COVER LETTER

ABC Medical Center, LLC
999 Beach Side Court, Sacramento, CA 95814
P: (999) 555-2626
F: (999) 555-2600
Email: JaneDoe@abcmedicalLLC.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 Hospital, located at 1800 Beach Drive, Sacramento, CA 95814, License #222222222.

To Whom It May Concern,

We are submitting a change of service application for Star Hospital, located at 1800 Beach Drive, Sacramento, CA 95814.

Our facility would like to add outpatient surgery to Star Outpatient Surgery Clinic, located at 1888 Beach Drive, CA 95814. Please see the report of change documents enclosed for this change of service application.

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@abcmedicalLLC.org
Phone: (999) 555-2626
Fax: (999) 555-2600
Alternate Email: JaneDoe@cmail.com
Phone (Text Messages): (999) 555-5555

Sincerely,

Jane Doe

Jane Doe, Owner
ABC Medical Center, LLC

SAMPLE

LICENSURE & CERTIFICATION APPLICATION

FOR DEPARTMENTAL USE ONLY	
District:	*ELMS Facility Number:*
Proposed name of facility/agency/clinic:	

A. APPLICATION INFORMATION

1. Type of application (check one):
   - ○ **a.** Initial
   - ○ **b.** Change of Ownership (see #2 below)
   - ○ **c.** Management company (see Sections C1-5, F, and Attachment E-1)
   - ◉ **d.** Other change (see Section A4): Adding Outpatient Surgery

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) Adding Outpatient Surgery

5. Type of facility, agency, or clinic (check one)
   - ○ **a.** Skilled Nursing Facility (SNF)
   - ○ **b.** Intermediate Care Facility (ICF)
   - ○ **c.** ICF/Developmentally Disabled (ICF/DD)
   - ○ **d.** ICF/DD-Habilitative (ICF/DD-H)
   - ○ **e.** ICF/DD-Nursing (ICF/DD-N)
   - ○ **f.** Primary care clinic – Free
   - ○ **g.** Primary care clinic – Community
   - ○ **h.** Surgical clinic
   - ○ **i.** Rural health clinic (for Certification "only")
   - ◉ **j.** General acute care hospital
   - ○ **k.** Adult day health care center
   - ○ **l.** Home Health Agency (HHA)
   - ○ **m.** Hospice
   - ○ **n.** Chronic dialysis clinic
   - ○ **o.** Other (specify)

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: 153
   b. Proposed facility bed capacity: 153

9. Age range of clients: 0-100

10. Days and hours of operation: 24/7 Monday thru Sunday

11. Is construction required? ○ ◉
    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: ABC Medical Center, LLC

2. Federal employer's tax ID number: 55555555

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): 999 Beach Side Court

Telephone number: (999) 555-2626

City, State, & Zip: Sacramento, CA 95814

E-Mail: JaneDoe@abcmedicalLLC.org

Fax number: (999) 555-2600

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: West Coast Health System

Parent federal tax ID Number: 888888888

P.O. Box or number & street: 554 Crystal Blvd, Suite 10

City, State, & Zip: Sacramento, CA 95814

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? If "yes", proceed to **Section E** (below).
   ○ Yes ◉ 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? If "yes", ***submit*** a copy of the "interim" management agreement.
   ○ Yes ◉ No

2. Name of **"proposed" facility**, agency, or clinic: Star Outpatient Surgery Clinic
   Current facility, agency, or clinic name (if change of ownership):
   Facility license number: 222222222

3. Address (number & street) of "proposed" facility, agency, or clinic: 1888 Beach Drive
   Telephone number: (999) 555-0695
   City, State, & Zip: Sacramento, CA 95814

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

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

6. **a.** Name of administrator: Wain Jones
   Date of hire: 05/13/2015
   Professional License number:
   Expiration date:

   b. Name of director of nursing: Amber Dixie
   Date of hire: 05/31/2015
   Professional License number: 777777
   Expiration date: 11/30/2019

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?		
(1)				○ Yes	○ No	
(2)				○ Yes	○ No	
(3)				○ Yes	○ No	
(4)				○ Yes	○ No	
(5)				○ Yes	○ No	

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: ABC Medical Center, LLC
   Address (number & street): 999 Beach Side Court
   City, State, & Zip: Sacramento, CA 95814

   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:

a. Comply with local ordinances concerning zoning, sanitation, building, and other appropriate ordinances.

b. Comply with the Labor Code on employment practices concerning nondiscrimination, liability insurance, wages, hour and working conditions.

c. 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	Date
	Administrator	03/11/2018
Signature	Title	Date
Signature	Title	Date
Signature	Title	Date

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.

OFFICE OF STATEWIDE HEALTHPLANNING AND DEVELOPMENT
FACILITIES DEVELOPMENT DIVISION

700 North Alameda Street, Suite 2-500, Los Angeles, CA 90012 Phone (213) 897-0166 Fax (213) 897-0168
2020 West El Camino Avenue, Suite 800, Sacramento, CA 95833 Phone (916) 440-8300 Fax (916) 324-9188

CO

CERTIFICATE OF OCCUPANCY

Facility Name and Address		Facility No.	Project No.
Star Hospital 1800 Beach Drive, Suite 10 Sacramento, CA 95814		13018	S172280-10-00
		Date 5/15/2018	Parent Project No. N/A
Contractor ABC Medical Center, Inc.			
Inspector of Record ~~John Jones~~	Telephone No. (999- 999-9999)	Approved Plans 3/27/2018	Project % Complete 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 (CBSC) 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 CBSC. 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

I met on site with the IOR (Kevin Lambert) and walked the site, reviewed the approved plan set and the TIO in support of occupancy for milestone 1A.

One of the 3 units was not anchored as approved on plan detail 2 on sheet S922. The IOR described the situation and explained that a non-material ASI#03 had been forwarded to the DSE (Gary Stone) for his review. In this case the approved plan set called for 4 ea 3/8" Hilti KB TZ anchors in a manufacturer supplied plate at each of 4 leg locations. The manufacturers plate only included 3 holes, not 4.

I contacted the DSE by phone and discussed the situation as I believed that 3 anchors each leg appeared to be more than adequate. Gary Agreed and I indicated acceptance by signing off the TIO anchorage and approving the equipment mounting in rooms 3NP12 & NP01 per phase Milestone 1A of the TIO. This equipment mounting represents the extent of work in these 2 rooms for this project thus Occupancy as requested is approved.

RECEIVED
JUN 07 2018
Centralized Applications Unit
Licensing & Certification Program

OSHPD FDD Staff: Gene Franklin, Compliance Officer — Date Printed: 5/15/2018

Report Received By/Title: Kevin Lambert — Date Printed: 5/15/2018

RECORDING REQUESTED BY
STEWARD TITLE OF CALIFORNIA

0118–272010

WHEN RECORDED MAIL TO:
ABC Medical Center, LLC
999 Beach Side Court
Sacramento, CA 95815

MAIL TAX STATEMENTS TO:
ABC Medical Center, LLC
999 Beach Side Court
Sacramento, CA 95815

Stephen L. Vagnini
Monterey County Recorder

RANJELIQUE
9/14/2017
02:50 PM

STEWART TITLE OF CA-ER SPL

DOCUMENT: 2017049575

Titles: 1	Pages: 3
Fees....	18.00
Taxes...	29480.00
Other...	.00
AMT PAID	$29498.00

SPACE A BOVE THIS LINE FOR RECORDER'S USE

The undersigned Grantor hereby declares:

- ☐ Documentary Transfer Tax is $29,480.00
- ☐ Computed on full value of the interest or property conveyed
- ☒ City of Sacramento

APN 999-999-999 and 999-999-999

Grant Deed

For Valuable consideration, ABC Medical Center, Inc., a California corporation, hereby grants to 999 Beach Side Court, LLC, a Delaware limited liability company, all of Grantor's interest in and to the real property located in the City of Sacramento, County of Sacramento, State of California described on Exhibit A attached hereto and incorporated herein.

