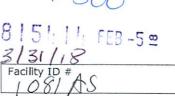
Health Care Facility Renewal Application As defined in rule 3701-83-04 of the Ohio Administrative Code



Please print legibly in ink or type		•			
1. Facility Name (DBA)					
Northeast Ohio Women's Con	ter LLC	Cuito			
2127 State Rd	/	Suite			
3 City 4 7in	5. County				
Cuyahoga Falls 44223 Summit					
6. Phone Number 330 · 923 · 4009 330 - 963 · 4085					
8. E-mail Address					
Neowc 2127 @ gmail. Com					
Mailing address, if different from above					
9. Name					
10. Address		Suite			
11. City	12. State	13. Zip			
14. Renewal application type					
Ambulatory surgical facility					
Is ASF a provider-based entity of hospital? \bowtie No \square If yes, hospital name:	Yes				
☐ Freestanding dialysis center					
☐ Freestanding inpatient rehabilitation facility					
☐ Freestanding birthing center					
15. Has there been a change in this facility's capacity?		No □ Ye	es		
If yes, has an amended license been requested?		□ No □ Ye	es		
16. a) Is your facility accredited by an national accrediting body approved by CMS?		No □ Ye	es		
If yes, and there has been a change or update to this facility's most recent accreditation status report or findings, explain and provide a copy of the most recent accreditation inspection report and findings, unless the department has been previously notified.			REGULATOR		
Explanation:		018 FEB	LAT		
16. b) Is your facility deemed to meet or exceed the approved Naccreditation?	Medicare program requirements th		ORY EN		
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17. Has there been a change in ownership?	™No	□ Yes	
If yes, has a change of ownership application been submitted?	□ No	☐ Yes	
18. Has there been a change of onsite administrator?	X No	☐ Yes	
A) If yes, provide name of new administrator:	Ad	-	
B) Has the new administrator 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?	Kilo	□ Yes	
C) Has the new administrator been convicted of any criminal activity or been involved in a civil judgment or administrative adjudication for an offense related to the provision of care or bearing a direct or substantial relationship to the job responsibilities?		□ Yes	
19. Has there been a change of medical director or individual responsible for the provision of health care services?		□ Yes	
A) If yes, provide name of new medical director/individual:			
B) License/certification #			
C) Has the new medical director been affiliated through ownership or employment with any of the facilities in rule 3701-83-04 (A)(1)(c) of the OAC within five years prior to the date of this application?		□ Yes	
D) Has the new medical director/individual been convicted of any criminal activity or been involved in a civil judgment or administrative adjudication for an offense related to the provision of care or bearing a direct or substantial relationship to the job responsibilities?		☐ Yes	
			
20. If you answered yes to question 18 (C) or 19 (D) provide a full explanation stating charge(s), date(s) and disposition on a separate page.			
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 change occurs.			
I certify that I am an owner of the facility or the authorized representative of the owner.			
Print/type owner's or representative's name Title			
David M/Bu, Kons, MD OWNER			
Signature / Date /			
1/29/18			