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MUNICIPAL BOND INVESTORS ASSURANCE CORPORATION
APPROVAL APPLICATION FOR
1985 POOL LOAN PROGRAM

One executed copy and 3 photocopies (including the attachments hereto) of this application are to be delivered to the Issuer of the Bonds or its designee at the following address:

North Carolina Medical Care Commission
LOCATION: 701 BARBOUR DRIVE 27603
2701 MAIL SERVICE CENTER
Raleigh, North Carolina 27699-2701
Attention: Robert J. Fitzgerald

The Issuer or its designee, NCMCC, will deliver two copies of this application to the Municipal Bond Investors Assurance Corporation, 113 King Street, Armonk, New York 10504.

Title of Issue
North Carolina Medical Care Commission
Hospital Revenue Bonds, Series 1985
(Pooled Financing Loan Program)

Loan Amount_____

1. General Hospital Information

Name:_____

Address:_____

_____

Description of Services -- Please note those services provided principally or exclusively by your institution as opposed to competitors.

_____

_____

_____

_____

Contact:_____
Phone Number:_____
Date Submitted:_____

2. Loan Amount $ _____ Term of Loan _____ years

Projected Debt Service -- State annual amounts of principal and interest due for each year in loan program. Include as separate items:

a. Annual Loan Repayment amount for this proposal $_____

b. Maximum Annual Debt Service (MADS) on all other Long-Term Indebtedness -- Please itemize Indebtedness and its MADS

(1) Issue _____ MADS $ _____
(2) Issue _____ MADS $ _____
(3) Issue _____ MADS $ _____

Please outline in detail use of proceeds for this program, specifying whether proceeds are for new expenditures and/or reimbursement for prior expenditures.

_____

_____

_____

_____

_____

3. Future Financing -- Please detail any future financing plans.

_____

_____

_____

_____

_____

4. Current Credit Ratings of Hospital

Moody's Investors Service, Inc.
Rating _____

Standard & Poor's Corporation
Rating _____

Other (please specify) _____
Rating _____

5. Management

Board of Directors

In the space below briefly provide a general overview of the Board of Directors, including tenure, background, length of term of individual board members, committee activity, physician representation, ex officio members and any other pertinent data:

_____

_____

_____

_____

_____

_____

_____

Administration

List below the key members of the Administration, including tenure, work experience and educational background:

Administrator/Chief Executive Officer

_____
_____
_____

Chief Financial Officer

_____
_____
_____

Assistant Administrator

_____
_____
_____

Director of Nursing

_____
_____
_____

Others

_____

6. Breakdown of Beds

List below the breakdown of licensed beds and (indicate in parentheses) beds in operation. Note in the remaining spaces any proposed changes to the bed complement.

Medical/Surgical _____(_____) Obstetrics _____(_____)
Intensive Care _____(_____) Psychiatric _____(_____)
Coronary Care _____(_____) Long-term Care _____(_____)
Pediatrics _____(_____) Other _____(_____)

_____

_____

_____

7. Utilization Data

Outline below the historic utilization of the hospital for the last four years.

Year Ended --	19____	19____	19____	19____	Y-T-D ____/____ mo. yr.
Licensed (Operated beds)	___(__)	___(__)	___(__)	___(__)	___(__)
Admissions.....	_____	_____	_____	_____	_____
Patient Days.....	_____	_____	_____	_____	_____
Average Length of Stay..	_____	_____	_____	_____	_____
Occupancy*.....	_____	_____	_____	_____	_____
Emergency.....	_____	_____	_____	_____	_____
Outpatient.....	_____	_____	_____	_____	_____
Outpatient Surgery.....	_____	_____	_____	_____	_____

*based on _____ bed

Interim Utilization

Please discuss utilization information for the interim period since the end of the last fiscal year, as noted above, and reasons for variations from prior periods.

_____

_____

_____

_____

8. Medical Staff

Fill in the indicated medical staff information for the last four years.

	19___	19___	19___	19___
Active Physicians.....	_____	_____	_____	
Associate Physicians.....	_____	_____	_____	
Percentage Board Certified.....	_____	_____	_____	

Average Age of Active Physicians	_____	_____	_____

Top 10 Admitters (individuals)

Specialty	% Admissions	Age
	Total	Average

9. Competing Service Area Hospitals

List below other service area hospitals.

Hospital (Location)	Beds	Occupancy (19__)	Estimated Distance Away

Describe briefly your competitive position in the service area, specifying your market share in both primary and secondary markets.

_____

_____

_____

_____

10. Revenue Composition

a. Outline as indicated below the source of hospitals revenues for the last three years.

	19____	19____	19____
Medicare	_____%	_____%	_____%
Medicaid	_____	_____	_____
Blue Cross	_____	_____	_____
Commercial Insurance	_____	_____	_____
Self-Pay	_____	_____	_____
Other	_____	_____	_____

b. Indicate net effect of Prospective Payment System. Outline your DRG case mix; effect of top ten DRG's; impact of top ten admitters on DRG admissions/cost.

_____

_____

_____

_____

c. Health Maintenance Organization(s) Contracts

_____

_____

_____

d. Preferred Provider Organization(s) Contracts

_____

_____

_____

11. Economy

Population Trends	**19_____**	**19_____**	**19_____**
City			
County			

Major employers in Service Area **Total Employees**

_____

_____

_____

_____

_____

Current Unemployment Rate _____ % as of _____

Area Credit Ratings	**Moody's**	**Standard & Poor's**
City		
County		

12. Insurance

For the various categories listed below indicate the amount and type of insurance carried.

Medical Malpractice

_____

_____

Fire and Hazard

_____

_____

General Liability

_____

_____

Worker's Compensation

_____

_____

Business Interruption

_____

_____

Disaster Insurance -- Please specify if Earthquake Insurance is included.

_____

_____

Litigation

Outline below any major litigation which would significantly exceed the levels of insurance coverage at the time of the incident.

_____

_____

_____

_____

13. Required documentation to be supplied with the application.

* **Audits for the last four years.**

* **Interim financial statements (with year-to-year comparisons).**

* **Documentation related to existing and proposed financings. Please include Official Statements for past issues and Feasibility Studies.**

* **Information on corporate structure, affiliates (including affiliate foundation), description of physical facilities and/or campus -- if not already included in the Official Statement or Feasibility Study.**

* **Copies of existing legal covenants -- unless those outlined in the Official Statement are the sum total of your institution's legal covenants.**

Future Information Requirements

* **Annual audit and utilization data for the year as soon as available.**

* **In connection with this Application, the hospital agrees to supply any additional information to the insurer upon reasonable request.**

_____

Name of Institution

By _____