

Cover Letter

ABC Medical Center, LLC

999 Beach Side Court, Sacramento, CA 95814

P: (999) 555-2626

F: (999) 555-2600

Email: JaneDoe@abcmmedicalLLC.org

March 15, 2019

VIA PRIORITY MAIL:

California Department of Public Health

Licensing and Certification

P. O. Box 997377, MS 3207

Sacramento, CA 95899

Attn: Centralized Applications Branch

RE: CHANGE OF SERVICE

Application for Star Medical Center, located at 1800 Beach Drive Sacramento, CA
95814 License #222222222

To Whom It May Concern,

This is a submission of an application for a **Change of Service** for Star Medical Center. We recently completed renovations, and would like to request an addition of a procedure room.

Enclosed the required application forms and supporting documents needed to process the Change of Service request.

Should you have any questions, I will be the direct contact regarding this Change of Service application.

Emergency Contact Information (available 365/24/7)

Name: Jane Doe

Email: JaneDoe@abcmmedicalLLC.org

Phone: (999) 555-2626

Fax: (999) 555-2600

Alternate Email: JaneDoe@cmail.com

Phone (Text Messages): (999) 555-5555

Sincerely,



Jane Doe, Owner

ABC Medical Center, LLC

HS 200

LICENSURE & CERTIFICATION APPLICATION

FOR DEPARTMENTAL USE ONLY	
Proposed name of facility/agency/clinic:	

A. APPLICATION INFORMATION

1. Type of application (check one):

☐ a. Initial ☐ c. Management company (see Sections C1-5, F, and Attachment E-1)

☐ b. Change of Ownership (see #2 below) ☒ d. Other change (see Section A4): Change of Service

2. Change of Ownership Only - For Certification Purposes:

We wish to make certain that our records correctly show the effective date of the ownership change for certification. This date should reflect the actual date on which you took charge of the financial management of the facility rather than the date of sale or date of state license change. Effective date of change:

3. Amount of fee enclosed: \$
-

4. Type of Change (check all that apply):

☐ a. Not applicable
☐ b. Change of capacity (see # 8 below)
☐ c. Change of location
☒ d. Change of services
☐ e. Change of facility type

☐ f. Change of bed classification
☐ g. Change of name
☐ h. Construction of new or replacement facility
☐ i. Stock transfer
☐ j. Other (specify)

5. Type of facility, agency, or clinic (check one)

☐ a. Skilled Nursing Facility (SNF)
 ☐ i. Rural health clinic (for Certification "only")

☐ b. Intermediate Care Facility (ICF)
 ☐ j. General acute care hospital

☐ c. ICF/Developmentally Disabled (ICF/DD)
 ☐ k. Adult day health care center

☐ d. ICF/DD-Habilitative (ICF/DD-H)
 ☐ l. Home Health Agency (HHA)

☐ e. ICF/DD-Nursing (ICF/DD-N)
 ☐ m. Hospice

☐ f. Primary care clinic – Free
 ☐ n. Chronic dialysis clinic

☐ g. Primary care clinic – Community
 ☒ o. Other (specify) Rehabilitation Clinic- OT/SP

☐ h. Surgical clinic

6. **a.** Do you wish to apply for the Medicare program? ☐ Yes ☒ No Medicare Provider #:
- b.** Fiscal Intermediary choice:

7. Do you wish to apply for the Medi-Cal (Medicaid) program? ☒ Yes ☐ No

8. **a.** Current facility bed capacity:
- b.** Proposed facility bed capacity:

9. Age range of clients: 18-100

10. Days and hours of operation: Monday through Friday 8AM - 5PM

11. Is construction required? ☐ Yes ☒ No

If "yes", submit copy of "OSHPD" form (see instructions on page 6)

If "yes", date construction to begin:

If "yes", date construction to be completed: _____

B. LICENSEE INFORMATION

1. Licensee name:

2. Federal employer's tax ID number:

3. Owner type (check one): **Submit** organizational chart for b, c, d, and e.

☐ a. Sole proprietorship (Individual)

☐ b. Profit corporation

☐ c. Nonprofit corporation

☒ d. Limited Liability Company (LLC)

☐ e. Partnership – General

☐ f. Partnership – Limited

☐ g. City

☐ h. County

☐ i. State agency

☐ j. Other agency (specify)

☐ k. Public agency (specify)

4. Licensee address (number & street):

Telephone number:

City, State, & Zip:

E-Mail:

Fax number:

5. a. Identify other facilities, agencies, or clinics the licensee has been licensed for, operated, managed, held a **5%** or more interest in, or served as a director or officer. Include facilities both in and outside of California. **Submit** an attachment for additional facilities that includes all of the required information listed below.

(1) Facility Name:

Facility Type:

Facility address (number & street):

City, State, & Zip:

(2) Facility Name:

Facility Type:

Facility address (number & street):

City, State, & Zip:

(3) Facility Name:

Facility Type:

Facility address (number & street):

City, State, & Zip:

(4) Facility Name:

Facility Type:

Facility address (number & street):

City, State, & Zip:

5. b. If any facility, agency, or clinic identified in 5.a. has had a license revocation action filed, license placed on probation, suspended, or revoked (whether stayed or not) or, for agency or clinic resolved by settlement, receiver appointed, or had a final Medi-Cal decertification action taken, please **submit** additional information, including all ownership and facility information, date and any final action.

6. Is the licensee a **subsidiary** of another organization?

☐ Yes ☒ No

If "yes", complete the information below and **submit** an organizational chart:

Parent organization name:

Parent federal tax ID Number:

P.O. Box or number & street:

City, State, & Zip:

C. FACILITY, AGENCY OR CLINIC INFORMATION

Management Agreement (this only applies to SNF's & ICF's):

1. a. Is the facility, agency, or clinic going to be operated under a management contract/agreement between the proposed owner and a management company? ☐ Yes
If "yes", proceed to **Section E** (below). ☒ No

- b. Is there an "interim" management agreement, between the proposed owner and the current owner, to run the facility, agency, or clinic until the change of ownership is completed? ☐ Yes
If "yes", **submit** a copy of the "interim" management agreement. ☒ No

2. Name of "proposed" facility, agency, or clinic:
Current facility, agency, or clinic name (if change of ownership):
 Facility license number:

3. Address (number & street) of "proposed" facility, agency, or clinic: Telephone number:
City, State, & Zip:

4. Mailing address, if different from above: Telephone number:
Number & Street: Fax number: E-mail address:
City, State, & Zip:

5. **Name of person to be in charge of facility, agency, or clinic:**
Title: Professional License number:

6. a. Name of administrator: Date of hire:
Professional License number: Expiration date:
b. Name of director of nursing: Date of hire:
Professional License number: Expiration date:

7. List persons having **5 percent** or more direct or indirect (42 CFR, Section 455.102) interest in the ownership of this facility if applying for skilled nursing or intermediate care licensure, and **10 percent** for all other facilities, agencies, or clinics. Provide federal employer's tax ID number. Are any of these persons (listed below) related to one another as spouse, parent, child or sibling? **Submit** an attachment for additional names that includes all of the required information listed below.

