COVER LETTER

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

March 15, 2019

VIA PRIORITY MAIL:

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

RE: **CHANGE OF INDIRECT OWNERSHIP** Application for General Acute Care Hospital known as Star Hospital, located at 1800 Beach Drive, Sacramento, CA 95814, License # 222222222

To Whom It May Concern,

We are submitting a **Change of Indirect Ownership** application for Star Hospital, located at 1800 Beach Drive, Sacramento, CA 95814.

Effective March 15, 2019, West Coast Health System is no longer the sole owner of ABC Medical Center, LLC. West Coast Health System has entered into a Membership Interest Purchase Agreement with East Coast Corporation, under which East Coast Corporation will acquire 30% ownership of ABC Medical Center, LLC. This ownership restructure affects the indirect ownership of the health facility, Star Hospital. I enclosed the required application forms and supporting documents needed to process my Change of Indirect Ownership request.

Notably, the transaction will not result in a direct ownership change of the licensed providers. They will continue to be the licensees and their EINs will not change. Further, the transaction does not involve changes in the administration, staff, management, or day-to-day operations of the licensed providers, nor changes that would negatively affect the type of quality of services and care the licensed providers current offer their patients.

The new ownership structure following the transaction is included in this application. While the new ownership structure reflects changes above the ABC Medical Center, LLC level, the internal structure of ABC Medical Center, LLC and below will remain unchanged from what you currently have on file.

Should you have any questions, I will be the direct contact regarding this Change of Indirect Ownership 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	
District:	*ELMS Facility Number:*
Proposed name of facility/agency/clinic:	

A. APPLICATION INFORMATION

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

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

3. Amount of fee enclosed: $

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

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

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

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

8. **a.** Current facility bed capacity: 153
   b. Proposed facility bed capacity: 153

9. Age range of clients: 0-100

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

11. Is construction required? ○ Yes ◉ No
    If "yes", submit copy of "OSHPD" form (see instructions on page 6)
    If "yes", date construction to begin:
    If "yes", date construction to be completed:

B. LICENSEE INFORMATION

1. Licensee name: ABC Medical Center, LLC

2. Federal employer's tax ID number: 55555555

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

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

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

Telephone number: (999) 555-2626

City, State, & Zip: Sacramento, CA 95814

E-Mail: JaneDoe@abcmedicalLLC.org

Fax number: (999) 555-2600

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

(1) Facility Name:

Facility Type:

Facility address (number & street):

City, State, & Zip:

(2) Facility Name:

Facility Type:

Facility address (number & street):

City, State, & Zip:

(3) Facility Name:

Facility Type:

Facility address (number & street):

City, State, & Zip:

(4) Facility Name:

Facility Type:

Facility address (number & street):

City, State, & Zip:

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

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

Parent organization name: West Coast Health System

Parent federal tax ID Number: 888888888

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

City, State, & Zip: Sacramento, CA 95814

C. FACILITY, AGENCY OR CLINIC INFORMATION

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

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

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

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

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

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

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

6. **a.** Name of administrator: Wain Jones Date of hire: 05/13/2015
Professional License number: Expiration date:
b. Name of director of nursing: Amber Dixie Date of hire: 05/31/2015
Professional License number: 777777 Expiration date: 11/30/2019

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

	Name of individual	% Owned	EIN Number	Are they related to one another as a spouse, parent, child or sibling?		Relationship
(1)				○ Yes	○ No	
(2)				○ Yes	○ No	
(3)				○ Yes	○ No	
(4)				○ Yes	○ No	
(5)				○ Yes	○ No	

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

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

10. **Program Plan -- Only applies to ICF/DD, ICF/DD-H and ICF/DD-N (H&S Code, Section 1275.3(b)(3))**
Has the program plan been approved by the Department of Developmental Services? ○ Yes ○ No
If "yes", ***Submit*** a copy of the approval letter. The "current licensee" can grant permission for their Program Plan to be used for 6 months if they ***submit*** a letter to CDPH. If "no", the application package will be delayed until a copy of the approved program letter is received.

D. PROPERTY INFORMATION

1. Property ownership: Check one and ***submit*** evidence of control of property: ◉ Own ○ Rent ○ Lease ○ Sublease ○ Other (specify):

2. **Owner of Record** name in the real estate: ABC Medical Center, LLC
   Address (number & street): 999 Beach Side Court
   City, State, & Zip: Sacramento, CA 95814

   Lessee name:
   Address (number & street):
   City, State, & Zip:

   Sub-Lessee name:
   Address (number & street):
   City, State, & Zip:

E. MANAGEMENT COMPANY

If the proposed facility, agency, or clinic will be operated by a management company, under a management contract between the proposed owner and a management company, complete Attachment E-1 (next page). NOTE: if the facility is a SNF or ICF, the management company will have to SUBMIT a separate application to the Department, unless previously approved.

F. I (we) Accept responsibility to:

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

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

Signature	Title	Date
	Managing Member	03/11/2018
Signature	**Title**	**Date**
	Member	03/11/2018
Signature	**Title**	**Date**
	Member	03/11/2018
Signature	**Title**	**Date**
	Member	03/11/2018

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.

