

NURSING FACILITY CHANGE OF OWNERSHIP (CHOW)

Please refer to the following Oregon Administrative Rules for more details:

- [411-085-0025](#)
Change of Ownership or Operator and Closure
 - [411-085-0010](#)
Issuance of License
 - [411-085-0013](#)
New Applicant Qualifications
-

Submit the following application materials for approval in accordance with the above OARs:

Letter of Intent to NFLicensing@state.or.us that includes:

Summary of proposed action that includes:

- Name and signature of the current owner/licensee
- Name and signature of the prospective owner/licensee
- The proposed date of transfer
- The type of transfer (e.g. sale, lease or rental, etc.)

Note: Please submit this at least 45 days in advance of the expected CHOW effective date; Please attempt to provide as much advance notice as possible)

Submit the following documents using the correct form for the proposed business owner/licensee and one form for the proposed operator. If owner and operator are the same, only one form is required.

Nursing Facility License Application (s) from the prospective owner/licensee and operator (if applicable), [SE0466](#)

Statement of ownership and control, owner/licensee and operator (if applicable) form [SE0466D](#)

As outlined below, an invoice for the appropriate licensing fee will be generated following the effective date of the CHOW (PLEASE DO NOT SEND A CHECK.)

Fewer than 16 beds, \$1000
16-49 beds, \$1500
50-99 beds, \$2000
100-150 beds, \$2500
150 or more beds, \$2500

MCU: 16 or fewer beds, \$50

MCU: 17-50 beds, \$75

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MCU: 51 or more beds, \$100

Financial Approval – Review includes:

Proof of Fiscal Responsibility

Auditor’s certified financial statement and other verifiable documentary evidence of fiscal solvency, documenting that the prospective licensee has sufficient resources to operate the facility for 60 days.

Proof of fiscal solvency must include liquid assets sufficient to operate the facility for 45 days.

Anticipated Medicaid income is not considered to be “liquid assets” but may be considered “financial resources”. Liquid assets may be demonstrated by:

- An Unencumbered line of credit; or
- A joint escrow account with APD or
- A performance bond; or
- Any other method satisfactory to APD
- The Division will require for each facility, \$50,000 in:
 - Unencumbered line of credit or
 - An escrow account; or
 - A performance bond

Pro Forma Statement (financial review)

Revenues, expenditures and resident days, by month for first 12 months of operation of the facility and demonstrate the ability to cover any cash flow problems identified by the pro forma.

Credit Reports – Signed Approval for Credit Checks, form [SE0466C](#)

Authorized and signed by each owner or entity with 10% or greater ownership interest, *If Medicare or Medicaid certified, complete a signed approval for credit check for each individual or entity with 55 or greater ownership interest in the owner/licensee and operator entities.*

New Owner or Plan of Correction Compliance Agreement

Certificate of Performance and Financial History, form [SE0466F](#)

Each individual and/or entity with 5% or greater ownership interest must complete/sign this form.

Facility Floor Plan

For resident rooms, ensure the floor plan shows the room number, location of each bed and room dimensions; dining room, activity area, shower/tub room, toilet room, clean/dirty utility rooms, therapy services, laundry and dietary service areas.

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Fitness Determination – Criminal History Request (SE0466C)

Complete for each individual with 10% or greater ownership interest in the ownership entity and the operating entity. *If Medicare or Medicaid certified, complete for each individual with 5% or greater ownership interest in the owner/licensee and operator entities.*

For more information: <https://www.oregon.gov/DHS/BUSINESS-SERVICES/CHC/Pages/CRIMS.aspx>

- Please complete and original form for each individual, and complete section 2 of the form completely, leaving no spaces blank.
- Please send Form 301 QED to NF.Licensing@state.or.us .

Physical Plant or Care Corrections - (last survey)

- Indicate amount of funds needed for correction
- Indicate how funds will be made available
- Indicate when the corrections will be made

Legal Agreements Purchase Sale Agreement or Business Lease

Legally binding agreement that describes the business sale or transfer from the current licensee to the prospective licensee.

Operations Transfer Agreement

Legally binding agreement that describes all aspects of business operations that will occur as result of the business sale (or transfer). The OTA will address all aspects of business function including accounts payable and receivable, provider tax, personnel, inventories, etc.

Management/Operator Agreement (if the owner/licensee is not the operator)

Legal agreement that defines specific responsibilities of the prospective nursing facility operator.

Property Lease

Legal agreement delineating land/physical plant ownership and proposed legal agreement with the prospective licensee and/or operator. Including

Verification to Legally Operate. The applicant must demonstrate that they have the legal right to possess the nursing facility property and operate the nursing facility business.

MEDICARE/MEDICAID Certification (if applicable)

Medicare Provider/Supplier Enrollment Form (CMS 855), provider submits to Fiscal Intermediary (FI), copy to NF.licensing@state.or.us; forms can be located at:

<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/Enrollment-Applications>

Long – Term Facility Application for Medicare and Medicaid

(HCFA 671), provider must submit original form plus three copies to

NF.licensing@ohadhs.state.or.us; <https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/CMS671.pdf>

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Assurance of Compliance (HHS 690), please provide a copy of webpage verification "Assurance of Compliance with Non-Discrimination Laws and Regulations". This is now an electronic submission through the CMS online portal:

<https://ocrportal.hhs.gov/ocr/aoc/instruction.jsf>

Health Insurance Benefit Agreement (CMS 1561) please submit two copies with original signatures to NF.licensing@state.or.us

<https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1561.pdf>

CMS 1539 Approved/Signed by Region X

MEDICAID ONLY

Long – Term Facility Application for Medicare and Medicaid ([HCFA 671](#))