Name of individual		% Owned	EIN Number	Are they related to one another as a spouse, parent, child or sibling?		Relationship
(1)	Jane Doe	100	55-5555555	<input type="radio"/> Yes	<input type="radio"/> No	<input type="text"/>
(2)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes	<input type="radio"/> No	<input type="text"/>
(3)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes	<input type="radio"/> No	<input type="text"/>
(4)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes	<input type="radio"/> No	<input type="text"/>
(5)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes	<input type="radio"/> No	<input type="text"/>

8. **Financial resources -- Only applies to SNF and ICF:**

Submit evidence, i.e., bank statements, line of credit, certificate(s) of deposit, satisfactory to the department(s) that the licensee possesses financial resources sufficient to operate the facility for a period of at least 45 days. (The amount is determined by multiplying 45 days X number of beds X rate).

9. **Over-concentration -- Only applies to ICF/DD, ICF/DD-H and ICF/DD-N:**

- a. Are there any ICF/DD, ICF/DD-H, ICF/DD-N, RCF (residential care facility), or pediatric day health or respite care facilities within 300 feet of this facility? (H&S Code, Section 1267.9) ☐ Yes ☐ No ☐ Don't know
b. Are there any congregate living health facilities within 1,000 feet of this facility? ☐ Yes ☐ No ☐ Don't know

10. **Program Plan -- Only applies to ICF/DD, ICF/DD-H and ICF/DD-N (H&S Code, Section 1275.3(b)(3))**

Has the program plan been approved by the Department of Developmental Services? ☐ Yes ☐ No
If "yes", **Submit** a copy of the approval letter. The "current licensee" can grant permission for their Program Plan to be used for 6 months if they **submit** a letter to CDPH. If "no", the application package will be delayed until a copy of the approved program letter is received.

D. PROPERTY INFORMATION

1. Property ownership: Check one and **submit** evidence of control of property: ☐ Own ☐ Rent ☒ Lease

☐ Sublease ☐ Other (specify):

2. **Owner of Record** name in the real estate:

Address (number & street):

City, State, & Zip:

Lessee name:

Address (number & street):

City, State, & Zip:

Sub-Lessee name:

Address (number & street):

City, State, & Zip:

E. MANAGEMENT COMPANY

If the proposed facility, agency, or clinic will be operated by a management company, under a management contract between the proposed owner and a management company, complete Attachment E-1 (next page).

NOTE: if the facility is a SNF or ICF, the management company will have to **SUBMIT** a separate application to the Department, unless previously approved.

F. I (we) Accept responsibility to:

- Comply with local ordinances concerning zoning, sanitation, building, and other appropriate ordinances.
- Comply with the Labor Code on employment practices concerning nondiscrimination, liability insurance, wages, hour and working conditions.
- Comply with Health and Safety Code and regulations concerning licensing and fire safety.

I (we) declare under penalty of perjury that the statements on this application and on the accompanying attachments are correct to my (our) knowledge.

Signature	Title <input type="text" value="Owner"/>	Date <input type="text" value="03/11/2019"/>
Signature	Title <input type="text"/>	Date <input type="text"/>
Signature	Title <input type="text"/>	Date <input type="text"/>
Signature	Title <input type="text"/>	Date <input type="text"/>

Release of Information Statement

This information shall be provided to the state department upon initial licensure. **Any changes must be provided to the state department within 10 days of the change.** The information shall be made available to the public upon request and shall be included in the public file of the facility.

The information provided on this form is mandatory and is necessary for licensure approval. It will be used to determine individual applicants or applicant facility's ability to provide health services. The information is requested by the California Department of Public Health, Licensing and Certification, in accordance with Health and Safety Code, Sections 1212, 1253, 1265, 1267.5, and 1728, and California Code of Regulations (CCR), Title 22, Sections 70107, 71107, 73205, 74105, 75022, 76205, and 78205.

Failure to provide the information as requested may result in nonissuance of a license or license revocation.

The information is considered public information and will be made available to the public upon request. The information shall be included and maintained in the individual facility's public files located in Licensing and Certification district offices.

ATTACHMENT E-1

MANAGEMENT COMPANY INFORMATION ONLY FOR SNF's or ICF's

1. **Submit** a copy of the Management Agreement with this application.

Name of management company: EIN:
Address (number & street):
City, State, & Zip:

Name of facility to be managed: EIN:
Address (number & street):
City, State, & Zip:

2. Provide the following information for **each** individual having a **5 percent** or more interest in the management company. **Submit** an attachment for additional names that includes all of the required information listed below.

(1) Individual's name: % Owner:
Address (number & street):
City, State, & Zip:

(2) Individual's name: % Owner:
Address (number & street):
City, State, & Zip:

(3) Individual's name: % Owner:
Address (number & street):
City, State, & Zip:

(4) Individual's name: % Owner:
Address (number & street):
City, State, & Zip:

3. Provide a list of all facilities, agencies, or clinics with which you have entered into a management agreement. **Submit** an attachment for additional facility, agency, or clinic names that includes all of the required information listed below.

(1) Facility, agency, or clinic name:
Address (number & street):
City, State, & Zip: Dates of involvement:

(2) Facility, agency, or clinic name:
Address (number & street):
City, State, & Zip: Dates of involvement:

(3) Facility, agency, or clinic name:
Address (number & street):
City, State, & Zip: Dates of involvement:

(4) Facility, agency, or clinic name:
Address (number & street):
City, State, & Zip: Dates of involvement:

INSTRUCTIONS

SNF or ICF Management Company Application: See Attachment E-1 below.

Type or print clearly. Return original and maintain a copy for your records. The Licensee's name must be consistent throughout all documents submitted. **Submit** all supplemental paperwork requested to complete your application. **Do not leave items blank. If not applicable, mark N/A.**

A. APPLICATION INFORMATION

1. Type of application: select items a, b, c, or d.
If b is selected, provide effective date of change in number 2.
If c is selected, complete Sections C1-5; F, and Attachment E-1.
If d is selected you must select an option in number 4 -- "Type of Change."
2. Provide actual date applicant took charge of the financial management of facility.
This date is used to show effective date of the ownership change for certification purposes only.
3. Amount of fee enclosed: enter the amount of money enclosed with this application.
If no fee is required, enter "N/A". (Refer to fee schedule for appropriate fee requirements.)
4. Type of change: check all that apply.
5. Type of facility, agency, or clinic: select the appropriate category.
6. (a) Check "yes" if requesting certification for Medicare. ICF/DD, ICF/DD-N, ICF/DD-H facilities and primary care clinics that are not certified as rural health clinics are not eligible for Medicare.
(b) If "yes" to item 6(a), provide name of fiscal intermediary under item 6(b).
7. Check "yes" if requesting participation in Medi-Cal (Medicaid).
8. (a) Current facility bed capacity: enter the total number of persons for whom care can currently be provided in any 24-hour period. This figure must agree with the "Certificate of Occupancy".
(b) Proposed facility bed capacity: enter the proposed total number of persons for whom care will be provided in any 24-hour period.
9. Enter age range of persons to receive/receiving care.
10. Enter days and hours of facility operation.
11. Enter date construction is to begin, and date construction is to be completed (not applicable for ICF/DD, ICF/DD-N, ICF/DD-H facilities).
☐ **Submit** a copy of the form "Construction Advisory Board" (form OSH-FDD 377) if OSHPD has approved construction.
☐ **Submit** a copy of the above form to the local district office *prior* to the survey if OSHPD has not yet approved construction.

B. LICENSEE INFORMATION

1. Licensee name: enter the full legal organization name (LLC, partnership, and corporation) or individual(s) responsible for the facility/agency. If "Inc." is included in your legal name, it must appear in the name. Individuals enter first, middle, and last name. Husband and wife, if joint applicants, must both be listed.

NOTE: All individuals including owners, partners, principal officers of corporations/LLCs, members, managers, and administrators (clinics only) must complete "Applicant Individual Information" (HS 215A).

2. Enter the federal employer's tax ID number.
3. Owner Type: select one of the options and then:
☐ **Submit** an organizational chart, for items b, c, d, or e showing entity, persons, facilities, and tax EIN numbers.
☐ **Submit** a copy of the Internal Revenue Service and Franchise Tax Board letters of determination of nonprofit status, if item c, "nonprofit corporation" is selected, and the facility is a primary care Clinic.

4. Licensee address: enter address of legal organization (LLC, corporation, partnership) or individual(s) responsible for the facility, agency, or clinic. Provide phone number with area code, fax number, and e-mail address.
5. Other Facilities:
 - (a) Identify all other facilities, agencies, or clinics the licensee (LLC, corporation, partnership, individual) has been involved in, both in and outside of California.
 - ☐ **Submit** an attachment, if needed, for additional entities, which includes the facility, agency or clinic type (including "affiliate" clinics), name, address, nature of involvement, and dates of involvement. This attachment must include all of the required information listed.
 - ☐ **Submit** an attachment, if needed, for any entity identified in number 5a, which has had a license revocation action filed, license placed on probation, suspended, or revoked (whether stayed or not) or, for SNFs and ICFs, resolved by settlement, receiver appointed, or has a final Medi-Cal decertification action taken. Include all ownership and facility information, dates, and any final action.
6. Subsidiary: check "yes" if the licensee is a subsidiary of another organization and complete the information requested.
 - ☐ **Submit** a detailed organizational chart, including parent and all subsidiary information, and federal tax ID numbers.

C. FACILITY, AGENCY, OR CLINIC INFORMATION

1. Management Agreement:
 - (a) Check "yes" if the facility, agency, or clinic is going to be operated under a management contract/agreement, between the proposed owner and a management company. Proceed to Section "E" (below).
 - (b) Check "yes" if there is an "interim" management agreement, between the proposed owner and the current owner, to run the facility until the change of ownership is completed.
 - ☐ **Submit** a copy of the "interim" management agreement, if applicable.
2. Facility, agency, or clinic name: Enter the name used to designate the single facility, agency or clinic under the license being requested. Also, provide the current facility, agency, or clinic name, and current license number (if different). Change of ownership usually results in a name change.
3. Provide facility, agency, or clinic address, including phone number with area code, fax number, and e-mail.
4. Provide facility, agency, or clinic mailing address, if different from number 3 (above).
5. Provide the name and title of the individual to be in charge of the facility, agency, or clinic as well as any professional license number (if applicable).
6. Administrator:
 - (a) Provide the name of the facility administrator, date of hire, license number, and license expiration date.
 - (b) Provide the name of the director of nursing services (if applicable), date of hire, license number, and license expiration date.
7. Provide name(s) of all individuals having a **5 percent** or more interest in the ownership of this facility, if applying for SNF or ICF licensure. For all other facility, agency, or clinic types, provide the name(s) of those having **10 percent** or more interest in the ownership. Specify how these persons are related to one another as spouse, parent, child or sibling.
 - ☐ **Submit** an attachment for all additional names. This attachment must include all of the required information.
8. Financial Resources: Only applies to SNF, ICF, and ICF/DD:
 - ☐ **Submit** evidence, satisfactory to the Department, that the licensee has sufficient financial resources to operate the facility for at least 45 days (bank statement, certificate of deposit etc.). The amount is determined by multiplying 45 days X number of beds X rate.
9. Over-concentration -- Only applies to ICF/DD, ICF/DD-H and ICF/DD-N:
 - (a) Are there other ICF/DD, ICF/DD-H, ICF/DD-N residential care, pediatric day health, or respite care facilities within 300 feet of this facility? Check "yes", "don't know" or "no".
 - (b) Are there any congregate living health facilities within 1,000 feet of this facility? Check "yes", "don't know" or "no".

10. Program Plan -- Only applies to ICF/DD, ICF/DD-H and ICF/DD-N:
Indicate if the program plan has been approved by the Department of Developmental Services. The "current licensee" can grant permission for their Program Plan to be used for 6 months if a letter is submitted to CDPH. If "no" is checked, the application package will be held until a copy of the approved program plan letter is received.
- ☐ **Submit** a letter to CDPH from the "current" licensee that the "proposed" licensee has their permission to use the "current" licensee's Program Plan for up to 6 months, if applicable.
- ☐ **Submit** a copy of the Program Plan approval letter, if "yes".

D. PROPERTY INFORMATION

1. Licensee must show evidence of control of property.
- ☐ **Submit** a copy of the deed and/or bill of sale, if property is owned.
- ☐ **Submit** a copy of the rental agreement, if property is rented.
- ☐ **Submit** a copy of the lease agreement, if property is leased.
- ☐ **Submit** a copy of the original lease plus a copy of the sublease, if property is subleased.
- ☐ **Submit** appropriate evidence if "other" is checked.
2. Provide name and address of the Owner of Record, Lessee and Sub-lessee as applicable.

E. MANAGEMENT COMPANY INFORMATION

(Complete Sections A1, C1-5, F & ATTACHMENT E-1)

F. STATEMENT OF RESPONSIBILITIES

Application must be signed by licensee or authorized representative.

ATTACHMENT E-1

MANAGEMENT COMPANY INFORMATION ONLY FOR SNF's OR ICF's

1. If the proposed facility, agency, or clinic will be operated by a management company, under a management contract between the proposed owner and a management company, provide the name, address, and federal tax ID number of Management Company and name of facility to be managed.
- ☐ **Submit** a copy of the Management Agreement.
2. Provide the name, address, and percent of ownership for each person having a **5 percent** or more interest in the Management Company.
- ☐ **Submit** an attachment for additional names. This attachment must include all of the required information.
3. Provide a list of all facilities, agencies, or clinics that you have contracted to manage.
- ☐ **Submit** an attachment for additional facilities, agencies, or clinics. This attachment must include all of the required information.

CDPH 270

**CERTIFICATION FORM FOR CLINICS AND FREESTANDING
OUTPATIENT CLINIC SERVICES OF A HOSPITAL**

I certify that the following facility conforms to current applicable edition of the California Building Standards Code* and as such meets the applicable clinic standards (OSHDP 3) propounded by the Office of Statewide Health Planning and Development.

Facility Star Medical Center
Street Address 1800 Beach Drive
City Sacramento

Type of Facility

- ☐ Chronic Dialysis Clinic (see note 1)
☐ Surgical Clinic (see note 1)
☒ Rehabilitation Clinic
☐ Primary Care Clinic
☐ Birthing Clinic
☐ Psychology Clinic
☐ Out Patient Clinic Service of a Hospital
Service(s): _____

Name _____
Title _____
Street Address _____
City _____

Signature _____

Date _____

*2015 IBC and 2016 California Amendments (2016 California Building Code – Part 2, Title 24, CCR)
2014 NEC and 2016 California Amendments (2016 California Electrical Code – Part 3, Title 24, CCR)
2015 UMC and 2016 California Amendments (2016 California Mechanical Code – Part 4, Title 24, CCR)
2015 UPC and 2016 California Amendments (2016 California Plumbing Code – Part 5, Title 24, CCR)
2015 IFC and 2016 California Amendments (2016 California Fire Code – Part 9, Title 24, CCR)

Also see attached amended CAN 1.

Note 1: Per Health and Safety Code § 129885 certification of chronic dialysis and surgical services are required to be provided by city or county building department with jurisdiction over the project. If the building jurisdiction will not be providing this certification, plans shall be submitted to OSHPD for certification review.

Enforceable Codes

The following are the enforceable codes for facilities under the authority of the Alfred E. Alquist Hospital Facilities Seismic Safety Act of 1983:

Application means the submission of a Preliminary or Final Application for Plan Review.

Code means the official compilation and publication of the adoptions, amendments and repeal of administrative regulations to California Code of Regulations, Title 24, also referred to as the California Building Standards Code.

APPLICATION	CODE
All applications submitted on or after January 1, 2017	2016 California Administrative Code (CAC) Part 1, Title 24, California Code of Regulations (CCR)
	2016 California Building Code (CBC) Part 2, Title 24, CCR <i>Based on the 2015 International Building Code (IBC)</i>
	2016 California Electrical Code (CEC) Part 3, Title 24, CCR <i>Based on the 2014 National Electrical Code (NEC)</i>
	2016 California Mechanical Code (CMC) Part 4, Title 24, CCR <i>Based on the 2015 Uniform Mechanical Code (UMC)</i>
	2016 California Plumbing Code (CPC) Part 5, Title 24, CCR <i>Based on the 2015 Uniform Plumbing Code (UPC)</i>
	2016 California Fire Code (CFC) Part 9, Title 24, CCR <i>Based on the 2015 International Fire Code (IFC)</i>
All applications submitted between January 1, 2014 and December 31, 2016.	2013 California Administrative Code (CAC) Part 1, Title 24, California Code of Regulations (CCR)
	2013 California Building Code (CBC) Part 2, Title 24, CCR <i>Based on the 2012 International Building Code (IBC)</i>
	2013 California Electrical Code (CEC) Part 3, Title 24, CCR <i>Based on the 2011 National Electrical Code (NEC)</i>
	2013 California Mechanical Code (CMC) Part 4, Title 24, CCR <i>Based on the 2012 Uniform Mechanical Code (UMC)</i>
	2013 California Plumbing Code (CPC) Part 5, Title 24, CCR <i>Based on the 2012 Uniform Plumbing Code (UPC)</i>
	2013 California Fire Code (CFC) Part 9, Title 24, CCR <i>Based on the 2012 International Fire Code (IFC)</i>



OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT
FACILITIES DEVELOPMENT DIVISION

700 North Alameda Street, Suite 2-500, Los Angeles, CA 90012
2020 West El Camino Avenue, Suite 800, Sacramento, CA 95833

Phone (213) 897-0166 Fax (213) 897-0168
Phone (916) 440-8300 Fax (916) 324-9188

CO

CERTIFICATE OF OCCUPANCY

Facility Name and Address		Facility No.	Project No.
Star Medical Center 1800 Beach Drive Sacramento, CA 95814 Contractor		13018	S172280-10-00
		Date	Parent Project No.
		5/15/2018	N/A
XYZ Medical Centers, Inc.			
Inspector of Record	Telephone No. (999- 999-9999)	Approved Plans	Project % Complete
John Jones		3/27/2018	10
Title or Scope of Project ePC • 172-T20 FSA Inpatient 797/800 upgrade			

CERTIFICATE OF OCCUPANCY- This occupancy applies to all rooms, spaces and/or areas as described in the scope of work above and/or

on the approved plans for this project, unless noted otherwise below. The described building, or portion of the building, has been inspected for compliance with the requirements of the California Building Standards Code (CBCS) for the group and division of occupancy and use for

which it is intended. Issuance of a certificate of occupancy shall not be construed as an approval of a violation of the provisions of the CBCS. This certificate of occupancy shall be kept on file with the facility for which it was issued and shall be made available upon request by representatives of jurisdictional agencies.

PATIENT ADMITTING, TREATMENT OR CARE: This Certificate of Occupancy is not an approval for patient admitting, treatment or care. The owner/health care provider must contact Licensing and Certification for their review and approval prior to patient admitting,

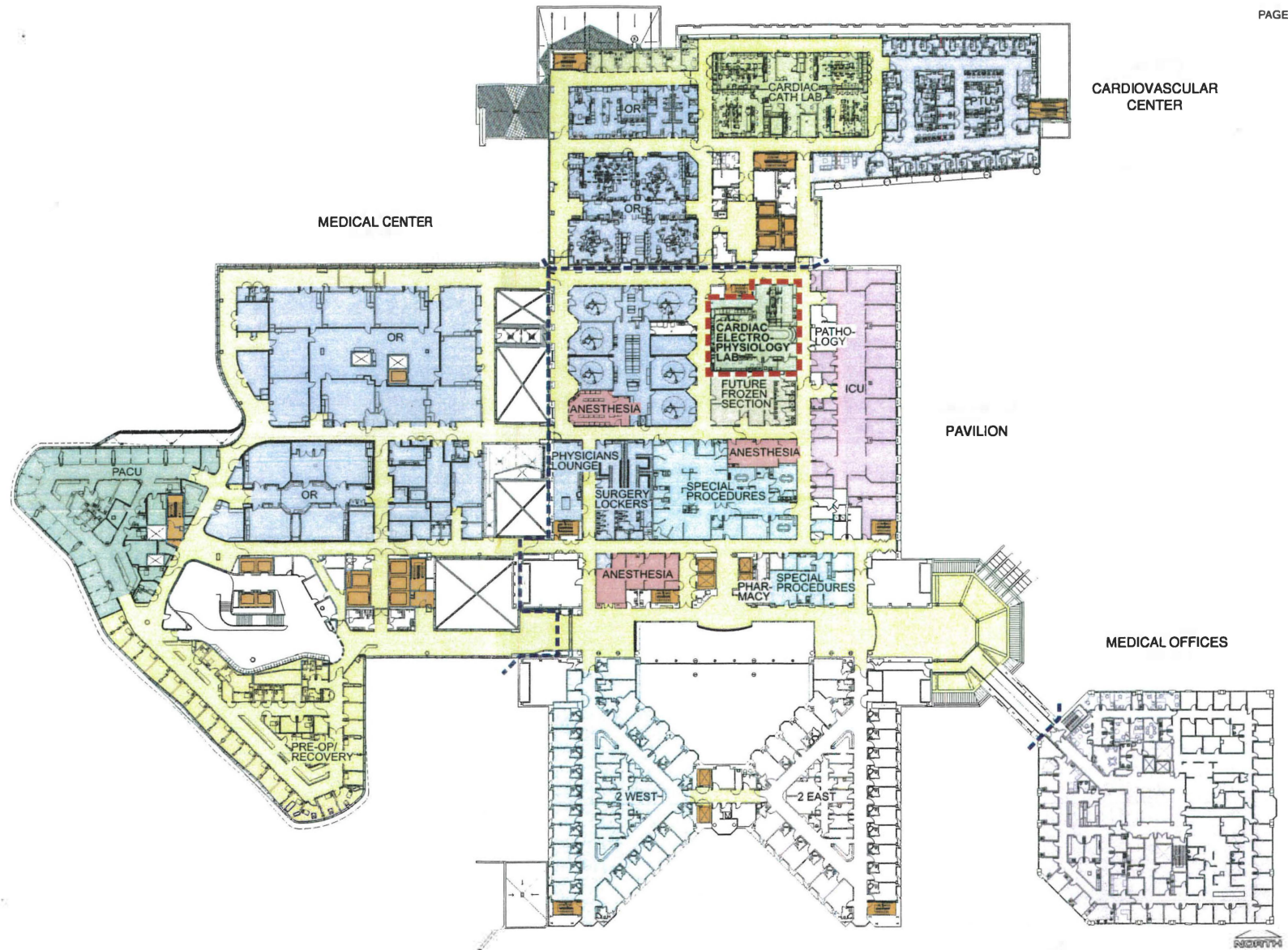
Treatment or care in the effected room, space or area. Clearances may also be required from the local Fire Department and/or the State Fire Marshal.

Comments or Additional Conditions

--

Request approved

- COLOR LEGEND**
- SPECIAL PROCEDURES
 - OPERATING ROOMS / SURGERY
 - CARDIAC ELECTROPHYSIOLOGY
 - INTENSIVE CARE UNIT -ICU
 - ANESTHESIA
 - FUTURE FROZEN SECTION
 - PRE/POST TREATMENT UNIT -PTU
 - CARDIAC CATH LABS
 - PACU
 - PRE-OP / RECOVERY
 - 2 WEST
 - 2 EAST
 - MEDICAL OFFICES
 - MECHANICAL / SUPPORT
 - HORIZONTAL CIRCULATION
 - VERTICAL CIRCULATION
 - BUILDING BOUNDARY
 - EP LAB



Level 2 North Renovation -Cardiac Electrophysiology

L2 - OVERALL PLAN

ABC Medical Center, LLC

COLOR LEGEND

- SPECIAL PROCEDURES
- OPERATING ROOMS / SURGERY
- CARDIAC ELECTROPHYSIOLOGY
- INTENSIVE CARE UNIT - ICU
- ANESTHESIA
- FUTURE FROZEN SECTION
- PRE/POST TREATMENT UNIT - PTU
- CARDIAC CATH LABS
- PACU
- PRE-OP / RECOVERY
- 2 WEST
- 2 EAST
- MEDICAL OFFICES
- MECHANICAL / SUPPORT
- HORIZONTAL CIRCULATION
- VERTICAL CIRCULATION



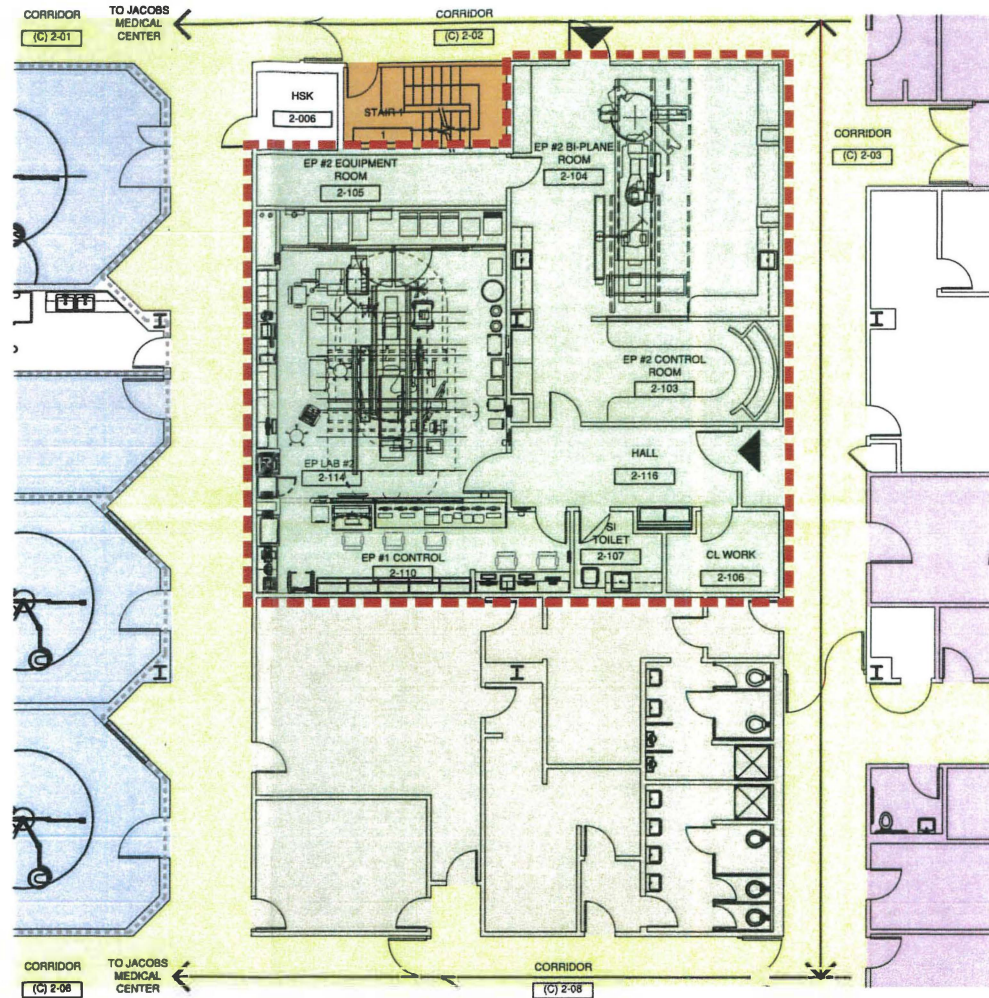
Level 2 North Renovation - Cardiac Electrophysiology

L2 - OVERALL PLAN

ABC Medical Center, LLC

COLOR LEGEND

- SPECIAL PROCEDURES
- OPERATING ROOMS / SURGERY
- CARDIAC ELECTROPHYSIOLOGY
- INTENSIVE CARE UNIT - ICU
- ANESTHESIA
- FUTURE FROZEN SECTION
- PRE/POST TREATMENT UNIT - PTU
- CARDIAC CATH LABS
- PACU
- PRE-OP / RECOVERY
- 2 WEST
- 2 EAST
- MEDICAL OFFICES
- MECHANICAL / SUPPORT
- HORIZONTAL CIRCULATION
- VERTICAL CIRCULATION



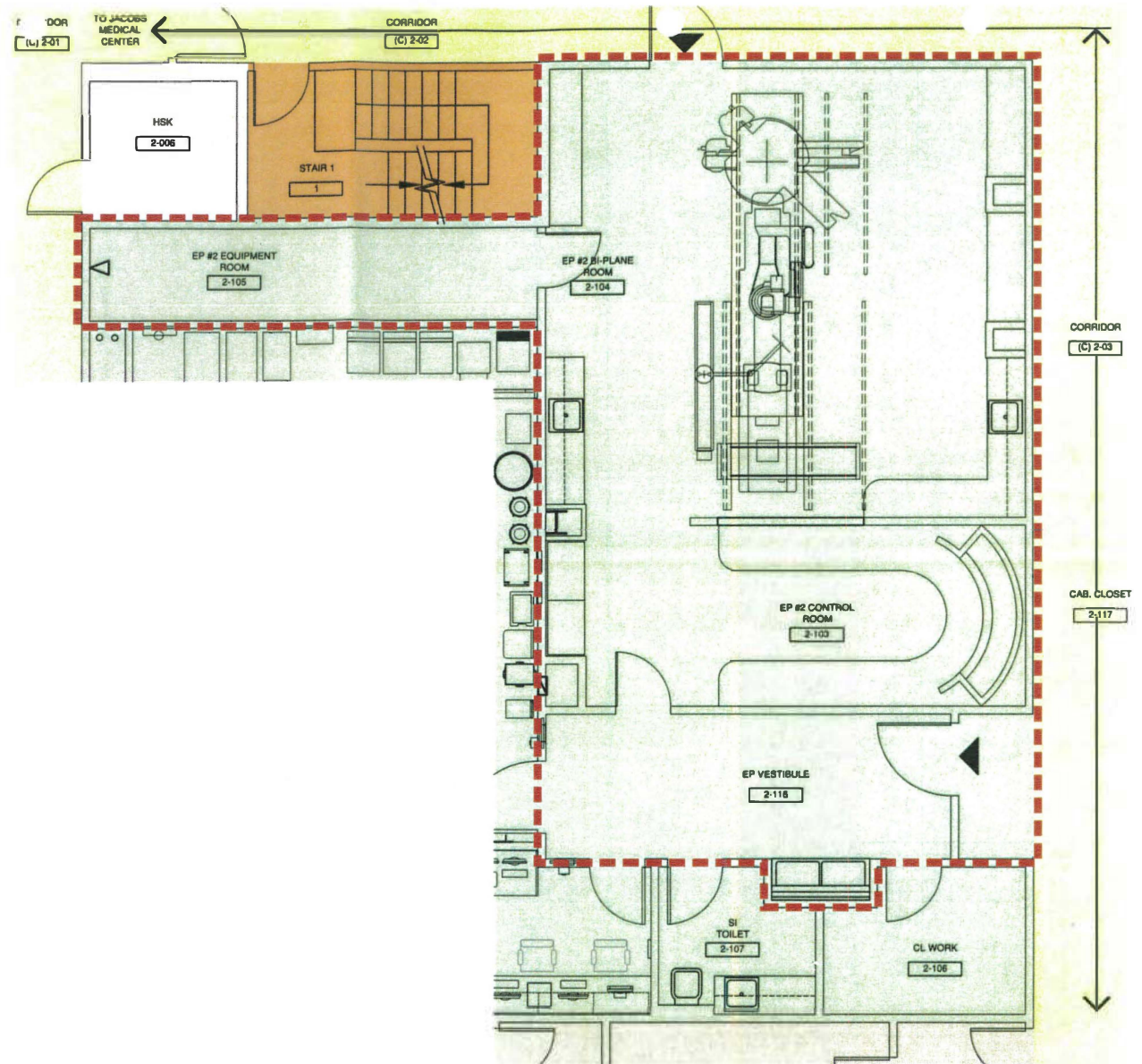
Level 2 North Renovation - Cardiac Electrophysiology

L2 - ENLARGED EXISTING FLOOR PLAN

ABC Medical Center, LLC

COLOR LEGEND

















- SPECIAL PROCEDURES
- OPERATING ROOMS / SURGERY
- CARDIAC ELECTROPHYSIOLOGY
- INTENSIVE CARE UNIT - ICU
- ANESTHESIA
- FUTURE FROZEN SECTION
- PRE/POST TREATMENT UNIT - PTU
- CARDIAC CATH LABS
- PACU
- PRE-OP / RECOVERY
- 2 WEST
- 2 EAST
- MEDICAL OFFICES
- MECHANICAL / SUPPORT
- HORIZONTAL CIRCULATION
- VERTICAL CIRCULATION

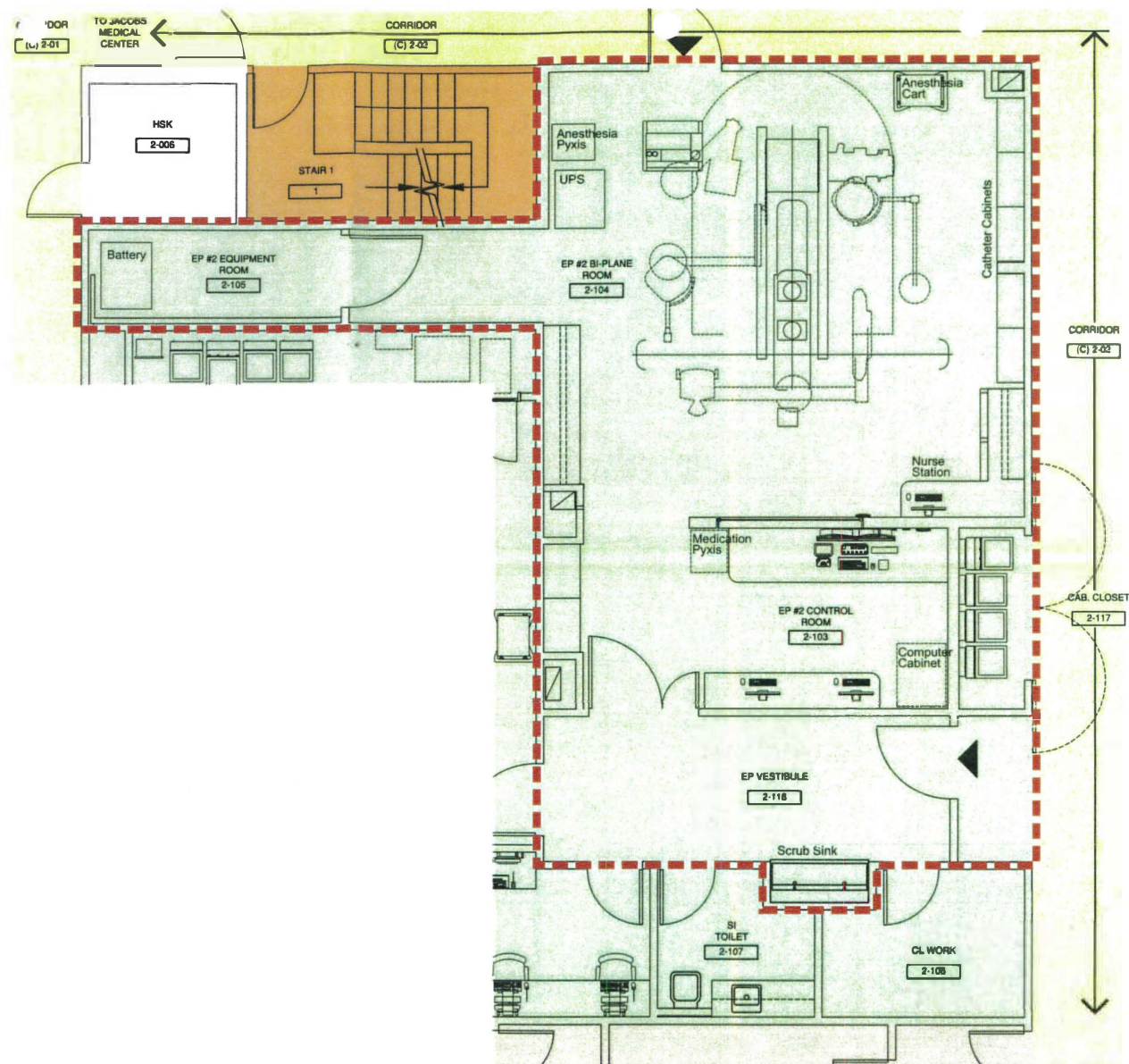


Level 2 North Renovation - Cardiac Electrophysiology

L2 - ENLARGED AREA - EXISTING PLAN

ABC Medical Center, LLC

COLOR LEGEND	
	SPECIAL PROCEDURES
	OPERATING ROOMS / SURGERY
	CARDIAC ELECTROPHYSIOLOGY
	INTENSIVE CARE UNIT - ICU
	ANESTHESIA
	FUTURE FROZEN SECTION
	PRE/POST TREATMENT UNIT - PTU
	CARDIAC CATH LABS
	PACU
	PRE-OP / RECOVERY
	2 WEST
	2 EAST
	MEDICAL OFFICES
	MECHANICAL / SUPPORT
	HORIZONTAL CIRCULATION
	VERTICAL CIRCULATION



Level 2 North Renovation - Cardiac Electrophysiology

L2 - ENLARGED AREA - REMODEL PLAN

ABC Medical Center, LLC

STD 850

FIRE SAFETY INSPECTION REQUEST

STD. 850 (REV. 4-2000)

See instructions on reverse.

