

**LICENSE APPLICATION FOR NURSING HOME,
 FACILITY FOR THE DEVELOPMENTALLY DISABLED,
 OR INSTITUTE FOR MENTAL DISEASE**

FOR OFFICE USE ONLY
License Number
License Fee
Caregiver Background Fee
License Type
Effective Date
Expiration Date

Type of Facility
<input type="checkbox"/> Nursing Home
<input type="checkbox"/> Facility for the Developmentally Disabled
<input type="checkbox"/> Institute for Mental Disease

Type of Application
<input type="checkbox"/> Initial
<input type="checkbox"/> Change of Ownership
<input type="checkbox"/> Replacement Facility

Completion of this form is required by Chapter 50.50.03(3)(b), Wis. Stats., and HFS 132.14(2) and HFS 134.14(1), Wis. Admin. Code. The department will not issue a license until the applicant has supplied all requested information. The personally identifiable information collected on this form will be used to determine licensure eligibility and for statistical information and for no other purpose.

RETURN THE COMPLETED APPLICATION TO: Division of Quality Assurance
 Bureau of Technology, Licensing and Education
 P.O. Box 2969
 Madison, WI 53701-2969

I. GENERAL INFORMATION

Name – Facility			
Previous Name (if applicable)			
Street (physical) Address			
City	County	State	Zip Code
Mailing Address (if different from physical address)			
City		State	Zip Code
Telephone Number	FAX Number	E-mail Address	

Level of License

<p>HFS 132</p> <input type="checkbox"/> A. Skilled Care – Nursing Home <input type="checkbox"/> B. Intermediate Care – Nursing Home <input type="checkbox"/> C. Skilled Care – Institute for Mental Disease (IMD) <input type="checkbox"/> D. Intermediate Care – Inst. for Mental Disease (IMD)	<p>HFS 134</p> <input type="checkbox"/> E. Facility for the Developmentally Disabled
Licensed Bed Capacity	Fiscal Year End Date

Type of Certification

- Medicare (Title XVIII)
 Distinct Part
 Fully Participating
 State Licensed only (no certification)
 Medicaid (Title XIX)
 Medicare and Medicaid (Dual Certification)

II. ADMINISTRATION

A. Administrator

Status:

- Permanent
 Acting (temporary and unlicensed)
 Interim (temporary and licensed)
 QMRP (only if facility is licensed as an FDD for 16 or fewer beds)

Name – Administrator	License Number	Begin Date
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Indicate if the administrator is also the **designee** (person authorized to accept personal service and receive registered and certified mail.) If “No,” complete the Designee section. Yes No

B. Designee

Name – Designee	Title	Begin Date
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C. Director of Nursing

Name – Director of Nursing	Status <input type="checkbox"/> Permanent <input type="checkbox"/> Acting (temporary)	Begin Date
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D. Medical Director

Name – Medical Director	Begin Date
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III. OWNERSHIP INFORMATION

A. Applicant / Licensee [person(s) or business entity having the authority to direct the management or policies of the facility]

Name – Applicant

Street (physical) Address

City	State	Zip Code	County
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Mailing Address (if different from physical address)

City	State	Zip Code	County
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Telephone Number	Fax Number	E-mail Address
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Contact Person	Telephone Number
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B. Type of Organization (Check type of ownership.)

Governmental	Proprietary	Voluntary Non-Profit
<input type="checkbox"/> City	<input type="checkbox"/> Sole Proprietary	<input type="checkbox"/> Corporation
<input type="checkbox"/> County	<input type="checkbox"/> Partnership	<input type="checkbox"/> Church
<input type="checkbox"/> State	<input type="checkbox"/> Corporation	<input type="checkbox"/> Association
<input type="checkbox"/> Federal	<input type="checkbox"/> Limited Liability Company	<input type="checkbox"/> Church / Corporation
<input type="checkbox"/> City / County	<input type="checkbox"/> Limited Liability Partnership	<input type="checkbox"/> Private Non-Profit
<input type="checkbox"/> Tribal	<input type="checkbox"/> Trust	<input type="checkbox"/> Limited Liability Company
		<input type="checkbox"/> Limited Liability Partnership
		<input type="checkbox"/> Trust

C. Interested Parties

List all names, principal business addresses, and the percentage of ownership interest of all officers, directors, stockholders owning 5% or more of stock, members, partners, and all other persons having authority or responsibility for the operation of the organization. For non-profit organizations or governmental organizations, list the names and principal business address of all officers, directors, and board members. Attach additional pages if necessary.

