NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH SERVICE REGULATION
NURSING HOME LICENSURE AND CERTIFICATION SECTION
2711 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-2711
TELEPHONE: (919) 855-4520

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2022

NURSING HOME APPLICATION - CHANGE OF OWNERSHIP
(Including Adult Care Home Beds in Combination Facilities)

LEGAL IDENTITY OF APPLICANT:

_____
{Full legal name of corporation, partnership, individual, or other legal entity owning the enterprise or service.}

DOING BUSINESS AS (d/b/a) - names under which the facility or services are advertised or presented to the public:

PRIMARY: _____

Other: _____

If the above names are **NOT IDENTICAL** to the names on the current license, please check reason for the change:

___ Change of Ownership/Licensee ____ Facility Name Change
___ Other (Specify):
_____

NORTH CAROLINA LICENSE NUMBER: _____

NPI Number:_____

FACILITY MAILING ADDRESS:

Street/P O Box: _____

City: _____ State: _____ Zip: _____-_____

FACILITY SITE:

Street: _____

City: _____ County:_____

Telephone: (____)_____ Zip: _____-_____ Fax:: _____

E-mail Address for Administrator: _____

"The N.C. Department of Health and Human Services does not discriminate on the basis of race, color, national origin, religion, age or disability in employment or the provision of services."

PART A OWNERSHIP AND MANAGEMENT DISCLOSURE

1. The following information is required by Nursing Home Licensure Rule 10A NCAC 13D .2101.

   a. What is the name of the **LEGAL ENTITY** with the ownership responsibility and liability? If it is a Corporation, please write the exact wording of the corporate office name as on file with the NC Secretary of State. If the legal entity is a Unit of government, please write the name of the unit which has ownership responsibility and liability for the services offered.

      NAME: _____

   b. Mailing Address: _____

      City: _____ State: _____ Zip: _____

      Telephone: (___) _____ Fax: (___) _____

      Senior Officer: _____

   c. Indicate the Percent of Ownership of the Legal Identity: _____

   d. Is legal entity: (check one)
      For Profit _____ Not For Profit _____

   e. Is the legal entity a: (check 1, 2, 3 or 4)

      (1) PROPRIETOR ____

      (2) LIMITED LIABILITY CORPORATION _____

      (3) PARTNERSHIP ____

      (a) General _____ If General, where is it registered? County _____State _____

      (b) Limited _____ If Limited, where is it registered? State _____

      (c) Is the limited partnership registered with the North Carolina Corporations Division in the NC Department of the Secretary of State?
      YES _____ NO _____

      (d) List the names and addresses of ALL persons who have a 5% financial interest or more and the names of all officers:

      Name: _____ Title: _____

      Address: _____ Percent of Ownership: _____

      Name: _____ Title: _____

      Address: _____ Percent of Ownership: _____

      Name: _____ Title: _____

      Address: _____ Percent of Ownership: _____

      (4) CORPORATION ___

(a) Where was the corporation originally established? State _____

(b) List the names and addresses of ALL persons who have a 5% financial interest or more and the names of all officers:

Name: _____ Title: _____

Address: _____ Percent of Ownership: _____

Name: _____ Title: _____

Address: _____ Percent of Ownership: _____

Name: _____ Title: _____

Address: _____ Percent of Ownership: _____

(5) UNIT OF GOVERNMENT

(a) What is the name and title of the official in charge of the above governmental unit?

Name: _____

Title: _____

(b) Check the word which best describes the above type of governmental unit:

CITY ____ COUNTY ____ STATE ____ AUTHORITY ____

2. Does the licensee (legal entity: individual, partnership, corporation or unit) own the building from which services are offered? **YES** _____ **NO** _____

If **NO**, who owns the building?

Name: _____

Mailing Address: _____ City: _____

State: _____ Zip: _____-_____ Telephone: (___) _____

Note: If neither the building owner nor the lessee is shown as the license applicant, explain on a separate page.

3. Is this facility part of a multiple facility system **within North Carolina**? (A multiple facility system is defined as two or more nursing homes or health care facilities under the same ownership.)

YES _____ **NO** _____

If "YES", give the name and address of the multiple facility system whether or not the Parent Company is located within North Carolina.

a. Name of the Parent Company: _____

b. Mailing Address: _____ c. City: _____

d. State: _____ e. Zip: _____-_____ f. Telephone: (___) _____

g. Name of Senior Officer: _____

4. Does the facility operate under a management contract?

YES _____ **NO** _____

If "YES", give the name, address and name of chief executive officer of the organization that manages the facility.

a. Name of Organization: _____

b. Mailing Address: _____ c. City: _____

d. State: _____ e. Zip: _____-_____ f. Telephone: (___) _____

g. Name of Chief Executive Officer: _____

PART B OPERATIONS

PROVIDE NAMES FOR THE FOLLOWING:

1. FACILITY PERSONNEL
   a. Full-time administrator as required in 10A NCAC 13D .2201(c).

   Name of Administrator: Full first name _____ Middle initial____ Last name_____
   Date Hired As Administrator: _____ N. C. License No: _____

   b. Nursing

   1. Director of Nursing: Full first name_____ Middle initial____ Last name_____
      N.C. License No:_____ Date Hired as DON: _____

2. MEDICAL STAFF FOR EMERGENCY CALL
   a. Medical Director's Name Address

   1. Full first name _____ _____
      Middle name_____ _____
      Last name_____ _____
      e-mail address:_____ N.C. License No:_____

PART C PATIENT SERVICES

1. Continuing Care Retirement Communities (CCRC)

   a. Is the facility licensed by the Department of Insurance as a "Continuing Care Retirement Community"? a. **YES** ____ **NO** ____

   b. If so, please submit Department of Insurance approval of the change of ownership.

2. **NUMBER OF BEDS BY TYPE (*Must complete required data supplement form)**

   a. **Nursing Beds (NF)** **(TOTAL)** a. _____

   1. General Nursing Facility Beds 1. _____
   2. *Alzheimer's Special Care Unit Resident Beds 2. _____*
   3. Ventilator Dependent Resident Beds 3. _____
   4. Traumatic Brain Injury Beds 4. _____

   Are you equipped to accommodate bariatric residents? Y ___ N ____

b. **Adult Care Home (ACH)** **(TOTAL)** b. _____

1. General Adult Care Home Beds 1. _____
2. *Alzheimer's Special Care Unit Resident Beds 2. _____*
   Are you equipped to accommodate bariatric residents? Y ___ N ____

c. **TOTAL LICENSED BEDS** **(TOTAL a & b)** c. _____

PART D CURRENT OPERATING STATISTICS

Current Per Diem Reimbursement Rates/Charges.
Please state the CURRENT (today's date or date the application is signed) basic daily charges/rates for patients or residents in your facility in the following categories of care.

*** If you have questions on how to complete this portion, please contact Certificate of Need at 919-855-3873.**

Private Pay (Usual Customary Charge)	Private Room (1 bed/room)	Semi-Private (2 beds/room)	Ward
Nursing Care	$	$	$
Adult Care Home	$	$	$
Special Care Unit (specify)_____	$	$	$
Special Care Unit (specify)_____	$	$	$

Medicare	Code	Rate
Three most frequent RUGS codes and rates paid for them.	1.	$
	2.	$
	3.	$

	Quarterly Rates			
Medicaid	Oct.-Dec.	Jan.-Mar.	Apr.-June	July-Sept.
Nursing Care	$	$	$	$

Medicaid Nursing Care	Current Rate
Special Care Unit (specify)_____	$
Special Care Unit (specify)_____	$

State/County Special Assistance	Rate
Adult Care Home	$
Special Care Unit (specify)_____	$
Special Care Unit (specify)_____	$

Please complete only if applicable:

Alzheimer's/Dementia Special Care Unit	Rate
Additional cost or fee to resident	$

PART E LICENSE FEE

A non-refundable license fee is required and must accompany this application prior to the issuance of a nursing home license. The payment should be in the form of check, certified check or money order and must be made payable to: "**The Division of Health Service Regulation**." A separate check is required for each licensed entity.

Pursuant to §131E-102(b), effective August 14, 2009 annual license fees will be $420.00 (base fee) plus $17.50 per bed. Fees for change of ownership licensure effective during the months of October – December will be credited to the license renewal fee.

This application must be completed and submitted to the Nursing Home Licensure and Certification Section, Division of Health Service Regulation, with the license fee, prior to the issuance of a nursing home license. The legislation (SB 622, Session Law 2005-276) prohibits a license from being issued if the fee has not been paid.

The undersigned submits this application for licensure for the year 2016 {subject to the provisions of the Nursing Home Licensure Act, Article 6, Chapter 131E of the General Statutes of North Carolina and to the rules adopted thereunder by the North Carolina Medical Care Commission} and certifies the accuracy of this information.

Typed Name of Chief Administrative Officer or Authorized Official	(Written Signature)
Title:	Date: