Cover Letter

ABC Healthcare Services, Inc.
999 Beach Side Court, Sacramento, CA 95814
P: (999) 555-2626
F: (999) 555-2600
Email: ABChealthcareservices@gmail.com

March 15, 2019

VIA PRIORITY MAIL:

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

RE: **Change of Ownership** Application for Pediatric Day Health and Respite Care

To Whom It May Concern,

We are submitting an change of ownership application for a Pediatric Day Health and Respite Care known as ABC Healthcare PDHRC, located at 1800 Beach Drive, Sacramento, CA 95814.

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

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

Emergency Contact Information (available 365/24/7)
Name: Jane Doe
Email: ABChealthcareservices@gmail.com 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 Healthcare Services, Inc.

HS 200

LICENSURE & CERTIFICATION APPLICATION

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

A. APPLICATION INFORMATION

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

2. **Change of Ownership Only - For Certification Purposes:**
   We wish to make certain that our records correctly show the effective date of the ownership change for certification. This date should reflect the actual date on which you took charge of the financial management of the facility rather than the date of sale or date of state license change. Effective date of change: 05/01/2019

3. Amount of fee enclosed: $ 2,238.00

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

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

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: 6
   b. Proposed facility bed capacity: 6

9. Age range of clients: 0-21

10. Days and hours of operation: M-F: 8:30AM - 5:00PM

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: JJJ Healthcare Services, Inc.

2. Federal employer's tax ID number: 333333333

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: JJJhealthcareservices@gmail.com

Fax number: (999) 555-2600

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

(1) Facility Name: | Facility Type:

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

(2) Facility Name: | Facility Type:

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

(3) Facility Name: | Facility Type:

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

(4) Facility Name: | Facility Type:

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

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

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

Parent organization name:

Parent federal tax ID Number:

P.O. Box or number & street:

City, State, & Zip:

C. FACILITY, AGENCY OR CLINIC INFORMATION

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

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

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

2. Name of **"proposed" facility**, agency, or clinic:
   Current facility, agency, or clinic name (if change of ownership):
   ABC Healthcare PDHRC Facility license number: 000000001

3. Address (number & street) of "proposed" facility, agency, or clinic: 1800 Beach Drive Telephone number: (999) 555-0695
   City, State, & Zip: Sacramento, CA 95814

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

5. **Name of person to be in charge of facility, agency, or clinic:** Wain Jones
   Title: Administrator Professional License number: 88888888

6. **a.** Name of administrator: Wain Jones Date of hire: 05/13/2019
   Professional License number: 88888888 Expiration date: 10/31/2020
   b. Name of director of nursing: Larry Smith Date of hire: 05/13/2019
   Professional License number: 33333333 Expiration date: 12/31/2020

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

	Name of individual	% Owned	EIN Number	Are they related to one another as a spouse, parent, child or sibling?		Relationship
(1)	Jane Doe	50	33-3333333	○ Yes	◉ No	
(2)	Harry Stone	50	33-3333333	○ Yes	◉ No	
(3)				○ Yes	○ No	
(4)				○ Yes	○ No	
(5)				○ Yes	○ No	

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

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

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

D. PROPERTY INFORMATION

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

2. **Owner of Record** name in the real estate: 123 Properties, LLC
   Address (number & street): 123 Boxview Street
   City, State, & Zip: Sacramento, CA 95814

   Lessee name: JJJ Healthcare Services, Inc.
   Address (number & street): 999 Beach Side Court
   City, State, & Zip: Sacramento, CA 95814

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

E. MANAGEMENT COMPANY

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

F. I (we) Accept responsibility to:

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

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

Signature	Title	Date
	Owner	05/01/2019
Signature	**Title**	**Date**
Signature	**Title**	**Date**
Signature	**Title**	**Date**

Release of Information Statement

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

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

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

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

ATTACHMENT E-1

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

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

Name of management company: EIN:
Address (number & street):
City, State, & Zip:

Name of facility to be managed: EIN:
Address (number & street):
City, State, & Zip:

2. Provide the following information for ***each*** individual having a **5 percent** or more interest in the management company. ***Submit*** an attachment for additional names that includes all of the required information listed below.

(1) Individual's name: % Owner:
Address (number & street):
City, State, & Zip:

(2) Individual's name: % Owner:
Address (number & street):
City, State, & Zip:

(3) Individual's name: % Owner:
Address (number & street):
City, State, & Zip:

(4) Individual's name: % Owner:
Address (number & street):
City, State, & Zip:

3. Provide a list of all facilities, agencies, or clinics with which you have entered into a management agreement. ***Submit*** an attachment for additional facility, agency, or clinic names that includes all of the required information listed below.

