

STATE OF NORTH CAROLINA
THE NORTH CAROLINA MEDICAL CARE COMMISSION
Division of Health Service Regulation
(CCRC)
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 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. 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.
- 8. 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.
- 9. 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>).
- 10. 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.

- 11. 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.

12. Financial Information Applicable to This Project

A. SOURCES:

(1) Cash and negotiable securities from reserves	\$_____
(2) Principal amount of bonds to be issued/converted	\$_____
(3) Other:_____	\$_____
(4) Other:_____	\$_____
(5) Other:_____	\$_____
(6) Other:_____	\$_____
	\$_____
Total Sources of Funds	\$_____

B. REFINANCING OR OTHER COSTS:

(1) Amount required to prepay loan	\$_____
(2) Escrow amount to refund bonds	\$_____
(3) Other	\$_____

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 Fee	\$ _____
j. Other: (List)	
(1) _____	\$ _____
(2) _____	\$ _____
(3) _____	\$ _____
(4) _____	\$ _____
Total Refinancing Costs or Other Costs	\$ _____
Total Uses of Funds	\$ _____

13. 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.

Revised 06/15/2016

14. 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 Projection including actual debt service coverage for fiscal year and projected debt service coverage for the three succeeding fiscal years.
- _____ Audited Financial Statements for Previous Three Years
- _____ Form 990 – Schedule K
- _____ Community Benefits/Charity Care GS 105 Form
- _____ Board of Trustees/Board of Directors Diversity
- _____ Resident Diversity
- _____ Entrance and monthly fee schedules

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
809 Ruggles 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

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

