



AMBULATORY SURGICAL TREATMENT CENTER CHANGE OF OWNERSHIP PROCEDURES

1. Submit a notarized application along with the appropriate fee and a letter of intent 60 days prior to the anticipated Change of Ownership (CHOW) to the address at the bottom of the application. The letter of intent should include the name of the facility, the name of the seller/lessee of the facility, acknowledgement by the seller/lessee authorizing the sale or lease of the facility's operations and the projected date of the CHOW. Submission of a CHOW application indicates the acquisition and sale/lease of the entire facility operations including the associated license.
2. A letter will be sent acknowledging receipt of the application, fee and notice of intent. 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, including lease of operations agreements, that indicate that you are now the owner or lessee of the facility to:

Health Facilities Commission
Andrew Jackson Building
502 Deaderick Street, 9th Floor
Nashville, Tennessee 37243

3. This office will notify the regional office in your area to request their recommendation for the intended CHOW. The regional office will review the facility file to determine when the last annual survey was conducted with no outstanding deficiencies, and secondly to determine survey performance history including both scheduled and complaint surveys. If the most current annual survey and the facility's survey history including complaint surveys is satisfactory, a form recommending approval of the CHOW will be submitted to the central office in Nashville. If any complaint(s) rises to the level of a detriment to the health, safety, and welfare of the residents of the facility has been reported then; an on-site survey of the facility will be conducted. The regional office **will not** recommend approval of the CHOW, until an on-site survey is conducted with substantial compliance and/or deficiencies from either this on-site survey or a previous survey is corrected. The applicant/buyer will be notified by the central office if an on-site survey is necessary.
4. Once the recommendation is received in the central office from the regional office, a letter will be forwarded to you initially approving the CHOW pending the completion and submission of the final bill of sale (closing document(s)). The effective date of the CHOW will be the date of the closing document(s) is signed and dated by the seller/buyer or lessee; or the date regional office recommends approval of the CHOW, if occurring after the closing date. The application will then be presented to the Commission at the next regularly scheduled Commission meeting for ratification. If the Commission ratifies the approval of the CHOW the license number listed above will become your permanent license number and a letter will be forwarded to you within three (3) working days notifying you of the Commission's final decision. You should receive your wall license within seven (7) to ten (10) business days thereafter.
5. If the Commission does not ratify the initial approval of the CHOW, that initial authorization shall cease to be effective. A letter will be mailed to you providing an explanation and specific instructions as to any action you may take to have the decision reviewed.

All applicable laws, rule, policies, and guidelines affecting your practice are available for viewing at <https://www.tn.gov/hfc/division-of-licensure-and-regulation/hfc-licensure/licensure-applications.html>. Please check this website periodically for updates.



**AMBULATORY SURGICAL TREATMENT CENTER
APPLICATION FOR CHANGE OF OWNERSHIP**

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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 _____

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) \$1,404

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

General Hospital _____ Maternity _____ Gynecological _____ Dental _____ Other (specify) _____
Abortion _____ Plastic Surgery _____ Ophthalmological _____ Acupuncture _____
EENT _____ Urological _____ Gastroenterology _____ Cancer Treatment _____

2. a. List the number of Magnetic Resonance Imaging (MRI) machines & Positron Emission Tomography (PET) units utilized in your facility.

MRI machines _____ PET units _____

b. If MRI &/or PET machines/units are utilized, does your facility hold accreditation by a nationally recognized & CMS approved accrediting organization per machine, unit, and/or diagnostic type? If so, provide proof of accreditation.

Yes _____ No _____ Expiration Date _____

3. Briefly state the overall objective of the surgical treatment center: _____

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 (____) _____

Street _____

City _____ State _____ Zip _____

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)

e. If a government/county owned facility, does the administrator have authority to act on behalf of the government/county as it relates to the operation of this facility? Yes _____ No _____

f. If no to e., who has said authority? _____

2. a. Is the ambulatory surgical treatment center a hospital-based ambulatory surgical treatment center?
Yes _____ No _____
- b. Is the ambulatory surgical treatment center a non-hospital ambulatory surgical treatment center?
Yes _____ No _____
3. a. In accordance with Rule 0720-20-.02, is this CHOW a lease of operation? Yes _____ No _____
- b. If yes, please provide the lessor's information below:
Name _____ Phone Number (_____) _____
Address _____
4. a. Is your facility/organization accredited by a **federally approved** accrediting body including but not limited to JCAHO, CARF, etc? **Provide proof of accreditation.**
Yes _____ No _____ Expiration Date _____
5. Is this facility chain affiliated? Yes _____ No _____
6. If you have a parent company, please provide the following information:
Name _____ Phone Number (_____) _____
Address _____
7. a. If a corporation is there a holding company? Yes _____ No _____
- b. If yes, list the name, address, and phone number of the holding company:
Name _____ Phone Number (_____) _____
Street _____
City _____ State _____ Zip _____
8. 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. *(If additional space is needed, please use a separate sheet)*

9. 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 _____

10. For any item in (9) a-h below, please identify, explain and provide documentation of the item(s) noted if response is "Yes". Have either the licensed entity for any of the other health care facilities in Tennessee and/or other states on the list in question (8.b.), above, OR the management firm listed in question (9.) above; been subjected to any of the following within the last (5) years:

a. **Licensure**

- i) Denied a license? Yes_____No_____
- ii) Had a license suspended or revoked by any state licensure agency? Yes_____No_____
- iii) Been subject to a final order or judgment in a state licensure action? Yes_____No_____

b. **Convictions**

- i) Convicted of a criminal offense related to that person's involvement in any program under any state or Federal health care program (including Medicare, Medicaid, and Tricare)?
Yes_____No_____

c. **Exclusion**

- i) Excluded from participation in Federal health care programs (Medicare, Medicaid, CHIP, or Tricare) in the past? Yes_____No_____

(Note: "Excluded" is defined as a provider or entity has been told by the Department of Health and Human Services, Office Of the Inspector General (HHS-OIG) that they may no longer be a provider for any federally funded healthcare program).

d. **Termination/Suspension**

- i) Suspended or terminated from participation in Medicare or Medicaid/TennCare programs?
Yes_____No_____

(Note: This would include involuntary termination of a nursing facility or skilled nursing facility by the Centers for Medicare and Medicaid Services (CMS) or state Medicaid agency).

e. **Fraud and Abuse**

- i) Paid through settlement, or civil or criminal fines, any monies to the federal government or any state as a result of any administrative or judicial proceeding based on allegations of fraud or abuse involving claims related to the provision of health care items and services? Yes_____No_____

f. **Corporate Integrity Agreement**

- i) Is presently an entity covered by and subject the terms of a corporate integrity agreement?
(Note: If yes, provide a copy of CIA) Yes_____No_____

g. **Bankruptcy**

- i) Filed bankruptcy under any provision of the United States Bankruptcy Code? Yes_____No_____

h. **Civil Monetary Penalty (CMP)**

- i) Paid to the Centers for Medicare and Medicaid Services or any state Medicaid agency a civil money penalty equal to or greater than \$250,000.00 as a result of an enforcement action during a survey?

