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Indiana Medicaid Long Term Care Rate Setting

**CHECKLIST OF MANAGEMENT'S REPRESENTATIONS
CONCERNING CHANGE IN OWNERSHIP**

Date of This Request: _____

Name of Facility: _____

AIM Number: _____

We have received notification that the above facility may have undergone a change in ownership. This could be the result of a sale, lease or other transaction. The information requested by this checklist of management's representations is required under 42 CFR 455.100 and under the rate setting Criteria 405 IAC 1 - 14.6 for Nursing Facilities or 405 IAC 1-12 for Non-State Owned Intermediate Care Facilities for the Mentally Retarded and Community Residential Facilities for the Developmentally Disabled. This checklist of management's representations must be completed in its entirety and submitted to the rate setting contractor at the address above. Based on the responses represented and a review of documentation attached, a determination will be made by the Family and Social Services Administration as to the effect, if any, the transaction in question shall have on reimbursement rates.

Unless otherwise noted, terms used in this request that are not defined in the applicable Criteria take on their customary meaning as used in generally accepted accounting principles (GAAP). The use of the singular form of a term also includes the plural form of the term.

This request is a series of questions that will establish, through management representations, the facts and circumstances surrounding the transaction or transactions in question. Some of the questions require that supporting documentation be attached. Except where it is appropriate to attach a copy of an actual document, it is expected that documentation will take the form of brief explanations and summaries, similar in scope to disclosures required on audited financial statements. Please briefly identify the attachment (e.g., Summary of Transactions, Sales Contract, Letter of Understanding, etc.) in the space provided and write the question number to which the attachment pertains at the top of the first page of the attachment. If an attachment pertains to more than one question, list all question numbers to which it pertains at the top of the front page of the document. If no space is provided for a description of attachments, no documentation is expected.

The completion of this questionnaire does not preclude a request for further information or documentation, from either the rate setting contractor or the Family and Social Services Administration.

GENERAL PROVIDER INFORMATION

Physical Address of the facility in question: _____

Mailing Address of the facility in question: _____
(If different from physical address above)

TYPE OF CONTROL: (Check One)

Proprietary For Profit

- [11] Individual
- [12] Partnership
- [13] C Corporation
- [14] S Corporation
- [15] Other (specify)

Voluntary Non-Profit

- [21] Church
- [22] Other (specify)

Government

- [31] State
- [32] County
- [33] City
- [34] Other (specify)

Fiscal Year End for Tax Reporting Purposes: _____

Federal Identification Number: _____

CHECKLIST

**MANAGEMENT'S
REPRESENTATION**
YES **NO**

**RATE SETTING
CONTRACTOR USE ONLY**
BY **NOTES**

1. Have you attached a brief summary that describes, in all material respects, the transaction that is the subject of this inquiry?

Description of Attachment: _____

YES NO

2. Have you attached all relevant agreements, contracts, correspondence and legal documentation that reveal in all material respects and have a bearing on the transaction in question?

Description of Attachment: _____

YES NO

3. Have you attached a schedule which completely discloses the ownership or leasehold interest of the physical property and stockholder or other residual financial interest from the date of this request back to the transaction immediately preceding the transaction in question which involved a bona fide sale or lease of the physical property between arms length, unrelated parties in which the seller, lessor or previous lessee severed all ownership interest?

(Typically, this is a complete disclosure of ownership back to the purchase or lease by the seller or lessee.)

Description of Attachment: _____

YES NO

4. Have you attached a listing of all parties that assume or are reasonably expected to assume any or the following roles during any of the time period from one year before to one year after the date of the transaction in question: Owner, Lessor, Lessee, Provider or Management including the names of all individuals of authority involved? (Typically, this involves two listings of the relevant parties and dates, one marked "Before" the transaction and another marked "After" the transaction.)

Description of Attachment: _____

YES NO

CHECKLIST

**MANAGEMENT'S
REPRESENTATION**

**RATE SETTING
CONTRACTOR USE ONLY**

YES

NO

BY

NOTES

5. Have you attached a chart or schedule disclosing all ownership, familial or contractual relationships, both direct and indirect, among all parties identified in the answers to questions 1, 2, 3 or 4 that is sufficient in detail to accomplish full disclosure?

Description of Attachment: _____

YES

NO

6. Indicate the nature of the change in ownership transaction that is the subject of this inquiry. (Check One)

Note: Lease classifications should be determined in conformance with FASB 13.

