
ATTACHMENT 1: SKILLED NURSING FACILITY DISCLOSURES

All skilled nursing facilities (SNFs) must complete this attachment with their application during:

- Initial enrollment
- Revalidation
- Change of information (though only with respect to the information that is changing)
- Change of Ownership (CHOW)

ORGANIZATION INSTRUCTIONS

Ownership interest, managing control, additional disclosable party information

- Complete this section to report an organization identified below. Visit [CMS.gov/medicare/enrollment-renewal/providers-suppliers](https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers) for examples of organizations to report
- Report information on any adverse legal actions that have been imposed against the organization
- To report more than 1 organization, copy and complete this section for each organization
- Don't report individuals in this section

Submit 2 organizational structure diagrams or flowcharts:

- One chart must identify all the entities listed in Section A and show their relationships with the provider and each other.
- One chart must identify the organizational structures of all its owners, including owners not listed in this attachment (e.g., less than 5% direct or indirect owners).

Report these ownership interests in this section:

- **Direct ownership interest**

A direct owner has an actual ownership interest in the provider itself (e.g., owns stock in the business).

Examples:

- Company A wholly (100%) owns the enrolling SNF provider. The provider would report Company A because Company A is a direct owner of the SNF and owns the assets of the business.
- Company X owns 50% of the enrolling SNF provider. The provider would report Company X as a direct owner because Company X has 50% ownership of the SNF.

- **Indirect ownership interest**

An indirect owner has an ownership interest in an organization that owns the provider or in another indirect owner. Many organizations that directly own a provider are themselves wholly or partly owned by other organizations or individuals. This is often the result of the use of holding companies and parent/subsidiary relationships. Such organizations and individuals are considered to be "indirect" owners of the provider. Using the example above, if Company B owned 100% of Company A, Company B is considered to be an indirect owner of the provider.

Example:

LEVEL 3	Individual X	Individual Y
	5%	30%
LEVEL 2	Company C	Company B
	60%	40%
LEVEL 1	Company A	
	100%	

- Company A owns 100% of the enrolling provider
- Company B owns 40% of Company A
- Company C owns 60% of Company A
- Individual X owns 5% of Company C
- Individual Y owns 30% of Company B

ATTACHMENT 1: SKILLED NURSING FACILITY DISCLOSURES (Continued)

In this example, Company A (Level 1) is the direct owner of the provider. Companies B and C, as well as individuals X and Y, are indirect owners of the provider. To calculate ownership shares using the example above, use these steps:

- **Level 1**

Company A owns 100% of the enrolling provider. You must report Company A.

- **Level 2**

To calculate the percentage of ownership held by Company C of the enrolling provider:

- The percentage of ownership the Level 1 owner has in the enrolling provider **multiplied by** the percentage of ownership the Level 2 owner has in the Level 1 owner.
- Company A, the Level 1 (or direct) owner, owns 100% of the provider. In the diagram Company C, a Level 2 owner, owns 60% of Company A. Multiply 100% (or 1.0) by 60% (.60). The result is .60. Company C indirectly owns 60% of the provider. You must report it.
- Repeat this process for Company B, the other Level 2 owner. Because Company B owns 40% of Company A, multiply this figure by 100% (the ownership stake Company A has in the enrolling provider). Company B indirectly owns 40% of the enrolling provider. You must report it.

Continue this process until all Level 2 owners are accounted for.

- **Level 3**

To calculate the percentage of ownership that Individual X has in the enrolling provider:

- The percentage of ownership the Level 2 owner has in the enrolling provider **multiplied by** the percentage of ownership the Level 3 owner has in that Level 2 owner.
- Company C owns 60% of the provider. In the example above, Individual X (Level 3) owns 5% of Company C. Multiply 60% (.60) by 5% (.05). The result is .03. Individual X indirectly owns 3% of the provider, which does not meet the 5% threshold. You do not report it.
- Repeat this process for Company B, which owns 40% of the provider. In the diagram Individual Y (Level 3) owns 30% of Company B. Multiply 40% (.40) by 30% (.30). The result is .12, or 12%. Individual Y owns 12% of the provider. You must report it.

Continue this process until all Level 3 owners are accounted for. Repeat this process for Levels 4 and beyond.

- **General and limited partnerships interests**

Report all general and limited partnership interests—regardless of the percentage. This includes all partnership interests in a non-limited partnership, and all general and limited partnership interests in a limited partnership.

- **Mortgage or security interest**

Report all entities with at least a 5% mortgage, deed of trust, or other security interest in the SNF. To calculate whether this interest meets the 5% threshold, use the following formula:

- Dollar amount of the mortgage, deed of trust, or other obligation secured by the SNF or any of the property or assets of the SNF **divided by** dollar amount of the total property and assets of the SNF.

