Cover Letter

ABC Medical Center, LLC
999 Beach Side Court, Sacramento, CA 95814
P: (999) 555-2626
F: (999) 555-2600
Email: JaneDoe@abcmedicalLLC.org

March 15, 2019

VIA PRIORITY MAIL:

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

RE: **INITIAL** Application for Chemical Dependency Recovery Hospital

To Whom It May Concern,

We are submitting an Initial application for a Chemical Dependency Recovery Hospital known as Star Medical Center, located at 1800 Beach Drive, Sacramento, CA 95814.

I enclosed the required application forms and supporting documents needed to process my Initial application.

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

Emergency Contact Information (available 365/24/7)
Name: Jane Doe
Email: JaneDoe@abcmedicalLLC.org Alternate Email: JaneDoe@cmail.com
Phone: (999) 555-2626 Phone (Text Messages): (999) 555-5555
Fax: (999) 555-2600

Sincerely,

Jane Doe

Jane Doe, Owner
ABC Medical Center, LLC

HS 200

LICENSURE & CERTIFICATION APPLICATION

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

A. APPLICATION INFORMATION

1. Type of application (check one):
   - (●) **a.** Initial
   - ( ) **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:

3. Amount of fee enclosed: $ 49,113

4. Type of Change (check all that apply):
   - ☐ **a.** Not applicable
   - ☐ **b.** Change of capacity (see # 8 below)
   - ☐ **c.** Change of location
   - ☐ **d.** Change of services
   - ☐ **e.** Change of facility type
   - ☐ **f.** Change of bed classification
   - ☐ **g.** Change of name
   - ☐ **h.** Construction of new or replacement facility
   - ☐ **i.** Stock transfer
   - ☐ **j.** Other (specify)

5. Type of facility, agency, or clinic (check one)
   - ( ) **a.** Skilled Nursing Facility (SNF)
   - ( ) **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) Chemical Dependency Recovery Hospital

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:

9. Age range of clients: 18-100

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: ABC Medical Center, LLC

2. Federal employer's tax ID number: 555555555

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

- ○ **a.** Sole proprietorship (Individual)
- ○ **b.** Profit corporation
- ○ **c.** Nonprofit corporation
- ◉ **d.** Limited Liability Company (LLC)
- ○ **e.** Partnership – General
- ○ **f.** Partnership – Limited
- ○ **g.** City
- ○ **h.** County
- ○ **i.** State agency
- ○ **j.** Other agency (specify)
- ○ **k.** Public agency (specify)

4. Licensee address (number & street): 999 Beach Side Court

Telephone number: (999) 555-2626

City, State, & Zip: Sacramento, CA 95814

E-Mail: JaneDoe@abcmedicalLLC.org

Fax number: (999) 555-2600

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

(1) Facility Name:

Facility Type:

Facility address (number & street):

City, State, & Zip:

(2) Facility Name:

Facility Type:

Facility address (number & street):

City, State, & Zip:

(3) Facility Name:

Facility Type:

Facility address (number & street):

City, State, & Zip:

(4) Facility Name:

Facility Type:

Facility address (number & street):

City, State, & Zip:

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

6. Is the licensee a **subsidiary** of another organization? ○ Yes ◉ No
If "yes", complete the information below and ***submit*** an organizational chart:

Parent organization name:

Parent federal tax ID Number:

P.O. Box or number & street:

City, State, & Zip:

C. FACILITY, AGENCY OR CLINIC INFORMATION

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

1. **a.** Is the facility, agency, or clinic going to be operated under a management contract/agreement between the proposed owner and a management company? 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 Medical Center 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: Date of hire:
   Professional License number: Expiration date:

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

	Name of individual	% Owned	EIN Number	Are they related to one another as a spouse, parent, child or sibling?		Relationship
(1)	Jane Doe	100	55-5555555	○ 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: 123 Properties, LLC
Address (number & street): 123 Boxview Street
City, State, & Zip: Sacramento, CA 95814

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

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
	Owner	03/11/2019
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.

