Department of Health and Human Services
Health Care Financing Administration

Form Approved
OMB 0938-0086/HCFA-1513

INSTRUCTIONS FOR COMPLETING DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT (HCFA-1513)

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 or in termination of existing agreements.

SPECIAL INSTRUCTIONS FOR TITLE XX PROVIDERS

All Title XX providers must complete Part II(a) and (b) of this form. Only those Title XX providers rendering medical, remedial, or health-related homemaker services must complete Parts II and III. Title V providers must complete Parts II and III.

GENERAL INSTRUCTIONS

For definitions, procedures and requirements, refer to the appropriate Regulations:

Title V	42CFR 51a.144
Title XVIII	42CFR 420.200-206
Title XIX	42CFR 455.100-106
Title XX	45CFR 228.72-73

Please answer all questions as of the current date. If the yes block for any item is checked, list requested additional information under Remarks on Page 2, referencing the item. If additional space is needed use an attached sheet.

Return the original to the State agency; retain a copy for your files.

This form is to be completed annually. Any substantial delay in completing the form should be reported to the State survey agency.

DETAILED INSTRUCTION

These instructions are designed to clarify certain questions on the form. Instructions are listed in question order 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.

Item I (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 5% 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 service 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% or more in the disclosing entity. Example: If A owns 10% of the stock in a corporation that owns 80% of the stock of the disclosing entity, A's interest equates to an 8% 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-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% or more financial interest in the facility or in an owning corporation, or any change of ownership.

Items IV-VII If the yes box is checked, list additional information requested under Remarks. Clearly identify which item is being continued.

Item IV (a and 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 of the management firm and employer identification number (EIN), or the name of the leasing organization. A management company is defined as any organization that operates and manages 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 free-standing health care facility that is either owned, controlled, or operated under lease or contract by an organization consisting of two or more free-standing 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.

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DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

1.	IDENTIFYING INFORMATION				
(a)	Name of Entity DBA	Provider No.	Vendor No.		Phone
	Street Address	City	County	State	Zip

(b) (To be completed by HCFA Regional Office) Chain Affiliate No.

II. Answer the following questions by marking "Yes" or "No." If any of the questions are answered "Yes," list names and addresses of individuals or corporations under Remarks on Page 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 5% or more in the institution, organization, 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 Title 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 or a controlling interest in the entity. (See instructions for definition of ownership and controlling interest.) List any additional names and addresses under Remarks on Page 2. If more than one individual is reported and any of these persons are related to each other, this must be reported under Remarks on Page 2.

NAME	ADDRESS	EIN

(b) Type of Entity:

___ Sole Proprietorship ___ Partnership ___ Unincorporated Associations ___ Corporation
___ Other (specify) _____

(c) If the disclosing entity is a corporation, list names, addresses of the Directors, and EINS for corporations under Remarks on Page 2.

Mark appropriate answer for each of the following questions:

(d) Are any owners of the disclosing entity also owners of 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

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IV. (a) Has there been a change in ownership or control within the last year?
Yes No If yes, give date.

(b) Do you anticipate any change of ownership or control within the year?
Yes No If yes, when?

(c) Do you anticipate filing for bankruptcy within the year?
Yes No If yes, when?

V. Is this facility operated by a management company, or leased in whole or part by another organization? Yes No
If yes, give date of change in operation.

VI. Has there been a change in Administrator, Director of Nursing or Medical Director within the last year? Yes No

VII. (a) Is this facility chain affiliated? If yes, list name, address of Corporation, and EIN.

Name _____ EIN _____
Address _____

(b) If the answer to question VII (a) is No, was the facility ever affiliated with a chain? If Yes, list name, address of Corporation, and EIN.

Name _____ EIN _____
Address _____

VIII. Have you increased your bed capacity by 10% or more or by 10 beds, whichever is greater, within the last 2 years: Yes No
If yes, give year of change: Current bed space: Prior bed space:

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.

Name of Authorized Representative (Typed)	Title
Signature	Date

Remarks: