Appendix A
Form HS 215A and form HS 309 for
Premiere Rehabilitation and Wellness Center of Lancaster, LP.

FOR DEPARTMENTAL USE ONLY	
District: LA West	ELMS Facility Number: 630016690
Proposed name of facility/agency/clinic: The Ellison John Transitional Care Center	

App ID 15493194.

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: Shlomo Rechnitz

Date of Birth: July 29, 1971

Business address (number, street, apartment/suite number or letter if applicable): 43830 10th Street West

City, State, & Zip: Lancaster, CA 93534

Title in relation to this facility: CEO/Managing Member

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.

N/A

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
N/A		

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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:	07/2005	Brius, LLC	CEO
To:	Present	5967 W. 3rd Street Suite 200 L.A., CA 90036	
From:	01/1995	Twin Med	CEO
To:	Present	11333 Greenstone Ave. Santa Fe Springs, CA	
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 <u>5 percent</u> 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 **<u>If YES, check all applicable:</u>**

○ 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: [signature] *Date:* 9-1-16

<u>RELEASE OF INFORMATION STATEMENT</u>

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.

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ORGANIZATIONAL STRUCTURE

See other side 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.

Shlomo Rechnitz - Owns 93.9% of Premiere Rehabilitation & Wellness Center of Lancaster LP, Licensee

5900 Wilshire Blvd., Suite 1600

Los Angeles, CA 90036

PARTNERSHIPS

Attach a copy of partnership agreement.

First partner	☑ Limited ☐ General	Name: Shlomo Rechnitz Business address: 43830 10th Street West Lancaster, CA 93534
Second partner	☑ Limited ☐ General	Name: Jose Lynch Business address: 43830 10th Street West Lancaster, CA 93534

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.

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2. Agency providing services:

   Name | Address

   Mailing Address (if different from above)

   Contact person | Title | Phone number
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   Shlomo Rechnitz - Owns 93.9% of Premiere Rehabilitation & Wellness Center of Lancaster LP, Licensee

   5900 Wilshire Blvd., Suite 1600

   Los Angeles, CA 90036

PARTNERSHIPS

Attach a copy of partnership agreement.

First partner	☐ Limited ☑ General	Name: Premiere Wellness of Lancaster GP, LLC Business address: 43830 10th Street West Lancaster, CA 93534
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.

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Appendix B

CDPH letter documenting a Brius facility's decertification from participation in the Medicare and Medi-Cal Programs, dated December 18, 2014.

PSA-19-3

State of California—Health and Human Services Agency

California Department of Public Health

RON CHAPMAN, MD, MPH
Director & State Health Officer

EDMUND G. BROWN JR.
Governor

December 18, 2014

OVERNIGHT MAIL

CCN: 05-5931

Administrator
South Pasadena Convalescent Hospital
904 Mission Street
South Pasadena, CA 91030

RE: Notice of Termination from Medi-Cal Program

Dear Administrator:

The Centers for Medicare and Medicaid Services (CMS), Region IX, San Francisco, has advised this office your facility does not meet the requirements for participation in the Medicare program.

Pursuant to Title 42, Code of Federal Regulations (C.F.R.), Sections 483.1(a) and 483.1(b), participation in the Medi-Cal program is contingent upon your meeting the requirements for Medicare certification.

Therefore, based on your current noncompliance with Medicare requirements and a CMS decision to terminate your Provider Agreement **at 12:01 a.m. on January 5, 2015**, termination from the Medi-Cal program will simultaneously occur **at 12:01 a.m. on January 5, 2015.**

And pursuant to 42 C.F.R. Section 441.11 to facilitate appropriate movement and placement of Medi-Cal residents in your facility due to termination from the Medi-Cal program, payments for the remaining Medi-Cal residents in your facility as of **January 5, 2015**, will be limited to 30 days through **February 4, 2015**.

CMS has advised you of your right to appeal the action. If CMS revises its determination, you will again be eligible for Medi-Cal participation.

Questions related to Medi-Cal certification may be discussed with Mary Cansimbe, Certification Specialist, at (916) 552-8675.

Sincerely,

John Dexter, Chief
Provider Certification Unit

cc: South Pasadena Rehabilitation Center, LLC, Licensee
904 Mission Street
South Pasadena, CA 91030

Nwamaka Oranusi, RN
Acting Chief
Los Angeles County Department of Public Health
Health Facilities Inspection Division
5050 Commerce Drive
Baldwin Park, CA 91706

Christina Miura, NE IV, FOA
Department of Health Care Services
San Bernardino Medi-Cal Field Office
MS 4514
464 West Fourth Street, Suite 530
San Bernardino, CA 92401

