DEPARTMENT OF HEALTH

Nursing Home Change of Ownership License Application

In accordance with Minnesota Statutes, section 13.41 (https://www.revisor.mn.gov/statutes/cite/13.41), **all data submitted on this license application shall be classified public information upon issuance of a license.**

Answer all questions completely and accurately to avoid unnecessary delay. Mail the completed application, fee payment, and applicable supporting documents to MDH (see last page for mailing address).

An incomplete application will be communicated to the provider via email.

The Commissioner of Health may deny, revoke, suspend, restrict, or refuse to renew license or impose conditions on a license in accordance with Minnesota Statutes, section 144A.031(c) (https://www.revisor.mn.gov/statutes/cite/144A.031).

The undersigned hereby makes application to operate a nursing home subject to the provisions of Minnesota Statutes, section 144A (https://www.revisor.mn.gov/statutes/cite/144A), chapter 4658 and the rules adopted thereunder.

Keep a copy of the application and attachments for your records.

Application and review process

An application for licensure must be submitted at least 60 days before the requested date for licensure and must be accompanied by a license fee Minnesota Rules, chapter 4658.0025 (https:/www.revisor.mn.gov/rules/4658.0025/).

The application is deemed complete when all documentation and background studies have been correctly submitted and verified and payment is received. MDH will contact you to request additional information, if needed. Answer all questions completely and accurately to avoid unnecessary delay.

The current licensee remains responsible for the operation of the nursing home until the nursing home is licensed to the new licensee.

Last Updated: 08/12/2024

Reason for change of ownership

- Minnesota Statutes, section 144A.06, subdivision 2 (https://www.revisor.mn.gov/statutes/cite/144A.06)

Select one the reason for change of ownership (CHOW):

☐ Licensee's legal entity structure is converting/changing to a different type of legal entity structure.

☐ Licensee is dissolving, consolidating, or merging with another legal organization and the licensee's legal organization does not survive.

☐ Within the previous 24 months, 50% or more of licensee's ownership is transferred, whether by a single transaction or multiple transactions to a different person or multiple different persons; or a person or multiple persons who had less than 5% ownership interest at the time of the first transaction.

☐ Any other event(s) resulting in a substitution, elimination, or withdrawal of the licensee's responsibility for the nursing home. If this box is checked, please explain in a separate attachment.

Proposed effective date: ______________________________

Application contact information

Provide the legal name and contact information of the person MDH can contact regarding questions about this application.

First name: ______________________________

Last name: ______________________________

Title: ______________________________

Telephone: ______________________________

Email address: ______________________________

NETStudy 2.0 Sensitive Information Person (SIP)

- Minnesota Statutes, section 144A.03, subdivision 1b(7) (https://www.revisor.mn.gov/statutes/cite/144A.03)

The NETStudy 2.0 Sensitive Information Person (SIP) is the individual the Department of Human Services (DHS) will communicate with. This person will be authorized to submit information for background checks.

Name: ______________________________

Title: ______________________________

Telephone: ______________________________

Email address: ______________________________

Nursing home information

- Minnesota Statutes, section 144A.03, subdivision 1(b)(1)-(2) (https://www.revisor.mn.gov/statutes/cite/144A.03)
- Minnesota Rules, chapter 4658.0025, subpart 14A-B (https://www.revisor.mn.gov/rules/4658.0025/)

Nursing home physical address: ______________________________

City: ____________________ State: ____________________

Zip: ____________________ County: ____________________

Telephone: ____________________ Fax: ____________________

Health Facility Identification (HFID) number: ______________________________

CMS Certification Number (CCN): ______________________________

Do you have a Federal Nurse Aide Training Competency and Evaluation Program (NATCEP) and/or an In-Facility Test Site?

☐ Yes

☐ No

Will you wish to continue the Federal Nurse Aide Training Competency and Evaluation Program (NATCEP) and/or an In-Facility Test Site after the change of ownership (CHOW)?

☐ Yes

☐ No

If yes, complete Appendix D: Federal Nurse Aide Training Competency and Evaluation Program (NATCEP) and In-Facility Test Site Change of Ownership (CHOW).

Agent

Provide the agent's legal name and contact information. MDH will use the mailing and/or email address below to send correspondence(s) to the Facility.

Please ensure this information is correct.

The **agent** is the person(s) who shall be responsible for dealing with the commissioner of health on all matters and whom personal service of all notices and orders shall be made, and who shall be authorized to accept service on behalf of all the controlling persons of the facility. Minnesota Statutes, section 144A.03, subdivision 2 (https://www.revisor.mn.gov/statutes/cite/144A.03#stat.144A.03.2)

Full legal name: ______________________________

Mailing address: ______________________________

City: ______________ State: ______________ Zip: ______________

Telephone: ______________________________

Email address: ______________________________

Applicant Information

Provide the information below for the applicant (i.e., the new owner).

- Minnesota Statutes, section 144A.03, subdivision 1(b)(1)-(2) (https://www.revisor.mn.gov/statutes/cite/144A.03)

Assumed name or Doing Business As (DBA) name: ______________________________

Provide the legal entity name that is responsible for the operation of this facility, as it appears on file with the. Office of the Minnesota Secretary of State (https://mblsportal.sos.state.mn.us/Business/Search).