Example: Two years ago, a SNF obtained a \$20 million loan from Entity X to add a third floor to its facility. Various assets of the SNF secure the mortgage. The total value of the SNF's property and assets is \$100 million.

Using the formula above, divide \$20 million (the dollar amount of the secured mortgage) by \$100 million (the total property and assets of the Enrolling SNF). This results in .20, or 20%. Entity X must be reported because their interest represents at least 5% of the total property and assets of the enrolling SNF.

- **Operational/managing control**

- Any organization that exercises operational, managerial control over the provider, or directly or indirectly conducts the day-to-day operations of the provider. The organization need not have an ownership interest in the provider to qualify as a managing organization. For instance, it could be a management services organization under contract with the provider to furnish management services for the business.
- Any organization that has direct responsibility for the performance of your organization or can change the leadership, allocation of resources, or other processes of your organization to improve performance.

ATTACHMENT 1: SKILLED NURSING FACILITY DISCLOSURES *(Continued)*

- Any managing relationship with a management services organization under contract with the provider to furnish management services for the business. Faculty practice plans, university-based health systems, hospital outpatient departments, medical foundations, and groups that primarily treat enrollees of group model HMOs should review this definition of managing control (organizations) carefully to determine if it applies.
- **Additional disclosable party**
 - Any organization that exercises operational, financial, or managerial control over the facility, provides policies procedures for any of the operations of the facility, or provides financial or cash management services to the facility;
 - Any organization that leases or subleases real property to the facility, or owns a whole or part interest equal to or exceeding 5 percent of the total value of such real property; or
 - Any organization that provides management or administrative services, management or clinical consulting services, or accounting or financial services to the facility.

The organizational structure (as that term is defined in section 1124(c)(5)(D) of the Social Security Act) of each additional disclosable party must be identified in section D of the Organizations portion of this attachment. This means that the following parties must be reported:

- For ADPs that are corporations: All their 5% or greater direct and indirect owners.
- For ADPs that are LLCs: All their direct and indirect owners (regardless of the percentage) and all their managing organizations and individuals.
- For ADPs that are general partnerships: All the partners, regardless of the percentage.
- For ADPs that are limited partnerships: All general partners (regardless of the percentage) and all limited partners with at least a 10 percent interest.
- For ADPs that are trusts: All trustees.

Along with furnishing the above data in section D, the SNF must also submit a diagram of the organizational structure of each additional disclosable party of the facility. This must include a written description of the relationship of each such additional disclosable party to the facility and to all the SNF's other additional disclosable parties. For examples of organizations to report, visit [CMS.gov/medicare/enrollment-renewal/providers-suppliers](https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers).

- **Additional ownership interests and/or managing control**

The organizations above include, but are not limited to, the following. You must report them in this attachment:

- Entities with an investment interest in the provider (like investment firms)
- Private equity companies
- Real estate investment trusts
- Banks and financial institutions (like mortgage interests)
- Holding companies
- Trusts and trustees
- Governmental/tribal organizations: **Federal, state, county, city, or other level of government, or an Indian tribe, legally and financially responsible for Medicare payments received (including any potential overpayments), must report the name of that government or Indian tribe in the applicable section.** The provider must submit a letter on the letterhead of the responsible government (like a government agency) or tribal organization, which attests that the government or tribal organization will be legally and financially responsible if there is any outstanding debt owed to CMS. This letter must be signed by an "authorized official" of the government or tribal organization who has the authority to legally and financially bind the government or tribal organization to the laws, regulations, and program instructions of Medicare. Go to section 15 for further information on "authorized officials."
- Charitable and Religious Organizations: Many non-profit organizations are charitable or religious in nature and are operated and/or managed by a Board of Trustees or other governing body. **Report the actual name of the Board of Trustees or other governing body in the applicable section.**

ATTACHMENT 1: SKILLED NURSING FACILITY DISCLOSURES (Continued)

A. ORGANIZATION IDENTIFICATION INFORMATION

Check this box if you have no organizations with ownership or managing control to report.

Not Applicable

To change, add, or remove information about the organization, check the applicable box, enter the effective date, and complete the appropriate fields.

Change Add Remove Effective date (mm/dd/yyyy): _____

Legal Business Name as reported to the Internal Revenue Service (IRS)

"Doing business as" name (if different than Legal Business Name)

Address line 1 (street name and number)

Address line 2 (suite, room, etc.)

City/town

State

ZIP Code + 4

Telephone number

Fax number (if applicable)

E-mail address (if applicable)

National Provider Identifier (NPI)

Tax Identification Number (TIN)

Medicare Identification Number for this location – PTAN (if issued)

B. TYPE OF ORGANIZATION

Complete this section with information for the organization listed in section A.

Definitions

- **Private equity company (for Medicare purposes):** A publicly traded or non-publicly traded company that collects capital investments from individuals or entities (like investors) and purchases a direct or indirect ownership share of a provider (like a SNF or home health agency). (Go to 42 C.F.R. § 424.502.)
- **Real estate investment trust (for Medicare purposes):** For purposes of this attachment, a real estate investment trust as defined in 26 U.S.C. § 856. (Go to 42 C.F.R. § 424.502.)
- **Holding company:** A business entity, usually a corporation or limited liability company (LLC), created to hold the controlling stock or membership interests in other companies.

ATTACHMENT 1: SKILLED NURSING FACILITY DISCLOSURES (Continued)

IRS business designation

Identify how your business is registered with the IRS (*Check one*).

If your business is a federal or state government supplier, check "Non-profit" and specify the level. Government-owned entities don't need to provide IRS Form 501(c)(3)).

- Proprietary
- Non-profit (Submit IRS Form 501(c)(3))
- Disregarded entity (Submit IRS Form 8832, if applicable)

NOTE: If a checkbox identifying how the business is registered with the IRS is not completed, the supplier will be defaulted to "Proprietary."

Identify the type of business structure: (*check one*)

- | | |
|---|--|
| <input type="checkbox"/> Corporation | <input type="checkbox"/> Federal and/or state government type: |
| <input type="checkbox"/> Limited Liability Company | <input type="checkbox"/> Federal |
| <input type="checkbox"/> Partnership (general or limited) | <input type="checkbox"/> State |
| <input type="checkbox"/> Sole proprietor | <input type="checkbox"/> City |
| <input type="checkbox"/> Other (specify): _____ | <input type="checkbox"/> County |
| | <input type="checkbox"/> City-county |
| | <input type="checkbox"/> Hospital district |
| | <input type="checkbox"/> Other (specify): _____ |

Identify the type of organization.

Answer all questions. You may need to check "yes" for more than 1 box.

- | | | |
|--|---------------------------|--------------------------|
| Bank or other financial institution..... | <input type="radio"/> Yes | <input type="radio"/> No |
| Chain home office (complete section 3)..... | <input type="radio"/> Yes | <input type="radio"/> No |
| Consulting firm..... | <input type="radio"/> Yes | <input type="radio"/> No |
| Corporation..... | <input type="radio"/> Yes | <input type="radio"/> No |
| Holding company..... | <input type="radio"/> Yes | <input type="radio"/> No |
| Investment firm (other than private equity company)..... | <input type="radio"/> Yes | <input type="radio"/> No |
| Limited Liability Company..... | <input type="radio"/> Yes | <input type="radio"/> No |
| Management services company..... | <input type="radio"/> Yes | <input type="radio"/> No |
| Medical provider/supplier..... | <input type="radio"/> Yes | <input type="radio"/> No |
| Medical staffing company..... | <input type="radio"/> Yes | <input type="radio"/> No |
| Private equity company..... | <input type="radio"/> Yes | <input type="radio"/> No |
| Real estate investment trust..... | <input type="radio"/> Yes | <input type="radio"/> No |
| Trust or trustee..... | <input type="radio"/> Yes | <input type="radio"/> No |
| Other (specify): _____..... | <input type="radio"/> Yes | <input type="radio"/> No |

Answer all questions about your organization. You may need to check "yes" for more than 1 box.

- | | | |
|---|---------------------------|--------------------------|
| Was this organization solely created to acquire or buy the provider or the provider's assets? | <input type="radio"/> Yes | <input type="radio"/> No |
| Is this organization the ultimate parent company in a multi-organizational group of entities? | <input type="radio"/> Yes | <input type="radio"/> No |
| Is this organization itself owned by any other organization or individual? | <input type="radio"/> Yes | <input type="radio"/> No |

ATTACHMENT 1: SKILLED NURSING FACILITY DISCLOSURES (Continued)

C. CHAIN HOME OFFICES ONLY

If you're a chain home office, we'll use the information you provide to ensure proper reimbursement when the provider files their year-end cost report with the MAC.

For more information on chain organizations, go to 42 C.F.R. section 421.404.

