COVER LETTER

XYZ Medical Center, LLC
555 Lake Side Court, Sacramento, CA 95814
P: (999) 555-2626
F: (999) 555-2600
Email: PatrickStar@xyzmedicalLLC.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 OWNERSHIP** Application for General Acute Care Hospital known as Star Hospital, located at 1800 Beach Drive, Sacramento, CA 95814,
License #222222222

To Whom It May Concern,

We are submitting a change of ownership application for Star Hospital, located at 1800 Beach Drive, Sacramento, CA 95814. The licensee will change from ABC Medical Center, LLC to the new licensee XYZ Medical Center, LLC effective 12/11/2019.

Enclosed are the required documents to support processing my change of ownership application.

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

Emergency Contact Information (available 365/24/7)
Name: Patrick Star
Email: PatrickStar@xyzmedicalLLC.org Alternate Email: PatrickStar@cmail.com
Phone: (999) 555-2626 Phone (Text Messages): (999) 555-5555
Fax: (999) 555-2600

Sincerely,

Patrick Star

Patrick Star, Owner
XYZ 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):

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: 03/11/2018

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) Change of Ownership

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? ○ 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: XYZ Medical Center, LLC

2. Federal employer's tax ID number: 444444444

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): 555 Lake Side Court

Telephone number: (999) 555-2626

City, State, & Zip: Sacramento, CA 95814

E-Mail: JaneDoe@xyzmedicalLLC.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 Beach 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: ____
   Current facility, agency, or clinic name (if change of ownership): Star Hospital
   Facility license number: 222222222

3. Address (number & street) of "proposed" facility, agency, or clinic: 1800 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?		Relationship
(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: XYZ Medical Center, LLC
   Address (number & street): 555 Lake 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

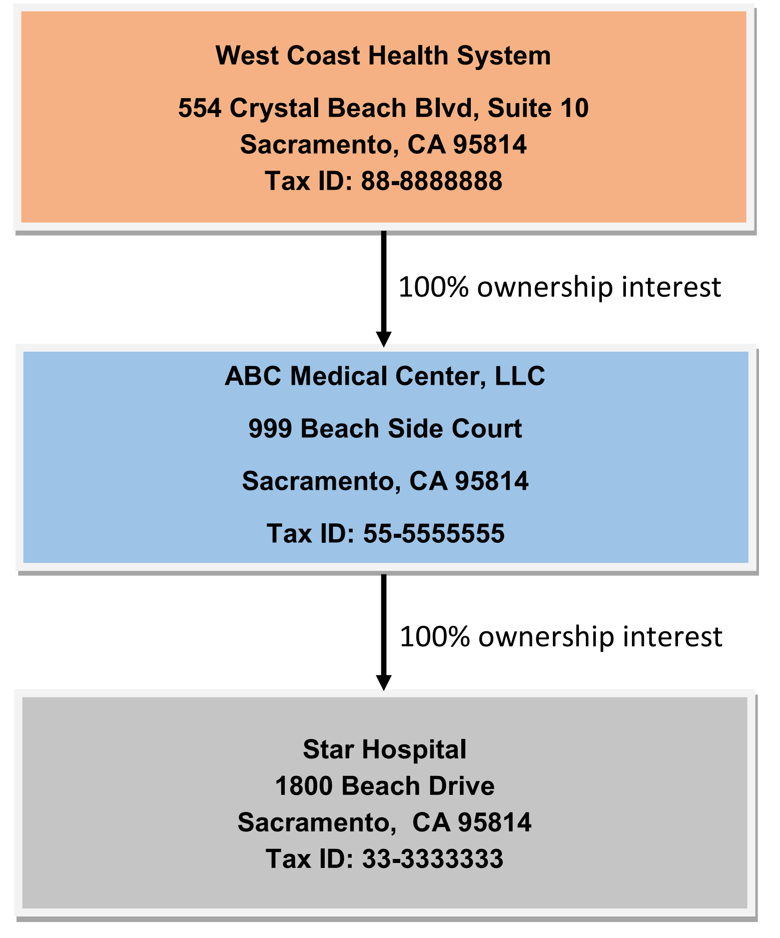
MANAGEMENT COMPANY INFORMATION ONLY FOR SNF's OR ICF's

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.

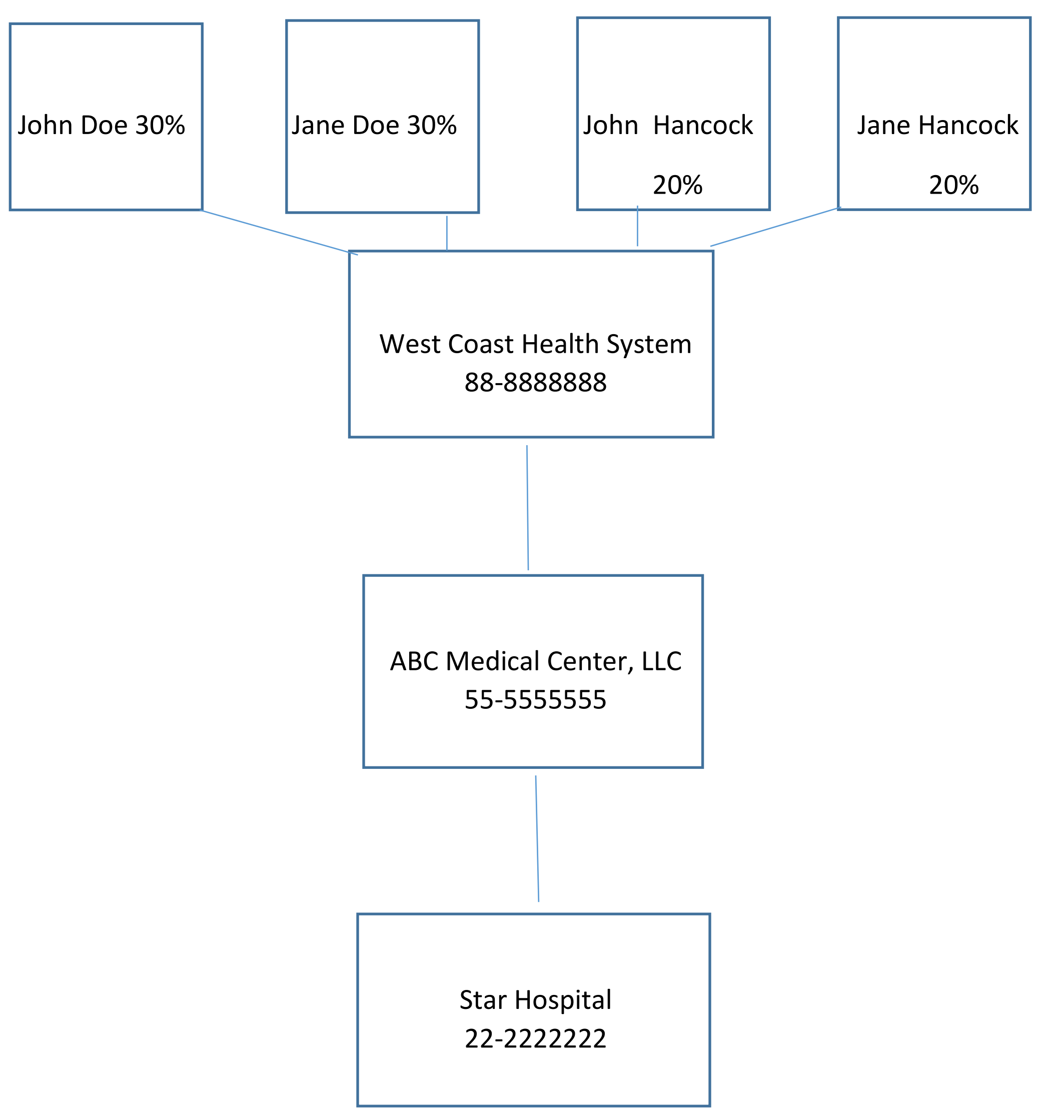
2. Provide the name, address, and percent of ownership for each person having a **5 percent** or more interest in the Management Company.
   - ☐ ***Submit*** an attachment for additional names. This attachment must include all of the required information.

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.

Organization Chart



ORGANIZATIONAL CHART FOR ABC MEDICAL CENTER, LLC
55-5555555
999 Beach Side Court
Sacramento, CA 95814



John Doe – Managing Member
Jane Doe – Member
John Hancock – Member
Jane Hancock – Member

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 ABOVE 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 [signature: Jose Doe]
Jose Doe, Chief Financial Officer

Mail Tax statements as set forth above.

45006999

IRS DEPARTMENT OF THE TREASURY
INTERNAL REVENUE SERVICE
CINCINNATI OH 45999-0023

Date of this notice:

07-07-2017 Employer

Identification Number:

55-5555555

Form: SS-4

Number of this notice: CP 575 A

For assistance you may call us at:
1-800-829-4933

ABC Medical Center, LLC
John Doe
999 Beach Side Court
Sacramento, CA 95814

IF YOU WRITE, ATTACH THE
STUB AT THE END OF THIS NOTICE.

WE ASSIGNED YOU AN EMPLOYER IDENTIFICATION NUMBER

Thank you for applying for an Employer Identification Number (EIN). We assigned you EIN 55-5555555. This EIN will identify you, your business accounts, tax returns, and documents, even if you have no employees. Please keep this notice in your permanent records.

When filing tax documents, payments, and related correspondence, it is very important that you use your EIN and complete name and address exactly as shown above. Any variation may cause a delay in processing, result in incorrect information in your account, or even cause you to be assigned more than one EIN. If the information is not correct as shown above, please make the correction using the attached tear off stub and return it to us.

Based on the information received from you or your representative, you must file the following form(s) by the date(s) shown.

Form 941	10/31/2017
Form 940	01/31/2018
Form 1065	03/15/2018

If you have questions about the form(s) or the due date(s) shown, you can call us at the phone number or write to us at the address shown at the top of this notice. If you need help in determining your annual accounting period (tax year), see Publication 538, *Accounting Periods and Methods*.

We assigned you a tax classification based on information obtained from you or your representative. It is not a legal determination of your tax classification, and is not binding on the IRS. If you want a legal determination of your tax classification, you may request a private letter ruling from the IRS under the guidelines in Revenue Procedure 2004-1, 2004-1 I.R.B. 1 (or superseding Revenue Procedure for the year at issue). Note: Certain tax classification elections can be requested by filing Form 8832, *Entity Classification Election*. See Form 8832 and its instructions for additional information.

A limited liability company (LLC) may file Form 8832, *Entity Classification Election*, and elect to be classified as an association taxable as a corporation. If the LLC is eligible to be treated as a corporation that meets certain tests and it will be electing S corporation status, it must timely file Form 2553, *Election by a Small Business Corporation*. The LLC will be treated as a corporation as of the effective date of the S corporation election and does not need to file Form 8832.

If you are required to deposit for employment taxes (Forms 941, 943, 940, 944, 945, CT-1, or 1042), excise taxes (Form 720), or income taxes (Form 1120), you will receive a Welcome Package shortly, which includes instructions for making your deposits electronically through the Electronic Federal Tax Payment System (EFTPS). A Personal Identification Number (PIN) for EFTPS will also be sent to you under separate cover. Please activate the PIN once you receive it, even if you have requested the services of a tax professional or representative. For more information about EFTPS, refer to Publication 966, *Electronic Choices to Pay All Your Federal Taxes*. If you need to make a deposit immediately, you will need to make arrangements with your Financial Institution to complete a wire transfer.

The IRS is committed to helping all taxpayers comply with their tax filing obligations. If you need help completing your returns or meeting your tax obligations, Authorized e-file Providers, such as Reporting Agents (payroll service providers) are available to assist you. Visit the IRS Web site at www.irs.gov for a list of companies that offer IRS e-file for business products and services. The list provides addresses, telephone numbers, and links to their Web sites.

To obtain tax forms and publications, including those referenced in this notice, visit our Web site at www.irs.gov. If you do not have access to the Internet, call 1-800-829-3676 (TTY/TDD 1-800-829-4059) or visit your local IRS office.

IMPORTANT REMINDERS:

* Keep a copy of this notice in your permanent records. **This notice is issued only one time and the IRS will not be able to generate a duplicate copy for you.** You may give a copy of this document to anyone asking for proof of your EIN.

* Use this EIN and your name exactly as they appear at the top of this notice on all your federal tax forms.

* Refer to this EIN on your tax-related correspondence and documents.

If you have questions about your EIN, you can call us at the phone number or write to us at the address shown at the top of this notice. If you write, please tear off the stub at the bottom of this notice and send it along with your letter. If you do not need to write us, do not complete and return the stub.

Your name control associated with this EIN is HONO. You will need to provide this information, along with your EIN, if you file your returns electronically.

Thank you for your cooperation.

Keep this part for your records. CP 575 A (Rev. 7-2007)

Return this part with any correspondence
so we may identify your account. Please
correct any errors in your name or address.

CP 575 A

9999999999

Your Telephone Number	Best Time to Call	
( ) -		DATE OF THIS NOTICE: 07-07-2017
		EMPLOYER IDENTIFICATION NUMBER: 55-5555555
		FORM: SS-4 NOBOD

INTERNAL REVENUE SERVICE
CINCINNATI OH 45999-0023

ABC Medical Center, LLC
John Doe
999 Beach Side Court
Sacramento, CA 95814

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.

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

State of California-Health and Human Services Agency — California Department of Public Health

BED OR SERVICE REQUEST

Date: 3/11/2018

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		REQUESTED BEDS	
______	Acute Respiratory Care Services	______	Acute Respiratory Care Services
______	Burn Center	______	Burn Center
______	Cardiovascular Surgery Service	______	Cardiovascular Surgery Service
______	Coronary Care Unit	______	Coronary Care Unit
153	General Acute Care (Unspecified)	153	General Acute Care (Unspecified)
______	General Nursing (Long-Term)	______	General Nursing (Long-Term)
______	Intensive Care (Newborn)	______	Intensive Care (Newborn)
______	Intensive Care Unit	______	Intensive Care Unit
______	Pediatric Service	______	Pediatric Service
______	Perinatal Unit	______	Perinatal Unit
______	Psychiatric Unit	______	Psychiatric Unit
______	Rehabilitation Center	______	Rehabilitation Center
______	Renal Transplant Center	______	Renal Transplant Center
______	Respiratory Care Service	______	Respiratory Care Service
______	Skilled Nursing Service (DP)	______	Skilled Nursing Service (DP)
______	Other (specify) ______	______	Other (specify) ______
______	Other (specify) ______	______	Other (specify) ______
153	**APPROVED CAPACITY**	______	**APPROVED CAPACITY** (For Departmental use only)

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

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

MEDICAL CENTER

CARDIOVASCULAR CENTER

PAVILION

MEDICAL OFFICES

OR

CARDIAC CATH LAB

PTU

OR

OR

CARDIAC ELECTRO-PHYSIOLOGY LAB

PATHO-LOGY

ICU

FUTURE FROZEN SECTION

ANESTHESIA

PACU

OR

PHYSICIANS LOUNGE

SURGERY LOCKERS

SPECIAL PROCEDURES

ANESTHESIA

ANESTHESIA

PHAR-MACY

SPECIAL PROCEDURES

PRE-OP/ RECOVERY

2 WEST

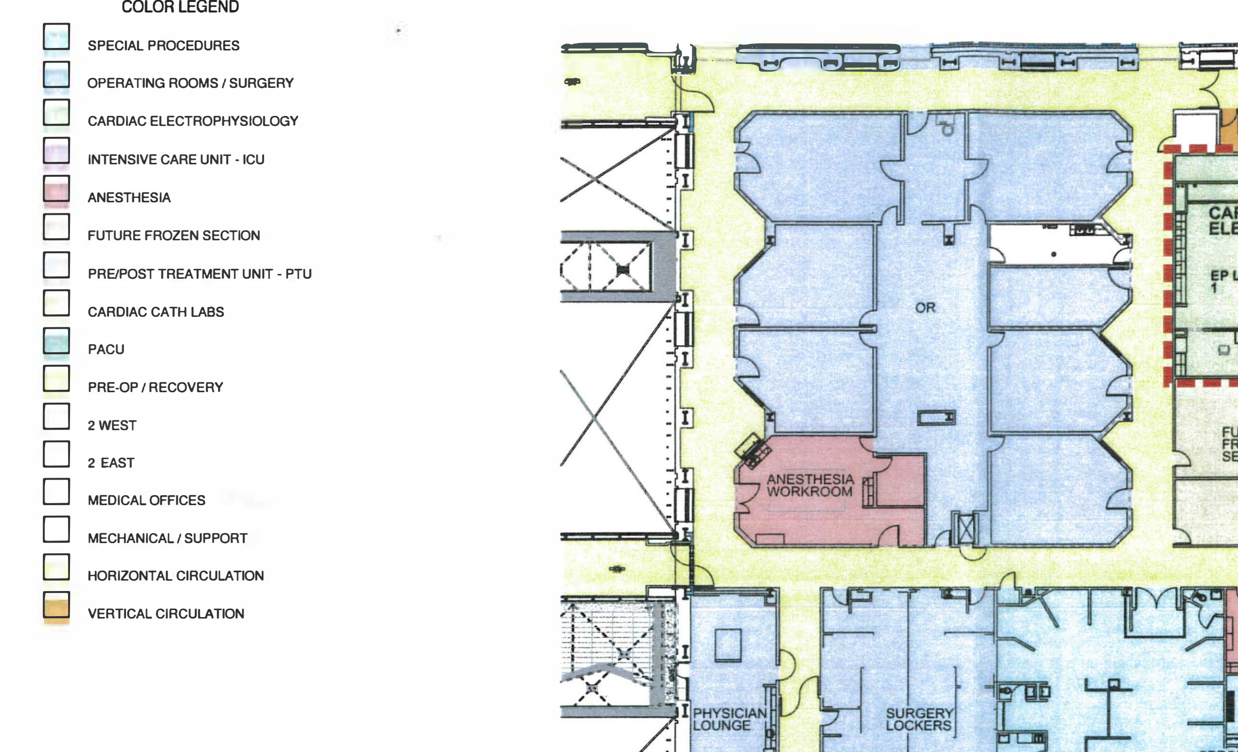
2 EAST

NORTH

Level 2 North Renovation -Cardiac Electrophysiology

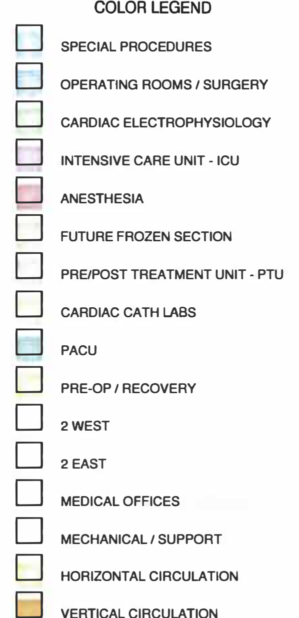
L2 - OVERALL PLAN

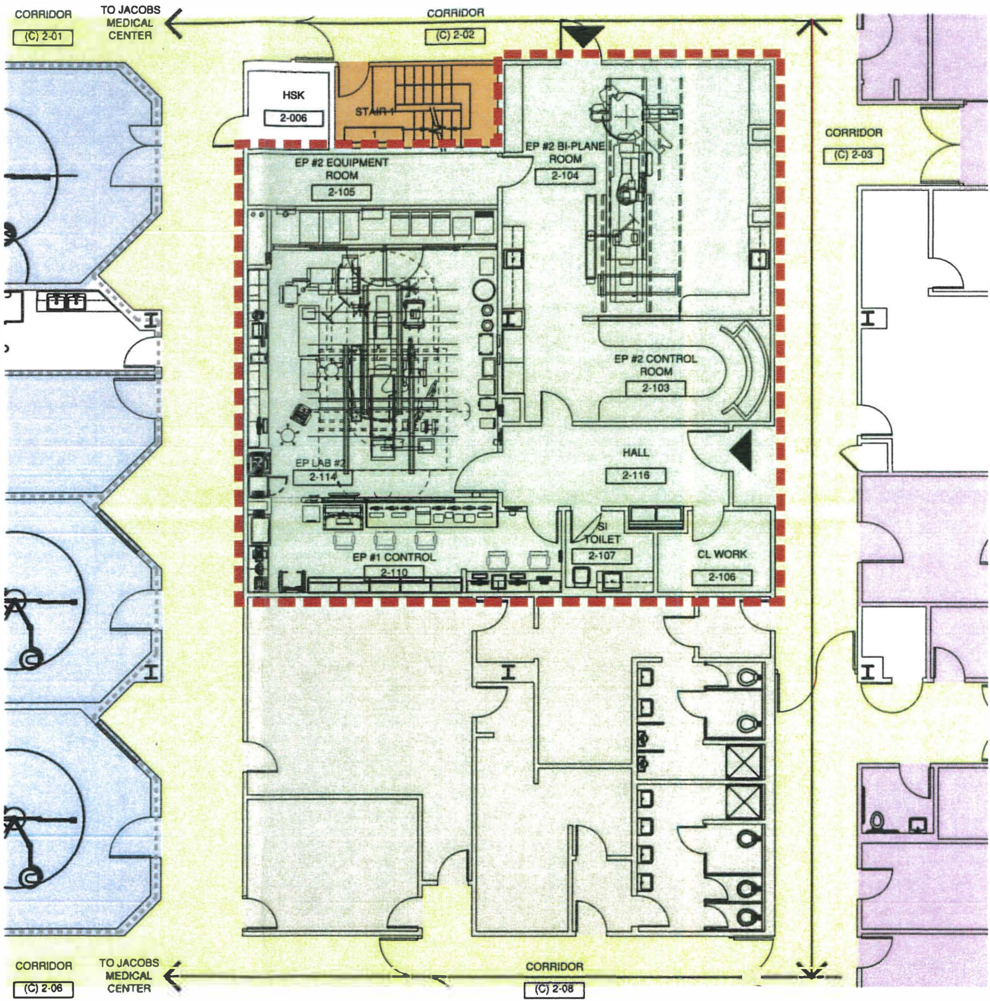
ABC Medical Center, LLC



Level 2 North Renovation - Cardiac Electrophysiology

L2 - OVERALL PLAN

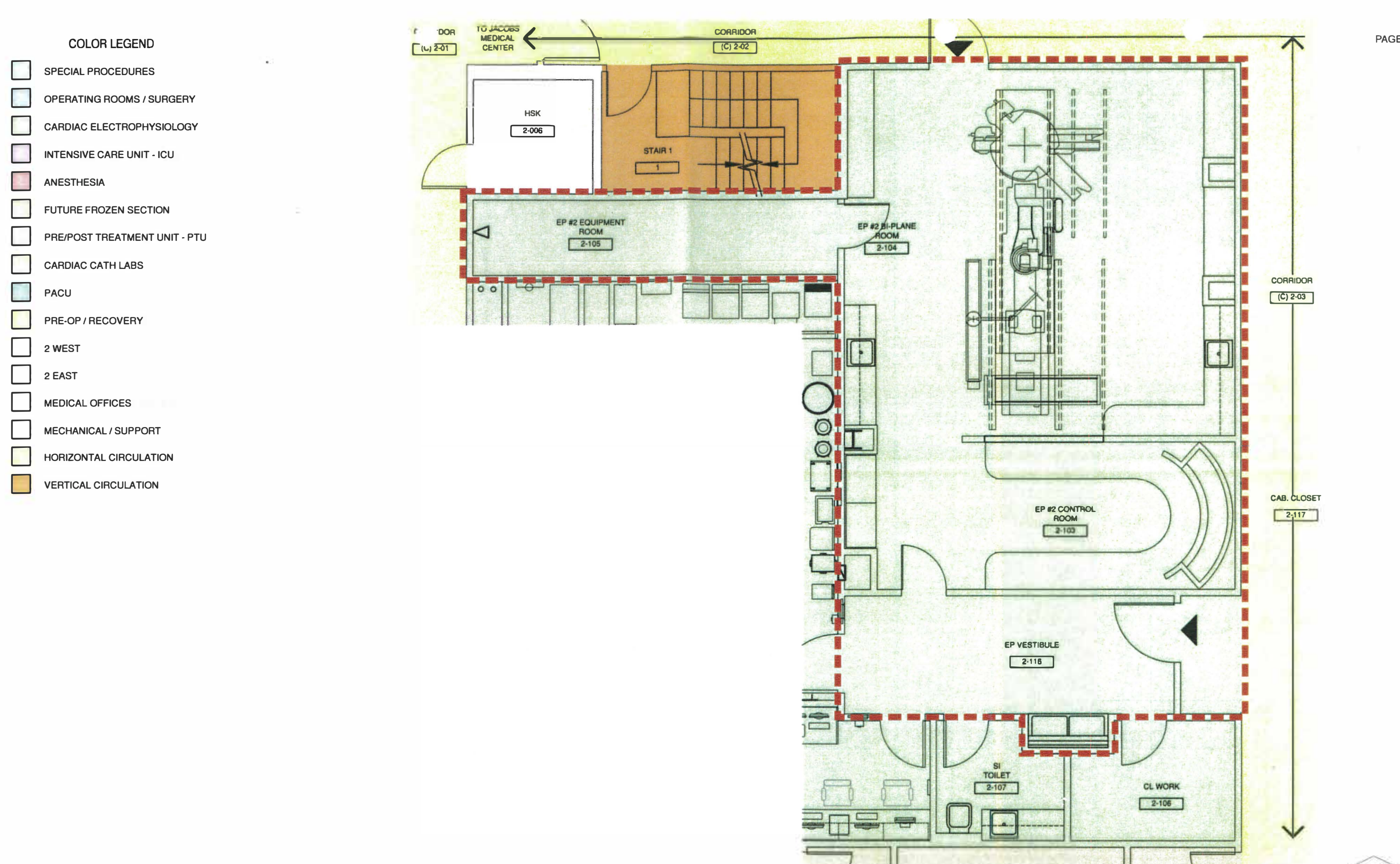




Level 2 North Renovation - Cardiac Electrophysiology

L2 - ENLARGED EXISTING FLOOR PLAN

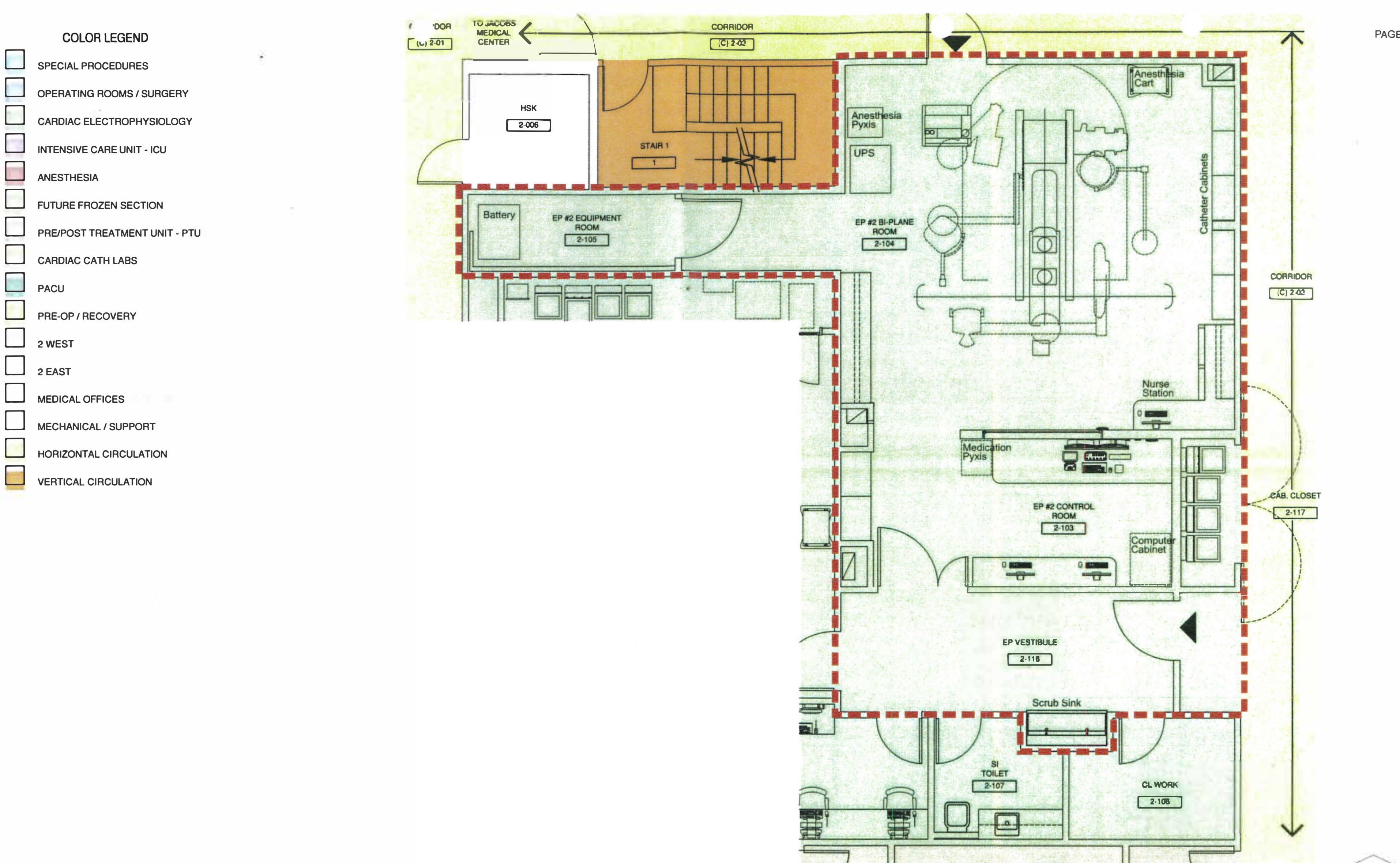
ABC Medical Center, LLC



Level 2 North Renovation - Cardiac Electrophysiology

L2 - ENLARGED AREA - EXISTING PLAN

ABC Medical Center, LLC



Level 2 North Renovation - Cardiac Electrophysiology

L2 - ENLARGED AREA - REMODEL PLAN

ABC Medical Center, LLC

HS 215A

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

APPLICANT INDIVIDUAL INFORMATION

This form is intended for any individual owning the applicant facility or for any individual involved (now or in the past) with any health or community care facility. **Refer to the INSTRUCTION SHEET to see who needs to complete this form.**

This HS 215A form needs to be completed as part of an application package plus it needs to be completed for disclosure purposes when changes are reported in officers, directors, purchase of stock, etc., as required by law, **even though no change in legal ownership is occurring.**

A. Identifying Information

Name: Wain Jones

Date of Birth: 06/27/1970

Business address (number, street, apartment/suite number or letter if applicable): 1800 Beach Drive

City, State, & Zip: Sacramento, CA 95814

Title in relation to this facility: Administrator

Have you applied for ANY license for a health facility or community care facility using any name other than your true full name? If yes, list all other names.

No

If an Administrator for proposed clinic, list hours that will be spent at the clinic each week. If an Administrator at more than one licensed clinic, list the name of **each clinic** and the number of hours spent in each licensed clinic per week.

Star Hospital - 40 hours per week

B. Criminal Record

1. Have you ever been convicted of an offense that is still on your record, whether misdemeanor or felony? ○ **Yes** ◉ **No**

2. Has there been a judgment against you for Medicare or Medicaid (Medi-Cal) fraud or by a health care professional/technical licensing entity? ○ **Yes** ○ **No**

If yes to questions 1 or 2 above, please explain and provide dates and conviction information (attach additional pages if necessary):

C. Professional Licenses/Certificates – This requirement is mandatory for Primary Care Clinics and optional for Health facilities.

TYPE	PERIOD HELD	ISSUING AGENCY
RN	06/1996 - Present	Board of Registered Nursing

D. Employment/Business Summary (for last 10 years). Please list any additional experience that qualifies you to operate this type of facility. Begin with your most recent job. Attach additional pages if necessary.

	Dates	Name and address of employer	Job title
From:	5/13/2015	Star Hospital	Administrator
To:	Present	1800 Beach Drive, Sacramento, CA 95814	
From:	1/29/2010	Get Well Hospital	Administrator
To:	5/12/2015	1234 Healthy Avenue, Suite 1A, Sacramento, CA 95810	
From:	3/2/2007	Care Free Medical Center	Director of Nursing
To:	1/28/2010	9876 Pain Free Drive, Elk Grove, CA 95624	
From:			
To:			

E. Facility, Agency, Clinic Involvement (in or out of California)

The questions below are for "individuals" and do not pertain to the facility that is applying for licensure.

1. **Have** you ever been involved with a business entity that operated a health facility or community care facility?
   (●) **Yes** ( ) **No** **If YES, complete Section F (below) and the "Facility Information Sheet" (attached).**

2. Have you ever operated or managed (including management agreements) any of the following facility types?
   ( ) **Yes** (●) **No** **If YES, complete Section F (below) and the "Facility Information Sheet" (attached).**

Adult Day Health Care Center	ICF/DD
Clinics	ICF/DD-H
COMMUNITY CARE FACILITY	ICF-DD-N
General Acute Care Hospital	Intermediate Care Facility
Health Facility	Pediatric Day Health & Respite Care
Home Health Agency	Residential Care Facility for the Elderly
Hospice	Skilled Nursing Facility
	Other

3. Have you ever held a **5 percent** or more beneficial ownership interest in any of the facility types above?
   ( ) **Yes** (●) **No** **If YES, complete Section F (below) and the "Facility Information Sheet" (attached).**

F. Adverse Actions

Have you been affiliated with any facility, either past or present, that has been identified as having one or more of the following adverse actions? ( ) **Yes** (●) **No** **If YES, check all applicable:**

☐ Had a final Medi-Cal decertification action taken ☐ Placed on probation ☐ Receiver appointed
☐ Resolved by settlement ☐ Revocation action filed ☐ Revoked (whether stayed or not) ☐ Suspension

If yes, please explain (including facility name and address). Attach additional pages if necessary:

I declare under penalty of perjury that the statements on this form and any accompanying attachments are correct to the best of my knowledge.

Signature: *Date:* 3/11/18

RELEASE OF INFORMATION STATEMENT

The information provided on this form is mandatory and is necessary for licensure approval. It will be used to determine individual applicant's 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 the Health and Safety Code. 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.

FACILITY INFORMATION SHEET

You are required to complete the following for **each** facility (including all facilities in all business entities) with which you have a current relationship or have had a past relationship (going back 3 years). **Refer to the INSTRUCTION SHEET.**

Facility name:	Facility address (number, street, city):	State:	Zip code:
Star Hospital	1800 Beach Drive, Sacramento	CA	95814

Type of Facility	"Type" of Business Entity	Individual's "Nature" of Involvement
○ Adult Day Health Care Center	For EACH business entity, identify the name & EIN of the entity:	⊙ Administrator of Clinic, SNF or ICF
○ Clinic	○ Corporation:	○ Agent
○ COMMUNITY CARE FACILITY		○ Director
⊙ General Acute Care Hospital	○ Individual:	○ Licensee
○ Health Facility		○ Manager of "parent" organization
○ HHA	⊙ LLC:	○ Managing employee of a HHA
○ Hospice	ABC Medical Center, LLC EIN:55-5555555	○ Member
○ ICF	○ Management Company:	○ Officer of corporation
○ ICF/DD		○ Owner
○ ICF/DD-H	○ Partnership:	○ Partner
○ ICF/DD-N		○ Sole Proprietorship
○ ICF	○ OTHER Business Entity (explain):	○ Stockholder -- Ownership %:
○ Residential Care for the Elderly		○ Trustee
○ SNF	Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain.	○ OTHER Nature of Involvement (explain):
○ OTHER FACILITY TYPE (explain):	○ Yes	Dates of involvement:
	⊙ No	From: 5/13/2015
		To: Present

Facility name:	Facility address (number, street, city):	State:	Zip code:

Type of Facility	"Type" of Business Entity	Individual's "Nature" of Involvement
○ Adult Day Health Care Center	For EACH business entity, identify the name & EIN of the entity:	○ Administrator of Clinic, SNF or ICF
○ Clinic	○ Corporation:	○ Agent
○ COMMUNITY CARE FACILITY		○ Director
○ General Acute Care Hospital	○ Individual:	○ Licensee
○ Health Facility		○ Manager of "parent" organization
○ HHA	○ LLC:	○ Managing employee of a HHA
○ Hospice		○ Member
○ ICF	○ Management Company:	○ Officer of corporation
○ ICF/DD		○ Owner
○ ICF/DD-H	○ Partnership:	○ Partner
○ ICF/DD-N		○ Sole Proprietorship
○ ICF	⊙ OTHER Business Entity (explain):	○ Stockholder -- Ownership %:
○ Residential Care for the Elderly		○ Trustee
○ SNF	Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain.	⊙ OTHER Nature of Involvement (explain):
⊙ OTHER FACILITY TYPE (explain):	○ Yes	Dates of involvement:
	⊙ No	From:
		To:

Facility name:	Facility address (number, street, city):	State:	Zip code:

Type of Facility	"Type" of Business Entity	Individual's "Nature" of Involvement
○ Adult Day Health Care Center	For EACH business entity, identify the name & EIN of the entity:	○ Administrator of Clinic, SNF or ICF
○ Clinic	○ Corporation:	○ Agent
○ COMMUNITY CARE FACILITY		○ Director
○ General Acute Care Hospital	○ Individual:	○ Licensee
○ Health Facility		○ Manager of "parent" organization
○ HHA	○ LLC:	○ Managing employee of a HHA
○ Hospice		○ Member
○ ICF	○ Management Company:	○ Officer of corporation
○ ICF/DD		○ Owner
○ ICF/DD-H	○ Partnership:	○ Partner
○ ICF/DD-N		○ Sole Proprietorship
○ ICF	○ OTHER Business Entity (explain):	○ Stockholder -- Ownership %:
○ Residential Care for the Elderly		○ Trustee
○ SNF	Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain.	○ OTHER Nature of Involvement (explain):
○ OTHER FACILITY TYPE (explain):	○ Yes	Dates of involvement:
	○ No	From:
		To:

Facility name:	Facility address (number, street, city):	State:	Zip code:

Type of Facility	"Type" of Business Entity	Individual's "Nature" of Involvement
○ Adult Day Health Care Center	For EACH business entity, identify the name & EIN of the entity:	○ Administrator of Clinic, SNF or ICF
○ Clinic	○ Corporation:	○ Agent
○ COMMUNITY CARE FACILITY		○ Director
○ General Acute Care Hospital	○ Individual:	○ Licensee
○ Health Facility		○ Manager of "parent" organization
○ HHA	○ LLC:	○ Managing employee of a HHA
○ Hospice		○ Member
○ ICF	○ Management Company:	○ Officer of corporation
○ ICF/DD		○ Owner
○ ICF/DD-H	○ Partnership:	○ Partner
○ ICF/DD-N		○ Sole Proprietorship
○ ICF	○ OTHER Business Entity (explain):	○ Stockholder -- Ownership %:
○ Residential Care for the Elderly		○ Trustee
○ SNF	Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain.	○ OTHER Nature of Involvement (explain):
○ OTHER FACILITY TYPE (explain):	○ Yes	Dates of involvement:
	○ No	From:
		To:

Facility name:	Facility address (number, street, city):	State:	Zip code:

Type of Facility	"Type" of Business Entity	Individual's "Nature" of Involvement
○ Adult Day Health Care Center	For EACH business entity, identify the name & EIN of the entity:	○ Administrator of Clinic, SNF or ICF
○ Clinic	○ Corporation:	○ Agent
○ COMMUNITY CARE FACILITY		○ Director
○ General Acute Care Hospital	○ Individual:	○ Licensee
○ Health Facility		○ Manager of "parent" organization
○ HHA	○ LLC:	○ Managing employee of a HHA
○ Hospice		○ Member
○ ICF	○ Management Company:	○ Officer of corporation
○ ICF/DD		○ Owner
○ ICF/DD-H	○ Partnership:	○ Partner
○ ICF/DD-N		○ Sole Proprietorship
○ ICF	○ OTHER Business Entity (explain):	○ Stockholder -- Ownership %:
○ Residential Care for the Elderly		○ Trustee
○ SNF	Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain.	○ OTHER Nature of Involvement (explain):
○ OTHER FACILITY TYPE (explain):	○ Yes	Dates of involvement:
	○ No	From:
		To:

Facility name:	Facility address (number, street, city):	State:	Zip code:

Type of Facility	"Type" of Business Entity	Individual's "Nature" of Involvement
○ Adult Day Health Care Center	For EACH business entity, identify the name & EIN of the entity:	○ Administrator of Clinic, SNF or ICF
○ Clinic	○ Corporation:	○ Agent
○ COMMUNITY CARE FACILITY		○ Director
○ General Acute Care Hospital	○ Individual:	○ Licensee
○ Health Facility		○ Manager of "parent" organization
○ HHA	○ LLC:	○ Managing employee of a HHA
○ Hospice		○ Member
○ ICF	○ Management Company:	○ Officer of corporation
○ ICF/DD		○ Owner
○ ICF/DD-H	○ Partnership:	○ Partner
○ ICF/DD-N		○ Sole Proprietorship
○ ICF	○ OTHER Business Entity (explain):	○ Stockholder -- Ownership %:
○ Residential Care for the Elderly		○ Trustee
○ SNF	Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain.	○ OTHER Nature of Involvement (explain):
○ OTHER FACILITY TYPE (explain):	○ Yes	Dates of involvement:
	○ No	From:
		To:

INSTRUCTIONS FOR HS 215A

The HS 215A must contain an original signature and date. The date of this form should be within the last three months.
This form is intended for the following:

1. Any individual owning an applicant facility;
2. Each agent, each partner, each director, each member, each managing employee of a HHA, each officer of a corporation;
3. Each agent, each partner, each director, each officer, each member or manager of a parent organization of licensee applicant;
4. Each manager, each member of a limited liability company;
5. Administrators;
6. Each person having a beneficial interest of 5 percent or more in the applicant corporation, applicant limited liability company, applicant partnership, applicant management company, applicant facility or private agency; and
7. Each officer and each director of the parent of the management company.

District office and ELMS Number	To be completed by the California Department of Public Health
Proposed name of facility/agency/clinic	Enter the name of your facility as it appears on your application (HS 200).

A. IDENTIFYING INFORMATION

Name	Please enter your full legal name.
Date of birth	Day/Month/Year
Business Address	Location of your business; number, street, apartment/suite number or letter if applicable.
City	City where business is located.
State	State where business is located.
Zip code	Zip code where business is located
Title in relation to this facility	Your title in relation to this facility.
If an Administrator for proposed clinic, list hours that will be spent at the clinic each week. If an Administrator at more than one licensed clinic, list the name of each clinic and the number of hours spent in each licensed clinic per week.	Please list hours spent at each clinic per week. If your title is not administrator, please list N/A.
Have you applied for any license for a health facility or community care facility regardless of your role or title using any name other than your true full name? If yes, list all other names.	Please answer yes or no. If yes, list any other names you have used if you have ever applied for a health facility or community care facility license.

B. CRIMINAL RECORD

Please check appropriate box. If you have checked 'yes', please provide dates and conviction information. If not applicable, please enter 'N/A'.

C. PROFESSIONAL LICENSES/CERTIFICATES

Type	Type of licenses or certificate that you hold.
Period held	Dates that you held your license.
Issuing Agency	Agency that issued you a license and/or certificate.

D. EMPLOYMENT/BUSINESS SUMMARY (FOR LAST 10 YEARS). Please list any additional experience that qualifies you to operate this type of facility. If self employed, never worked or now retired, indicate the 'From' and 'To' dates. Begin with your most recent job. Attach additional pages if necessary.

Dates (From/To)	Dates that you were employed in position from the start to the end date.
Name and Address of Employer(s)	Name and street, city, state address of the employer.
Job Title	Title that you held within your company/place of employment.

E. FACILITY, AGENCY, CLINIC INVOLVEMENT (IN OR OUT OF CALIFORNIA)

Questions No. 1-3	Please check appropriate box(es). If you have checked yes, you must fill out the attached "Facility Information Sheet" and complete Section F.

F. ADVERSE ACTIONS

Please check appropriate box. If box is checked yes, please explain and include facility information.

FACILITY INFORMATION SHEET

Facility Name	Name of Facility that correlates to the checkboxes you have checked as 'yes' in Section E.
Facility address	Number and street address of the facility involved.
City	City where facility is located.
State	State where facility is located.
ZIP code	Zip code where facility is located.
Type of Facility	Check appropriate health facility.
"Type" of Business Entity	Check appropriate business entity and identify if this entity is a "parent" corporation to the applicant facility.
Individual "Nature" of Involvement	Check appropriate position held at that facility.

Wain Jones

955 Delta Rd. Sacramento, CA 95841 | 999-555-2222 | Wain_Jones@msn.com

Education

NURSING UNIVERISTY | 1995

- Master of Science in Nursing
- Licensed Registered Nurse – License #8888888
- Nursing Home Administrator – License #NHA2222

Experience

ADMINISTRATOR **MAY 2015 – PRESENT**

Starr Hospital, 1800 Beach Drive, Sacramento, CA 95814

- Serve as Administrator of 500 bed Acute Care Hospital
- Primary Focus on Business Development, Strategic Planning Initiatives and Operations
- Physician Liaison
- Oversight of Managers monthly actual and budgeted financials
- Provide leadership and direction of all aspects of hospital activities to ensure quality patient care
- Oversee daily operations of clinical, research and academic administration

ADMINISTRATOR **JANUARY 2010 – MAY 2015**

Get Well Hospital, 1234 Healthy Avenue, Suite 1A, Sacramento, CA 95810

- Ensure consistent and effective execution of key systems and processes
- Manage budget and operations of the hospital
- Ensure quality patient care and compliance with established objectives
- Participate with medical staff and senior management in the development and implementation of strategic plans
- Manage employee relations and implement policies and procedures
- Coordinate, implement and monitor processes to ensure the integration of strategic direction and operational goals
- Develop, oversee and execute an annual marketing plan for the hospital

DIRECTOR OF NURSING **MARCH 2007 – JANUARY 2010**

Care Free Medical Center, 9876 Pain Free Drive, Elk Grove, CA 95624

- Coordinate services provided to patients through supervision and management of staff
- Attract, retain and manage nursing staff

- Make effective use of organizational resources
- Participate with leaders from the governing body, management, and medical staff to collaborate in the accomplishment of the vision, mission, values and strategic goals of the organization
- Provide expertise, education, guidance, and professional development to staff and management in order to support daily operations

HS 309

ADMINISTRATIVE ORGANIZATION

Page one is for corporations only. See page two for other organizations.

CORPORATION

1. Name (as filed with Secretary of State): ABC Medical Center, LLC
2. Administrator: John Doe, Owner
3. Incorporation date:
4. Place of incorporation:
5. Please attach (1) a copy of Articles of Incorporation and any amendments, (2) a copy of by-laws and any amendments, (3) a copy of resolution authorizing the filing of this application.
6. Principal Office of Business

Address	City	ZIP code	County	Phone number
999 Beach Side Court	Sacramento	95814	Sacramento	999-555-2626

7. Foreign (out-of-state) applicants complete the following:

a. Name of California Representative	Address	City	ZIP code	Phone number

b. Please attach a copy of authorization of a foreign corporation to do business in California.

8. If applicant has ever owned or operated a facility, please list the name of each facility, address, size, type of care provided, and the dates and duration of ownership or operation. (if more space is needed, please attach a separate list.)

9. Governing Board of Directors

Size of Board	Term of office	Frequency of meetings	Method of selection
4	Perpetual	Annual	Appointment

10. Board Officers

Office	Name	Term Expires
Manager	John Doe	N/A
Member	Jane Doe	N/A
Member	John Hancock	N/A
Member	Jane Hancock	N/A

RELEASE OF INFORMATION STATEMENT

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 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, 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.

ORGANIZATIONAL STRUCTURE

See page one for corporations.

PUBLIC AGENCY

1. Check type of public agency: ◯ Federal ◯ State ◯ County ◯ City ◯ Other, specify below

2. Agency providing services:

Name	Address	
Mailing Address (if different from above)		
Contact person	Title	Phone number

3. District or area to be served: (attach map if necessary)

Specify geographic area

4. Required supplemental materials: Attach a copy of Resolution or legal document authorizing this application.

5. (1267.5 Health and Safety Code)
For profit corporations and partnerships, list the name(s) and business address of each person having a beneficial ownership interest of 10 percent or more in the applicant corporation or partnership. If person is a minor, identify and indicate by name and address who exercises rights during minor's minority.

West Coast Health System owns 100% of Licensee
554 Crystal Beach Blvd., Suite 10
Sacramento, CA 95814

West Coast Health System is owned by:
30% John Doe - 999 Beach Side Court, Sacramento, CA 95814
30% Jane Doe - 999 Beach Side Court, Sacramento, CA 95814
20% John Hancock - 999 Beach Side Court, Sacramento, CA 95814
20% Jane Hancock - 999 Beach Side Court, Sacramento, CA 95814

PARTNERSHIPS

Attach a copy of partnership agreement.

First partner	☐ Limited ☐ General	Name
		Business address
Second partner	☐ Limited ☐ General	Name
		Business address

For additional partners, use space above or attach a separate sheet.

OTHER ASSOCIATIONS/BUSINESS ENTITIES

Other associations/business entities, i.e., limited liability companies, etc., must also provide a similar list of persons legally responsible for the organization, appropriate legal documents which set forth legal responsibility of the organization, and accountability for operating the facility.

RELEASE OF INFORMATION STATEMENT

The information provided on this form is mandatory and is necessary for licensure approval. It will be used to determine individual applicant's or applicant facility's ability to provide health services. The information is requested by the 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, 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 files located in Licensing and Certification district offices.

Alex Padilla
California Secretary of State

Business Search - Entity Detail

The California Business Search is updated daily and reflects work processed through Thursday, March 14, 2019. Please refer to document **Processing Times** for the received dates of filings currently being processed. The data provided is not a complete or certified record of an entity. Not all images are available online.

ABC MEDICAL, LLC

Registration Date:	05/20/2014
Jurisdiction:	CALIFORNIA
Entity Type:	DOMESTIC
Status:	
Agent for Service of Process:	To find the most current California registered Corporate Agent for Service of Process address and authorized employee(s) information, click the link above and then select the most current 1505 Certificate.
Entity Address:	
Entity Mailing Address:	
LLC Management	Member Managed

Document Type	File Date	PDF
	07/03/2014	
SI-COMPLETE	06/09/2014	
REGISTRATION	05/20/2014	

* Indicates the information is not contained in the California Secretary of State's database.

Note: If the agent for service of process is a corporation, the address of the agent may be requested by ordering a status report.

- For information on checking or reserving a name, refer to **Name Availability**.
- If the image is not available online, for information on ordering a copy refer to **Information Requests**.
- For information on ordering certificates, status reports, certified copies of documents and copies of documents not currently available in the Business Search or to request a more extensive search for records, refer to **Information Requests**.
- For help with searching an entity name, refer to **Search Tips**.

AFFIDAVIT REGARDING PATIENT MONEY

In accordance with California Health and Safety Code, Section 1318, this form is intended to ensure that all licensed health facilities comply with statutory bonding requirements if they handle patient money. This form is required on all new applications and whenever the Department deems it is necessary to reevaluate the bonding need of a health facility.

I (We) ABC Medical Center, LLC
Name(s) of Applicants (i.e., licensee)

As applicant(s) for Star Hospital
Name of Facility

Facility address 1800 Beach Drive | Sacramen | CA | 95814 | Sacramen
Street | City | State | ZIP Code | County

I (We) certify that I (check A or B below):

☐ A. Will handle less than $25 per patient and less than $500 for all patients in any one month.

☑ B. Will handle more than $25 per patient or more than $500 for all patients in any one month. (If B is checked, please indicate the maximum amount of money that will be handled.)
Amount of money to be handled. .... $ 5,500.00

Note: If "B" is checked, you will need to submit a Surety Bond Verification (form HS 402).

Money Handled	Bond Required	Money Handled	Bond Required
$ 500.00 to 750.00	$ 1,000.00	$10,501.00 to 11,500.00	$12,000.00
751.00 to 1,500.00	2,000.00	11,501.00 to 12,500.00	13,000.00
1,501.00 to 2,500.00	3,000.00	12,501.00 to 13,500.00	14,000.00
2,501.00 to 3,500.00	4,000.00	13,501.00 to 14,500.00	15,000.00
3,501.00 to 4,500.00	5,000.00	14,501.00 to 15,500.00	16,000.00
4,501.00 to 5,500.00	6,000.00	15,501.00 to 16,500.00	17,000.00
5,501.00 to 6,500.00	7,000.00	16,501.00 to 17,500.00	18,000.00
6,501.00 to 7,500.00	8,000.00	17,501.00 to 18,500.00	19,000.00
7,501.00 to 8,500.00	9,000.00	18,501.00 to 19,500.00	20,000.00
8,501.00 to 9,500.00	10,000.00	19,501.00 to 20,500.00	21,000.00
9,501.00 to 10,500.00	11,000.00	20,501.00 to 21,500.00	22,000.00

Every additional increment of $1,000.00 or fraction thereof shall require an additional $1,000.00 on the bond.

Licensees are required to:

- Immediately notify the licensing agency in writing when the stated amount is exceeded.
- Maintain adequate safeguards and accurate records of monies and valuables entrusted to the facility, in accordance with regulations of the State Department of Public Health.

I (We) certify that the foregoing statements are true to the best of my (our) knowledge.

Owner of ABC Medical Center, LLC | Owner
Print name | Title

| March 11, 2019
Signature | Date

RELEASE OF INFORMATION STATEMENT

The information provided on this form is mandatory and is necessary for licensure approval. It will be used to determine individual applicant's 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 1253, 1265, and 1267.5, and California Code of Regulations (CCR), Title 22, Sections 70107, 70137, 71107, 71135, 73205, 73241, 76205, and 76241.

Failure to provide the information as requested or submission of willful false statements 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.

RECEIPT BY NEW LICENSEE OF PATIENT FUNDS

The undersigned, ABC Medical Center, LLC, hereby acknowledges receipt of the sum of $14,504.42 from the current licensee of Patient Trust Funds.

DATED: March 1, 2019

ABC Medical Center, LLC, a California limited liability company

By: John Doe

Name: John Doe

Title: Managing Member

SAMPLE

ABC MEDICAL CENTER, LLC

Dba Star Hospital

SCHEDULE OF RESIDENT TRUST FUNDS

JANUARY 1, 2018

123 ACCOUNTING FIRM

CPA + Business Advisors

Phone 888-888-8888 l Fax 888-888-8888 l www,123accountingfirm.com
Sacramento l 666 Capital Avenue l Sacramento l CA l 95814

T A B L E   O F   C O N T E N T S

PAGE

INDEPENDENT ACCOUNTANT'S COMPLIATION REPORT 1

SCHEDULE OF RESIDENT TRUST FUNDS 2

SAMPLE

123 ACCOUNTING FIRM
CPA + Business Advisors

ABC Medical Center, LLC
999 Beach Side Court
Sacramento, CA 95814

Management is responsible for the preparation and fair presentation of the accompanying schedule of resident trust funds of ABC Medical, LLC, dba Star Hospital, (a California Limited Liability Company), (the "Company") as of Month, Day, Year, in accordance with accounting principles generally accepted in the United States of America. We have performed a compilation engagement in accordance with Statements on Standards for Accounting and Review Services promulgated by the Accounting and Review Services Committee of the AICPA. We did not audit or review the schedule of resident trust funds nor were we required to perform any procedures to verify the accuracy or completeness of the information provided by management. Accordingly, we do not express an opinion, a conclusion, nor provide any form of assurance on the schedule of resident trust funds.

Management has elected to omit substantially all of the disclosures required by accounting principles generally accepted in the United States of America. If the omitted disclosures were included in the schedule of resident trust funds, they might influence the user's conclusions about the Company's schedule of resident trust funds. Accordingly, the schedule of resident trust funds is not designed for those who are not informed about such matters.

123 Accounting Firm
Signature
Certified Public Account

SAMPLE

ABC Medical Center, LLC
Dba Star Hospital

SCHEDULE OF RESIDENT TRUST FUNDS
MARCH 1, 2018

Patient #1 Name	$ 1,333.45
Patient #2 Name	4,512.10
Patient #3 Name	1,211.14
Patient #4 Name	1,314.80
Patient #5 Name	112.45
Patient #6 Name	2,060.44
Patient #7 Name	3,789.99
Patient #8 Name	10.00
Patient #9 Name	160.05
	$14,504.42

SAMPLE

HS 402

HS 402

SURETY BOND VERIFICATION

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

California Health and Safety Code, Section 1318, Chapter 2, Division 2, requires that licensed health facilities that handle money in excess of $25 per patient or over $500 for all patients in any month, be bonded for not less than $1,000. This is to serve as a guarantee for the faithful and honest handling of the money of such patients.

INSTRUCTIONS: This form is to be completed by the bonding agency. In addition, attach an ***original copy of the bond***. In the event of cancellation of the bond, please send notice to the above licensing office.

BE IT KNOWN THAT:

Facility name Star Hospital

Facility address 1800 Beach Drive City Sacramento County Sacramento ZIP code 95814

State of California, as *Principal,* and

Bonding agency WESTERN SURETY COMPANY

Agency address P. O. Box 5077 City Sioux Falls County Minnehaha ZIP code 57117

State of South Dakota, as *Surety,* are held and firmly bound unto the STATE OF CALIFORNIA in the full and just sum of Seven Thousand and 00/100 DOLLARS ($ 7,000.00), for the payment of which the said Principal and said Surety bind themselves, their respective heirs, successors, and assigns, jointly and severally, firmly by these presents.

The CONDITION of this obligation is such that

WHEREAS, the Principal has applied for or has been issued a license by the California Department of Public Health to maintain or conduct a health facility pursuant to Chapter 2, Division 2, of the Health and Safety Code of the State of California; and

WHEREAS, by the terms of Section 1318 of said code, the Principal is required to file with the California Department of Public Health, Licensing and Certification, the bond running to the State of California.

NOW, THEREFORE, if the above bounden Principal shall faithfully and honestly handle money of patients in the care of said Principal, then this obligation shall be null and void; otherwise to remain in full force and effect.

Every patient injured as a result of any improper or unlawful handling of the money of a patient of a health facility may bring an action in a proper court on the bond required to be posted by the licensee pursuant to this section for the amount of damage he/she suffered as a result thereof to the extent covered by the bond.

This bond may be canceled by the Surety in accordance with the provisions of Section 996.310 et seq. of the Code of Civil Procedure. This bond is effective 03/11/19 (Date) and continuous.

IN WITNESS WHEREOF, we have subscribed our names and impressed our seal this 28th (Day), February (Month), 2019 (Year).

L. Davis, Assistant Secretary
Bonding agent name (please print)

Bonding agent signature

BONDING AGENCY SEAL

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

CLEARANCE /DENIAL CODE

FIRE AUTHORITY NAME AND ADDRESS

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|0|22LP SRV

FILED
Secretary of State
State of California
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

John Doe, Managing Member

ABC MEDICAL CENTER, INC. a California Corporation

John Doe, Senior

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

DHCS 6207

DHCS 6207

V. SUBCONTRACTOR INFORMATION AND SIGNIFICANT BUSINESS TRANSACTIONS

A. Does the applicant/provider (as named in Section I, Part A on Page One of this form) have direct or indirect ownership of 5 percent or more in any of its subcontractors that provide healthcare services or goods? ☐ Yes ☒ No

Do any of the entities named in Section III, Part A on Page Six of this form have direct or indirect ownership of 5 percent or more in any of the applicant provider's subcontractors that provide healthcare services or goods? ☐ Yes ☒ No

Do any of the individuals named in Section IV, Part A on Page Nine of this form have direct or indirect ownership of 5 percent or more in any of the applicant provider's subcontractors that provide healthcare services or goods? ☐ Yes ☒ No

If you answered NO to ALL of the above, please proceed to Section V, Part C on Page 15.

If you answered YES to ANY of the above, please complete the following information about the subcontractor and attach a copy of any written agreement(s) that you have with the subcontractor that relate to its functions/responsibilities.

1. Subcontractor's full legal name			2. Subcontractor's phone number
N/A			
3. Subcontractor's address (number, street)	City	State	ZIP code (9-digit)
4. Subcontractor's federal employer identification number (if applicable)		5. Subcontractor's corporation number (if applicable)	

5. If there is more than one subcontractor, provide a separate sheet with all required information (label "Additional Section V, Part A").
☐ Check here if additional sheet(s) is attached. Number of pages attached: ____

Do not leave any questions, boxes, lines, etc., blank.

V. SUBCONTRACTOR INFORMATION AND SIGNIFICANT BUSINESS TRANSACTIONS *(Cont.)*

B. List the following information for any person or entity, other than the applicant/provider, with 5 percent or more ownership and/or control interest in any **subcontractor** listed in Part A. If there is more than one subcontractor, provide a separate sheet with all required information (label "Additional Section V, Part B").

☐ Check here if additional sheet(s) is attached. Number of pages attached: ____

Name of Subcontractor in Part A
N/A

1. Full legal name of person or entity with ownership or control interest in the Subcontractor N/A			Phone number
Address (number, street)	City	State	ZIP code (9-digit)

What is this individual's role with the subcontractor reported in Part A? Check all that apply.

☐ 5% or greater owner – Percent of ownership: ____ ☐ Partner ☐ Managing employee

☐ Director/officer, title: ______________________ ☐ Other (specify): __________________

Is the above individual related to any individual listed in Section IV, Table A (Page 9)? ☐ Yes ☐ No

If yes, check the appropriate box and list the name of the related individual.

☐ Spouse ☐ Parent ☐ Child ☐ Sibling ☐ Other (explain): __________________

Name of related individual:

2. Full legal name of person or entity with ownership or control interest in the Subcontractor N/A			Phone number
Address (number, street)	City	State	ZIP code (9-digit)

What is this individual's role with the subcontractor reported in Part A? Check all that apply.

☐ 5% or greater owner – Percent of ownership: ____ ☐ Partner ☐ Managing employee

☐ Director/officer, title: ______________________ ☐ Other (specify): __________________

Is the above individual related to any individual listed in Section IV, Table A (Page 9)? ☐ Yes ☐ No

If yes, check the appropriate box and list the name of the related individual.

☐ Spouse ☐ Parent ☐ Child ☐ Sibling ☐ Other (explain): __________________

Name of related individual:

Do not leave any questions, boxes, lines, etc., blank.

V. SUBCONTRACTOR INFORMATION AND SIGNIFICANT BUSINESS TRANSACTIONS *(Cont.)*

Name of Subcontractor in Part A
N/A

3. Full legal name of person or entity with ownership or control interest in the Subcontractor N/A			Phone number
Address (number, street)	City	State	ZIP code (9-digit)

What is this individual's role with the subcontractor reported in Part A? Check all that apply.

☐ 5% or greater owner – Percent of ownership: ____ ☐ Partner ☐ Managing employee

☐ Director/officer, title: ______________________ ☐ Other (specify): ______________

Is the above individual related to any individual listed in Section IV, Table A (Page 9)?
If yes, check the appropriate box and list the name of the related individual. ☐ Yes ☐ No

☐ Spouse ☐ Parent ☐ Child ☐ Sibling ☐ Other (explain): ______________

Name of related individual:

4. Full legal name of person or entity with ownership or control interest in the Subcontractor N/A			Phone number
Address (number, street)	City	State	ZIP code (9-digit)

What is this individual's role with the subcontractor reported in Part A? Check all that apply.

☐ 5% or greater owner – Percent of ownership: ____ ☐ Partner ☐ Managing employee

☐ Director/officer, title: ______________________ ☐ Other (specify): ______________

Is the above individual related to any individual listed in Section IV, Table A (Page 9)?
If yes, check the appropriate box and list the name of the related individual. ☐ Yes ☐ No

☐ Spouse ☐ Parent ☐ Child ☐ Sibling ☐ Other (explain): ______________

Name of related individual:

C. Has the applicant/provider had any significant business transactions with any wholly owned supplier or with any subcontractor (not listed on Part A) during the 5-year period immediately preceding the date of this Application? ☐ Yes ■ No

"Significant business transaction" means any business transaction or series of transactions that involve health care services, goods, supplies, or merchandise related to the provision of services to Medi-Cal beneficiaries that, during any one fiscal year, exceed the lesser of $25,000 or 5 percent of an applicant's or provider's total operating expenses.

"Wholly owned supplier" means a supplier whose total ownership interest is held by an applicant or provider or by a person, persons, or other entity with an ownership or control interest in an applicant or provider.

Do not leave any questions, boxes, lines, etc., blank.

V. SUBCONTRACTOR INFORMATION AND SIGNIFICANT BUSINESS TRANSACTIONS *(Cont.)*

"Subcontractor" means an individual, agency, or organization: (a) To which an applicant or provider has contracted or delegated some of its management functions or responsibilities of providing healthcare services, equipment or supplies to its patients. (b) With whom an applicant or provider has entered into a contract, agreement, purchase order, lease, or leases of real property, to obtain space, supplies, equipment, or services provided under the Medi-Cal Program.

If **No**, please proceed to Section V, Part D.

If **Yes**, complete the following information about the supplier or subcontractor:

1. Subcontractor's or supplier's full legal name			2. Subcontractor's or supplier's phone number
N/A			
3. Subcontractor's or supplier's address (number, street)	City	State	ZIP code (9-digit)
4. Describe the transaction(s):			

If there is more than one subcontractor or supplier, provide a separate sheet with all required information (label "Additional Section V, Part C").

☐ Check here if additional sheet(s) is attached. Number of pages attached: ____

D. List the name and address of each person(s) with an **ownership or control interest** in any subcontractor (listed in Part C) with whom the applicant or provider has had business transaction involving health care services, goods, supplies or merchandise related to the provision of services to a Medi-Cal beneficiary that total more than $25,000 during the 12-month period immediately preceding the date of the Application, or immediately preceding the date on the Department's request for such information. If there is more than one subcontractor, provide a separate sheet with all required information. (label "Additional Section V, Part D").