____

Legal entity business address: ______________________________

Federal Tax Identification Number (FEIN) registered with the Internal Revenue Service (IRS) (https://www.irs.gov/): ______________________________

Minnesota Tax ID Number as registered with Minnesota Department of Revenue (https://www.revenue.state.mn.us): ______________________________

Capacity

- Minnesota Statutes, section 144A.03, subdivision 1b(5) (https://www.revisor.mn.gov/statutes/cite/144A.03)
- Minnesota Rules, chapter 4658.0025, subp. 14(D) (https://www.revisor.mn.gov/rules/4658.0025/)
- Minnesota Statutes, section 144A.07, subdivision 4b (https://www.revisor.mn.gov/statutes/cite/144A.071)

Active licensed bed capacity: ______________________________

Current number of beds on layaway: ______________________________

(Beds may remain on layaway for up to 10 years from the date the beds were initially placed on layaway status.)

Certification type

- Minnesota Statutes, section 144A.03, subdivision 1 (https://www.revisor.mn.gov/statutes/cite/144A.03)

☐ Medicare (Title XVIII)

☐ Medicaid (Title XIX)

☐ Medicare and Medicaid (dual certification)

☐ State-licensed only (no certification)

Legal entity type

- Minnesota Rules, chapter 4658.0025, subdivision 14E (https://www.revisor.mn.gov/rules/4658.0025/)

Fill in the code that corresponds to the type of entity legally responsible for operating the facility: ___________

Governmental Non-Federal	Governmental Federal	Non-Governmental	Other
11. State 12. County 13. City 15. Hospital district of Authority	18. Veterans Administration	24. Partnership 32. Sole Proprietorship 33. For-Profit LLC 34. Non-Profit LLC 35. Non-Profit Corporation 36. For-Profit Corporation	27. Tribal

Owners, Controlling Persons, and Managerial Officials

- Minnesota Statutes, section 144A.03, subdivision 1(b)(3)(12) (https://www.revisor.mn.gov/statutes/cite/144A.03)

Complete the table in Appendix A with the name, contact information, and ownership information of each owner, controlling person, and managerial official.

Refer to the definitions below to determine individuals and legal entities that must be disclosed.

Direct ownership interest means an individual or legal entity with the possession of at least five percent equity in capital, stock, or profits of the licensee, or who is a member of a limited liability company of the licensee.

Indirect ownership interest means an individual or legal entity with a direct ownership interest in an entity that has a direct or indirect ownership interest of at least five percent in an entity that is a licensee.

A **controlling person** means an owner and the following individuals or entities, if applicable: each officer of the organization, including the chief executive officer and chief financial officer; the nursing home administrator; each managerial official; any lease or sublease of the land, structure; facilities compromising a nursing home; any entity or natural person who has any direct or indirect ownership in any corporation, partnership or other business association which is a controlling person the land or structure on which a nursing home is located, any entity with at least a 5% mortgage, contract for deed of trust, or other security interests in the land or structure comprising the nursing home Any lease of sublease of the land, structure; facilities compromising a nursing home.

Managerial official means an individual who has the decision-making authority related to the operations of the nursing home and responsibility for either the ongoing management of the nursing home or the direction of policies, services, or employees of the nursing home.

Minnesota Statutes, section 144A.01 (https://www.revisor.mn.gov/statutes/cite/144A.01)

Disclosure of managerial employees

- Minnesota Statutes, section 144.03 , subdivision 1(b)(3) (https://www.revisor.mn.gov/statutes/cite/144A.03)
- Minnesota Rules, chapter 4658.0025, subp. 16 (https://www.revisor.mn.gov/rules/4658.0025/)

Nursing home administrator

Status:

☐ Permanent ☐ Acting (temporary and unlicensed) ☐ Interim

Full legal name: ____________________

Direct Telephone: ____________________

Direct Email address: ____________________

Start date: ____________________ License number: ____________________

Assistant administrator (if applicable)

Full legal name: ____________________

Direct Telephone: ____________________

Direct Email address: ____________________

Start date: ____________________ License number: ____________________

Director of Nursing

Full legal name: ____________________

Direct Telephone: ____________________

Direct Email address: ____________________

Start date: ____________________ License number: ____________________

Medical Director

Full legal name: ____________________

Address: ____________________

City: ____________________ State: ____________________ Zip: ____________________

Direct Telephone: ____________________

Direct Email address: ____________________

Start date: ______________________ License number: ______________________

Ownership of nursing home building

- Minnesota Statutes, section 144A.01, subdivision 4(b) (https://www.revisor.mn.gov/statutes/cite/144A.01)

Complete the information in this section and use Appendix A: Owners, Controlling Persons, and Managerial Officials to disclose any legal entity(s) and individual owner(s) having a 5% or greater interest in the building or real property.

Building ownership

Building owner legal entity name: ______________________

Name of contact person: ______________________

Title of contact person: ______________________

Business address: ______________________

City: ______________________ State: ______________________

Zip: ______________________ County: ______________________

Telephone: ______________________

Email: ______________________

Legal Entity Type of Building Ownership (i.e., Corporation, LLC): ______________________

Is the licensee applicant the owner of the physical building? If no, provide the lease information below.

☐ Yes

☐ No

Lease information

Fill in the information below for the lessee and sub-lessee (if applicable) of the building where the nursing home is located.

License applicant:

☐ Is the lessee

☐ Is the sub-lessee

Lessee full legal name: ______________________

Lessee business address: ______________________

City: ______________________ State: ______________________

Zip: ______________________________ County: ______________________________

Lessee contact person: ______________________________

Telephone: ______________________________

Email address: ______________________________

Sub-lessee full legal name: ______________________________

Sub-lessee business address: ______________________________

City: ______________________________ State: ______________________________

Zip: ______________________________ County: ______________________________

Sub-lessee contact person: ______________________________

Telephone: ______________________________

Email address: ______________________________

Related organization

Related organization means (a) a person that furnishes goods or services to a nursing facility and that is a close relative of a nursing facility, an affiliate of a nursing facility, a close relative of an affiliate of a nursing facility, or an affiliate of a close relative of affiliate of a nursing facility. As used in this subdivision, paragraph (b) to (e) apply.

(b) Affiliate means a person that directly, or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with another person.

(c) Person means an individual, a corporation, a partnership, an association, a trust, an unincorporated organization, or a government or political subdivision.

(d) Close relative of an affiliate of a nursing facility means an individual whose relationship by blood, marriage, or adoption to an individual who is an affiliate of a nursing facility is no more remote than first cousin.

(e) Control including the terms “controlling,” “controlled by,” and “under common control with” means the possession, direct or indirect, of the power to direct or cause the direction of the management, operations, or policies of a person, whether through the ownership of voting securities, by contract, or otherwise.

Minnesota Statutes, section 256R.02, subdivision 43 (https://www.revisor.mn.gov/statutes/cite/256R.02#stat.256R.02.43)

Is the owner of the nursing home building or property a related organization to the licensee of the nursing home?

☐ Yes

☐ No

If yes, explain relationship: ______________________________

Eligibility and Qualification

- Minnesota Statutes, section 144A.03 (https://www.revisor.mn.gov/statutes/cite/144A.03)

Complete the following questions 1 to 8 below. For any yes responses, complete and submit Appendix B: Eligibility and Qualifications for **each individual**.

1. Within the last 10 years, preceding submission of the license application, has the license applicant; direct/indirect owner(s); controlling person(s); managerial official(s); or nursing home administrator been convicted of a crime or found civilly liable for a federal or state felony-related offense that was detrimental to the best interests of the facility and its resident? This includes:
    - Felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas, and adjudicated pretrial diversions.
    - Financial crimes such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes for which the individual was convicted, including guilty pleas, and adjudicated pretrial diversions.
    - Any felonies involving malpractice that resulted in a conviction of criminal neglect or misconduct.
    - Any felonies that would result in a mandatory exclusion under section 1128(a) of the Social Security Act.

    ☐ Yes - Submit Appendix B: Eligibility and Qualifications for each owner/controlling person/managerial official.

    ☐ No

2. Within the last 10 years, preceding submission of the license application, has the license applicant; direct/indirect owner(s); controlling person(s); managerial official(s); or nursing home administrator been convicted of any misdemeanor under federal or state law relating to:
    - The delivery of a service under Medicaid or a state health care program or the abuse or neglect of a patient in connection with the delivery of a health care item or service.
    - Theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.

    ☐ Yes - Submit Appendix B: Eligibility and Qualifications for each owner/controlling person/managerial official.

    ☐ No

3. Within the last 10 years, preceding submission of the license application, has the license applicant; direct/indirect owner(s); controlling person(s); managerial official(s); or nursing home administrator been convicted of any felony or misdemeanor under federal or state law relating to:
   - Interference with or obstruction or any investigation into any criminal offense described in Code of Federal Regulations, title 42, 1001.101 or 1001.201.
   - Unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

   ☐ Yes - Submit Appendix B: Eligibility and Qualifications for each owner/controlling person/managerial official.

   ☐ No

4. Has the license applicant, any direct/indirect owner(s), controlling persons, managerial official, or nursing home administrator ever had any license to provide health care revoked or suspended by any state license authority? This includes any of the following:
   - Any revocation or suspension of a license to provide health care by any state licensing authority.
   - Surrendering a license while a formal disciplinary proceeding was pending before a state licensing authority.
   - Any revocation or suspension of accreditation.
   - Any suspension or exclusion from participation in, or any sanction imposed by, a federal or state health care program.
   - Any debarment from participation in any federal executive branch procurement or non-procurement program.

   ☐ Yes - Submit Appendix B: Eligibility and Qualifications for each owner/controlling person/managerial official.

   ☐ No

5. Has the license applicant, any direct/indirect owner(s), controlling persons, managerial official, or nursing home administrator, currently, or in the past ever had their license or federal certification for a long-term care, community-based, or health care facility or agency:
   - Denied, suspended, restricted, conditioned, refused, not renewed, or revoked under a private or state-controlled receivership?
   - Are these same actions listed above pending under the laws of any state or federal authority?

   ☐ Yes, or pending - Submit Appendix B: Eligibility and Qualifications for each owner/controlling person/managerial official.

   ☐ No

6. In the preceding three years, has the license applicant, direct/indirect owners, controlling persons, nursing home administrator, manager, or managerial official have a record of defaulting in the payment of money collected for others, including the discharged debts through bankruptcy proceedings?

   ☐ Yes - Submit Appendix B: Eligibility and Qualifications for each owner/controlling person/managerial official.

   ☐ No

7. In the preceding three years has there been any unsatisfied judgments against the license applicant, direct/indirect owners, controlling persons, nursing home administrator, manager, or managerial official?

   ☐ Yes - Submit Appendix B: Eligibility and Qualifications for each owner/controlling person/managerial official.

   ☐ No

8. In the preceding three years, are there any liens against the license applicant, direct/indirect owners, controlling persons, nursing home administrator, manager, or managerial official or their property?

   ☐ Yes - Submit Appendix B: Eligibility and Qualifications for each owner/controlling person/managerial official.

   ☐ No

Affiliations

Affiliated means held a position defined in MN Statutes Minnesota Statutes, sections 144A.01 (https://www.revisor.mn.gov/statutes/cite/144A.01) as an owner, Controlling Person or Managerial Official.

Has the license applicant, direct/indirect owner(s), controlling person(s), managerial official(s), or nursing home administrator been affiliated in the past five years with a long-term care, community-based, or health care facility or agency in Minnesota or in any other state?

☐ Yes

☐ No

If **yes**, complete and submit the Appendix C: Affiliations.

Financial responsibility

State law requires that the license applicant possesses financial resources sufficient to permit full service of operation of the nursing home for six months without regard to income from resident Minnesota Rules, chapter 4658.0050, subp. 3F (https://www.revisor.mn.gov/rules/4658.0050/#rule.4658.0050.3.F). This means not relying on Medicare, Medicaid, and private pay revenue for this six-month period to cover expenses.

To determine the amount necessary to operate for six months, please complete the table below. Review Minnesota Statutes, chapter 256R Nursing Facility Rates (https://www.revisor.mn.gov/statutes/cite/256R/full), and Minnesota Rules, chapter 9549 (https://www.revisor.mn.gov/rules/9549/) for detailed information on rate setting requirements.

See also:

- Relevant successor liability clauses, Minnesota Statutes, section 256B.0641, Recovery of Overpayments, subdivision 2 (https://www.revisor.mn.gov/statutes/cite/256B.0641),
- Minnesota Statutes, section 256.9657 Provider Surcharges, subdivision 7a(f) (https://www.revisor.mn.gov/statutes/cite/256.9657)

Debt incurred by a nursing home will be transferred to the new licensee and reflected in future rates.

Estimated average gross annual revenues from all sources (rounded to the nearest thousand dollars)

Revenue Source	Amount (in thousands of dollars)
NF Medicaid Daily Rate	$
NF Private Pay	$
NF Other	$
Other Revenues	$
TOTAL	$

Estimated annual costs (rounded to the nearest thousand dollars)

Annual Costs	Amount (in thousands of dollars)
Operating Expenses	$
Capital Outlays	$
TOTAL	$

Chain organization

Provide the information requested below for chain organizations.

A **chain organization** means an entity that provides centralized management and/or administrative services to a nursing home under common control, such as centralized accounting, purchasing, personnel services, management direction and control, and other similar services.

Common control exits when an individual, a group of individuals, or an organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of the nursing home.

- Minnesota Statutes, section 144A.03, subdivision 1(b)(18) License Application (https://www.revisor.mn.gov/statutes/cite/144A.03#stat.144A.03.1)
- Code of Federal Regulations; 42 CFR § 421.404 Assignment of providers and suppliers to MACs (https://www.ecfr.gov/current/title-42/section-421.404)
- Medicare Enrollment Application; CMS-885A, section 5(C) Chain Home Offices Only (https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/cms855a.pdf)

Is the license applicant under the control of a chain organization?

☐ Yes

☐ No

If **yes**, provide the following:

Full legal name (or entity name): ______________________________

Name of Contact Person: ______________________ Title: ______________________

Business address: ______________________________

City: ______________________ State: ______________ Zip: ______________________

Telephone: ______________________ Email address: ______________________

Management agreement

- [Minnesota Statutes, section 144A.03, subdivision 1(b)(10) License Application (https://www.revisor.mn.gov/statutes/cite/144A.03#stat.144A.03.1)](https://www.revisor.mn.gov/statutes/cite/144A.03#stat.144A.03.1)

Management Agreement means a written, executed agreement between a licensee and a manager regarding the provision of certain services of behalf of the licensee.

Manager means an individual or legal entity designated by the licensee through a management agreement to act on behalf of the licensee in the on-site management of the nursing home.

1. Is the operation of the nursing home under a management agreement?

☐ Yes

☐ No

If **yes**, provide the following:

Legal entity type of ownership (i.e., Corporation, LLC): ______________________________

Doing Business As (DBA): ______________________________

Company name as registered with the MN Secretary of State: ______________________________

Federal Tax Identification Number (FEIN): ______________________________

Name of Contact Person: ______________________ Title: ______________________

Business address: ______________________________

City: ______________________ State: ______________ Zip: ______________________

Telephone: ______________________ Email address: ______________________

2. Is the manager a related organization to the license applicant?

☐ Yes

☐ No

If **yes**, please explain the relationship: ____

____

____

Background studies

All license applicants, direct/indirect owners, managerial officials, and controlling persons on the nursing home application must undergo a background study under chapter 245C, as required by Minnesota Statutes, section 144.057, subdivision 1(6) (https://www.revisor.mn.gov/statutes/cite/144.057#stat.144.057.1), prior to MDH issuing the nursing home license. Background studies must be completed and cleared by the Department of Human Services (DHS).

