

**Revised 03-24-2009**

STATE OF NORTH CAROLINA  
THE NORTH CAROLINA MEDICAL CARE COMMISSION  
Division of Health Service Regulation  
(CCRC)  
EQUIPMENT 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(s) for utilization of proposed equipment:

County \_\_\_\_\_ City or Town \_\_\_\_\_

B. Has site been acquired? Yes \_\_\_\_\_ No \_\_\_\_\_

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 for licensure but which has not been reviewed by the 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 issues which should be addressed as a part of this bond issue? 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.ncdhs.gov/dhsr/ncmcc>)

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:

**Revised 03-24-2009**

- (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) Total Moveable Equipment Budget (including installation) \$ \_\_\_\_\_
- (2) Total Fixed Equipment Budget (attach list of any construction projects associated with installation) \$ \_\_\_\_\_

Total Project Costs \$ \_\_\_\_\_

- (3) Consultant Fees (Related to Project- List)
  - 1. \_\_\_\_\_ \$ \_\_\_\_\_
  - 2. \_\_\_\_\_ \$ \_\_\_\_\_
  - 3. \_\_\_\_\_ \$ \_\_\_\_\_

Total Project Costs \$ \_\_\_\_\_

- (4) 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) Debt Service Reserve Fund \$ \_\_\_\_\_

**Revised 03-24-2009**

(2) Bond Insurance/Letter of Credit Fee	\$ _____
(3) Underwriters' Discount/Placement Fee	\$ _____
(4) 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. 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. Equipment Acquisition Time Table:

FYE \_\_\_\_\_  
FYE \_\_\_\_\_  
FYE \_\_\_\_\_

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: \_\_\_\_\_

**Revised 03-24-2009**

Title: \_\_\_\_\_

Signature of Officer: \_\_\_\_\_

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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)
  
- \_\_\_ 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
  
- \_\_\_ 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

**Revised 03-24-2009**