

CHECK IMAGE DETAIL REPORT

Processing Date : 03/11/2019

Seq#	Check Acct#	Amount	RT#	BatchID	Batch#	Check#	AuxOnUs	Box	DDA
000014	2030000083150	\$195.00	054001220	00720476	000001	000000504		08126	30954665

WASHINGTON SURGI-CLINIC
 2112 F STREET NW STE. 400
 WASHINGTON, DC 20037

5045
15-129/540 7352

DATE 3/4/2019

PAY TO THE ORDER OF DC Treasurer \$ 195⁰⁰

One hundred ninety five exactly DOLLARS

FOR Application fee for license for 2019

[Signature]

WELLS FARGO
 Wells Fargo Bank, N.A.
 District of Columbia
 wells Fargo.com

⑈0000005045⑈ ⑆054001220⑆ 2030000083150⑈

DEPARTMENT OF HEALTH
AMBULATORY SURGICAL TREATMENT CENTER
APPLICATION

195.00

AMBULATORY SURGICAL TREATMENT CENTER APPLICATION

To: Health Regulations and Licensing Administration
899 North Capitol Street, NE
2nd Floor
Washington, DC 20002

We, (1) Cesare F. Santangelo, MD and (2) _____

Resident at (1) 4751 Reservoir Road, NW. 1
(2) Washington, DC 20007
Street Address City State Zip Code

Officers of the center named below, certifying that we are twenty-one years of age or older and of reputable and responsible character do hereby apply for a license to maintain and operate a center during the 2019 calendar year subject to the provisions of District of Columbia Law 2-66, and to any regulations and standards adopted thereunder.

Name of ambulatory surgical treatment center: Washington Surgi Clinic, Inc.

Location: 2112 F Street, NW, Suite #400 Wash. DC 20037
Street Address City State Tele. Zip Code

Name of person in charge: Maria Barrera, Clinic Administrator

Medical director or principal physician: Cesare F Santangelo, MD

Street Address City State Zip Code

Name of organization owning and conducting center: Same as above.

Type of organization: Non-Profit Corp. _____, Private Corp.
(Attach lists of board officers and members)

Class of institution for which application is made: (Check one)

[] General Surgery Family Planning [] Other (Specify)

Transfer agreement with a hospital within twenty minutes ambulance time [] Yes No

Name of hospital: None

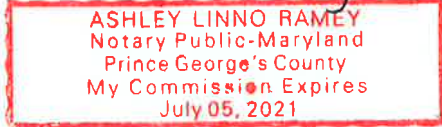
Number of surgical procedures performed in the previous fiscal year 748

Application and license fee* of \$195⁰⁰ One hundred ninety five dollars, exactly drawn payable to: "D.C. Treasurer" is attached to this application. (Fee is not refundable.) There is also attached documentary evidence of financial responsibility on the part of the applicant institution in the sum of not less than One Hundred Thousand Dollars (\$100,000.00) per occurrence and Three Hundred Thousand Dollars in the aggregate which become readily available for the benefit of any person who may become aggrieved as the result of the center.

Signatures of Applicants
(1) [Signature] Title Owner/President
(2) _____ Title _____

Sworn and subscribed to before me this 27 day of February, 2019

Notary Public for the Maryland District of Columbia



My commission expires July 5, 2021

NOTE: THIS FORM FOR APPLICATION OF ASSOCIATION OR OTHER NON-INDIVIDUAL APPLICANT

* Refer to license fees for ambulatory surgical centers for correct fee



DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

Identifying Information

(a) Name of Entity <i>Washington Surgi Clinic</i>	D/B/A	Provider No.	Vendor No.	Telephone No. <i>202 659 9403</i>
Street Address <i>2112 F Street, NW, #400</i>		City, County, State <i>Washington DC</i>		Zip Code <i>20037</i>

II. Answer the following questions by checking "Yes" or "No". If any of the questions are answered "Yes", list names and addresses of individuals or corporations under Remarks on page 2. Identify each item number to be continued.

A. Are there any individuals or organizations having a direct or indirect ownership or control interest of 5 percent or more in the institution, organizations, or agency that have been convicted of a criminal offense related to the involvement of such persons, or organizations in any of the programs established by Titles XVII, XIX, or XX?

Yes No

B. Are there any directors, officers, agents, or managing employees of the institution, agency or organization who have ever been convicted of a criminal offense related to their involvement in such programs established by Titles XVII, XIX, or XX?

Yes No

C. Are there any individuals currently employed by the institution, agency, or organization in a managerial, accounting, auditing, or similar capacity who were employed by the institution's organization's, or agency's fiscal intermediary or carrier within the previous 12 months? (Title XVII providers only)

Yes No

III. (a.) List names, addresses for individuals, or the EIN for organization having direct or indirect ownership or a controlling interest in the entity. (See instructions for definition of ownership and controlling interest.) List any additional names and addresses under "Remarks" on Page 2. If more than one individual is reported and any of these persons are related to each other, this must be reported under Remarks.