(1) Facility, agency, or clinic name:
Address (number & street):
City, State, & Zip: Dates of involvement:

(2) Facility, agency, or clinic name:
Address (number & street):
City, State, & Zip: Dates of involvement:

(3) Facility, agency, or clinic name:
Address (number & street):
City, State, & Zip: Dates of involvement:

(4) Facility, agency, or clinic name:
Address (number & street):
City, State, & Zip: Dates of involvement:

INSTRUCTIONS

SNF or ICF Management Company Application: See Attachment E-1 below.

Type or print clearly. Return original and maintain a copy for your records. The Licensee's name must be consistent throughout all documents submitted. ***Submit*** all supplemental paperwork requested to complete your application. **Do not leave items blank. If not applicable, mark N/A.**

A. APPLICATION INFORMATION

1. Type of application: select items a, b, c, or d.
   If b is selected, provide effective date of change in number 2.
   If c is selected, complete Sections C1-5; F, and Attachment E-1.
   If d is selected you must select an option in number 4 -- "Type of Change."
2. Provide actual date applicant took charge of the financial management of facility.
   This date is used to show effective date of the ownership change for certification purposes only.
3. Amount of fee enclosed: enter the amount of money enclosed with this application.
   If no fee is required, enter "N/A". (Refer to fee schedule for appropriate fee requirements.)
4. Type of change: check all that apply.
5. Type of facility, agency, or clinic: select the appropriate category.
6. (a) Check "yes" if requesting certification for Medicare. ICF/DD, ICF/DD-N, ICF/DD-H facilities and primary care clinics that are not certified as rural health clinics are not eligible for Medicare.
   (b) If "yes" to item 6(a), provide name of fiscal intermediary under item 6(b).
7. Check "yes" if requesting participation in Medi-Cal (Medicaid).
8. (a) Current facility bed capacity: enter the total number of persons for whom care can currently be provided in any 24-hour period. This figure must agree with the "Certificate of Occupancy".
   (b) Proposed facility bed capacity: enter the proposed total number of persons for whom care will be provided in any 24-hour period.
9. Enter age range of persons to receive/receiving care.
10. Enter days and hours of facility operation.
11. Enter date construction is to begin, and date construction is to be completed (not applicable for ICF/DD, ICF/DD-N, ICF/DD-H facilities).
    - ☐ ***Submit*** a copy of the form *"Construction Advisory Board "* (form OSH-FDD 377) if OSHPD has approved construction.
    - ☐ ***Submit*** a copy of the above form to the local district office *prior* to the survey if OSHPD has not yet approved construction.

B. LICENSEE INFORMATION

1. Licensee name: enter the full legal organization name (LLC, partnership, and corporation) or individual(s) responsible for the facility/agency. If "Inc." is included in your legal name, it must appear in the name. Individuals enter first, middle, and last name. Husband and wife, if joint applicants, must both be listed.

   NOTE: All individuals including owners, partners, principal officers of corporations/LLCs, members, managers, and administrators (clinics only) must complete "Applicant Individual Information" (HS 215A).

2. Enter the federal employer's tax ID number.
3. Owner Type: select one of the options and then:
   - ☐ ***Submit*** an organizational chart, for items b, c, d, or e showing entity, persons, facilities, and tax EIN numbers.
   - ☐ ***Submit*** a copy of the Internal Revenue Service and Franchise Tax Board letters of determination of nonprofit status, if item c, "nonprofit corporation" is selected, and the facility is a primary care Clinic.

4. Licensee address: enter address of legal organization (LLC, corporation, partnership) or individual(s) responsible for the facility, agency, or clinic. Provide phone number with area code, fax number, and e-mail address.

5. Other Facilities:
   (a) Identify all other facilities, agencies, or clinics the licensee (LLC, corporation, partnership, individual) has been involved in, both in and outside of California.
   ☐ ***Submit*** an attachment, if needed, for additional entities, which includes the facility, agency or clinic type (including "affiliate" clinics), name, address, nature of involvement, and dates of involvement. This attachment must include all of the required information listed.
   ☐ ***Submit*** an attachment, if needed, for any entity identified in number 5a, which has had a license revocation action filed, license placed on probation, suspended, or revoked (whether stayed or not) or, for SNFs and ICFs, resolved by settlement, receiver appointed, or has a final Medi-Cal decertification action taken. Include all ownership and facility information, dates, and any final action.

6. Subsidiary: check "yes" if the licensee is a subsidiary of another organization and complete the information requested.
   ☐ ***Submit*** a detailed organizational chart, including parent and all subsidiary information, and federal tax ID numbers.