Dated:
March 11, 2019

ABC Medical Center, Inc.
a California corporation

By Jose Doe
Jose Doe, Chief Financial Officer

Mail Tax statements as set forth above.

45006999

CDPH 609

BED OR SERVICE REQUEST

Date
03/11/2018

This form is intended to identify the types of beds or services requested for adult day health center, acute psychiatric hospitals, general acute care hospitals, special hospitals and skilled nursing facilities. For new facilities, complete the column marked "Requested Beds." For existing facilities, complete both columns. The form is to accompany the application form (HS 200) for any new facility, change in capacity, service, or bed classification.

Name of facility	Type		
Star Hospital	General Acute Care Hospital		
Address (number, street)	City	State	ZIP code
1800 Beach Drive	Sacramento	CA	95814

Please enter the number of beds requested for each category:

EXISTING BEDS

_____ Acute Respiratory Care Services
_____ Burn Center
_____ Cardiovascular Surgery Service
_____ Coronary Care Unit
_____ General Acute Care (Unspecified)
_____ General Nursing (Long-Term)
_____ Intensive Care (Newborn)
_____ Intensive Care Unit
_____ Pediatric Service
_____ Perinatal Unit
_____ Psychiatric Unit
_____ Rehabilitation Center
_____ Renal Transplant Center
_____ Respiratory Care Service
_____ Skilled Nursing Service (DP)
_____ Other (specify) ____________________
_____ Other (specify) ____________________

_____ **APPROVED CAPACITY**

REQUESTED BEDS

_____ Acute Respiratory Care Services
_____ Burn Center
_____ Cardiovascular Surgery Service
_____ Coronary Care Unit
_____ General Acute Care (Unspecified)
_____ General Nursing (Long-Term)
_____ Intensive Care (Newborn)
_____ Intensive Care Unit
_____ Pediatric Service
_____ Perinatal Unit
_____ Psychiatric Unit
_____ Rehabilitation Center
_____ Renal Transplant Center
_____ Respiratory Care Service
_____ Skilled Nursing Service (DP)
_____ Other (specify) ____________________
_____ Other (specify) ____________________

_____ **APPROVED CAPACITY** (For Departmental use only)

Please check services which the facility currently provides or is requesting:

EXISTING SERVICES

_____ Adult Day Program (only applies to an ADHC)
✓ Basic Emergency Physician on Duty
_____ Cardiovascular Surgery
_____ Chronic Dialysis Service
_____ Comprehensive Emergency
_____ Dental Service
_____ Nuclear Medicine Service
✓ Occupational Therapy Service
_____ Outpatient Service (i.e. Family Practice, Pediatrics, Primary Care, Rural Health Clinic, etc.)
Specify: ____________________
Specify: ____________________
✓ Physical Therapy
_____ Podiatric Service
✓ Radiation Therapy
_____ Social Service
_____ Speech Pathology and/or Audiology Service
_____ Other (specify): ____________________
_____ Other (specify): ____________________

REQUESTED SERVICES

_____ Adult Day Program (only applies to an ADHC)
_____ Basic Emergency Physician on Duty
_____ Cardiovascular Surgery
_____ Chronic Dialysis Service
_____ Comprehensive Emergency
_____ Dental Service
_____ Nuclear Medicine Service
_____ Occupational Therapy Service
_____ Outpatient Service (i.e. Family Practice, Pediatrics, Primary Care, Rural Health Clinic, etc.)
Specify: ____________________
Specify: ____________________
_____ Physical Therapy
_____ Podiatric Service
_____ Radiation Therapy
_____ Social Service
_____ Speech Pathology and/or Audiology Service
✓ Other (specify): adding Outpatient Surgery
_____ Other (specify): ____________________

CDPH 241 - 267

APPLICATION FOR
CARDIOVASCULAR SURGERY SERVICE

Reply to:

Star Hospital
HOSPITAL NAME

1. Name, experience or board eligibility or certification status of physician responsible for the catheterization laboratory:

   John Doe, MD - Board Certified by the American Board of Internal Medicine, 1980

   Board Certified in Cardiovascular Disease by the American Board of Internal Medicine, 1990

2. Name, board eligibility or certification status, and training or experience of the radiologist(s) available to the service:

   Jane Doe, MD - Board Certified by the American Board of Radiology, 1985; John Doe, MD - Board

   Certified by the American Board of Interventional Radiology and Diagnostic Radiology, 2000

3. Number of persons assisting during cardiac catheterization procedures: 4

4. Names, disciplines, training and experience, (i.e., RN's or cardiovascular technicians, etc.) of personnel who assist during catheterization procedures:

   John Doe, RN - 16 years experience in Cardiac Catheterization Labs; Jane Doe, RN - 5 years

   experience in Cardiac Catheterization Labs

5. Name and address of biomedical engineer consultant:

   Jane Doe, Biomedical Manager, 123 Medical Center, Sacramento, CA 95814

6. Name and board eligibility or certification status of physician responsible for cardiovascular surgery:

   John Doe, MD - Board Certified by the American Board of Thoracic Surgery,1999

7. Number of surgeons constituting the team for performance of cardiovascular procedures requiring extracorporeal bypass:

   4

8. Names and board eligibility or certification status of the surgical team surgeons:

   Jane Doe, MD - Board Certified by the American Board of Thoracic and Cardiac Surgery, 2000

   John Doe, MD - Board Certified by the American Board of Thoracic and Cardiac Surgery, 2005

9. Names and board eligibility or certification status of anesthesiologists available to the service:

   Jane Doe, MD - Board Certified by the American Board of Anesthesiology, 2012

10. Number of cardiac catheterizations performed annually: 2,000

11. Number of cardiovascular procedures requiring extracorporeal bypass performed annually: 100

12. Does the hospital have an intensive care service with respiratory care capabilities? (●) YES ( ) NO

13. Mortality (within 24 hours of catheterization or surgery):

Catheterization:	Over age 1 year:	0.43%
	Under age 1 year:	N/A
Surgery:	Over age 1 year:	0.47%
	Under age 1 year:	N/A

APPLICATION FOR CHRONIC DIALYSIS SERVICE

Reply to:

Star Hospital
HOSPITAL NAME

1. Name, board eligibility or certification status and experience of physician responsible for the service:
   John Doe, MD - Board Certified by the American Board of Internal Medicine, 1990
   10 years of experience in the care of patients with end-stage renal disease

2. Name, board eligibility or certification status and experience of physician(s) performing vascular access procedures:
   Jane Doe, MD - Board Certified by the American Board of Surgery, 2005
   10 years of experience in vascular surgery

3. Name, board eligibility or certification status of physician(s) treating the children, when applicable:
   Jane Doe, MD - Board Certified by the American Board of Pediatrics, 2001

4. Has a roster of specialty physician consultants been developed? YES NO

5. Name and experience of the registered nurse responsible for nursing care:
   John Doe, RN - Six months of experience in the care of patients with end-stage renal disease