■ Check here if no subcontractors listed in Part C or applicant/provider has had no business transactions with subcontractors involving health care services, goods, supplies or merchandise related to the provision of services to a Medi-Cal beneficiary that total more than $25,000 during the 12-month period immediately preceding the date of the Application, or immediately preceding the date on the Department's request for such information. **Proceed to Section VI**.

☐ Check here if additional sheet(s) is attached. Number of pages attached: ____

Name of Subcontractor in Part C			
N/A			
1. Full legal name of person or entity with ownership or control interest			Phone number
Address (number, street)	City	State	ZIP code (9-digit)

Do not leave any questions, boxes, lines, etc., blank.

V. SUBCONTRACTOR INFORMATION AND SIGNIFICANT BUSINESS TRANSACTIONS *(Cont.)*

Name of Subcontractor in Part C
N/A

2. Full legal name of person or entity with ownership or control interest			Phone number
N/A			
Address (number, street)	City	State	ZIP code (9-digit)

3. Full legal name of person or entity with ownership or control interest			Phone number
N/A			
Address (number, street)	City	State	ZIP code (9-digit)

4. Full legal name of person or entity with ownership or control interest			Phone number
N/A			
Address (number, street)	City	State	ZIP code (9-digit)

- Proceed to Section VI.

Do not leave any questions, boxes, lines, etc., blank.

DHCS 9098

INSTRUCTIONS FOR THE COMPLETION OF THE MEDI-CAL PROVIDER AGREEMENT (Institutional Provider)

- **Type or print clearly.**
- **Return original and maintain a copy for your records.**
- **The Legal name and Business name must be consistent throughout the Medi-Cal Provider Agreement and any of its attachments.**
- **DO NOT LEAVE any questions, boxes, lines, etc. blank. Enter N/A if not applicable to you. If this document is incomplete, it will be returned to you.**

Page 2 (Please enter the date)

Legal name is the name listed with the Internal Revenue Service (IRS).

Business name is the facility, hospital, agency, or clinic name (name of business/DBA)

Provider Number (NPI) is the ten-digit National Provider Identifier for the business address, as registered with the National Plan and Provider Enumeration System (NPPES).

Business telephone number is the primary business telephone number used at the business address.

Business address is the actual business location including the street name and number, room or suite number or letter, city, state, and nine-digit ZIP code. A post office box or commercial box is not acceptable.

Mailing address is the location at which the applicant or provider wishes to receive general Medi-Cal correspondence. General Medi-Cal correspondence includes bulletin updates and Provider Manual updates.

Pay-to address is the address at which the applicant or provider wishes to receive payment.

Previous business address is the address where the applicant or provider was previously enrolled. If the applicant or provider is not submitting an application for a change of location, enter N/A.

Taxpayer Identification Number is the Taxpayer Identification Number (TIN) issued by the IRS under the name of the applicant or provider.

Page 12

1. **Legal name** is the name listed with the IRS.
2. **Printed name** of the person signing this agreement.
3. **Original signature** of the person signing this agreement.
4. **Title** of the person signing this agreement.
5. **Notary Public** box is for Certificate of Acknowledgment, signature and seal of Notary Public. (See California Civil Code Section 1189).

MEDI-CAL PROVIDER AGREEMENT
(Institutional Provider)
(To Accompany Applications for Enrollment)*

For State Use Only
Date: 3/11/2019

Do not use staples on this form or any attachments.

Type or print clearly in ink. If you must make corrections, please line through, date, and initial in ink.

Do not leave any questions, lines, etc. blank. Enter N/A if not applicable to you.

Legal name of applicant or provider (as listed with the IRS)	Business name (if different than legal name)
ABC Medical Center, LLC	Star Hospital

Provider number (NPI)	Business Telephone Number
6666666666	(999) 555-2626

	City	State	ZIP code (9-digit)
Business address (number, street): 1800 Beach Blvd. Suite 10	Sacramento	CA	95814-9999
Mailing address (number, street, P.O. Box number): 1800 Beach Blvd. Suite 10	Sacramento	CA	95814-9999
Pay-to address (number, street, P.O. Box number): 1800 Beach Blvd. Suite 10			
Previous business address (number, street): N/A			

Taxpayer Identification Number (TIN)**
55-5555555

EXECUTION OF THIS PROVIDER AGREEMENT BETWEEN AN APPLICANT OR PROVIDER (HEREINAFTER JOINTLY REFERRED TO AS "PROVIDER") AND THE DEPARTMENT OF HEALTH CARE SERVICES (HEREINAFTER "DHCS"), IS MANDATORY FOR PARTICIPATION OR CONTINUED PARTICIPATION AS A PROVIDER IN THE MEDI-CAL PROGRAM PURSUANT TO 42 UNITED STATES CODE, SECTION 1396a(a)(27), TITLE 42, CODE OF FEDERAL REGULATIONS, SECTION 431.107, WELFARE AND INSTITUTIONS CODE, SECTION 14043.2, AND TITLE 22, CALIFORNIA CODE OF REGULATIONS, SECTION 51000.30(a)(2).

AS A CONDITION FOR PARTICIPATION OR CONTINUED PARTICIPATION AS A PROVIDER IN THE MEDI-CAL PROGRAM, PROVIDER AGREES TO COMPLY WITH ALL OF THE FOLLOWING TERMS AND CONDITIONS, AND WITH ALL OF THE TERMS AND CONDITIONS INCLUDED ON ANY ATTACHMENT(S) HERETO, WHICH IS/ARE INCORPORATED HEREIN BY REFERENCE:

---

* Every applicant and provider must execute this Provider Agreement.
** The taxpayer identification number may be a Taxpayer Identification Number (TIN) or a social security number for sole proprietors.

1. **Term and Termination.** This Agreement will be effective from the date applicant is enrolled as a provider by DHCS, or, from the date provider is approved for continued enrollment. Provider may terminate this Agreement by providing DHCS with written notice of intent to terminate, which termination shall result in Provider's immediate disenrollment and exclusion (without formal hearing under the Administrative Procedure Act) from further participation in the Medi-Cal program, including deactivation of any provider agreement, unless and until such time as Provider is re-enrolled by DHCS in the Medi-Cal Program. DHCS may immediately terminate this Agreement for cause if Provider is suspended/excluded for any of the reasons set forth in Paragraph 25(a) below, which termination will result in Provider's immediate disenrollment and exclusion (without formal hearing under the Administrative Procedures Act) from further participation in the Medi-Cal program.

2. **Compliance With Laws and Regulations.** Provider agrees to comply with all applicable provisions of Chapters 7 and 8 of the Welfare and Institutions Code (commencing with Sections 14000 and 14200), and any applicable rules or regulations promulgated by DHCS pursuant to these Chapters. Provider further agrees that if it violates any of the provisions of Chapters 7 and 8 of the Welfare and Institutions Code, or any other regulations promulgated by DHCS pursuant to these Chapters, it may be subject to all sanctions or other remedies available to DHCS. Provider further agrees to comply with all federal laws and regulations governing and regulating Medicaid providers.

3. **National Provider Identifier (NPI).** Provider agrees not to submit any treatment authorization requests (TARs) or claims to DHCS using an NPI unless that NPI is appropriately registered for this provider with the Centers for Medicare and Medicaid Services (CMS) and is in compliance with all NPI requirements established by CMS as of the date the claim is submitted. Provider agrees that submission of an NPI to DHCS as part of an application to use that NPI to obtain payment constitutes an implied representation that the NPI submitted is appropriately registered and in compliance with all CMS requirements at the time of submission. Provider also agrees that any subsequent defect in registration or compliance of the NPI constitutes an "addition or change in the information previously submitted" which must be reported to DHCS under the requirements of Title 22, California Code of Regulations, Section 51000.40 and 51000.52(b).

4. **Forbidden Conduct.** Provider agrees that it shall not engage in conduct inimical to the public health, morals, welfare and safety of any Medi-Cal beneficiary, or the fiscal integrity of the Medi-Cal program.

5. **Nondiscrimination.** Provider agrees that it shall not exclude or deny aid, care, service or other benefits available under Medi-Cal or in any other way discriminate against any Medi-Cal patient because of that person's race, color, ancestry, marital status, national origin, gender, age, economic status, physical or mental disability, political or religious affiliation or beliefs in accordance with California and federal laws. In addition, Provider shall not discriminate against Medi-Cal beneficiaries in any manner, including, but not limited to, admission practices, room selection and placement, meals provision and waiting time for surgical procedures. Without exception, Provider shall provide to Medi-Cal patients their specific Medi-Cal benefit Inpatient Services in the same manner as Provider also directly, or indirectly, renders those same services to non-Medi-Cal patients, regardless of payor source.

6. **Scope of Health and Medical Care.** Provider agrees that the health care services it provides may include diagnostic, preventive, corrective, and curative services, goods, supplies, and merchandise essential thereto, provided by qualified personnel for conditions that cause suffering, endanger life, result in illness or infirmity, interfere with capacity for normal activity, including employment, or for conditions which may develop into some significant handicap or disability. Provider further agrees such health care services may be subject to prior authorization to determine medical necessity.

7. **Licensing.** Provider agrees to possess at the time this Agreement becomes effective, and to maintain in good standing throughout the term of this Agreement, valid and unexpired license(s), certificate(s), or other approval(s) to provide health care services, which is appropriate to the services, goods, supplies, and merchandise being provided, if required by the state or locality in which Provider is located, or by the Federal Government. Provider further agrees it shall be automatically suspended as a provider in the Medi-Cal program pursuant to Welfare and Institutions Code, Section 14043.6, if Provider has license(s), certificate(s), or other approval(s) to provide health care services, which are revoked or suspended by a federal, California, or another state's licensing, certification, or approval authority, has otherwise lost that/those license(s), certificate(s), or approval(s), or has surrendered that/those license(s), certificate(s), or approval(s) while a disciplinary hearing on that/those license(s), certificate(s), or approval(s) was pending. Such suspension shall be effective on the date that Provider's license, certificate, or approval was revoked, suspended, lost, or surrendered. Provider further agrees to notify DHCS within ten business days of learning that any restriction has been placed on, or of a suspension of Provider's license, certificate, or other approval to provide health care. Provider further agrees to provide DHCS complete information related to any restriction to, or revocation or loss of, Provider's license, certificate, or other approval to provide health care services.

8. **Record Keeping and Retention.** Provider agrees to make, keep and maintain in a systematic and orderly manner, and have readily retrievable, such records as are necessary to fully disclose the type and extent of all services, goods, supplies, and merchandise provided to Medi-Cal beneficiaries, including, but not limited to, the records described in Section 51476 of Title 22, California Code of Regulations, and the records described in Section 431.107 of Title 42 of the Code of Federal Regulations. Provider further agrees that such records shall be made at or near the time at which the services, goods, supplies, and merchandise are delivered or rendered, and that such records shall be retained by Provider in the form in which they are regularly kept for a period of three years from the date the goods, supplies, or merchandise were delivered or the services rendered or a claim was submitted. Providers using billing agents shall assure that the billing agents maintain and submit documents required.

9. **DHCS, CDPH, AG and Secretary Access to Records; Copies of Records.** Provider agrees to make available, during regular business hours, all pertinent financial records, all records of the requisite insurance coverage, and all records concerning the provision of health care services to Medi-Cal beneficiaries to any duly authorized representative of DHCS, CDPH, the California Attorney General's Medi-Cal Fraud Unit ("AG") or the Health, Education and Welfare Unit, and the Secretary of the United States Centers for Medicare and Medicaid Services (Secretary). Provider further agrees to provide, if requested by any of the above, copies of the records and documentation, and that failure to comply with any request to examine or receive copies of such records shall be grounds for immediate suspension of Provider or its billing agent from participation in the Medi-Cal program. Provider will be reimbursed for reasonable copy costs as determined by DHCS, CDPH, AG or Secretary.

10. **Confidentiality of Beneficiary Information.** Provider agrees that all documents, whether paper, electronic or in any media, that contain protected health information as defined under the Health Information Portability and Accountability Act or personal, confidential information of beneficiaries made or acquired by Provider, shall be confidential and shall not be released without the written consent of the beneficiary or his/her personal representative, or as otherwise authorized by law. Provider agrees to enter into a business associate agreement with any billing agents to assure that they comply with these requirements.

11. **Disclosure of Information to DHCS.** Provider agrees to disclose all information as required in Federal Medicaid laws and regulations and any other information required by DHCS, and to respond to all requests from DHCS for information. Provider further agrees that the failure of Provider to disclose the required information, or the disclosure of false information shall, prior to any hearing, result in the denial of the application for enrollment or shall be grounds for termination of enrollment status or suspension from the Medi-Cal program, which shall include deactivation of all provider numbers used by Provider to obtain reimbursement from the Medi-Cal program. Provider further agrees that all bills or claims for payment to DHCS by Provider shall not be due and owing to Provider for any period(s) for which information was not reported or was reported falsely to DHCS. Provider further agrees to reimburse those Medi-Cal funds received during any period for which information was not reported, or reported falsely, to DHCS.

12. **Background Check.** Provider agrees that DHCS may conduct a background check on Provider for the purpose of verifying the accuracy of the information provided in the application and in order to prevent fraud or abuse. The background check may include, but not be limited to, the following: (1) on-site inspection prior to enrollment; (2) review of medical and business records; and, (3) data searches.