Change Add Remove Effective date (mm/dd/yyyy): _____

1. Type of action this provider is reporting

CHECK ONLY 1:	COMPLETE THIS SECTION
<input type="checkbox"/> Provider in chain is enrolling in Medicare for the first time (Initial Enrollment or Change of Ownership)	Section C
<input type="checkbox"/> Provider is no longer associated with the chain	Section C (to identify the former chain home office)
<input type="checkbox"/> Provider has changed from one chain to another	Section C (to identify the new chain home office).
<input type="checkbox"/> The provider's chain home office is changing its name (all other information remains the same)	Section A

2. Chain home office administrator or CEO contact information

First name of home office administrator or CEO	Middle initial	Last name	Jr., Sr., etc.
Title of home office administrator			
Social Security Number	Date of birth (mm/dd/yyyy)		

3. Provider's affiliation to the chain home office

Check one:

- Joint venture/partnership
- Managed/related
- Leased
- Operated/related
- Wholly owned
- Other (specify): _____

ATTACHMENT 1: SKILLED NURSING FACILITY DISCLOSURES (Continued)

D. RELATIONSHIP TO SNF AND/OR TO ADDITIONAL DISCLOSABLE PARTY (ADP) OF SNF

Questions 1–7 should only be completed if it applies to your business structure. Furnish the additional information, including the Effective date and exact percentage of ownership, if applicable. Combined percentage totals for direct owners can't exceed 100%.

1. If the SNF is a corporation

Does the reported organization have a 5% or greater direct ownership interest in the SNF? Yes No

If **yes**, complete the below fields.

Effective date (mm/dd/yyyy)	Exact percentage of ownership _____ %
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2. If the SNF is an LLC

Does the reported organization have any direct ownership interest in the SNF regardless of the percentage? Yes No

If **yes**, complete the below fields.

Effective date (mm/dd/yyyy)	Exact percentage of ownership _____ %
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3. If the SNF is a general partnership

Does the reported organization have any direct general partnership/ownership interest in the SNF regardless of the percentage? Yes No

If **yes**, complete the below fields.

Effective date (mm/dd/yyyy)	Exact percentage of ownership _____ %
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4. If the SNF is a limited partnership

Does the reported organization have any direct general or limited partnership/ownership interest in the SNF regardless of the percentage? Yes No

If **yes**, complete the below fields.

Effective date (mm/dd/yyyy)	Exact percentage of ownership _____ %
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5. If the SNF has a business structure not identified in 1–4

Does the reported organization have a 5% or greater direct ownership interest in the SNF? Yes No

If **yes**, complete the below fields.

Effective date (mm/dd/yyyy)	Exact percentage of ownership _____ %
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6. If the SNF is a business structure other than an LLC, general partnership, or limited partnership

Does the reported organization have a 5% or greater *indirect* ownership interest in the SNF? Yes No

If **yes**, complete the below fields.

Effective date (mm/dd/yyyy)	Exact percentage of ownership _____ %
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ATTACHMENT 1: SKILLED NURSING FACILITY DISCLOSURES (Continued)

7. If the SNF is an LLC, general partnership, or limited partnership

Does the reported organization have any *indirect* ownership interest in the SNF regardless of the percentage? Yes No

If **yes**, complete the below fields.

Effective date (mm/dd/yyyy)	Exact percentage of ownership _____ %
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Questions 8–13 must be completed regardless of the SNF’s business structure. Include the Effective date and exact percentage of ownership, if applicable.

8. Does the reported organization have a 5% or greater mortgage or security interest in the SNF?..... Yes No

If **yes**, complete the below fields.

Effective date (mm/dd/yyyy)	Type of interest: <input type="radio"/> Mortgage <input type="radio"/> Security	Exact percentage of mortgage/security interest _____ %
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9. Is the reported organization a trustee of the SNF? Yes No

If **yes**, complete the below fields.

Effective date (mm/dd/yyyy)

10. Does the reported organization exercise any of the following types of control, either directly or indirectly, over the SNF or any part of the SNF? (This includes, but is not limited to, entities that meet the definition of “managing organization” as defined in § 424.502.)..... Yes No

If **yes**, complete the below fields.

Operational: Yes No Effective date (mm/dd/yyyy): _____

Managerial: Yes No Effective date (mm/dd/yyyy): _____

Financial: Yes No Effective date (mm/dd/yyyy): _____

The type(s) of control (e.g., the type and form of financial control): _____

Which part(s) of the SNF the control applies to: _____

Whether this control is furnished under contract: _____

ATTACHMENT 1: SKILLED NURSING FACILITY DISCLOSURES (Continued)

11. Does the reported organization provide any of the following—either directly or indirectly—to the SNF or any part of the SNF? Yes No

If yes, complete the below fields.

Policies or procedures for any of the SNF's operations Yes No Effective date (mm/dd/yyyy): _____

Financial services Yes No Effective date (mm/dd/yyyy): _____

Cash management services Yes No Effective date (mm/dd/yyyy): _____

Management services Yes No Effective date (mm/dd/yyyy): _____

Administrative services Yes No Effective date (mm/dd/yyyy): _____

Clinical consulting services Yes No Effective date (mm/dd/yyyy): _____

Accounting services Yes No Effective date (mm/dd/yyyy): _____

The type(s) of services (e.g., accounting services and the type/form of the accounting services)

Whether these services are furnished under contract:

12. Does the reported organization lease or sublease real property to the SNF? Yes No

If yes, complete the below fields.