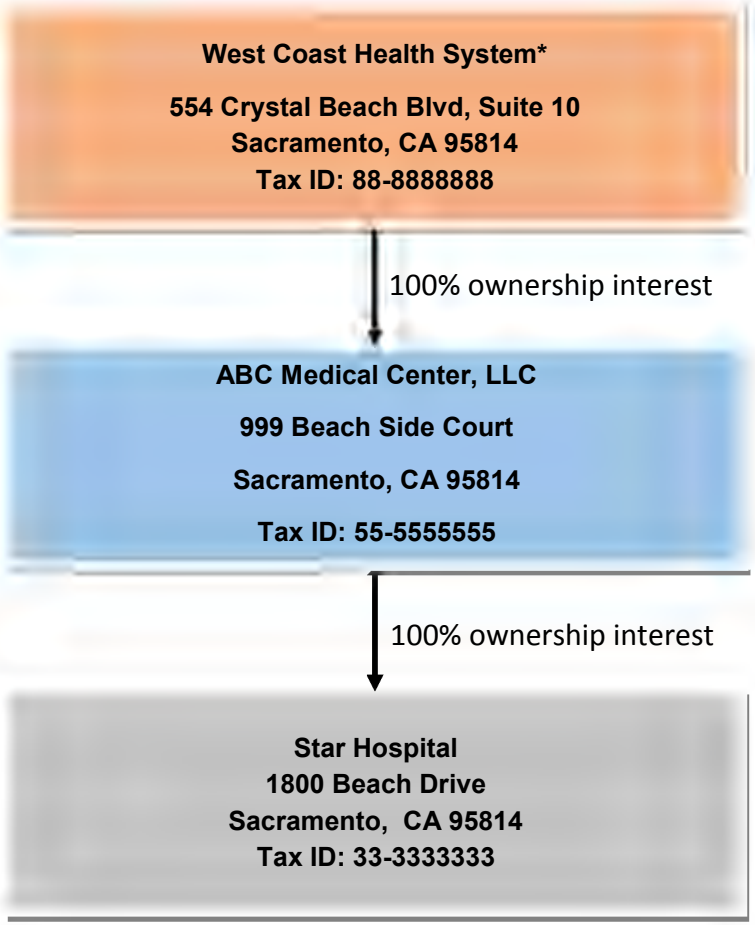
2. Provide the name, address, and percent of ownership for each person having a **5 percent** or more interest in the Management Company.

☐ ***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.