Judi Wilkinson, RN
Training Program Review Unit Supervisor
Aide Tech Certification Section
California Department of Public Health
Licensing and Certification Program
MS 3301
1615 Capitol Avenue
P.O. Box 997416
Sacramento, CA 95899-7416

cc: ✓ California Department of Aging
State Long Term Care Ombudsman
1300 National Drive, Suite 200
Sacramento, CA 95834

Mr. Javier Portela, Chief
Plan Management Branch
Department of Health Care Services
Medi-Cal Managed Care Division
MS 4407
1501 Capitol Avenue
P.O. Box 997413
Sacramento, CA 95899-7413

Ms. Tanya L. Homman, Chief
Department of Health Care Services
Provider Enrollment Division
MS 4704
1501 Capitol Avenue
P.O. Box 942732
Sacramento, CA 94234-7320

Mr. Steven Chickering
Associate Regional Administrator
Centers for Medicare and Medicaid Services
Western Division of Survey and Certification
90 7th Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

Ms. Paula Perse, Manager
Long Term Care Survey, Certification Enforcement Branch
Centers for Medicare and Medicaid Services
Western Division of Survey and Certification
90 7th Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

Appendix C

CDPH notice of application denial, dated July 8, 2016.

State of California—Health and Human Services Agency
California Department of Public Health

KAREN L. SMITH, MD, MPH
Director and State Health Officer

EDMUND G. BROWN JR.
Governor

July 8, 2016

CERTIFIED MAIL
70150640000351362294

Mr. Shlomo Rechnitz
Chico Terrace Healthcare & Wellness Centre, LP
5900 Wilshire Blvd., Suite 1600
Los Angeles, CA 90036

Dear Mr. Rechnitz,

RE: NOTICE OF DENIAL OF APPLICATION

On February 20, 2015, you applied for a license from the California Department of Public Health (CDPH), to operate the Chico Terrace Healthcare & Wellness Centre, LP located at 188 Cohasset Road, Chico, CA 95926.

After careful review and consideration of your application and all of the supporting information, CDPH denies your application for a license to operate the above-reference facility.

This denial action is pursuant to Health & Safety Code, Section 1265, subdivision (f).

In determining an applicant's ability to comply with Chapter 2 (commencing with Section 1250) of the Health and Safety Code and the rules and regulations promulgated under that chapter, CDPH reviews the compliance history of facilities owned, managed, or operated, either directly or indirectly, by the applicant for the past three years. The enclosure provides a list of the facilities CDPH included in its compliance review for this application.

CDPH's review revealed 265 federal regulatory violations at a deficiency scope and severity level of F or higher in facilities the applicant owned, managed, or operated, directly or indirectly, at any time from June 22, 2013 through June 22, 2016. The table below shows the number of deficiencies by deficiency level.

Three-Year Federal Regulatory Violation History

Deficiency Level	Scope & Severity Level Description	Number of Deficiencies
F	No actual harm with potential for more than minimal harm that is not immediate jeopardy but is widespread	172
G	Actual harm that is not immediate jeopardy and is isolated	45
H	Scope is pattern present, severity level of actual harm that is not immediate jeopardy.	9
J	Immediate jeopardy to resident health or safety and is isolated	11
K	Immediate jeopardy to resident health or safety and is a pattern	16
L	Immediate jeopardy to resident health and safety and is widespread	12

Below are details by facility, including the federal regulatory violation designation, of the "J", "K" and "L" level deficiencies (those that presented immediate jeopardy) included in the above chart.

Alta Vista Healthcare and Wellness Centre

On September 15, 2015, during a complaint investigation survey at the Alta Vista Healthcare Centre, located at 9020 Garfield Avenue, Riverside, CA 92123, one (1) immediate jeopardy was identified and violations written at harm level:

- **Level J – F223 – Free from Abuse / Involuntary Seclusion**

  The facility failed to provide for five residents an environment free from verbal abuse, harassment, and intimidation by Resident A.

  This failure resulted in emotional distress and fear for four residents, placing them in jeopardy of severe, negative psychosocial response from ongoing persistent expressions of anger and harassment from Resident A.

Clairemont Healthcare & Wellness Centre, LLC

On September 8, 2014, during a recertification survey at the Clairemont Healthcare & Wellness Centre, LLC, located at 8060 Frost Street, San Diego, CA 92123, three (3) immediate jeopardies were identified and violations written at harm level:

- **Level K – F431 – Drug Records, Label / Store Drugs & Biologicals**

  The facility failed to ensure controlled substance (CS) medications were accurately accounted for as evidenced by:

  1. A review of controlled substance records for residents reflected 126 tablets of CS medications were not accurately accounted for five residents since August 1, 2014, as follows:
     a. 65 tablets of Percocet & Tylenol 325 mg, a Schedule II (high potential for abuse) narcotic for pain) for Resident 48 from 8/17/14 to 9/17/14 (a one-month period);
     b. 11 tablets of oxycodone 10 mg, a Schedule II narcotic for severe pain for Resident 63;

c. 24 tablets of Norco (hydrocodone 5 mg & acetaminophen 325 mg, a potent narcotic for moderate to severe pain) for Resident 38;
d. 18 tablets of Norco 5/325 mg for Resident 80; and
e. 8 tablets of Norco 5/325 mg for Resident 39;

