



Application for a Change of Ownership Residential Care Facilities

Enclosed are the application forms and required documentation for a change of ownership for state licensed residential facilities. An application should include the following forms and/or documentation:

1. State Form 8200, Application for License to Operate a Health Facility, with required attachments (State Form 8200 enclosed);
2. State Form 19733, Implementing Indiana Code 16-28-2-6 (enclosed);
3. Documentation of the applicant entity's registration with the Indiana Secretary of State;
4. Internal Revenue Services (IRS) documentation - form SS-4 or comparable document from the IRS that reflects direct owner's corporation, limited liability company, partnership etc name, d/b/a if applicable and EIN number. The document must be **from the IRS sent to the provider** not a form/document the provider completed and sent to the IRS;
5. Licensure Fee, payable by check or money order to the Indiana State Department of Health, in the amount of two hundred dollars (\$200.00) for the first fifty (50) beds; ten dollars (\$10.00) for each additional bed;
6. State Form 51996, Independent Verification of Assets and Liabilities, with required documentation (State Form 51996 enclosed);
7. The fully executed copy of the Bill of Sale, Lease, Asset Purchase Agreement, or other legal document for the change of ownership, which indicates the effective date for the change of ownership transaction
8. Completed State Form 4332, Bed Inventory (enclosed);
9. Facility floor plan on 8 1/2" x 11" paper to show room numbers and number of beds per room;
10. Copy(s) of the Patient Transfer Agreement between the facility and local hospital(s);
11. A staffing plan that should include the number, educational level and personal health of employees;
12. Agreements/Contracts between the applicant entity with various providers of services for residents within the facility: Dietician, Emergency Shelter, Emergency Water Supply, Hospital Transfer Agreement(s) (if applicable), Pharmacy Services, Pharmacy Consultant Services (if applicable).

The following documents must be submitted prior to the effective date for the change of ownership in order for the Division of Long Term Care to grant authorization for the new owner to occupy the facility:

1. Completed State Form 8200, Application for License to Operate a Health Facility, with required attachments
2. Documentation of the applicant entity's registration with the Indiana Secretary of State
3. State Form 51996, Independent Verification of Assets and Liabilities, with required attachments
4. Internal Revenue Services (IRS) documentation - form SS-4 or comparable document from the IRS that reflects direct owner's corporation, limited liability company, partnership etc name, d/b/a if applicable and EIN number. The document must be **from the IRS sent to the provider** not a form/document the provider completed and sent to the IRS;

5. Licensure Fee, payable by check or money order to the Indiana State Department of Health, in the amount of two hundred dollars (\$200.00) for the first fifty (50) beds; ten dollars (\$10.00) for each additional bed;
6. The fully executed copy of the Bill of Sale, Lease, Asset Purchase Agreement, or other legal document for the change of ownership, which indicates the effective date for the change of ownership transaction

Upon receipt of the above-mentioned items the following will occur:

- The Director may grant authorization for the applicant entity to occupy the facility
- The applicant entity has twenty-one (21) days after the authorization to operate the facility has been granted to submit the remainder of the application materials

Under normal circumstances, a licensure survey for a change of ownership is not required.

Please do not hesitate to contact Provider Services at 317/233-7613 or 317/233-7794 should you have questions regarding the application process.



**APPLICATION FOR LICENSE
TO OPERATE A HEALTH FACILITY**

(Pursuant to IC 16-28 and 410 IAC 16.2)
State Form 8200 (R3/8-00)

Indiana State Department of Health-Division of Long Term Care

DIVISION OF LONG TERM CARE

Date Received _____
Date Approved _____
Approved by _____

Please Print or Type

SECTION I - TYPE OF APPLICATION

Application *(check appropriate item)*

Change of Ownership *(Anticipated date of Sale/Purchase/Lease)* _____ New Facility Other _____

SECTION II - IDENTIFYING INFORMATION

A. Practice Location (facility)

Name of Facility _____

Street Address _____

P.O. Box: _____

City _____

County _____

Zip Code +4 _____

Telephone Number
() () _____

Fax Number
() () _____

Facility's Cost Reporting Year
From (mm/dd): _____

To (mm/dd): _____

B. Licensee/Ownership Information

Licensee *(Operator(s) of the facility)* The licensee and the applicant entity as described in Item IV-A of this application should be the same.

Street Address _____

P.O. Box _____

City _____

State _____

Zip Code+4 _____

Telephone Number
() () _____

Fax Number
() () _____

EIN Number _____

Fiscal Year End Date
(mm/dd) _____

C. Building Information

1. Status of building to be used *(check appropriate item)*

Proposed New Construction Alteration of Existing Building Existing Licensed Health Facility Other _____

2. Type of Construction (materials) *(if new, as certified by architect or engineer registered in the state of Indiana)*

| D. Type of Services to be Provided | | | |
|--|--|---|---|
| 1. Level of Care <input type="checkbox"/> Residential <input type="checkbox"/> Comprehensive (Certified) <input type="checkbox"/> Comprehensive (Non-certified) <input type="checkbox"/> Children's Facility <input type="checkbox"/> Developmentally Disabled Total Number of Licensed Beds | Number of Beds in Each Category (to be licensed) _____ _____ _____ _____ _____ _____ | 2. Certification Designation <input type="checkbox"/> SNF (Title 18 – Medicare) <input type="checkbox"/> SNF/NF (Title 18 – Medicare/Title 19 – Medicaid) <input type="checkbox"/> NF (Title 19 – Medicaid) <input type="checkbox"/> ICF/MR Total Certified Beds | Number of Beds in Each Category (to be licensed) _____ _____ _____ _____ _____ |

SECTION III – STAFFING

| A. Administrator | | |
|---|----------------|--------------------------------|
| Name (enter full name) | | |
| Indiana License Number (please include a copy of license with application) | Date of Birth | Date employed in this position |
| 1. List post secondary education and health related experience _____ _____ _____ | | |
| 2. On a separate sheet, list the facilities in Indiana, or any other state, in which the Administrator has been previously employed, including the dates of employment and reason for leaving. Identify on this list any of these facilities which were operating with less than a full license at the time the Administrator was employed. | | |
| 3. Has the administrator ever been convicted of any criminal offense related to a dependent population? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, state on a separate sheet the facts of each case completely and concisely)</i> | | |
| 4. Has the administrator's license ever lapsed, been suspended or revoked? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, state on a separate sheet the facts of each case completely and concisely)</i> | | |
| 5. Is the administrator presently in good health and physically able to fully carry out all of the duties in the operation of this health facility? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, explain on a separate sheet)</i> | | |
| B. Director of Nursing | | |
| Name (enter full name) | | |
| Indiana License Number (please include a copy of license with application) | Date of birth | Date employed in this position |
| Education (Name of School of Nursing) | | |
| School Degree | Year Graduated | |
| Other College Education | | |
| Qualifications or Experience | | |
| 1. Has the Director of Nursing ever been convicted of any criminal offense related to a dependent population? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, state on a separate sheet the facts of each case completely and concisely)</i> | | |

2. Has the Director of Nurse's License ever lapsed, or ever been suspended or revoked? Yes No
(If yes, state on a separate sheet the facts of each case completely and concisely)

SECTION IV - DISCLOSURE OF OWNERSHIP AND CONTROLLING INTEREST STATEMENT
 (In compliance with the Indiana Health Facilities Rules (410 IAC 16.2))

A. Applicant Entity

Name of Applicant Entity *(operator(s) of the facility)*

D/B/A *(Name of Facility)*

B. Ownership Information

List names and addresses of individuals or organizations having direct or indirect ownership interest of five percent (5%) or more in the applicant entity. Indirect ownership interest is interest in an entity that has an ownership interest in the applicant entity. Ownership in any entity higher in a pyramid than the applicant constitutes indirect ownership. *(use additional sheet if necessary)*

| Name | Business Address | EIN Number |
|------|------------------|------------|
| | | |
| | | |
| | | |
| | | |
| | | |

C. Type of Change of Ownership

- Assignment of Interest
 Lease
 Merger
 New Partnership
 Sale
 Sublease
 Termination of Lease
 Other _____

D. Type of Entity

| <u>For Profit</u> | <u>NonProfit</u> | <u>Government</u> |
|--|--|---|
| <input type="checkbox"/> Individual | <input type="checkbox"/> Church Related | <input type="checkbox"/> State |
| <input type="checkbox"/> * Partnership | <input type="checkbox"/> Individual | <input type="checkbox"/> County |
| <input type="checkbox"/> ** Corporation | <input type="checkbox"/> * Partnership | <input type="checkbox"/> City |
| <input type="checkbox"/> *** Limited Liability Company | <input type="checkbox"/> ** Corporation | <input type="checkbox"/> City/County |
| <input type="checkbox"/> Other <i>(specify)</i> _____ | <input type="checkbox"/> *** Limited Liability Company | <input type="checkbox"/> Hospital District |
| _____ | <input type="checkbox"/> Other <i>(specify)</i> _____ | <input type="checkbox"/> Federal |
| _____ | _____ | <input type="checkbox"/> Other <i>(specify)</i> _____ |

*If a Limited Partnership, submit a copy of the "Application For Registration" and "Certificate of Registration" signed by the Indiana Secretary of State.

**If a Corporation, submit a copy of the "Articles of Incorporation" and "Certificate of Incorporation" signed by the Indiana Secretary of State. If a foreign Corporation, submit a copy of the "Certificate to do Business in the State of Indiana" signed by the Indiana Secretary of State.

***If a Limited Liability Company, submit a copy of the "Articles of Organization" and the "Certificate of Organization" signed by the Indiana Secretary of State.

SECTION V - DISCLOSURE OF APPLICANT ENTITY

A. Officers/Directors/Members/Partners/Managers

1. List all individuals (persons) associated with the applicant entity and indicate the individual's title (i.e. officer, director, member, partner, etc). If the applicant is a partnership, list the name and title of each partner or the name and title of all individuals associated with each entity that forms the partnership. If the applicant is a Limited Liability Company, list the name and title for all individuals associated with each member entity that forms the Limited Liability Company. *(use additional sheet if necessary)*

| Name | Title | Business Address | Telephone Number |
|------|-------|------------------|------------------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

2. Are any individuals (persons) associated with the applicant entity (as listed in Sections IV.B and V.A.1) also associated with any other entity operating health facilities in Indiana or any other states? Yes No

If "yes," list names and addresses of facilities owned by each individual. *(use additional sheet if necessary)*

| Facility Name | Address | City, County, State, Zip Code |
|---------------|---------|-------------------------------|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

3. Is the licensee (applicant) a lease entity? Yes No

If yes, explain _____

Please submit a copy of the lease showing an effective date. If this is a sublease or assignment of interest of a lease, submit a copy of all Leases affected by this transaction.

4. Is the applicant a subsidiary of another entity or corporation or does the applicant have subsidiaries under its control? Yes No

(If yes, list each entity (affiliated entity) on a separate sheet and explain the relationship)

B. Licensure/Operating History

Are any of the individuals (as listed in Sections IV.B. and V.A.1.), associated with or have they been associated with, any other entity that is operating, or has operated, health facilities in Indiana or any other state, that:

- 1. Has/had a record of operation of less than a full license (i.e. three month probationary, provisional, etc)
 Yes No (If "Yes", provide name of facility, state, date(s), restrictions and type)
- 2. Had a facility's license revoked, suspended or denied. Yes No (If "Yes", provide name of facility, state, type of actions and date(s))
- 3. Was the subject of decertification, termination, or had a finding of patient abuse, mistreatment or neglect.
 Yes No (If "Yes", provide name of facility, state, date, type of action, results of action)
- 4. Had a survey finding of Substandard Quality of Care or Immediate Jeopardy Yes No (If "Yes", provide all correspondence and deficiency reports, including the current or final resolution of the matter)
- 5. Filed for bankruptcy, reorganization or receivership. Yes No (If "Yes", include all relevant documentation and provide a detailed summary of the events and circumstances. Include state, dates and names of facilities)

NOTE: If any of the answers above are "Yes", list each facility on a separate sheet of paper and explain the facts clearly and concisely.

SECTION VI - CERTIFICATION OF APPLICATION

I hereby certify that the operational policies of the health facility will not provide for discrimination based upon race, color, creed or national origin.

I swear or affirm that all statements made in this application and any attachments thereto are correct to the best of my knowledge and that the applicant entity will comply with all laws, rules and regulations governing the licensing of health facilities in Indiana.

Applicant's signature, as indicated in V-A of this application, or signature of applicant's agent should appear below.

IF SIGNED BY ANY INDIVIDUAL (EG., THE ADMINISTRATOR) OTHER THAN INDICATED IN SECTION V.A.1. OF THIS APPLICATION, AN AFFIDAVIT MUST BE SUBMITTED WITH THE APPLICATION AFFIRMING THAT SAID PERSON HAS BEEN GIVEN THE POWER TO BIND THE APPLICANT/LICENSEE.

| | |
|---|-------|
| Name of Authorized Representative (Typed) | Title |
|---|-------|

| | |
|-----------|------|
| Signature | Date |
|-----------|------|

STATE OF _____ COUNTY OF _____

Subscribed and sworn to before me, a Notary Public, for _____ County, State of _____,
this _____ day of _____, 20_____

(SEAL) (Signature) _____

_____, Notary Public
(Type or Print Name)

My Commission expires _____



IMPLEMENTING INDIANA CODE 16-28-2-6

State Form 19733 (R4/11-00)

Indiana State Department of Health-Division of Long Term Care

PLEASE READ BEFORE COMPLETING THIS FORM

IC 16-28-2-6 created a reporting requirement for some facilities which charge certain fees and have a name which implies association with a religious, charitable, or other nonprofit organization.

This form was developed and approved by the Indiana Health Facilities Council in order to obtain the information required by law. Please read the attached form carefully. If your facility is **not** one of those included in the category affected by this law, you need only check the appropriate box in Section A, have the form notarized, signed by the appropriate person, and return it with your application.

If you **are** included in the category affected, read and follow the directions, have the form notarized, signed by the appropriate person and return it with your application.

The information required on this form is necessary in order for a health facility to be licensed.

Name of Facility

Street Address

City

State

Zip+4

SECTION A

This health facility does does not have charges other than daily or monthly rates for room, board, and care consisting of a required admission payment of money or investment of money or other consideration for admission.

IF SECTION A ABOVE IS ANSWERED IN THE NEGATIVE, SKIP TO SECTION F BELOW

SECTION B

The name of this health facility or the name of the person operating the health facility does does not imply affiliation with a religious, charitable, or other nonprofit organization.

SECTION C

Is this health facility affiliated with a religious, charitable, or other nonprofit organization? yes no

SECTION D

If Section C was answered "yes", list the nature and extent of such affiliation, including the name of such affiliated organization, its address, and the extent, if any, to which it is responsible for the financial and contractual obligations of the health facility. (This material, if lengthy, may be submitted as an attachment. Attachments must be numbered and referenced on lines provided below.)

SECTION E

Unless Sections B and C above are answered in the negative, complete this Section, and NOTE THE OBLIGATIONS OF HEALTH FACILITY

1. The health facility hereby agrees that all health facility's advertisements and solicitations shall include a summary statement disclosing any affiliation between the health facility and the religious, charitable, or other nonprofit organization; and the extent, if any, to which the affiliated organizations is responsible for the financial and contractual obligations of the health facility. **Please attach the summary statement.** If not attached, explain why not, and if, an when, it will be furnished.
2. The health facility shall furnish each prospective resident with a disclosure statement as contemplated by Indiana law. **Please attach the disclosure statement.** If not attached, explain why not, and if, and when, it will be furnished.

SECTION F

THE HEALTH FACILITY HEREBY AGREES THAT, WHENEVER THERE IS A CHANGE IN ITS ACTUAL OR IMPLIED AFFILIATION WITH A RELIGIOUS, CHARITABLE OR NONPROFIT ORGANIZATION, AND THE FACILITY HAS ADMISSION CHARGES OTHE THAN DAILY OR MONTHLY RATES FOR ROOM, BOARD, AND CARE, THEN THE FACILITY WILL PREPARE OR AMEND A SUMMARY STATEMENT, AND THE DISCLOSURE STATEMENT, IF THAT IS NECESSARY UNDER THE PROVISIONS OF INDIANA CODE 16-28-2-6, AND IMMEDIATELY FILE SUCH PREPARED STATEMENT(S) WITH THE INDIANA HEALTH FACILITIES COUNCIL.

I affirm, under the penalties of perjury, that the information and undertakings set out above are made in good faith, true, and complete, to the best of my knowledge and belief, and that the person signing the foregoing form is the duly authorize representative of the health facility for that purpose.

Board Chairman or Owner

Print Name of Signer

STATE OF _____)

COUNTY OF _____)

Subscribed and sworn to before me, this _____ day of _____, 20_____

(Seal)

Notary Public

County of Residence

My commission expires _____

PLEASE RETURN FORM TO:

Indiana State Department of Health
Division of Long Term Care
2 North Meridian Street, Section 4-B
Indianapolis, IN 46204

SECTION III – SELECTED BALANCE SHEET ITEMS AS OF _____
(date)

| A. Current Assets: | | B. Current Liabilities: | |
|---|---|---|---|
| <i>Asset</i> | <i>Amount (rounded to nearest dollar)</i> | <i>Liability</i> | <i>Amount (rounded to nearest dollar)</i> |
| Cash | | Accounts Payable | |
| Accounts Receivable | | Other Current Liabilities | |
| Less: Allowance for bad debt | | Intercompany Liabilities | |
| Prepaid Expenses | | Non-related Party Working Capital Loans | |
| Inventories and Supplies | | Related Party Working Capital | |
| Intercompany Receivables | | Other Current Liabilities | |
| All Loans to Owners, Officers & Related Parties | | Total Current Liabilities | |
| Assets Held for Investment | | | |
| Other Current Assets | | | |
| Total Current Assets | | | |

C. Working Capital: (Total Current Assets minus Total Current Liabilities) \$ _____

D. Total Liabilities: \$ _____ E. Total Owner's Equity or Fund Balance: \$ _____

F. Lines of Credit *(List all letters of credit or other open lines of credit available, attach additional sheet(s) if necessary):*

| <u>Name of Institution or Lender</u> | <u>Amount of Credit Available</u> |
|--------------------------------------|-----------------------------------|
| 1. | \$ _____ |
| 2. | \$ _____ |
| 3. | \$ _____ |
| 4. | \$ _____ |

G. Number of Facility Beds: _____
Projected Monthly Revenue: \$ _____
Projected Monthly Operating Expenses: \$ _____

SECTION IV – CERTIFICATION STATEMENTS

Under penalty of perjury: I certify that the foregoing information, including any attached exhibits, schedules, and explanations is true, accurate, and complete. Having reviewed each section, together with the identified attachments, I am satisfied that each section is correctly answered and that the answers and any attachments are sufficient in scope and clarity to accomplish full disclosure (full disclosure requires that a knowledgeable financial reader, after reviewing the explanations and attachments, would not be misled). I understand that any false claims, statements, or documents, or concealment of material fact may be prosecuted under applicable federal or state law.

| | |
|--|-----------------------|
| Name of Authorized Person (Typed) | Title/Position |
| Signature of Authorized Person | Date |

This is to confirm that I (we) have prepared a compilation of financial information which is the basis for the data indicated in sections A through E inclusive, and have verified the existence of the lines of credit listed in section F, pursuant to agreed upon procedures between myself (us) and the licensee(s) listed herein (see attached compilation and agreed upon procedures report).

| | |
|--|---|
| Name of Certified Public Accountant representing the firm (Typed) | Title/Position |
| Signature of Certified Public Accountant representing the firm | License/Certification Number Date |



BED INVENTORY

State Form 4332 (R8/1-02)
Indiana State Department of Health-Division of Long Term Care

| Name of Facility | | | | | | | | | | | |
|--|--------|-----------------------|--------|----------------|--------|---|--------|--------------|--------|----------------------|----------|
| Street Address | | | | | | | | | | | |
| City | | | | County | | | | Zip+4 | | | |
| PLEASE SPECIFY THE NUMBER OF BEDS IN EACH ROOM AS FOLLOWS: Each room should be listed only once and listed in numerical order under each classification column. | | | | | | | | | | Room No. | No. Beds |
| Title 18 SNF = Medicare ONLY beds Title 18 SNF/NF 19 NF = Medicare/Medicaid (Dually Certified) Title 19 NF = Medicaid NCC = Non-Certified Comprehensive Residential Level of Care All licensed beds must be listed. | | | | | | | | | | 8 | 2 |
| | | | | | | | | | | 9 | 2 |
| | | | | | | | | | | 10 | 2 |
| | | | | | | | | | | 11 | 3 |
| | | | | | | | | | | 12 | 2 |
| 20 | 2 | | | | | | | | | | |
| Title 18 SNF | | Title 18/19 SNF/NF | | Title 19 NF | | | | NCC | | Residential | |
| Room # | # Beds | Room # | # Beds | Room # | # Beds | Room # | # Beds | Room # | # Beds | Room # | # Beds |
| | | | | | | | | | | | |
| Total 18 SNF | | Total 18/19 SNF/NF | | Total 19 NF | | | | Total NCC | | Total Residential | |
| Current SNF Census | | | _____ | | | NOTE <i>Completion of this form is not an official bed change request or a change from those beds classifications and numbers currently licensed and certified for.</i> | | | | | |
| Current SNF/NF Census | | | _____ | | | | | | | | |
| Current NF Census | | | _____ | | | | | | | | |
| Current NCC Census | | | _____ | | | | | | | | |
| Current Residential Census | | | _____ | | | | | | | | |
| TOTAL CURRENT CENSUS | | | _____ | | | | | | | | |
| TOTAL LICENSED CAPACITY | | | _____ | | | | | | | | |
| Completed by | | | | Position | | | | Date | | | |