

**Official Use Only-Date Received:**

**Application for Certificate of Need  
Lease 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)**

**Lessor (Owner):**

Legal Name of Lessor:

Address of Lessor:

Name and Title of Responsible Officer: **(Print)**

Signature of Responsible Officer

Date:

Telephone:

**Lessee (Operator):**

Legal Name of Lessee:

Address of Lessee:

Name and Title of Responsible Officer: **(Print)**

Signature of Responsible Officer

Date:

Telephone:

**Current Ownership Type:**

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

**Lessee Type:**

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

**Project Description Summary:**

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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 Lease 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.)

- 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 **\$34,457**. 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

#### To mail overnight, UPS or FedEx:

Department of Health  
Certificate of Need Program  
310 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.

### A. Applicant (Lessee) Description

1. Legal name(s) of lessee(s)
2. Address of each lessee(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.
  - c. Entity Name
  - d. Address
  - e. Phone number
  - f. Contact person
  - g. Applicant or related party facility name

## II. General Information

### A. Facility Information

1. Name of Facility to be leased: \_\_\_\_\_  
 Address: \_\_\_\_\_

### B. Capacity and Service Information

1. Provide the following Bed Capacity information:

	Current	Proposed
24 hr assigned and set-up (acute care)	_____	_____
24 hr assignable-not set-up (acute care). <small>These are spaces that meet licensure standards and the hospital has ready access to required movable equipment.</small>	_____	_____
Dedicated or PPS exempt Psychiatric	_____	_____
Dedicated or PPS exempt Rehabilitation	_____	_____
Long Term Care/Nursing Home Beds	_____	_____
Intermediate Care Nursery Level II	_____	_____
Neonatal Intensive Care Level III	_____	_____
Total Licensed Beds (sum of above)	_____	_____
Banked LTC/Nursing Home Beds	_____	_____
Swing Beds (as defined by Medicare)	_____	_____

2. Identify the primary geographic planning/service area currently served by this facility.

3. Provide the following Scope of Service information:

<b>Obstetrical/Medical/Surgical Services</b>	Current	Proposed
Perinatal/Obstetrical Services		
Cesarean Section	<input type="checkbox"/>	<input type="checkbox"/>
Intermediate Care Nursery	<input type="checkbox"/>	<input type="checkbox"/>
LDRP	<input type="checkbox"/>	<input type="checkbox"/>
NICU	<input type="checkbox"/>	<input type="checkbox"/>
Critical Care	<input type="checkbox"/>	<input type="checkbox"/>
Pediatric	<input type="checkbox"/>	<input type="checkbox"/>
Emergency	<input type="checkbox"/>	<input type="checkbox"/>
Dialysis		
Acute	<input type="checkbox"/>	<input type="checkbox"/>
Diagnostic Services		
Cardiac Cath Lab	<input type="checkbox"/>	<input type="checkbox"/>
Endoscopy	<input type="checkbox"/>	<input type="checkbox"/>
Imaging	<input type="checkbox"/>	<input type="checkbox"/>
Laboratory	<input type="checkbox"/>	<input type="checkbox"/>
Other (list)	<input type="checkbox"/>	<input type="checkbox"/>
Therapeutic Services		
Cardiac Cath Lab	<input type="checkbox"/>	<input type="checkbox"/>
Endoscopy	<input type="checkbox"/>	<input type="checkbox"/>
Other (list)	<input type="checkbox"/>	<input type="checkbox"/>
Medical Services-Other (list)	<input type="checkbox"/>	<input type="checkbox"/>
Surgical Services		
Inpatient	<input type="checkbox"/>	<input type="checkbox"/>
Outpatient	<input type="checkbox"/>	<input type="checkbox"/>
Contracted Services (list)	<input type="checkbox"/>	<input type="checkbox"/>
Outpatient Services (list)	<input type="checkbox"/>	<input type="checkbox"/>
Mobile Services (list)	<input type="checkbox"/>	<input type="checkbox"/>

**Other services**

Dialysis

Outpatient

Long Term Care/Nursing Home

Chemical Dependency

Inpatient

Outpatient

Psychiatric

Rehabilitation

4. 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.