DHS will provide the onboarding process to the Background Study. Any questions about the background study or NETStudy 2.0 can be directed to DHS Background studies (https://mn.gov/dhs/general-public/background-studies/), email: dhs.netstudy2@state.mn.us.

Please note: The legal name must match NETStudy 2.0, legal documents and the nursing home CHOW application.

Evidence of Compliance with Workers' Compensation Coverage Provisions

State law requires that the Commissioner of Health shall withhold the license for the operation of a health care provider until the applicant presents acceptable evidence of compliance with workers' compensation coverage provisions.

You cannot be issued a license and may not operate as a health care provider unless acceptable evidence of compliance with workers' compensation coverage provisions is provided.

One of the following documents must accompany this application. Please check which document is attached.

☐ **Certificate of Insurance** supplied by an authorized Workers' Compensation carrier pursuant to Minnesota Statutes, section 60A.06, subdivision 1(5b) (https://www.revisor.mn.gov/statutes/cite/60A.06). The Certificate should include the name of the licensee, the name of the corporation legally responsible for the licensee, or the name that the licensee is doing business as. The Certificate of Insurance must be in effect prior to the issuance of an initial license or have an effective date on or after the effective date of renewal license.

☐ **Self-insured workers' compensation (including its Attachment "A").** This type of coverage is generally held by large organizations. The certificate is issued from the commissioner of commerce permitting an organization to self-insure pursuant to Minnesota Statutes, section 79A (https://www.revisor.mn.gov/statutes/cite/79A) and Minnesotate Rules, chapter 2780 (https://www.revisor.mn.gov/rules/2780/). Questions regarding self-insurance should be directed to the Minnesota Department of Commerce.

☐ Written confirmation from your Third-Party Administrator or evidence of coverage from the Workers' Compensation Reinsurance Association (WCRA) allowing you to **self-insure as a Government**

Entity/Political Subdivision pursuant to Minnesota Statutes, section 176.181, subdivision 2 (https://www.revisor.mn.gov/statutes/cite/176.181). The Reinsurance Certificate must be renewed annually on a calendar year basis.

Fees

All applications must be accompanied by the appropriate nonrefundable fee based on the following fee schedule set by Minnesota Statutes, section 144.122, clause (d) (https://www.revisor.mn.gov/statutes/cite/144.122).

Licensing fees includes the following:

Type	Fees
Base Fee	$183.00
License Fee per Bed	$105.00
Funding of Advisory Council Education per Bed	$ 5.00

For example: Base Fee + (License Fee per Bed + Funding of Advisory Council Education fee per Bed x number of active beds) = licensing fee payment due.

For example: $183 + ($110 Combined Fees x Number of Beds) = licensing fee payment due.

Affirmation and License Fee

☐ I certify that the information provided on this form is accurate and complete.

☐ I have enclosed the appropriate evidence of compliance with Workers' Compensation Coverage Provisions.

☐ Enclosed is the license fee made payable to the **Minnesota Department of Health**.

In accordance with Minnesota Statutes, section 144.52 Application (https://www.revisor.mn.gov/statutes/cite/144.52), the law requires that an application on behalf of a corporation, association or governmental unit shall be made by any two officers thereof or by its managing agents. **This requires two (2) signatures**. All other applications require one (1) signature.

Signature of Authorized Representative: ______________________________

Name (print or type): ______________________________

Title: ______________________________

Date: ______________________________

Signature of Authorized Representative: ______________________________

Name (print or type): ______________________________

Title: ______________________________

Date: ______________________________

Attachments checklists

- ☐ Application form and license fee.
- ☐ Appendix A: Owners/Controlling Persons/Managerial Officials.
- ☐ Appendix B: Eligibility and Qualifications (if applicable).
- ☐ Appendix C: Affiliations (if applicable).
- ☐ Appendix D: Federal Nurse Aide Training Competency and Evaluation Program (NATCEP) and In-Facility Test Site Change of Ownership (CHOW) (if applicable).
- ☐ Evidence of compliance with Worker's Compensation Coverage Provisions.
- ☐ IRS letter CP575 or 147C
- ☐ MN Secretary of State Certificate of Assumed Name if Doing Business As name has changed.
- ☐ Proposed lease and sublease agreement (if applicable).
- ☐ Proposed management agreement between the management company and licensee applicant (if applicable).
- ☐ Proposed operations transfer agreement or similar agreement (if applicable).
- ☐ Transfer agreement between hospital and related health facility found on this page: Nursing Home Licensure and Certification (https://www.health.state.mn.us/facilities/regulation/nursinghomes/licnh.html)
- ☐ Executed purchase agreement (if applicable).
- ☐ Proposed bill of sale or other suitable documents. (e.g., stock transfer or merger documents)
- ☐ An organizational chart identifying management structure and all legal entities and individuals with an ownership interest in the licensee of 5% or greater and that specifies their relationship with the licensee and with each other to include direct and indirect owners.
- ☐ Submit copies of the licensee's organizational agreements. If the license applicant is:
  - ☐ A limited liability company (LLC): Articles of organization & LLC operating agreement
  - ☐ A for profit corporation: Articles of incorporation and bylaws
  - ☐ A Non-profit corporation: Articles of organization and bylaws
  - ☐ A partnership: Partnership agreement
  - ☐ A public agency: Resolution
- ☐ Submit evidence of adequate financing to comply with Minnesota Rules, chapter 4658.0050, subp. 3(F) (https://www.revisor.mn.gov/rules/4658.0050/#rule.4658.0050.3.F). Examples include but are not limited to the following:
  - Certified statement of line of credit,
  - Personal financial statement along with a signed affidavit committing personal resources,
  - A copy of the corporation's annual report along with a signed affidavit committing corporate resources, or

- Other financial documentation

☐ Executed bill of sale, stock transfer or merger documents upon closing.

