STATE OF TENNESSEE
DEPARTMENT OF HEALTH
BUREAU OF HEALTH LICENSURE AND REGULATION
DIVISION OF HEALTH CARE FACILITIES
227 FRENCH LANDING, SUITE 501
HERITAGE PLACE METROCENTER
NASHVILLE, TENNESSEE 37243
(615) 741-7221

HOSPITAL
CHANGE OF OWNERSHIP PROCEDURES

1. Submit a notarized application along with the appropriate fee and a letter of intent to the address at the top of the application. Include the name of the facility and the projected date of the change of ownership.

2. A letter will be sent acknowledging the receipt of the application and fee. Once the change of ownership has occurred and you receive the closing documents, you will need to send a copy of the bill of sale or the documents that indicate that you are now the owner of the facility to:

   Health Care Facilities
   227 French Landing, Suite 501
   Heritage Place Metrocenter
   Nashville, Tennessee 37243

3. When the bill of sale or closing documents are received, this office will notify the regional office in your area to request a recommendation for the change of ownership which will be effective the date the closing documents were signed. The regional office will review the facility file to see if a survey has been conducted within the previous twelve (12) months with no deficiencies. If so, a form recommending approval of the change of ownership will be submitted to the central office in Nashville. If a survey has not been conducted within the previous twelve (12) months an on-site survey of the facility will be conducted before the regional office will recommend approval of the change of ownership. If the facility has any deficiencies from either that survey or a previous survey the deficiencies must be corrected before the regional office will recommend approval of the change of ownership.

4. Once the recommendation is received in the central office a letter will be forwarded to you to initially approve the change of ownership. The application will then be presented to the Board for Licensing Health Care Facilities at the next regularly scheduled board meeting for ratification. If the Board ratifies the approval of the change of ownership the license number listed above will become your permanent license number and a letter will be forwarded to you within three working days notifying you of the Board's final decision. You should receive your wall license within seven (7) to ten (10) days thereafter.

5. If the Board does not ratify the initial approval of the change of ownership a letter will be mailed to you providing an explanation and specific instructions as to any actions you may take to have the decision reviewed, at which time this authorization shall cease to be effective.

All applicable laws, rules, policies, and guidelines affecting your practice are available for viewing at www.state.tn.us/health. Please check this website periodically for updates.

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HOSPITAL
APPLICATION FOR CHANGE OF OWNERSHIP

All applicable laws, rules, policies, and guidelines affecting your practice are available for viewing at www.state.tn.us/health. Please check this website periodically for updates.

Name of the Facility/Agency _____

Location of the Facility:

Street _____ City _____

County _____ State _____ Zip _____

Phone Number (____) _____ Fax Number (____) _____

Twenty-four (24) Hour Emergency Phone Number (____) _____

E-Mail Address _____

Total Bed Capacity _____

Administrator Information:

Administrator _____

Have you (Administrator) ever been convicted of a crime involving injury or harm to person(s), financial or business management (e.g., assault, battery, robbery, embezzlement or fraud)? Yes _____ No _____

If yes, what charge(s)? _____

Location of Conviction _____ Date _____
(City) (County) (State)

Mailing address if different from the Facility location address:

Name _____

Street _____

City _____ State _____ Zip _____

Ownership of Building:

Name _____ Phone Number (____) _____

Street _____

City _____ State _____ Zip _____

FEE SCHEDULE: (FEES ARE NON-REFUNDABLE)

Bed Capacity	Fee	Bed Capacity	Fee
Less than 25	$ 800	100 thru 124	$1,600
25 thru 49	$1,000	125 thru 149	$1,800
50 thru 74	$1,200	150 thru 174	$2,000
75 thru 99	$1,400	175 thru 199	$2,200

Facilities with 200 beds or more shall pay a flat rate of $2400 + $200 for each additional 25 beds or fraction thereof (i.e., 200-224 pays $2,400; 225-249 pays $2,600).

1. Check classification of institution for which application is made:

   ____ General Hospital ____ Orthopedic ____ Pediatric ____ EENT ____ Rehab _____ Chronic Disease

2. List the number of beds in each category, if applicable, for which acute care beds are utilized.

   Swing beds ____ Psychiatric Beds ____ Alcohol and Drug Abuse Beds ____ NICU ____ Rehab ____

3. Check type of services provided:

a	_____ Surgical	f.	_____ Chronic	k.	_____ ICU/CCU/NICU
b.	_____ Obstetrics	g.	_____ Orthopedics	l.	_____ Burn
c.	_____ Well Baby Nursery	h.	_____ Pediatrics	m.	_____ Trauma
d.	_____ Psychiatric	i.	_____ Rehabilitation	n.	_____ Cancer Treatment
e.	_____ Alcohol and Drug	j.	_____ Emergency	o.	_____ Outpatient

4. If trauma was indicated above, what is the trauma designation? _____

5. If pediatrics was indicated above, what is the pediatric emergency designation? _____

OWNERSHIP OF BUSINESS:

1. a. Check the type of Legal Entity:

   _____ Individual _____ Partnership _____ Corporation _____ Limited Liability Company

   _____ Church Related _____ Government/County _____ Other

   b. Check One: _____ For Profit _____ Non-profit

   c. Legal Entity checked in 1.a:

   Name _____ Phone Number (_____) _____

   Address _____

   d. List name(s) and address(es) of individual owners, partners, directors of the corporation, or head of the governmental entity:

   _____

   Name Street City, State, Zip

   _____

   Name Street City, State, Zip

   (If additional space is needed, please use a separate sheet)

2. a. Is your facility/organization accredited by a **federally approved** accrediting body (i.e., JCAHO, CARF, etc)?

   Yes _____ No _____ Expiration Date _____

   b. Is your facility/organization deemed by a **federally approved** accrediting body (i.e., JCAHO, CARF, etc)?

   Yes _____ No _____ Expiration Date _____

3. If you have a parent company please provide the following information:

   Name _____ Phone Number (_____) _____

   Address _____

4. a. Are any owners of the disclosing entity or also owners of other health care facilities in Tennessee and/or other states? Yes ____ No ____

   b. If yes, list names and addresses of all such facilities:

   _____

   _____

5. a. Do you have a contract with a management firm to operate this facility? Yes _____ No _____

   If yes, specify dates: From _____ To _____

   b. If yes, specify name of firm: _____

   Phone Number (_____) _____

   _____

   Street City, State, Zip

6. a. Have any owners of the disclosing entity ever been denied a license, had a license suspended or revoke, had a suspension of admissions or paid any civil monitory penalties for a health care facility in Tennessee or in any other state? Yes _____ No _____

   b. If yes, where? _____ When? _____

   c. For what reason? _____

VERIFICATION BY NOTARY PUBLIC:

Signee for application certifies that he or she is of responsible character and able to comply with the minimum standards and regulations established by Tennessee pertaining to the type of facility or agency for which application for licensure is made and with the rules promulgated under Tennessee Code Annotated (TCA) § 68-11-201.

Signee also certifies that a policy has been implemented to inform all employees of their obligation under TCA § 71-6-103 to report incidents of abuse or neglect.

_____ _____ _____

Applicant Signature Title or Position Date

STATE OF TENNESSEE

County of _____

The above named applicant (print name) _____, being by me duly sworn on his/her oath, deposes and says that he/she has read the forgoing application and knows the contents thereof: that the statements concerning the above named facility or agency, therein contained, are correct and true to his/her own knowledge.

Subscribed to and sworn to on this _____ day of _____

Month Year

Notary Public: _____

My commission expires: _____