NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH SERVICE REGULATION
NURSING HOME LICENSURE AND CERTIFICATION SECTION
2711 MAIL SERVICE CENTER RALEIGH, NORTH CAROLINA 27699-2711 TELEPHONE: (919) 855-4520

2025

NURSING HOME APPLICATION - CHANGE OF OWNERSHIP
(Including Adult Care Home Beds in Combination Facilities)

LEGAL IDENTITY OF APPLICANT:

_____
(Full legal name of corporation, partnership, individual, or other legal entity owning the enterprise or service.)

DOING BUSINESS AS (d/b/a) - names under which the facility or services are advertised or presented to the public:

PRIMARY: _____

Other: _____

If the above names are **NOT IDENTICAL** to the names on the current license, please check reason for the change:

___ Change of Ownership/Licensee ____ Facility Name Change ____ Other (Specify):

NC NH LICENSE NUMBER: _____ **CMS CERTIFICATION NUMBER (CCN):** _____

NPI NUMBER: _____

FACILITY MAILING ADDRESS:

Street/P O Box: _____

City: _____ State: _____ Zip: _____- _____

FACILITY SITE ADDRESS:

Street: _____

City: _____ State: _____ Zip: _____- _____

County: _____

Telephone: _____ Fax: _____

PART A OWNERSHIP AND MANAGEMENT DISCLOSURE

1. The following information is required by Nursing Home Licensure Rule 10A NCAC 13D .2101.

   a. What is the name of the **LEGAL ENTITY** with the ownership responsibility and liability? If it is a Corporation, please write the exact wording of the corporate office name and address as on file with the NC Secretary of State. If the legal entity is a Unit of government, please write the name of the unit which has ownership responsibility and liability for the services offered.

      NAME: _____

   b. Mailing Address (***as reported tp NC Secretary of State)***: _____

      City: _____ State: _____ Zip: _____

      Telephone: _____ Fax: _____

      Senior Officer/Title: _____ Email: _____

   c. Indicate the Percent of Ownership of the Legal Identity: _____

   d. Is legal entity: (check one)

      For Profit _____ Not for Profit _____

   e. Is the legal entity a: (check 1, 2, 3 or 4)

      (1) PROPRIETOR ____

      (2) LIMITED LIABILITY CORPORATION _____

      (3) PARTNERSHIP ____

         (a) General _____ If General, where is it registered? County _____ State _____

         (b) Limited _____If Limited, where is it registered? State _____

         (c) Is the limited partnership registered with the North Carolina Corporations Division in the NC Department of the Secretary of State?
         YES _____ NO _____

         (d) List the names and addresses of ALL persons who have a 5% financial interest or more and the names of all officers:

         Name: _____ Title: _____

         Address: _____ Percent of Ownership: _____

         Name: _____ Title: _____

         Address: _____ Percent of Ownership: _____

Name: _____ Title: _____

Address: _____ Percent of Ownership: _____

(4) CORPORATION ___

(a) Where was the corporation originally established? State _____

(b) List the names and addresses of ALL persons who have a 5% financial interest or more and the names of all officers:

Name: _____ Title: _____

Address: _____ Percent of Ownership: _____

Name: _____ Title: _____

Address: _____ Percent of Ownership: _____

Name: _____ Title: _____

Address: _____ Percent of Ownership: _____

(5) UNIT OF GOVERNMENT

(a) What is the name and title of the official in charge of the above governmental unit?

Name: _____

Title: _____

(b) Check the word which best describes the above type of governmental unit:

CITY ____ COUNTY _____ STATE _____ AUTHORITY ____

2. Does the licensee (legal entity: individual, partnership, corporation, or unit) own the building from which services are offered? **YES** _____ **NO** _____

If **NO**, who owns the building?

Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____ Email: _____

Note: If neither the building owner nor the lessee is shown as the license applicant, explain on a separate page.

3. Is this facility part of a multiple facility system **within North Carolina?** (A multiple facility system is defined as two or more nursing homes or health care facilities under the same ownership.) **YES** _____ **NO** _____

If "YES", give the name and address of the multiple facility system and name of senior officer for said organization.

Parent Company Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

Senior Officer/Title: _____ Email: _____

4. Does the facility operate under a management contract? **YES** _____ **NO** _____

If "YES", give the name and address of the organization that manages the facility and name of senior officer for said organization.

Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

Senior Officer/Title: _____ Email: _____

PART B OPERATIONS

PROVIDE NAMES FOR THE FOLLOWING:

1. FACILITY PERSONNEL
   a. Full-time administrator as required in 10A NCAC 13D .2201(c).

   Name of Administrator _____
   (Full First, Middle Initial, Last Name)
   Email: _____ Date Hired: _____ NC License No.: _____

   b. Name of Director of Nursing _____
   (Full First, Middle Initial, Last Name)
   Date Hired: _____ NC License No.: _____

   c. Name of Medical Director _____
   (Full First, Middle Initial, Last Name)

   Email: _____ Date Hired: _____ NC License No.: _____

PART C PATIENT SERVICES

1. Continuing Care Retirement Communities (CCRC)
   a. Is the facility licensed by the Department of Insurance as a "Continuing Care Retirement Community"?

   YES _____ **NO** _____

   If yes, submit Department of Insurance approval of the change of ownership.

2. Is the facility a Combination Facility, thereby incorporating ACH beds? _____

If **YES**, indicate which rules the facility chooses to apply to the operation of the ACH beds (NH rules, ACH rules or both NH & ACH).

_____NH Licensure Rules _____ACH Licensure Rules _____NH & ACH Licensure Rules

3. **NUMBER OF BEDS BY TYPE (*Must complete required data supplement form)**

a. **Nursing Beds (NF)** **(TOTAL)** a. _____

1. General Nursing Facility Beds 1. _____
Alzheimer's Special Care Unit Resident Beds 2. _____
3. Ventilator Dependent Resident Beds 3. _____
4. Traumatic Brain Injury Beds 4. _____
Are you equipped to accommodate bariatric residents? Y ___ N ____

b. **Adult Care Home (ACH)** **(TOTAL)** b. _____

1. General Adult Care Home Beds 1. _____
2. *Alzheimer's Special Care Unit Resident Beds 2.*_____
Are you equipped to accommodate bariatric residents? Y ___ N ____

c. **TOTAL LICENSED BEDS** **(TOTAL a & b)** c. _____

PART D LICENSE FEE - A non-refundable license fee is required and must accompany this application prior to the issuance of a nursing home license. The payment should be in the form of check, certified check or money order and must be made payable to: "**The Division of Health Service Regulation**." A separate check is required for each licensed entity.

Pursuant to §131E-102(b), effective August 14, 2009, annual license fees will be $420.00 (base fee) plus $17.50 per bed. CCRC facility type annual license fees will be $450.00 (base fee) plus $12.50 per bed. Fees for change of ownership licensure effective during the months of October – December will be credited to the license renewal fee.

This application must be completed and submitted to the Nursing Home Licensure and Certification Section, Division of Health Service Regulation, with the license fee, prior to the issuance of a nursing home license. The legislation (SB 622, Session Law 2005-276) prohibits a license from being issued if the fee has not been paid.

The undersigned submits this application for licensure for the year 2025 (subject to the provisions of the Nursing Home Licensure Act, Article 6, Chapter 131E of the General Statutes of North Carolina and to the rules adopted thereunder by the North Carolina Medical Care Commission) and certifies the accuracy of this information.

_____
Authorized Agent Name & Title (print)

_____ _____
Authorized Agent (signature) Date