

APPENDIX A

Information Concerning Hillsdale Community Health Center

This Appendix A contains forward-looking statements which are not historical facts. These statements include expressions of the management of Hillsdale Community Health Center (the “Corporation”) about the Corporation’s organizational characteristics, existing and new facilities, services, programs and collaborative ventures, regulatory environment, competitors, market conditions, relationships, technology, demographic trends, operations, fundraising efforts, investment performance and financial condition. These statements are identified with such forward-looking terminology as “expect,” “look,” “believe,” “anticipate,” “may,” “will” or similar terms or variations of such terms. Such forward-looking statements involve risks and uncertainties. Actual results may differ materially from such forward-looking statements. The Corporation assumes no responsibility for updating any such forward-looking statements. This Appendix A should be read together with the section of the Official Statement entitled, “BONDHOLDERS’ RISKS” herein.

TABLE OF CONTENTS

Introduction	A-1
Organizational Information	A-1
History	A-1
Governance	A-3
Management	A-5
Employees and Labor Relations	A-7
Collaborative Ventures	A-7
Licenses, Accreditations, Approvals and Memberships	A-8
Facilities and Services	A-9
The Hospital Facility	A-9
McGuire Unit	A-11
Home Care	A-11
Medical Staff	A-12
Characteristics of the Active Staff	A-12
Referral Patterns	A-14
Medical Staff Recruiting	A-16
Service Volumes and Utilization	A-16
Inpatient Acute Care	A-16
McGuire Unit	A-20
Outpatient and Ancillary Services	A-20
Service Area	A-24
Competing Facilities	A-28
Competing Acute Care Hospitals	A-28
Competing Skilled Nursing Facilities	A-28
Financial Information	A-29
Third-Party Reimbursement Methodologies	A-29
Sources of Acute Care Revenue	A-33
Recent Financial Performance	A-33
Other Financial Information	A-37
Information Systems	A-39

INTRODUCTION

Hillsdale Community Health Center (the “Corporation”) owns and operates a general acute care community hospital (the “Hospital”) in which skilled nursing care is also provided. The Corporation delivers most acute and skilled nursing care in a four-story building (the “Hospital Facility”) located in the City of Hillsdale, Michigan (the “City”). The “Mac” McGuire Skilled Nursing Facility (the “McGuire Unit”) occupies a portion of one floor of the Hospital Facility. The Hospital serves residents of Hillsdale County (the “County”) and surrounding areas.

The Corporation has designated a July 1 to June 30 fiscal year (“FY”). All quantitative data are presented by FY, unless otherwise specifically indicated. Unless otherwise indicated, the source for all information presented is the Corporation’s records.

ORGANIZATIONAL INFORMATION

HISTORY

The Corporation was first organized by the City as a nonprofit corporation under Act 327 of 1931, the Michigan General Corporation Act, which was subsequently superceded, in part, by Act 162 of 1982, the Michigan Nonprofit Corporation Act. Effective May 1995, the Corporation was reorganized under the Michigan Nonprofit Corporation Act as a community-based non-stock membership corporation (the “Reorganization”). The Corporation is exempt from Federal income taxation as an organization described in Section 501(c)(3) of the Internal Revenue Code (the “Code”) since 1975.

Toward the end of the 1980s, the Corporation found itself suffering from poor community image, an exodus of affiliated physicians and administrative disarray. These factors caused a loss in market share, a reduction in service volumes and significant deterioration of its financial performance. In FY1991, the Corporation experienced a deficiency of revenue over expenses of \$750,000 on total revenue of \$12.3 million.

Charles A. Bianchi, the Corporation’s current President and CEO, was specifically recruited to spearhead an operational and financial turn-around. Upon his arrival in December 1991, the Hospital’s inpatient census numbered only eight, the Corporation had only three days’ cash on hand and the only affiliated obstetrician had just departed from the area. Under Mr. Bianchi’s leadership, the Corporation embarked on a multi-faceted program which would ultimately result in the substantial improvement in all common financial measures. This program featured the following key elements:

- P** the recruitment and retention of several physicians, including those who practice in specialties that had been theretofore unavailable in the County;

- P an improvement in medical staff relations which has fostered the establishment of Hillsdale Health Partners, L.L.C. (“Health Partners”), a physician-hospital organization (PHO);
- P the commencement of new and expansion of existing services, including a hospital-based skilled nursing unit and a home care agency;
- P the development and implementation of a strategic planning process, one outcome of which has been the formation of a clinical (non-governance) affiliation with the Borgess Health Alliance (the “Borgess Alliance”), an affiliate of Borgess Medical Center (“Borgess”), a tertiary care provider headquartered in Kalamazoo, Michigan, approximately 80 miles west of the Hospital Facility;
- P the initiation of a master facility planning process which has provided a framework for the Series 1998 Improvement Project;
- P the acquisition of technological advances that are suitable to the size and scope of services provided by the Hospital;
- P the conversion of the Corporation’s organizational format to an independent, community-based non-profit corporation which has provided greater flexibility in entering into collaborative ventures;
- P the recruitment and development of capable senior and middle management personnel, along with enhanced accountability protocols;
- P the imposition of numerous financial controls, and improvements in record-keeping and reporting; and
- P the implementation of quality, patient satisfaction and community relations improvement programs, which provided a foundation for a successful capital fundraising campaign and subsequent fundraising annual appeals.

As a result of these and other initiatives, the Corporation’s gross revenue has increased by 115 percent between FY1991 and FY1997, while operating expenses increased by only 61 percent over the same interval. Moreover, this growth in gross revenue was achieved through increased volumes, rather than charge increases. The Corporation has now achieved a positive excess of revenue over expenses for six consecutive FYs, with FY1998 expected to extend this streak to seven. The balance of cash and investments has improved to nearly \$4.1 million as of April 30, 1998, representing 67 days cash on hand. The accounts of this turn-around have been presented to audiences of hospital executives, and have served as the basis for a case study used by graduate students in health care management.

GOVERNANCE

The Corporation is a membership corporation governed by fifty members (the “Members”), all of whom are individuals, and a Board of Trustees (the “Board”) comprised of thirteen persons. The Members have reserved certain powers, and have delegated others to the Board.

MEMBERS

According to Amended By-Laws adopted in February 1995, Members of the Corporation are appointed for terms of three years. The initial group of fifty Members was appointed in 1995, in the following manner. Half of this first group was appointed by the Hillsdale City Council. The other half was appointed by the Corporation Reorganization Committee, a body comprised of City Council members and members of the board that governed the Corporation prior to the Reorganization. The Nominating Committee (the “Nominating Committee”) presented its first slate of candidates to serve as Members at the annual meeting of the Membership held in January 1998. The Nominating Committee consists of the Chairperson of the Board, one of two Trustees elected from the City Council Slate (as defined below), and three Members who are neither Trustees nor employees of the Corporation. The President and CEO of the Corporation also serves on the Nominating Committee, but without vote.

The Membership has reserved the following powers:

- P** to approve changes in the purpose or philosophy of the Corporation;
- P** to elect Trustees;
- P** to adopt changes in the Corporation’s Articles of Incorporation;
- P** to approve plans of merger or consolidation;
- P** to approve a disposition of substantially all of the Corporation’s assets; and
- P** to approve a dissolution of the Corporation.

All other powers are delegated to the Board.

BOARD OF TRUSTEES

The Board is responsible for setting policy for the Corporation. Two standing committees of the Board exist: a Finance Committee and a Joint Conference Committee. The Joint Conference Committee serves as a forum for policy-level discussions among representatives of the Board, the Medical Staff (as hereinafter defined) and management.

Two Trustees serve in *ex officio* capacities, without voting powers: the President and CEO and the Chief of the Medical Staff. The other eleven Trustees are elected from slates proposed by the Nominating Committee. The Board must include at least three Trustees elected from slates

proposed by the Medical Staff, and two Trustees from slates proposed by the City Council (“City Council Slates”). Trustees serve staggered three-year terms.

The following twelve individuals currently serve as Trustees. There is presently one vacancy on the Board.

<i>Board of Trustees</i>			
<i>Name</i>	<i>Year First Elected</i>	<i>Year Term Expires</i>	<i>Occupation / Affiliation</i>
Duke E. Anderson, M.P.H., M.B.A., <i>Treasurer</i>	1994	2000	<i>County Administrator, Branch County</i>
Gregory Bailey, C.P.A.	1996	2001	<i>Mayor, City of Hillsdale; Partner, Bailey & Bailey, P.C. (public accounting)</i>
Keith Baron, M.D.	1995	2001	<i>Director of Emergency Medicine, Hillsdale Community Health Center</i>
Charles A. Bianchi	<i>ex officio</i>		<i>President/CEO, Hillsdale Community Health Center</i>
Fr. Thomas Butler	1995	2000	<i>Pastor, St. Anthony Catholic Church</i>
Beverly Goldsmith	1994	1999	<i>Office Manager, Michigan Employment Security Agency</i>
Sue Hayes, <i>Secretary</i>	1993	2000	<i>Educator, Hillsdale High School</i>
William G. Keating, M.D., <i>Vice Chairman</i>	1992	1999	<i>Director of Radiology, Hillsdale Community Health Center</i>
Deborah Lusty, M.D.	1994	2001	<i>Family Practitioner in Private Practice</i>
Dale R. McCririe, D.O.	<i>ex officio</i>		<i>Chief of the Medical Staff, Hillsdale Community Health Center; General Surgeon in Private Practice</i>
Samuel Trego	1997	2001	<i>Vice President of Human Resources, Hillsdale Tool Company</i>
Ronald L. Trowbridge, Ph.D., <i>Chairman</i>	1992	1999	<i>Vice President for External Programs and Communications, Hillsdale College</i>

Certain Trustees’ service pre-dates the Reorganization.