AGENCY CONTACT'S NAME Departmental Use Only		TELEPHONE NUMBER Departmental Use Only		REQUEST DATE 03/15/2019	PROGRAM Departmental Use Only	
EVALUATOR'S NAME Departmental Use Only		REQUESTING AGENCY FACILITY NUMBER Departmental Use Only			REQUEST CODE Departmental Use Only	
LICENSING AGENCY NAME AND ADDRESS California Department of Public Health Licensing and Certification Program Centralized Applications Branch P.O. Box 997377, MS 3207 Sacramento, CA 95899-7377					CODES 1. ORIGINAL A. FIRE CLEARANCE 2. RENEWAL B. LIFE SAFETY 3. CAPACITY CHANGE 4. OWNERSHIP CHANGE 5. ADDRESS CHANGE 6. NAME CHANGE 7. OTHER	
AMBULATORY		NONAMBULATORY		BEDRIDDEN		TOTAL CAPACITY
CAPACITY	PREVIOUS CAPACITY	CAPACITY	PREVIOUS CAPACITY	CAPACITY	PREVIOUS CAPACITY	
FACILITY NAME Star Medical Center					LICENSE CATEGORY	
STREET ADDRESS (<i>Actual Location</i>) 1800 Beach Drive					NUMBER OF BUILDINGS	
CITY Sacramento, CA 95814					RESTRAINT	
FACILITY CONTACT PERSON'S NAME Jane Doe			FACILITY CONTACT PERSON'S TELEPHONE NUMBER 999-555-2626		HOURS M-F 8am-5pm	
SPECIAL CONDITIONS						

TO BE COMPLETED BY INSPECTING AUTHORITY

FIRE AUTHORITY NAME AND ADDRESS				CLEARANCE /DENIAL CODE
				CODES 1. FIRE CLEARANCE GRANTED 2. FIRE CLEARANCE DENIED A. EXITS B. CONSTRUCTION C. FIRE ALARM D. SPRINKLERS E. HOUSEKEEPING F. SPECIAL HAZARD G. OTHER
INSPECTOR'S NAME (<i>Typed or Printed</i>)		TELEPHONE NUMBER	CFIRS NUMBER	OCCUPANCY CLASS
INSPECTION DATE	INSPECTOR'S SIGNATURE (<i>Typed or Printed</i>)			
EXPLAIN DENIAL OR LIST SPECIAL CONDITIONS				

FIRE SAFETY INSPECTION REQUEST

STD. 850 (REV. 4-2000) (REVERSE)

INSTRUCTIONS

This form is designed for use with a window envelope

Licensing or Requesting Agencies--Complete the following 19 sections on this form before submitting it to the fire authority having jurisdiction.

1. AGENCY CONTACT, 2. TELEPHONE NUMBER,

5. EVALUATOR. Enter the name and telephone number of agency contact person.

3. PROGRAM. Licensing agency use.

4. REQUEST DATE. Enter date request was prepared.

6. REQUESTING AGENCY FACILITY NUMBER. This is the file number assigned by the licensing agency.

7. REQUEST CODE. Use the seven codes shown and insert the appropriate number in the box following "Request Code". If NAME CHANGE, please list previous name. Insert date of original request is other than an original.

8. AGENCY NAME AND ADDRESS. Enter the name and address of the licensing facility requesting the inspection.

9. AMBULATORY--NONAMBULATORY--BEDRIDDEN.

Capacity: Insert in the appropriate section, the capacity of licensed ambulatory or nonambulatory occupants covered by this request.

Previous Capacity: If request is for renewal or capacity change, insert capacity of previous clearance.

Total Capacity: Show total licensed capacity. If the facility is intended to house part ambulatory, nonambulatory, and part bedridden, show the total of the three types of occupants.

10. FACILITY NAME. Insert the name of the facility as it will appear on the license. List identifying sub name if known (i.e., Hacienda Corp/Medina Lodge).

11. LICENSE CATEGORY. Insert the category of license being sought as it will appear on the license certificate.

12. ADDRESS. Insert street address and city only. A post office box is not acceptable as only location.

13. NUMBER OF BUILDINGS. Insert the total number of buildings to be used for housing of the occupants covered by the license.

14. RESTRAINT. Indicate if physical restraint (locked in a room or the building) is to be used in the housing of the occupants.

15. FACILITY CONTACT PERSON--TELEPHONE NUMBER. Indicate the name and telephone number of the responsible individual at the facility to be contacted by the fire authority.

16. HOURS. Indicate the number of hours the occupants are housed at the facility (less than 24 or 24+).

17. SPECIAL CONDITIONS. Indicate any conditions unique to this request. As an example, if the inspection request is for one building in a multi-building facility.

FIRE AUTHORITY CONDUCTING THE INSPECTION--COMPLETE THE FOLLOWING:

18. FIRE AUTHORITY, NAME AND ADDRESS. Insert the name and address of the fire authority where the facility is located.

19. CLEARANCE/DENIAL CODE. Use the two codes: 1 for clearance granted, and 2 for clearance denied. If denied, also include the appropriate letter code. As an example, Denial based upon exiting would be coded 2A.

20. INSPECTOR'S NAME. Print the initial of the inspector's first name and full last name; insert the telephone number where the inspector may be contacted.

21. CFIRS I.D. NUMBER. Insert the fire department's number assigned by California Fire Incident Reporting System.

22. OCCUPANCY CLASSIFICATION. Use California Building Code occupancy classifications and insert the occupancy determined by the inspector.

23. INSPECTION DATE. Enter the actual date of the inspection.

24. INSPECTOR'S SIGNATURE. To be signed by the inspector conducting the inspection.

25. EXPLAIN DENIAL OR SPECIAL CONDITIONS. If clearance code #2 is used, briefly explain reason. This space is also to be used to specify any additional limitations placed by the fire authority, such as the use of certain floors or sleeping rooms approved for nonambulatory clients.

Insert
CMS-1856
Here