



180 N. Stetson Ave.  
Suite 2555  
Chicago, IL 60601  
312-651-1300 (phone)  
312-651-1350 (fax)  
[www.il-fa.com/healthcare](http://www.il-fa.com/healthcare)

## **Revolving Fund Pooled Financing Program Application for Approval of Participation**

*Please deliver two (2) copies of this application, including required attachments, to the Illinois Finance Authority.*

If you have questions regarding this application, contact:  
Pamela A. Lenane at 312-651-1340, [plenane@il-fa.com](mailto:plenane@il-fa.com).

*Please complete all questions. If not applicable, write N/A.*

**Name of Institution:** \_\_\_\_\_

**Address:** \_\_\_\_\_

\_\_\_\_\_

**Contact Person:** \_\_\_\_\_  
**(Please list two)** (Name)

\_\_\_\_\_  
(Phone Number)

\_\_\_\_\_  
(Name)

\_\_\_\_\_  
(Phone Number)

**Date of Application:** \_\_\_\_\_

**I. AMOUNT & DESCRIPTION OF REQUESTED LOAN(S)**

- A) The maximum amount of the loan is \$\_\_\_\_\_. The requested term of the loan is \_\_\_\_\_ years.
- B) Please describe the use of the requested loan proceeds. Loan proceeds can be used to refinance or reimburse the Institution for the costs of qualified capital expenditures. Please specify whether the term loan is for an acquisition, refinancing, or reimbursement. If the loan proceeds will be used in more than one facility, indicate how much of the proceeds of the loan will be used in each facility.

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**II. DOCUMENTS & INFORMATION TO BE ATTACHED TO APPLICATION**

- A) Copies of the Institution's last five audited financial statements including all supplements and notes.
- B) A copy of the latest internally prepared financial statement of the Institution.
- C) Utilization statistics and payor mix for the periods coinciding with those of the financial statements.
  - a.) Payor mix as a percentage of gross patient revenues
  - b.) Adult inpatient admissions
  - c.) Total number of admitting physicians, and the % of adult admissions from the top 10 admitting physicians (including specialty and age)
  - d.) Adult patient days
  - e.) Average adult length of stay
  - f.) Newborn admissions
  - g.) Beds in service and licensed beds
  - h.) % of Adult occupancy
  - i.) ER visits
  - j.) Total outpatients visits
  - k.) Total inpatient surgeries
  - l.) Total outpatient surgeries
  - m.) SNF Admissions (skilled nursing facility located with the hospital, if applicable)
  - n.) SNF Beds in service
  - o.) SNF % occupancy
- D) A copy of the Institution's annual budget and any long-range plan, including capital expenditures.
- E) A copy of the Institution's latest Official Statement or Private Placement Memoranda, if applicable.
- F) Please provide a summary of senior management and Board members.
- G) Please provide a brief history of your Institution.

**Note:**

***If your Institution has issued public debt within the past five years, please use the Official Statement or Private Placement Memoranda as the basis of your information packet and insert updated information wherever appropriate.***

***The Credit Provider requests the information above to provide them with a preliminary overview of your Institution and loan request. The Credit Provider reserves the right to request additional information and perform reasonable due diligence in the future.***

**I hereby certify that, to the best of my knowledge,  
all information on this Application is true and complete.**

\_\_\_\_\_  
*Name of Institution*

**By:** \_\_\_\_\_

**Title:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Please deliver two (2) copies of  
this application, including  
required attachments, to:**

**Illinois Finance Authority**  
Attention: Pamela Lenane  
180 N. Stetson Ave, Ste. 2555  
Chicago, IL 60601  
312-651-1339 (phone)  
312-651-1350 (fax)  
plenane@il-fa.com

[www.il-fa.com](http://www.il-fa.com)

Thank you for your application.