MANAGEMENT

The Board has delegated day-to-day management of the Corporation to Charles A. Bianchi, President and CEO. The senior management team assembled by the CEO consists of the CFO, the Chief Executive Officer of Health Partners, the Director of Nursing and Risk Management, the Administrator of the McGuire Unit, the Administrator of Hillsdale Community Home Care (“Home Care”), the Director of Human Resources, and the Patient Advocate and Quality Improvement Coordinator (collectively, the “Managers” or “Management”). Resumes of these individuals follow.

Charles A. Bianchi, President and CEO, Age 56. Mr. Bianchi assumed his present position in 1991. Prior to joining the Corporation, Mr. Bianchi held the position of President and CEO of Fairview Hospital, Great Barrington, Massachusetts, for four years. Shortly before his departure from Fairview Hospital, Mr. Bianchi received commendations from the Governor and the Speaker of the House of Representatives of the Commonwealth of Massachusetts for his accomplishments. During the course of his thirty-year health care management career, Mr. Bianchi has also served as:

- P Senior Vice President at CVPH Medical Center, Plattsburgh, New York for six years, where he was responsible for several clinical and support departments, as well as for an affiliated hospital; and
- P Assistant Administrator for Inpatient and Ambulatory Care, Assistant Administrator for the Nursing Services Division, and Radiology Administrator for a total of ten years, all at St. Vincent’s Hospital, Worcester, Massachusetts.

Mr. Bianchi began his health care career as a radiologic technician. Mr. Bianchi is a member of several hospital associations, and has chaired local United Way campaigns.

Ronald M. Larsen, C.P.A., Chief Financial Officer, Age 55. Mr. Larsen possesses a total of twenty years’ experience in health care management positions, and has been a certified public accountant for nearly thirty years. Prior to assuming his position at the Corporation in 1991, Mr. Larsen held management positions with various health care organizations since 1978. He has also been a partner in a public accounting firm, and served as an accounting instructor at Western Michigan University, Kalamazoo.

Mr. Larsen holds a Masters in Business Administration degree from Michigan State University, East Lansing, and a Bachelors in Business Administration degree from Western Michigan University. He is a member of the Healthcare Financial Management Association, the American Institute of Certified Public Accountants and the Michigan Association of Certified Public Accountants.

William D. Steger, Chief Executive Officer of Hillsdale Health Partners, L.L.C., Age 56. Mr. Steger joined the Corporation in 1997 after a varied career in management and the military. Prior to his employment at the Corporation, Mr. Steger served as the Hillsdale County Director for the Region 11 Community Action Agency, a government-sponsored anti-poverty agency. Earlier in his career, Mr. Steger held the positions of Vice President of Support Services and Director of Human Resources at Community Health Center of Branch County, Coldwater, Michigan. He also served as

the State of Michigan Director for the Vietnam Veterans Leadership Program. Mr. Steger retired from the United States Army as a Sergeant Major after 23 years of duty.

Mr. Steger holds a Masters degree in management, with a concentration in health care, from Central Michigan University, Mount Pleasant, and a Bachelors in Business Administration degree from Northwood University, Midland, Michigan. He is the holder of several military honors.

Doris L. Whorley, RN, Director of Nursing and Risk Management, Age 49. Ms. Whorley maintains overall responsibility for the nursing department budget and staffing and resource allocation decisions, as well as for the hospital-wide risk management program.. Ms. Whorley's entire nursing career has been in the employ of the Corporation. Prior to her promotion to her present position in 1995, Ms. Whorley held the position of Patient Representative and Quality Improvement Coordinator.

Ms. Whorley holds a Bachelors degree in Management of Health Promotion from Spring Arbor College, Spring Arbor, Michigan, an Associates degree in Healthcare Risk Management and Quality Review from Lansing Community College, Lansing, Michigan, and an Associates degree in Nursing from Kellogg Community College, Battle Creek, Michigan. She is a candidate for a Masters of Business Administration degree at Spring Arbor College. Ms. Whorley is a member of the National Society for Patient Representation and Consumer Affairs.

Darrell J. Hoag, Administrator of the "Mac" McGuire Skilled Nursing Facility, Age 34. Mr. Hoag has served as the "Mac" McGuire Skilled Nursing Facility's only Administrator since its opening in 1996. In this capacity, Mr. Hoag is responsible for the McGuire Unit's overall operations. Prior to joining the Corporation, Mr. Hoag managed a branch of a home care agency, and held positions in sales and as a skilled craftsman. Mr. Hoag was conferred a Bachelors degree from Michigan State University, East Lansing. He is a licensed nursing home administrator in Michigan.

Janice Gutowski, RN, Administrator of Hillsdale Community Home Care, Age 47. Ms. Gutowski had held the position of Clinical Nurse Supervisor of Hillsdale Community Home Care prior to her promotion to her current position in 1997. Prior to joining the Corporation, Ms. Gutowski held staff nursing positions at Wyandotte General Hospital, Wyandotte, Michigan, and at Outer Drive Hospital, Lincoln Park, Michigan. Ms. Gutowski holds an Associates degree in Nursing from Wayne County Community College, Detroit, Michigan. She is a candidate for a Bachelors degree in Management of Health Services at Spring Arbor College, Spring Arbor, Michigan.

Christine A. Galloway, Director of Human Resources, Age 45. Ms. Galloway has held her present position since 1991, having been promoted from Assistant Director of Human Resources. Prior to joining the Corporation, Ms. Galloway held human resources and other positions in private industry. She is a graduate of Spring Arbor College, Spring Arbor, Michigan, with a Bachelors degree in Management of Human Resources.

Amy Zoll, RN, Patient Advocate and Quality Improvement Coordinator, Age 33. Ms. Zoll has served in this capacity since 1995. Prior to that, she held charge nursing positions in the Corporation's medical-surgical and obstetrical units. Before returning to school for her nursing education, Ms. Zoll held positions in the education of pre-school and emotionally and behaviorally

impaired children. Ms. Zoll was conferred her Associates degree in Nursing by Jackson Community College, Jackson, Michigan. She also holds a Bachelors degree from Hillsdale College, Hillsdale, Michigan.

EMPLOYEES AND LABOR RELATIONS

The Corporation's average complement of full-time equivalent ("FTE") employees for the ten-month period ended April 30, 1998 was 251 FTEs. The Corporation has not experienced difficulty in recent years in recruiting and retaining clinical or technical personnel, including registered nurses. None of the Corporation's employees are unionized, nor have any unions made any recent attempts at organizing the Hospital's employees. The last union to represent any Hospital employees was decertified in 1984. Management considers the Corporation's relationship with employees to be highly satisfactory.

COLLABORATIVE VENTURES

Since the Reorganization, the Corporation has enjoyed greater latitude to enter into collaborative arrangements with other health care providers. Described below are three key ventures in which the Corporation is presently involved. From time to time, Corporation representatives have entered into discussions with counterparts at other health care organizations regarding collaborative ventures. Corporation management expects discussions on such matters to continue, but cannot predict the outcomes of these discussions. In addition, management can give no assurance that these existing collaborations will continue to be beneficial.

BORGESS HEALTH ALLIANCE

In 1994, following the completion of a deliberate, multi-step process, The Corporation formed a clinical affiliation with Borgess. The Corporation is a member of the Borgess Alliance, an affiliate of Borgess, which maintains similar arrangements with a number of community hospitals. Under this arrangement, Borgess has no governance involvement with the Corporation, but collaborates on a number of programs designed to improve County residents' access to specialized care not available at the Hospital. In addition, the Corporation purchases certain services from Borgess, such as reference laboratory, marketing and consulting. Borgess honors preferred provider arrangements that the Corporation maintains with certain employers located in the County in connection with services provided to patients insured in that manner.

The Corporation and the Borgess Alliance jointly own a medical building located in Jonesville, approximately five miles north of the City of Hillsdale, in which the Jonesville Medical Specialties Clinic (the "Specialty Clinic") is situated. The Specialty Clinic provides a venue for County residents to be diagnosed and treated by physician specialists who visit periodically from Kalamazoo, Battle Creek, Jackson and Adrian. Physicians specializing in the following disciplines currently provide services at the Specialty Clinic:

- P Cardiology
- P Gastroenterology
- P General Surgery
- P Hematology / Oncology
- P Neurosurgery
- P Ophthalmology
- P Otorhinolaryngology
- P Physiatry
- P Pulmonology
- P Urology
- P Vascular Surgery

HILLSDALE HEALTH PARTNERS

Health Partners is a physician-hospital organization (PHO) that was initially formed in 1997. Its two members are the Corporation and the Baw Beese Medical Group (“Baw Beese”). Baw Beese is a physician organization (PO) to which most of the Hospital’s active medical staff members belong. Health Partners is in the process of working with employers with which the Corporation maintains preferred provider arrangements to “bundle” the physician component. As of May 31, 1998, Health Partners had not reached definitive agreement with any such employer.

Health Partners also coordinates physician recruiting on behalf of the Corporation and Baw Beese.