C. FACILITY, AGENCY, OR CLINIC INFORMATION

1. Management Agreement:
   (a) Check "yes" if the facility, agency, or clinic is going to be operated under a management contract/agreement, between the proposed owner and a management company. Proceed to Section "E" (below).
   (b) Check "yes" if there is an "interim" management agreement, between the proposed owner and the current owner, to run the facility until the change of ownership is completed.
   ☐ ***Submit*** a copy of the "interim" management agreement, if applicable.

2. Facility, agency, or clinic name: Enter the name used to designate the single facility, agency or clinic under the license being requested. Also, provide the current facility, agency, or clinic name, and current license number (if different). Change of ownership usually results in a name change.

3. Provide facility, agency, or clinic address, including phone number with area code, fax number, and e-mail.

4. Provide facility, agency, or clinic mailing address, if different from number 3 (above).

5. Provide the name and title of the individual to be in charge of the facility, agency, or clinic as well as any professional license number (if applicable).

6. Administrator:
   (a) Provide the name of the facility administrator, date of hire, license number, and license expiration date.
   (b) Provide the name of the director of nursing services (if applicable), date of hire, license number, and license expiration date.

7. Provide name(s) of all individuals having a **5 percent** or more interest in the ownership of this facility, if applying for SNF or ICF licensure. For all other facility, agency, or clinic types, provide the name(s) of those having **10 percent** or more interest in the ownership. Specify how these persons are related to one another as spouse, parent, child or sibling.
   ☐ ***Submit*** an attachment for all additional names. This attachment must include all of the required information.

8. Financial Resources: Only applies to SNF, ICF, and ICF/DD:
   ☐ ***Submit*** evidence, satisfactory to the Department, that the licensee has sufficient financial resources to operate the facility for at least 45 days (bank statement, certificate of deposit etc.). The amount is determined by multiplying 45 days X number of beds X rate.

9. Over-concentration -- Only applies to ICF/DD, ICF/DD-H and ICF/DD-N:
   (a) Are there other ICF/DD, ICF/DD-H, ICF/DD-N residential care, pediatric day health, or respite care facilities within 300 feet of this facility? Check "yes", "don't know" or "no".
   (b) Are there any congregate living health facilities within 1,000 feet of this facility? Check "yes", "don't know" or "no".

10. Program Plan -- Only applies to ICF/DD, ICF/DD-H and ICF/DD-N:
Indicate if the program plan has been approved by the Department of Developmental Services. The "current licensee" can grant permission for their Program Plan to be used for 6 months if a letter is submitted to CDPH. If "no" is checked, the application package will be held until a copy of the approved program plan letter is received.

☐ ***Submit*** a letter to CDPH from the "current" licensee that the "proposed" licensee has their permission to use the "current" licensee's Program Plan for up to 6 months, if applicable.

☐ ***Submit*** a copy of the Program Plan approval letter, if "yes".

D. PROPERTY INFORMATION

1. Licensee must show evidence of control of property.

☐ ***Submit*** **a** copy of the deed and/or bill of sale, if property is owned.

☐ ***Submit*** a copy of the rental agreement, if property is rented.

☐ ***Submit*** a copy of the lease agreement, if property is leased.

☐ ***Submit*** a copy of the original lease plus a copy of the sublease, if property is subleased.

☐ ***Submit*** appropriate evidence if "other" is checked.

2. Provide name and address of the Owner of Record, Lessee and Sub-lessee as applicable.

E. MANAGEMENT COMPANY INFORMATION
(Complete Sections A1, C1-5, F & ATTACHMENT E-1)

F. STATEMENT OF RESPONSIBILITIES
Application must be signed by licensee or authorized representative.

ATTACHMENT E-1

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

1. If the proposed facility, agency, or clinic will be operated by a management company, under a management contract between the proposed owner and a management company, provide the name, address, and federal tax ID number of Management Company and name of facility to be managed.

☐ ***Submit*** a copy of the Management Agreement.

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

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

3. Provide a list of all facilities, agencies, or clinics that you have contracted to manage.

☐ ***Submit*** an attachment for additional facilities, agencies, or clinics. This attachment must include all of the required information.

Insert

Evidence of Compliance with Local Building Code Requirements

Here

IRS

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

Date of this notice: 06-20-2017

Employer Identification Number:
33-3333333

Form: SS-4

Number of this notice: CP 575 A

JJJ Healthcare Services Inc
999 Beach Side Court
Sacramento, CA 95814

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

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

WE ASSIGNED YOU AN EMPLOYER IDENTIFICATION NUMBER

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

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

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

Form 941	01/31/2018
Form 940	01/31/2018
Form 1120	04/15/2018

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.

IMPORTANT INFORMATION FOR S CORPORATION ELECTION:

If you intend to elect to file your return as a small business corporation, an election to file a Form 1120-S must be made within certain timeframes and the corporation must meet certain tests. All of this information is included in the instructions for Form 2553, *Election by a Small Business Corporation.*

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 ABCH. You will need to provide this information, along with your EIN, if you file your returns electronically.

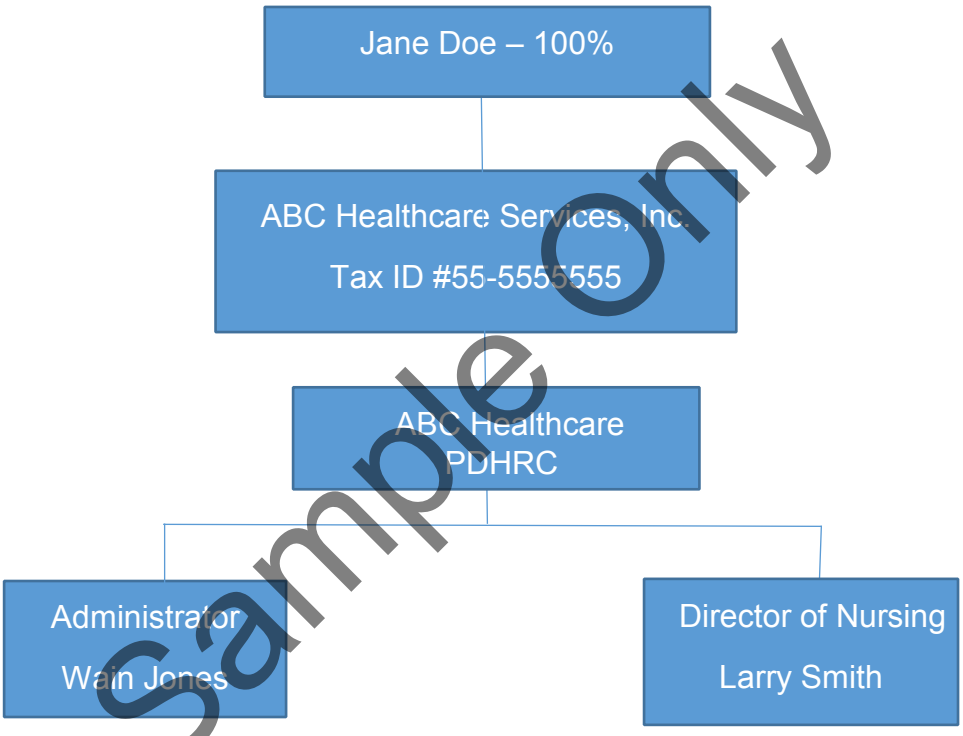
Thank you for your cooperation.

BEFORE ORGANIZATIONAL CHART

ABC Healthcare Services, Inc.

