CAMBRIDGE

Senior Housing & Healthcare Capital

1 NORTH LASALLE STREET | 37TH FLOOR | CHICAGO, IL 60602 | M 312-357-1601 | F 312-357-1611

WWW.CAMBRIDGECAP.COM

MINIMUM CRITERIA FOR CONSIDERATION FOR FHA 242 HOSPITAL MORTGAGE INSURANCE

(Internal Document Prepared for Usage by HUD Lenders)

This "Customer Self-Determination" Pre-Test offers guidelines to help potential applicants reach their own preliminary assessments on whether or not they meet the following minimum criteria for HUD Section 242 Mortgage Insurance. Passing this Pre-Test **DOES NOT** assure that an application will be approved.

1. Is your facility a licensed hospital? (Requisite Response: **YES**)

   a. For the most recently completed Fiscal Year, was the total of revenues earned by delivering the following services more than 50% of the hospital's total revenues? (Requisite Response: **NO**)

      1.1 Chronic convalescent and rest
      1.2 Drug and alcoholic
      1.3 Epileptic
      1.4 Nervous and mental
      1.5 Mentally deficient
      1.6 Tuberculosis care

   a. Through the end of the project construction and for two complete Fiscal Years thereafter, do you anticipate that during any Fiscal Year the total of revenues earned by delivering the above services will be more than 50% of the hospital's total revenues? (Requisite Response: **NO**)

   b. Does your State have a Certificate of Need (CON) process?

   c. If yes, has a CON been issued? (Requisite Response: **YES** or **PENDING**)

   d. If no, would the State be willing to commission or conduct an independent Feasibility Study, paid for by the hospital and which may be reimbursed from mortgage proceeds? (Requisite Response: **YES**)

(**Note**: If you have questions about your State's CON program or do not know whom to contact, then we encourage you to contact first your State Health Planning and Development Agency, State Hospital Licensure Agency, or State Department of Health. We are available to answer questions that your State's CON agency may have).

e. After the project construction is completed, will the mortgage exceed 90% of the estimated book value of all property (existing before project, new additions and/or renovations after project) that secures the mortgage? (Requisite Response: **NO**)

f. Will you grant to the HUD-insured lender a first mortgage on the entire hospital, including all additions, annexes, parcels, and fixtures, such as parking lots, physical plants, etc.? (**Note:** exceptions may include leased equipment, off-site property, capital associated with affiliations, etc.) (Requisite Response: **YES**)

g. Are you willing to make monthly payments into a Mortgage Reserve Fund that will build to: (a) a balance equal to one year of debt service after five years, and (b) a balance equal to two years of debt service after 10 years? (Requisite Response: **YES**)

h. Over the last three full Fiscal Years, has the average operating margin been equal to or greater than 0.00? (Requisite Response: **YES**)

Operating Margin =

$$\frac{\begin{array}{l}\textit{Operating Net Income from Last Full FY} \\ + \quad \textit{Operating Net Income from Two Full FYs Ago} \\ + \quad \textit{Operating Net Income/from Three Full FYs Ago}\end{array}}{\begin{array}{l}\quad \textit{Total Operating Revenues from Last Full FY} \\ + \quad \textit{Total Operating Revenues from Two Full FYs Ago} \\ + \quad \textit{Total Operating Revenues from Three Full FYs Ago}\end{array}}$$

(**Note:** Include leases in calculations for both Operating Margin and Debt Service Coverage Ratio below.)

i. Over the last three full Fiscal Years, has the average debt service coverage ratio been equal to or greater than 1.257 (Requisite Response: **YES**)

Debt Service Coverage Ratio (DSC) =

$$\frac{\textit{Net Income + Depreciation Expense + Interest Expense}}{\textit{Current Portion of Long-Term Debt (Prior Year) + Interest Expense}}$$

Compute the DSC for each of the last three full Fiscal Years, then compute the average DSC for the three years.

Checklist of Required Documents

1. Audited financial statements for the last three years.
2. A completed copy of Exhibit 1.
3. Amount and sources of funds for the project equity contribution.
4. General Description of the hospital and the proposed project.
    a. Overview of the services offered in the hospital (including inpatient, outpatient, and long-term care services).
    b. Narrative of need and justification for construction and equipment, including existing physical deficiencies and operational problems in providing services.
    c. Description of the project and how construction and equipment will eliminate deficiencies, affect patient care programs and improve services.
    d. Listing of key management personnel and qualifications (including at a minimum: CEO, CFO, Medical Director and Nursing Directors).
    e. Description of real property and any existing liens.
5. Business Organization and Corporate Relationships
    a. Description of organizational structure (e.g., non-profit / 501[c](3) tax-exempt).
    b. Description and documentation of ownership and governance including board members with background information or a list of stockholders for investor owned hospitals.
    c. List and describe all affiliated organizations (including all subsidiaries, parent organizations / holding companies and joint ventures) and describe basis for affiliation, indicating name, address and type of legal relationship. Include an organization chart clearly showing the linkages with all subsidiary / parent / related organizations.
    d. Describe the hospital's collaboration with other entities to integrate healthcare delivery as well as its relationship with existing and developed managed care organizations in its service area.
6. A copy of this hospital's board minutes or resolution authorizing the proposed project, the proposed loan amount and the individual(s) to act on behalf of the hospital.
7. Certificate of Need (if required by the State) and a copy of the CON application and review documents.
8. Last JCAHCO or State License survey (deficiencies and corrections).
9. Copy of facility license.

Exhibit 1

Project Name: ____

Location and Description of Property

Address: ______________________________ City: ____________________

County: ____________________ State: ____________ Zip Code: ______________

Number of Beds: __________

Multi-Story: __________

One Story: __________

Number of Elevators: __________

Type of Project Proposed: __________

Estimated Replacement Costs

1. Total Construction Cost Per contracts __________
2. Fees
   - Architect's Fee - Design ____________
   - Architect's Fee - Supervisory ____________
   - Construction Management Fee ____________
   - Other Fees ____________

   Total Fees:
3. Other
   - Site Demolition Costs ____________
   - Other (Identify) ____________
   - Other (Identify) ____________
   - Other (Identify) ____________
   - Other (Identify) ____________
   - Other (Identify) ____________

   Total Other __________
4. Equipment and Furnishing (Actual Cost) __________

   Total for All Improvements and Equipment ____________

5. Legal & Organization Costs

Organization	____________	
Consultant	____________	
Total Legal & Organization		_________

6. Total Estimated Replacement Cost (Exclusive of Land) _________
7. Net Book Value on Existing Property, Plant & Equipment _________
8. Total Estimated Replacement Cost of Project _________

DISCLAIMER: This financing outline is designed to provide immediate information regarding a specific real estate capital structure on the above-captioned transaction utilizing HUD insured financing. It is not a Commitment Letter and is subject to complete review and underwriting by HUD and Cambridge Realty Capital Ltd. of Illinois. The information contained herein is for preliminary review purposes only and is subject to errors, omissions, and changes, all without notice. N:\GoldMine\FaxRush\Outfax\execacutehudselftest.doc