The CS were signed off the Controlled Drug Record (CDR) without subsequent documentation on the medication administration record (MAR) and/or pain assessment flow sheet (PAF) as given in accordance with facility procedures. It was undeterminable what happened to these medications. Also, for two residents with identified CS drug unaccountability, the facility could not provide controlled drug records prior to 8/17/14 for Resident 48, and records prior to 8/19/14 for Resident 80.

The frequent and repeated failures to document CS medication administration on the MAR and/or on the PAF, and failure to account for all CS medications had the potential to result in CS medication overdose (such as when the medication is given too soon before due time) for a universe of 32 residents who were receiving CS medications, and the misuse/diversion of controlled substances in the facility. Overdosing of CS narcotic medication could lead to adverse effects such as respiratory depression (a condition of having a breathing rate that becomes too low to ventilate the lung), extreme sedation, muscle weakness, slow heart rhythms, low blood pressure, loss of consciousness, and death.

2. The facility could not provide controlled drug disposition records to account for all discontinued/discharged controlled drugs from 5/5/14 to 8/11/14.

- **Level L – F441 – Infection Control, Prevent Spread, Linens**

The facility failed to ensure an Infection Control Program was in place. As a result, staff were not following infection control practices, which placed all residents at risk for acquiring the transmission of disease and infection.

- **Level L – F520 – QAA Committee – Members / Meet Quarterly**

The facility failed to provide evidence of a viable, ongoing, and comprehensive Quality Assurance Program which evaluated the facility's ability to provide continuous assessment of issues related to quality of care, quality of life and facility practices.

As a result, the facility was unable to identify system issues, develop and implement plans to address areas of concern and opportunities for improvement in a timely manner.

On October 7, 2014, during a recertification survey at the Clairemont Healthcare & Wellness Centre, LLC, located at 8060 Frost Street, San Diego, CA 92123, one (1) immediate jeopardy was identified and violations written at harm level:

- **Level L – F224 – Prohibit Mistreatment/Neglect/Misappropriation**

The facility failed to ensure Resident A, who was unable to care for self, unable to walk, unable to provide food for herself, unable to toilet self, and unable to obtain necessary medications for her illnesses, was safely discharged to an appropriate care setting. In addition, the facility failed to provide goods and services to ensure a safe and appropriate discharge.

As a result, Resident A was physically unable to care for self, was discharged to her trailer without a physician being notified, was discharged with a urinary catheter in place, and without means to care for herself. Resident A did not have a phone to call for help in case of an emergency, was unable to get out of bed on her own, unable to walk, unable to use the toilet, was a diabetic without medications or means to test her blood sugars, was a diabetic that had not eaten since lunch time, had no food in her trailer, and had no medications for her pain, and other critical medications that were required. Resident A laid in her bed at her home for hours before the police arrived. Resident A was found dirty and without necessary care/equipment to sustain life. More concerning is that any of the 93 residents in the facility could have been discharged before the facility ensured goods and services were arranged for a safe and appropriate discharge.

<u>Gridley Healthcare & Wellness Centre, LLC</u>

On March 25, 2014, during a recertification survey at the Gridley Healthcare & Wellness Centre, LLC, located at 246 Spruce Street, Gridley, CA 95948, two (2) immediate jeopardies were identified and violations written at harm level:

- **Level J – F309 – Provide Care / Services For Highest Well-Being**

The facility failed to provide the necessary care and services to attain or maintain the highest practicable well-being of residents by failing to:

1. Provide prompt emergency care when a Licensed Nurse (LN) failed to adequately assess, monitor and intervene for one Resident. The LN failed to notify resident's physician of their ongoing complaint of chest pain for more than eight hours. This had the potential to worsen an existing heart condition and cause a heart attack and/or death, and resulted in an extended hospitalization.
2. Adequately orient new nurses as well as ensure nurse competency to investigate and address the situation, and develop and implement a plan of action to prevent similar occurrences.
3. Complete nursing assessments before and after dialysis treatments for two residents. This had the potential for serious complications to go unnoticed and untreated.

- **Level J – F327 – Sufficient Fluids to Maintain Hydrations**
  The facility failed to provide sufficient fluids to maintain proper hydration and prevent dehydration for one resident. This resulted in severe dehydration and caused and/or contributed to the death of the resident.

  The facility did not respond and intervene to resident's change of condition over four days, including adequate oversight of resident fluid intake and notification of the physician, investigating and addressing the situation, and developing and implementing a plan of action to prevent similar occurrences.

