

# Instructions for Completing the Disclosure of Ownership and Control Interest Statement

Completion and submission of this form is a condition of participation, certification or recertification under any of the programs established by Titles V, XVIII, XIX and XX or as a condition of approval or renewal of a contractor agreement between the disclosing entity and the secretary of appropriate state agency under any of the above-titled programs, a full and accurate disclosure of ownership and financial interest is required. Failure to submit requested information may result in a refusal by the Secretary or appropriate State agency to enter into an agreement or contract with any such institution in termination of existing agreements.

## GENERAL INSTRUCTIONS

Please answer all questions as of the current date. If the **yes** block for any item is checked, list requested additional information under the Remarks Section on page 11.2 referencing the item number to be continued. If additional space is needed, use an attached sheet.

## DETAILED INSTRUCTIONS

These instructions are designed to clarify certain questions on the form. Instructions are listed in order of question for easy reference. NO instructions have been given for questions considered self-explanatory.

IT IS ESSENTIAL THAT ALL APPLICABLE QUESTIONS BE ANSWERED ACCURATELY AND THAT ALL INFORMATION BE CURRENT.

### ITEM I

- (a) Under identifying information specify in what capacity the entity is doing business as (DBA), example, name of trade or corporation.
- (b) **For Regional Office Use Only.** If the **yes** box is checked for item VII the Regional Office will enter the 5-digit number assigned by HCFA to chain organizations.

### ITEM II – Self-explanatory.

### ITEM III

List the names of all individuals and organizations having direct or indirect ownership interests, or controlling interest separately or in combination amounting to an ownership interest of 25 percent or more in the disclosing entity.

Direct ownership interest is defined as the possession of stock, equity in capital or any interest in the profits of the disclosing entity. A disclosing entity is defined as a Medicare provider or supplier or other entity that furnishes services or arranges for furnishing services under Medicaid or the Maternal and Child Health program or health related services under the social services program.

Indirect ownership interest is defined as ownership interest in an entity that has direct or indirect ownership interest in the disclosing entity. The amount of indirect ownership in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. An indirect ownership interest must be reported if it equates to an ownership interest of 5 percent or more in the disclosing entity. Example: if "A" owns 25 percent of the stock in a corporation that owns 80 percent of the stock of the disclosing entity, "A's" interest equates to an 8 percent indirect ownership and must be reported.

Controlling interest is defined as the operational direction or management of a disclosing entity which may be maintained by any or all of the following devices; the ability or authority, expressed or reserved to amend or change the corporate identity (i.e., joint venture agreement, unincorporated business status) of the disclosing entity; the ability or authority to nominate or name members of the Board of Directors or Trustees of the disclosing entity; the ability or authority, expressed or reserved to amend or change the by-laws, constitution or other operating or management direction of the disclosing entity; the right to control any or all of the assets or other property of the disclosing entity upon the sale or dissolution of that entity; the ability or authority, expressed or reserved to control the sale of any or all of the assets to encumber such assets by way of mortgage or other indebtedness, to dissolve the entity or to arrange for the sale or transfer of the disclosing entity to new ownership or control.

### ITEMS IV through VII – Changes in Provider Status

Change in provider status is defined as any change in management control. Examples of such changes would include a change in Medical or Nursing Director, a new Administrator, contracting the operation of the facility to a management corporation, a change in the composition of the owning partnership which under applicable State law is not considered a change in ownership, or the hiring or dismissing of any employees with 5 percent or more financial interest in the facility or in an owning corporation, or any change of ownership.

For items IV through VII, if the **yes** box is checked, list additional information requested under Remarks. Clearly identify which item is being continued.

**ITEM IV – (a & b)** If there has been a change in ownership within the last year or if you anticipate a change, indicate the date in the appropriate space.

**ITEM V –** If the answer is **yes**, list name or the management firm and employer identification number (EIN) or the leasing organization. A management company is defined as any organization that operates and names a business on behalf of the owner of that business with the owner retaining ultimate legal responsibility for operation of the facility.

**ITEM VI –** If the answer is **yes**, identify which has changed (Administrator, Medical Director or Director of Nursing) and the date the change was made. Be sure to include name of the new administrator, Director of Nursing or Medical Director, as appropriate.

**ITEM VII –** A chain affiliate is any freestanding health care facility that is owned, controlled, or operated under lease or contract by an organization consisting of two or more freestanding health care facilities organized within or across State lines which is under the ownership or through any other device, control and direction of a common party. Chain affiliates include such facilities whether public, private, charitable or proprietary. They also include subsidiary organizations and holding corporations. Provider-based facilities such as hospital-based home health agencies are not considered to be chain affiliates.