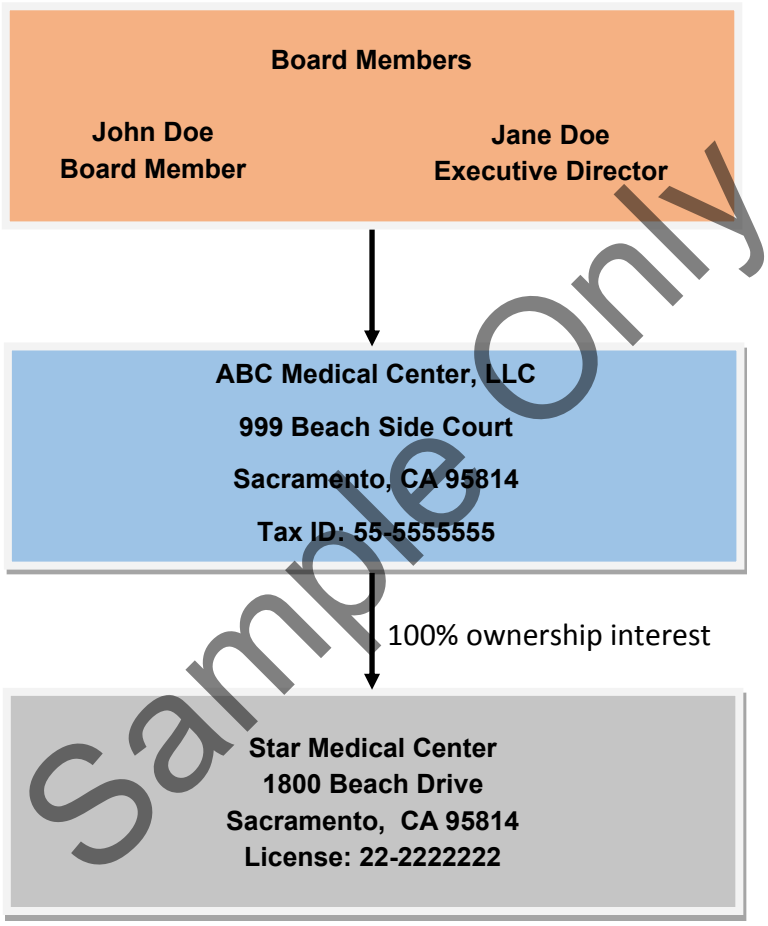
☐ ***Submit*** an attachment for additional names. This attachment must include all of the required information.

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.

Insert Construction Documents

Organization Chart



Insert
Control of Property
Here

CDPH 609

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

BED OR SERVICE REQUEST

Date: 03/15/2019

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 Medical Center	Chemical Dependency Recovery 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
_____ General Acute Care (Unspecified)	_____ 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)
153 Other (specify) CDRH	153 Other (specify) CDRH
_____ 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.)	_____ Outpatient Service (i.e. Family Practice, Pediatrics, Primary Care, Rural Health Clinic, etc.)
Specify: _____	Specify: _____
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): _____

Insert Written Listing of Services

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 Medical Center						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								

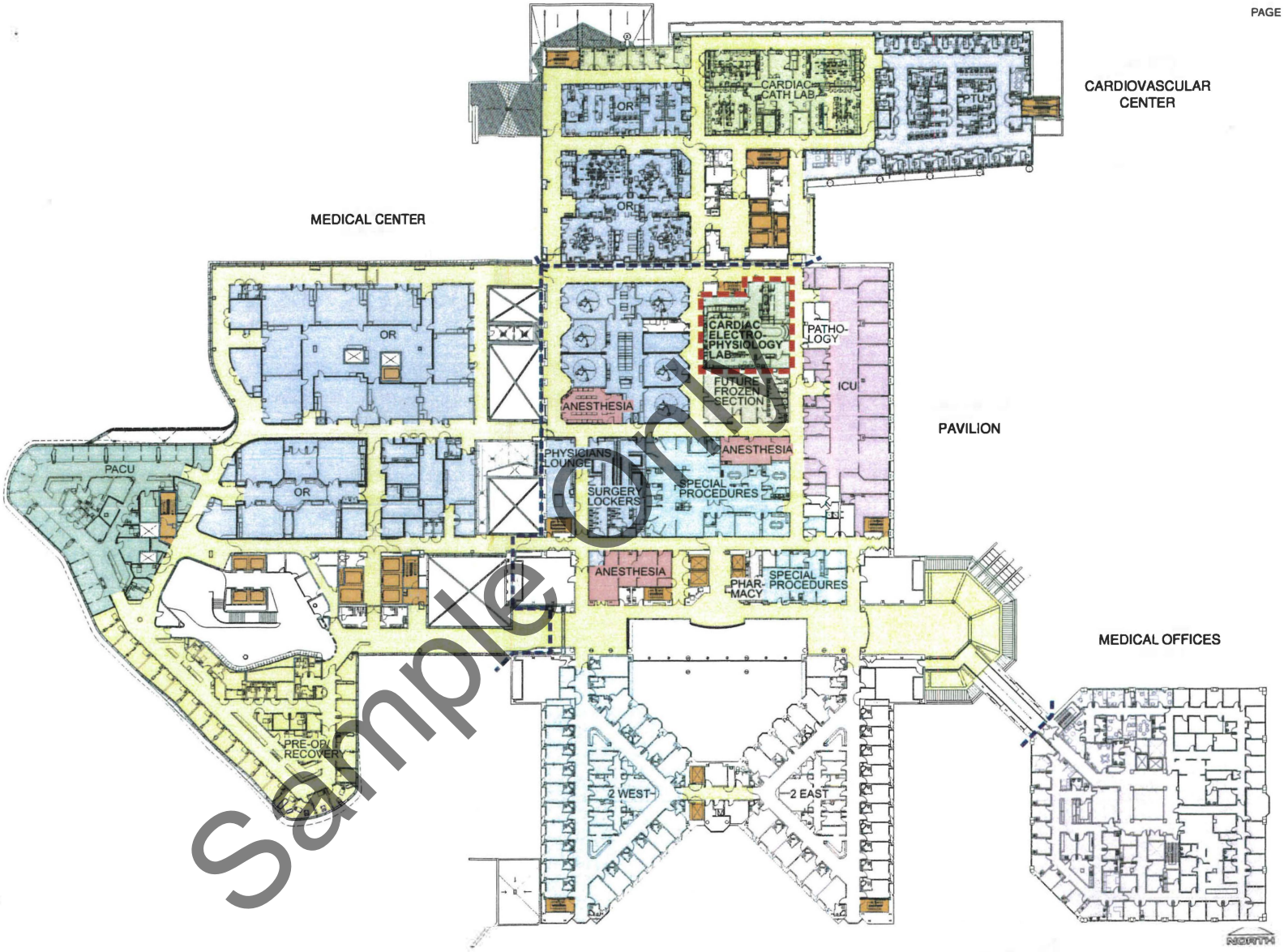
Building	Floor	Room	Activity	Room Size	Floor Area	Approved Capacity	Non-ambulatory	Ambulatory
Additional Rooms (This space may also be used for individual rooms where necessary.)								