☐ Executed lease and sub-lease agreement upon closing, (if applicable).

☐ Executed operations transfer agreement or similar agreement upon closing, (if applicable).

Minnesota Statutes, section 144A.03, subdivision 1(18) states that any other relevant information which the commissioner of health by rule or otherwise may determine is necessary to properly evaluate an application for license.

If you have questions concerning this license application, please email Health.HRD-FedLCR@state.mn.us or call 651-201-4200.

Mailing Address
Minnesota Department of Health
Health Regulation Division | Federal Licensing, Certification and Registration section
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Contact Information
Main office line: 651-201-4200
Email: Health.HRD-FedLCR@state.mn.us

To obtain this information in a different format, call: 651-201-4200.

Appendix A: Owners, Controlling Persons, and Managerial Officials

Submit the following document with the application form. Complete additional copies of this form if needed.

Examples of common titles include:

- Indirect owner, direct owner, building owner.
- Company Management: CEO, COO, CFO, VP of Operations, Regional Operations Director. (Include management company or chain organization, if applicable)
- All members of the board of directors to include the chair and the treasurer.
- Facility Management: Administrator, Executive Director, Director of Nursing or Clinical Services, Medical Director.
- The holder of the mortgage, contract for deed of trust or other security interest in land or structure of nursing home.
- Government: City council, county board

This is not an all-inclusive list. See the section above titled Owners, Controlling Persons, and Managerial Officials above for definitions of terms.

For the **Type** column, check all that apply.

Full Name of Individual / Legal Entity	Title	Address	Telephone	Email Address	Type	Direct / Indirect Ownership	Ownership Percentage
					☐ Owner ☐ Controlling ☐ Managerial		
					☐ Owner ☐ Controlling ☐ Managerial		
					☐ Owner ☐ Controlling ☐ Managerial		

Full Name of Individual / Legal Entity	Title	Address	Telephone	Email Address	Type	Direct / Indirect Ownership	Ownership Percentage
					☐ Owner ☐ Controlling ☐ Managerial		
					☐ Owner ☐ Controlling ☐ Managerial		
					☐ Owner ☐ Controlling ☐ Managerial		
					☐ Owner ☐ Controlling ☐ Managerial		
					☐ Owner ☐ Controlling ☐ Managerial		
					☐ Owner ☐ Controlling ☐ Managerial		
					☐ Owner ☐ Controlling ☐ Managerial		

Full Name of Individual / Legal Entity	Title	Address	Telephone	Email Address	Type	Direct / Indirect Ownership	Ownership Percentage
					☐ Owner ☐ Controlling ☐ Managerial		
					☐ Owner ☐ Controlling ☐ Managerial		

☐ I certify that the information provided on this form is accurate and complete.

Legal name of Authorized Representative (print or type):______________________________

Signature of Authorized Representative: ______________________________

Title: ______________________________

Date: ______________________________

Appendix B: Eligibility and Qualifications

Submit the following document with your application if additional eligibility and qualifying questions need to be answered when submitting the Nursing Home Change of Ownership License Application.

Complete one copy of this form for each owner/controlling person/managerial official that had a yes response in the Eligibility and Qualification section of the application form.

Name of Individual: ______________________________

Title: ______________________________

Mailing Address: ______________________________

City and State: ______________________________

Email: ______________________________

Phone number: ______________________________

1. Within the last 10 years, preceding submission of the license application, has the license applicant; direct/indirect owner(s); controlling person(s); managerial official(s); or nursing home administrator been convicted of a crime or found civilly liable for a federal or state felony-related offense that was detrimental to the best interests of the facility and its resident? This includes:
   - Felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas, and adjudicated pretrial diversions.
   - Financial crimes such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes for which the individual was convicted, including guilty pleas, and adjudicated pretrial diversions.
   - Any felonies involving malpractice that resulted in a conviction of criminal neglect or misconduct. Any felonies that would result in a mandatory exclusion under section 1128(a) of the Social Security Act.

   ☐ Yes

   ☐ No

If **yes**, complete and submit the required information below, including who owned the facility at the time of the conviction/findings and copies of relevant court records.

Title of position at the health care facility: ______________________________

Type of conviction: ______________________________

Date of conviction/findings: ______________________________

2. Within the last 10 years, preceding submission of the license application, has the license applicant; direct/indirect owner(s); controlling person(s); managerial official(s); or nursing home administrator been convicted of any misdemeanor under federal or state law relating to:
   - The delivery of a service under Medicaid or a state health care program or the abuse or neglect of a patient with the delivery of a health care item or service.
   - Theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.

   ☐ Yes

   ☐ No

If **yes**, complete and submit the required information below, including all ownership, facility information, and copies of relevant court records.

Title of position at the health care program: ______________________________

Type of conviction: ______________________________

Date of conviction: ______________________________

3. Within the last 10 years, preceding submission of the license application, has the license applicant; direct/indirect owner(s); controlling person(s); managerial official(s); or nursing home administrator been convicted of any felony or misdemeanor under federal or state law relating to:
   - Interference with or obstruction or any investigation into any criminal offense described in Code of Federal Regulations, title 42, 1001.101 or 1001.201.
   - Unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

   ☐ Yes

   ☐ No

If **yes**, complete and submit the required information below, including all ownership, facility information, and copies of relevant court records.

Title of position at the health care program: ______________________________

Type of conviction: ______________________________

Date of conviction: ______________________________

4. Has the license applicant, any direct/indirect owner(s), controlling persons, managerial official(s), or nursing home administrator ever had any license to provide health care revoked or suspended by any state license authority? This includes any of the following:
   - Any revocation or suspension of a license to provide health care by any state licensing authority.
   - Surrendering a license while a formal disciplinary proceeding was pending before a state licensing authority.
   - Any revocation or suspension of accreditation.
   - Any suspension or exclusion from participation in, or any sanction imposed by, a federal or state health care program.
   - Any debarment from participation in any federal executive branch procurement or non-procurement program.

   ☐ Yes

   ☐ No

If **yes** or pending, complete and submit the required information below for each health care program such actions apply to and copies of the federal/state disposition of the action. Submit additional sheets if needed.

Title of position at health care program: ______________________________

Percent (%) of ownership (if applicable): ______________________________

Name of health care program: ______________________________

Program Address: ______________________________

City and State: ______________________________

Type of adverse action: ______________________________

Effective date of adverse action: ______________________________

5. Has the license applicant, any direct/indirect owner(s), controlling persons, managerial official(s), or nursing home administrator, currently, or in the past ever had their license or federal certification for a long-term care, community-based, or health care facility or agency:
   - Denied, suspended, restricted, conditioned, refused, not renewed, or revoked under a private or state-controlled receivership?
   - Are these same actions listed above pending under the laws of any state or federal authority?

   ☐ Yes

   ☐ No

If **yes** or pending, complete and submit the required information below for each health care program such actions apply to and copies of the federal/state disposition of the action. Submit additional sheets if needed.

Title of position at health care program: ______________________________

Percent (%) of ownership (if applicable): ______________________________

Name of health care program: ______________________________

Program Address: ______________________________

City and State: ______________________________

Type of adverse action: ______________________________

Effective date of adverse action: ______________________________

6. In the preceding three years, has the license applicant, direct/indirect owners, controlling persons, managerial official(s), or nursing home administrator have a record of defaulting in the payment of money collected for others, including the discharged debt through bankruptcy proceedings?

   ☐ Yes

   ☐ No

If **yes**, complete and submit the required information below and provide names of all parties, dates, court, and disposition of each action.

Name of all parties: ______________________________

Dates: ______________________________

Name of the court: ______________________________

Disposition of each action: ______________________________

7. In the preceding three years has there been any unsatisfied judgments against the license applicant, direct/indirect owner(s), controlling person(s), managerial official(s), or nursing home administrator?

☐ Yes

☐ No

If **yes**, complete and submit the required information below and provide names of all parties, dates, court, addresses of creditor(s), amount(s), and the reasons for non-payment. Submit additional sheets if needed.

Name of all parties: ______________________________

Date(s) of judgments: ______________________________

Name of the court: ______________________________

Name of creditor(s): ______________________________

Address of creditor(s): ______________________________

Amount: ______________________________

Reasons: ______________________________

8. In the preceding three years, are there any liens against the license applicant, direct/indirect owner(s), controlling person(s), managerial official(s), nursing home administrator or their property?

   ☐ Yes

   ☐ No

If **yes**, complete and submit the required information below and provide names of all parties, dates, court, addresses of creditor(s), amount(s), and the reasons for non-payment. Submit additional sheets if needed.

Name of all parties: ____________________

Date(s) of liens: ____________________

Name of the court: ____________________

Name of creditor(s): ____________________

Address of creditor(s): ____________________

Amount: ____________________

Reasons: ____________________

☐ I certify that the information provided on this form is accurate and complete.

☐ I have submitted the required documents.

Legal name (print or type): ____________________

Signature of Authorized Representative: ____________________

Title: ____________________

Date: ____________________

Appendix C: Affiliations

Submit the following document with the application form. Complete additional copies of this form if needed.

Provide all affiliations for each direct/indirect owner(s), controlling person(s), managerial official(s), or nursing home administrator affiliated in the past five years with a long-term care, community-based, or health care facility or agency in Minnesota or in any other state.

- For the **Type** column, check all that apply.
- Examples of **Facility Type** include but are not limited to: nursing home, hospice, home care, assisted living, or any long-term care, community-based, health care facility or agency in Minnesota or in any other state.