Name	Title	Ownership Percentage	
Street		City	State Zip Code
Name	Title	Ownership Percentage	
Street		City	State Zip Code
Name	Title	Ownership Percentage	
Address		City	State Zip Code
Name	Title	Ownership Percentage	
Address		City	State Zip Code
Name	Title	Ownership Percentage	
Address		City	State Zip Code
Name	Title	Ownership Percentage	
Street		City	State Zip Code
Name	Title	Ownership Percentage	
Address		City	State Zip Code

D. Ownership The licensee owns the:

- Operation Yes No
- Building Yes No
- Land Yes No

NOTE: If the licensee is **not the owner of the operation, building, or land**, complete the following section or sections as appropriate.

D1. Owner of the: **Operation** **Building** **Land**

Name – Owner of the Operation or Operation, Building, and Land

Street (physical) Address

City	State	Zip Code	County
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Mailing Address (if different from physical address)

City	State	Zip Code	County
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Telephone Number	Fax Number	E-mail Address
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Contact Person	Telephone Number
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Type of Organization (Check type of ownership.)

Governmental	Proprietary	Voluntary Non-Profit
<input type="checkbox"/> City <input type="checkbox"/> County <input type="checkbox"/> State <input type="checkbox"/> Federal <input type="checkbox"/> City / County <input type="checkbox"/> Tribal	<input type="checkbox"/> Sole Proprietary <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Limited Liability Company <input type="checkbox"/> Limited Liability Partnership <input type="checkbox"/> Trust	<input type="checkbox"/> Corporation <input type="checkbox"/> Church <input type="checkbox"/> Association <input type="checkbox"/> Church / Corporation <input type="checkbox"/> Private Non-Profit <input type="checkbox"/> Limited Liability Company <input type="checkbox"/> Limited Liability Partnership <input type="checkbox"/> Trust

Interested Parties

List all names, principal business addresses, and the percentage of ownership interest of all officers, directors, stockholders owning 5% or more of stock, members, partners, and all other persons having authority or responsibility for the operation of the organization. For non-profit organizations or governmental organizations, list the names and principal business address of all officers, directors, and board members. Attach additional pages if necessary.

Name	Title	Ownership Percentage	
Address		City	State Zip Code
Name		Title	
Address		City	State Zip Code

D2. Owner of the: Building Land

Name – Owner of the Building or Building and Land

Street (physical) Address

City	State	Zip Code	County
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Mailing Address (if different from physical address)

City	State	Zip Code	County
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Telephone Number	Fax Number	E-mail Address
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Contact Person	Telephone Number
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Interested Parties

List all names, principal business addresses, and the percentage of ownership interest of all officers, directors, stockholders owning 5% or more of stock, members, partners, and all other persons having authority or responsibility for the operation of the organization. For non-profit organizations or governmental organizations, list the names and principal business address of all officers, directors, and board members. Attach additional pages if necessary.

Name	Title	Ownership Percentage	
Street		City	State Zip Code
Name		Title	
Street		City	State Zip Code

D3. Owner of the: Land

Name – Owner of the Land

Street (physical) Address

City	State	Zip Code	County
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Mailing Address (if different from physical address)

City	State	Zip Code	County
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Telephone Number	Fax Number	E-mail Address
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Contact Person	Telephone Number
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Interested Parties

List all names, principal business addresses and the percentage of ownership interest of all officers, directors, stockholders owning 5% or more of stock, members, partners, and all other persons having authority or responsibility for the operation of the organization. For non-profit organizations or governmental organizations, list the names and principal business address of all officers, directors and board members. Attach additional pages if necessary.

