Revised 06/16/2016

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).

_____

_____

_____

_____

_____

7. Site Information:

A. Geographic location of proposed equipment location/installation:

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. 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.)

9. 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.

10. 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.

11. 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.

12. 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)

13 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 set forth the items of noncompliance in a separate attachment to this application.

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15. Financial Information Applicable to This Project:
A. Sources:

(1) Cash and negotiable securities from reserves $_____

(2) Principal amount of bonds to be issued $_____

(3) Other: _____ $_____

(4) Other: _____ $_____

(5) Other: _____ $_____

(6) Other: _____ $_____

Total Sources of Funds **$**_____

16. Project Cost Estimates:
B. 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 $_____

17. 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 $_____

d. Bond Counsel $_____

e. Rating Agencies $_____

f. Trustee Fees $_____

g. Printing Costs $_____

h Division of Health Service Regulation Reimbursables $_____

i. Local Government Commission Fee $_____

j. Other: (List)

1) _____ $_____

2) _____ $_____

3) _____ $_____

4) _____ $_____

Total Financing Costs $_____

Total Uses of Funds $_____

18. Timetable for Equipment Purchases:

A. Target date for beginning purchases_____

B. Target date for completion of purchases_____

C. Equipment purchases by fiscal year 20____

fiscal year 20____

fiscal year 20____

fiscal year 20____

19. 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.

20. 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 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)

___ Form 990 – Schedule K

___ NCHA ANDI Form

_____ Board of Trustees/Board of Directors Diversity

Distribution

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

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