

STATE OF NORTH CAROLINA
THE NORTH CAROLINA MEDICAL CARE COMMISSION
Division of Health Service Regulation
(CCRC)
CONSTRUCTION AND/OR REFINANCING
APPLICATION FOR PROJECT FINANCING ASSISTANCE
UNDER AUTHORITY OF THE HEALTH CARE FACILITIES FINANCE ACT

Pursuant to Chapter 131A of the North Carolina General Statutes, the undersigned hereby makes application for financing assistance for the proposed project described below:

1. Legal Name of Applicant: _____

2. Address of Applicant: _____

(Street and Number)

(Zip)

(City)

(State)

(County)

(Mailing Address if Different From Above)

3. Chief Executive Officer: _____

Phone No: _____

Fax No: _____

Email address: _____

4. Project Contact Person: _____

Phone No: _____

Fax No: _____

Email address: _____

5. Organization: _____

a. Ownership: _____

b. Tax Status: _____

6. Describe briefly but completely the scope of the proposed project (attach additional sheet if necessary).

7. Site Information:

A. Geographic location of proposed project:

County: _____ City or Town: _____

B. Has site been acquired? Yes _____ No _____ Size of Site: _____
Acres

(1) Does the applicant hold an option on the potential site? _____

(2) Describe terms of option: _____

C. If site has been acquired:

(1) Describe interest in site:

_____ Fee Simple Title _____ Leasehold

_____ Other (explain): _____

(2) If interest is leasehold, give following information:

Term of leasehold (99 yrs., 50 yrs., etc.) _____ years

(b) Is lease renewable? Yes _____ No _____

8. Do you have any outstanding State or Federal licensure, certification, or regulatory issues (including investigations and/or litigation) which have not been resolved as of the date of this application? If the answer is yes, please attach an explanation.

9. Do you have any life safety issues, which should be addressed as a part of this bond issue? If the answer is yes, please attach an explanation.

10. Community Benefits Reporting – the attached form related to Community Benefits should be completed as a part of this application. (Forms on the MCC Website at <http://www.ncdhhs.gov/dhsr/ncmcc>).

11. Do you currently meet the requirements for full property tax exemption under Section 105-278.6A (c)(6) of the General Statutes of North Carolina? _____ Yes _____ No

NOTE: G.S. 105-278.6A Qualified Retirement Facility provides that land, buildings and personal property owned and used by a qualified retirement facility in the operation of that facility, are eligible to be excluded from taxation provided certain criteria set out in the statute are met, including at least 5% of the facilities resident revenue is provided in charity care and contributions.

12. Are you in compliance with the covenants set forth in the agreements governing all your outstanding Medical Care Commission debt? Yes _____ No _____. If the answer is no, please set forth the items of noncompliance in a separate attachment to this application.

13. Financial Information Applicable to This Project

A. Sources:

(1) Cash and negotiable securities from reserves	\$ _____
(2) Principal amount of bonds to be issued/converted	\$ _____
(3) Other: _____	\$ _____
(4) Other: _____	\$ _____
(5) Other: _____	\$ _____
(6) Other: _____	\$ _____
(7) Other: _____	\$ _____
Total Sources of Funds	\$ _____

B. Project Cost Estimates:

(1) Site Costs:

a. Land acquisition including survey fees, legal fees and subsoil investigation	\$ _____
b. Site utility development and accessibility costs including necessary engineering fees	\$ _____

Total Site Costs \$ _____

(2) Construction Costs:

a. Construction contracts (including fixed equipment, installation, associated construction costs: list separate projects)	\$ _____
b. Architect's fees (____% of construction)	\$ _____
1. Architect's reimbursables	\$ _____
c. Contingency – 1% of construction contracts	\$ _____
d. Total Moveable Equipment Budget	\$ _____
e. Surveys, Tests, Insurance, etc.	\$ _____
f. Consultant Fees (Related to Construction –List)	
1. _____	\$ _____
2. _____	\$ _____
3. _____	\$ _____

Total Construction Costs \$ _____

(3) Refinancing and/or Other Project Costs:	\$ _____
a. Amount required to prepay loan	\$ _____
b. Escrow amount of refund bonds	\$ _____
c. Other refinancing items:	\$ _____
1. _____	\$ _____
2. _____	\$ _____
3. _____	\$ _____
d. Other project costs:	
1. Division of Health Service Regulation	\$ _____
2. _____	\$ _____
3. _____	\$ _____
4. _____	\$ _____

Total Refinancing & Other Costs **\$ _____**

(4) Financing Costs:	
(a) Bond Interest during Construction	\$ _____
(b) Debt Service Reserve Fund	\$ _____
(c) Bond Insurance/Letter of Credit Fee	\$ _____
(d) Underwriters' Discount/Placement Fee	\$ _____
(5) Other Cost of Issuance	
a. Feasibility Fees	\$ _____
b. Accountants Fees	\$ _____
c. Legal Fees for Corporation Counsel	\$ _____
d. Bond Counsel	\$ _____
E. Rating Agencies	\$ _____
f. Trustee Fees	\$ _____
g. Printing Costs	\$ _____
h. Local Government Commission Fee	\$ _____

i. Other: (List)

(1) _____ \$ _____

(2) _____ \$ _____

(3) _____ \$ _____

(4) _____ \$ _____

Total Financing Costs and Costs of Issuance \$ _____

Total Uses of Funds \$ _____

14. Equal Employment Opportunity Certification

This facility is committed to equal employment opportunity for all applicants and employees. Accordingly, this facility neither practices nor condones any form of discriminatory behavior against applicants or employees based on race, color, national origin, religion, sex, age or handicapping condition.

15. Please list the Bankers, Attorneys and Consultants that you will be using for the financing of this Project:

- (1) _____
- (2) _____
- (3) _____

The undersigned hereby certifies that the attachments and foregoing statements are correct to the best of his knowledge and belief.

Date: _____

Name of Responsible Officer: _____

Title: _____

Signature of Officer: _____

Please include the following:

- ___ Certificate of Need for Proposed Project if one is required
- ___ Preliminary Equipment List – (Provide an itemized breakdown of equipment over \$100,000)
- ___ Preliminary Feasibility Study or internally Generated Projection of actual debt service coverage for fiscal year and projected debt service coverage for five succeeding fiscal years.
- ___ Schematic Plans with Narrative (if not already submitted to the Construction Section, DHSR)
- ___ Audited Financial Statements for Previous Three Years
- ___ Community Benefits/Charity Care GS 105 Form
- ___ Board of Trustees/Board of Directors Diversity
- ___ Resident Diversity
- ___ Entrance and monthly fee schedules

Please answer the following:

Does Organization have a formal post tax issuance compliance policy?
Who in the Organization will be designated to ensure appropriate compliance with the issuance?
What is the Organization’s compliance monitoring plan?
How will the Organization report compliance deficiencies to leadership and the Board?

Distribution

Geary W. Knapp, JD, CPA, Assistant Secretary.

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