13. **Unannounced Visits By DHCS, AG and Secretary.** Provider agrees that DHCS, AG and/or Secretary may make unannounced visits to Provider, at any of Provider's business locations, before, during or after enrollment, for the purpose of determining whether enrollment, continued enrollment, or certification is warranted, to investigate and prosecute fraud against the Medi-Cal program, to investigate complaints of abuse and neglect of patients in health care facilities receiving payment under the Medi-Cal program, and/or as necessary for the administration of the Medi-Cal program and/or the fulfillment of the AG's powers and duties under Government Code Section 12528. Premises subject to inspection include billing agents, as defined in Welfare and Institutions Code Section 14040.1. Pursuant to Welfare and Institutions Code Section 14043.7(b), such unannounced visits are authorized should the department have reason to believe that the provider will defraud or abuse the Medi-Cal program or lacks the organizational or administrative capacity to provide services under the program. Failure to permit inspection by DHCS, AG or Secretary or any agent, investigator or auditor thereof, shall be grounds for immediate suspension of provider from participation in the Medi-Cal program.

14. **Provider Fraud and Abuse.** Provider agrees that it shall not engage in or commit fraud or abuse. "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself or some other person. It includes any act that constitutes fraud under applicable federal or state law. "Abuse" means either: (1) practices that are inconsistent with sound fiscal or business practices and result in unnecessary cost to the Medicare program, the Medi-Cal program, another state's Medicaid program, or other health care programs operated, or financed in whole or in part, by the Federal Government or any state or local agency in this state or any other state; (2) practices that are inconsistent with sound medical practices and result in reimbursement by the Medi-Cal program or other health care programs operated, or financed in whole or in part, by the Federal Government or any state or local agency in this state or any other state, for services that are unnecessary or for substandard items or services that fail to meet professionally recognized standards for health care.

15. **Investigations of Provider for Fraud or Abuse.** Provider certifies that, at the time this Agreement was signed, it was not under investigation for fraud or abuse pursuant to Subpart A (commencing with Section 455.12) of Part 455 of Title 42 of the Code of Federal Regulations or under investigation for fraud or abuse by any Federal, state or local law enforcement agency, including the Medicaid investigation units of DHCS and the Office of the Inspector General for the Federal Department of Health and Human Services. Provider further agrees to notify DHCS within ten business days of learning that it is under

investigation for fraud or abuse by any such entity. Provider further agrees that it may be subject to temporary suspension pursuant to Welfare and Institutions Code, Section 14043.36(a), which may include temporary deactivation of all provider numbers used by Provider to obtain reimbursement from the Medi-Cal program, if it is discovered that Provider is under investigation as described in that section. Provider further agrees to cooperate with and assist DHCS and any state or federal agency charged with the duty of identifying, investigating, sanctioning, or prosecuting suspected fraud and abuse, although Provider does not waive any timely and properly asserted rights it may have under the 5th Amendment privilege against self-incrimination.

16. **Provider Fraud or Abuse Convictions and/or Civil Fraud or Abuse Liability.** Provider certifies that it and its owners, officers, directors, employees, and agents, have not: (1) been convicted of any felony or misdemeanor involving fraud or abuse in any government program, within the last ten years; or (2) been convicted of any felony or misdemeanor involving the abuse of any patient; or (3) been convicted of any felony or misdemeanor substantially related to the qualifications, functions, or duties of a provider; or (4) entered into a settlement in lieu of conviction for fraud or abuse, within the last ten years; or, (5) been found liable for fraud or abuse in any civil proceeding, within the last ten years. Provider further agrees that DHCS shall not enroll Provider if within the last ten years, Provider has been convicted of any felony, or any misdemeanor involving fraud or abuse in any government program, has entered into a settlement in lieu of conviction for fraud or abuse, or has been found liable for fraud or abuse in any civil proceeding.

17. **Changes to Provider Information.** Provider agrees to keep its application for enrollment in the Medi-Cal program current by informing the California Department of Public Health (CDPH), District Office, in writing on a form or forms to be specified by DHCS, within 35 days of any changes to the information contained in its application for enrollment, its disclosure statement, this Agreement, and/or any attachments to these documents.

18. **Prohibition of Rebate, Refund, or Discount.** Provider agrees that it shall not offer, give, furnish, or deliver any rebate, refund, commission, preference, patronage, dividend, discount, or any other gratuitous consideration, in connection with the rendering of health care services to any Medi-Cal beneficiary. Provider further agrees that it shall not solicit, request, accept, or receive, any rebate, refund, commission, preference, patronage, dividend, discount, or any other gratuitous consideration, in connection with the rendering of health care services to any Medi-Cal beneficiary. Provider further agrees that it will not take any other action or receive any other benefit prohibited by state or federal law.

19. **Payment From Other Health Coverage Prerequisite to Claim Submission.** Provider agrees that it shall first seek to obtain payment for services provided to Medi-Cal beneficiaries from any private or public health insurance coverage to which the beneficiary is entitled, where Provider is aware of this coverage and to the extent the coverage extends to these services, prior to submitting a claim to DHCS for the payment of any unpaid balance for these services. In the event that a claim submitted to a private or public health insurer has not been paid within 180 days of billing by Provider, Provider may submit a claim to DHCS but must provide documentation of denial when requested to do so by DHCS. Providers billing for services to beneficiaries who are dual eligible Medicare-Medi-Cal must submit payment denial from Medicare Part A&B with all claims.

20. **Beneficiary Billing.** Provider agrees that it shall not submit claims to or demand or otherwise collect reimbursement from a Medi-Cal beneficiary, or from other persons on behalf of the beneficiary, for any service included in the Medi-Cal program's scope of benefits in addition to a claim submitted to the Medi-Cal program for that service, except to: (1) collect payments due under a contractual or legal entitlement pursuant to Welfare and Institutions Code, Section 14000(b); (2) bill a long-term care patient for the amount of his/her liability; and, (3) collect a co-payment pursuant to Welfare and Institutions Code,

Sections 14134 and 14134.1. Provider further agrees that, in the event that a beneficiary willfully refuses to provide current other health care coverage billing information as described in Section 50763(a)(5) of Title 22, California Code of Regulations, Provider may, upon giving the beneficiary written notice of intent, bill the beneficiary as a private pay patient.

21. **Payment From Medi-Cal Program Shall Constitute Full Payment.** Provider agrees that payment received from DHCS in accordance with Medi-Cal fee structures shall constitute payment in full, except that Provider, after making a full refund to DHCS of any Medi-Cal payments received for services, goods, supplies, or merchandise, may recover all of Provider's fees to the extent that any other contractual entitlement, including, but not limited to, a private group or indemnification insurance program, is obligated to pay the charges for the services, goods, supplies, or merchandise provided to the beneficiary. Providers agree to submit all claims within 60 days of the dates of service but no later than six months to receive full payment. Providers agree to comply with Welfare and Institutions Code Section 14115 and California Code of Regulations, Title 22, Section 51008 and 51008.5.

22. **Return of Payment for Services Otherwise Covered by the Medi-Cal Program.** Provider agrees that any beneficiary who has paid Provider for health care services, goods, supplies, or merchandise otherwise covered by the Medi-Cal program received by the beneficiary shall be entitled to a prompt return from Provider of any part of the payment which meets any of the following: (1) was rendered during any period prior to the receipt of the beneficiary's Medi-Cal card, for which the card authorizes payment under Welfare and Institutions Code, Sections 14018 or 14019; (2) was reimbursed to Provider by the Medi-Cal program, following audits and appeals to which Provider is entitled; (3) is not payable by a third party under contractual or other legal entitlement; (4) was not used by the beneficiary to satisfy his/her paid or obligated liability for health care services, goods, supplies, or merchandise, or to establish eligibility.

23. **Compliance With Requirements.** Provider and any billing agent agree that it shall comply with all of the requirements set forth in the Welfare and Institutions Code and its implementing regulations, and the Medi-Cal Provider Manuals, including applicable changes to the Medi-Cal Provider Manuals published by DHCS subsequent to the effective date of this Agreement. Providers and their billing agents agree to comply with Welfare and Institutions Code Section 14115 and California Code of Regulations, Title 22, Section 51008 and 51008.5. Providers agree to submit all claims within 60 days of the dates of service but no later than six months to receive full payment. Provider and its billing agent also agree to exhaust all administrative remedies with the fiscal intermediary prior to filing a writ of mandate pursuant to Welfare and Institutions Code Section 14104.5. In the event DHCS determines a reimbursement overpayment has been made to Provider or monies are otherwise owed pursuant to this Agreement, Provider agrees to promptly repay the amounts owed in accordance with applicable federal and California statutes and regulations, and rules and policies of DHCS. DHCS may recoup any overpayment from monies otherwise payable to Provider under this Agreement under any provider number of Provider.

24. **Deficit Reduction Act of 2005, Section 6032 Implementation.** To the extent applicable, as a condition of payment for services, goods, supplies and merchandise provided to beneficiaries in the Medical Assistance Program ("Medi-Cal"), providers must comply with the False Claims Act employee training and policy requirements in 1902(a) of the Social Security Act (42 USC 1396a(a)(68)), set forth in that subsection and as the federal Secretary of Health and Human Services may specify.

25. **Provider Suspension; Appeal Rights; Reinstatement.** Provider agrees that it is to be subject to the following suspension actions. Provider further agrees that the suspension of Provider shall include deactivation of all of Provider's provider numbers and shall preclude Provider from submitting claims for payment, either personally or through claims submitted by any individual, clinic, group, corporation, or other association to the Medi-Cal program for any services, supplies, goods, or merchandise that

provider has provided directly or indirectly to a Medi-Cal beneficiary, except for services, supplies, goods, or merchandise provided prior to the suspension.

a. **Automatic Suspensions/Mandatory Exclusions.** The provider shall be automatically suspended under the following circumstances:

(1) Upon notice from the Secretary of the United States Department of Health and Human Services that Provider has been excluded from participation in the Medicare or Medicaid programs. No administrative appeal of a suspension on this ground shall be available to Provider. (Welfare and Institutions Code, Section 14123(b),(c)).

(2) If Provider has license(s), certificate(s), or other approval(s) to provide health care services, revoked or suspended by a federal, California, or another state's licensing, certification, or approval authority, has otherwise lost that/those license(s), certificate(s), or approval(s), or has surrendered that/those license(s), certificate(s), or approval(s) while a disciplinary hearing on that license, certificate, or approval was pending. (Welfare and Institutions Code, Section 14043.6).

(3) If Provider is convicted of any felony or any misdemeanor involving fraud, abuse of the Medi-Cal program or any patient, or otherwise substantially related to the qualifications, functions, or duties of a provider of service. Suspension following conviction is not subject to the proceedings under Welfare and Institutions Code Section 14123(c). However, the director may grant an informal hearing at the request of the provider to determine in the director's sole discretion if the circumstances surrounding the conviction justify rescinding or otherwise modifying the suspension.

b. **Permissive Suspensions/Permissive Exclusions.** The provider may be suspended under the following circumstances:

(1) Provider violates any of the provisions of Chapter 7 of the Welfare and Institutions Code (commencing with Section 14000 except for Sections 14043-14044), or Chapter 8 (commencing with Section 14200) or any rule or regulations promulgated by DHCS pursuant to those provisions. Administrative appeal pursuant to Health and Safety Code, Section 100171. (Welfare and Institutions Code, Section 14123(a),(c)).

(2) Provider fails to comply with DHCS's request to examine or receive copies of the books and records pertaining to services rendered to Medi-Cal beneficiaries. Administrative appeal pursuant to Health and Safety Code, Section 100171. (Welfare and Institutions Code, Section 14124.2).

(3) Provider participating in the Medi-Cal dental program provides services, goods, supplies, or merchandise that are below or less than the standard of acceptable quality, as established by the California Dental Association Guidelines for the Assessment of Clinical Quality and Professional Performance, Copyright 1995, Third Edition, as periodically amended. (Welfare and Institutions Code, Section 14123(f)).

c. **Temporary Suspension.** The provider may be temporarily suspended under the following circumstances:

(1) Provider fails to disclose all information as required in federal Medicaid regulations or any other information required by DHCS, or discloses false information. Administrative appeal pursuant to Welfare and Institutions Code, Section 14043.65. (Welfare and Institutions Code, Section 14043.2(a)).

(2) If it is discovered that Provider is under investigation for fraud or abuse. Administrative appeal pursuant to Welfare and Institutions Code, Section 14043.65. (Welfare and Institutions Code, Section 14043.36(a)).

(3) Provider fails to remediate discrepancies discovered as a result of an unannounced visit to Provider. Administrative appeal pursuant to Welfare and Institutions Code, Section 14043.65. (Welfare and Institutions Code, Section 14043.7(c)).

(4) When necessary to protect the public welfare or the interests of the Medi-Cal program. Administrative appeal pursuant to Health and Safety Code, Section 100171. (Welfare and Institutions Code, Section 14123(c)).

(5) Provider submits claims for payment under any provider number from an individual or entity that is suspended, excluded or otherwise ineligible. This includes a provider on the Suspended and Ineligible Provider List or any list published by the Office of the Inspector General or the Department of Health and Human Services. Appeal pursuant to Welfare and Institutions Code, Section 14043.65. (Welfare and Institutions Code, Section 14043.61).