999 Beach Side Court, Sacramento, CA 95814

EIN #: 55-5555555



Jane Doe - President

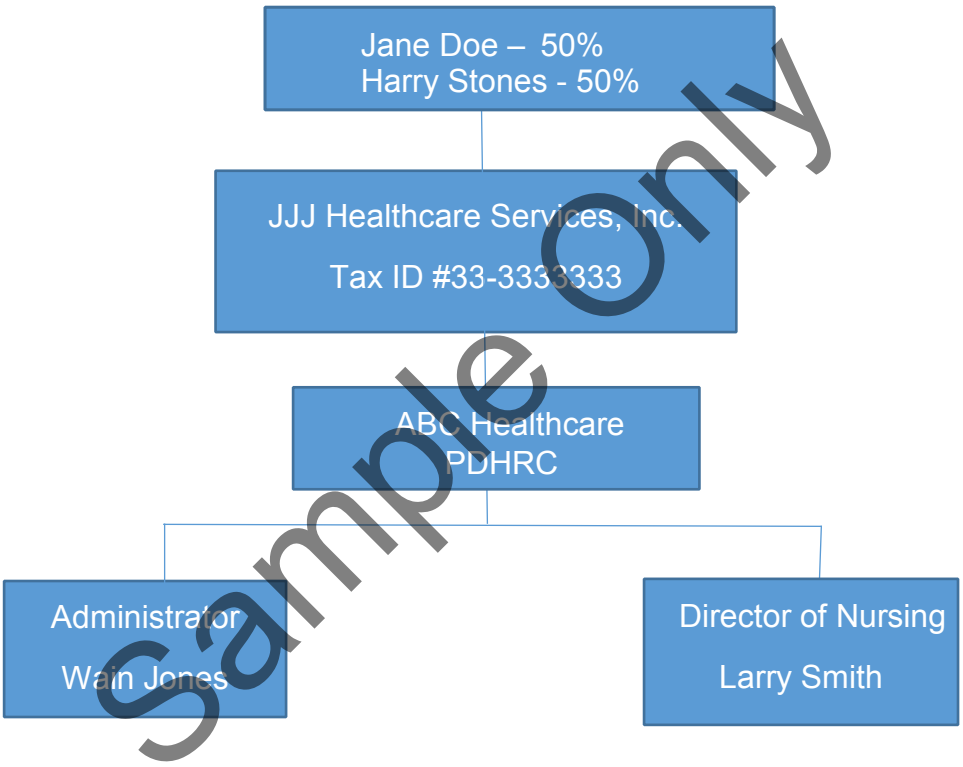
Harry Stones – Secretary/CFO

AFTER ORGANIZATIONAL CHART

JJJ Healthcare Services, Inc.

999 Beach Side Court, Sacramento, CA

95814 EIN #: 33-3333333



Jane Doe - President

Harry Stones – Secretary/CFO

Insert Lease Agreement

Here

If applicable, Include the Sub-Lease

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: Jane Doe

Date of Birth: 07/12/1975

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

City, State, & Zip: Sacramento, CA 95814

Title in relation to this facility: Owner- 50%/ President

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:	03/1/2019	ABC Healthcare Services, Inc.	President
To:	Present	999 Beach Side Court, Sacramento, CA 95814	
From:	04/01/2013	Health Technology	Office Manager
To:	Present	1278 Health Avenue, Suite 100, Elk Grove, CA 95624	
From:	02/01/2009	Happy Medication Corporation	Administrator Assistant
To:	03/31/2013	2005 Harley Drive, Sacramento CA 95823	
From:			
To:			

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

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

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

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

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

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

F. Adverse Actions

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

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

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

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

Signature: *Date:* 3/11/2019

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:

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

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

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

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

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

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

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

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

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

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

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

INSTRUCTIONS FOR HS 215A

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

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

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

A. IDENTIFYING INFORMATION

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

B. CRIMINAL RECORD

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

C. PROFESSIONAL LICENSES/CERTIFICATES

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

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

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

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

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

F. ADVERSE ACTIONS

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

FACILITY INFORMATION SHEET

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

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

APPLICANT INDIVIDUAL INFORMATION

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

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

A. Identifying Information

Name: Wain Jones

Date of Birth: 06/27/1970

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

City, State, & Zip: Sacramento, CA 95814

Title in relation to this facility: Administrator

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

No

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

40 hours

B. Criminal Record

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

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

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

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

TYPE	PERIOD HELD	ISSUING AGENCY
RN	06/30/1996 - Present	Board of Registered Nursing

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

		Name and address of employer	Job title
From:	05/13/2015	Star Hospital	Vice President
To:	Present	1800 Beach Drive, Sacramento, CA 95814	
From:	01/28/2010	Get Well Hospital	Administrator
To:	05/12/2015	1234 Health Avenue, Suite 1A, Sacramento, CA 95814	
From:	03/02/2007	Care Free Medical Center	Director of Nursing
To:	01/27/2010	9876 Pain Free Drive, Elk Grove, CA 95624	
From:			
To:			

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

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

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

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

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

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

F. Adverse Actions

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

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

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

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

Signature: *Date:* 3/11/2019

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	800 Star Struck Drive, 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	ABC Medical Center, LLC EIN:22-2222222	○ Member
○ ICF	○ Management Company:	◉ Officer of corporation
○ ICF/DD		○ Owner
○ ICF/DD-H	○ Partnership:	○ Partner
○ ICF/DD-N		○ Sole Proprietorship
○ ICF	○ OTHER Business Entity (explain):	○ Stockholder -- Ownership %:
○ Residential Care for the Elderly		○ Trustee
○ SNF	Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain.	○ OTHER Nature of Involvement (explain):
○ OTHER FACILITY TYPE (explain):	○ Yes	Dates of involvement:
	◉ No	From: 5/13/2015
		To: Present