- () Purchase
- () Capital Lease*
- () Operating Lease**
- () Lease Type
- () Unknown**

--- If the transaction in question is a lease transaction, please respond to the two following questions regarding the lease:

* If you checked Capital Lease, attach a copy of all accountant's workpapers with supporting calculations, relevant notes and assumptions supporting the determination of the lease as capital.

Description of Attachment: _____

**If you checked Operating Lease or Lease Type Unknown, complete and attach Schedule L from the applicable Medicaid Financial Report.

Description of Attachment: _____

7. Was the transaction in question recognized and reported by all parties in substantially the same manner, scope and amount as proposed for Medicaid cost reporting purposes for federal income tax purposes?

YES

NO

8. Is any party that is a seller, lessor or previous lessee associated with the facility in any way after the sale other than as a passive lessor or creditor?

YES

NO

CHECKLIST

**MANAGEMENT'S
REPRESENTATION**

**RATE SETTING
CONTRACTOR USE ONLY**

YES

NO

BY

NOTES

9. Are all parties that are buyers or lessees actively engaged in the operation of the facility after the transaction in question? If not, please provide a detailed explanation.

Description of Attachment: _____

YES

NO

10. Do earnings from the facility accrue to the buyer or lessee primarily as salaries or self-employment income and not as leases, rents or other passive income?

YES

NO

11. Is the primary business purpose for the transaction in question increasing the established Medicaid rate?

Description of Attachment: _____

YES

NO

12. On what date was the previous provider certified by Medicaid?

(Only non-state owned ICFs/MR and CRFs/DD need respond to question 12.)

DATE: _____

13. Is the transaction in question a family sale or lease within the meaning of 405 IAC 1-14.6-15(b) for nursing facilities or 405 IAC 1-12-17(f) for non-state owned ICFs/MR and CRFs/DD?

YES

NO

If yes, has an MAI appraisal been done within ninety (90) days of the date of the sale in accordance with 405 IAC 1-14.6-15(c) for nursing homes and with 405 IAC 1-12-17(g) for non-state owned ICFs/MR and CRFs/DD?

If so, please attach a copy.

YES

NO

14. Is the transaction in question a bona fide sale or lease arising from an arm's length transaction between unrelated parties?

YES

NO

Note: Related parties are defined at 405 IAC 1-14.6-11 for nursing facilities and 405 IAC 1-12-11 for non-state owned ICFs/MR and CRFs/DD.

CHECKLIST

<u>MANAGEMENT'S REPRESENTATION</u>		<u>RATE SETTING CONTRACTOR USE ONLY</u>	
<u>YES</u>	<u>NO</u>	<u>BY</u>	<u>NOTES</u>

15. Does the transaction in question involve any services, facilities or supplies obtained from related parties or organizations within the meaning of 405 IAC 1-14.6-11 for nursing facilities or 405 IAC 1-12-11 for non-state owned ICFs/MR and CRFs/DD?
 Description of Attachment: _____

YES

NO

16. Has the nature of all common control relationships been disclosed in this document or submissions in accordance with GAAP if the nature of those relationships could significantly affect the reporting enterprise?

YES

NO

17. Full disclosure requires that a knowledgeable financial reader, after reviewing the explanations and attachments, would not be misled. After you have reviewed each question, together with the identified attachments, are you satisfied that each question is correctly answered and that the answers and any attachments are sufficient in scope and clarity to accomplish full disclosure?

YES

NO

18. Please provide the current mailing address of the former provider of the facility in question. (Please note that the address for the former provider should not be the address of the facility in question.)

CERTIFICATION STATEMENT

This is to certify that the information contained herein, including any exhibits, schedules, and explanations is true, accurate and complete. Representations concerning all items have been adequately disclosed. I understand that this information is submitted for the purpose of developing payment rates under the Indiana Medicaid Program, and that ultimate payment and satisfaction of claims will be based upon the information contained herein. I understand that any false claims, statements, or documents or concealment of material fact may be prosecuted under applicable federal or state law. Declaration of preparer is based on all information of which the preparer has any knowledge.

Name of Authorized Person

Title/Position

Address

Signature of Authorized Person

Date

Telephone Number

Name of Preparer

Title/Position

Address of Preparer

Signature of Preparer

Date

Telephone Number