# Health Care Facility Licensure Application

As defined in section 3702.30 of the ORC and 3701-83-04 of the OAC

| ODH Use Only | |
|---|---|
| ID # | 1214AS |
| OHL # | 42116 |

Print Legibly in Ink or Type

| 1. Application Type | 2. Date of operation or projected opening date or date of change of ownership. |
|---|---|
| ☑ Initial ☐ Change of Ownership<br>☐ Initial/Replacing existing facility, ID# | 03/04/2018 |

3. Licensure Type √ only one

| | |
|---|---|
| ☑ **Ambulatory surgical facility** | ☐ **Freestanding dialysis center** |
| # of operating rooms 2 | # of hemodialysis stations |
| # of procedure rooms | # of peritoneal stations |
| | # of training stations |
| Is this facility located in a building that houses in-patient care? ☐ No ☐ Yes | |
| ☐ **Freestanding inpatient rehabilitation facility** | ☐ **Freestanding birthing center** |
| # of patient care beds | # of birthing rooms |

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| 4. Facility name (DBA) | Telephone number |
|---|---|
| Capital Care Network of Toledo | (419) 478-6801 |
| 6. Previous facility name, if applicable | |
| 7. Address<br>1160 West Sylvania Avenue | |
| City: Toledo | Zip: 43612 — County: Lucas |
| 8. E-mail address<br>1160sylvania@gmail.com | |

9. Mailing address, if different from above

| | | |
|---|---|---|
| Name | | |
| Address | | |
| City | State | Zip |

8181 35 MAR 19 18

#300

10. Days and hours of operation for this facility

| | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|---|---|---|---|---|---|---|---|
| A.M. | | | | | | | |
| P.M. | | | | | | | |

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11. Is this health care facility accredited or certified? ☐ No ■ Yes

If yes, type NAF

If yes, enclose a copy the current accreditation inspection report with this application.

12. This business is a/an ☐Individual ☒Partnership ☐Limited Liability Company ☐Corporation ☐Association ☐Other:

**Individual owner:** Skip questions 19 through 29 **only.**

More than one owner, partnership, corporation, limited liability company or association, skip questions 13 through 18 **only.**

| 13. Owner's name | | |
|---|---|---|
| Terrie Hubbard | | |
| 14. Address | | |
| City | State | Zip |
| Marengo | OH | |
| 15. Phone number | 16. Owner's occupation | |
| (614) 251-1800 | CEO | |

17. Owner's business address, if different from question #7

| Address | | | |
|---|---|---|---|
| 1243 East Broad Street | | | |
| City | State | Zip | 18. Phone number |
| Columbus | OH | 43205 | (614) 251-1800 |

**Multiple Owners, Partnership, Limited Liability Company, Corporation, Association, Other**

| 19. Business entity name (Legal name as registered with the Secretary of State) | | | |
|---|---|---|---|
| 20. Address | | | |
| City | State | Zip | 21. Phone number |
| 22. Business Activity | | | |
| 23. This business is a ☐ For profit ☐ Not for Profit ☐ Government | 24. Date of incorporated or registration | 25. Charter/registration number | |

26. List the **name of each person** who has an ownership interest of 5% or more in the business (attach additional sheets if necessary).

| Name | Name |
|---|---|
| Name | Name |
| Name | Name |

27. Officers names, titles, addresses and phone numbers

| Title | Name | Address | Phone Number |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

| 28. Statutory agent's name (As Registered with the Secretary of State) | Address | Phone Number |
|---|---|---|
| | | |

29. If state agency or local government, the name, address and phone number of individual authorized to enter into agreement on behalf of state agency or local government. ☒ Not Applicable

| Name | Address | Phone Number |
|---|---|---|
| | | |

30. On-site administrator's name

Schuyler Beckwith

31. Medical director's name or individual responsible for the provision of health care services

Lucy Nunnally MD

32. License/Certification #

33. Has the new owner(s), administrator or medical director been affiliated through ownership or employment with any of the facilities listed in rule 3701-83-04(A)(1)(c) of the OAC within five years prior to the date of this application?

☐ No ☒ Yes *If "yes", provide in writing the individual's name(s) and address(es) of the facilities.*

34. Has the owner(s), administrator or medical director been convicted of any criminal conviction, civil judgment or administrative adjudication related to the provision of care or bearing a direct or substantial relationship to the job responsibilities he/she is to carry out?

☒ No ☐ Yes *If "yes", provide in writing the individual's name, full explanation stating the charge(s), date(s) and disposition(s).*

I affirm that to the best of my knowledge and belief, the answers provided herein and all accompanying materials are true and correct. I understand that section 3702.30 of the Ohio Revised Code and paragraph (E) of rule 3701-83-04 of the Ohio Administrative Code require the owner to inform the Director, in writing, of any changes in the information contained in the statement of ownership set forth in the initial application and any change in accreditation status, no later than 30 days after the occurrence of the change. ☑ Affirm

Any owner named herein may sign the application. That owner's name must appear in question #13 or #26. If the signatory is not an owner, attach a notarized affidavit that the individual is the authorized representative of the owner.

| Print/Type owner's/representative's name & title | Signature | Date |
|---|---|---|
| Terrie A. Hubbard owner | Terrie A. Hubbard | 3-02-18 |
| Print/Type administrator's name | Signature | Date |
| Schuyler Beckwith | | 3/13/18 |
| Print/Type medical director's name | Signature | Date |
| L. ANN NUNNALLY MD | L. Ann Nunnally MD | 3/13/18 |