Name	Address	EIN
<i>Csore F Santangel MD</i>	<i>2112 F Street, NW #400 Washington DC 20037</i>	<i>52-0983925</i>

(b) Type of Entity: Sole Proprietorship Partnership Corporation
 Unincorporated Associations Other (Specify)

(c) If the disclosing entity is a corporation, list names, addresses of the Directors, and EINs for corporations under Remarks.

Check appropriate box for each of the following questions

(d) Are any owners of the disclosing entity also owners of other Medicare/Medicaid facilities? (Example, sole proprietor, partnership or members of Board of Directors.) If yes, list names, addresses of individuals and provider numbers.

Yes No

Name	Address	Provider Number



DEPARTMENT OF HEALTH
HEALTH REGULATION ADMINISTRATION

IV. (a) Has there been a change in ownership or control within the last year? Yes No
If yes, give date _____

(b) Do you anticipate any change of ownership or control within the year? Yes No
If yes, when? _____

(c) Do you anticipate filing for bankruptcy within the year? Yes No
If yes, when _____

V. Is this facility operated by a management company, or leased in whole or part by another organization? Yes No
If yes, give date of change in operations _____

VI. Has there been a change in Administrator, Director of Nursing or Medical Director within the last year? Yes No

VII. (a) Is this facility chain affiliated? (If yes, list name, address of Corporation, and EIN) Yes No
Name _____ EIN# _____

Address _____

VIII. Have you increased your bed capacity by 10% or more or by 10 beds, whichever is greater, within the last 2 years? Yes No
If yes give year change _____

Current Beds N/A Prior beds NA

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE OR WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE D. C. STATE AGENCY AS APPROPRIATE.

Name of Authorized Representative (Typed) Cesare F. Santangelo, MD Title _____

Signature *Cesare F. Santangelo* Date 2/27/2019

Remarks _____



Government of the District of Columbia
Department of Health



Health Regulation and Licensing Administration

“CLEAN HANDS” SELF-CERTIFICATION FORM

TO THE APPLICANT:

Please read the following statement carefully before signing. A false statement on this Certification requires that the Department proceed immediately to revoke the license or permit for which you are now applying and fine you \$1,000.00. This Self-Certification Form is required by the “Clean Hands Before Receiving A License or Permit Act of 1996”, effective May 11, 1996, as amended, (D.C. Law 11-118; D.C. Official Code § 47-2861 *et seq.*) (2015).

I, Cesare F. Santangelo, MD _____ certify that as of 2/27/19 _____,
Print Name Clearly Date

- (1) I do not owe more than \$100 to the District of Columbia Government in outstanding fines, penalties, or interest assessed pursuant to the following acts or any regulations promulgated under the authority of any of the following acts, the:
- (A) Litter Control Administrative Act of 1985, effective March 25, 1986 (D.C. Law 6-100; D.C. Official Code § 8-801 *et seq.*);
 - (B) Illegal Dumping Enforcement Act of 1994, effective May 20, 1994 (D.C. Law 10-117; D.C. Official Code § 8-901 *et seq.*);
 - (C) District of Columbia Traffic Adjudication Act of 1978, effective September 12, 1978 (D.C. Law 2-104; D.C. Official Code § 50-2301.01 *et seq.*);
 - (D) Department of Consumer and Regulatory Affairs Civil Infractions Act of 1985, effective October 5, 1985 (D.C. Law 6-42; D.C. Official Code § 2-1801.01 *et seq.*);
 - (E) District of Columbia Taxicab Commission Establishment Act of 1985, effective March 25, 1986 (D.C. Law 6-97; D.C. Official Code § 50-301 *et seq.*); or
 - (F) The Compulsory/No-Fault Motor Vehicle Insurance Act of 1982, effective September 18, 1982 (D.C. Law 4-155; D.C. Official Code § 31-2401 *et seq.*);

I also certify that I do not owe:

- (2) More than \$100 to the District of Columbia Government in past due taxes;
- (3) Fines assessed to car dealers pursuant to § 50-1501.02(i);
- (4) Parking fines or penalties assessed by another jurisdiction; provided, that a reciprocity agreement is in effect between the jurisdiction and the District;
- (5) Past due District of Columbia Water and Sewer Authority service charges or fees;
- (6) A vehicle conveyance fee, as that term is defined in § 50-2302.01(i);
- (7) The District more than \$ 100 in outstanding fines, penalties, or interest;

And, I further certify that:

- (8) I have filed required District tax returns; [and]
- (9) I do not owe the District any past due fines, penalties, or past due restitution on behalf of an employee due to a violation of Chapter 13 of Title 32, Chapter 1A of Title 32, Chapter 10 of Title 32, or Subchapter X-A of Chapter 2 of Title 2.

I understand the Department will move to immediately revoke each license or permit for which I am applying that contains a false certification, and to fine me \$1,000.00 for each false certification.

I understand that the Department may conduct an investigation to ascertain the veracity of this certification.

I further understand that this Certification is required to accompany my application for a license or permit, and that by completing this Certification, I am not guaranteed that my license or permit will be approved.

Cesare F. Santangelo, MD
PRINT NAME


SIGNATURE OF APPLICANT

2/27/2019