- Month/Year 25% toward completion
- Month/Year 50% toward completion
- Month/Year 75% toward completion
- 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 lease. 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 lease.
- 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
  - b. Copy of the hospital's community service report, if available
  - c. 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.
  - d. Other information as appropriate
- 3. Provide the following for the post lease hospital operations:
  - a. Copy of the hospital's admissions policy
  - b. Copy of the hospital's community service report, if available
  - c. 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 these charity care policies.
  - d. Other information as appropriate
- 4. Charity Care Levels: Lessor's hospital operations:

	Historical Year	Historical Year	Last full Year
Dollar Amount			
% of total Revenue			
% of Adjusted Revenue			

5. Charity Care Levels: Lessee'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)**

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

**A. Financial Statements**

1. Provide a copy of the proposed lease. 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 lease.

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 lease.

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 lease.

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 lessee's current operation.

**C. 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. <b>Total</b> (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 lease.
- 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, physician privileges, etc. as a result of this proposed lease.

### **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 in 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 Lessee 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.
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 lessee or lessor is organizationally connected to a hospital district, provide a discussion of how the lease 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      Historical      Historical      Historical  
 YR \_\_\_\_\_ YR \_\_\_\_\_ YR              YR \_\_\_\_\_

Operating Revenue:

Inpatient Revenue				
Outpatient Revenue				
<b>Total Patient Service Revenue</b>				

Deductions From Revenue:

Provision for Bad Debt				
Contractual Adjustments				
Charity and Uncompensated Care				
Other Adjustments and Allowances				
<b>Total Deductions From Revenue</b>				
<b>Net Patient Service Revenue</b>				

Other Operating Revenue

Other Operating Revenue				
Tax Revenues				
<b>Total Other Operating Revenue</b>				
<b>Total Operating Revenue</b>				

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				
<b>Total Operating Expenses</b>				

**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**

Current      Historical      Historical      Historical  
YR \_\_\_\_\_ YR \_\_\_\_\_ YR \_\_\_\_\_ YR \_\_\_\_\_

Acct: Item:

5800	Provision For Bad Debts				
<b>Contractual Adjustments</b>					
5810	Medicare				
5820	Medicaid				
5830	Workers Compensation				
5840	Other Government Programs				
5850	Negotiated Rates				
5860	Other				
	<b>Total Contractual Adjustments</b>				
<b>Charity Care</b>					
5900	Inpatient				
5910	Outpatient				
	<b>Total Charity Care</b>				
5970	Administrative Adjustments				
5980	Other Deductions (Specify)				
	<b>Total Deductions From Revenue</b>				

Explanation:

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

<b>Assets</b>	Current YR _____	Historical YR _____	Historical YR _____	Historical YR _____
<b>Current Assets:</b>				
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				
<b>Total Current Assets</b>				
<b>Board Designated Assets:</b>				
Cash				
Marketable Securities				
Other Assets				
<b>Total Board Designated Assets</b>				
<b>Property, Plant and Equipment:</b>				
Land				
Land Improvements				
Buildings				
Fixed Equipment - Building Service				
Fixed Equipment - Other				
Equipment				
Leasehold Improvements				
Construction In Progress				
<b>Total Property, Plant &amp; Equipment</b>				
Less Accumulated Depreciation				
<b>Net Property, Plant &amp; Equipment</b>				
<b>Investments and Other Assets:</b>				
Investments In Property, Plant & Equipment				
Less - Accumulated Depreciation				
Other Investments				
Other Assets				
<b>Total Investments &amp; Other Assets</b>				
<b>Intangibles Assets:</b>				
Goodwill				
Unamortized Loan Costs				
Preopening And Other Organization Costs				
Other Intangible Assets				
<b>Total Intangible Assets</b>				
<b>Total Assets</b>				

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

<b>Liabilities and Fund Balances-Unrestricted</b>	Current YR_____	Historical YR_____	Historical YR_____	Historical YR_____
<b>Current Liabilities:</b>				
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				
<b>Total Current Liabilities</b>				
<b>Deferred Credits:</b>				
Deferred Income Taxes				
Deferred Third Party Revenue				
Other Deferred Credits				
<b>Total Deferred Credits</b>				
<b>Long Term Debt:</b>				
Mortgage Payable				
Construction Loans - Interim Financing				
Notes Payable				
Capitalized Lease Obligations				
Bonds Payable				
Notes and Loans Payable to Parent				
Noncurrent Liabilities				
<b>Total t</b>				
Less Current Maturities of Long Term Debt				
<b>Total Long Term Debt</b>				
<b>Unrestricted Fund Balance</b>				
<b>Equity (Investor Owned)</b>				
Preferred Stock				
Common Stock				
Additional Paid In Capital				
Retained Earnings (Capital Account for Partnership or Sole Proprietorship)				
Less Treasury Stock				
<b>Total Equity</b>				
<b>Total Liabilities and Fund Balance or Equity</b>				

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

Partial      Projected      Projected      Projected  
 YR \_\_\_\_\_ YR \_\_\_\_\_ YR \_\_\_\_\_ YR \_\_\_\_\_

Operating Revenue:

Inpatient Revenue				
Outpatient Revenue				
<b>Total Patient Service Revenue</b>				

Deductions From Revenue:

Provision for Bad Debt				
Contractual Adjustments				
Charity and Uncompensated Care				
Other Adjustments and Allowances				
<b>Total Deductions From Revenue</b>				

**Net Patient Service Revenue**

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Other Operating Revenue

Other Operating Revenue				
Tax Revenues				
<b>Total Other Operating Revenue</b>				

**Total Operating Revenue**

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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				
<b>Total Operating Expenses</b>				

**Net Operating Revenue**

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**Non-Operating Revenue-Net of Expenses**

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**Net Revenue Before Items Listed Below**

--	--	--	--	--

Extraordinary Item

--	--	--	--	--

Federal Income Tax

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**Net Revenue or (Expense)**

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Explanation:

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Hospital Information  
Deductions From Revenue-**Hospital Aggregate**

Partial      Projected      Projected      Projected  
YR \_\_\_\_\_ YR \_\_\_\_\_ YR \_\_\_\_\_ YR \_\_\_\_\_

Acct:    Item:

5800	Provision For Bad Debts				
<b>Contractual Adjustments</b>					
5810	Medicare				
5820	Medicaid				
5830	Workers Compensation				
5840	Other Government Programs				
5850	Negotiated Rates				
5860	Other				
	<b>Total Contractual Adjustments</b>				
<b>Charity Care</b>					
5900	Inpatient				
5910	Outpatient				
	<b>Total Charity Care</b>				
5970	Administrative Adjustments				
5980	Other Deductions (Specify)				
	<b>Total Deductions From Revenue</b>				

Explanation:

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

<b>Assets</b>	Partial YR _____	Projected YR _____	Projected YR _____	Projected YR _____
<b>Current Assets:</b>				
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				
<b>Total Current Assets</b>				
<b>Board Designated Assets:</b>				
Cash				
Marketable Securities				
Other Assets				
<b>Total Board Designated Assets</b>				
<b>Property, Plant and Equipment:</b>				
Land				
Land Improvements				
Buildings				
Fixed Equipment - Building Service				
Fixed Equipment - Other				
Equipment				
Leasehold Improvements				
Construction In Progress				
<b>Total Property, Plant &amp; Equipment</b>				
Less Accumulated Depreciation				
<b>Net Property, Plant &amp; Equipment</b>				
<b>Investments and Other Assets:</b>				
Investments In Property, Plant & Equipment				
Less - Accumulated Depreciation				
Other Investments				
Other Assets				
<b>Total Investments &amp; Other Assets</b>				
<b>Intangibles Assets:</b>				
Goodwill				
Unamortized Loan Costs				
Preopening And Other Organization Costs				
Other Intangible Assets				
<b>Total Intangible Assets</b>				
<b>Total Assets</b>				

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

<b>Liabilities and Fund Balances-Unrestricted</b>	Partial YR_____	Projected YR_____	Projected YR_____	Projected YR_____
<b>Current Liabilities:</b>				
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				
<b>Total Current Liabilities</b>				
<b>Deferred Credits:</b>				
Deferred Income Taxes				
Deferred Third Party Revenue				
Other Deferred Credits				
<b>Total Deferred Credits</b>				
<b>Long Term Debt:</b>				
Mortgage Payable				
Construction Loans - Interim Financing				
Notes Payable				
Capitalized Lease Obligations				
Bonds Payable				
Notes and Loans Payable to Parent				
Noncurrent Liabilities				
<b>Total t</b>				
Less Current Maturities of Long Term Debt				
<b>Total Long Term Debt</b>				
<b>Unrestricted Fund Balance</b>				
<b>Equity (Investor Owned)</b>				
Preferred Stock				
Common Stock				
Additional Paid In Capital				
Retained Earnings (Capital Account for Partnership or Sole Proprietorship)				
Less Treasury Stock				
<b>Total Equity</b>				
<b>Total Liabilities and Fund Balance or Equity</b>				