6. Licensed nurse to patient ratio / shift: 1:1

7. Number of registered nurses assigned to the service: 3

APPLICATION FOR CHRONIC DIALYSIS SERVICE

8. Number of licensed vocational nurses assigned to the service: 3

9. Name and qualifications of the dietitian available to the service:
   John Doe, RDN - 5 years of experience

10. Name of the social worker available to the service:
    Jane Doe, MSW - Renal social worker with 10 years of experience

11. Does the hospital participate in a registry of prospective recipient patients? (●) YES ( ) NO

12. Does the hospital participate in kidney procurement preservation and transportation program? (●) YES ( ) NO

13. Is a review mechanism established to determine the appropriateness of patient treatment modality which includes self dialysis, home dialysis and renal transplantation? (●) YES ( ) NO

14. Number of dialyses performed annually: 500

15. Number of chronic dialysis stations in the service: 2

16. Is the written hepatitis control program consistent with recommendations of the hepatitis surveillance program of the Centers for Disease Control? (●) YES ( ) NO

17. Is an isolation area available? (●) YES ( ) NO

18. What provision is made for disposal of infectious wastes?
    Per 22 CCR Section 70847: "Infectious wastes are handled and disposed of in accordance with the Hazardous Waste Control Law, Chapter 6.5, Division 20, Health and Safety Code"

APPLICATION FOR DENTAL SERVICE

Reply to:

Star Hospital
HOSPITAL NAME

1. Name and qualifications of dentist with overall responsibility for the service: Jane Doe, DDS - 20 years of experience
2. Number of dentists with staff privileges: 2
3. Number of dental hygienists: 3
4. Number of dental assistants or dental laboratory technicians: 1
5. Describe method by which a dental patient receives necessary medical care: John Doe, MD, of the medical staff shall be responsible for the care of any medical problem arising during the hospitalization of dental patients

APPLICATION FOR NUCLEAR MEDICINE SERVICE

Reply to:

Star Hospital
HOSPITAL NAME

1. Name and board eligibility or certification status and other qualifications of physician responsible for the service:

   Jane Doe, MD - Board Certified by the American College of Radiology, 1997

2. Name and experience of radiological physicists available to the service:

   John Doe, M.Sc. - Board Certified by the American Board of Radiology, 1995

3. Number of technologists available to the service: 2

4. Briefly describe scope of services provided:

   Diagnostic nuclear medicine exams including, but not limited to, bleed scans, lung scans and bone scans

5. Number of patient evaluations annually: 2,000

APPLICATION FOR OUTPATIENT SERVICE

Reply to:

Star Hospital
HOSPITAL NAME

1. Names, qualifications and experience of person responsible for the service: Jane Doe, MD - Board Certified by the American Board of Obstetrics and Gynecology, 2000; Nurse Practitioner - John Doe, MSN
2. Number of physicians providing services: 2
3. Number of dentists providing services: 0
4. Number of podiatrists providing services: 0
5. Are all physicians, dentists and podiatrists who provide services members of the medical staff? ◉ YES ○ NO
6. Number of outpatient visits annually: 15,000
7. Briefly describe scope of services provided: Provide obstetrical and gynecological services including screening to women of all ages
8. Types of operative procedures performed, if applicable: Urine pregnancy test; cryotherapy; ultrasound (abdominal/transvaginal)
9. Types of anesthesia provided, if applicable: No general anesthesia
10. Number of licensed nurses assigned to the service: 1

CLEAR

APPLICATION FOR PEDIATRIC SERVICE

Reply to:

Star Hospital
HOSPITAL NAME

1. Name, board eligibility or certification status of physician responsible for the service:
   Jane Doe, MD - Board Certified by the American Board of Pediatrics, 1997

2. If the responsible physician is not a pediatrician, list the name, board eligibility or certification status and frequency of consultation of a qualified pediatrician:
   N/A

3. Name, training and experience of the registered nurse responsible for nursing care:
   Jane Doe, RN - 8 years of experience with oversight of inpatient pediatric unit

4. Is a registered nurse on duty on each shift? (●) YES ( ) NO

5. Number of registered nurses assigned to the service: 30

6. Number of licensed vocational nurses assigned to the service: 4

7. Describe the pediatric nursing continuing education and training which has been developed and include frequency of training:
   Bi-annual pediatric nursing training to discuss the newest methods and research in pediatric care

8. Is a copy of the American Academy of Pediatrics (Care of Children in Hospitals) available to and utilized by staff? (●) YES ( ) NO

9. Number of cases treated annually: 280

10. Number of cribs, bassinets and beds: cribs: 0 bassinets: 0 beds: 20

APPLICATION FOR PERINATAL UNIT

Reply to:

Star Hospital
HOSPITAL NAME

1. Name, eligibility or certification status of physician responsible for the service:
John Doe, MD - Board Certified by the American Board of Obstetrics & Gynecologist, 1998

2. If the responsible physician is not a pediatrician or obstetrician-gynecologist, list the name, board eligibility or certification status, and frequency of consultation of a qualified specialist:
N/A

3. Name, eligibility or certification status of the physician responsible for the nursery:
John Doe, MD - Board Certified by the American Board of Pediatrics, 2000

4. Is at least one registered nurse on duty for each shift in the antepartum and postpartum areas? ◉ YES ○ NO

5. Is at least one registered nurse on duty each shift in the labor and delivery suite? ◉ YES ○ NO

6. Is at least one registered nurse trained in infant resuscitation on duty each shift? ◉ YES ○ NO

7. Name, training and neonatal care experience of registered nurse responsible for the nursery:
John Doe, RN - 20 years of training and experience in neonatal nursing; trained in infant resuscitation

8. Licensed nurse to infant ratio/shift: 1:8 AM 1:8 PM 1:8 NIGHT

9. Number of registered nurses assigned to the service 5

10. Number of licensed vocational nurses assigned to the service: 2

11. Name and address of the intensive care newborn nursery service with which formal arrangements have been made:
Star Hospital NICU, 1800 Beach Drive, Sacramento, CA 95814

APPLICATION FOR PODIATRIC SERVICE

Reply to:

Star Hospital
HOSPITAL NAME

1. Name of podiatrist responsible for the service:
   Jane Doe, MD - Board Certified by the American Board of Podiatric Medicine, 1999
2. Describe the method by which a podiatric patient receives necessary medical care:
   Podiatrists conduct physical examinations and complete history for patients undergoing podiatry procedures
3. Number of podiatrists on the medical staff: 10
4. Number of podiatry admissions annually: 50
5. Scope of services provided:
   Podiatric medical and surgical diagnosis and treatment of disorders of the foot by podiatrists with the appropriate staff, space, equipment and supplies for both inpatient and outpatients
6. Describe how the podiatric service relates to the medical staff:
   Medical staff are credentialed members of the Department of Orthopedic Surgery

APPLICATION FOR PSYCHIATRIC UNIT

Reply to:

Star Hospital
HOSPITAL NAME

1. Name and qualifications of the person responsible for the service:
   John Doe MD - Board Certified in Adult and Child-Adolescent Psychiatry by the American Board of Psychiatry, 2005; 10 years of experience in an inpatient psychiatric unit

2. If the responsible person is not a psychiatrist, list the name, board eligibility or certification status of the physician responsible for the medical care and services:
   N/A

3. Number of psychiatrists on the medical staff: 6

4. Name, qualifications and hours per month of the psychologist:
   Jane Doe, Ph.D. - 80 hours/month

5. Names and years of psychiatric nursing experience of the registered nurse responsible for nursing care:
   John Doe, RN - 5 years of experience in psychiatric nursing for inpatient psychiatric units