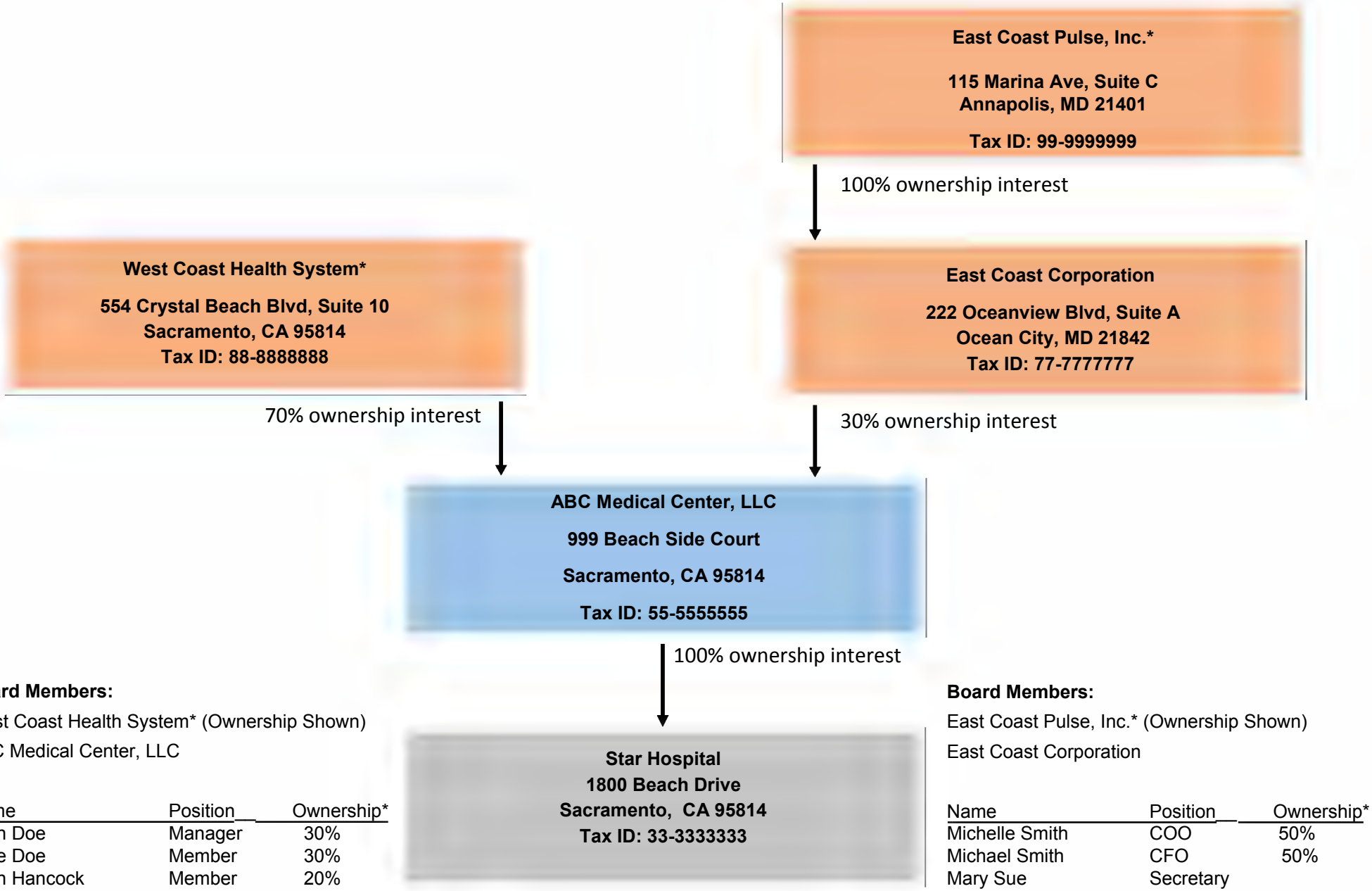
Pre Transaction Organization Chart



Board Members:
West Coast Health System* (Ownership Shown)
ABC Medical Center, LLC

Name	Position	Ownership
John Doe	Manager	30%
Jane Doe	Member	30%
John Hancock	Member	20%
Jane Hancock	Member	20%

Post Transaction Organization Chart



Board Members:

West Coast Health System* (Ownership Shown)

ABC Medical Center, LLC

Name	Position	Ownership*
John Doe	Manager	30%
Jane Doe	Member	30%
John Hancock	Member	20%
Jane Hancock	Member	20%

Board Members:

East Coast Pulse, Inc.* (Ownership Shown)

East Coast Corporation

Name	Position	Ownership*
Michelle Smith	COO	50%
Michael Smith	CFO	50%
Mary Sue	Secretary	
Marty Stu	CEO	

INSERT INDIRECT OWNERSHIP AGREEMENT HERE

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: Marty Stu

Date of Birth: 2/20/1978

Business address (number, street, apartment/suite number or letter if applicable): 115 Marina Ave, Suite C

City, State, & Zip: Annapolis, MD 21401

Title in relation to this facility: Board Officer of grandparent organization (East Coast Pulse, Inc.) and parent organization (East Coast Corporation)

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
Physician License	2006 to present	Medical Board of Maryland

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:	3/1/2016	East Coast Corporation	Chief Executive Officer
To:	Present	222 Oceanview Blvd, Suite A, Ocean City, MD 21842	
From:	3/1/2016	East Coast Pulse, Inc.	Chief Executive Officer
To:	Present	115 Marina Ave, Suite C, Annapolis, MD 21401	
From:	6/16/2010	Montclair Medical Hospital	Medical Director
To:	2/20/2016	5000 Cedar Grove, Marybury, MD 20658	
From:	6/17/2006	North East Children's Hospital	Medical Staff Physician
To:	06/15/2010	333 S. 7th Street, Scotland, MD 20687	

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

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

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

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

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

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

F. Adverse Actions

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

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

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

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

Signature: *Date:* 3/10/19

RELEASE OF INFORMATION STATEMENT

The information provided on this form is mandatory and is necessary for licensure approval. It will be used to determine individual applicant's or applicant facility's ability to provide health services. The information is requested by the California Department of Public Health, Licensing and Certification, in accordance with the Health and Safety Code. Failure to provide the information as requested may result in nonissuance of a license or license revocation. The information is considered public information and will be made available to the public upon request. The information shall be included and maintained in the individual facility's public files located in Licensing and Certification district offices.

FACILITY INFORMATION SHEET

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

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

Type of Facility	"Type" of Business Entity	Individual's "Nature" of Involvement
○ Adult Day Health Care Center	For EACH business entity, identify the name & EIN of the entity:	○ Administrator of Clinic, SNF or ICF
○ Clinic	○ Corporation:	○ Agent
○ COMMUNITY CARE FACILITY		○ Director
○ General Acute Care Hospital	○ Individual:	○ Licensee
○ Health Facility		● Manager of "parent" organization
○ HHA	○ LLC:	○ Managing employee of a HHA
○ Hospice	ABC Medical Center, LLC EIN:55-5555555	○ Member
○ ICF	○ Management Company:	○ Officer of corporation
○ ICF/DD		○ Owner
○ ICF/DD-H	○ Partnership:	○ Partner
○ ICF/DD-N		○ Sole Proprietorship
○ ICF	○ OTHER Business Entity (explain):	○ Stockholder -- Ownership %:
○ Residential Care for the Elderly		○ Trustee
○ SNF	Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain.	○ OTHER Nature of Involvement (explain):
○ OTHER FACILITY TYPE (explain):	○ Yes	Member
	● No	Dates of involvement:
		From: 3/10/2019
		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	
	● 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:

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.