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



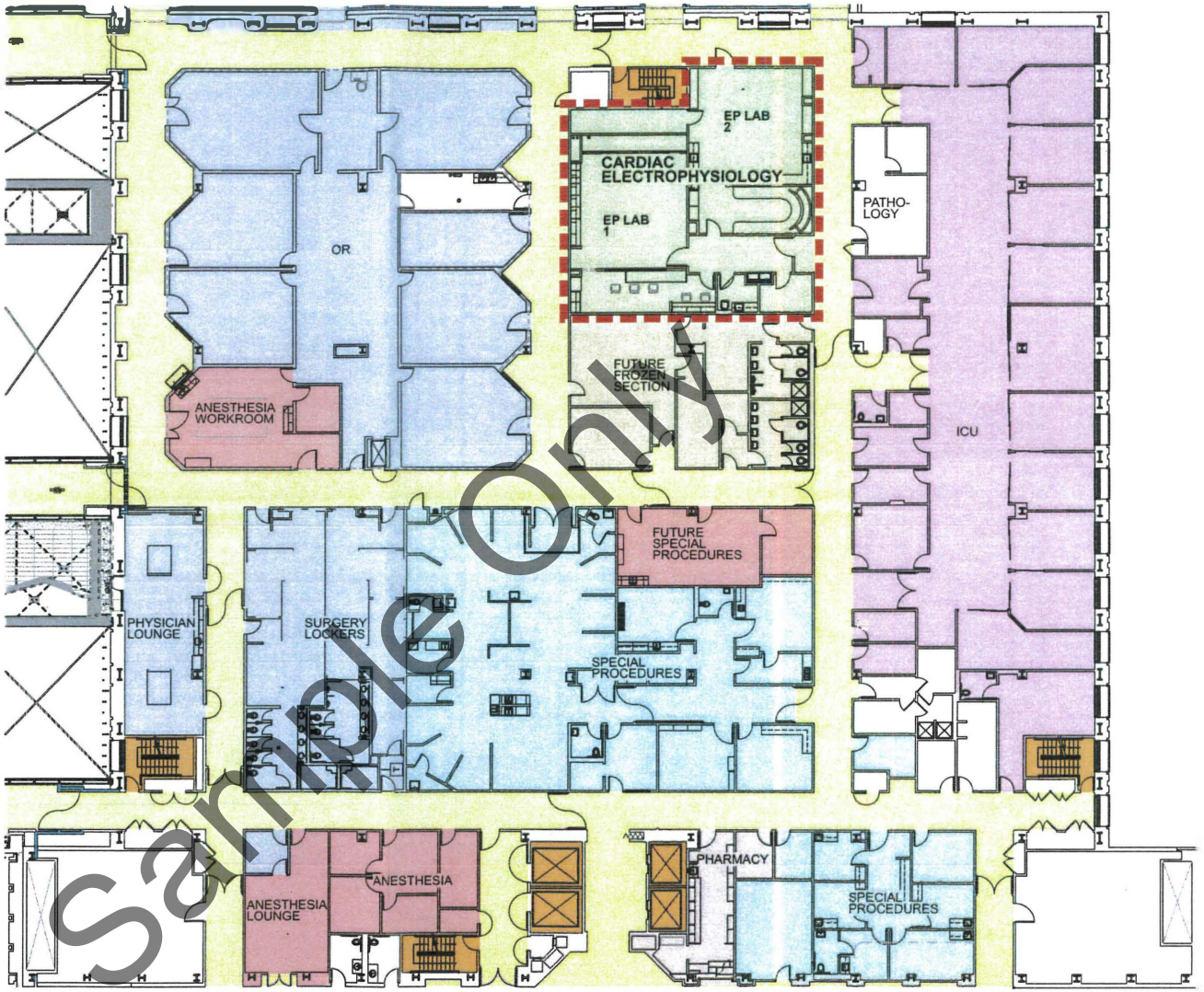
Level 2 North Renovation -Cardiac Electrophysiology