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

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

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

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

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

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

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

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

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

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

INSTRUCTIONS FOR HS 215A

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

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

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

A. IDENTIFYING INFORMATION

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

B. CRIMINAL RECORD

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

C. PROFESSIONAL LICENSES/CERTIFICATES

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

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

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

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

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

F. ADVERSE ACTIONS

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

FACILITY INFORMATION SHEET

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

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: Larry Smith

Date of Birth: 01/01/1972

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

City, State, & Zip: Sacramento, CA 95814

Title in relation to this facility: Director of Nursing

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

No

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

B. Criminal Record

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

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

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

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

TYPE	PERIOD HELD	ISSUING AGENCY
RN	07/2007- Present	Board of Registered Nursing

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

		Name and address of employer	Job title
From:	03/01/2015	Sunshine PDHRC	Director of Nursing
To:	Present	1800 Happy Circle, Sacramento, CA 95818	
From:	05/01/2008	Healthy Life PDHRC	Director of Nursing Designee
To:	5/12/2015	1234 Olympic Drive, Sacramento, CA 95816	
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:* 3/11/19

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:
Sunshine PDHRC			

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	Sunshine PDHRC, LLC EIN:11-1111111	○ 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:
PDHRC	◉ No	From: 03/01/2015
		To: Present

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

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

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

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

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

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

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

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

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

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

INSTRUCTIONS FOR HS 215A

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

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

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

A. IDENTIFYING INFORMATION

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

B. CRIMINAL RECORD

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

C. PROFESSIONAL LICENSES/CERTIFICATES

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

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

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

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

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

F. ADVERSE ACTIONS

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

FACILITY INFORMATION SHEET

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

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: Harry Stones

Date of Birth: 11/07/1973

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

City, State, & Zip: Sacramento, CA 95814

Title in relation to this facility: CFO/ Secretary/ Owner- 50%

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:	05/01/2014	RCT Realtor	Realtor
To:	Present	8765 New Homes Drive. Sacramento. CA 95822	
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:* 3/11/19

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:

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

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

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

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

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

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

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

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

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

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

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

INSTRUCTIONS FOR HS 215A

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

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

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

A. IDENTIFYING INFORMATION

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

B. CRIMINAL RECORD

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

C. PROFESSIONAL LICENSES/CERTIFICATES

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

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

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

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

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

F. ADVERSE ACTIONS

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

FACILITY INFORMATION SHEET

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

Wain Jones

9008 Jerry Lane, Sacramento, CA 95823 | 999-555-2222 | Wain_Jones@msn.com

Education

NURSING UNIVERISTY | 1995

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

Experience

Vice President **MAY 2015 – PRESENT**

Star Hospital, 800 Star Struck Drive, Sacramento, CA 95814

- Oversee daily operations of facility, research and academic administration
- Primary Focus on Business Development, Strategic Planning Initiatives and Operations
- Physician Liaison
- Oversight of Managers monthly actual and budgeted financials
- Provide leadership and direction of all aspects of hospital activities to ensure quality patient care

ADMINISTRATOR **JANUARY 2010 – MAY 2015**

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

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

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

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

- Coordinate services provided to patients through supervision and management of staff
- Attract, retain and manage nursing staff
- Make effective use of organizational resources
- Participate with leaders from the governing body, management, and medical staff to collaborate in the accomplishment of the vision, mission, values and strategic goals of the organization

- Provide expertise, education, guidance, and professional development to staff and management in order to support daily operations

Larry Smith

4382 River Way, Sacramento, CA 95823 | 999-562-4444 | Larry_Smith@msn.com

Education

California Sacramento State University | 2008

- Master of Social Work
- Bachelor of Arts in Sociology

Experience

Director of Nursing **MARCH 2015 – PRESENT**

Sunshine PDHRC, 18 Happy Circle, Sacramento, CA 95818

- Manage and lead all nursing personnel operations.
- Develop short and long-term goals for the entire nursing department.
- Establish new policies and update existing policies to improve the standard of care for patients.
- Plan and oversee admission, nursing, and patient care processes.
- Maintain department budgets and record all expenses.
- Respond to any nursing-related issues in a timely manner.
- Coordinate with medical staff and other departments to ensure hospital efficiency.
- Oversee all record-keeping processes and ensure all necessary documents are accurate and up-to-date.
- Hire and train new nursing staff members.
- Evaluate staff performance and prepare accurate reports detailing your findings.

Director of Nursing Designee **May 2008 – MARCH 2015**

Healthy Life PDHRC, 1234 Olympic Drive, Sacramento, CA 95816

- Assist with managing and leading all nursing personnel operations.
- Assist with implanting new policies to improve the standard of care for patients.
- Act as a lead when the Director of Nursing is unavailable.
- Provide training for new nursing staff members.
- Respond to any nursing-related issues in a timely manner.

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 Healthcare Services, Inc.	Jane Doe

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

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

6. Principal Office of Business

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

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

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

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

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

N/A

9. Governing Board of Directors

Size of Board	Term of office	Frequency of meetings	Method of selection
2	1 year	Annual	Election

10. Board Officers

Office	Name	Term Expires
President	Jane Doe	12/31/19
CFO / Secretary	Harry Stones	12/31/19

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 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.

