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 MANAGEMENT COMPANY** 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 Management Company** application for Star Hospital, located at 1800 Beach Drive, Sacramento, CA 95814.

Effective March 15, 2019, ABC Medical Center, LLC has entered into a management agreement with Universal Management Company, LLC. Under this management agreement, Universal Management Company, LLC will oversee the daily operations of Star Hospital. I enclosed the required application forms and supporting documents needed to process my Change of Management Company request.

Should you have any questions, I will be the direct contact regarding this Change of Management Company 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

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): Management Company

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) Updating Management Company

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: -

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

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

B. LICENSEE INFORMATION

1. Licensee name: ABC Medical Center, LLC

2. Federal employer's tax ID number: 555555555

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

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

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

Telephone number: (999) 555-2626

City, State, & Zip: Sacramento, CA 95814

E-Mail: JaneDoe@abcmedicalLLC.org

Fax number: (999) 555-2600

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

(1) Facility Name: | Facility Type:

Facility address (number & street): | City, State, & Zip:

(2) Facility Name: | Facility Type:

Facility address (number & street): | City, State, & Zip:

(3) Facility Name: | Facility Type:

Facility address (number & street): | City, State, & Zip:

(4) Facility Name: | Facility Type:

Facility address (number & street): | City, State, & Zip:

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

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

Parent organization name: 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:
1800 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**
	Administrator	03/11/2018
Signature	**Title**	**Date**
Signature	**Title**	**Date**
Signature	**Title**	**Date**

Release of Information Statement

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

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

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

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

ATTACHMENT E-1

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

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

Name of management company: Universal Management Company, LLC EIN: 77-7777777
Address (number & street): 444 Park Street
City, State, & Zip: Sacramento, CA 95814

Name of facility to be managed: Star Hospital EIN: 33-3333333
Address (number & street): 999 Beach Side Court
City, State, & Zip: Sacramento, CA 95814

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: Bob Smith % Owner: 50
Address (number & street): 444 Park Street
City, State, & Zip: Sacramento, CA 95814

(2) Individual's name: Sophia Smith % Owner: 50
Address (number & street): 444 Park Street
City, State, & Zip: Sacramento, CA 95814

(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

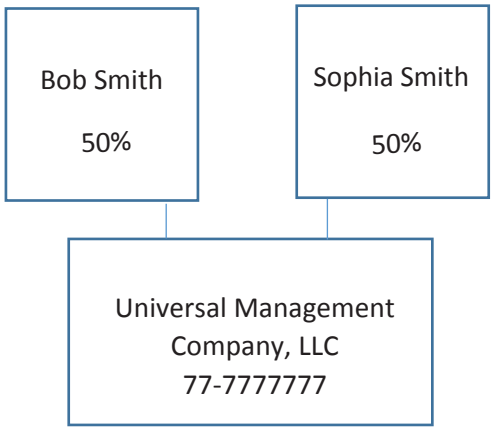
MANAGEMENT COMPANY INFORMATION ONLY FOR SNF's OR ICF's

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.

ORGANIZATIONAL CHART FOR UNIVERSAL MANAGEMENT COMPANY, LLC
77-7777777
444 Park Street
Sacramento, CA 95814



Management company for:
Star Hospital

INSERT MANAGEMENT AGREEMENT HERE

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

Date of this notice:
01-01-2009

Employer Identification Number:
77-7777777

Form: SS-4

Number of this notice: CP 575 A

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

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

Universal Management Company, LLC
Bob Smith
444 Park Street
Sacramento, CA 95814

WE ASSIGNED YOU AN EMPLOYER IDENTIFICATION NUMBER

Thank you for applying for an Employer Identification Number (EIN). We assigned you EIN 77-77777777. This EIN will identify you, your business accounts, tax returns, and documents, even if you have no employees. Please keep this notice in your permanent records.

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

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

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

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

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

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

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

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

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

IMPORTANT REMINDERS:

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

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

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

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

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

Thank you for your cooperation.

(IRS USE ONLY) 575A 01-01-2009 HONO B 9999999999 SS-4

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

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

CP 575 A

9999999999

Your Telephone Number Best Time to Call
( ) -
_____ _____

DATE OF THIS NOTICE: 01-01-2009
EMPLOYER IDENTIFICATION NUMBER: 77-7777777
FORM: SS-4 NOBOD

INTERNAL REVENUE SERVICE
CINCINNATI OH 45999-0023

Universal Management Company, LLC
Bob Smith
444 Park Street
Sacramento, CA 95814

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: Bob Smith

Date of Birth: 03/14/1967

Business address (number, street, apartment/suite number or letter if applicable): 444 Park Street