COMMUNITY HEALTH CENTER OF BRANCH COUNTY

The Community Health Center of Branch County (“CHCBC”), located approximately 25 miles northwest of the Hospital Facility in Coldwater, Michigan, is the Hospital’s nearest competitor. Nevertheless, the two organizations actively seek opportunities to collaborate for mutual benefit. In 1995, the Corporation and CHCBC jointly recruited a physician specializing in occupational medicine to serve the two communities. This physician, an employee of CHCBC, maintains offices in both Coldwater and Hillsdale and splits his time evenly. The Corporation pays CHCBC for approximately half of the physician’s salary and benefits, along with an administrative component. This physician provides such services as pre-employment physicals, treatments for injuries associated with workers’ compensation, and work-hardening experience.

The two organizations are in the process of recruiting one Neurologist and two Psychiatrists to serve the two communities. No assurance can be given that these recruitment efforts will be successful, or, if they are, whether the desired results will be achieved.

LICENSES, ACCREDITATIONS, APPROVALS AND MEMBERSHIPS

The Corporation, including Home Care, the McGuire Unit and the clinical laboratory, is accredited by the Joint Commission on the Accreditation of Healthcare Organizations (“JCAHO”). The JCAHO conducted its most recent inspection of all of the above entities in July 1996, and

extended the Corporation's accreditation for three years, the maximum term possible. The Corporation received a final score of 93 percent.

The Michigan Department of Community Health ("MDCH"), on behalf of the Michigan Department of Consumer & Industry Services ("CIS"), conducts a separate licensure survey, the most recent of which occurred in March 1997. The Corporation's most recent license renewal was issued by CIS in May 1997. The McGuire Unit was more recently inspected by MDCH in January 1998. The McGuire Unit holds a separate three-year license.

The McGuire Unit was rated as the best in Michigan and among the 600 best nationwide in *The Inside Guide to America's Nursing Homes*, by Robert Bua. This book rated the country's skilled nursing facilities by examining government inspection reports.

The Corporation maintains the following memberships:

- P American Hospital Association
- P Michigan Health & Hospital Association
- P Quorum/Premier Group Purchasing Alliance

FACILITIES AND SERVICES

The Hospital Facility is situated on a six-acre parcel of real property situated in a residential area of the City. The City is located in the center of Hillsdale County, approximately eighteen miles from the Ohio border in south-central Michigan. The Hospital is the only hospital located in the County.

THE HOSPITAL FACILITY

The Hospital Facility consists of a 106,000 square foot, four-story main building that was originally constructed in the 1930s. Two modular units which house the Corporation's administrative offices, along with the 8,000 square foot Hillsdale Medical Building (the "Medical Building") are also situated on the Hospital's campus.

The Series 1998 Improvement Project is expected to complete the modernization of the Hospital Facility and provide a solution to various shortcomings. Upon completion, the Hospital Facility will feature the following configuration of available beds:

- Third Level 10-bed acute care unit featuring a cooperative care model

- Second Level 21-bed McGuire Unit; 8-bed obstetrical unit, including three labor, delivery, recovery, post partum ("LDRP") rooms

First Level Acute care unit, including 21 adult medical-surgical beds, 4 pediatrics beds, a 6-bed critical care unit and a 4-bed “stepdown” unit

Ground Level All outpatient, ancillary and support functions, including the Emergency Department, surgical suite, radiology, clinical laboratory, and therapy areas

The Corporation’s available acute care bed complement of 43 will increase by ten to 53 as a result of the completion of the Series 1998 Improvement Project. The Corporation plans to continue to be licensed for 65 acute care beds, plus 21 skilled nursing beds.

The Third Floor Acute Care Unit is being designed according to a cooperative care model. This cooperative care concept involves patient education and encourages family involvement in the patient’s recovery. This acute care unit will feature private rooms with integrated accommodations for family members. This concept has been advanced by a newly-recruited orthopedic surgeon as an ideal setting for the recovery of joint replacement patients following surgery.

BED CAPACITY

The Hospital’s current bed capacity is as follows:

<i>Average Bed Capacity</i>										
	<i>Fiscal Years Ended June 30</i>									
	<i>1997</i>		<i>1996</i>		<i>1995</i>		<i>1994</i>		<i>1993</i>	
	<i>L</i>	<i>A</i>	<i>L</i>	<i>A</i>	<i>L</i>	<i>A</i>	<i>L</i>	<i>A</i>	<i>L</i>	<i>A</i>
Medical/Surgical	47	31	47	31	68	45	68	45	68	45
Pediatrics	9	4	9	9	9	9	9	9	9	9
Obstetrics	9	8	9	9	9	9	9	9	9	9
Total Acute Care	65	43	65	49	86	63	86	63	86	63
McGuire Unit*	21	21	8	8	0	0	0	0	0	0
Total	86	64	73	57	86	63	86	63	86	63

L = Licensed; A = Available
 * The McGuire Unit bed complement in FY1996 reflects the McGuire Unit’s February 15, 1996 opening for the remaining 135 days of the Fiscal Year.

The McGuire Unit is Medicare-certified for all 21 beds.

SPECIALIZED PROGRAMS AND SERVICES

The Corporation maintains, on-site, the equipment and capability to provide a number of specialized services, including:

- P** total joint replacement
- P** a wide range of diagnostic imaging facilities, including a full-body CT Scanner, and nuclear medicine, ultrasound and mammography equipment
- P** LDRP Program
- P** a clinical laboratory under the supervision of one FTE pathologist
- P** special diagnostic procedures such as Holter monitoring, vascular studies, stress tests, and sleep studies
- P** cardiac rehabilitation
- P** respiratory therapy
- P** physical therapy

In addition, a mobile MRI visits the Hospital Facility once weekly.

MCGUIRE UNIT

Since its inception in February 1996, the McGuire Unit has earned an exceptional reputation within the community. The McGuire Unit achieved a score of 95 in the most recent survey conducted by MDCH and JCAHO. Because of the higher concentration of Medicare beneficiaries who are continuing their recovery from joint replacement and other major surgical procedures, the McGuire Unit has more characteristics in common with hospital-based subacute care units than it does with free-standing nursing homes. Accordingly, the McGuire Unit offers an extensive array of rehabilitation capabilities. The McGuire Unit reached full capacity in April 1996, and has remained virtually full ever since (see “SERVICE VOLUMES AND UTILIZATION – McGuire Unit”). Management believes that the Corporation benefits financially from Medicare’s cost-based reimbursement formula.

HOME CARE

The Home Care service was established in FY1997 as a traditional hospital-based home care agency (see “SERVICE VOLUMES AND UTILIZATION – Outpatient and Ancillary Services”). Like the McGuire Unit, management believes that the Medicare cost-based reimbursement formula provides financial benefits to the Corporation.

MEDICAL STAFF

As of March 31, 1998, the Hospital's medical staff numbered 94 physicians and podiatrists (the Medical Staff), not including physicians providing services on a *locum tenens* basis. Physicians on the Medical Staff are categorized as either Active, Consulting or Courtesy. Forty-three physicians hold privileges in the Active category (the "Active Staff")

CHARACTERISTICS OF THE ACTIVE STAFF

Numerous areas of specialization and sub-specialization are represented on the Active Staff, as detailed below:

<i>Active Staff Specialization</i>					
<i>Internal Medicine</i>		<i>Surgery</i>		<i>Other</i>	
General	7	General Surgery	4	Family Practice	6
Gastroenterology	2	Ophthalmology	1	Obstetrics/Gynecology	2
		Orthopedic Surgery	3	Pediatrics	2
		Otorhinolaryngology	1	Emergency Medicine	2
		Podiatry	3	Anesthesiology	2
		Urology	1	Pathology	2
		Vascular Surgery	2	Radiology	3
<i>Total Internal Medicine</i>	9	<i>Total Surgery</i>	15	<i>GRAND TOTAL</i>	43

One of the internists subspecializes in anesthesiology.

The median age of the Active Staff is 43. The distribution of the physicians' ages is set forth in the following table.

<i>Age Distribution of the Active Staff</i>		
<i>Age Range</i>	<i>Number of Physicians</i>	<i>Percent of Active Staff</i>
34 and under	6	14.0%
35 - 44	17	39.5%
45 - 54	14	32.6%
55 - 64	6	14.0%
65 and over	0	0.0%
TOTAL	43	
Note: Column may not add to 100.0 due to rounding		

All members of the Active Staff are either Board-Certified or -Eligible. Thirty-three of the 43 Active Staff physicians are Board-Certified. The table below details certain characteristics of the Active Staff major specialties:

<i>Active Staff Physicians, by Major Specialty</i>				
	<i>Number</i>	<i>Median Age</i>	<i>Number Board-Certified</i>	<i>Number Board-Eligible</i>
Family Practice	6	40	6	0
Internal Medicine	9	42	7	2
Surgery	15	44	10	5
Obstetrics/Gynecology	2	47	1	1

Most Active Staff physicians maintain offices in the City. Locations of their practices are tabulated below.

<i>Active Staff Physicians, by Practice Location</i>	
Medical Building	8
Other City of Hillsdale Locations	17
Hospital-Based	9
<i>Subtotal, City of Hillsdale Locations</i>	34
Litchfield	1
Jonesville	1
Hudson	2
Battle Creek	5
Total	43

Litchfield and Jonesville are two other communities located in the County. Hudson is located just across the County's eastern border in Lenawee County. The physicians whose offices are located in Battle Creek also practice at the Specialty Clinic, and treat sufficient patients there to warrant their holding Active Staff privileges.