100% Jane Doe - 999 Beach Side Court, Sacramento, CA 95814

PARTNERSHIPS

Attach a copy of partnership agreement.

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

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

OTHER ASSOCIATIONS/BUSINESS ENTITIES

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

RELEASE OF INFORMATION STATEMENT

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

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

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

Business Search - Entity Detail

The California Business Search is updated daily and reflects work processed through Wednesday, August 7, 2019. Please refer to document **Processing Times** for the received dates of filings currently being processed. The data provided is not a complete or certified record of an entity. Not all images are available online.

312928321545 ABC HEALTHCARE SERVICES, INC.

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

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

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

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

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

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

Insert Articles of Incorporation Here

Insert
By-Laws
Here

HS 400

AFFIDAVIT REGARDING PATIENT MONEY

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

I (We) ABC Healthcare Services, Inc.
Name(s) of Applicants (i.e., licensee)

As applicant(s) for ABC Healthcare PDHRC
Name of Facility

Facility address 1800 Beach Drive (Street) Sacramento (City) CA (State) 95814 (ZIP Code) Sacramento (County)

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

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

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

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

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

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

Licensees are required to:

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

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

Jane Doe
Print name

Owner / President
Title

Signature

05/01/2019
Date

RELEASE OF INFORMATION STATEMENT

The information provided on this form is mandatory and is necessary for licensure approval. It will be used to determine individual applicant's or applicant facility's ability to provide health services. The information is requested by the California Department of Public Health, Licensing and Certification, in accordance with Health and Safety Code, Sections 1253, 1265, and 1267.5, and California Code of Regulations (CCR), Title 22, Sections 70107, 70137, 71107, 71135, 73205, 73241, 76205, and 76241.

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

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

HS 402

SURETY BOND VERIFICATION

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

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

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

BE IT KNOWN THAT:

Facility name ABC Healthcare PDHRC

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

State of California, as *Principal,* and

Bonding agency Healthcare Loans

Agency address 1002 Loan Way City Sacramento County Sacramento ZIP code 95834

State of California, as *Surety,* are held and firmly bound unto the STATE OF CALIFORNIA in the full and just sum of

Five Thousand DOLLARS ($ 5,000.00), for the payment of which the said Principal and said Surety bind themselves, their respective heirs, successors, and assigns, jointly and severally, firmly by these presents.

The CONDITION of this obligation is such that

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

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

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

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

This bond may be canceled by the Surety in accordance with the provisions of Section 996.310 et seq. of the Code of Civil Procedure. This bond is effective 05/01/19 (Date) and continuous.

IN WITNESS WHEREOF, we have subscribed our names and impressed our seal this 01 (Day), May (Month), 2019 (Year).

Ella R. Williams
Bonding agent name (please print)

Bonding agent signature

BONDING AGENCY SEAL

Original Bond Seal

HS 602

TRANSFER AGREEMENT BETWEEN

Sunnyside Hospital
Name of Hospital

1835 Sunny Drive
Street Address

Sacramento, CA 95814
City, State, and ZIP Code

AND

ABC Healthcare PDHRC
Name of Facility

1800 Beach Drive
Street Address

Sacramento, CA 95814
City, State, and ZIP Code

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

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

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

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

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

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

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

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

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

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

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

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

3/11/2019	3/14/2019
Date	Date
Wain Jones /	Kent Lee /
Administrator	Administrator
ABC Healthcare PDHRC	Sunnyside Hospital
Facility	Hospital
N/A	12931782239
Facility Provider Number	Hospital Provider Number

STD 850

STATE OF CALIFORNIA - FORESTRY AND FIRE PROTECTION

FIRE SAFETY INSPECTION REQUEST

STD. 850 (REV. 4-2000)

See instructions on reverse.

AGENCY CONTACT'S NAME	TELEPHONE NUMBER	REQUEST DATE	PROGRAM
Departmental Use Only	Departmental Use Only	CAB	Departmental Use Only

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

LICENSING AGENCY NAME AND ADDRESS

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

CODES

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

AMBULATORY		NONAMBULATORY		BEDRIDDEN		TOTAL CAPACITY
CAPACITY	PREVIOUS CAPACITY	CAPACITY	PREVIOUS CAPACITY	CAPACITY	PREVIOUS CAPACITY	
		6				6

FACILITY NAME	LICENSE CATEGORY
ABC Healthcare PDHRC	PDHRC
STREET ADDRESS *(Actual Location)*	NUMBER OF BUILDINGS
1800 Beach Drive	1
CITY	RESTRAINT
Sacramento, CA 95814	None