City, State, & Zip: Sacramento, CA 95814

Title in relation to this facility: Owner/Managing Member of Management Company

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:	01/01/2009	Universal Management Company, LLC	Owner
To:	Present	444 Park Street, Sacramento, CA 95814	
From:			
To:			
From:			
To:			
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	Management Company
	◉ No	Dates of involvement:
		From: 3/15/2019
		To: Present

Facility name:	Facility address (number, street, city):	State:	Zip code:
Universal Management Company, LLC	444 Park Street, Sacramento		

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	Universal Management Company, LLC EIN: 77-7777777	○ 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: 01/01/2009
		To: Present

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

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

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

Type of Facility	"Type" of Business Entity	Individual's "Nature" of Involvement
Adult Day Health Care Center	For EACH business entity, identify the name & EIN of the entity:	Administrator of Clinic, SNF or ICF
Clinic	Corporation:	Agent
COMMUNITY CARE FACILITY		Director
General Acute Care Hospital	Individual:	Licensee
Health Facility		Manager of "parent" organization
HHA	LLC:	Managing employee of a HHA
Hospice		Member
ICF	Management Company:	Officer of corporation
ICF/DD		Owner
ICF/DD-H	Partnership:	Partner
ICF/DD-N		Sole Proprietorship
ICF	OTHER Business Entity (explain):	Stockholder -- Ownership %:
Residential Care for the Elderly		Trustee
SNF	Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain.	OTHER Nature of Involvement (explain):
OTHER FACILITY TYPE (explain):	Yes	
	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: Sophia Smith

Date of Birth: 07/29/1970

Business address (number, street, apartment/suite number or letter if applicable): 444 Park Street

City, State, & Zip: Sacramento, CA 95814

Title in relation to this facility: Owner/Managing Member of Management Company

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:	01/01/2009	Universal Management Company, LLC	Owner
To:	Present	444 Park Street, Sacramento, CA 95814	
From:			
To:			
From:			
To:			
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	Management Company
	◉ No	Dates of involvement:
		From: 3/15/2019
		To: Present

Facility name:	Facility address (number, street, city):	State:	Zip code:
Universal Management Company, LLC	444 Park Street, Sacramento		

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	Universal Management Company, LLC EIN: 77-7777777	○ 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: 01/01/2009
		To: Present

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

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

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

Type of Facility	"Type" of Business Entity	Individual's "Nature" of Involvement
○ Adult Day Health Care Center	For EACH business entity, identify the name & EIN of the entity:	○ Administrator of Clinic, SNF or ICF
○ Clinic	○ Corporation:	○ Agent
○ COMMUNITY CARE FACILITY		○ Director
○ General Acute Care Hospital	○ Individual:	○ Licensee
○ Health Facility		○ Manager of "parent" organization
○ HHA	○ LLC:	○ Managing employee of a HHA
○ Hospice		○ Member
○ ICF	○ Management Company:	○ Officer of corporation
○ ICF/DD		○ Owner
○ ICF/DD-H	○ Partnership:	○ Partner
○ ICF/DD-N		○ Sole Proprietorship
○ ICF	○ OTHER Business Entity (explain):	○ Stockholder -- Ownership %:
○ Residential Care for the Elderly		○ Trustee
○ SNF	Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain.	○ OTHER Nature of Involvement (explain):
○ OTHER FACILITY TYPE (explain):	○ Yes ○ 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
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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 %:
○ 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 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
Universal Management Company, LLC	Bob Smith, Owner

3. Incorporation date	4. Place of incorporation
01/01/2009	Sacramento, CA

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
444 Park Street	Sacramento	95814	Sacramento	999-555-4223

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

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

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

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

9. Governing Board of Directors

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

10. Board Officers

Office	Name	Term Expires
Manager	Bob Smith	N/A
Manager	Sophia Smith	N/A

RELEASE OF INFORMATION STATEMENT

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

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

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

ORGANIZATIONAL STRUCTURE

See page one for corporations.

PUBLIC AGENCY

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

2. Agency providing services:

Name	Address

Mailing Address (if different from above)

Contact person	Title	Phone number

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

Specify geographic area

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

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

50% Bob Smith - 444 Park Drive, Sacramento, CA 95814
50% Sophia Smith - 444 Park Drive, Sacramento, CA 95814

PARTNERSHIPS

Attach a copy of partnership agreement.

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

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

OTHER ASSOCIATIONS/BUSINESS ENTITIES

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

RELEASE OF INFORMATION STATEMENT

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

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

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

Alex Padilla
California Secretary of State

Business Search - Entity Detail

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

[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: *Universal Management Company, 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:

Bob Smith , 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: *444 Park Street*

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.

Bob Smith
Signature of organizer

Bob Smith
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