**ITEM VIII –** If **yes**, list the actual number of beds in the facility now and the previous number.

This form similar to HCFA – 11513

# Disclosure of Ownership and Control Interest Statement

This Form is Required for all Individuals, Groups & Facilities (exclude performing providers)

**I. Identifying Information**

(a) 

Legal Name According to the IRS	D/B/A	Telephone No
Physical Address	Suite	City
		State
		ZIP

(b) **Chain Affiliate Number:**  
To be completed by HCFA Regional Office

**II. Answer the following questions by checking "Yes" or "No."**  
If any of the questions are answered Yes, list names and addresses of individuals or corporations under Remarks on page 11.2 Identify each item number to be continued.

(a) Are there any individuals or organizations having a direct or indirect ownership or control interest of five percent or more in the institution, organizations, or agency that have been convicted of a criminal offense related to the involvement of such persons, or organizations, in any of the programs established by Titles XVIII, XIX, or XX?  Yes  No

(b) Are there any directors, officers, agents, or managing employees of the institution, agency, or organization who have ever been convicted of a criminal offense related to their involvement in such programs established by Titles XVIII, XIX, or XX?  Yes  No

(c) Are there any individuals currently employed by the institution, agency, or organization in a managerial, accounting, auditing, or similar capacity who were employed by the institution's, organization's, or agency's fiscal intermediary, or carrier within the previous 12 months? (Title XVIII providers only)  Yes  No

**III. (a) List names, addresses, for individuals, or the EIN for organizations having direct or indirect ownership of a controlling interest in the entity.**  
See Instructions for **Completing the Disclosure of Ownership and Control Interest Statement** on page 10. List any additional names and addresses under **Remarks** on page 11.2. If more than one individual is reported and any of these persons are related to each other, this must be reported under **Remarks**.

Name	Physical Address	EIN

**(b) Type of Entity: (SELECT ONLY ONE ENTITY) (Must match entity on W-9)**

Sole Proprietorship   
  Partnership   
  Corporation   
  Unincorporated   
  Association   
  Other (Specify):

**Please Note:** When claiming "Corporation" providers must complete and return the following forms:

- Corporate Board of Directors Resolution Form (page 14) must be completed with signature and notary stamp or seal
- Certificate of Incorporation or Certificate of Authority
- Letter of Good Standing from the Texas State Comptroller's Office. It is a requirement of H.B. 175. A certificate can be obtained by contacting:

**State Comptroller's Office — Tax Assistance Section**  
 Interstate WATS Telephone Number 1-800-252-5555  
 Austin Telephone Number 1-512-463-4600

There is no charge for this request. The request may be made by telephone, and the certificate will be mailed to the requestor. Callers must have the taxpayer's name, taxpayer's identification number, and charter number available at the time of the request. If the corporation has a 501c Internal Revenue Exemption, Letter of Good Standing is not required. Please indicate this by signing below:

**Do you have a 501c Internal Revenue Exemption?**  Yes  No

<b>Entity Name</b>	<b>Name (Written/Typed)</b>
<b>Signature</b>	<b>Date</b>

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**III. (Continued)**

(c) If the disclosing entity is a corporation, list names, addresses of the directors and EINs for corporations in remarks. (Attach additional pages if needed)

**REMARKS:**

(d) Are any owners of the disclosing entity also owners of other Medicare/Medicaid facilities? (Example: sole proprietor, partnership, or members of Board of Directors.)  Yes  No

If yes, list names, addresses of individuals, and provider numbers:

Name	Address	Provider Number

<b>IV. (a) Has there been a change in ownership or control within the last year?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, give date:
<b>(b) Do you anticipate any change of ownership or control within the year?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, when?
<b>(c) Do you anticipate filing for bankruptcy within the year?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, when?

<b>V. Is this facility operated by a management company or leased in whole or in part by another organization?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, give date of change in operations:
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<b>VI. Has there been a change in Administrator, Director of Nursing, or Medical Director within the last year?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
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<b>VII. (a) Is this facility chain affiliated?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<i>If yes, list name, address of corporation, and EIN:</i>		
Name	Address	EIN
<b>(b) If the answer to Question VII.A. is No, was the facility ever affiliated with a chain?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<i>If yes, list name, address of corporation, and EIN:</i>		
Name	Address	EIN

<b>VIII. Have you increased your bed capacity by 10 percent or more or by 10 beds, whichever is greater, within the last two years?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<i>If yes, give year of change:</i>	<b>Current Beds:</b>	<b>Prior Beds:</b>

Whoever knowingly and willfully makes or causes to be made a false statement or representation of this statement may be prosecuted under applicable federal or state laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate or where the entity already participates, a termination of its agreement or contract with the state agency or the secretary, as appropriate.

<b>Name of Authorized Representative (Typed)</b>
<b>Signature</b>

<b>Title</b>
<b>Date</b>