FACILITY CONTACT PERSON'S NAME	FACILITY CONTACT PERSON'S TELEPHONE NUMBER	HOURS
Wain Jones	999-555-2626	Mon-Fri: 8:30AM- 5:00PM

SPECIAL CONDITIONS

TO BE COMPLETED BY INSPECTING AUTHORITY

FIRE AUTHORITY NAME AND ADDRESS

CLEARANCE /DENIAL CODE

CODES

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

INSPECTOR'S NAME *(Typed or Printed)*	TELEPHONE NUMBER	CFIRS NUMBER	OCCUPANCY CLASS

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

EXPLAIN DENIAL OR LIST SPECIAL CONDITIONS

STATE OF CALIFORNIA - FORESTRY AND FIRE PROTECTION

FIRE SAFETY INSPECTION REQUEST

STD. 850 (REV. 4-2000) (REVERSE)

INSTRUCTIONS

This form is designed for use with a window envelope

Licensing or Requesting Agencies--Complete the following 19 sections on this form before submitting it to the fire authority having jurisdiction.

1. AGENCY CONTACT, 2. TELEPHONE NUMBER, 5. EVALUATOR. Enter the name and telephone number of agency contact person.

3. PROGRAM. Licensing agency use.

4. REQUEST DATE. Enter date request was prepared.

6. REQUESTING AGENCY FACILITY NUMBER. This is the file number assigned by the licensing agency.

7. REQUEST CODE. Use the seven codes shown and insert the appropriate number in the box following "Request Code". If NAME CHANGE, please list previous name. Insert date of original request is other than an original.

8. AGENCY NAME AND ADDRESS. Enter the name and address of the licensing facility requesting the inspection.

9. AMBULATORY--NONAMBULATORY--BEDRIDDEN.

Capacity: Insert in the appropriate section, the capacity of licensed ambulatory or nonambulatory occupants covered by this request.

Previous Capacity: If request is for renewal or capacity change, insert capacity of previous clearance.

Total Capacity: Show total licensed capacity. If the facility is intended to house part ambulatory, nonambulatory, and part bedridden, show the total of the three types of occupants.

10. FACILITY NAME. Insert the name of the facility as it will appear on the license. List identifying sub name if known (i.e., Hacienda Corp/Medina Lodge).

11. LICENSE CATEGORY. Insert the category of license being sought as it will appear on the license certificate.

12. ADDRESS. Insert street address and city only. A post office box is not acceptable as only location.

13. NUMBER OF BUILDINGS. Insert the total number of buildings to be used for housing of the occupants covered by the license.

14. RESTRAINT. Indicate if physical restraint (locked in a room or the building) is to be used in the housing of the occupants.

15. FACILITY CONTACT PERSON--TELEPHONE NUMBER. Indicate the name and telephone number of the responsible individual at the facility to be contacted by the fire authority.

16. HOURS. Indicate the number of hours the occupants are housed at the facility (less than 24 or 24+).

17. SPECIAL CONDITIONS. Indicate any conditions unique to this request. As an example, if the inspection request is for one building in a multi-building facility.

FIRE AUTHORITY CONDUCTING THE INSPECTION--COMPLETE THE FOLLOWING:

18. FIRE AUTHORITY, NAME AND ADDRESS. Insert the name and address of the fire authority where the facility is located.

19. CLEARANCE/DENIAL CODE. Use the two codes: 1 for clearance granted, and 2 for clearance denied. If denied, also include the appropriate letter code. As an example, Denial based upon exiting would be coded 2A.

20. INSPECTOR'S NAME. Print the initial of the inspector's first name and full last name; insert the telephone number where the inspector may be contacted.

21. CFIRS I.D. NUMBER. Insert the fire department's number assigned by California Fire Incident Reporting System.

22. OCCUPANCY CLASSIFICATION. Use California Building Code occupancy classifications and insert the occupancy determined by the inspector.

23. INSPECTION DATE. Enter the actual date of the inspection.

24. INSPECTOR'S SIGNATURE. To be signed by the inspector conducting the inspection.

25. EXPLAIN DENIALOR SPECIAL CONDITIONS. If clearance code #2 is used, briefly explain reason. This space is also to be used to specify any additional limitations placed by the fire authority, such as the use of certain floors or sleeping rooms approved for nonambulatory clients.

Insert

Purchase Agreement or Operating Transfer Agreement

Here

Insert

Written Verification For Patient Monies Here

Insert

Copy of Receipt with amount received signed by new Licensee Here

Insert

Patient Medical Record Storage Statement Here