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: Michael Smith

Date of Birth: 11/2/1971

Business address (number, street, apartment/suite number or letter if applicable): 115 Marina Ave, Suite C

City, State, & Zip: Annapolis, MD 21401

Title in relation to this facility: Board Officer of grandparent organization (East Coast Pulse, Inc.) and parent organization (East Coast Corporation)

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:	1/14/2013	East Coast Corporation	Chief Financial Officer
To:	Present	222 Oceanview Blvd, Suite A, Ocean City, MD 21842	
From:	1/14/2013	East Coast Pulse, Inc.	Chief Financial Officer
To:	Present	115 Marina Ave, Suite C, Annapolis, MD 21401	
From:	9/20/2004	Lenae Healthcare Holdings, LLC	Managing Member
To:	12/5/2012	2000 Ravyn Lane, Portland, ME	
From:			
To:			

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

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

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

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

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

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

F. Adverse Actions

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

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

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

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

Signature: *Date:* 3/10/19

RELEASE OF INFORMATION STATEMENT

The information provided on this form is mandatory and is necessary for licensure approval. It will be used to determine individual applicant's or applicant facility's ability to provide health services. The information is requested by the California Department of Public Health, Licensing and Certification, in accordance with the Health and Safety Code. Failure to provide the information as requested may result in nonissuance of a license or license revocation. The information is considered public information and will be made available to the public upon request. The information shall be included and maintained in the individual facility's public files located in Licensing and Certification district offices.

FACILITY INFORMATION SHEET

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

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

Type of Facility	"Type" of Business Entity	Individual's "Nature" of Involvement
○ Adult Day Health Care Center	For EACH business entity, identify the name & EIN of the entity:	○ Administrator of Clinic, SNF or ICF
○ Clinic	○ Corporation:	○ Agent
○ COMMUNITY CARE FACILITY		○ Director
○ General Acute Care Hospital	○ Individual:	○ Licensee
○ Health Facility		● Manager of "parent" organization
○ HHA	○ LLC:	○ Managing employee of a HHA
○ Hospice	ABC Medical Center, LLC EIN:55-5555555	○ Member
○ ICF	○ Management Company:	○ Officer of corporation
○ ICF/DD		○ Owner
○ ICF/DD-H	○ Partnership:	○ Partner
○ ICF/DD-N		○ Sole Proprietorship
○ ICF	○ OTHER Business Entity (explain):	○ Stockholder -- Ownership %:
○ Residential Care for the Elderly		○ Trustee
○ SNF	Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain.	○ OTHER Nature of Involvement (explain):
○ OTHER FACILITY TYPE (explain):	○ Yes	Member
	● No	Dates of involvement:
		From: 3/10/2019
		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	
	● 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
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○ 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	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.

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: Michelle Smith

Date of Birth: 06/27/1970

Business address (number, street, apartment/suite number or letter if applicable): 115 Marina Ave, Suite C

City, State, & Zip: Annapolis, MD 21401

Title in relation to this facility: Board Officer of grandparent organization (East Coast Pulse, Inc.) and parent organization (East Coast Corporation)

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:	10/16/2009	East Coast Corporation	Chief Operating Officer
To:	Present	222 Oceanview Blvd, Suite A, Ocean City, MD 21842	
From:	10/16/2009	East Coast Pulse, Inc.	Chief Operating Officer
To:	Present	115 Marina Ave, Suite C, Annapolis, MD 21401	
From:	1/5/2005	The Board Company	Senior VP
To:	10/15/2012	555 Governing Street, New York, NY 10017	
From:			
To:			

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

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

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

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

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

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

F. Adverse Actions

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

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

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

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

Signature: *Date:* 3/10/19

RELEASE OF INFORMATION STATEMENT

The information provided on this form is mandatory and is necessary for licensure approval. It will be used to determine individual applicant's or applicant facility's ability to provide health services. The information is requested by the California Department of Public Health, Licensing and Certification, in accordance with the Health and Safety Code. Failure to provide the information as requested may result in nonissuance of a license or license revocation. The information is considered public information and will be made available to the public upon request. The information shall be included and maintained in the individual facility's public files located in Licensing and Certification district offices.

FACILITY INFORMATION SHEET

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

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

Type of Facility	"Type" of Business Entity	Individual's "Nature" of Involvement
○ Adult Day Health Care Center	For EACH business entity, identify the name & EIN of the entity:	○ Administrator of Clinic, SNF or ICF
○ Clinic	○ Corporation:	○ Agent
○ COMMUNITY CARE FACILITY		○ Director
○ General Acute Care Hospital	○ Individual:	○ Licensee
○ Health Facility		● Manager of "parent" organization
○ HHA	○ LLC:	○ Managing employee of a HHA
○ Hospice	ABC Medical Center, LLC EIN: 55-5555555	○ Member
○ ICF	○ Management Company:	○ Officer of corporation
○ ICF/DD		○ Owner
○ ICF/DD-H	○ Partnership:	○ Partner
○ ICF/DD-N		○ Sole Proprietorship
○ ICF	○ OTHER Business Entity (explain):	○ Stockholder -- Ownership %:
○ Residential Care for the Elderly		○ Trustee
○ SNF	Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain.	○ OTHER Nature of Involvement (explain):
○ OTHER FACILITY TYPE (explain):	○ Yes	Member
	● No	Dates of involvement:
		From: 3/10/2019
		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	
	● 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	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.

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: Mary Sue

Date of Birth: 8/14/1978

Business address (number, street, apartment/suite number or letter if applicable): 115 Marina Ave, Suite C

City, State, & Zip: Annapolis, MD 21401

Title in relation to this facility: Board Officer of grandparent organization (East Coast Pulse, Inc.) and parent organization (East Coast Corporation)

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:	10/16/2012	East Coast Corporation	Secretary
To:	Present	222 Oceanview Blvd, Suite A, Ocean City, MD 21842	
From:	10/16/2012	East Coast Pulse, Inc.	Secretary
To:	Present	115 Marina Ave, Suite C, Annapolis, MD 21401	
From:	2/6/2007	Hospital Holdings, LLC	Member
To:	1/24/2014	555 Governing Street, New York, NY 10017	
From:	5/4/2004	Atlantic Health, Incorporated	Chief Financial Officer
To:	2/1/2007	949 N. Pacific Coast Highway, New York, NY 10016	

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

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

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

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

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

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

F. Adverse Actions

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

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

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

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

Signature: *Date:* 3/10/19

RELEASE OF INFORMATION STATEMENT

The information provided on this form is mandatory and is necessary for licensure approval. It will be used to determine individual applicant's or applicant facility's ability to provide health services. The information is requested by the California Department of Public Health, Licensing and Certification, in accordance with the Health and Safety Code. Failure to provide the information as requested may result in nonissuance of a license or license revocation. The information is considered public information and will be made available to the public upon request. The information shall be included and maintained in the individual facility's public files located in Licensing and Certification district offices.

FACILITY INFORMATION SHEET

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

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

Type of Facility	"Type" of Business Entity	Individual's "Nature" of Involvement
○ Adult Day Health Care Center	For EACH business entity, identify the name & EIN of the entity:	○ Administrator of Clinic, SNF or ICF
○ Clinic	○ Corporation:	○ Agent
○ COMMUNITY CARE FACILITY		○ Director
◉ General Acute Care Hospital	○ Individual:	○ Licensee
○ Health Facility		◉ Manager of "parent" organization
○ HHA	◉ LLC:	○ Managing employee of a HHA
○ Hospice	ABC Medical Center, LLC EIN: 55-5555555	○ Member
○ ICF	○ Management Company:	○ Officer of corporation
○ ICF/DD		○ Owner
○ ICF/DD-H	○ Partnership:	○ Partner
○ ICF/DD-N		○ Sole Proprietorship
○ ICF	○ OTHER Business Entity (explain):	○ Stockholder -- Ownership %:
○ Residential Care for the Elderly		○ Trustee
○ SNF	Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain.	○ OTHER Nature of Involvement (explain):
○ OTHER FACILITY TYPE (explain):	○ Yes	Member
	◉ No	Dates of involvement:
		From: 3/10/2019
		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
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○ 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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○ 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
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○ COMMUNITY CARE FACILITY		○ Director
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○ ICF/DD		○ Owner
○ ICF/DD-H	○ Partnership:	○ Partner
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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:

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
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○ 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 %:
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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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○ General Acute Care Hospital	○ Individual:	○ Licensee
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○ ICF/DD		○ Owner
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○ ICF	○ OTHER Business Entity (explain):	○ Stockholder -- Ownership %:
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○ 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:

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○ HHA	○ LLC:	○ Managing employee of a HHA
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○ ICF/DD		○ Owner
○ ICF/DD-H	○ Partnership:	○ Partner
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○ 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.

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	John Doe, Owner

3. Incorporation date	4. Place of incorporation
06/05/1995	

5. Please attach (1) a copy of Articles of Incorporation and any amendments, (2) a copy of by-laws and any amendments, (3) a copy of resolution authorizing the filing of this application.

6. Principal Office of Business

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

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

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

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

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

9. Governing Board of Directors

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

10. Board Officers

Office	Name	Term Expires
See Attachment		

RELEASE OF INFORMATION STATEMENT

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

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

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

ORGANIZATIONAL STRUCTURE

See page one for corporations.

PUBLIC AGENCY

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

2. Agency providing services:

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

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

Specify geographic area

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

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

West Cost Health System owns 70% of Licensee
554 Crystal Beach Blvd., Suite 10
Sacramento, CA 95814

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

PARTNERSHIPS

Attach a copy of partnership agreement.

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

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

OTHER ASSOCIATIONS/BUSINESS ENTITIES

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

RELEASE OF INFORMATION STATEMENT

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

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

Alex Padilla
California Secretary of State

Business Search - Entity Detail

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

[redacted] ABC MEDICAL, LLC

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

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

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

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

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

STATE OF CALIFORNIA
ACTING SECRETARY OF STATE
TONY MILLER

LIMITED LIABILITY COMPANY
ARTICLES OF ORGANIZATION

IMPORTANT - Read instructions before completing the form.
This document is presented for filing pursuant to Section 17050 of the California Corporations Code.

