

STATE OF NORTH CAROLINA
THE NORTH CAROLINA MEDICAL CARE COMMISSION
Division of Health Service Regulation
(CCRC)
CONSTRUCTION AND/OR REFINANCING PROJECT
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).

Revised 03-24-2009

7. Site Information:

A. Geographic location of proposed construction:

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 size?

(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:

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

(b) Is lease renewable? Yes ___ No

(3) Describe on attachment any encumbrances which may interfere with use or enjoyment of premises for purposes of the facility (mortgages, liens, assessments, mineral or mining rights, restrictive clauses in the instrument of conveyance, easements, rights-of-way, zoning ordinances building restrictions, etc):

8. Have you completed any construction, renovation or purchase and installation of equipment which would be subject to review by the Construction Section for compliance with licensure and/or certification requirements but which has not been reviewed by the Construction Section, Division of Health Service Regulation? If the answer is yes, please attach an explanation.

9. Do you have any outstanding licensure, certification or regulatory issues which have not been resolved as of the date of this application? If the answer is yes please attach an explanation.

10. Do you have any life safety or physical plant issues which should be addressed as a part of this bond issue that are not addressed by your proposed project(s)? If the answer is yes please attach an explanation.

11. 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>)

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12. 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.

13. Financial Information Applicable to This Project

A. Sources:

- (1) Cash and negotiable securities from reserves \$ _____
- (2) Principal amount of bonds to be issued \$ _____
- (3) Interest earned during construction \$ _____
- (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, and associated construction costs: list separate projects) \$ _____
 - b. Architect's fees (___% of construction contracts) \$ _____
 - 1. Architect reimbursables \$ _____
 - c. Contingency - 1% of construction \$ _____
 - d. Total Moveable Equipment Budget (including installation) \$ _____
 - 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 to refund bonds \$ _____

c. Other refinancing items \$ _____

_____ \$ _____

_____ \$ _____

_____ \$ _____

d. Other project costs: \$ _____

_____ \$ _____

_____ \$ _____

_____ \$ _____

TOTAL REFINANCING OR OTHER COSTS \$ _____

TOTAL NON-FINANCING COSTS \$ _____

(Item 2 & Item 3)

C. Financing Costs:

(1) Bond Interest during Construction \$ _____

(2) Debt Service Reserve Fund \$ _____

(3) Bond Insurance/Letter of Credit Fee \$ _____

(4) 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 \$ _____

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- g. Printing Costs \$ _____
- h. Division of Health Service Regulation (Plan review fees) \$ _____
- i. Local Government Commission Reimbursables \$ _____
- j. Other: (List)
 - (1) _____ \$ _____
 - (2) _____ \$ _____
 - (3) _____ \$ _____
 - (4) _____ \$ _____

TOTAL FINANCING COSTS \$ _____
TOTAL PROJECT COSTS \$ _____

14. Construction Schedule Estimates:

- A. Target Dates for Final Construction Documents _____
- B. Target Dates for Starting Construction _____
- C. Target Dates for Construction Completion & Occupancy _____

15. 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 on the basis of race, color, national origin, religion, sex, age or handicapping condition.

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: _____

SHOULD BE INCLUDED IF AVAILABLE

The following documents are enclosed for your review:

___ Certificate of Need for Proposed Project if one is required

___ * Preliminary Equipment List - (Provide an itemized breakdown of equipment over \$100,000)

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- ___ Preliminary Feasibility Study or Internally Generated Projection for at Least One Year Past Project Completion including actual debt service coverage for last fiscal year and projected debt service coverage for the three succeeding fiscal years

- ___ Schematic Plans

- ___ Audited Financial Statements for Previous Three Years (if not part of Preliminary Feasibility Study)

- ___ Completed Community Benefits Form

Distribution

Forward original with attachments and two signed copies without attachments of this form to:
Mr. Christopher B. Taylor, CPA, Assistant Secretary.

Street Address for Overnight Delivery:

N.C. Medical Care Commission
701 Barbour Drive
Raleigh, North Carolina 27603
Telephone: (919) 855-3750

Mailing Address:

N.C. Medical Care Commission
2701 Mail Service Center
Raleigh, North Carolina 27699-2701
Fax: (919) 733-2757

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