REFERRAL PATTERNS

The Corporation's information system enables management to track gross revenue attributable to physician referrals. In the table below, "Unassigned Revenue" is that which cannot be attributable to any particular physician.

<i>Gross Revenue Attributable to Physician Referrals, FY1997</i>		
	<i>\$000 Omitted</i>	<i>Percentage</i>
Active Staff	28,544	79.9%
Physicians holding consulting or courtesy privileges, plus <i>locum tenens</i> physicians	5,844	16.3%
Unassigned Revenue	1,359	3.8%
Total Revenue	35,747	100.0%

The Corporation is not entirely dependent on the 43 Active Staff members for referrals. Gross revenue attributable to other affiliated physicians' referrals amounted to 16.3 percent of Total Revenue for FY1997. As discussed below, certain physicians relinquished their membership on the Medical Staff since the end of FY1997.

LEADING REFERRING PHYSICIANS

The following table details the top ten referring physicians (measured by the Corporation’s gross revenue) during FY1997.

<i>Leading Referring Physicians, FY1997</i>						
<i>Rank</i>	<i>Specialty or Subspecialty</i>	<i>Age</i>	<i>Board-Certified / Eligible</i>	<i>Gross Revenue (\$000s omitted)</i>	<i>Percent of Gross Revenue</i>	<i>Cumulative Percent</i>
1	Internal Medicine	43	C	3,815	10.7%	10.7%
2	Internal Medicine	34	C	2,829	7.9%	18.6%
3	Obstetrics/Gynecology	46	C	1,909	5.3%	23.9%
4	Gastroenterology	54	E	1,828	5.1%	29.0%
5	General Surgery	40	E	1,764	4.9%	34.0%
6	General Surgery	61	C	1,667	4.7%	38.6%
7	Internal Medicine	45	C	1,625	4.5%	43.2%
8	Gastroenterology	42	C	1,556	4.4%	47.5%
9	Family Practice	37	C	1,495	4.2%	51.7%
10	Family Practice	37	C	1,310	3.7%	55.4%
			C = Certified E = Eligible			

The median age of the top ten referring physicians on the basis of gross revenue is 42. Eight of the ten are Board-Certified.

All of the physicians ranked in the table above had been members of the Active Staff during FY1997. However, the leading referring physician left the area subsequent to FY1997 to attend to family matters in her hometown in Connecticut. Her practice has been assumed by a 31-year old Internist who had recently been recruited and commenced practicing earlier in FY1997. The Corporation management reports that his practice has become as busy as the departed physician’s practice, and is expected to be among the leading referring physicians in FY1998. In total, physicians whose referrals accounted for 18.1 percent of the Corporation’s gross revenue in FY1997 departed the Medical Staff since the close of the FY. Nevertheless, for the ten-month period ended April 30, 1998, the Corporation’s net patient service revenue has increased by over \$2.5 million, or nearly 15 percent, compared with the same period in FY1997, indicating that the Corporation has not been adversely impacted by the departure of these physicians.

MEDICAL STAFF RECRUITING

The Corporation has recruited thirty physicians over the past five FYs, only three of whom subsequently departed by March 31, 1998. Many of these physicians practice in specialties that theretofore had not been represented on the Medical Staff. The increased scope of the Medical Staff's capabilities has been a major factor in enabling the Corporation to decrease the number of patients transferred from its Emergency Department to other hospitals (see the table on Emergency Department Volumes) due to the lack of expertise available locally.

The County is designated as a "Health Professional Shortage Area" by the U.S. Department of Health and Human Services. This designation enables the Corporation to recruit foreign physicians who qualify for "J-1" visas. A small number of Medical Staff members originally came to the County under the "J-1" program and elected to remain after their service obligations were fulfilled. Corporation management considers the "J-1" program to be a useful tool in physician recruiting.

Health Partners coordinates physician recruiting on behalf of the Corporation and Baw Beese. Health Partners has adopted a five-year physician recruiting plan which identifies the following priorities:

Cardiology	1
Hematology/Oncology	2
Psychiatry	2
General Surgery	2
Ophthalmology	2
Urology	1
Anesthesiology	2
Otorhinolaryngology	1

Psychiatrists are being recruited in cooperation with CHCBC (see "ORGANIZATIONAL INFORMATION – Collaborative Ventures").

SERVICE VOLUMES AND UTILIZATION

INPATIENT ACUTE CARE

The prevalent inpatient reimbursement systems to which the Corporation is subject feature per-case, rather than per diem rates. Consequently, trends in the number of cases (as measured by admissions or discharges) per period are more meaningful than are trends measured in patient-days. Moreover, declines in patient-days given a certain number of cases, as well as average length of stay ("LOS"), are favorable. Occupancy rates can be inflated by excessive, financially detrimental average LOS. The following tables set forth the utilization of certain facilities and services of the Hospital for each of the periods designated. In all cases, occupancy rates are based on Available Beds rather than Licensed Beds.

<i>Historical Adult Medical/Surgical (Including CCU)Utilization (excludes newborns)</i>							
	<i>Ten Months Ended April 30</i>		<i>Fiscal Years Ended June 30</i>				
	<i>1998</i>	<i>1997</i>	<i>1997</i>	<i>1996</i>	<i>1995</i>	<i>1994</i>	<i>1993</i>
Days in Period	304	304	365	366	365	365	365
Licensed Beds	47	47	47	47	68	68	68
Available Beds	31	31	31	31	45	45	45
Admissions	1,817	1,831	2,231	2,159	1,846	1,644	1,353
Patient Days	8,040	8,845	10,643	10,382	9,033	7,376	7,069
Average Daily Census	26.4	29.1	29.2	28.4	24.7	20.2	19.4
Average LOS	4.4	4.8	4.8	4.8	4.9	4.5	5.2
Occupancy Rate (%)	85.3	93.9	94.1	91.5	55.0	44.9	43.0

<i>Historical Pediatrics Utilization (excludes newborns)</i>							
	<i>Ten Months Ended April 30</i>		<i>Fiscal Years Ended June 30</i>				
	<i>1998</i>	<i>1997</i>	<i>1997</i>	<i>1996</i>	<i>1995</i>	<i>1994</i>	<i>1993</i>
Days in Period	304	304	365	366	365	365	365
Licensed Beds	9	9	9	9	9	9	9
Available Beds	4	9	9	9	9	9	9
Admissions	119	145	171	235	193	282	282
Patient Days	382	418	481	769	607	1,059	1,065
Average Daily Census	1.3	1.4	1.3	2.1	1.7	2.9	2.9
Average LOS	3.2	2.9	2.8	3.3	3.1	3.8	3.8
Occupancy Rate (%)	31.4	15.3	14.6	23.3	18.5	32.2	32.4

<i>Historical Obstetrics Utilization (excludes newborns)</i>							
	<i>Ten Months Ended April 30</i>		<i>Fiscal Years Ended June 30</i>				
	<i>1998</i>	<i>1997</i>	<i>1997</i>	<i>1996</i>	<i>1995</i>	<i>1994</i>	<i>1993</i>
Days in Period	304	304	365	366	365	365	365
Licensed Beds	9	9	9	9	9	9	9
Available Beds	8	9	9	9	9	9	9
Admissions	346	303	370	405	463	421	326
Patient Days	746	619	753	803	927	933	774
Average Daily Census	2.5	2.0	2.1	2.2	2.5	2.6	2.1
Average LOS	2.2	2.0	2.0	2.0	2.0	2.2	2.4
Occupancy Rate (%)	30.7	22.6	22.9	24.4	28.2	28.4	23.6

Corporation management estimates that approximately 600 babies are delivered to County residents annually. Corporation management projects 400 obstetrical admissions for FY1998, and believes that 500 represents an achievable target volume due to the presence of more extensive physician resources and the availability of modern LRDP rooms.

Historical Acute Care Utilization (excludes newborns)							
	Ten Months Ended April 30		Fiscal Years Ended June 30				
	1998	1997	1997	1996	1995	1994	1993
Days in Period	304	304	365	366	365	365	366
Licensed Beds	65	65	86	86	86	86	86
Available Beds	43	49	43	49	63	63	63
Admissions	2,282	2,279	2,772	2,799	2,502	2,347	2,217
Adjusted Admissions*	4,422	4,229	5,121	5,459	5,319	5,201	4,892
Patient Days	9,168	9,882	11,877	11,954	10,567	9,368	9,960
Average Daily Census	30.2	32.5	32.5	32.7	29.0	25.7	27.2
Average LOS	4.0	4.3	4.3	4.3	4.2	4.0	4.5
Occupancy Rate (%)	70.1	66.3	75.7	66.7	46.0	40.7	43.2
Net Patient Revenue per Adjusted Admission**	\$4,698	\$4,311	\$4,357	\$3,777	\$3,408	\$3,137	\$3,449
Gross Outpatient Revenue per Adjusted Admission**	\$3,652	\$3,255	\$3,268	\$2,925	\$2,951	\$2,653	\$2,709
* Admissions are adjusted by the percentage gross revenue attributable to outpatient services							
** Calculated by management from the Corporation's audited financial statements and other records, using definitions published by Standard & Poor's Corporation in <i>CreditWeek Municipal</i> , October 20, 1997 and in <i>CreditWeek</i> , October 1994							

Total acute care admissions increased by 25 percent between FY1993 and FY1997.