Name	Title	Ownership Percentage
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Street	City	State	Zip Code
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Name	Title	Ownership Percentage
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Street	City	State	Zip Code
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D4. Subsidiary / Parent Information

a. Is the applicant a subsidiary company, either wholly or partially owned by another organization or business?

Yes No

If "Yes," provide the following information:

Legal Business Name – Parent Company

DBA (Doing Business As)

Type of Ownership

Address	City	State	Zip Code
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Contact Person	Telephone Number
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b. Is the applicant affiliated with any subsidiaries in the health care field in this state or any other state?

Yes No

If "Yes," provide one of the following:

- Names and addresses of all subsidiaries owned by the parent company, in this state or any other state, (relationship type: nursing homes, home health agencies, hospices, hospitals, rehabilitation facilities, etc.)
- Organizational chart exhibiting the legal business names and, if applicable, the dba name of all the subsidiaries currently owned by the parent company in the health care field in this state or any other state, (relationship type: nursing homes, home health agencies, hospices, hospitals, rehabilitation facilities, etc.)
- Complete annual report to shareholders.

D5. Chain Organization

Is the applicant under the control of a chain organization? Yes No

Chain organization is defined as multiple providers, and / or suppliers owned, leased, or through any other devices, **controlled** by a **single business entity** (defined as chain home office.) Each entity in the chain may have a different owner but the “home office” maintains **uniform procedures** in each facility for handling utilization review, reimbursement, handling admissions, also maintains and controls centrally, provider/suppliers cost reports, etc.

In addition, a chain facility would not necessarily be a subsidiary of the parent corporation but the chain facility or facilities could be owned by different subsidiaries of the same corporate parent.

Name – Chain Organization

If the applicant/licensee is a Limited Liability Company (LLC) or Limited Liability Partnership (LLP):

- Provide the names and addresses of all LLC's, LLP's or any other type of entity that any of the member(s) of the applicant are also members, officers, directors and/or board members.
- Provide an organizational chart exhibiting the legal business names of any and all subsidiaries, LLC's, LLP's involved with this applicant and its members.

IV. FIT AND QUALIFIED

The following information will be used to determine if the applicant meets the fit and qualified requirements under Chapter 50, Wis. Stats.:

A. Has the applicant, any of the interested parties and/or any of the members of a LLC / LLP, been affiliated in the past five years with a hospice (HSP), a home health agency (HHA), a residential care facility, e.g., Community Based Residential Facility (CBRF), Adult Family Home (AFH), or a health care facility (HCF), e.g., hospital, nursing home or facility for the developmentally disabled in the State of Wisconsin or in any other state?

Yes No

IF THE ANSWER IS “YES,” complete all information in the section below. Use the facility abbreviations (in parenthesis) from above to identify the type of facility.

IF THE ANSWER IS “NO,” complete questions A – I.

Facility Name and Address	City and State	Type of Health Care Provider	Owner / Operator / Mgr. Vendor / Provider No.	Dates of Affiliation

B. Has any adverse action initiated by any state licensing agency resulted in the denial (D), suspension (S), or revocation (R) of a license?

Yes No

If “Yes,” complete the following table. Use abbreviations to describe the type of adverse action and refer to the previous page for abbreviations for type of health care provider.

Facility Name and Address	City and State	Type of Health Care Provider	Type of Adverse Action	Effective Dates of Adverse Action

C. Has any adverse action initiated by a state or federal agency based on non-compliance resulted in civil money penalties (CMP), termination of provider agreement (TPA), suspension of payments (SOP), or the appointment of temporary management of the facility (TMF)?

Yes No

If "Yes," complete the following table. Use abbreviations to describe the type of adverse action and refer to the previous page for abbreviations for type of health care provider.

