

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES DIVISION OF REGULATION AND LICENSURE SECTION FOR LONG-TERM CARE REGULATION APPLICATION FOR LICENSE TO OPERATE A LONG-TERM CARE FACILITY

All forms may be found on our website at: <u>http://www.dhss.mo.gov/NursingHomes/AppsForms.html</u>

DO NOT WRITE IN THIS SPACE				
FACILITY NUMBER				
APPLICATION NUMBER				
RELICENSURE     NEW FACILITY     CHANGE OF OPERATOR				
EXPIRATION DATE		REGION		
DATE FEE REC'D	CHECK NO.	AMOUNT \$		

	FACILITY INFO	ORMATION			
INSTRUCTIONS:	1. Name of Facility				
1. The name of the					
facility must be indicated exactly as you want it to appear on the license. Indicate the mailing	Facility Street Address				
address of facility, if different from street address.	City		State	ZIP Code +4	
	Facility Mailing Address				
	City		State	ZIP Code +4	
	County in which the facility is located			!	
	Facility Telephone Number	Cacility Telephone Number Facility Fax Number			
	Facility E-Mail Address				
2 Indicate the license (c)	2. Skilled Nursing Facility (# of beds)	Intermediate	Care Facility (	# of beds)	
2. Indicate the license(s) and number of beds you are applying for by writing the number of	Assisted Living Facility** (# of beds)		Assisted Living Facility (# of beds)		
beds in the appropriate space.	Residential Care Facility* (# of beds)	Residential C	are Facility (#	of beds)	

\*\*Licensed as an assisted living facility (ALF) and chooses to accept or retain individuals with a physical, cognitive or other condition that prevents them from safely evacuating the facility with minimal assistance.

\*Licensed as a residential care facility II on August 27, 2006 and chooses to continue to meet all laws, rules and regulations that were in place on August 27, 2006 for a residential care facility II.

OPERATOR INFORMATION					
INSTRUCTIONS:	3. Type of Operator (check one)				
3. Indicate what type of	□ Sole Proprietorship □ Limited Liability Company		Limited Liability Partnership		
legal entity the operator is by checking the	General Business Corporation	Nonprofit Corp	oration	Nursing He	ome District
appropriate box.	General Partnership	Limited Partner	rship		
4. The name of the operator must be the exact legal name. If the	Other (Specify)				
operator is any entity other than a sole proprietor, the operator	4. Name of Operator				
name must match the Missouri Secretary of State filing. The operator	Street Address				
name should not be the name of any individual stockholder, partner, or	City			State	ZIP Code
member. Indicate the operator's mailing address, if different from the street address.	Mailing Address			1	
5. Principal means officer, director, owner, partner, key employee, or other	City			State	ZIP Code
person with primary management or supervisory responsibili-	Telephone Number		Fax Number	1	
ties.	E-Mail Address				
6. If the operator is an entity other than a sole proprietorship, then a list of its officers, directors, stockholders (owning 5% or more), LLC members, LLC managers, general partners or limited partners (owning 5% or more) must be filed, in discussional partners (owning 5% or more) must be filed,	<ul> <li>5. Attach a list of all principals in the operation of the facility, including name, address, social security number, and title or position. Use this list to indicate the operator's employer identification number (or social security number, if the operator is a sole proprietor).</li> <li>You may utilize form <i>MO 580-2925 <u>Principal List</u></i>.</li> <li>Attached</li> </ul>				
indicating the name, address, title, and percentage of ownership of each.	<ul> <li>6. Is the operator an entity other than a sole proprietorship?</li> <li>Yes No</li> </ul>				
Affiliate means: (a) With	If yes, attach a list of the affiliates including the name, address, title, and percentage of ownership.				
respect to a partnership, each partner; (b) with	Attached Previously submitted; no amendment or change				
respect to a limited	If an affiliate is itself an entity other than an individual person, a list of its affiliates is also required. (Attach a				
partnership, the general partner and each limited partner with an interest of 5% or more in the limited	E00 0000 Affiliate List Deutneuelsin au MO E00 0000 Affiliate List LLC				
partnership; (c) with respect to a corporation,					
each person who owns, holds, or has the power to vote 5% or more of any	<ul> <li>7. Does the operator currently operate or own any other long-term care facility in Missouri or any other state?</li> <li>Yes No</li> </ul>				
class of securities issued by the corporation, and	If yes, then it is necessary to atta		-		
each officer and director; (d) with respect to a	Attached Previously su	bmitted; no amendm	ent or change		
limited liability company, the LLC managers and LLC members with an interest of 5% or more.	If the operator currently operates or owns any other long-term care facility in Missouri or in any other state, then attach a list of such facility or facilities, including their names, addresses, and type of licenses.				