1. Limited liability company name: *ABC Medical Center, LLC*

(End the name with "LLC" or "Limited Liability Company". No periods between the letters in "LLC". "Limited" and "Company" may be abbreviated to "Ltd." and "Co.")

2. Latest date on which the limited liability company is to dissolve:
December 31, 2025

3. The purpose of the limited liability company is to engage in any lawful act or activity for which a limited liability company may be organized under the Beverly-Killea Limited Liability Company Act.

4. Enter the name of initial agent for service of process and check the appropriate provision below:

John Doe , which is

[XX] an individual residing in California. Proceed to Item 5.

[ ] a corporation which has filed a certificate pursuant to Section 1505 of the California Corporations Code. Skip Item 5 and proceed to Item 6.

5. If the initial agent for service of process is an individual, enter a business or residential street address in California:

Street address: *999 Beach Side Court*

City: *Sacramento* State: *California* Zip Code: *95814*

6. The limited liability company will be managed by : (check one)

[ ] one manager [ ] more than one manager [XX] limited liability company members

7. If other matters are to be included in the articles of organization attach one or more separate pages.

Number of pages attached, if any:

8. It is hereby declared that I am the person who executed this instrument, which execution is my act and deed.

John Doe
Signature of organizer

John Doe
Type or print name of organizer

Date: 6/15, 1995

10 1995999999

FILED: REGISTRN/ARTICLES OF ORG.
AT SACRAMENTO, CA ON JUN. 19, 1995
SECRETARY OF STATE OF CALIFORNIA

LLC-1
Filing Fee $80

Approved by the Secretary of State
08/31/94

INSERT OPERATING AGREEMENT HERE

ABC Medical Center, LLC

999 Beach Side Court, Sacramento, CA 95814
DBA Star Hospital

Attachment to HS 309, item 10

March 15, 2019

I hereby certify that the following is an excerpt of the minutes of the Board of ABC Medical Center, LLC duly convened on March 15, 2019.

The Governing Body formed to assume full legal authority and responsibilities for the operations of the company, including the authority for the program, policies, and procedures.

The Governing Board consists of the following individuals:

Governing Board Roster for ABC Medical Center, LLC

Name	Title
John Doe	Manager
Jane Doe	Member
John Hancock	Member
Jane Hancock	Member

Date: 03/15/2019

John Doe

John Doe, Owner
ABC Medical Center, LLC

Jane Doe

Jane Doe, Owner
ABC Medical Center, LLC

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
East Coast Pulse, Inc.	Michelle Smith

3. Incorporation date	4. Place of incorporation
9/28/1989	Maryland

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
115 Marina Ave, Suite C	Annapolis	21401	Anne Arundel	410-123-4567

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

a. Name of California Representative	Address	City	ZIP code	Phone number
First System Corporation	777 Office Line Drive	El Segundo	90245	310-475-1081

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.)

Indirect ownership:
Star Hospital, General Acute Care Hospital
1800 Beach Drive
Sacramento, CA 95814
Effective March 15, 2019 to present

9. Governing Board of Directors

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

10. Board Officers

Office	Name	Term Expires
See Attachment		

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.

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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.

East Coast Pulse, Inc. owns 100% of East Coast Corporation
222 Oceanview Blvd, Suite A
Ocean City, MD 21842

East Coast Pulse, Inc. is owned by:
50% Michelle Smith - 115 Marina Ave, Suite C, Annapolis, MD 21401
50% Michael Smith - 115 Marina Ave, Suite C, Annapolis, MD 21401

PARTNERSHIPS

Attach a copy of partnership agreement.

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

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

OTHER ASSOCIATIONS/BUSINESS ENTITIES

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

RELEASE OF INFORMATION STATEMENT

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3330011

FILED
in the office of the Secretary of State
of the State of California

NOV 09 2010

Statement and Designation by Foreign Corporation

Corvette Specialties Of Maryland Inc. East Coast Pulse, Inc.

(Name of Corporation)

_____, a corporation organized and existing under the laws of _____ Maryland _____, makes the following statements and designation:

(State or Place of Incorporation)

1. The address of its principal executive office is 1912 Liberty Rd Eldersburg, MD 21784
115 Marina Ave, Suite C Annapolis, MD 21401

2. The address of its principal office in the State of California is _____
(If none, leave item 2 blank.)
75100 St Charles Pl Suite A Palm Desert, CA 92211

Designation of Agent for Service of Process in the State of California

(Complete either Item 3 or Item 4.)

3. (Use this paragraph if the process **agent is a natural person.**)

Brian W. Tilles, a natural person residing in the State of California, whose complete street address is 48601 Shady View Dr Palm Desert, CA 92260

_____, is designated as agent upon whom process directed to this corporation may be served within the State of California, in the manner provided by law.

4. (Use this paragraph if the process **agent is another corporation.**)

First System Corporation

a corporation organized and existing under the laws of California is designated as agent upon whom process directed to this corporation may be served within the State of California, in the manner provided by law.

5. It irrevocably consents to service of process directed to it upon the agent designated above, and to service of process on the Secretary of State of the State of California if the agent so designated or the agent's successor is no longer authorized to act or cannot be found at the address given.

Michelle Smith President — Brian W. Tilles President

(Signature of Corporate Officer)

Michelle Smith, Chief Operating Officer

(Typed Name and Title of Officer Signing)

*If an individual is designated as the agent for service of process, include the agent's business or residential **street** address in California (a P.O. Box address is not acceptable). If another corporation is designated as the agent for service of process, do not include the address of the designated corporation. **Note:** Corporate agents must have complied with California Corporations Code section 1505 prior to designation, and a corporation cannot act as its own agent.*

STATE OF MARYLAND
Department of Assessments and Taxation

I, PAUL B. ANDERSON OF THE STATE DEPARTMENT OF ASSESSMENTS AND TAXATION OF THE STATE OF MARYLAND, DO HEREBY CERTIFY THAT THE DEPARTMENT, BY LAWS OF THE STATE, IS THE CUSTODIAN OF THE RECORDS OF THIS STATE RELATING TO THE FORFEITURE OR SUSPENSION OF CORPORATIONS, OR THE RIGHTS OF CORPORATIONS TO TRANSACT BUSINESS IN THIS STATE, AND THAT I AM THE PROPER OFFICER TO EXECUTE THIS CERTIFICATE.

I FURTHER CERTIFY THAT EAST COAST PULSE, INC., ON RECORD AS INCORPORATED SEPTEMBER 28, 1989, IS A CORPORATION DULY INCORPORATED AND EXISTING UNDER AND BY VIRTUE OF THE LAWS OF MARYLAND AND THE CORPORATION HAS FILED ALL ANNUAL REPORTS REQUIRED, HAS NO OUTSTANDING LATE FILING PENALTIES ON THOSE REPORTS, AND HAS A RESIDENT AGENT. THEREFORE, THE CORPORATION IS AT THE TIME OF THIS CERTIFICATE IN GOOD STANDING WITH THIS DEPARTMENT AND DULY AUTHORIZED TO EXERCISE ALL THE POWERS RECITED IN ITS CHARTER OR CERTIFICATE OF INCORPORATION, AND TO TRANSACT BUSINESS IN MARYLAND.

IN WITNESS WHEREOF, I HAVE HEREUNTO SUBSCRIBED MY SIGNATURE AND AFFIXED THE SEAL OF THE STATE DEPARTMENT OF ASSESSMENTS AND TAXATION OF MARYLAND AT BALTIMORE ON THIS NOVEMBER 04, 2010.

Paul B. Anderson

Paul B. Anderson
Charter Division

301 West Preston Street, Baltimore, Maryland 21201
Telephone Balto. Metro (410) 767-1340 / Outside Balto. Metro (888) 246-5941
MRS (Maryland Relay Service) (800) 735-2258 TT/Voice
Fax (410) 333-7097

crblnk

R6756082

INSERT

BY-LAWS

HERE

East Coast Pulse, Inc.

EIN: 99-9999999
115 Marina Ave, Suite C
Annapolis, MD 21401

Board of Directors and Officers

Directors

Michelle Smith
115 Marina Ave, Suite C
Annapolis, MD 21401

Officers

Michael Smith, Chief Financial Officer
115 Marina Ave, Suite C
Annapolis, MD 21401

Michelle Smith, Chief Operating Officer
115 Marina Ave, Suite C
Annapolis, MD 21401

Mary Sue, Secretary
115 Marina Ave, Suite C
Annapolis, MD 21401

Marty Stu, Chief Executive Officer
115 Marina Ave, Suite C
Annapolis, MD 21401

East Coast Corporation (EIN: 77-7777777) is a wholly owned subsidiary of
East Coast Pulse, Inc. (EIN: 99-9999999)

Attachment to HS 309, item 10

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
East Coast Corporation	Michelle Smith

3. Incorporation date	4. Place of incorporation
9/28/1989	Maryland

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
222 Oceanview Blvd, Suite A	Ocean City	21842	Worcester	222-444-6666

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

a. Name of California Representative	Address	City	ZIP code	Phone number
First System Corporation	777 Office Line Drive	El Segundo	90245	310-475-1081

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.)

Indirect ownership:
Star Hospital, General Acute Care Hospital
1800 Beach Drive
Sacramento, CA 95814
Effective March 15, 2019 to present

9. Governing Board of Directors

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

10. Board Officers

Office	Name	Term Expires
See Attachment		

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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.

East Coast Corporation owns 30% of Licensee
222 Oceanview Blvd, Suite A
Ocean City, MD 21842

East Coast Corporation is a subsidiary of East Coast Pulse, Inc.
The ownership of East Coast Pulse, Inc.:
50% Michelle Smith - 115 Marina Ave, Suite C, Annapolis, MD 21401
50% Michael Smith - 115 Marina Ave, Suite C, Annapolis, MD 21401

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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3330011

FILED
in the office of the Secretary of State
of the State of California

NOV 09 2010

Statement and Designation by Foreign Corporation

Corvette Specialties Of Maryland Inc. East Coast Corporation
(Name of Corporation)

_____, a corporation organized and existing under the laws of Maryland, makes the following statements and designation:
(State or Place of Incorporation)

1. The address of its principal executive office is 1912 Liberty Rd Eldersburg, MD 21784
222 Oceanview Blvd, Suite A Ocean City, MD 91842

2. The address of its principal office in the State of California is _____
(If none, leave item 2 blank.)
75100 St Charles Pl Suite A Palm Desert, CA 92211

Designation of Agent for Service of Process in the State of California
(Complete either Item 3 or Item 4.)

3. (Use this paragraph if the process **agent is a natural person.**)

Brian W. Tilles, a natural person residing in the State of California, whose complete street address is 48601 Shady View Dr Palm Desert, CA 92260

_____, is designated as agent upon whom process directed to this corporation may be served within the State of California, in the manner provided by law.

4. (Use this paragraph if the process **agent is another corporation**.)

First System Corporation, a corporation organized and existing under the laws of California is designated as agent upon whom process directed to this corporation may be served within the State of California, in the manner provided by law.

5. It irrevocably consents to service of process directed to it upon the agent designated above, and to service of process on the Secretary of State of the State of California if the agent so designated or the agent's successor is no longer authorized to act or cannot be found at the address given.

Michelle Smith President — Brian W. Tilles
(Signature of Corporate Officer)

Michelle Smith, Chief Operating Officer
(Typed Name and Title of Officer Signing)

*If an individual is designated as the agent for service of process, include the agent's business or residential **street** address in California (a P.O. Box address is not acceptable). If another corporation is designated as the agent for service of process, do not include the address of the designated corporation. **Note:** Corporate agents must have complied with California Corporations Code section 1505 prior to designation, and a corporation cannot act as its own agent.*

Secretary of State Form
S&DC-STOCK/NONPROFIT (REV 04/2010)

STATE OF MARYLAND
Department of Assessments and Taxation

I, PAUL B. ANDERSON OF THE STATE DEPARTMENT OF ASSESSMENTS AND TAXATION OF THE STATE OF MARYLAND, DO HEREBY CERTIFY THAT THE DEPARTMENT, BY LAWS OF THE STATE, IS THE CUSTODIAN OF THE RECORDS OF THIS STATE RELATING TO THE FORFEITURE OR SUSPENSION OF CORPORATIONS, OR THE RIGHTS OF CORPORATIONS TO TRANSACT BUSINESS IN THIS STATE, AND THAT I AM THE PROPER OFFICER TO EXECUTE THIS CERTIFICATE.

I FURTHER CERTIFY THAT EAST COAST CORPORATION, ON RECORD AS INCORPORATED SEPTEMBER 28, 1989, IS A CORPORATION DULY INCORPORATED AND EXISTING UNDER AND BY VIRTUE OF THE LAWS OF MARYLAND AND THE CORPORATION HAS FILED ALL ANNUAL REPORTS REQUIRED, HAS NO OUTSTANDING LATE FILING PENALTIES ON THOSE REPORTS, AND HAS A RESIDENT AGENT. THEREFORE, THE CORPORATION IS AT THE TIME OF THIS CERTIFICATE IN GOOD STANDING WITH THIS DEPARTMENT AND DULY AUTHORIZED TO EXERCISE ALL THE POWERS RECITED IN ITS CHARTER OR CERTIFICATE OF INCORPORATION, AND TO TRANSACT BUSINESS IN MARYLAND.

IN WITNESS WHEREOF, I HAVE HEREUNTO SUBSCRIBED MY SIGNATURE AND AFFIXED THE SEAL OF THE STATE DEPARTMENT OF ASSESSMENTS AND TAXATION OF MARYLAND AT BALTIMORE ON THIS NOVEMBER 04, 2010.

Paul B. Anderson

Paul B. Anderson
Charter Division

301 West Preston Street, Baltimore, Maryland 21201
Telephone Balto. Metro (410) 767-1340 / Outside Balto. Metro (888) 246-5941
MRS (Maryland Relay Service) (800) 735-2258 TT/Voice
Fax (410) 333-7097

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INSERT

BY-LAWS

HERE

East Coast Corporation

EIN: 77-7777777
222 Oceanview Blvd, Suite A
Ocean City, MD 21842

Board of Directors and Officers

Directors

Michelle Smith
115 Marina Ave, Suite C
Annapolis, MD 21401

Officers

Michael Smith, Chief Financial Officer
115 Marina Ave, Suite C
Annapolis, MD 21401

Michelle Smith, Chief Operating Officer
115 Marina Ave, Suite C
Annapolis, MD 21401

Mary Sue, Secretary
115 Marina Ave, Suite C
Annapolis, MD 21401

Marty Stu, Chief Executive Officer
115 Marina Ave, Suite C
Annapolis, MD 21401

East Coast Corporation (EIN: 77-7777777) is a wholly owned subsidiary of
East Coast Pulse, Inc. (EIN: 99-9999999)

Attachment to HS 309, item 10