6. Is a registered nurse on duty on each shift? ☑ YES ☐ NO

7. Number of registered nurses assigned to the service: 35

8. Number of licensed vocational nurses assigned to the service: 4

9. Number of licensed psychiatric technicians assigned to the service: 10

10. Name and qualifications of the therapist employed to conduct the therapeutic activity program:
    Jane Doe, MA, MT-BC - Board Certified music therapist since 1990; 9 years of experience working with inpatient and outpatient mental health patients

11. Name, qualifications and hours per month of the social worker: Jane Doe, LCSW - Over 5 years of experience in inpatient mental health services; 80 hours/month

12. Number of patients admitted annually: 800

13. Number of beds: 28

CLEAR

APPLICATION FOR RADIATION THERAPY SERVICE

Reply to:

Star Hospital
HOSPITAL NAME

1. Name, experience, and eligibility or certification status of physician responsible for the service:
   Jane Doe, MD - Board Certified by the American Board of Radiology, 2003; 16 years of experience as a practicing radiation oncology physician
2. Number of radiologists available to staff the service: 3
3. Name and certification status of the radiological physicist available to the service:
   Jane Doe, MSc - Diplomate of The American Board of Radiology, 1995
4. Name and qualifications of dosimetrist (treatment plan technologist):
   John Doe, PhD - Diplomate of the American Board of Radiology, 2005
   John Doe, MSc - Diplomate of the American Board of Radiology, 2004
5. Name and qualifications of the therapeutic radiological technologist:
   Jane Doe, Radiation Therapy Technologist - 10 years of experience in the field of radiation therapy
6. Number of licensed nurses assigned to the service: 1
7. List the major pieces of radiation therapy equipment:
   True Beam, Linear Accelerator, Varisource Brachytherapy Unit; Philips Big Bore CT simulator; Xstrahi-Orthovoltage Unit
8. Does the hospital have a tumor board, tumor registry, and/or cancer committee in which the service staff participates?

   Tumor Board: (●) YES ( ) NO   Tumor Registry: ( ) YES (●) NO

   Cancer Committee: (●) YES ( ) NO

APPLICATION FOR RENAL TRANSPLANT CENTER

Reply to:

Star Hospital
HOSPITAL NAME

1. Name, experience, eligibility or certification status of the physician responsible for the service:
   John Doe, MD - Board Certified by the American Board of Surgery, American Board of Urology, American Board of Internal Medicine;10 years of experience in the care of patients with renal transplant

2. Name, experience, eligibility or certification status of surgeons:
   John Doe, MD - Board Certified by the American Board of Surgery, 1995; 10 years of experience in renal transplantation

3. If children are treated, list the name, eligibility and certification status of pediatrician(s):
   John Doe, MD - Board Certified by the American Board of Pediatrics, 1990; 20 years of experience in transplant services

4. Names and eligibility or certification status of specialists available to provide evaluations and consultation to transplant patients:

   Internist: John Doe, MD - Board Certified by the American Board of Internal Medicine, 1990

   Neurologist: Jane Doe, MD - Board Certified by the American Board of Psychiatry and Neurology, 2000

   Psychiatrist: John Doe, MD - Board Certified by the American Board of Psychiatry and Neurology, 1995

   Orthopedic Surgeon: Jane Doe, MD - Board Certified by the American Board of Orthopedic Surgery, 1997

   Pathologist: John Doe, MD - Board Certified by the American Board of Pathology, 2001

   Urologist: Jane Doe, MD - Board Certified by the American Board of Urology, 1990

5. Name and experience of the registered nurse responsible for nursing care of transplant patients:
   Jane Doe, RN - 9 years of experience in the care of patients with renal transplants

6. Name and qualifications of dietitian available to the service:
   Jane Doe, Registered Dietician - 6 years of experience providing diet management and counseling to meet the needs of patients with renal transplants

7. Name and qualifications of social worker available to the service:
   Jane Doe, LCSW - 5 years of experience providing social services and counseling to meet the needs of patients with renal transplants

8. Number of transplants per year: 35

APPLICATION FOR RESPIRATORY CARE SERVICE

Reply to:

Star Hospital
HOSPITAL NAME

1. Name, eligibility or certification status of physician responsible for the service:
   John Doe, MD - Board Certified by the American Board of Internal Medicine, 1999; Board Certified in Pulmonary Diseases by the American Board of Internal Medicine, 2002

2. Name and qualifications of the technical director who supervises the operation of the service:
   Jane Doe - MSHA, RRT- 21 years of specialized training and advanced experience in the clinical application of respiratory care

3. Disciplines and numbers of personnel assigned to the service:
   - Registered Nurses: 0
   - Licensed Vocational Nurses: 0
   - Physical Therapists: 0
   - Respiratory Therapists: 22
   - Respiratory Therapy Technicians: 0
   - Cardiopulmonary Technologists: 0
   - Pulmonary Technologists: 1

4. Number of treatments provided annually: 5,600

APPLICATION FOR SOCIAL SERVICE

Reply to:

Star Hospital
HOSPITAL NAME

1. Name and qualifications of the social worker responsible for the service:
   Jane Doe, LCSW - 20 years of experience in the field of social work
2. Number of social workers assigned to the service: 2
3. Number of social work assistants assigned to the service: 0
4. Number of social work aides assigned to the service: 0
5. Number of patients assisted annually: 4,500/year

APPLICATION FOR STANDBY EMERGENCY MEDICAL SERVICE, PHYSICIAN ON CALL

Reply to:

Star Hospital
HOSPITAL NAME

1. Name and qualifications of physician responsible for the service: John Doe, MD - Board Certified by the American Board of Emergency Medicine, 2000; 10 years of experience as an emergency medicine physician

2. Has a method to assure 24 hour physician coverage been developed? ◉ YES ○ NO

3. Are all physicians, dentists and podiatrists providing services members of the medical staff? ◉ YES ○ NO

4. Is a registered nurse immediately available at all times? ◉ YES ○ NO

5. Has a list of referral services been developed? ◉ YES ○ NO

6. Number of treatments provided annually: 500

CLEAR

APPLICATION FOR BASIC EMERGENCY MEDICAL SERVICE, PHYSICIAN ON DUTY

Reply to:

Star Hospital
HOSPITAL NAME

1. Name, training and experience of physician responsible for the service: Jane Doe, MD - Board Certified by the American Board of Emergency Medicine, 1997; 22 years of experience as a practicing emergency medicine physician

2. Are physicians, dentists and podiatrists who staff the service members of the medical staff? (•) YES ( ) NO

3. Is the service staffed with at least one physician 24 hours, 7 days a week? (•) YES ( ) NO

4. Number of physicians available to staff the service: ______

5. Names and qualifications of salaried physicians:
   Jane Doe, MD - Board Certified by the American Board of Emergency Medicine, 2009
   John Doe, MD - Board Certified by the American Board of Emergency Medicine, 1996
   Jane Doe, MD - Board Certified by the American Board of Emergency Medicine, 2011

6. Has a roster of specialty physicians available for consultation been developed? (•) YES ( ) NO

7. Name, training and experience of registered nurse responsible for nursing care: Jane Doe, RN, BSN, MBA - 16 years of nursing experience specializing in emergency medicine

8. Number of registered nurses assigned to the service: 29

9. Number of licensed vocational nurses assigned to the service: 0

10. Has a list of referral services been developed? (•) YES ( ) NO

11. Number of treatments provided annually: 20,000

CLEAR

APPLICATION FOR COMPREHENSIVE EMERGENCY MEDICAL SERVICE

Reply to:

Star Hospital
HOSPITAL NAME

1. Name and experience of the full-time physician responsible for the service: John Doe, MD - Board Certified by the American Board of Emergency Medicine, 2001; 12 years of experience practicing as a emergency medicine physician

2. Are physicians, dentists and podiatrists who staff the service members of the medical staff? (●) YES ( ) NO

3. Names and qualifications of physicians who are in-house 24 hours a day in the following specialties:

Medicine: Jane Doe, MD - Board Certified by the American Board of Emergency Medicine, 2002

Surgery: John Doe, MD - Board Certified by the American Board of Surgery, 1998

Anesthesiology: Jane Doe, MD - Board Certified by the American Board of Anesthesiology, 2000

Neurosurgery: John Doe, MD - Board Certified by the American Board of Neurological Surgery, 1998

Pediatrics: Jane Doe, MD - Board Certified by the American Board of Pediatrics, 2000

Obstetrics-gynecology: John Doe, MD - Board Certified by the American Board of Physician Specialities, 1998

Other:

4. Name, training and experience of registered nurse responsible for nursing care:
   John Doe, RN - 15 years of experience in emergency medical service nursing

5. Number of registered nurses assigned to the service: 50

6. Number of licensed vocational nurses assigned to the service: 50

7. Name of the affiliated medical school:
   Star Medical School

8. Has a continuing education program for all emergency medical service personnel been developed? ◉ YES ○ NO

9. Number of treatments provided annually: 30,000

APPLICATION FOR REHABILITATION CENTER

Reply to:

Star Hospital
HOSPITAL NAME

NOTE: In addition to this application, complete the application forms for **PHYSICAL THERAPY SERVICE**, **OCCUPATIONAL THERAPY SERVICE and SPEECH PATHOLOGY and/or AUDIOLOGY SERVICE**.

1. Name and qualifications of the physician responsible for the service:
   John Doe, MD - Board Certified by the American Board of Physical Medicine and Rehabilitation, 1990; 20 years of experience in rehabilitation medicine
2. Name and experience of the registered nurse responsible for nursing management:
   Jane Doe, RN, CRRN - Certified Rehabilitation Registered Nurse; 10 years of experience in rehabilitation nursing
3. Number of registered nurses assigned to the service: 5
4. Number of licensed vocational nurses assigned to the service: 5
5. Number of nurses aides assigned to the service: 5
6. List the major diagnostic categories treated:
   Traumatic brain injury, neuromuscular disorders, orthopedic injury, spinal cord injury, stroke, burns, complex medical disease
7. Has a written utilization review plan for the rehabilitation center been developed? ◉ YES ○ NO
8. List the disciplines represented on the rehabilitation center utilization review committee:
   General medicine, osteopathy, neuropsychiatry
9. At what frequency are staff conferences held? 1 month

APPLICATION FOR
OCCUPATIONAL THERAPY SERVICE

Reply to:

Star Hospital
HOSPITAL NAME

1. Name and qualifications of the occupational therapist responsible for the service:
   John Doe, OTR/L - BA Medical Rehabilitation, 2005 CA License Board of Occupational Therapy
   OTR/L; 10 years of clinical experience in acute care acute rehabilitation and outpatient care
2. Number of full-time occupational therapists assigned to the service: 0
3. Number of part-time occupational therapists assigned to the service: 6
4. Number of occupational therapy assistants assigned to the service: 0
5. Number of occupational therapy aides assigned to the service: 0
6. Number of treatments provided annually: 5000

APPLICATION FOR PHYSICAL THERAPY SERVICE

Reply to:

Star Hospital
HOSPITAL NAME

1. Name and qualifications of the physical therapist responsible for the service: John Doe, PT, MA - Master of Arts in Physical Therapy; 30 years of clinical and managerial experience
2. Number of full-time physical therapists assigned to the service: 5
3. Number of part-time physical therapists assigned to the service: 10
4. Number of physical therapy assistants: 0
5. Number of physical therapy aides: 3
6. Number of treatments provided annually: 10,000

**APPLICATION FOR
SPEECH PATHOLOGY AND/OR
AUDIOLOGY SERVICE**

Reply to:

Star Hospital
HOSPITAL NAME

1. Name and qualifications of the person responsible for the service:
Jane Doe, Clinical Supervisor CCC - SLP - Master of Arts Communication Disorders; 20 years of experience in cognitive and speech/language impairments in the acute care setting

2. Name, board eligibility or certification status of otolaryngologist available to the service:
John Doe, MD - Board Certified by the American Board of Otolaryngology, 1997
Jane Doe, MD - Board Certified by the American Board of Otolaryngology, 2009

3. Number of speech pathologists available to the service: 4
4. Number of audiologists available to the service: 1
5. Number of unlicensed persons assigned to the service: 1
6. Number of speech pathology treatments provided annually: 2,000
7. Number of audiology treatments provided annually: 1,000

APPLICATION FOR
ACUTE RESPIRATORY CARE SERVICE

Reply to:

Star Hospital
HOSPITAL NAME

1. Name and board eligibility or certification status of physician responsible for the service:
   Jane Doe, MD - Board Certified by the American Board of Internal Medicine Board, 2010

2. Names and board eligibility or certification status of other physicians available to the service:
   John Doe, MD - Board Certified by the American Board of Internal Medicine, 1997; Board Certified by the American Board of Anesthesiology, 2000

3. Name, training and experience of registered nurse responsible for nursing care:
   Jane Doe, RN - 12 years of nursing experience in the care of acute respiratory failure patients

4. Number of registered nurses assigned to the service: 7
5. Number of licensed vocational nurses assigned to the service: 6
6. Number of nurses aides assigned to the service: 3
7. Registered nurse to patient ratio/shift: 1:4 AM 1:4 PM 1:4 NIGHT
8. Licensed nurse to patient ratio/shift: 1:2 AM 1:2 PM 1:2 NIGHT
9. Number of respiratory therapists available to the service: 3
10. Name of physical therapist available to the service : John Doe
11. Name of social worker available to the service: Jane Doe
12. Number of cases treated annually: 1,000
13. Number of beds in the service: 5

APPLICATION FOR BURN CENTER

Reply to:

Star Hospital
HOSPITAL NAME

1. Name and board eligibility or certification status of physician responsible for the service:
   John Doe, MD - Board Certified by the American Board of Surgery, 2000; member of the American Burn Association

2. Names and board eligibility or certification status of surgeons responsible for supervision and performance of burn care:
   Jane Doe, MD - Board Certified by the American Board of Plastic Surgery, 2001
   John Doe, MD - Board Certified by the American Board of Surgery, 1999

3. Is continuous in-house physician coverage provided? ◉ YES ○ NO

4. Has a roster of specialty physician consultants been developed? ◉ YES ○ NO

5. Name, burn care experience and continuing education training of registered nurse responsible for nursing care:
   Jane Doe, RN - Six months of nursing experience in the treatment of burn patients in a burn center with continuing education in burn care

6. Is a registered nurse with at least 3 months' burn care experience on duty each shift? ◉ YES ○ NO

7. Number of registered nurses assigned to the service: 2

8. Number of licensed vocational nurses assigned to the service: 3

9. Are psychiatrists, physical therapists, occupational therapists and social workers regularly available to provide care and consultation? ◉ YES ○ NO

10. Number of cases treated annually: 100

11. Number of beds in the service: 5

APPLICATION FOR CORONARY CARE SERVICE

Reply to:

Star Hospital
HOSPITAL NAME

1. Name, board eligibility or certification status and experience of physician responsible for the service:
   John Doe, MD - Board Certified in Cardiovascular Disease by the American Board of Internal Medicine, 1990; 14 years of experience in cardiovascular disease

2. If the responsible physician is not a cardiologist, name and board eligibility or certification status of the consultant cardiologist:
   N/A

3. Name and coronary care experience of registered nurse responsible for nursing care:
   Jane Doe, RN - 13 years of experience in coronary care nursing

4. Number of registered nurses assigned to the service: 2

5. Number of licensed vocational nurses assigned to the service: 1

6. Licensed nurse to patient ratio/ shift: 1:2 AM 1:2 PM 1:2 NIGHT

7. Number of cases treated annually: 1000

8. Number of beds in the service: 10

APPLICATION FOR INTENSIVE CARE NEWBORN NURSERY SERVICE

Reply to:

Star Hospital
HOSPITAL NAME

1. Name and board eligibility or certification status and additional neonatology training or experience of the physician responsible for the service:

   John Doe, MD - Board Certified in Neonatal-Perinatal Medicine by the American Board of Pediatrics, 2001

2. Name and board eligibility or certification status of anesthesiologist(s) available to the service:

   Jane Doe, MD - Board Certified in Anesthesia and Pediatric Anesthesia by the American Board of Anesthesiology, 1990

3. Name and qualifications of the surgeon(s) performing neonatal surgery:

   John Doe, MD - Board Certified by the American Board of Thoracic Surgery, 1985

4. Name and qualifications of pediatric cardiologist(s) available to the service:

   Jane Doe, MD, FACC

   John Doe, MD - Board Certified in Pediatric Cardiology by the American Board of Pediatrics, 1995

5. Name, training and newborn intensive care experience of the nurse responsible for the nursing care:

   Jane Doe, BSN, RN - 5 years of experience in newborn intensive care

6. Is a registered nurse with training and experience on duty each shift? ☒ YES ☐ NO

7. Is a registered nurse trained in infant resuscitation on duty each shift? ☒ YES ☐ NO

8. Registered nurse to infant ratio/ shift: 1:1 AM 1:1 PM 1:1 NIGHT

9. Does the service have a designated transportation team? (●) YES ( ) NO

10. Name of the physician on the transportation team: John Doe, MD

11. Name and qualifications of the registered nurse assigned to the transportation team:
Jane Doe, RN - 3 years of experience in newborn intensive care

12. Name of the respiratory therapist(s) on the transportation team, if provided:
Jane Doe, RT

13. List the referring perinatal units by hospital and address:
Hope Medical Center - 1010 Shoreline Drive, Fair Oaks, CA 95628
Peace Hospital - 123 Sand Avenue, Sacramento, CA 95826

14. Number of beds, cribs and bassinets: Beds: ______ Cribs: ______ Bassinets: 30

15. Does the service provide continuing education for staff of referring perinatal units? (●) YES ( ) NO

APPLICATION FOR
INTENSIVE CARE SERVICE

Reply to:

Star Hospital
HOSPITAL NAME

Jane Doe, MD - Board Certified in Critical Care by the American Board of Internal Medicine, 2005

1. Name and qualifications of physician responsible for the service:
   Jane Doe, MD - Board Certified in Critical Care by the American Board of Internal Medicine, 2005

2. Name, training and intensive care experience of registered nurse responsible for the nursing service:
   Jane Doe, RN - 13 years of experience as Charge Nurse/Critical Care RN for intensive care units and emergency departments

3. Number of licensed nurses assigned to the service: 27

4. Registered nurse to patient ratio/ shift: 1:2 AM 1:2 PM 1:2 NIGHT

5. Licensed vocational nurse to patient ratio/ shift: none AM none PM none NIGHT

6. Number of cases treated annually: 280

7. Number of beds in the service: 20

8. Has a continuing education program for medical staff and nursing personnel been developed? ☒ YES ☐ NO

CDPH 709

CDPH 709

CLIENT ACCOMMODATIONS ANALYSIS

This form is designed to provide a record of client accommodations approved for licensed care. It identifies the approved use of individual rooms and approved capacities. This is intended to be completed on initial license and subsequent changes of capacity, classification or accommodations. When a number of buildings are part of a licensed facility, a rough plot plan should be attached designating separate building by a letter or number code.

Facility name				Facility number
Star Hospital				111111111
Facility address (number, street)	City	State	ZIP code	
1800 Beach Drive	Sacramento	California	95814	

Building	Floor	Room	Activity	Room Size	Floor Area	Approved Capacity	Non-ambulatory	Ambulatory
Individual's Room								
Main	2nd	234	Patient room	20'-3x15'9	246	1		x
Main	2nd	235	Patient room	20'-3x15'9	246	1		x
Common Rooms (Dining, Recreation, Living, Library)								
Storage								

Building	Floor	Room	Activity	Room Size	Floor Area	Approved Capacity	Non-ambulatory	Ambulatory

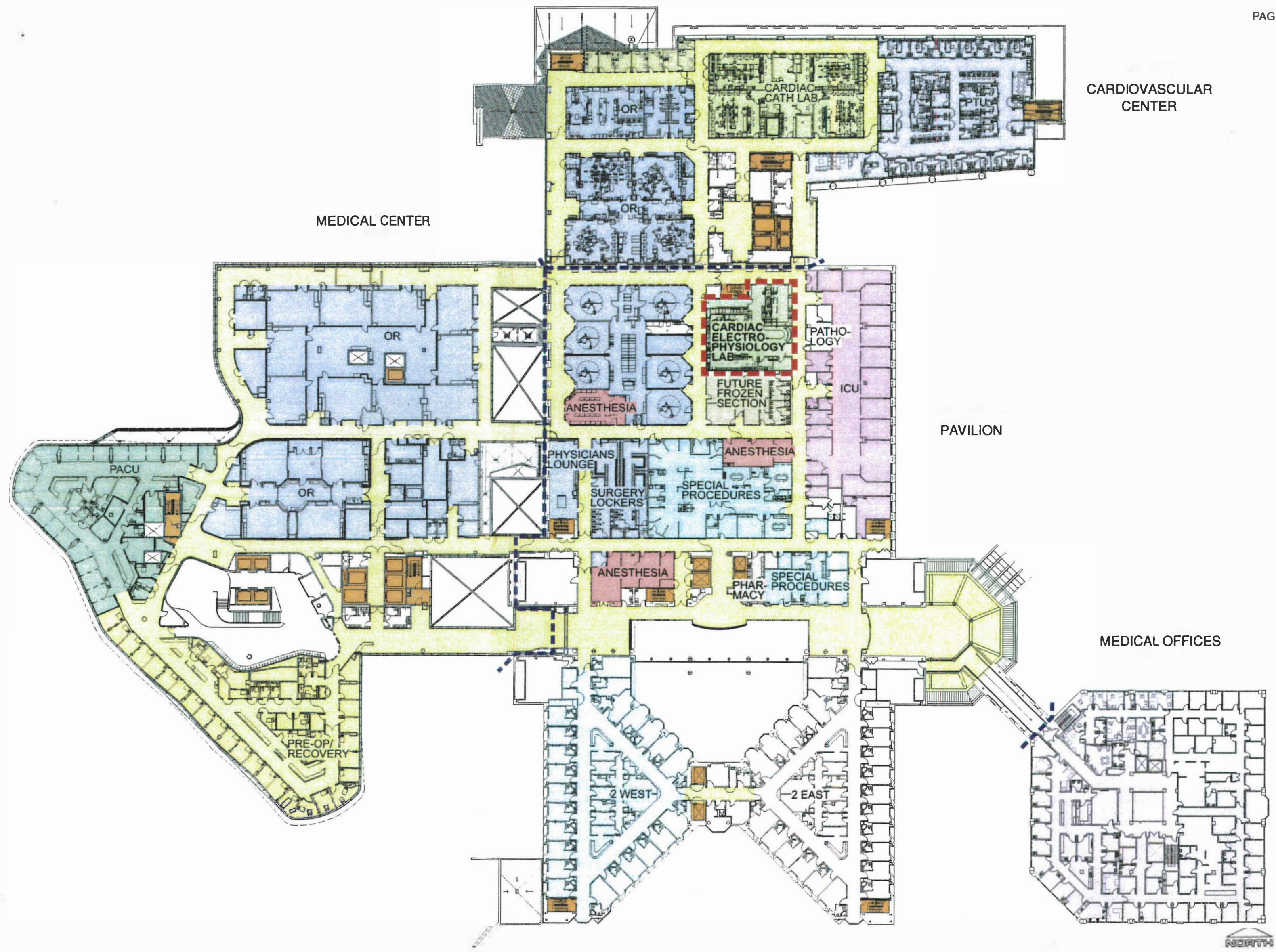
Additional Rooms (This space may also be used for individual rooms where necessary.)