MCGUIRE UNIT

Volume and utilization data for the McGuire Unit are presented in the table below.

<i>McGuire Unit Utilization</i>				
	<i>Ten Months Ended April 30</i>		<i>Fiscal Years Ended June 30</i>	
	<i>1998</i>	<i>1997</i>	<i>1997</i>	<i>1996</i>
Days in Period*	304	304	365	135
Licensed Beds	21	21	21	21
Patient Days	6,098	6,246	7,357	2,343
Average Daily Census	20.1	20.5	20.2	17.4
Occupancy Rate (%)	95.5	97.8	96.0	82.6
* 1996 figure reflects opening of McGuire Unit on February 15, 1996				

OUTPATIENT AND ANCILLARY SERVICES

SURGICAL PROCEDURES

Volumes and utilization of the Corporation's operating rooms are detailed below.

<i>Surgical Procedures</i>							
	<i>Ten Months Ended April 30</i>		<i>Fiscal Years Ended June 30</i>				
	<i>1998</i>	<i>1997</i>	<i>1997</i>	<i>1996</i>	<i>1995</i>	<i>1994</i>	<i>1993</i>
Inpatient	654	527	662	685	681	652	550
Outpatient	1,298	1,167	1,428	1,222	1,108	1,187	1,142
Total	1,952	1,694	2,090	1,907	1,789	1,839	1,692
Percent Outpatient (%)	66.5	68.9	68.3	64.1	61.9	64.5	67.5

OUTPATIENT SERVICES

The following tables portray volume and utilization data for the Corporation's outpatient and ancillary services.

<i>Emergency Department Volumes</i>							
	<i>Ten Months Ended April 30</i>		<i>Fiscal Years Ended June 30</i>				
	<i>1998</i>	<i>1997</i>	<i>1997</i>	<i>1996</i>	<i>1995</i>	<i>1994</i>	<i>1993</i>
Visits	19,216	18,598	22,499	22,194	22,157	20,389	18,367
Change over Previous Period (%)	3.3		1.4	0.2	8.7	11.0	
Transfers to Other Hospitals	104	136	180	185	226	216	213
Transfers per Thousand ED Visits	5.4	7.3	8.0	8.3	10.2	10.6	11.6

The "Transfers to Other Hospitals" data refers to the transfer of Emergency Department ("ED") patients to other facilities due to the complexity of their cases exceeding the capabilities of the Hospital and its affiliated physicians. Because of the improvement of the Hospital's service capabilities and the recruitment of physicians having skills theretofore unavailable, this figure has been reduced from over 400 in FY1991. Most of the transfers remaining involve complex neurosurgery, invasive cardiology and severe burn cases, as well as neonates requiring intensive care. A management task force evaluates the reasons for all such transfers to determine what measures could be instituted to prevent transfers for similar reasons in the future.

<i>Outpatient Service Volumes</i>							
	<i>Ten Months Ended April 30</i>		<i>Fiscal Years Ended June 30</i>				
	<i>1998</i>	<i>1997</i>	<i>1997</i>	<i>1996</i>	<i>1995</i>	<i>1994</i>	<i>1993</i>
Scheduled Registrations	75,716	69,573	84,320	82,448	79,718	73,210	63,670
Change over Previous Period (%)	8.8		2.3	3.4	8.9	15.0	

ANCILLARY SERVICES

Management believes that due to the prevalence of “per-case” reimbursement, stable or even decreasing volumes of ancillary services rendered to acute care inpatients is beneficial to the Corporation, all other factors being equal.

<i>Ancillary Services Provided to <u>Inpatients</u></i>							
	<i>Ten Months Ended April 30</i>		<i>Fiscal Years Ended June 30</i>				
	<i>1998</i>	<i>1997</i>	<i>1997</i>	<i>1996</i>	<i>1995</i>	<i>1994</i>	<i>1993</i>
Laboratory ¹	51,436	62,601	75,234	75,856	64,646	54,094	N/A
MRI Scanning ²	122	56	78	55	33	16	22
CT Scanning ²	527	452	576	543	4,885	318	336
Ultrasonography ²	1,156	1,686	2,021	1,010	364	252	299
Other Radiology ²	4,276	4,232	5,239	5,030	4,530	3,925	4,246
Nuclear Medicine ²	408	478	570	428	334	235	205
Electrocardiography ¹	3,598	4,269	5,097	4,769	N/A	N/A	N/A
Electroencephalography ¹	6	8	9	10	N/A	N/A	N/A
Cardiovascular Lab ^{3,4}	87	104	119	120	N/A	N/A	N/A
Physical Therapy ³	1,331	915	1,080	1,106	901	892	246
Respiratory Therapy ³	23,240	29,856	36,358	36,025	31,892	26,195	35,280
¹ Tests	² Examinations		³ Procedures	⁴ Includes stress tests, Holter monitors, vascular studies and cardiac rehabilitation			

<i>Ancillary Services Provided to Outpatients (includes ED, Home Care and McGuire Unit patients)</i>							
	<i>Ten Months Ended April 30</i>		<i>Fiscal Years Ended June 30</i>				
	<i>1998</i>	<i>1997</i>	<i>1997</i>	<i>1996</i>	<i>1995</i>	<i>1994</i>	<i>1993</i>
Laboratory ¹	144,350	132,426	160,073	156,640	153,008	146,705	N/A
MRI Scanning ²	755	613	727	580	545	453	463
CT Scanning ²	1,449	1,297	1,606	1,636	1,518	1,110	1,123
Ultrasonography ²	3,614	3,604	4,385	3,717	3,129	2,874	2,564
Other Radiology ²	17,596	16,780	20,498	20,455	20,798	18,608	17,748
Nuclear Medicine ²	2,206	1,678	2,107	1,494	1,231	886	646
Electrocardiography ¹	1,929	1,617	1,965	1,985	588	488	532
Electroencephalography ¹	71	54	60	90	N/A	N/A	N/A
Cardiovascular Lab ^{3,4}	1,772	1,472	1,812	2,015	N/A	N/A	N/A
Physical Therapy ³	15,855	14,217	17,430	19,865	N/A	N/A	N/A
Respiratory Therapy ³	5,050	4,365	5,216	5,665	6,094	4,970	7,828
Endoscopy ³	1,006	962	1,138	1,062	954	956	729
Sleep Studies ¹	58	54	59	N/A	N/A	N/A	N/A
¹ Tests	² Examinations		³ Procedures	⁴ Includes stress tests, Holter monitors, vascular studies and cardiac rehabilitation			

HOME CARE

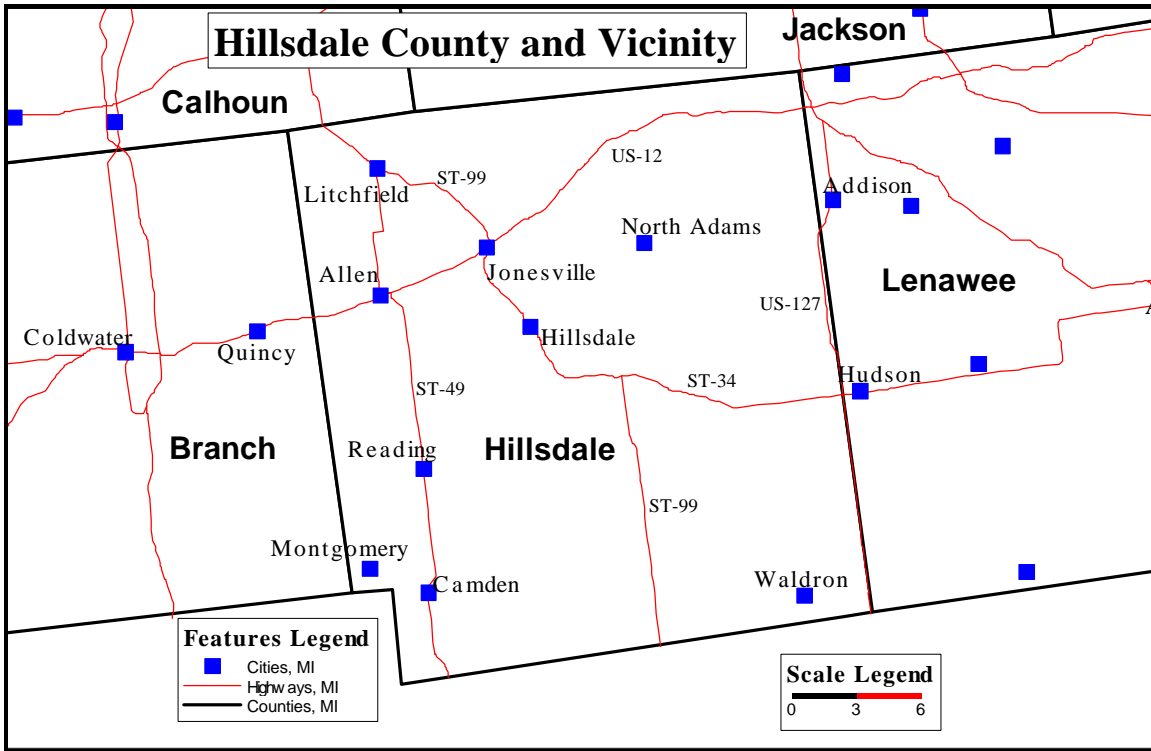
Home Care volumes are set forth in the table below.