Full Name of Individual / Legal Entity with affiliation	Title	Health Care Facility Name	City and State	Dates of Affiliation	Type of Facility	Type
						☐ Owner ☐ Controlling ☐ Managerial
						☐ Owner ☐ Controlling ☐ Managerial
						☐ Owner ☐ Controlling ☐ Managerial
						☐ Owner ☐ Controlling ☐ Managerial
						☐ Owner ☐ Controlling ☐ Managerial

Full Name of Individual / Legal Entity with affiliation	Title	Health Care Facility Name	City and State	Dates of Affiliation	Type of Facility	Type
						☐ Owner ☐ Controlling ☐ Managerial
						☐ Owner ☐ Controlling ☐ Managerial
						☐ Owner ☐ Controlling ☐ Managerial
						☐ Owner ☐ Controlling ☐ Managerial
						☐ Owner ☐ Controlling ☐ Managerial

☐ I certify that the information provided on this form is accurate and complete.

Legal name (print or type): ______________________________

Signature of Authorized Representative: ______________________________

Title: ______________________________

Date: ______________________________

Appendix D: Federal Nurse Aide Training Competency and Evaluation Program (NATCEP) and In-Facility Test Site Change of Ownership

This document outlines the application process for nurse aide training programs and/or in-facility test sites that are approved by MDH as a Federal Nurse Aide Training and Competency Evaluation Program (NATCEP) and/or Test Site that will be under new ownership and plan to continue operating the NATCEP and/or Test Site.

NATCEP and Test Site Identification

Name of existing NATCEP: ______________________

Name of existing In-Facility Test Site: ______________________

Existing NATCEP program code: ______________________

Existing In-Facility Test Site code: ______________________

Name of Proposed NATCEP: ______________________

Name of Proposed In-Facility Test Site: ______________________

NATCEP Training Program Coordinator

All approved training programs must designate a training program coordinator who is responsible to provide, receive and communicate all updates and notices to staff. In addition, receive periodic Nurse Aide Registry notifications and have access to D&SDT-Headmaster, also known as Headmaster, test data. The training program coordinator is required to update the Nurse Aide Registry and Headmaster of substantive change such as new coordinator and/or contact information.

Provide below the name, title, contact information for the designated coordinator.

Name: ______________________

Title: ______________________

Telephone: ______________________

Email: ______________________

Current NATCEP Services

Has the current NATCEP provided nurse aide training in the past 12 months?

☐ Yes

☐ No

If yes, provide the last date of class completion: ______________________

Curriculum

☐ Check box if there will be no change to the curriculum.

If the curriculum will change, declare curriculum of the training program: ______________________________

____

____

Satellite Training Locations

☐ Check box if there will be no change to the training locations.

Address(es): ____

____

____

Supervised Practical Training Locations

☐ Check box if there will be no change to the supervised practical training locations.

Address(es): ____

____

____

Instructor(s)

Instructor Qualifications Onsite visits completed by MDH will include review of the following to ensure approved training and competency programs are meeting the requirements of Code of Federal Regulations; 42 CFR § 483.152(a)(5) Requirements for approval of a nurse aide training and competency evaluation program (https://www.ecfr.gov/current/title-42/part-483/section-483.152#p-483.152(a)(5):

- Active Minnesota Register Nurse license by the Minnesota Board of Nursing (https://mbn.hlb.state.mn.us/#/services/onlineEntitySearch);
- A resume with experience working in licensed nursing facilities and including dates of employment;
- The resume must reflect at least 2 years of licensed nursing experience in the U.S. and at least 1 year of licensed nursing experience in the provision of long-term care facility services in the U.S.; and
- The training program coordinator shall maintain documentation of instructor qualifications for review at the time of the onsite visit.

Long-term care facilities including nursing homes and boarding care homes meet this requirement.

Licensed nursing experience providing home care services in private homes is not included as long-term care facility services. Licensed nursing experience may include LPN; however, nurse aide experience is not included.

Approved curricula may contain a section of instructor training or usage guide for the curriculum. This is not an MDH requirement.

☐ Check box if there will be no changes to the instructors.

Name: ______________________________

Email: ______________________________

Name: ______________________________

Email: ______________________________

Name: ______________________________

Email: ______________________________

Name: ______________________________

Email: ______________________________

Other Personnel

☐ Check box if there will be no changes to other personnel.

Name: ______________________________

Email: ______________________________

Name: ______________________________

Email: ______________________________

Name: ______________________________

Email: ______________________________

Name: ______________________________

Email: ______________________________

In-Facility Testing Site Coordinator

All approved In-Facility test sites must designate a test site coordinator who is responsible to provide, receive and communicate all updates and notices to staff. In addition, coordinators receive periodic Nurse Aide Registry notifications and have access to D&SDT-Headmaster, also known as Headmaster. The test site coordinator is required to update the Nurse Aide Registry and Headmaster of changes such as new coordinator and/or contact information.

Name: ______________________________

Title: ______________________________

Telephone: ______________________________

Email: ______________________________

Satellite In-Facility Test Locations

☐ Check box if there will be no changes to satellite in-facility test locations.

Address(es): ______________________________

____

____

D&SDT-Headmaster, testing contract with MDH

Entity is responsible to update test site forms required by Headmaster as part of the Change of Ownership.

Please identify if required forms have been completed with Headmaster:

☐ Yes

☐ No

If no, please contact Headmaster for additional guidance.

- Minnesota@HDmaster.com
- D&S - Minnesota Nurse Aide (hdmaster.com)

Verification of Information

I verify the information submitted herein as part of the change of ownership application for a nurse aide training program and/or test site by the Minnesota Department of Health is true and accurate.

Name (print or type): ______________________________

Title: ______________________________

Date: ______________________________

Signature: ______________________________