misdemeanor offense relating to the operation of a la acting in a management capacity, ever knowingly	ong-term care fa / acted or know	cility or other he ringly failed to	alth care facility or, while perform any duty which
	te or territory? If y	ves, attach an ex	planation.
REAL ESTATE INFORMAT	ION		
10. Name of owner of the land			
Street Address			
City		State	ZIP Code
Mailing Address	I		
City		State	ZIP Code
Contact Name	Contact Teleph	one Number	
11. Name of owner of the structure(s) (if different from the structure)	he owner of the	land shown abo	ve)
Street Address			
City		State	ZIP Code
Mailing Address			
City		Stata	ZIP Code
		Slale	
Contact Name	Contact Telephone Number		
			nership (of the land and
	misdemeanor offense relating to the operation of a l         acting in a management capacity, ever knowingly         materially and adversely affected the health, safe         explanation.         Yes         Yes         No         9. Is the operator or any principal in the operation of the (Medicare) or Title XIX (Medicaid) program of any state (Medicare) or Title XIX (Medicaid) program of any state (Medicare) or Title XIX (Medicaid) program of any state (Medicare) or Title XIX (Medicaid) program of any state (Medicare) or Title XIX (Medicaid) program of any state (Medicare) or Title XIX (Medicaid) program of any state (Medicare) or Title XIX (Medicaid) program of any state (Medicare) or Title XIX (Medicaid) program of any state (Medicare) or Title XIX (Medicaid) program of any state (Medicare) or Title XIX (Medicare) program of any state (Medicare) or Title XIX (Medicare) program of any state (Medicare) or Title XIX (Medicare) program of any state (Medicare) or Title XIX (Medicare) program of any state (Medicare) or Title XIX (Medicare) program of any state (Medicare) or Title XIX (Medicare) program of any state (Medicare) or Title XIX (Medicare) program of any state (Medicare) or Title XIX (Medicare) program of any state (Medicare) or Title XIX (Medicare) program of any state (Medicare) or Title XIX (Medicare) program of any state (Medicare) or Title XIX (Medicare) or Title X	misdemeanor offense relating to the operation of a long-term care fa         acting in a management capacity, ever knowingly acted or know         materially and adversely affected the health, safety, welfare or pr         explanation.         Yes       No         9. Is the operator or any principal in the operation of the facility under ex (Medicare) or Title XIX (Medicaid) program of any state or territory? If y         Yes       No         REAL ESTATE INFORMATION         10. Name of owner of the land         Street Address         City         Mailing Address         City         11. Name of owner of the structure(s) ( <i>if different from the owner of the</i> Street Address         City         Mailing Address         City	Yes       No         9. Is the operator or any principal in the operation of the facility under exclusion from part (Medicare) or Title XIX (Medicaid) program of any state or territory? If yes, attach an exclusion from part (Medicare) or Title XIX (Medicaid) program of any state or territory? If yes, attach an exclusion from part (Medicare) or Title XIX (Medicaid) program of any state or territory? If yes, attach an exclusion from part (Medicare) or Title XIX (Medicaid) program of any state or territory? If yes, attach an exclusion from part (Medicare) or Title XIX (Medicaid) program of any state or territory? If yes, attach an exclusion from part (Medicare) or Title XIX (Medicaid) program of any state or territory? If yes, attach an exclusion from the land         In Name of owner of the land       State         City       State         Contact Name       Contact Telephone Number         11. Name of owner of the structure(s) ( <i>if different from the owner of the land shown abo</i> Street Address       City         City       State         Mailing Address       City         City       State

