DEPARTMENT OF HEALTH
AMBULATORY SURGICAL TREATMENT CENTER
APPLICATION

$195

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 Rd, NW.,
(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 2021 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 Washington 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 [X] Family Planning [ ] Other (Specify)

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

Name of hospital: N/A

Number of surgical procedures performed in the previous fiscal year 981

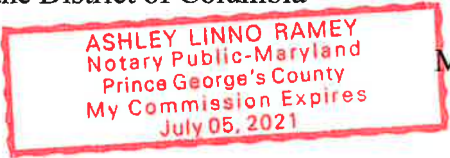
Application and license fee* of $195.00 (One hundred ninety five dollars exactly) drawn payable to: "D.C. Treasurer" is attached to this application. (Fee is not refundable.) There is also attached documentary evidence of financial responsibility on the part of the applicant institution in the sum of 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-Director

(2) ________________ Title ________________

Sworn and subscribed to before me this 23rd day of March, 2021

Notary Public for the 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

DEPARTMENT OF HEALTH
HEALTH REGULATION ADMINISTRATION

DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

Identifying Information

(a). Name of Entry	D/B/A	Provider No.	Vendor No.	Telephone No.
Washington Surgi Clinic				202 659 9403

Street Address	City, County, State	Zip Code
2112 F Street, NW #400	Washington DC	20037

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
Cesare F Santangelo MD	2112 F Street NW #400 Washington, DC 20037	52-0983925

(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

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 0 Prior beds 0

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 WILLFULY 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)	Title
Cesare F. Santangelo MD	Owner / President, Director
Signature: Cesare F. Santangelo MD	Date: 3/23/2021

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 3/23/2021,
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]

SIGNATURE OF APPLICANT

3/23/2021

CHECK IMAGE DETAIL REPORT

Processing Date : 04/05/2021

Seq#	Check Acct#	Amount	RT#	BatchID	Batch#	Check#	AuxOnUs	Box	DDA
000002	2030000083150	$195.00	054001220	00650704	000002	000000543		0E125	30954665

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

5431

15-120/540 7350

DATE 3/24/2021

PAY TO THE ORDER OF DC Treasurer $ 195,00

One hundred ninety five dollars exactly DOLLARS

WELLS FARGO

FOR Lic fee application 2021

⑈0000005431⑈ ⑆054001220⑆ 2030000083150⑈

FID: 4000979

00112

00176

FedEx Express — Package US Airbill

FedEx Tracking Number 8152 5902 4709

Form ID No. 0215

MURT

1 From

Date

Sender's Name — Phone

Company DEPT OF HEALTH REG

Address 899 N CAPITOL ST NE — Dept/Floor/Suite/Room

City WASHINGTON — State DC — ZIP 20002-4263

2 Your Internal Billing Reference

3 To

Recipient's Name — Phone

Company

Address — Dept/Floor/Suite/Room

We cannot deliver to P.O. boxes or P.O. ZIP codes.

☐ Hold Weekday — FedEx location address REQUIRED. NOT available for FedEx First Overnight.

Address

Use this line for the HOLD location address or for continuation of your shipping address.

☐ Hold Saturday — FedEx location address REQUIRED. Available ONLY for FedEx Priority Overnight and FedEx 2Day to select locations.

City — State — ZIP

8152 5902 4709

4 Express Package Service *To most locations.

Packages up to 150 lbs. For packages over 150 lbs., use the FedEx Express Freight US Airbill.

Next Business Day

- ☐ FedEx First Overnight — Earliest next business morning delivery to select locations. Friday shipments will be delivered on Monday unless Saturday Delivery is selected.
- ☐ FedEx Priority Overnight — Next business morning.* Friday shipments will be delivered on Monday unless Saturday Delivery is selected.
- ☐ FedEx Standard Overnight — Next business afternoon.* Saturday Delivery NOT available.

2 or 3 Business Days

- ☐ FedEx 2Day A.M. — Second business morning.* Saturday Delivery NOT available.
- ☐ FedEx 2Day — Second business afternoon.* Thursday shipments will be delivered on Monday unless Saturday Delivery is selected.
- ☐ FedEx Express Saver — Third business day.* Saturday Delivery NOT available.

5 Packaging *Declared value limit $500.

☐ FedEx Envelope* ☐ FedEx Pak* ☐ FedEx Box ☐ FedEx Tube ☐ Other

6 Special Handling and Delivery Signature Options Fees may apply. See the FedEx Service Guide.

☐ Saturday Delivery — NOT available for FedEx Standard Overnight, FedEx 2Day A.M., or FedEx Express Saver.

☐ No Signature Required — Package may be left without obtaining a signature for delivery.

☐ Direct Signature — Someone at recipient's address may sign for delivery.

☐ Indirect Signature — If no one is available at recipient's address, someone at a neighboring address may sign for delivery. For residential deliveries only.

Does this shipment contain dangerous goods?

One box must be checked.

☐ No ☐ Yes As per attached Shipper's Declaration. ☐ Yes Shipper's Declaration not required. ☐ Dry Ice Dry Ice, 9, UN 1845 ____ x ____ kg

Restrictions apply for dangerous goods — see the current FedEx Service Guide. ☐ Cargo Aircraft Only

7 Payment *Bill to:*

Enter FedEx Acct. No. or Credit Card No. below. Obtain recip. Acct. No. ☐

☐ Sender Acct. No. in Section 1 will be billed. ☐ Recipient ☐ Third Party ☐ Credit Card ☐ Cash/Check

Total Packages — Total Weight — lbs. — Credit Card Auth.

†Our liability is limited to US$100 unless you declare a higher value. See the current FedEx Service Guide for details.

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