<i>Home Care Visits</i>		
<i>Ten Months Ended April 30</i>		<i>Fiscal Year Ended June 30</i>
<i>1998</i>	<i>1997</i>	<i>1997</i>
8,581	5,621	7,225

FY1997 can be characterized as a “start-up” year.

SERVICE AREA

The Hospital's service area is defined as all of the County. The County is situated in south-central Michigan bordering the northwestern corner of Ohio. The County is bordered on its east by Lenawee County, on its north by Jackson County, and on its west by Branch County. The County is largely rural in character; the City of Hillsdale, population approximately 8,000, is the County's largest municipality. A map of the County and vicinity follows.



The population of the County is tabulated below.

<i>County Population</i>			
<i>Year</i>	<i>Type</i>	<i>Count</i>	<i>Change</i>
1970	Census	37,171	
1980	Census	42,071	13.2%
1985	Estimate	42,000	(0.2)%
1990	Census	43,431	3.4%
1997	Estimate	46,240	6.5%
2000	Projection	46,600	0.8%
2005	Projection	47,900	2.8%
2010	Projection	49,200	2.7%
2015	Projection	50,400	2.4%
2020	Projection	51,600	2.4%
Sources: Office of the State Demographer, January 1996, except the 1997 estimate for which the source is the U.S. Bureau of the Census, March 1998. Projections do not necessarily reflect the 1997 estimate.			

A list of the leading employers in the County follows.

<i>Leading Employers in Hillsdale County, 1996</i>					
<i>Rank</i>	<i>Organization</i>	<i>SIC</i>	<i>Location</i>	<i>Nature of Business</i>	<i>Employment</i>
1	Hillsdale Tool & Manufacturing	3714	Hillsdale	Automobile parts machining	716
2	Walker Manufacturing	3714	Litchfield	Automobile exhaust systems	716
3	Quincy LP	3469	North Adams	Metal stampings	585
4	Teleflex	3315	Hillsdale	Steel wire & related products	380
5	Hillsdale College	8221	Hillsdale	Higher education	330
6	Fayette Tubular Products	3714	Reading	Motor vehicle parts & accessories	326
7	Mark I Molded Plastics	3089	Jonesville	Plastic products	310
8	Hi-Lex Controls	3625	Litchfield	Relays & industrial controls	310
9	Bailey Manufacturing	3089	Hillsdale	Injection molded plastic products	270
10	Hillsdale Community Health Center	8062	Hillsdale	Health care	250

Sources: Michigan Jobs Commission, Economic Profile, 1996

Several of these leading employers are suppliers to the automobile industry. Accordingly, the County's economy could be susceptible to a downturn in this industry and/or changing business relationships between these firms and the major automobile manufacturers. No assurance can be given that these firms may not choose to relocate from the County or reduce their workforces.

Until February 1998, Hillsdale Tool & Manufacturing ("Hillsdale Tool") was an operating subsidiary of Eagle-Picher Industries, Inc. ("Eagle Picher"). In January 1991, Eagle Picher filed a voluntary petition for reorganization under the United States Bankruptcy Code. Eagle Picher emerged from bankruptcy in November 1996. In February 1998, Eagle Picher was acquired by Granaria Industries BV, a Dutch concern ("Granaria"). According to information filed by Granaria with the Securities and Exchange Commission, Granaria's Automotive Group designs, develops, and manufactures precision machined and rubber coated metal components for the global automotive industry. Its customers include Ford Motor Company, General Motors Corporation and Chrysler Corporation. Granaria has not publicly announced any planned material adverse changes in employment at the Hillsdale Tool unit.

In many rural counties nationwide, hospitals are usually among the leading employers. The Corporation's ability to contain staffing levels, coupled with the presence of several viable manufacturing concerns account for the Corporation's relatively low (favorable) rank in the above table.

Hillsdale College (the "College") is currently ranked by *U.S. News & World Report* as the second-leading liberal arts college in the Midwestern Region. This category includes neither national liberal arts colleges nor universities. Enrollment is approximately 1,200 students. The College's presence represents a stabilizing influence on the local economy, and enhances the Corporation's ability to recruit physicians in several ways. The College operates a private elementary school, maintains extensive recreational facilities, and sponsors lectures and cultural events, all of which are available to the public. The College has lent the expertise gained by managing its \$180 million endowment to the Corporation management.

The County's unemployment rate has been consistently less than that of the State, as tabulated below.

<i>Unemployment Rates (Annual Averages)</i>		
<i>Year</i>	<i>County</i>	<i>State</i>
1997	3.8%	4.2%
1996	4.5%	4.9%
1995	4.8%	5.3%
1994	5.3%	5.9%
1993	6.4%	7.1%

Source: Michigan Employment Security Agency

Employment trends continue to be favorable. The County's unemployment rates for the first four months of 1998 are tabulated below.

<i>County Unemployment Rates, 1998</i>	
January	3.9%
February	3.6%
March	3.5%
April	2.7%

Source: Michigan Employment Security Agency

COMPETING FACILITIES

COMPETING ACUTE CARE HOSPITALS

The Hospital is the only acute care hospital in the County. The Hospital’s primary competitor is CHCBC, located in Coldwater, Branch County, approximately 25 miles from the City of Hillsdale. CHCBC maintains approximately 85 acute care beds, and offers a similar array of services as does the Hospital. The Corporation collaborates with CHCBC from time to time (see “ORGANIZATIONAL INFORMATION – Collaborative Ventures”). County residents in need of services beyond the scope of those offered by the Hospital will often travel to larger hospitals located in Kalamazoo (Borgess; Bronson Methodist Hospital), Battle Creek (Battle Creek Health System), Jackson (W.A. Foote Memorial Hospital) and Adrian (Lenawee Health Alliance) (collectively, the “Medical Centers”). In addition, many County residents requiring rehabilitation services travel to Community Hospital of Williams County in Montpelier, Ohio, approximately 26 miles from Hillsdale. Corporation management believes that the flows of patients to the Medical Centers represent inevitable “leakage” largely due to the greater scope of services available there.

The Hospital’s market share of inpatient admissions originating from the County is tabulated below.

<i>Inpatient Market Shares</i>	
1996	53.8%
1995	49.4%
1994	49.1%
Source: Michigan Inpatient Data Base	

The market shares shown in the above table take into account all inpatient cases, including those which the Hospital is not equipped and staffed to treat.

COMPETING SKILLED NURSING FACILITIES

Two other skilled nursing facilities (“SNFs”) operate in the County: the Hillsdale County Medical Care Facility (the “MCF”), owned by the County, and the Litchfield Nursing Centre, an investor-owned facility. Together, they operate 241 beds. Both are oriented more toward long-term residential care than the shorter, post-hospitalization stay characteristic of the McGuire Unit. Management believes that the MCF is utilized mainly by Medicaid beneficiaries, and exhibits a much different payor mix than does the McGuire Unit.

FINANCIAL INFORMATION

THIRD-PARTY REIMBURSEMENT METHODOLOGIES

MEDICARE

The Corporation is reimbursed for providing inpatient care according to the patient's diagnosis-related group ("DRG") under the Prospective Payment System ("PPS"). As a hospital having fewer than 100 beds, the Corporation participates in the periodic interim payment (PIP) system, in which a constant amount is received biweekly, subject to an annual reconciliation.

BLUE CROSS

The Corporation has a contractual relationship with Blue Cross/Blue Shield of Michigan ("Blue Cross"). Blue Cross reimburses the Corporation for Blue Cross allowable budgeted costs as determined under a prospective payment program. Under this program, the Corporation and Blue Cross agreed on payments based on DRGs using a blended rate higher than Medicare. For outpatient services, Blue Cross reimburses the Corporation with interim payments using a fee schedule reconciled after the completion of the annual cost report.

COMMERCIAL INSURANCE

Most commercial insurance plans reimburse their subscribers or make direct payment to the Corporation for covered services at prevailing room rates plus ancillary service charges, subject to various limitations, coinsurance provisions and deductibles.

MEDICAID

The Michigan Medicaid program is administered by MDCH. Michigan Medicaid payments are based on a DRG methodology similar to that used by Medicare. A major difference between the Medicare and Medicaid methodologies is that Medicaid has phased capital payments into the DRG payment rate. The Medicaid program included the cost of major moveable equipment in the DRG prices from the beginning, unlike Medicare.

The DRG basis for Medicaid payment presently applies to all routine and ancillary service operating costs and special care unit operating costs relating to inpatient hospital services.

MANAGED CARE

Market penetration in the County by commercial managed care plans is extremely limited. The Corporation maintains contracts with two managed care plans pursuant to which the Corporation is paid 95 percent of its charges for services rendered. There has been virtually no impact on the Hospital's service volumes attributable to these managed care plans.

The State is in the process of requiring that non-elderly Medicaid recipients join approved managed care plans. Corporation management expects to contract with larger managed care plans which have the ability to spread the risk across a greater number of covered lives than exist in the County (approximately 2,800). Management does not expect that this initiative will have a material impact on the Corporation's financial performance.

The Corporation maintains preferred provider arrangements with several local employers who self-insure their employee health care benefits. One of these arrangements relates to over 700 employees of Hillsdale Tool, formerly a division of Eagle Picher, and the County's leading employer (see "SERVICE AREA"). Management has been advised by a Hillsdale Tool official that due to the Corporation's advantageous charge structure, this company's employee health benefits costs are approximately 85 percent of those experienced by other Eagle Picher operating units. Health Partners is in the process of negotiating with these and other local employers to "bundle" the physician component. No assurance can be given that these contracting efforts will be successful, or, if they are, whether the desired results will be achieved.