INSTRUCTIONS:	12. Is the owner of the land or structure(s) an entity other than a sole proprietorship?				
	If yes, attach a list of the affiliates including the name, address, title, and percentage of ownership.				
	Attached Previously submitted; no amendment or change				
	If an affiliate is itself an entity other than an individual p separate list for each entity.)	person, a list of its affiliates is	also required. (Attach a		
	You may utilize form MO 580-2626 <u>Affiliate List Corporatio</u> 580-2629 <u>Affiliate List Partnership</u> or MO 580-2630 <u>Affilia</u>		onprofit Corporation, MO		
	13. Does the owner currently own or operate any other lon	g-term care facility in Missouri o	or any other state?		
	Yes No				
14. A copy of the recorded deed of trust	If yes, attach a list of the facilities including their name	e, address, and type of license.			
(mortgage), UCC financing statement(s) or	Attached Previously submitted; no amendm	ent or change			
other legal documents showing the security pledged must be	14. Is the land, building, improvements, furnishings, fixture security on any contract?	es or accounts receivable pledo	ged in whole or in part as		
submitted.	Ses No				
15. A copy of the	If yes, then a copy of the security contract (i.e., deed of	trust (mortgage), UCC financing	statement(s)) is:		
executed real estate lease, sublease, contract for deed, rental	Attached Previously submitted; no amendm	ent or change			
agreement, or other legal document showing a	15. Is there any executed lease, sublease, contract for deed or rental agreement?				
present legal right to	□ Yes □ No				
possession of the premises must be	If yes, then a copy of any executed lease, sublease, contract for deed or rental agreement is:				
attached to this	Attached Previously submitted; no amendment or change				
application if it was not previously submitted by the applicant.	NOTE: If a change of operator has occurred and there was previously a lease between the owner of the facility and the prior operator, it is also necessary to submit a copy of the lease termination agreement.				
	MANAGEMENT COMPANY INFOR				
16. This refers to an	16. Is there an executed contract or agreement between the		management company?		
entity other than the	Yes No				
operator or administrator. If the operator has a	If yes, then a copy of the agreement or contract is:				
contract or agreement	Attached Previously submitted; no amendment or change				
manage the facility, then	with a separate entity to				
it is necessary to submit a copy of the contract or 17. Name of management company <i>(if applicable)</i>					
agreement.	Otract Address				
17. If the operator has a contract or agreement	Street Address				
with a separate entity to manage the facility, then					
it is necessary to indicate	City	State	ZIP Code		
the name and address of the management					
company.	Mailing Address				
	City	State	ZIP Code		
	Contact Name	Contact Telephone Number			

INSTRUCTIONS: 18. If the management company currently operates, owns, or manages any other long- term care facility in Missouri or in any other state, submit a list of such facility or facilities, including their addresses and type of license. 19. Every facility must	<ul> <li>18. If there is a management company, does the mana other long-term care facilities in Missouri or any oth</li> <li>Yes No</li> <li>If yes, then a list of the facilities is:</li> <li>Attached Previously submitted; no amend</li> </ul> ADMINISTRATOR AND DIRECTOR OF NUR 19. Name of the person in general administrative charg	ment o	e? r change INFORMATION	own, or manage any
have an individual designated to be in general administrative charge.	If the person is licensed as a Missouri Nursing Home Administrator, indicate the current license number:			icense number:
	Telephone Number	Fax N	Number	
	E-Mail Address	Emer	rgency Telephone Number	
20. If the person in general administrative charge of the facility is	20. Does the person in general administrative charge of the facility currently serve other facilities as administrator?			
serving in the same position with other facilities, indicate the	Name	City		Number of Beds
name and city and number of beds of each facility. Attach a separate	Name	City		Number of Beds
list to include all facilities, if necessary.	Name	City		Number of Beds
	<ul> <li>21. Is the person in general administrative charge of the facility currently employed in another position?</li> <li>Yes No</li> <li>If yes, submit a list of the other positions held.</li> <li>Attached Previously submitted; no amendment or change</li> <li>22. Name of Director of Nursing (if applicable)</li> </ul>			
	Telephone Number		Fax Number	
	E-Mail Address		Emergency Telephone Num	ber

#### **INSTRUCTIONS:**

All applicants must
submit financial
information
demonstrating that the
applicant has the
financial capacity to
operate a long-term care
facility.

If the financial information submitted (or information obtained during the term of the license) indicates an unstable or unsatisfactory financial condition. the Department shall have the right to request additional financial information.

The operator shall submit such information within ten (10) working days of receipt of the written request. Financial information may be submitted in the proper accounting format without the use of the forms provided by the Division.

24. An application for relicensure of a currently licensed facility may meet this requirement by submitting information indicated in any one of the options listed. All supporting schedules must also be submitted.

FINANCIAL INFORMATION

**NEW FACILITY OR CHANGE OF OPERATOR** 

23. Attach all THREE of the following:

- A recent Statement of Financial Position for the operator (or Statement of Financial Condition, if sole • proprietor). You may utilize form MO 580-2635 Statement of Financial Position - General or MO 580-2632 Statement of Financial Condition - Sole Proprietor, AND
- A forecasted income statement showing projected revenues and expenses for the operator's first twelve • (12) months of operation of the facility. You may utilize form MO 580-2636 Forecasted Income Statement, AND
- A detailed statement explaining the means by which expenses will be met during the period the license you are applying for will be in effect.

# RELICENSURE

24. Attach **ONE** of the following pieces of information:

- ☐ The form *MO 580-2633* <u>Relicensure Financial Information Statement</u> may be used or attach a similar document showing the actual figures for the operator's prior fiscal year; OR
- □ Title XIX Cost Report for the Operator's Prior Fiscal Year; (by marking this option, I authorize the MO Health Net Division to release to the Division of Regulation and Licensure all financial information contained in said cost report, including all tax forms submitted as part of that cost report.); OR
- Submit a notarized statement obtained within thirty (30) days of date of application from a bank or savings and loan institution indicating that the operator is in sound financial condition to operate a long-term care facility; OR
- Submit a copy of the Federal Income Tax Return for the prior fiscal year of the operator, including any amendments or changes to the form which are provided to the Internal Revenue Service, as follows:
  - SOLE PROPRIETORSHIP: Attach a completed copy of the enclosed statement of financial condition AND a copy of the operator's IRS Form 1040 Schedule C relating to the operation of the facility
  - GENERAL OR LIMITED PARTNERSHIP: Attach a copy of pages one and four\* of the operator's IRS Form 1065, and any supporting schedules to those pages
  - GENERAL BUSINESS CORPORATION: Attach a copy of pages one and four\* of IRS Form 1120 or 1120S, and any supporting schedules to those pages; or attach a copy of pages one and two\* of IRS Form 1120-A, and any supporting schedules to those pages;
  - NONPROFIT CORPORATION: Attach a copy of pages one, two, and three of IRS Form 990, and any supporting schedules to those pages; or pages one, three, and four of Form 990C, and any supporting schedules to those pages; or pages one and two of Form 990PF, and any supporting schedules to those pages.

\*or statement of financial position if information not contained in tax return.

	OTHER INFORMATION
	re any other buildings, wings or floors on the premises that are occupied by persons not considered by rator to be residents of this facility?
□ Yes	
-	attach a simple diagram and a statement disclosing who occupies the location, and the relationship of son(s) being excluded.
26. Are the	re any additional businesses operated on the facility premises?
☐ Yes	
	ttach a list indicating the name and nature of each business and a copy of the written approval by the nent of Health and Senior Services.

<b>INSTRUCTIONS:</b> 27. If the operator holds in trust personal funds of any resident, regardless of the amount of funds held or the length of time held, a nursing home bond or noncancelable escrow agreement is required, and must be submitted on the approved form. Submit form <i>MO 580</i> - 2624 <u>Nursing Home</u>	<ul> <li>27. Is the operator holding or handling personal funds of any resident(s)? (Facilities having contracts with the Department of Mental Health for placements are required by their Master Agreement to handle personal funds of a resident and should answer "Yes.")</li> <li>Yes No</li> <li>Yes, then the original nursing home surety bond or noncancelable escrow agreement is:</li> <li>Attached Previously submitted; no amendment or change</li> <li>NOTE: The ORIGINAL bond or noncancelable escrow agreement must be submitted to, and remain on file with, the Division. If a change of operator has occurred, it is also necessary to submit a residents' funds closeout report.</li> <li>28. Does this facility:</li> <li>a. provide care to any residents who have a diagnosis of mental retardation OR</li> <li>b. have a majority of residents (51% or more) with a diagnosis of mental illness?</li> </ul>
<u>Surety Bond</u> , or form MO 580-2628 <u>Noncancelable</u> <u>Escrow Agreement</u> , if the operator is holding or handling personal funds for any resident. The principal on the	Yes No If yes No If yes No If yes No If yes A No I
The principal on the bond form must be exactly the same as the operator of the facility shown on page two of the application. 31. The fee is based upon number of beds. Attach a money order, bank draft, or personal check payable to the Department of Health and Senior Services. This fee is nonrefundable unless the facility withdraws the application within ten (10) days of receipt by the Division.	<ul> <li>29. Is an Alzheimer's special care unit/program a part of this facility?</li> <li>Yes No</li> <li>If yes, attach the form <i>MO 580-2637 <u>Alzheimer's Special Care Services Disclosure</u> and a copy of your Alzheimer's program brochure with this application.</i></li> <li>30. The facility is required to comply with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975, and the Keyes Amendment to the Social Security Act. Attach the form <i>MO 580-2622 <u>Assurance of Compliance</u></i>.</li> <li>31. Each application for license must be accompanied by a licensure fee for each level of care as determined below:</li> </ul>

## AFFIDAVIT

I affirm that I as an individual, or that the operating entity for which I sign, have/has adequate financial resources to properly construct, equip, and operate the facility referred to in this application, and hereby authorize the Department of Health and Senior Services to obtain information from third parties verifying this.

I further affirm I am familiar with the requirements of the Omnibus Nursing Home Act as set out in Chapter 198 of the Missouri Revised Statutes and the regulations of the Division of Regulation and Licensure thereunder.

I further affirm that I understand the applicant is eligible for a license only if the facility and the operator are in substantial compliance with the law and the regulations thereunder, and that a license may be revoked at any time that the facility or the operator fail to comply substantially with such law and regulations.

I further affirm that all documents and information required by the Department of Health and Senior Services to be provided pursuant to this application are true and correct to the best of my knowledge and belief, that the statements contained in this application and any attached information are true and correct to the best of my knowledge and belief, and that all required documents are either included with the application or are currently on file with the Department of Health and Senior Services. I understand that if it is determined by the Department of Health and Senior Services that the statements contained herein are not true and correct, the application may be denied and any license issued based on the application may be revoked.

I further affirm that I have the express authority to sign this application on behalf of the operator.

My signature attests to the truth and accuracy of the foregoing affirmations.

AUTHORIZED SIGNATURE OF APPLICANT (OPERATOR)	DATE
PRINTED OR TYPED NAME	TELEPHONE NUMBER

TITLE OF SIGNATORY

### THE COMPLETED APPLICATION FORM MAY BE SUBMITTED BY MAIL OR ELECTRONICALLY

RETURN COMPLETED APPLICATION TO: DEPARTMENT OF HEALTH AND SENIOR SERVICES SECTION FOR LONG-TERM CARE REGULATION FEE RECEIPTS 920 WILDWOOD DRIVE P.O. BOX 570 JEFFERSON CITY, MO 65102 OR E-MAIL ADDRESS: LTCAPPLICATION@DHSS.MO.GOV

#### TO SUBMIT ELECTRONICALLY, SEND THE APPLICATION TO: <u>LTCAPPLICATION@DHSS.MO.GOV</u> THE APPLICATION FEE FOR LICENSURE PROCESSING MUST BE SUBMITTED BY MAIL PLEASE INDICATE THE FACILITY NAME ON THE CHECK OR MONEY ORDER

ALL FORMS MAY BE FOUND ON OUR WEBSITE: http://www.dhss.mo.gov/NursingHomes/AppsForms.html