| Current Portion Of Funds Held In Trust | | | | |
| **Total Current Assets** | | | | |
| Board Designated Assets: | | | | |
| Cash | | | | |
| Marketable Securities | | | | |
| Other Assets | | | | |
| **Total Board Designated Assets** | | | | |
| Property, Plant and Equipment: | | | | |
| Land | | | | |
| Land Improvements | | | | |
| Buildings | | | | |
| Fixed Equipment - Building Service | | | | |
| Fixed Equipment - Other | | | | |
| Equipment | | | | |
| Leasehold Improvements | | | | |
| Construction In Progress | | | | |
| **Total Property, Plant & Equipment** | | | | |
| Less Accumulated Depreciation | | | | |
| **Net Property, Plant & Equipment** | | | | |
| Investments and Other Assets: | | | | |
| Investments In Property, Plant & Equipment | | | | |
| Less - Accumulated Depreciation | | | | |
| Other Investments | | | | |
| Other Assets | | | | |
| **Total Investments & Other Assets** | | | | |
| Intangibles Assets: | | | | |
| Goodwill | | | | |
| Unamortized Loan Costs | | | | |
| Preopening And Other Organization Costs | | | | |
| Other Intangible Assets | | | | |
| **Total Intangible Assets** | | | | |
| **Total Assets** | | | | |

Hospital Information

Balance Sheet - Unrestricted Fund-**Hospital Aggregate**

| **Liabilities and Fund Balances-Unrestricted** | Partial YR_____ | Projected YR_____ | Projected YR_____ | Projected YR_____ |
|---|---|---|---|---|
| Current Liabilities: | | | | |
| Notes and Loans Payable | | | | |
| Accounts Payable | | | | |
| Accrued Compensation and Related Liabilities | | | | |
| Other Accrued Expenses | | | | |
| Advances from Third Party Payors | | | | |
| Payables to Third Party Payors | | | | |
| Due to Restricted Funds | | | | |
| Income Taxes Payable | | | | |
| Other Current Liabilities | | | | |
| Current Maturities of Long Term Debt | | | | |
| **Total Current Liabilities** | | | | |
| Deferred Credits: | | | | |
| Deferred Income Taxes | | | | |
| Deferred Third Party Revenue | | | | |
| Other Deferred Credits | | | | |
| **Total Deferred Credits** | | | | |
| Long Term Debt: | | | | |
| Mortgage Payable | | | | |
| Construction Loans - Interim Financing | | | | |
| Notes Payable | | | | |
| Capitalized Lease Obligations | | | | |
| Bonds Payable | | | | |
| Notes and Loans Payable to Parent | | | | |
| Noncurrent Liabilities | | | | |
| **Total t** | | | | |
| Less Current Maturities of Long Term Debt | | | | |
| **Total Long Term Debt** | | | | |
| **Unrestricted Fund Balance** | | | | |
| **Equity (Investor Owned)** | | | | |
| Preferred Stock | | | | |
| | | | | |
| Common Stock | | | | |
| | | | | |
| Additional Paid In Capital | | | | |
| | | | | |
| Retained Earnings (Capital Account for Partnership or Sole Proprietorship) | | | | |
| | | | | |
| Less Treasury Stock | | | | |
| **Total Equity** | | | | |
| **Total Liabilities and Fund Balance or Equity** | | | | |