L2 - OVERALL PLAN

ABC Medical Center, LLC

COLOR LEGEND

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



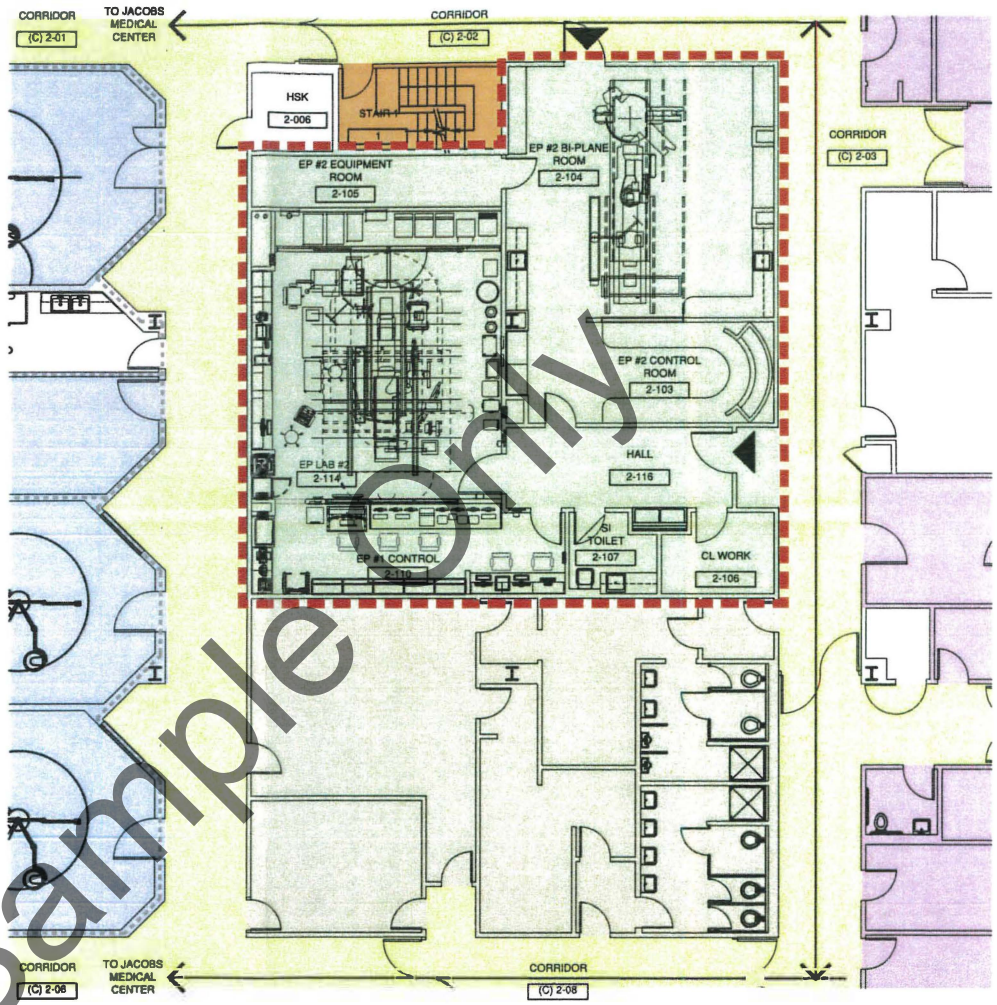
Level 2 North Renovation - Cardiac Electrophysiology

L2 - OVERALL PLAN

ABC Medical Center, LLC

COLOR LEGEND

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



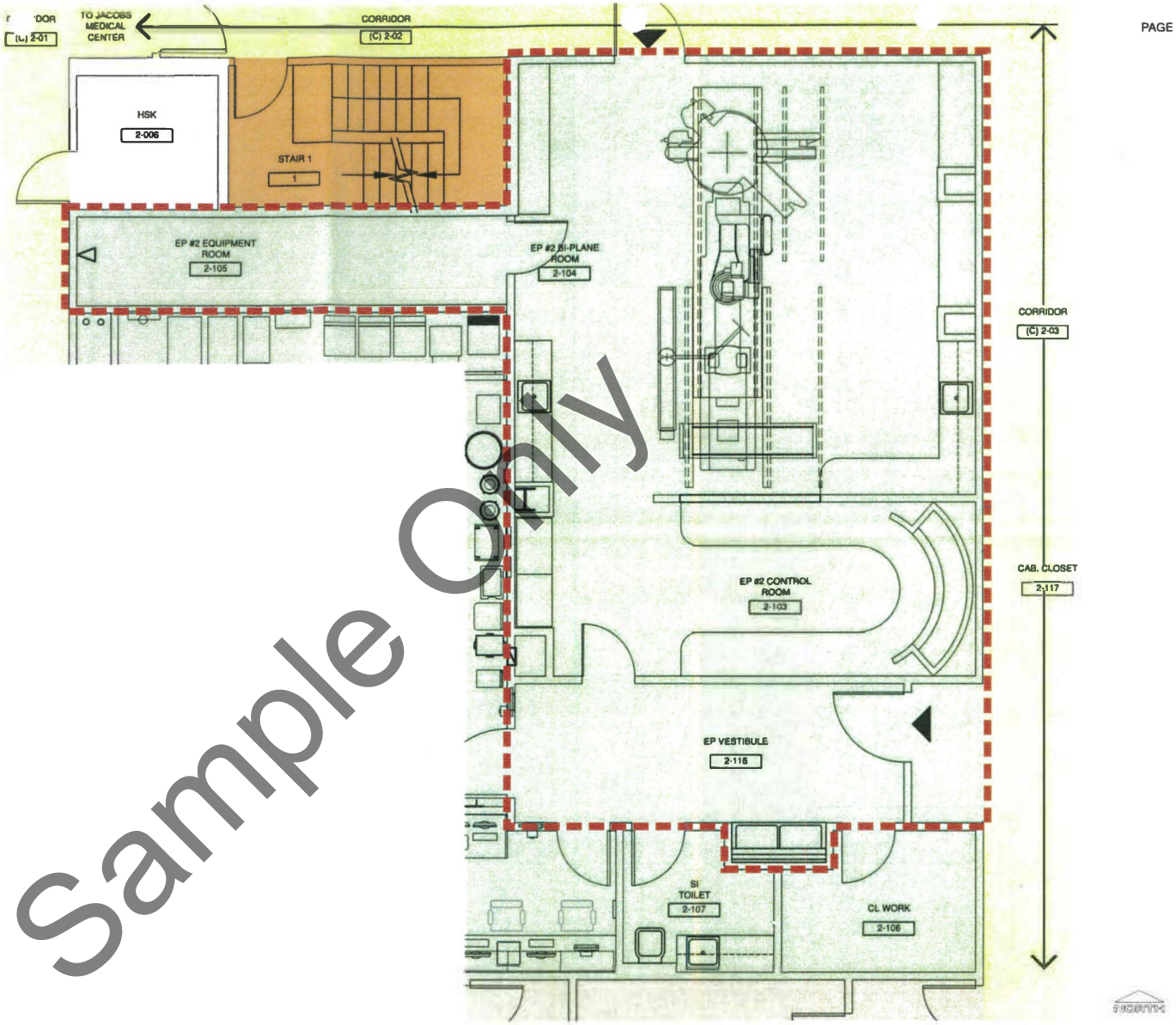
NORTH

Level 2 North Renovation - Cardiac Electrophysiology

L2 - ENLARGED EXISTING FLOOR PLAN

COLOR LEGEND

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



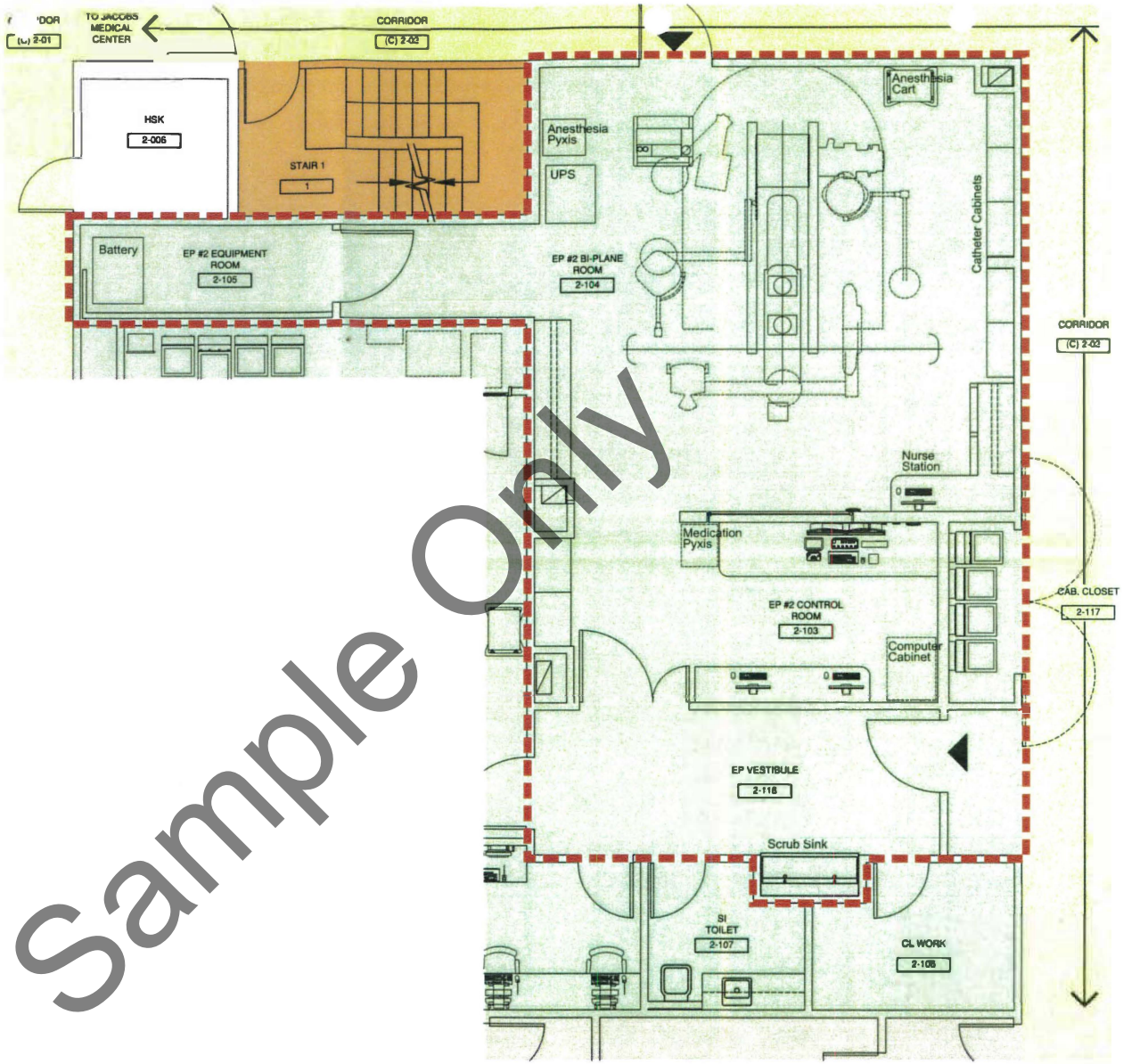
Level 2 North Renovation - Cardiac Electrophysiology

L2 - ENLARGED AREA - EXISTING PLAN

ABC Medical Center, LLC

COLOR LEGEND

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



Level 2 North Renovation - Cardiac Electrophysiology

L2 - ENLARGED AREA - REMODEL PLAN

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.

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.

		Name and address of employer	Job title
From:	5/13/2015	Star Medical Center	Administrator
To:	Present	1800 Beach Drive, Sacramento, CA 95814	
From:	1/28/2010	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:	1/29/2010	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:*

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 Medical Center	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: ABC Community Care	○ 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: 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 ○ No	Dates of involvement: 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 ○ No	Dates of involvement: 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 ○ No	Dates of involvement: 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**

Star Medical Center, 1800 Beach Drive, Sacramento, CA 95814

- Serve as Administrator of Star Medical Center
- Primary Focus on Business Development, Strategic Planning Initiatives and Operations
- Physician Liaison
- Oversight of Clinic monthly actual and budgeted financials
- Provide leadership and direction of all aspects of center activities to ensure quality patient care
- Oversee daily operations of clinical, research

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

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: John Doe

Date of Birth: 10/14/1970

Business address (number, street, apartment/suite number or letter if applicable): 999 Beach Side Court

City, State, & Zip: Sacramento, CA 95814

Title in relation to this facility: Board Member

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.

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

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.

		Name and address of employer	Job title
From:	5/13/2015	Star Medical Center	Board Member
To:	Present	1800 Beach Drive, Sacramento, CA 95814	
From:	1/28/2010	Get Well Community Care	Director of Operations
To:	5/12/2015	1234 Healthy Avenue, Suite 1A, Sacramento, CA 95810	
From:	3/2/2007	Care Free Community Care	Administrator
To:	1/29/2010	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:*

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 Medical Center	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	ABC Community Care EIN:55-5555555	○ 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: 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:
Care Free Medical Center	9816 Pain Free Drive, Elk Grove	CA	95624

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.

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: Jane Doe

Date of Birth: 07/07/1977

Business address (number, street, apartment/suite number or letter if applicable): 999 Beach Side Court

City, State, & Zip: Sacramento, CA 95814

Title in relation to this facility: CEO/President/Owner

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.

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

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.

		Name and address of employer	Job title
From:	5/13/2015	Star Medical Center	CEO/President
To:	Present	1800 Beach Drive, Sacramento, CA 95814	
From:	1/28/2010	Get Well Community Care	Director of Operations
To:	5/12/2015	1234 Healthy Avenue, Suite 1A, Sacramento, CA 95810	
From:	3/2/2007	Care Free Community Care	Administrator
To:	1/29/2010	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:*

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 Medical Center	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: ABC Community Care EIN:55-5555555	○ Agent
◉ COMMUNITY CARE FACILITY	○ Individual:	○ Director
○ General Acute Care Hospital		○ Licensee
○ Health Facility	○ LLC:	○ Manager of "parent" organization
○ HHA		○ Managing employee of a HHA
○ Hospice	○ Management Company:	○ Member
○ ICF		◉ Officer of corporation
○ ICF/DD	○ Partnership:	○ Owner
○ ICF/DD-H		○ Partner
○ ICF/DD-N	○ OTHER Business Entity (explain):	○ Sole Proprietorship
○ ICF		○ Stockholder -- Ownership %:
○ Residential Care for the Elderly	Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain.	○ Trustee
○ SNF	○ Yes	○ OTHER Nature of Involvement (explain):
○ OTHER FACILITY TYPE (explain):	◉ No	Dates of involvement: 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: From: To:
	◉ No	

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: From: To:
	○ No	

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:

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: Amber Dixie

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: Medical Director

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.

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.

Family First- 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
Physician's License 777777	06/1996- Present	Medical Board of California

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.

		Name and address of employer	Job title
From:	5/31/2015	Star Medical Center	Medical Director
To:	Present	1800 Beach Drive, Sacramento, CA 95814	
From:	1/28/2010	Get Well Home Health, Inc.	Administrator/DPCS
To:	5/12/2015	1234 Healthy Avenue, Suite 1A, Sacramento, CA 95810	
From:	3/2/2007	Care Free Home Health Inc.	Director of Nursing
To:	1/29/2010	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:*

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 Medical Center	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: ABC Community Care EIN:55-5555555	○ Agent
○ COMMUNITY CARE FACILITY	○ Individual:	◉ Director
○ General Acute Care Hospital		○ Licensee
○ Health Facility	○ LLC:	○ Manager of "parent" organization
○ HHA		○ Managing employee of a HHA
○ Hospice	○ Management Company:	○ Member
○ ICF		○ Officer of corporation
○ ICF/DD	○ Partnership:	○ Owner
○ ICF/DD-H		○ Partner
○ ICF/DD-N	○ OTHER Business Entity (explain):	○ Sole Proprietorship
○ ICF		○ Stockholder -- Ownership %:
○ Residential Care for the Elderly	Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain.	○ Trustee
○ SNF	○ Yes	○ OTHER Nature of Involvement (explain):
○ OTHER FACILITY TYPE (explain):	◉ No	Dates of involvement: 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: From: To:
	◉ No	

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: From: To:
	○ No	

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○ 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
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○ 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
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○ OTHER FACILITY TYPE (explain):	○ Yes	Dates of involvement:
	○ No	From:
		To:

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

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○ 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
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○ 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.

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.
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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.
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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.
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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.

Amber Dixie

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

Education

NURSING UNIVERISTY | 1995

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

Experience

MEDICAL DIRECTOR **MAY 2015 – PRESENT**

Star Medical Center, 1800 Beach Drive, Sacramento, CA 95814

- Serve as Medical Director of Star Medical Center
- Primary Focus on Business Development, Strategic Planning Initiatives and Operations
- Physician Liaison
- Oversight of Clinic monthly actual and budgeted financials
- Provide leadership and direction of all aspects of center activities to ensure quality patient care
- Oversee daily operations of clinical, research

ADMINISTRATOR/DIRECTOR OF PATIENT CARE SERVICES **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)	2. Administrator
ABC Medical Center, LLC	Jane Doe

3. Incorporation date	4. Place of incorporation
06/05/1994	California

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
2	1 Year	Annually	Vote

10. Board Officers

Office	Name	Term Expires
CEO	Jane Doe	03/03/2020
Board Member	John Doe	03/03/2020

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.

Jane Doe, Owner (100%) - 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.

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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.

Business Search - Entity Detail

The California Business Search is updated daily and reflects work processed through Wednesday, August 7, 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.

312928321545 ABC MEDICAL CENTER, LLC

Registration Date:	06/05/1995
Jurisdiction:	California
Entity Type:	Domestic Stock
Status:	Active
Agent for Service of Process:	Jane Doe 999 Beach Side Court Sacramento CA 95814
Entity Address:	999 Beach Side Court Sacramento CA 95814
Entity Mailing Address:	999 Beach Side Court Sacramento CA 95814

A Statement of Information is due EVERY EVEN-NUMBERED year beginning five months before and through the end of June.

* 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**.
- For descriptions of the various fields and status types, refer to **Frequently Asked Questions**.

Modify Search **New Search** **Back to Search Results**

Insert Articles of Organization Here

Insert Operating Agreement Here

HS 400

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 Medical Center
Name of Facility

Facility address 1800 Beach Drive (Street) Sacramento (City) CA (State) 95814 (ZIP Code) Sacramento (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. ..... $ _____

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.

Wain Jones
Print name

Administrator
Title

Signature

03/15/19
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.

HS 602

TRANSFER AGREEMENT BETWEEN

Star Hospital
Name of Hospital

1600 Ocean Avenue
Street Address

Sacramento, CA 95814
City, State, and ZIP Code

AND

Star Medical Center
Name of Facility

1800 Beach Drive
Street Address

Sacramento, CA 95814
City, State, and ZIP Code

To facilitate continuity of care and the timely transfer of patients and records between the hospital and the facility, the parties named above agree as follows:

1. When a patient's need for transfer from one of the above institutions to the other has been determined and substantiated by the patient's physician, the institution to which transfer is to be made agrees to admit the patient as promptly as possible, provided admission requirements in accordance with federal and state laws and regulations are met.

2. The transferring institution will send with each patient at the time of transfer, or in the case of emergency, as promptly as possible, the completed transfer and referral forms mutually agreed upon to provide the medical and administrative information necessary to determine the appropriateness of the placement and to enable continuing care to the patient. The transfer and referral forms will include such information as current medical findings, diagnoses, a brief summary of the course of treatment followed in the transferring institution, nursing and dietary information, ambulation status, and pertinent administrative and social information, as appropriate.

3. The hospital shall make available it's diagnostic and therapeutic services, including emergency dental care, on an outpatient basis as ordered by the attending physician subject to federal and state laws and regulations.

4. The institution responsible for the patient shall be accountable for the recognition of need for social services and for prompt reporting of such needs to the local welfare department or other appropriate sources.

5. The transferring institution will be responsible for the transfer or other appropriate disposition of personal effects, particularly money and valuables, and information related to these items.

6. The transferring institution will be responsible for effecting the transfer of the patient, including arranging for appropriate and safe transportation and care of the patient during the transfer in accordance with applicable federal and state laws and regulations.

7. Charges for services performed by either facility shall be collected by the institution rendering such services, directly from the patient, third-party payor, or other sources normally billed by the institution. Neither facility shall have any liability to the other for such charges.

8. The governing body of each facility shall have exclusive control of policies, management, assets, and affairs of its respective institutions. Neither institution shall assume any liability by virtue of the agreement for any debts or other obligations incurred by the other party to this agreement.

9. Nothing in this agreement shall be construed as limiting the rights of either institution to contract with any other facility on a limited or general basis.

10. This agreement shall be in effect from the date both parties sign. It may be terminated by either facility upon 30 days written notice, with copies sent to the district office of the Licensing and Certification Division, having jurisdiction for your facility.

11. This agreement shall be maintained in the facilities' files.

_____	_____
Date	Date
_____	_____
Administrator	Administrator
Star Medical Center	Star Hospital
Facility	Hospital
_____	_____
Facility Provider Number	Hospital Provider Number

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
Departmental Use Only	Departmental Use Only	CAB	Departmental Use Only

EVALUATOR'S NAME	REQUESTING AGENCY FACILITY NUMBER	REQUEST CODE
Departmental Use Only	Departmental Use Only	Departmental Use Only

LICENSING AGENCY NAME AND ADDRESS

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

CODES

1. ORIGINAL A. FIRE CLEARANCE
2. RENEWAL B. LIFE SAFETY
3. CAPACITY CHANGE
4. OWNERSHIP CHANGE
5. ADDRESS CHANGE
6. NAME CHANGE
7. OTHER

AMBULATORY		NONAMBULATORY		BEDRIDDEN		TOTAL CAPACITY
CAPACITY	PREVIOUS CAPACITY	CAPACITY	PREVIOUS CAPACITY	CAPACITY	PREVIOUS CAPACITY	

FACILITY NAME
Star Medical Center

LICENSE CATEGORY

STREET ADDRESS *(Actual Location)*
1800 Beach Drive

NUMBER OF BUILDINGS

CITY
Sacramento, CA 95814

RESTRAINT

FACILITY CONTACT PERSON'S NAME	FACILITY CONTACT PERSON'S TELEPHONE NUMBER	HOURS
Jane Doe	999-555-2626	Mon- Sun 8am-5pm

SPECIAL CONDITIONS

TO BE COMPLETED BY INSPECTING AUTHORITY

FIRE AUTHORITY NAME AND ADDRESS

CLEARANCE /DENIAL CODE

CODES

1. FIRE CLEARANCE GRANTED
2. FIRE CLEARANCE DENIED
   - A. EXITS
   - B. CONSTRUCTION
   - C. FIRE ALARM
   - D. SPRINKLERS
   - E. HOUSEKEEPING
   - F. SPECIAL HAZARD
   - G. OTHER

INSPECTOR'S NAME *(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.