

STATE OF NORTH CAROLINA
THE NORTH CAROLINA MEDICAL CARE COMMISSION
Division of Health Service Regulation
(Hospital)
REFINANCING COMMISSION 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 Number: _____ Fax Number: _____

Email address: _____

4. Project Contact Person: _____

Phone Number: _____ Fax Number: _____

Email address: _____

5. Organization:

Ownership: _____

Tax Status: _____

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

7. 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? Yes_____ No _____. If the answer is yes, please attach an explanation.
8. Do you have any outstanding issues with any national accrediting body e.g. JCAHO? Yes_____ No _____. 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? Yes_____ No_____. If the answer is yes, please attach an explanation.
10. Does the hospital have any provider based clinics, emergency departments, or other outpatient services, on or off the main hospital campus, that operate in the same county which the hospital is located and that are billed under the hospital's CMS provider number that have not been reviewed and approved for compliance with Construction and Licensure rules found at 10A NCAC 13B? Yes_____ No _____. 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.ncdhs.gov/dhsr/ncmcc>).
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 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 | \$ _____ |
| (3) Other: _____ | \$ _____ |
| (4) Other: _____ | \$ _____ |
| (5) Other: _____ | \$ _____ |
| (6) Other: _____ | \$ _____ |
| Total Sources of Funds | \$ _____ |

B. Refinancing and/or Other Costs:

| | |
|---|-----------------|
| (1) Amount required to prepay loan | \$ _____ |
| (2) Escrow amount of refund bonds | \$ _____ |
| (3) Other refinancing items: | \$ _____ |
| Total Refinancing or other costs | \$ _____ |

C. Financing Costs:

| | |
|---|-----------------|
| (1) Debt Service Reserve Fund | \$ _____ |
| (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 | \$ _____ |
| i. Local Government Commission Reimbursables | \$ _____ |
| j. Other: (List) | |
| (1) _____ | \$ _____ |
| (2) _____ | \$ _____ |
| (3) _____ | \$ _____ |
| (4) _____ | \$ _____ |
| Total Refinancing Costs or and Financing | \$ _____ |
| Total Uses of Funds | \$ _____ |

14. Equal Employment 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:

- ___ 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.

Street Address for Overnight Delivery:

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Mailing Address: (USPS Only)

North Carolina Medical Care Commission
2701 Mail Service Center
Raleigh, North Carolina 27699-2701

For email electronic delivery, please email to: Alice.Creech@DHHS.NC.Gov