The type of lease arrangement and the length of the lease.

13. Does the reported organization directly or indirectly own at least 5 percent of the total value of the SNF's real property or the real property on/in which the SNF operates (e.g., 5 percent of the real property the SNF leases)? Yes No

If yes, complete the below fields.

Effective date (mm/dd/yyyy)	Exact percentage of ownership _____ %
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Whether the ownership is of real property the SNF owns or whether it is of real property the SNF leases or subleases.

ATTACHMENT 1: SKILLED NURSING FACILITY DISCLOSURES (Continued)

Questions 14–18 ask whether the reported organization has an ownership or trustee interest in any additional disclosable party (ADP) of the SNF. Each question only applies to a particular ADP organizational type. (For instance, question 14 only applies to interests in ADPs that are corporations, question 15 only applies to interests in ADPs that are LLCs, etc.) These questions must be completed for all organizations reported in section A of this Attachment, regardless of whether the reported organization is itself an ADP. Please review the instructions to the Attachment for a definition of “Additional disclosable party.” Note that if the SNF checked “Yes” in question 9, 10, 11, 12, and/or 13 for a particular reported organization, that organization is considered an ADP.

14. ADPs that are corporations

Is the reported organization a 5% or greater direct or indirect owner of any ADP of the SNF that is a corporation? Yes No

If yes, complete the below fields.

Effective date (mm/dd/yyyy)	Type of ownership: <input type="radio"/> Direct <input type="radio"/> Indirect	Exact percentage of ownership _____ %
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List the corporation ADP(s) of which the organization is an owner (e.g., name of the ADP)

15. ADPs that are LLCs

Does the reported organization have any direct or indirect ownership interest in—or exercises managing control of—any ADP of the SNF that is an LLC, regardless of the percentage? Yes No

If yes, complete the below fields.

Effective date (mm/dd/yyyy)	Type of ownership: <input type="radio"/> Direct <input type="radio"/> Indirect	Exact percentage of ownership _____ %
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List the LLC ADP(s) of which the organization is an owner (e.g., name of the ADP)

16. ADPs that are general partnerships

Does the reported organization have any general partnership/ownership interest in any ADP of the SNF that is a general partnership, regardless of the percentage? Yes No

If yes, complete the below fields.

Effective date (mm/dd/yyyy)	Exact percentage of partnership interest _____ %
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List the general partnership ADP(s) of which the organization is a general partner (e.g., name of the ADP)

17. ADPs that are limited partnerships

Does the reported organization have any general partnership interest (regardless of the percentage) in any limited partnership ADP of the SNF or at least a 10 percent limited partnership interest in any ADP of the SNF? Yes No

If yes, complete the below fields.

Effective date (mm/dd/yyyy)	Type of partnership interest: <input type="radio"/> General <input type="radio"/> Limited	Exact percentage of partnership interest _____ %
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List the limited partnership ADP(s) of which the organization is a general or limited partner (e.g., name of the ADP)

ATTACHMENT 1: SKILLED NURSING FACILITY DISCLOSURES (Continued)

18. ADPs that are trusts

Is the reported organization a trustee of any ADP of the SNF? Yes No

If yes, complete the below fields.

Effective date (mm/dd/yyyy)

List the ADP(s) of which the organization is a trustee (e.g., name of the ADP)

19. Owners/Trustees of ADP(s)

Answer this question only if the SNF answered “Yes” to question 14, 15, 16, 17, or 18. For purposes of question 19 ONLY, the term “interest” means any of the interests (ownership, trustee, LLC managerial) listed in the “organizational structure” definition in section 1124(c)(5)(D) of the Social Security Act. (Go to the instructions for this definition.)

Does this ADP owner/trustee/LLC manager (as indicated in question 14, 15, 16, 17, or 18) have any interest in the SNF itself OR in **another** ADP of the SNF? Yes No

If yes, complete the below field.

List the LBN of the entity (i.e., the SNF itself or **another** ADP of the SNF) in which this ADP owner/trustee/LLC manager has an interest

ATTACHMENT 1: SKILLED NURSING FACILITY DISCLOSURES (Continued)

E. FINAL ADVERSE LEGAL ACTION

Complete this section for the organization you reported in section A. For more information on what to report, go to section 3 of this application. Include all supporting documentation described in section 3.

If you are changing information, check "change" box, furnish the effective date, and complete the appropriate fields in this section.

Change **Effective date (mm/dd/yyyy):** _____

1. Has the organization in section A, under any current or former name or business identity, ever had a final adverse action listed in section 3 of this application imposed against it?
 - YES – continue to item 2.
 - NO – skip to next section.
2. Report each final adverse legal action, when it occurred, and the federal or state agency or the court or administrative body that imposed the action.

FINAL ADVERSE LEGAL ACTION	DATE	ACTION TAKEN BY

To satisfy the reporting requirement, fill out this section and include all applicable attachments.

ATTACHMENT 1: SKILLED NURSING FACILITY DISCLOSURES *(Continued)*

INSTRUCTIONS FOR INDIVIDUALS

Ownership interest, managing control, additional disclosable party information

- Complete this section to report any individuals with direct or indirect ownership of, a partnership interest in, and/or managing control of the provider identified in Section 2B1 of this application. Visit [CMS.gov/medicare/enrollment-renewal/providers-suppliers](https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers) for examples of individuals to report
- Report information on any adverse legal actions that have been imposed against the individual
- To report more than 1 individual, copy and complete this section for each
- At least one managing employee must be reported.

Report these ownership control interests in this section:

- **Direct ownership interest**
- **Indirect ownership interest**
- **Mortgage or security interest**
- **General and limited partnership interests**
- **Report all general and limited partnership interests—regardless of the percentage.** This includes all interests in a non-limited partnership, and all general and limited partnership interests in a limited partnership.
- **Officers and directors**
 - If the entity is organized as a corporation.
- **Managing employees (for purposes of nursing facilities under section 1124(c))**
 - An individual, (including a general manager, business manager, administrator, director, or consultant) who directly or indirectly manages, advises, or supervises any element of the practices, finances, or operations of the facility. Report all managing employees of the SNF in this section. For purposes of this definition, this includes, but is not limited to, a hospice or skilled nursing facility administrator and a hospice or skilled nursing facility medical director.
- **Member of the governing body**
- **Trusts and trustees**
- **Additional disclosable party:**
 - Any individual that exercises operational, financial, or managerial control over the facility, provides policies procedures for any of the operations of the facility, provides financial or cash management services to the facility;
 - Any individual that leases or subleases real property to the facility, or owns a whole or part interest equal to or exceeding 5 percent of the total value of such real property; or
 - Any individual that provides management or administrative services, management or clinical consulting services, or accounting or financial services to the facility.

The organizational structure (as that term is defined in section 1124(c)(5)(D) of the Social Security Act) of each additional disclosable party must be identified in section B of the Individuals portion of this attachment. This means that the following parties must be reported:

- For ADPs that are corporations: All their officers, directors, and 5% or greater direct and indirect owners.
- For ADPs that are LLCs: All their direct and indirect owners (regardless of the percentage) and all their managing individuals.
- For ADPs that are general partnerships: All the partners, regardless of the percentage.
- For ADPs that are limited partnerships: All general partners (regardless of the percentage) and all limited partners with at least a 10 percent interest.
- For ADPs that are trusts: All trustees.

Along with furnishing the above data in Section B, the SNF must also submit a diagram of the organizational structure of each additional disclosable party of the facility. This must include a written description of the relationship of each such additional disclosable party to the facility and to all the SNF's other additional disclosable parties. For examples of individuals to report, visit [CMS.gov/medicare/enrollment-renewal/providers-suppliers](https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers).

For more information on these interests, go to the organization instructions. The diagrams referred to in the organization instructions must include all individuals with any of the ownership interests described above.

ATTACHMENT 1: SKILLED NURSING FACILITY DISCLOSURES (Continued)

A. INDIVIDUAL IDENTIFYING INFORMATION

Check this box if you have no individuals with ownership or managing control to report.

Not applicable

To change, add, or remove information about the individual, check the applicable box, enter the effective date, and complete the appropriate fields.

Change Add Remove **Effective date (mm/dd/yyyy):** _____

First name	Middle initial	Last name	Jr., Sr., etc.
Title			
Social Security Number (SSN) or Individual Tax Identification Number (ITIN)			Date of birth (mm/dd/yyyy)
Telephone number	Fax number (if applicable)	E-mail address (if applicable)	

B. RELATIONSHIP TO SNF AND/OR ADDITIONAL DISCLOSABLE PARTY (ADP) OF SNF

Identify the type of interest the individual in section A has in the SNF.

Questions 1–7 should only be completed if they apply to the SNF’s business structure. Furnish the additional information, including the effective date and exact percentage of ownership, if applicable. Combined percentage totals for direct owners can’t exceed 100%.

1. If the SNF is a corporation

Does the reported individual have a 5% or greater direct ownership interest in the SNF? Yes No

Effective date (mm/dd/yyyy)	Exact percentage of ownership _____ %
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2. If the SNF is an LLC

Does the reported individual have any direct ownership interest in the SNF regardless of the percentage? Yes No

Effective date (mm/dd/yyyy)	Exact percentage of ownership _____ %
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3. If the SNF is a general partnership

Does the reported individual have any direct general partnership/ownership interest in the SNF regardless of the percentage? Yes No

Effective date (mm/dd/yyyy)	Exact percentage of ownership _____ %
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4. If the SNF is a limited partnership

Does the reported individual have any direct general or limited partnership/ownership interest in the SNF regardless of the percentage? Yes No

Effective date (mm/dd/yyyy)	Exact percentage of ownership _____ %
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ATTACHMENT 1: SKILLED NURSING FACILITY DISCLOSURES (Continued)

5. If the SNF has a business structure other than those described in 1–4Does the reported individual have a 5% or greater direct ownership interest in the SNF? Yes No

Effective date (mm/dd/yyyy)	Exact percentage of ownership _____ %
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6. If the SNF is a business structure other than an LLC, general partnership, or limited partnershipDoes the reported individual have a 5% or greater *indirect* ownership interest in the SNF? Yes No

Effective date (mm/dd/yyyy)	Exact percentage of ownership _____ %
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7. If the SNF is a LLC, general partnership, or limited partnershipDoes the reported individual have any *indirect* ownership interest in the SNF regardless of the percentage? Yes No

Effective date (mm/dd/yyyy)	Exact percentage of ownership _____ %
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8. If the SNF is a corporationIs the reported individual an officer or director of the SNF? Yes No

Effective date (mm/dd/yyyy)	Type of position: <input type="radio"/> Officer <input type="radio"/> Director	Title
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9. If the SNF has a business structure other than that of a corporationIs the reported individual a member of the SNF's governing body? Yes No

Effective date (mm/dd/yyyy)	Type of governing body:	Title
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Questions 10–16 must be answered regardless of the SNF's business structure.

10. Does the reported individual have a 5% or greater mortgage or security interest in the SNF? Yes No

Effective date (mm/dd/yyyy)	Type of interest: <input type="radio"/> Mortgage <input type="radio"/> Security	Exact percentage of mortgage/security interest _____ %
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11. Is the reported individual a trustee of the SNF? Yes No

Effective date (mm/dd/yyyy)	
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ATTACHMENT 1: SKILLED NURSING FACILITY DISCLOSURES (Continued)

12. Does the reported individual exercise any of the following types of control, either directly or indirectly, over the SNF or any part of the SNF? Yes No
(This includes, but is not limited to, entities that meet the definition of "managing employee" as defined in § 424.502.)

If yes, complete the below fields.

Operational Yes No Effective date (mm/dd/yyyy): _____

Managerial Yes No Effective date (mm/dd/yyyy): _____

Financial Yes No Effective date (mm/dd/yyyy): _____

The type(s) of control (e.g., the type and form of financial control):

Which part(s) of the SNF the control applies to:

Whether this control is furnished as a W-2 employee, under contract, or under another arrangement

Any organization listed in this attachment of which the individual is a W-2 or contracted employee:

13. Does the reported individual provide any of the following—either directly or indirectly—to the SNF or any part of the SNF? Yes No

If yes, complete the below fields.

Policies or procedures for any of the SNF's operations Yes No Effective date (mm/dd/yyyy): _____

Financial services Yes No Effective date (mm/dd/yyyy): _____

Cash management services Yes No Effective date (mm/dd/yyyy): _____

Management services Yes No Effective date (mm/dd/yyyy): _____

Administrative services Yes No Effective date (mm/dd/yyyy): _____

Clinical consulting services Yes No Effective date (mm/dd/yyyy): _____

Accounting services Yes No Effective date (mm/dd/yyyy): _____

The type(s) of services (e.g., the type and form of financial control)

The part(s) of the SNF to which the services are furnished:

Whether these services are furnished as a W-2 employee, under contract, or under another arrangement:

Any organization listed in this attachment of which the individual is a W-2 or contracted employee:

14. Does the reported individual lease or sublease real property to the SNF? Yes No

If yes, clearly describe the type of lease arrangement and the length of the lease:

ATTACHMENT 1: SKILLED NURSING FACILITY DISCLOSURES (Continued)

15. Does the reported individual directly or indirectly own at least 5 percent of the total value of the SNF's real property or the real property on/in which the SNF operates (e.g., 5 percent of the real property the SNF leases)?..... Yes No

If yes, complete the below fields.

Effective date (mm/dd/yyyy)	Exact percentage of ownership _____ %
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Whether the ownership is of real property the SNF owns or whether it is of real property the SNF leases or subleases.

