Revised 03-24-2009

STATE OF NORTH CAROLINA
THE NORTH CAROLINA MEDICAL CARE COMMISSION
Division of Health Service Regulation
(HOSPITAL)
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).

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7. Describe on attachment any encumbrances which may interfere with use or enjoyment of premises for purposes of the facility or the installation of the equipment (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 ANDI form related to Community Benefits should be completed as a part of this application. (Form on MCC website at http://www.ncdhhs.gov/dhsr/ncmcc)

12. Project Cost Estimates:
    A. Project Costs
        (1) Total Moveable Equipment Budget (including installation) $_______________

        (2) Fixed equipment Budget (include description of scope of work) $_______________
            Attach list of any construction projects associated with equipment installation

        (3) Consultant Fees (Related to Project - List)
            a.______________________ $_______________
            b.______________________ $_______________
            c.______________________ $_______________

        (4) Refinancing Costs if Applicable
            a. Amount required to prepay loan $_______________
            b. Escrow amount to refund bonds $_______________
            c. Other refinancing items
                (i)____________________ $_______________
                (ii)___________________ $_______________

TOTAL PROJECT COSTS

13. Financing Costs:
    (1) Capitalized Interest $_______________

    (2) Debt Service Reserve Fund $_______________

    (3) Bond Insurance/Letter of Credit $_______________

    (4) Underwriters' Discount/Placement Fee $_______________

    (5) Other Cost of Issuance

        a. Feasibility Fees $_______________

        b. Accountants Fees $_______________

        c. Legal Fees for Corporation Counsel $_______________

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d. Bond Counsel $______________

e. Rating Agencies $______________

f. Trustee Fees $______________

g. Printing Costs $______________

h. Division of Health Service Regulation Reimbursables $______________

i. Local Government Commission Reimbursables $______________

j. Other: (List)
1) ______________ $______________

2) ______________ $______________

3) ______________ $______________

4) ______________ $______________

Total Financing Costs $______________

TOTAL PROJECT COSTS $______________

14. Timetable for Equipment Purchases:
A. Target date for beginning purchases______________________________

B. Target date for completion of purchases______________________________

C. Equipment purchases by fiscal year 200_

fiscal year 200_

fiscal year 200_

fiscal year 200_

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:______________________________

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The following documents are enclosed for your review:

___ Project Justification Including Alternative Financing Considered

___ Effect of any proposed refinancing on debt-service payments

___ Certificate of Need, if 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 the projected purchases - actual debt service coverage for last audited year plus three years projected debt service coverage

___ Audited Financial Statements (including management letters for last three years)

___ NCHA ANDI Form for Community Benefits

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

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