Facility Name and Address	Location of State	Federal or State	Type of Health Care Provider	Type of Adverse Action	Effective Dates of Adverse Action

D. Has the applicant, any of the interested parties and/or any of the members of a LLC / LLP, ever had a denial, suspension, enjoining or revocation of a health care provider license, in this state or any other state, as defined in Chapter 146.81, Wis. Stats., or any conviction for providing health care without a license?

Yes No

If "Yes," explain.

E. Has the applicant, any of the interested parties and/or any of the members of a LLC / LLP, ever been convicted of a crime involving neglect or abuse of patients, or involved in assaultive behavior, wanton disregard for the health and safety of others, or any act of elder abuse under Chapter 46.90, Wis. Stats.

Yes No

If "Yes," explain.

F. Has the applicant, any of the interested parties and/or any of the members of a LLC / LLP, ever been convicted of a crime related to the delivery of health care services or items?

Yes No

If "Yes," explain.

G. Has the applicant, any of the interested parties and/or any of the members of a LLC / LLP, ever been convicted of a crime involving controlled substances under Chapter 161, Wis. Stats.?

Yes No

If "Yes," explain.

H. Has the applicant, any of the interested parties, and/or any of the members of a LLC / LLP had any prior circumstances that resulted in bankruptcy or in the closing of a hospice, home health agency, or an inpatient health care facility, e.g., nursing home or hospital, or the relocation of its patients or residents?

Yes No

If "Yes," explain.

I. Identify the other types of providers owned by the applicant / licensee.

If more than two, check here and attach additional pages.

Name – Provider

City	State	Zip Code
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Relationship Type (nursing home, home health agency, community based residential facility, hospital, hospice)

Name – Provider

City	State	Zip Code
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Relationship Type (nursing home, home health agency, community based residential facility, hospital)

V. FINANCIAL RESPONSIBILITY

The questions in this section are to be answered **ONLY** by the applicant / licensee.

- A. Has the applicant / licensee, any of the interested parties and/or any of the members of a LLC / LLP, been adjudicated bankrupt?

Yes No

If "Yes," explain on a separate page. Provide the dates, court, and disposition of each action.

- B. Are there any unsatisfied judgements against the applicant / licensee, any of the interested parties and/or any of the members of a LLC / LLP?

Yes No

If "Yes," explain on a separate page. Provide the names and addresses of creditors, amounts, and the reasons for non-payment.

- C. Does the applicant / licensee, any of the interested parties and/or any of the members of a LLC / LLP, owe any debts that are 90 days past due?

Yes No

If "Yes," explain on a separate page. Provide the names and addresses of creditors, amounts, and reasons for non-payment.

- D. Are there any liens filed against the applicant / licensee, any of the interested parties and/or any of the members of a LLC / LLP, or their property?

Yes No

If "Yes," explain on a separate page.

- E. Estimated average gross annual revenues from all sources. Round to the nearest thousand dollars.

Daily Rate: Title XIX	\$
Private Pay	\$
Other	\$
Other Revenues	\$
TOTAL	\$

- F. Estimated annual costs. Round to the nearest thousand dollars.

Operating Expenses	\$
Capital Outlays	\$
TOTAL	\$

G. HFS 132.14(3)(a)4(c), Wis. Admin. Code, **requires** the applicant to have sufficient financial resources to permit operation of the facility for six (6) months. This amount is one-half of the figure shown in your answer to question F. (estimated annual costs). **NOTE:** Daily rate charges are automatically taken into consideration.

- Complete the following HCF projected financial statement forms F-01022 A - E, located in the DHS Forms Library at <http://dhs.wisconsin.gov/forms/DHCFnum.asp>

- F-01022 A Instructions for Projected Financial Statements
- F-01022 B Projected Income Statement
- F-01022 C Projected Cash Flow
- F-01022 D Related Party Transactions
- F-01022 E Projected Balance Sheet

- Include the following information (if applicable):
 1. Certified statement of line of credit; or
 2. Personal financial statement along with a signed affidavit committing personal resources or a copy of the corporation's annual report along with a signed affidavit committing corporate resources; or
 3. Other financial documentation to support sufficient resources to cover operating losses.