16. Check the applicable box if the reported individual is the SNF's medical director or administrator:

SNF medical director SNF administrator

Questions 17–22 ask whether the reported individual has an ownership, trustee, or governing/managing interest in any ADP of the SNF. Each question only applies to a particular ADP organizational type. (For instance, question 17 only applies to interests in ADPs that are corporations, question 18 only applies to interests in ADPs that are LLCs, etc.) These questions must be completed for all individuals reported in section A of this Attachment, regardless of whether the individual himself/herself is an ADP. Note that if the SNF checked "Yes" in question 10, 11, 12, 13, 14, and/or 15 (or checked one of the boxes in question 16) for a particular reported individual, that individual is considered an ADP.

17. ADPs that are a corporation

Does the reported individual have a 5 percent or greater direct or indirect ownership interest in any ADP of the SNF that is a corporation? Yes No

If yes, complete the below fields.

Effective date (mm/dd/yyyy)	Type of ownership: <input type="radio"/> Direct <input type="radio"/> Indirect	Exact percentage of ownership _____ %
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List the corporation ADP(s) of which the individual is an owner (e.g., name of the ADP)

18. ADPs that are LLCs

Does the reported individual have any direct or indirect ownership interest in any ADP of the SNF that is an LLC, regardless of the percentage? Yes No

If yes, complete the below fields.

Effective date (mm/dd/yyyy)	Type of ownership: <input type="radio"/> Direct <input type="radio"/> Indirect	Exact percentage of ownership _____ %
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List the LLC ADP(s) of which the individual is an owner (e.g., name of the ADP)

19. ADPs that are general partnerships

Does the reported individual have any general partnership/ownership interest in any ADP of the SNF regardless of the percentage? Yes No

If yes, complete the below fields.

Effective date (mm/dd/yyyy)	Exact percentage of ownership _____ %
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List the ADP(s) of which the individual is a general partner (e.g., name of the ADP)

ATTACHMENT 1: SKILLED NURSING FACILITY DISCLOSURES (Continued)

20. ADPs that are limited partnerships

Does the reported individual have any general partnership interest (regardless of the percentage) in any limited partnership ADP of the SNF or at least a 10 percent limited partnership interest in any ADP of the SNF? Yes No

If yes, complete the below fields.

Effective date (mm/dd/yyyy)	Type of partnership interest: <input type="radio"/> General <input type="radio"/> Limited	Exact percentage of partnership interest _____ %
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List the limited partnership ADP(s) of which the individual is a general or limited partner (e.g., name of the ADP)

21. ADPs that are trusts

Is the reported individual a trustee of any ADP of the SNF? Yes No

If yes, complete the below fields.

Effective date (mm/dd/yyyy)

List the ADP(s) of which the individual is a trustee (e.g., name of the ADP)

22. Governing/Managing/Other Individuals

Is the reported individual a corporate officer, corporate director, or LLC manager of any ADP of the SNF? Yes No

If yes, complete the below fields.

Effective date (mm/dd/yyyy)	Type of position: <input type="radio"/> Corporate officer <input type="radio"/> Corporate director <input type="radio"/> LLC manager
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Title

List the ADP(s) which the individual is a corporate officer, corporate director, or LLC manager.

23. Owners/Trustees of ADP(s)

Answer this question only if the SNF answered "Yes" to question 17, 18, 19, 20, 21, or 22. For purposes of question 23 ONLY, the term "interest" means any of the interests (ownership, trustee, LLC managerial) listed in the "organizational structure" definition in section 1124(c)(5)(D) of the Social Security Act. (Go to the instructions for this definition.)

Does this ADP owner/trustee/director, etc. (as indicated in question 17, 18, 19, 20, 21, or 22) have any interest in the SNF itself OR in another ADP of the SNF? Yes No

If yes, complete the below field.

List the LBN of the entity (i.e., the SNF itself or another ADP of the SNF) in which this ADP owner/trustee/LLC manager has an interest.

ATTACHMENT 1: SKILLED NURSING FACILITY DISCLOSURES (Continued)

C. FINAL ADVERSE LEGAL ACTION

Complete this section for the individual you reported in section A. For more information on what to report, go to section 3 of this application. Include all supporting documentation described in section 3.

If you are changing information, check "change" box, furnish the effective date, and complete the appropriate fields in this section.

Change **Effective date (mm/dd/yyyy):** _____

1. Has the individual in section A, under any current or former name or business identity, ever had a final adverse action listed in section 3 of this application imposed against them?

YES – continue to item 2.

NO

2. Report each final adverse legal action, when it occurred, and the federal or state agency or the court or administrative body that imposed the action.

FINAL ADVERSE LEGAL ACTION	DATE	ACTION TAKEN BY

To satisfy the reporting requirement, fill out this section and include all applicable attachments.