MCGUIRE UNIT MEDICAID AND MEDICARE

The federal Social Security Act, as amended, provides the legal basis for the Medicare program (Title XVIII) and the Medicaid program (Title XIX).

MEDICARE

Medicare consists of two distinct parts: Part A describes coverage of and conditions for payment for inpatients hospital services and services provided by other institutional health care providers, such as nursing homes (like the McGuire Unit), home care agencies and hospices. Part B relates to a voluntary supplementary medical insurance benefit for the aged and disabled that covers, among other services, certain physician care, diagnostic testing, durable medical equipment and medical supplies. The Balanced Budget Act of 1997 mandates the implementation of a prospective payment system for SNFs commencing on July 1, 1998. Under this system, the amount paid to SNFs will be capped on a per-case or a per day of patient care basis, and may include certain diagnostic services covered under Part B. The Medicare program is administered by the Health Care Financing Administration (HCFA) through its fiscal intermediary (the "FI").

Medicare coverage of SNF services is available only if (a) the required skilled nursing or rehabilitative services can only be provided in a SNF; (b) the SNF resident had been hospitalized for at least three consecutive days (not including the day of discharge) prior to the SNF admission; (c) the need for the SNF services is directly related to the reason for the hospitalization; (d) the resident was admitted to the SNF within 30 days of discharge from the hospital. Medicare coverage of SNF services is limited to 100 days per benefit period; and (e) a medical professional certifies that daily skilled nursing or rehabilitative care is necessary. There is no annual limitation on the number of covered benefit periods that a SNF resident might ever encounter. Medicare, through the FI, reimburses the Corporation a per diem rate that is based on allowable costs, subject to certain limits. Residents must pay to the Corporation a deductible for each SNF stay and a coinsurance amount applicable to the 21st through the 100th days of each Medicare-covered SNF stay. Eligibility for Medicare reimbursement of a SNF stay is predicated on the coincidence of several facts.

MEDICAID

The Medicaid program is a joint federal/state health insurance program for the categorically needy, aged or disabled. It is administered by HCFA and MDCH. HCFA funds approximately half of the aggregate payments to nursing homes in Michigan, with the State funding the other half through MDCH.

Medicaid coverage of SNF services is conditioned on financial eligibility rather than prior hospitalization. While Medicare Part A coverage is virtually universal among persons age 65 and over, eligibility for Medicaid coverage involves a “means-testing” procedure. The Medicaid program reimburses the Corporation a per-diem rate with respect to each Medicaid-eligible SNF resident, without any limit on the number of days of care. Typical of Medicaid programs nationwide, residents are required to assign their social security and similar benefits to the Corporation, except for a nominal spending allowance. The Medicaid reimbursement formula recognizes these resident payments, and funds a net amount so that the Corporation realizes no more than the allowable Medicaid per diem rate.

The Medicaid per-diem rate formula includes the recognition of certain variable operating and capital costs, as modified by other factors, as tabulated below.

<i>McGuire Unit Per Diem Medicaid Reimbursement Rate, 1998</i>	
Variable Cost Component	\$88.03
Plant Cost Component	0.00
Continuous Quality Improvement Incentive	2.08
Wage Pass-through Add-on	3.99
OBRA Training & Testing Add-on	0.00
Medicaid Reimbursement Rate	\$94.10

Except for the Wage Pass-through Add-on, all other components reflect audited costs from two years prior (in this case, FY1996).

The Variable Cost Component is trended forward by an inflation factor. The Variable Cost Component is subject to a limit which most non-profit SNFs in the State routinely reach. MDCH establishes the limit by first ranking all nursing homes in the State in order of their Variable Cost Components. Then, starting with the SNF having the lowest Variable Cost Component, MDCH accumulates the number of beds licensed to each SNF until it reaches 80 percent of the total licensed SNF bed count in the State. The Variable Cost Component of that SNF in the 80th percentile of licensed beds then becomes the limit. This limit is further modified by a limit on the ratio of support costs to base costs. In recent years, the limit has increased at rates exceeding the general inflation rate. These rate increases have been attributable largely to the pass-through of the costs of legislatively-mandated services and administrative requirements.

The Plant Cost Component reflects debt service and the original cost of facilities and equipment, the latter of which is trended forward. Management has been given verbal advice by a Medicaid official that the Plant Cost Component will be revised in an amount not to exceed \$10.00 per diem, retroactive to the McGuire Unit's commencement of operations. The McGuire Unit qualifies for a Continuous Quality Improvement Incentive, \$2.08 per diem for 1998. The Wage Pass-through Add-on is an amount by which MDCH increases reimbursement without being subject to the two-year lag. The \$3.99 per diem reflects an allowable increase of \$0.50 per hour for all SNF employees. The State legislature has enacted an amendment that raises that allowable increase to \$0.75 per hour for 1998. However, the State's fiscal year 1998 budget contains an increase of only \$0.50. The OBRA Training & Testing Add-on reflects certain costs of training and certifying personnel in order to comply with the Omnibus Budget Reconciliation Act of 1987, the statute that mandated several significant additional quality of care requirements on nursing homes.

MCGUIRE UNIT PAYOR MIX

Data relating to the payor mix for the McGuire Unit is set forth below.

<i>McGuire Unit Payor Mix (expressed as percentages of patient-days)</i>				
	<i>Ten Months Ended April 30</i>		<i>Fiscal Years Ended June 30</i>	
	<i>1998</i>	<i>1997</i>	<i>1997</i>	<i>1996</i>
Medicare	37.8%	31.4%	30.5%	N/A
Medicaid	31.4%	22.9%	25.4%	N/A
Private Pay and Commercial Insurance	30.8%	45.7%	44.1%	N/A
TOTALS	100.0%	100.0%	100.0%	N/A

SOURCES OF ACUTE CARE REVENUE

The Corporation's gross revenue and acute care patient-days were attributable to the following third-party payors:

<i>Payor Mix</i>									
	<i>By Gross Revenue</i>				<i>By Acute Care Patient-Days</i>				
	<i>Fiscal Years Ended June 30</i>				<i>Fiscal Years Ended June 30</i>				
	<i>1997</i>	<i>1996</i>	<i>1995</i>	<i>1994</i>	<i>1997</i>	<i>1996</i>	<i>1995</i>	<i>1994</i>	<i>1993</i>
Medicare	45.1	42.3	40.0	36.7	64.3	58.7	57.0	50.5	55.6
Medicaid	9.6	11.2	12.3	14.5	8.1	10.3	10.8	14.3	11.0
Blue Cross	18.0	17.4	18.9	17.9	11.1	12.3	13.4	14.2	11.3
Commercial Insurance	23.8	24.2	24.5	24.8	14.4	14.8	15.6	16.7	17.8
Self-Pay	3.5	4.9	4.3	6.1	2.1	3.9	3.2	4.3	4.3
TOTALS	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Note: Payor Mix data by Gross Revenue for FY1993 is not available

RECENT FINANCIAL PERFORMANCE

The percentage of gross revenue attributable to outpatient care has decreased over the past several years due mainly to increased inpatient volumes, as illustrated in the following table.

<i>Gross Patient Revenue by Service</i>							
	<i>Ten Months Ended April 30</i>		<i>Fiscal Years Ended June 30</i>				
	<i>1998</i>	<i>1997</i>	<i>1997</i>	<i>1996</i>	<i>1995</i>	<i>1994</i>	<i>1993</i>
Inpatient	44.3%	46.6%	46.8%	49.1%	47.0%	45.1%	45.3%
Outpatient	48.4%	46.1%	45.9%	48.7%	53.0%	54.9%	54.7%
McGuire Unit	4.9%	5.4%	5.3%	2.2%	0.0%	0.0%	0.0%
Home Care	2.4%	1.9%	2.0%	0.0%	0.0%	0.0%	0.0%
TOTALS	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

PROFITABILITY

The Corporation's recent financial performance is summarized in the following table.

<i>Summary of Statements of Operations – Unrestricted</i> (<i>\$000s omitted</i>)							
	<i>Unaudited</i>		<i>Audited</i>				
	<i>Ten Months Ended April 30</i>		<i>Fiscal Years Ended June 30</i>				
	<i>1998</i>	<i>1997</i>	<i>1997</i>	<i>1996</i>	<i>1995</i>	<i>1994</i>	<i>1993</i>
Net Patient Service Revenue	20,772	18,230	22,313	20,619	18,128	16,314	16,873
Other Operating Revenue	<u>217</u>	<u>208</u>	<u>252</u>	<u>248</u>	<u>215</u>	<u>206</u>	<u>189</u>
Total Operating Revenue	20,989	18,438	22,565	20,867	18,343	16,520	17,062
Depreciation Expense	730	566	730	660	550	565	588
Interest Expense	192	162	197	127	113	126	134
Bad Debt Expense	1,196	860	913	1,270	1,280	907	1,156
Other Operating Expenses	<u>17,188</u>	<u>15,295</u>	<u>18,774</u>	<u>16,953</u>	<u>15,140</u>	<u>14,255</u>	<u>13,990</u>
Total Operating Expenses	19,306	16,883	20,614	19,010	17,083	15,853	15,868
Income from Operations	1,683	1,555	1,951	1,857	1,260	667	1,194
Net Nonoperating Gains (Losses)	<u>(252)</u>	<u>(250)</u>	<u>(347)</u>	<u>(700)</u>	<u>(483)</u>	<u>(366)</u>	<u>(493)</u>
Revenue and Gains in Excess of Expenses	1,431	1,305	1,604	1,157	777	301	701
Depreciation included in net nonoperating gains (losses)	N/A	N/A	28	28	28	28	30
Net Income Available for Debt Service (EBIDA)			2,559	1,972	1,468	1,020	1,453
Capital Expenditures			2,296	2,160	1,238	147	387

* Calculated by management from the Corporation's audited financial statements, using definitions published by Standard & Poor's Corporation in *CreditWeek Municipal*, October 20, 1997

The nonoperating losses are attributable largely to expenses associated with physician recruiting and retention, and, to a lesser extent, the operation of the Medical Building.

The following ratios are calculated from the above data.

Profitability Ratios					
	Fiscal Years Ended June 30				
	1997	1996	1995	1994	1993
Pro Forma Debt Service Coverage Ratio *	3.04	2.34	1.74	1.21	1.73
Excess Margin	7.22%	5.74%	4.35%	1.86%	4.23%
Operating Margin	8.65%	8.90%	6.87%	4.04%	7.00%

* Based on Pro Forma Maximum Annual Debt Service on the Series 1998 Bonds of \$841,350.
 Note: Calculated by management from the Corporation's audited financial statements, using definitions published by Standard & Poor's Corporation in *CreditWeek Municipal*, October 20, 1997 and in *CreditWeek*, October 1994

The following tables set forth certain cost and productivity measures.

Cost and Productivity Measures					
	Fiscal Years Ended June 30				
	1997	1996	1995	1994	1993
Total FTEs	249.5	248.2	225.3	226.2	224.3
FTEs per Adjusted Admission	0.049	0.045	0.042	0.043	0.046
FTEs per Adjusted Occupied Bed	3.9	3.8	3.7	4.0	3.7
Adjusted Acute Care Patient-Days	23,511	23,824	22,466	20,579	21,894
Paid-hours per Adjusted Patient-Day	22.0	21.4	20.7	22.3	21.1
McGuire Unit Paid Hours per Patient-Day	6.6	N/A	N/A	N/A	N/A
Capital Expense / Total Expenses	4.6%	4.3%	4.0%	4.5%	4.7%
Bad Debt Expense / Operating Revenue	4.0%	6.1%	7.0%	5.5%	6.8%

Note: Calculated by management from the Corporation's audited financial statements and other records, using definitions published by Standard & Poor's Corporation in *CreditWeek Municipal*, October 20, 1997

The increase in FTEs between FY1995 and FY1996 was due largely to the opening of the McGuire Unit.

LIQUIDITY AND CAPITAL STRUCTURE

A summary of the Corporation's balance sheet follows.

<i>Balance Sheet Summary</i> (<i>\$000s omitted</i>)						
	<i>Unaudited</i>	<i>Audited</i>				
	<i>Ten Months Ended</i>	<i>Fiscal Years Ended June 30</i>				
	<i>April 30, 1998</i>	<i>1997</i>	<i>1996</i>	<i>1995</i>	<i>1994</i>	<i>1993</i>
Cash and Temporary Investments*	1,092	1,179	1,303	1,000	813	206
Net Patient Accounts Receivable	3,887	3,210	3,367	2,872	2,690	2,452
Other Current Assets	<u>1,871</u>	<u>1,537</u>	<u>1,487</u>	<u>1,075</u>	<u>885</u>	<u>1,445</u>
Total Current Assets	6,850	5,926	6,157	4,947	4,388	4,103
Non-Current Cash and Investments (unrestricted)*	2,993	2,434	559	31	30	27
Property and Equipment	10,549	8,542	6,926	5,385	4,521	4,773
Other Assets	279	317	318	547	1,236	179
Total Assets	20,671	17,219	13,960	10,910	10,175	9,082
Current Liabilities	3,983	3,396	3,064	2,805	3,236	3,090
Long-Term Debt	6,087	4,603	3,401	1,840	1,456	1,666
Net Assets	<u>10,601</u>	<u>9,220</u>	<u>7,495</u>	<u>6,265</u>	<u>5,483</u>	<u>4,326</u>
Total	20,671	17,219	13,960	10,910	10,175	9,082

* Used in "Days' Cash on Hand," "Cushion Ratio" and "Quick Ratio" calculations

As a hospital licensed for fewer than 100 beds, the Corporation remains under Medicare's Periodic Interim Payment (PIP) system, as well as similar interim funding mechanisms offered by Medicaid and Blue Cross. Indicators of the Corporation's liquidity appear below:

<i>Liquidity Ratios</i>					
	<i>Fiscal Years Ended June 30</i>				
	<i>1997</i>	<i>1996</i>	<i>1995</i>	<i>1994</i>	<i>1993</i>
Current Ratio	1.75	2.01	1.76	1.36	1.33
Quick Ratio	2.31	1.82	1.61	1.30	1.11
Days in Patient Accounts Receivable	52.5	59.6	57.8	60.2	53.0
Days Cash on Hand	66.3	37.0	22.8	20.1	5.6
Cash-to-Debt*	72.0%	50.4%	48.4%	47.5%	12.0%
<p>* The denominator of this ratio includes the current portion of long-term debt Note: Calculated by management from the Corporation's audited financial statements and other records, using definitions published by Standard & Poor's Corporation in <i>CreditWeek Municipal</i>, October 20, 1997 and <i>CreditWeek</i>, October 1994, and by Moody's Investors Service in <i>Health Care Medians</i>, June 1996</p>					

OTHER FINANCIAL INFORMATION

PROFESSIONAL AND GENERAL LIABILITY INSURANCE

The Corporation maintains professional liability insurance coverage through the MHA Insurance Company at the following levels:

Liability Insurance Schedule

<i>Professional Liability and Commercial General Liability</i>	
Each Occurrence / Incident	\$1,000,000
Aggregate	\$3,000,000
<i>Directors, Officers and Trustees Indemnity</i>	
Limit per Policy Period	\$2,000,000

PROFESSIONAL LIABILITY LITIGATION

There are various asserted medical malpractice claims pending against the Corporation. Corporation management is of the opinion, based upon the advice of counsel, that existing funding levels and coverage limits will adequately cover these potential liability exposures.

OTHER PENDING LITIGATION

There are various lawsuits pending against the Corporation involving other than medical malpractice claims. Corporation management is of the opinion, based upon the advice of counsel, that the final disposition of these matters will not have a material adverse effect on the financial condition of the Corporation.

PPS AND RELATED INFORMATION

The Corporation tracks its case-mix indices monthly index with respect to Medicare, Medicaid and Blue Cross patients. Such case-mix indices are tabulated below.

<i>Case-Mix Indices</i>						
	<i>Ten Months Ended April 30</i>	<i>Fiscal Years Ended June 30</i>				
	<i>1998</i>	<i>1997</i>	<i>1996</i>	<i>1995</i>	<i>1994</i>	<i>1993</i>
Medicare	1.1407	1.1307	1.1204	1.1553	1.1171	1.1426
Medicaid	0.7570	0.7388	0.7694	0.6776	0.7141	0.7263
Blue Cross	0.7079	0.7837	0.7701	0.7268	0.7043	0.7203

The top ten DRGs encountered during FY1997 along with their average LOS, are enumerated in the table below.

<i>Top Ten DRGs, FY 1997</i>					
<i>DRG</i>	<i>Description</i>	<i>Discharges</i>	<i>Percent</i>	<i>Cumulative Percent</i>	<i>Average LOS</i>
341	Normal Newborn	241	7.7%	7.7%	1.7
373	Vaginal Delivery without Complications	225	7.2%	15.0%	2.0
127	Heart Failure & Shock	159	5.1%	20.1%	5.1
89	Simple Pneumonia & Pleurisy > Age 17 with Complications	124	4.0%	24.1%	7.6
88	Chronic Obstructive Pulmonary Disease	100	3.2%	27.3%	5.2
132	Atherosclerosis with Complications	96	3.1%	30.4%	3.1
143	Chest Pain	90	2.9%	33.2%	2.2
494	Laparoscopic Cholecystectomy without C.D.E., without Complications	72	2.3%	35.6%	1.2
371	Caesarean Section without Complications	68	2.2%	37.7%	3.9
140	Angina Pectoris	60	1.9%	39.7%	3.0

INFORMATION SYSTEMS

Most of the Corporation's computer applications software is provided and maintained by Sysdacomp, Inc. ("Sysdacomp"). Sysdacomp, headquartered in Bath, Michigan, provides similar services to approximately twelve smaller hospitals in Michigan. The Sysdacomp software operates on an IBM A/S 400 mainframe owned by the Corporation.

YEAR 2000 COMPLIANCE

The Corporation utilizes information systems and related technologies that will be affected by the date change in the year 2000 (the "Y2K Issue"). Sysdacomp commenced converting its systems to address the Y2K Issue in 1997. Sysdacomp has advised Corporation management that it expects to resolve the Y2K Issue with respect to its software prior to the end of 1999. However, Corporation management cannot measure the impact that the Year 2000 issue will have on insurance companies and other third-party payors, vendors, suppliers and other parties with which the Corporation conducts business.