

Date:

**HEALTH RESOURCES AND SERVICES ADMINISTRATION
TITLE XVI HEALTH CENTER LOAN GUARANTEE
PROGRAM APPLICATION**

I. BACKGROUND

Legal Name of Borrower: _____

Current Address: _____

Address of Project: _____

Executive Director: _____

Telephone: _____

Contact Name (if different): _____

Title: _____

Telephone: _____

Amount of Guaranteed Loan: _____

The following index lists the documentation that **must** be submitted as part of any loan guarantee request. Please number and submit each item consistent with the numbers in this index.

1. Business Plan

Applicants for HRSA's Loan Guarantee Program must submit a well-developed business plan as part of the process for requesting a loan guarantee. Attachment 1 is a document entitled "Creating a Business Plan for a Community Health Center Capital Project," which was developed by Capital Link to assist health centers in this endeavor. Please use it as a model for developing your business plan. **All of the major topic areas shown in the Suggested Business Plan Outline on page 5 of this document must be addressed in your business plan in order to provide for expedited processing of your loan guarantee application.**

Capital Link has also developed a spreadsheet application called ForecasT, to assist health centers with developing financial projections for their business plans. The business plan schedules lists later in this section are included as part of ForecasT. Capital Link is available to assist you without charge in the development of application materials for the Loan Guarantee Program, including your business plan. You are encouraged to contact Ms. Allison Coleman of Capital Link at (617) 422-0350 for assistance in this area.

Historical information included in the business plan should cover the last three fiscal years. Budget projections included in the business plan must cover the period from the present through completion of construction, plus three additional years after occupancy. **It is critical that the health center clearly enumerate all assumptions used in developing the utilization and financial projections.** The following items must be included as part of your business plan:

Schedule 1: Historical and Projected Income Statements

Schedule 2: Historical and Projected Statements of Cash Flow

Schedule 3: Historical and Projected Balance Sheets

Schedule 4: Historical and Projected utilization and reimbursement information

Schedule 5: Historical and Projected Payor mix and description of reimbursement methodologies

Schedule 6: Historical and Projected grants and contract information

Schedule 7: Historical and Projected staffing information

Schedule 8: Detailed capital project budget

Schedule 9: Sources and uses of project funds

- 2. Audited financial statements (including opinion letter and all notes) for the last three fiscal years.**
- 3. Management Letters, along with management's responses, for the last three fiscal years.**
- 4. Year-to-date internal financial statements and operating statistics with comparisons to the same period in the previous fiscal year. Financial statements should be prepared using the accrual methodology and should conform to GAAP.**
- 5. Budget (income and expense projections) for the current fiscal year. If your health center is in the final quarter of its current fiscal year, also include the budget for the next fiscal year.**
- 6. Complete list of your Board of Directors, including names, addresses, employer and position. All officers should be identified.**
- 7. Staffing chart showing all senior managers.**
- 8. Resumes for all senior managers.**

Please also provide the following items, in addition to the business plan items described above.

- 9. Completed questionnaire providing additional background information (see Attachment 2).**
- 10. Bank letter stating preliminary terms and conditions.**
- 11. Building plans and materials specifications (or at least at a 30% design review phase of development).**
- 12. Certification by an authorized official of the health center (see Attachment 3).**

PLEASE SUBMIT THREE COPIES OF YOUR BUSINESS PLAN AND APPLICATION TO:

Joe Fitzmaurice, Facility Development Coordinator
Bureau of Primary Health Care
Division of Community and Migrant Health
4350 East West Highway, 7th Floor
Bethesda, MD 20814

Questionnaire -- Additional Background Information

(Please answer all questions as completely and accurately as possible. If you have included this information in your business plan, you may reference the applicable page # of your plan in lieu of repeating the information here.)

I. BUSINESS ORGANIZATION AND CORPORATE RELATIONSHIPS

A. Are you corporately integrated with (e.g., a subsidiary of) any other organization? Yes____ No

If yes, please indicate name, address, type of legal relationship, and nature of integration.

B. Are you involved in any joint ventures? Yes____ No

If yes, please indicate names, addresses, and types of legal relationships.

C. Is there a developing or operating Health Center managed care network in your marketplace?

Yes____ No

If yes, is your health center involved? Yes____ No

D. How is the health center collaborating with other entities to integrate service delivery?

II. PROJECT INFORMATION

A. Construction financing will be needed: From: _____ to _____

Permanent financing will be needed: From: _____ to _____

B. The facility housing the project to be financed is: Owned ____ To Be Purchased

If you currently own, is your facility mortgaged? Yes ____ No

C. Site Control:

If you do not presently own the site, please describe the status of your plans to purchase the site (i.e. what needs to be done for you to control the site). Indicate the estimated acquisition price for the proposed site and, if applicable, provide a copy of the sales agreement.

D. Facility Square Footage: In the table below, please indicate the total square footage of your current facility and the projected total square footage following the project. If you operate more than one site, complete this chart for each site.

Description of Area	Current Site (Sq. ft.)	Projected Site (Sq. ft.)
Medical		
Dental		
Laboratory		
Administrative		
Other (specify)		
Total Sq. Footage		

E. Will any other organization occupy space at this facility? Yes ____ No

If yes, please attach a list showing the name of the organization(s), amount of space to be occupied, and terms of lease(s).

F. In the table below, please indicate the daily hours of operation of the health center.

Hours of Operation	Sun.	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Total:
Existing								
Planned								

III. FINANCIAL INFORMATION

A. Please provide the following information for each outstanding loan:

- Date of Loan: _____ Original Amount: _____

Lender: _____ Outstanding: _____

Interest Rate: _____ Expiration of term: _____

Fixed? Floating? _____ Amortization: _____

Purpose of Loan: _____

Collateral: _____

Please attach additional pages with above information if there is more than one outstanding loan.

B. Does your health center have a working capital line of credit? Yes_____ No_____

If yes, what is the maximum amount of credit availability under your line? \$

What is the current amount outstanding under the line of credit? \$_____

What is used to secure the line of credit?

Is the line extendable to at least 1 year after receipt of loan guarantee? Yes_____ No_____

C. Has the health center ever defaulted on a loan or filed for bankruptcy or protection against creditors?

Yes_____ No

If yes, please attach an explanation.

IV. LITIGATION

Are you aware of any litigation pending against the health center that might materially affect the health center's ability to borrow funds or to repay them? Yes_____ No

If yes, please attach an explanation.

V. ADDITIONAL CONTACTS

Legal Counsel (Firm):_____

Address:_____

Attorney's Name:_____

Telephone:_____

Borrower's Accountant (contact person) : _____

Telephone:_____

Certification by an Authorized Official of the Health Center

The undersigned hereby represents and certifies to the best of his/her knowledge and belief that the information contained in this application and exhibits or attachments hereto is true and complete and accurately describes the nature of the health center and the proposed project, and agrees to promptly inform the Health Resources and Services Administration's Bureau of Primary Health Care of any relevant changes in the proposed/actual project or the information contained herein.

Authorized Official:

Signature:

Title:

Date: