INDIANA STATE DEPARTMENT OF HEALTH

CHANGE OF OWNERSHIP APPLICATION
TITLE 18 SNF OR TITLE 18 SNF/ TITLE 19 NF

This letter is to inform applicants of the required documentation for a change of ownership application for Medicare and/or Medicaid certified health facilities. For additional information on the rules and regulations involving this action please refer to: http://www.in.gov/isdh/20511.htm

A cover letter, that includes a contact name, phone number, email and address, should be submitted with items 1-5 and 7 listed below for the Change of Ownership (CHOW) application **at least 30 days prior** to **the effective date of the CHOW**. Item 6 should be submitted to the Department of Health (Department) within one (1) working day of the effective date. Submission of the application form and supporting documents within the time frames set out above will avoid expiration of the license and/or unnecessary delays in assuming control of an existing facility. Items 1-7 must be received and approved prior to the Department issuing a license. Applications will be reviewed in the order received at the Department.

An application should include a cover letter and the following forms and/or documentation:

1. State Form 8200, Application for License to Operate a Health Facility, with required attachments. This form is available at https://forms.in.gov/Download.aspx?id=4691
2. State Form 19733, Implementing Indiana Code 16-28-2-6. This form is available at https://forms.in.gov/Download.aspx?id=9627
3. Documentation of the applicant entity's registration with the Indiana Secretary of State with d/b/a if applicable
4. State Form 51996, Independent Verification of Assets and Liabilities, to include required attachments. This form is available at https://forms.in.gov/Download.aspx?id=6250
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. **Fully executed copy(ies)** of the Bill of Sale, Lease, Asset Purchase Agreement, or other legal documents for the change of ownership, which indicates the effective date for the change of ownership transaction. The documents provided must establish a clear and unbroken chain between the current licensee and the CHOW applicant.
7. Internal Revenue Services (IRS) documentation – Submit a document from the IRS that reflects the legal entity's name and EIN. The document must be **from the IRS sent to the provider** not a form/document the provider completed and sent to the IRS
8. Form CMS-671, Long Term Care Facility Application for Medicare and Medicaid (enclosed)
9. One (1) signed original of the Form CMS-1561, Health Insurance Benefit Agreement (enclosed)
10. Documentation of compliance with Civil Rights should be filed online at https://ocrportal.hhs.gov/ocr/aoc/instruction.jsf per S&C 16-37
    - A copy of the online confirmation **from** OCR showing the provider has completed the civil rights submission online should be submitted to ISDH
11. Completed State Form 4332, Bed Inventory. This form is available at https://forms.in.gov/Download.aspx?id=4659
12. Facility floor plan on 8 ½" x 11" paper to show room numbers (must be legible) and number of beds per room, use multiple pages if needed, example attached
13. Copy(s) of the Patient Transfer Agreement between the facility and local hospital(s)
14. SF 55283 Contract and Service Agreement Checklist and copy(s) of **new** Services Agreements/Contracts between the applicant entity and third parties. This form is available at https://forms.in.gov/Download.aspx?id=11172
15. SF 55282 Proposed Staffing Structure. This form is available at https://forms.in.gov/Download.aspx?id=11170 and
16. Copy of the facility's disaster plan.

In addition, the facility must contact the Medicare Fiscal Intermediary (FI), Wisconsin Physician Service (WPS), **or** their CMS approved Fiscal Intermediary, for Form CMS-855A. The form can be downloaded at http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/cms855a.pdf . The facility may reach Wisconsin Physician Service (WPS) at 608-221-4711. The completed Form CMS-855A should be forwarded directly to Wisconsin Physician Service (WPS), or the appropriate FI, for review and recommendation for approval.

NOTE: The facility must contact HP, the State Medicaid Agency Contractor, to obtain a Provider Enrollment Agreement for Medicaid participation. This should be submitted directly back to HP for processing.

The following is a general outline of the application process:

1. Upon receipt of the above items 1-7, and upon the Division Director's satisfaction that the applicant entity meets the requirements of Indiana Code 16-28-2-1 *et seq*., the Director may grant authorization for the applicant entity to operate the facility;

3. If the authorization is granted, the remainder of the application items are due **no later** than twenty-one (21) days from the date of the authorization to operate letter;

4. Upon receipt of the completed change of ownership application documentation, the Division of Long Term Care will forward appropriate documents to the Centers for Medicare and Medicaid Services ("CMS") and/or the State Medicaid Agency for processing;

5. The Fiscal Intermediary will forward to the facility its determination of the CMS-855A *Medicare General Enrollment Application*, and will copy the Division of Long Term Care and CMS;

6. CMS will forward to the facility a letter acknowledging the change of ownership, and will copy the Division of Long Term Care.

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

Please mail completed application packets to the following address:
Long Term Care – Provider Services
Indiana State Department of Health
2 N. Meridian St., Section 4-B
Indianapolis, IN 46204

Bed changes should be submitted as a separate request.

If you have any questions regarding the application process please call Provider Services at 317-233-7794, 317-234-3071 or 317-233-7613 or by email at ltcproviderservices@isdh.IN.gov .

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

LONG TERM CARE FACILITY APPLICATION FOR MEDICARE AND MEDICAID

Standard Survey

From: F1 ☐☐ ☐☐ ☐☐ To: F2 ☐☐ ☐☐ ☐☐
MM DD YY MM DD YY

Extended Survey

From: F3 ☐☐ ☐☐ ☐☐ To: F4 ☐☐ ☐☐ ☐☐
MM DD YY MM DD YY

Name of Facility	Provider Number	Fiscal Year Ending: F5 ☐☐ ☐☐ ☐☐ MM DD YY

Street Address	City	County	State	Zip Code

Telephone Number: F6	State/County Code: F7	State/Region Code: F8

A. F9 ☐☐

01 Skilled Nursing Facility (SNF) - Medicare Participation
02 Nursing Facility (NF) - Medicaid Participation
03 SNF/NF - Medicare/Medicaid

B. Is this facility hospital based? F10 Yes ☐ No ☐

If yes, indicate Hospital Provider Number: F11 ☐☐☐☐☐☐

Ownership: F12 ☐☐

For Profit	NonProfit	Government	
01 Individual	04 Church Related	07 State	10 City/County
02 Partnership	05 Nonprofit Corporation	08 County	11 Hospital District
03 Corporation	06 Other Nonprofit	09 City	12 Federal

Owned or leased by Multi-Facility Organization: F13 Yes ☐ No ☐

Name of Multi-Facility Organization: F14

Dedicated Special Care Units (show number of beds for all that apply)

F15 ☐☐☐ AIDS
F16 ☐☐☐ Alzheimer's Disease
F17 ☐☐☐ Dialysis
F18 ☐☐☐ Disabled Children/Young Adults
F19 ☐☐☐ Head Trauma
F20 ☐☐☐ Hospice
F21 ☐☐☐ Huntington's Disease
F22 ☐☐☐ Ventilator/Respiratory Care
F23 ☐☐☐ Other Specialized Rehabilitation

Does the facility currently have an organized residents group?	F24	Yes ☐	No ☐
Does the facility currently have an organized group of family members of residents?	F25	Yes ☐	No ☐
Does the facility conduct experimental research?	F26	Yes ☐	No ☐
Is the facility part of a continuing care retirement community (CCRC)?	F27	Yes ☐	No ☐

If the facility currently has a staffing waiver, indicate the type(s) of waiver(s) by writing in the date(s) of last approval. Indicate the number of hours waived for each type of waiver granted. If the facility does not have a waiver, write NA in the blanks.

Waiver of seven day RN requirement. Date: F28 ☐☐ ☐☐ ☐☐ Hours waived per week: F29_____
Waiver of 24 hr licensed nursing requirement. Date: F30 ☐☐ ☐☐ ☐☐ Hours waived per week: F31_____
MM DD YY

Does the facility currently have an approved Nurse Aide Training and Competency Evaluation Program? F32 Yes ☐ No ☐

FACILITY STAFFING

		A			B					C					D				
	Tag Number	Services Provided			Full-Time Staff (hours)					Part-Time Staff (hours)					Contract (hours)				
		1	2	3															
Administration	F33																		
Physician Services	F34																		
Medical Director	F35																		
Other Physician	F36																		
Physician Extender	F37																		
Nursing Services	F38																		
RN Director of Nurses	F39																		
Nurses with Admin. Duties	F40																		
Registered Nurses	F41																		
Licensed Practical/ Licensed Vocational Nurses	F42																		
Certified Nurse Aides	F43																		
Nurse Aides in Training	F44																		
Medication Aides/Technicians	F45																		
Pharmacists	F46																		
Dietary Services	F47																		
Dietitian	F48																		
Food Service Workers	F49																		
Therapeutic Services	F50																		
Occupational Therapists	F51																		
Occupational Therapy Assistants	F52																		
Occupational Therapy Aides	F53																		
Physical Therapists	F54																		
Physical Therapists Assistants	F55																		
Physical Therapy Aides	F56																		
Speech/Language Pathologist	F57																		
Therapeutic Recreation Specialist	F58																		
Qualified Activities Professional	F59																		
Other Activities Staff	F60																		
Qualified Social Workers	F61																		
Other Social Services	F62																		
Dentists	F63																		
Podiatrists	F64																		
Mental Health Services	F65																		
Vocational Services	F66																		
Clinical Laboratory Services	F67																		
Diagnostic X-ray Services	F68																		
Administration & Storage of Blood	F69																		
Housekeeping Services	F70																		
Other	F71																		

Name of Person Completing Form	Time
Signature	Date

GENERAL INSTRUCTIONS AND DEFINITIONS

(use with CMS-671 Long Term Care Facility Application for Medicare and Medicaid)

This form is to be completed by the Facility

For the purpose of this form "the facility" equals certified beds (i.e., Medicare and/or Medicaid certified beds).

Standard Survey - LEAVE BLANK - Survey team will complete
Extended Survey - LEAVE BLANK - Survey team will complete

INSTRUCTIONS AND DEFINITIONS

Name of Facility - Use the official name of the facility for business and mailing purposes. This includes components or units of a larger institution.

Provider Number - Leave blank on initial certifications. On all recertifications, insert the facility's assigned six-digit provider code.

Street Address - Street name and number refers to physical location, not mailing address, if two addresses differ.

City - Rural addresses should include the city of the nearest post office.

County - County refers to parish name in Louisiana and township name where appropriate in the New England States.

State - For U.S. possessions and trust territories, name is included in lieu of the State.

Zip Code - Zip Code refers to the "Zip-plus-four" code, if available, otherwise the standard Zip Code.

Telephone Number - Include the area code.

State/County Code - LEAVE BLANK - State Survey Office will complete.

State/Region Code - LEAVE BLANK - State Survey Office will complete.

Block F9 - Enter either 01 (SNF), 02 (NF), or 03 (SNF/NF).

Block F10 - If the facility is under administrative control of a hospital, check "yes," otherwise check "no."

Block F11 - The hospital provider number is the hospital's assigned six-digit Medicare provider number.

Block F12 - Identify the type of organization that controls and operates the facility. Enter the code as identified for that organization (e.g., for a for profit facility owned by an individual, enter 01 in the F12 block; a facility owned by a city government would be entered as 09 in the F12 block).

Definitions to determine ownership are:

FOR PROFIT - If operated under private commercial ownership, indicate whether owned by individual, partnership, or corporation.

NONPROFIT - If operated under voluntary or other nonprofit auspices, indicate whether church related, nonprofit corporation or other nonprofit.

GOVERNMENT - If operated by a governmental entity, indicate whether State, City, Hospital District, County, City/County, or Federal Government.

Block F13 - Check "yes" if the facility is owned or leased by a multi-facility organization, otherwise check "no." A Multi-Facility Organization is an organization that owns two or more long term care facilities. The owner may be an individual or a corporation. Leasing of facilities by corporate chains is included in this definition.

Block F14 - If applicable, enter the name of the multi-facility organization. Use the name of the corporate ownership of the multi-facility organization (e.g., if the name of the facility is Soft Breezes Home and the name of the multi-facility organization that owns Soft Breezes is XYZ Enterprises, enter XYZ Enterprises).

Block F15 – F23 - Enter the number of beds in the facility's Dedicated Special Care Units. These are units with a specific number of beds, identified and dedicated by the facility for residents with specific needs/diagnoses. They need not be certified or recognized by regulatory authorities. For example, a SNF admits a large number of residents with head injuries. They have set aside 8 beds on the north wing, staffed with specifically trained personnel. Show "8" in F19.

Block F24 - Check "yes" if the facility currently has an organized residents' group, i.e., a group(s) that meets regularly to discuss and offer suggestions about facility policies and procedures affecting residents' care, treatment, and quality of life; to support each other; to plan resident and family activities; to participate in educational activities or for any other purposes; otherwise check "no."

Block F25 - Check "yes" if the facility currently has an organized group of family members of residents, i.e., a group(s) that meets regularly to discuss and offer suggestions about facility policies and procedures affecting residents' care, treatment, and quality of life; to support each other, to plan resident and family activities; to participate in educational activities or for any other purpose; otherwise check "no."

GENERAL INSTRUCTIONS AND DEFINITIONS

(use with CMS-671 Long Term Care Facility Application for Medicare and Medicaid)

Block F26 - Check "yes" if the facility conducts experimental research; otherwise check "no." Experimental research means using residents to develop and test clinical treatments, such as a new drug or therapy, that involves treatment and control groups. For example, a clinical trial of a new drug would be experimental research.

Block F27 - Check "yes" if the facility is part of a continuing care retirement community (CCRC); otherwise check "no." A CCRC is any facility which operates under State regulation as a continuing care retirement community.

Blocks F28 – F31 - If the facility has been granted a nurse staffing waiver by CMS or the State Agency in accordance with the provisions at 42CFR 483.30(c) or (d), enter the last approval date of the waiver(s) and report the number of hours being waived for each type of waiver approval.

Block F32 - Check "yes" if the facility has a State approved Nurse Aide Training and Competency Evaluation Program; otherwise check "no."

FACILITY STAFFING

GENERAL INSTRUCTIONS

This form requires you to identify whether certain services are provided and to specify the number of hours worked providing those services. Column A requires you to enter "yes" or "no" about whether the services are provided onsite to residents, onsite to nonresidents, and offsite to residents. Columns B-D requires you to enter the specific number of hours worked providing the service. To complete this section, base your calculations on the staff hours worked in the most recent complete pay period. If the pay period is more than 2 weeks, use the last 14 days. For example, if this survey begins on a Tuesday, staff hours are counted for the previous complete pay period.

Definition of Hours Worked - Hours are reported rounded to the nearest whole hour. Do not count hours paid for any type of leave or non-work related absence from the facility. If the service is provided, but has not been provided in the 2-week pay period, check the service in Column A, but leave B, C, or D blank. If an individual provides service in more than one capacity, separate out the hours in each service performed. For example, if a staff person has worked a total of 80 hours in the pay period but has worked as an activity aide and as a Certified Nurse Aide, separately count the hours worked as a CNA and hours worked as an activity aide to reflect but not to exceed the total hours worked within the pay period.

Completion of Form

Column A - Services Provided - Enter Y (yes), N (no) under each sub-column. For areas that are blocked out, do not provide the information.

Column A-1 - Refers to those services provided onsite to residents, either by employees or contractors.

Column A-2 - Refers to those services provided onsite to non-residents.

Column A-3 - Refers to those services provided to residents offsite/or not routinely provided onsite.

Column B - Full-time staff, C - Part-time staff, and D - Contract - Record hours worked for each field of full-time staff, part-time staff, and contract staff (do not include meal breaks of a half an hour or more). Full-time is defined as 35 or more hours worked per week. Part-time is anything less than 35 hours per week. Contract includes individuals under contract (e.g., a physical therapist) as well as organizations under contract (e.g., an agency to provide nurses). If an organization is under contract, calculate hours worked for the individuals provided. Lines blocked out (e.g., Physician services, Clinical labs) do not have hours worked recorded.

REMINDER - Use a 2-week period to calculate hours worked.

DEFINITION OF SERVICES

Administration - The administrative staff responsible for facility management such as the administrator, assistant administrator, unit managers and other staff in the individual departments, such as: Health Information Specialists (RRA/ARTI), clerical, etc., who do not perform services described below. Do not include the food service supervisor, housekeeping services supervisor, or facility engineer.

Physician Services - Any service performed by a physician at the facility, except services performed by a resident's personal physician.

Medical Director - A physician designated as responsible for implementation of resident care policies and coordination of medical care in the facility.

Other Physician - A salaried physician, other than the medical director, who supervises the care of residents when the attending physician is unavailable, and/or a physician(s) available to provide emergency services 24 hours a day.

Physician Extender - A nurse practitioner, clinical nurse specialist, or physician assistant who performs physician delegated services.

Nursing Services - Coordination, implementation, monitoring and management of resident care plans. Includes provision of personal care services, monitoring resident responsiveness to environment, range-of-motion exercises, application of sterile dressings, skin care, naso-gastric tubes, intravenous fluids, catheterization, administration of medications, etc.

GENERAL INSTRUCTIONS AND DEFINITIONS

(use with CMS-671 Long Term Care Facility Application for Medicare and Medicaid)

Director of Nursing - Professional registered nurse(s) administratively responsible for managing and supervising nursing services within the facility. Do not additionally reflect these hours in any other category.

Nurses with Administrative Duties - Nurses (RN, LPN, LVN) who, as either a facility employee or contractor, perform the Resident Assessment Instrument function in the facility and do not perform direct care functions. Also include other nurses whose principal duties are spent conducting administrative functions. For example, the Assistant Director of Nursing is conducting educational/in-service, or other duties which are not considered to be direct care giving. Facilities with an RN waiver who do not have an RN as DON report all administrative nursing hours in this category.

Registered Nurses - Those persons licensed to practice as registered nurses in the State where the facility is located. Includes geriatric nurse practitioners and clinical nurse specialists who primarily perform nursing, not physician-delegated tasks. Do not include Registered Nurses' hours reported elsewhere.

Licensed Practical/Vocational Nurses - Those persons licensed to practice as licensed practical/vocational nurses in the State where the facility is located. Do not include those hours of LPN/LVNs reported elsewhere.

Certified Nurse Aides - Individuals who have completed a State approved training and competency evaluation program, or competency evaluation program approved by the State, or have been determined competent as provided in 483.150(a) and (3) and who are providing nursing or nursing-related services to residents. Do not include volunteers.

Nurse Aides in Training - Individuals who are in the first 4 months of employment and who are receiving training in a State approved Nurse Aide training and competency evaluation program and are providing nursing or nursing-related services for which they have been trained and are under the supervision of a licensed or registered nurse. Do not include volunteers.

Medication Aides/Technicians - Individuals, other than a licensed professional, who fulfill the State requirement for approval to administer medications to residents.

Pharmacists - The licensed pharmacist(s) who a facility is required to use for various purposes, including providing consultation on pharmacy services, establishing a system of records of controlled drugs, overseeing records and reconciling controlled drugs, and/or performing a monthly drug regimen review for each resident.

Dietary Services - All activities related to the provision of a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident.

Dietitian - A person(s), employed full, part-time or on a consultant basis, who is either registered by the Commission of Dietetic Registration of the American Dietetic Association, or is qualified to be a dietitian on the basis of experience in identification of dietary needs, planning and implementation of dietary programs.

Food Service Workers - Persons (excluding the dietitian) who carry out the functions of the dietary service (e.g., prepare and cook food, serve food, wash dishes). Includes the food services supervisor.

Therapeutic Services - Services, other than medical and nursing, provided by professionals or their assistants, to enhance the residents' functional abilities and/or quality of life.

Occupational Therapists - Persons licensed/registered as occupational therapists according to State law in the State in which the facility is located. Include OTs who spend less than 50 percent of their time as activities therapists.

Occupational Therapy Assistants - Person(s) who, in accord with State law, have licenses/certification and specialized training to assist a licensed/certified/registered Occupational Therapist (OT) to carry out the OT's comprehensive plan of care, without the direct supervision of the therapist. Include OT Assistants who spend less than 50 percent of their time as Activities Therapists.

Occupational Therapy Aides - Person(s) who have specialized training to assist an OT to carry out the OT's comprehensive plan of care under the direct supervision of the therapist, in accord with State law.

Physical Therapists - Persons licensed/registered as physical therapists, according to State law where the facility is located.

Physical Therapy Assistants - Person(s) who, in accord with State law, have licenses/certification and specialized training to assist a licensed/certified/registered Physical Therapist (PT) to carry out the PT's comprehensive plan of care, without the direct supervision of the PT.

Physical Therapy Aides - Person(s) who have specialized training to assist a PT to carry out the PT's comprehensive plan of care under the direct supervision of the therapist, in accord with State law.

Speech-Language Pathologists - Persons licensed/registered, according to State law where the facility is located, to provide speech therapy and related services (e.g., teaching a resident to swallow).

Therapeutic Recreation Specialist - Person(s) who, in accordance with State law, are licensed/registered and are eligible for certification as a therapeutic recreation specialist by a recognized accrediting body.

Qualified Activities Professional - Person(s) who meet the definition of activities professional at 483.15(f)(2)(i)(A) and (B) or 483.15(f)(2)(ii) or (iii) or (iv) and who are providing an on-going program of activities designed to meet residents' interests and physical, mental or psychosocial needs. Do not include hours reported as Therapeutic Recreation Specialist, Occupational Therapist, OT Assistant, or other categories listed above.

Other Activities Staff - Persons providing an on-going program of activities designed to meet residents' needs and interests. Do not include volunteers or hours reported elsewhere.

Qualified Social Worker(s) - Person licensed to practice social work in the State where the facility is located, or if licensure is not required, persons with a bachelor's degree in social work, a bachelor's degree in a human services field including but not limited to sociology, special education, rehabilitation counseling and psychology, and one year of supervised social work experience in a health care setting working directly with elderly individuals.

Other Social Services Staff - Person(s) other than the qualified social worker who are involved in providing medical social services to residents. Do not include volunteers.

Dentists - Persons licensed as dentists, according to State law where the facility is located, to provide routine and emergency dental services.

Podiatrists - Persons licensed/registered as podiatrists, according to State law where the facility is located, to provide podiatric care.

Mental Health Services - Staff (excluding those included under therapeutic services) who provide programs of services targeted to residents' mental, emotional, psychological, or psychiatric well-being and which are intended to:

- Diagnose, describe, or evaluate a resident's mental or emotional status;
- Prevent deviations from mental or emotional well-being from developing; or
- Treat the resident according to a planned regimen to assist him/her in regaining, maintaining, or increasing emotional abilities to function.

Among the specific services included are psychotherapy and counseling, and administration and monitoring of psychotropic medications targeted to a psychiatric diagnosis.

Vocational Services - Evaluation and training aimed at assisting the resident to enter, re-enter, or maintain employment in the labor force, including training for jobs in integrated settings (i.e., those which have both disabled and nondisabled workers) as well as in special settings such as sheltered workshops.

Clinical Laboratory Services - Entities that provide laboratory services and are approved by Medicare as independent laboratories or hospitals.

Diagnostic X-ray Services - Radiology services, ordered by a physician, for diagnosis of a disease or other medical condition.

Administration and Storage of Blood Services - Blood bank and transfusion services.

Housekeeping Services - Services, including those of the maintenance department, necessary to maintain the environment. Includes equipment kept in a clean, safe, functioning and sanitary condition. Includes housekeeping services supervisor and facility engineer.

Other - Record total hours worked for all personnel not already recorded, (e.g., if a librarian works 10 hours and a laundry worker works 10 hours, record 00020 in Column C).

FORM APPROVED
OMB No. 0938-0832

HEALTH INSURANCE BENEFIT AGREEMENT

(Agreement with Provider Pursuant to Section 1866 of the Social Security Act,
as Amended and Title 42 Code of Federal Regulations (CFR)
Chapter IV, Part 489)

AGREEMENT

between
THE SECRETARY OF HEALTH AND HUMAN SERVICES
and

_____

doing business as (D/B/A) _____

In order to receive payment under title XVIII of the Social Security Act,_____
_____
D/B/A _____ as the provider of services, agrees to conform to the provisions of section of 1866 of the Social Security Act and applicable provisions in 42 CFR.

This agreement, upon submission by the provider of services of acceptable assurance of compliance with title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 as amended, and upon acceptance by the Secretary of Health and Human Services, shall be binding on the provider of services and the Secretary.

In the event of a transfer of ownership, this agreement is automatically assigned to the new owner subject to the conditions specified in this agreement and 42 CFR 489, to include existing plans of correction and the duration of this agreement, if the agreement is time limited.

ATTENTION: Read the following provision of Federal law carefully before signing.

Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or make any false, fictitious or fraudulent statement or representation, or makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry, shall be fined not more than $10,000 or imprisoned not more than 5 years or both (18 U.S.C. section 1001).

Name _____ Title _____

Date _____

ACCEPTED FOR THE PROVIDER OF SERVICES BY:

NAME *(signature)*

TITLE	DATE

ACCEPTED BY THE SECRETARY OF HEALTH AND HUMAN SERVICES BY:

NAME *(signature)*

TITLE	DATE

ACCEPTED FOR THE SUCCESSOR PROVIDER OF SERVICES BY:

NAME *(signature)*

TITLE	DATE