H. Do you have any other commitments to transfer residents from other facility closings or phasedowns?

Yes No

If "Yes," explain on a separate page.

I. Provide projected patient days, by month and by type of payer, for the first six months of operation.

J. Provide the following, if applicable.

- Explain large variances in the projected revenues and/or expenses from those of the current operator's latest cost report.
- Explain changes in occupancy rate or mix from those of the current owner's latest cost report.
- Provide proof of commitment of mortgages when the purchase of the real estate is involved in the change of ownership.
- Evidence of commitment of a working capital loan and/or a line of credit from the financial institution providing financing.

VI. APPLICANT / LICENSEE

If the applicant/licensee has never been licensed to operate a nursing home in Wisconsin, we request that you respond to the following:

1. Provide resumes for each officer (if the applicant is a corporation), or each partner (if partnership) or member (if limited liability company), etc. to assist the Department in determining the applicant's ability to operate a long term care facility.
2. Is your licensed Nursing Home Administrator (NHA) in good standing in Wisconsin? What nursing facilities has this individual directed and what time periods and bed size? What accomplishments has the NHA achieved?

VII. MANAGEMENT COMPANY

A. Is the operation of the facility under a management contract?

Yes No

If "yes," provide the following information regarding any management company retained to operate this facility or program.

Type of Management Company: Corporation Partnership LLC Other _____

Name - Management Company

Name - Contact Person

Telephone Number

Address

City

State

Zip Code

B. Identify officers, directors, trustees or supervisors of the management company. Attach additional pages if necessary.

Name		Title	
Address	City	State	Zip Code
Name		Title	
Address	City	State	Zip Code

C. Identify other facilities the management company has owned, operated or managed in the last 5 years. Attach additional pages if necessary.

Name			
Address	City	State	Zip Code
Dates of Involvement			

Name			
Address	City	State	Zip Code
Dates of Involvement			

Name			
Address	City	State	Zip Code
Dates of Involvement			

D. While managing any of the above facilities identified in item C.:

1. Has any adverse action initiated by any state licensing agency resulted in the denial (D), suspension (S), or revocation (R) of a license?

Yes No

If "Yes," complete the following table. Use abbreviations to describe the type of adverse action and refer to page 6 for abbreviations for type of health care provider.

Facility Name and Address	City and State	Type of Health Care Provider	Type of Adverse Action	Effective Dates of Adverse Action

2. Has any adverse action been initiated by a state or federal agency based on non-compliance resulted in civil money penalties (CMP), termination of provider agreement (TPA), suspension of payments (SOP), or the appointment of temporary management of the facility (TMF)?

Yes No

If "Yes," complete the following table. Use abbreviations to describe the type of adverse action and refer to page 6 for abbreviations for type of health care provider.

Facility Name and Address	City and State	Type of Health Care Provider	Type of Adverse Action	Effective Dates of Adverse Action

- E. If there is a management company involved, how will you monitor the success of this management company in complying with HFS 132, Wisconsin Administrative Code, and CFR (Code of Federal Regulation)? Provide resumes for each individual of the management company who will exercise operational or managerial control in the long term care facility.

- F. Attach a copy of the signed contract with the management company.

VII. CONTACT PERSON

Identify the person responsible for completing this application and who can be contacted if we have questions.

Name		Title	
Telephone Number	FAX Number	Date Application Completed	

VIII. ATTESTATION

I attest, under penalty of law, that the information provided above is truthful and accurate to the best of my knowledge and that knowingly providing false information or omitting information may result in a fine of up to \$10,000 or imprisonment not to exceed 6 years, or both (per Chapter 946.32, Wis. Stats.).

SIGNATURE (FULL) – Applicant (Potential Licensee)	Name - Applicant's (Print or type.)	
Title – Applicant	Date Signed	

NOTE: The Management Company cannot attest to or sign on behalf of the applicant (potential licensee).