Additional Information: Use this space to list information necessary to ensure adequate accommodation. Example: Type of ventilation (number of windows); important furnishing (number of toilets, showers, tubs). Note allowance for activity area, parking, garage, detached building, etc.

Name of person completing form	Date
Wain Jones	3/11/18

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

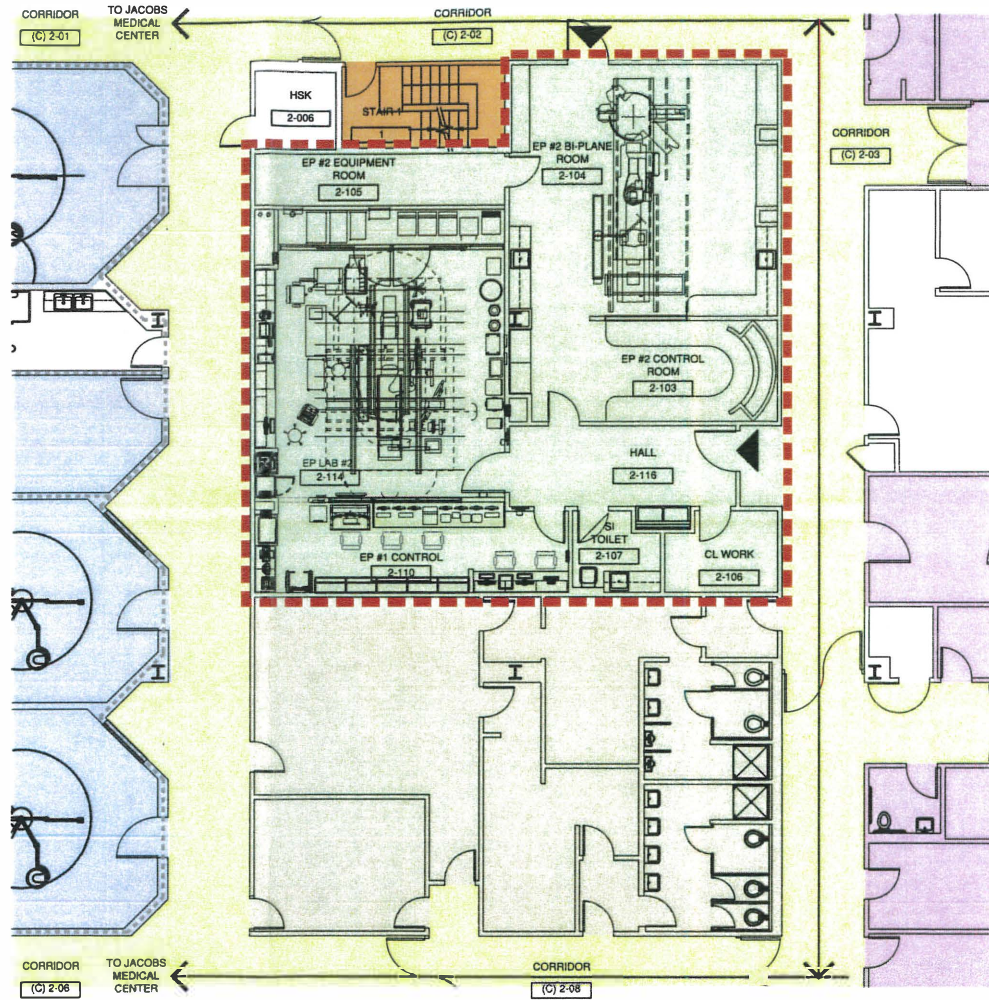
Level 2 North Renovation - Cardiac Electrophysiology

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

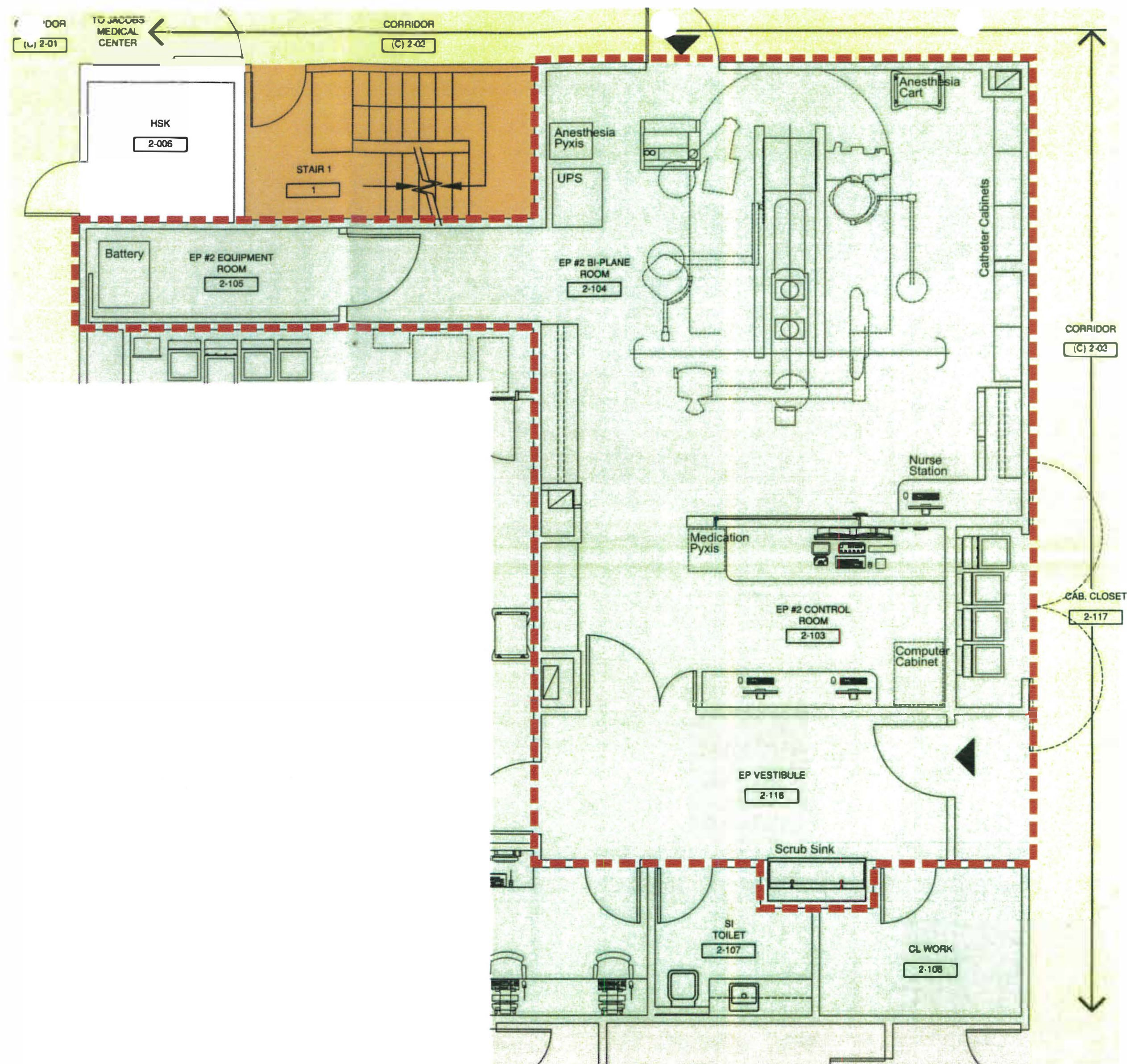
- SPECIAL PROCEDURES
- OPERATING ROOMS / SURGERY
- CARDIAC ELECTROPHYSIOLOGY
- INTENSIVE CARE UNIT - ICU
- ANESTHESIA
- FUTURE FROZEN SECTION
- PRE/POST TREATMENT UNIT - PTU
- CARDIAC CATH LABS
- PACU
- PRE-OP / RECOVERY
- 2 WEST
- 2 EAST
- MEDICAL OFFICES
- MECHANICAL / SUPPORT
- HORIZONTAL CIRCULATION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

Level 2 North Renovation - Cardiac Electrophysiology

L2 - ENLARGED AREA - EXISTING PLAN

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

STATE OF CALIFORNIA – FORESTRY AND FIRE PROTECTION

FIRE SAFETY INSPECTION REQUEST

STD. 850 (REV. 4-2000)

See instructions on reverse.

AGENCY CONTACT'S NAME	TELEPHONE NUMBER	REQUEST DATE	PROGRAM
Completed by Centralized Applications Branch	Completed by CAB	CAB	L & C
EVALUATOR'S NAME	REQUESTING AGENCY FACILITY NUMBER		REQUEST CODE
Completed by Centralized Applications Branch	Completed by CAB		1

LICENSING AGENCY NAME AND ADDRESS

California Department of Public Health
Licensing & Certification Program
Centralized Applications Branch
P. O. Box 997377, MS 3207
Sacramento, CA 95899-7377

CODES

1. ORIGINAL
2. RENEWAL
3. CAPACITY CHANGE
4. OWNERSHIP CHANGE
5. ADDRESS CHANGE
6. NAME CHANGE
7. OTHER

A. FIRE CLEARANCE
B. LIFE SAFETY

AMBULATORY		NONAMBULATORY		BEDRIDDEN		TOTAL CAPACITY
CAPACITY	PREVIOUS CAPACITY	CAPACITY	PREVIOUS CAPACITY	CAPACITY	PREVIOUS CAPACITY	
125	125	25	25	3	3	153

FACILITY NAME		LICENSE CATEGORY
Star Hospital		GACH
STREET ADDRESS *(Actual Location)*		NUMBER OF BUILDINGS
1800 Beach Drive		Total number of buildings
CITY		RESTRAINT
Sacramento, CA 95814		# if any
FACILITY CONTACT PERSON'S NAME	FACILITY CONTACT PERSON'S TELEPHONE NUMBER	HOURS
Wain Jones	999-555-0695	8-5

SPECIAL CONDITIONS

Make notes here if there are any special contact arrangements.

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 *(Typed or Printed)*	TELEPHONE NUMBER	CFIRS NUMBER	OCCUPANCY CLASS

INSPECTION DATE	INSPECTOR'S SIGNATURE *(Typed or Printed)*

EXPLAIN DENIAL OR LIST SPECIAL CONDITIONS

STATE OF CALIFORNIA – FORESTRY AND FIRE PROTECTION

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 DENIALOR 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.

A0797160

0|6|226 SRV

FILED
Secretary of State
State of California
ICC DEC 29 2018

PURCHASE AGREEMENT

BY AND BETWEEN

ABC Medical Center, LLC and ABC Medical Centers, Inc.

This Agreement of Acquisition is entered into by and between ABC MEDICAL CENTER, LLC, a California limited liability company, and ABC MEDICAL CENTERS, INC, a California corporation.

The parties agree as follows:

1. Merging Corporation shall be merged into Surviving Corporation (the "Merger").
2. Upon the Merger, the separate existence of Merging Corporation shall cease and Surviving LLC shall succeed, without any other transfer, to all the debts and liabilities thereof in the same manner as if Surviving Corporation had itself incurred them. All rights of creditors and all liens upon the property of the Merging Corporation shall be preserved unimpaired, provided that such liens upon property of Merging Corporation shall be limited to the property affected thereby immediately prior to the time the Merger is effective.
3. Merging Corporation shall, from time to time as requested by Surviving Corporation, execute and deliver all reasonable documents and instruments and take all reasonable actions necessary or desirable to evidence or carry out the Merger.
4. The effect of the Merger is a prescribed by law.

[signature page to follow]

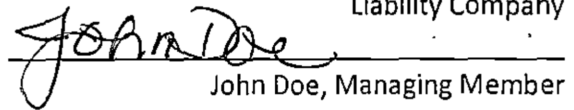
A0797160

We declare under penalty of perjury under the laws of the State of California that the matters set forth in this certificate are true and correct of our own knowledge.

INWITNESS WHEREOF, the parties have executed this Purchase Agreement.

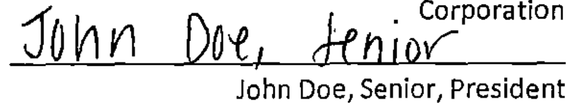
December 28, 2018

ABC MEDICAL CENTER, LLC a California Limited Liability Company



John Doe, Managing Member

ABC MEDICAL CENTER, INC. a California Corporation



John Doe, Senior, President

I hereby certify that the foregoing transcript of 3 page(s) is a full, true and correct copy of the original record in the custody of the California Secretary of State's office.

Date: DEC 29 2018

ALEX PADILLA, Secretary of State

March 11, 2019

California Department of Public Health
Licensing and Certification Program
Centralized Applications Branch
P. O. Box 997377, MS 3207
Sacramento, CA 95899-7377

RE: Change of Ownership of ABC Medical Center, Inc.

TO WHOM IT MAY CONCERN:

This correspondence shall serve as notice to the Department of Public Health regarding the storage of and access to, the resident's records after the change of ownership of the above referenced General Acute Care Hospital to **ABC Medical Center, LLC**, (the new licensee) dba **Star Hospital**.

The New Licensee will store the current residents' records at the facility address of 1800 Beach Drive, Sacramento, CA 95814. The current records will be made available to the prior licensee, where applicable, and to other authorized persons, as needed.

Discharge resident health records will be stored at the facility at 1800 Beach Drive, Sacramento, CA 95814. The discharge resident health records will be accessible 7 days a week, 24 hours a day, and will be made available to the prior licensee, and to other authorized persons, as needed.

Sincerely,

John Doe
Managing Member, Owner