26. **Provider Grievances and Complaints.** A provider who has a grievance or complaint concerning the processing or payment of money alleged to be payable for services provided to eligible Medi-Cal beneficiaries shall comply with and exhaust all administrative remedies and procedures outlined in statute, regulation or the Provider Manual, including the following:

   a. The provider and its billing agent shall comply with and exhaust all administrative remedies provided by the Fiscal Intermediary or Contractor prior to filing a court action.

   b. The provider and its billing agent shall comply with and exhaust all proceeding for claims processing outlined in the Provider Manual including all appeal procedures.

   c. The provider and its billing agent shall submit to the Fiscal Intermediary or Contractor all source documentation to support its claim, including but not limited to the source documentation outlined in California Code of Regulations, Title 22, Section 51476.

   d. The provider and its billing agent shall comply with all timeliness requirements including but not limited to those outlined in Welfare and Institutions Code Section 14115 and California Code of Regulations, Title 22, Section 51008 and 51008.5.

27. **Provider Termination, Imposition of Federal Sanctions, and Appeal Rights for Long Term Care Facilities.** Provider agrees that it is subject to any federal sanctions authorized under the state plan including termination of this provider agreement in accordance with federal law. Provider further agrees that the termination of this provider agreement or imposition of other federal sanctions authorized under the state plan shall include deactivation of all of Provider's provider numbers and shall preclude Provider from submitting claims for payment either personally or through claims submitted by any individual, clinic, group, corporation, or other association to the Medi-Cal program for any services, supplies, goods, or merchandise that provider has provided directly or indirectly to a Medi-Cal beneficiary, except for services, supplies, goods, or merchandise provided prior to the termination or imposition of sanctions.

   a. Skilled Nursing Facility and Intermediate Care Facility Appeal Procedures. SNF and ICF Medi-Cal Providers shall have the appeal rights set forth in Article 1.6 of Chapter 3 of Division 3 of Title 22.

   b. Intermediate Care Facilities-Mental Retardation Appeal Procedures. Intermediate Care Facilities Developmentally Disabled; Intermediate Care Facilities-Developmentally Disabled-Habilitative;

Intermediate Care Facilities- Developmentally Disabled-Nursing shall have the appeal rights set forth in 42 CFR 431.153 and 431.154.

28. **Liability of Group Providers.** Provider agrees that, if it is a provider group, the group, and each member of the group, are jointly and severally liable for any breach of this Agreement, and that action against any of the providers in the provider group may result in action against all of the members of the provider group.

29. **Legislative and Congressional Changes.** Provider agrees that this Agreement is subject to any future additional requirements, restrictions, limitations, or conditions enacted by the California Legislature or the United States Congress which may affect the provisions, terms, conditions, or funding of this Agreement.

30. **Provider Capacity.** Provider agrees that Provider, and the officers, directors, employees, and agents of Provider, in the performance of this Agreement, shall act in an independent capacity and not as officers or employees or agents of the State of California.

31. **Indemnification.** Provider agrees to indemnify, defend, and save harmless the State of California, its officers, agents, and employees, from any and all claims and losses accruing or resulting to any and all persons, firms, or corporations furnishing or supplying services, materials, or supplies in connection with Provider's performance of this Agreement, and from any and all claims and losses accruing or resulting to any Medi-Cal beneficiary, or to any other person, firm, or corporation who may be injured or damaged by Provider in the performance of this Agreement.

32. **Governing Law.** This Agreement shall be governed by and interpreted in accordance with the laws of the State of California.

33. **Venue.** Venue for all actions, including federal actions, concerning this Agreement, lies in Sacramento County, California, or in any other county in which the California Department of Justice maintains an office.

34. **Titles.** The titles of the provisions of this Agreement are for convenience and reference only and are not to be considered in interpreting this Agreement.

35. **Severability.** If one or more of the provisions of this Agreement shall be invalid, illegal, void, or unenforceable, the validity, legality, and enforceability of the remaining provisions shall not in any way be affected or impaired. Either party having knowledge of such a provision shall promptly inform the other of the presumed non-applicability of such provision. Should the non-applicable provision go to the heart of this Agreement, the Agreement shall be terminated in a manner commensurate with the interests of both parties.

36. **Assignability.** Provider agrees that it has no property right in or to its status as a Provider in the Medi-Cal program or in or to the provider number(s) assigned to it, and that Provider may not assign its provider number for use as a Medi-Cal provider, or any rights and obligations it has under this Agreement except to the extent purchasing owner is joining this provider agreement with successor joint and several liability.

37. **Waiver.** Any action or inaction by DHCS or any failure of DHCS on any occasion, to enforce any right or provision of this Agreement, shall not be interpreted to be a waiver by DHCS of its rights hereunder and shall not prevent DHCS from enforcing such provision or right on any future occasion. The rights and remedies of DHCS herein are cumulative and are in addition to any other rights or remedies that DHCS may have at law or in equity.

38. **Complete Integration.** This Agreement, including any attachments or documents incorporated herein by express reference, is intended to be a complete integration and there are no prior or contemporaneous different or additional agreements pertaining to the subject matter of this Agreement, unless such additional agreement(s) is between DHCS and the Provider, expressly references or incorporates all or part of this Agreement, and is signed by the Provider.

39. **Amendment.** Any alteration or modification by the applicant or Provider of this Medi-Cal Provider Agreement (DHCS Form 9098) or to any of the terms in its exhibits or attachments, shall automatically and immediately void this agreement upon submission of the signed agreement to the State, unless such agreement is also signed by the State.

40. **Provider Attestation.** Provider agrees that all information it submits on the application form for enrollment, this Agreement, and all attachments or changes to either, is true, accurate, and complete to the best of Provider's knowledge and belief. Provider further agrees to sign the application form for enrollment, this Agreement, and all attachments or changes to either, under penalty of perjury under the laws of the State of California.

The parties agree that this agreement is a legal and binding document and is fully enforceable in a court of competent jurisdiction. The provider signing this agreement warrants that he/she has read this agreement and understands it.

I declare under penalty of perjury under the laws of the State of California that the foregoing information is true, accurate, and complete to the best of my knowledge and belief.

I declare I am the provider or I have the authority to legally bind the provider, which is an entity and not an individual person.

1. Printed legal name of provider
   ABC Medical Center, LLC
2. Printed name of person signing this declaration on behalf of provider (if an entity or business name is listed in item 1 above)
   John Doe
3. Original signature of provider or representative if this provider is an entity other than an individual person as sole proprietor
4. Title of person signing this declaration
   Manager
5. Notary Public (Affix notary seal or stamp in the space below)

Executed at: Sacramento (City), CA (State) on 3/11/2109 (Date)

Applicants and providers licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act ARE NOT REQUIRED to have this form notarized. If notarization is required, the Certificate of Acknowledgment signed by the Notary Public must be in the form specified in Section 1189 of the Civil Code.

6. **Contact Person's Information**

▣ Check here if you are the same person identified in item 2. If you checked the box, provide only the e-mail address and telephone number below.

Contact Person's Name (Last, First, Middle)		Gender ☐ Male ☐ Female
Title/Position	E-mail Address janeDoe@abcmedicalLLC.org	Telephone Number (999) 555-2626

Privacy Statement
(Civil Code Section 1798 et seq.)

All information requested on the Application, the disclosure statement, and the provider agreement is mandatory. This information is required by the California Department of Health Care Services and any other California State Departments that are delegated responsibility to administer the Medi-Cal program, by the authority of the Welfare and Institutions Code, Sections 14043 – 14043.75, the California Code of Regulations, Title 22, Sections 51000 – 51451 and the Code of Federal Regulations, Title 42, Part 455. The consequences of not supplying the mandatory information requested are denial of enrollment as a Medi-Cal provider or denial of continued enrollment as a provider and deactivation of all provider numbers used by the provider to obtain reimbursement from the Medi-Cal program. Some or all of this information may also be provided to the California State Controller's Office, the California Department of Justice, the California Department of Consumer Affairs, the California Department of Corporations, the California Franchise Tax Board or other California state or local agencies as appropriate, fiscal intermediaries, managed care plans, the Federal Bureau of Investigation, the Internal Revenue Service, Medicare Fiscal Intermediaries, Centers for Medicare and Medicaid Services, Office of the Inspector General, Medicaid, or as required or permitted by law. For more information or access to records containing your personal information maintained by this agency, contact the Provider Enrollment Division at (916) 323-1945.

HS 328

NOTICE—EFFECTIVE DATE OF PROVIDER AGREEMENT

This notice is to inform you of the regulations that govern the effective date of participation for providers of services. These regulations are found in the Code of Federal Regulations (CFR), 42 CFR 442.13 (Medicaid) and 42 CFR 489.13 (Medicare) and are listed below. These regulations can be ordered from U.S. Government Printing Office, Superintendent of Documents, Mail Stop: SSOP, Washington, D.C. 20402-9328.

I. Federal regulations 42 CFR 442.13 and 42 CFR 489.13 describe the circumstances under which provider agreements are made effective.

   The term provider means Title XIX (Medicaid), any entity providing services under an approved state Medicaid plan. Under Title XVIII (Medicare), a provider is a hospital, skilled nursing facility, home health agency, rural health clinic, clinic, rehabilitation agency, and public health agency.

   The term effective date means the first day the provider may be reimbursed for rendering covered services to a Medicare and Medicaid patient. Services rendered prior to the effective date cannot be reimbursed by the Medicare or Medicaid program.

II. The effective date of the provider agreement is the date the onsite survey is completed (or on the day following the expiration of the current agreement) if on the date of the survey, the provider meets:

   A. All federal health and safety standards; and

   B. Any other requirements imposed by the Centers for Medicare and Medicaid Services (CMS) or the State Medicaid Agency.

   Meets all health and safety standards meaning compliance with each and every federal requirement including each element, standard, and condition of participation.

III. If the provider fails to meet any of the above requirements, the agreement must be effective on the earlier of the following dates:

   A. The date on which the provider meets all requirements.

   B. The date on which the provider submits a correction plan acceptable to CMS (Medicare Title XVIII), or the State Survey Agency (Medicaid Title XIX), or an approvable waiver request or both.

   (Waivers will only be considered for such requirements as Life Safety Codes, Seven-day Registered Nurse, Medical Director, and the American National Standards Institute (ANSI) requirements.)

A plan of correction cannot be accepted for a condition (or conditions) of participation found not met. In those cases, the survey agency must first verify that the condition(s) has been corrected.

Return signed copy to state agency listed below:

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

I have received, read, and understand the notice given to me regarding the effective date of reimbursement by the Medicare and Medicaid programs.

Signature	Print name	Date
	John Doe	March 11, 2019

CMS 1561

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0832

HEALTH INSURANCE BENEFIT AGREEMENT

(Agreement with Provider Pursuant to Section 1866 of the Social Security Act, as Amended and Title 42 Code of Federal Regulations (CFR) Chapter IV, Part 489)

AGREEMENT

between
THE SECRETARY OF HEALTH AND HUMAN SERVICES
and
ABC Medical Center, LLC

doing business as (D/B/A) Star Hospital

In order to receive payment under title XVIII of the Social Security Act, ABC Medical Center, LLC

D/B/A Star Hospital as the provider of services, agrees to conform to the provisions of section of 1866 of the Social Security Act and applicable provisions in 42 CFR.

This agreement, upon submission by the provider of services of acceptable assurance of compliance with title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 as amended, and upon acceptance by the Secretary of Health and Human Services, shall be binding on the provider of services and the Secretary.

In the event of a transfer of ownership, this agreement is automatically assigned to the new owner subject to the conditions specified in this agreement and 42 CFR 489, to include existing plans of correction and the duration of this agreement, if the agreement is time limited.

ATTENTION: Read the following provision of Federal law carefully before signing.

Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or make any false, fictitious or fraudulent statement or representation, or makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry, shall be fined not more than $10,000 or imprisoned not more than 5 years or both (18 U.S.C. section 1001).

Name John Doe Title Manager

Date March 11, 2019

ACCEPTED FOR THE PROVIDER OF SERVICES BY:

NAME *(signature)*

TITLE	DATE

ACCEPTED BY THE SECRETARY OF HEALTH AND HUMAN SERVICES BY:

NAME *(signature)*

SIGN Here for Initial Applications SUBMIT TWO COPIES with ORIGINAL Signatures

TITLE	DATE

ACCEPTED FOR THE SUCCESSOR PROVIDER OF SERVICES BY:

NAME *(signature)*

SIGN Here for CHOW Applications SUBMIT TWO COPIES with ORIGINAL Signatures

TITLE	DATE

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0832. The time required to complete this information collection is estimated to average 5 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

Assurance of Compliance

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. **Title VI of the Civil Rights Act of 1964** (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. **Section 504 of the Rehabilitation Act of 1973** (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of his or her disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. **Title IX of the Education Amendments of 1972** (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. **The Age Discrimination Act of 1975** (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. **Section 1557 of the Affordable Care Act** (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a

purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

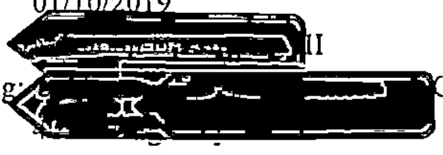
You have successfully submitted the HHS-690 for your organization. You confirmation number is 15946178

The following information was provided:

Date: 01/10/2019

Name and Title of Authorized Official: II

Name of Healthcare Facility Receiving / Requesting Funding: C



Address: 560