On September 2, 2014, during a complaint investigation survey at the Gridley Healthcare & Wellness Centre, LLC, located at 246 Spruce Street, Gridley, CA 95948 by federal suveryors from the Centers for Medicare and Medicaid Services (CMS) two (2) immediate jeopardies were identified and violations written at harm level:

- **Level K – F224 – Prohibit Mistreatment / Neglect / Misappropriation**
  The facility failed to protect residents from neglect. The facility failed to provide the necessary (staff supervision) services to protect residents from physical altercations, verbal altercations, fear and intimidation by confused, and wandering residents. The failure to assure that residents received the necessary services to prevent physical, verbal, and mental abuse affected three residents.

- **Level K – F323 – Free of Accident Hazards / Supervision / Devices**
  The facility failed to ensure that each resident receives adequate supervision and assistance to prevent accidents. This failure affected residents who were wanderers, elopers, smokers, with recurrent falls, and with suicidal ideation.

As a result of the findings of this survey, the Centers for Medicare and Medicaid Services (CMS) placed Gridley Healthcare & Wellness Centre, LLC on a termination track for the Medicare program, issued civil monetary penalties and denied payment for new admissions. The facility was terminated from the Medicare program on October 2, 2014. CMS also imposed a 2-year bar on re-enrollment in the Medicare and Medicaid Programs.

<u>**Lakewood Healthcare Center**</u>
On May 30, 2014, during a complaint investigation survey at the Lakewood Healthcare Center, located at 12023 Lakewood Blvd., Downey, CA 90242 (2) immediate jeopardies were identified and violations written at harm level:

- **Level K – F323 – Free Of Accidents Hazards / Supervision / Devices**
  The facility failed to provide a safe and secure environment and supervision for a resident who was assessed at high risk for elopement, who also had short and long-term memory problems and was experiencing auditory hallucinations telling him/her to kill him/herself, with no established measures to prevent the resident from eloping.

  Resident eloped from the facility by using the linen barrels and trash can as a

stepping stool to climb over the fence. Resident came back and was sent out to the acute care hospital for evaluation. Resident was not re-admitted back to the facility. This failure placed resident and 67 other residents, who were also assessed at risk for elopement, at risk for harm and injuries.

The facility was also identified with a systems failure by not implementing corrective actions after the facility identified Resident 1 being at risk for elopement and having other residents elope from the same facility. According to the facility's discharge lists, in 2013, there were 3 residents who eloped. In 2014, there were 2 residents who eloped from the same facility.

- **Level K – F520 – QAA Committee-Members / Meets Quarterly / Plan**
The Quality Assessment and Assurance (QAA) committee failed to monitor the effects of implemented changes and make needed revisions to the action plans in order to correct the residents' potential risks for elopement.

Las Flores Convalescent Hospital
On June 26, 2014, during a recertification survey at the Las Flores Convalescent Hospital, located at 14165 Purche Avenue, Gardena, CA 90249, one (1) immediate jeopardy was identified and violations written at harm level:

- **Level K – F323 – Free of Accidents Hazards / Supervision / Devices**
The facility failed to implement preventive or corrective measures to ensure residents with escalating behavior problems were supervised; were not placed in situations where law enforcement and/or staff intervention was required to prevent serious injury, and all residents in the facility were protected from being placed at risk for injury from a resident with behavioral needs the facility was not able to meet. This deficient practice resulted in:

1. All residents in the facility that walked or used wheelchairs in the hallways of the facility being placed at risk for injury from being hit by a motorized wheelchair used by a problematic resident.
2. Resident 12 leaving the facility unsupervised in a motorized wheelchair, without a valid physician's order. The resident's assessment had indicated he was incapable of safely operating the wheelchair.
3. Law enforcement intervening to prevent Resident 12 from pulling Resident 2, a visually impaired resident through the streets on his motorized wheelchair while Resident 2 was held onto in a manual wheelchair.
4. Resident 12 turning off the alarm that would notify staff whenever Resident 16, a resident with a history of multiple falls, was standing up unassisted.

Oxnard Manor Healthcare Center
On May 19, 2015, during a recertification survey at the Oxnard Manor Healthcare Center, located at 1400 W. Gonzales Road, Oxnard, CA 93036, one (1) immediate jeopardy was identified and violations written at harm level:

- **Level J – F281 – Service Provided Meet Professional Standards**
The facility failed to ensure services provided to three residents met professional standards of quality. The facility failed to ensure residents on insulin (a medication for diabetes) received the correct dose, as ordered by the physician.

These failures placed three residents at risk for serious harm, including change in mental status, coma, and death.

<u>Pacific Rehabilitation & Wellness Center, LP</u>
On December 19, 2013, during a complaint investigation survey at the Pacific Rehabilitation & Wellness Center, LP, located at 2211 Harrison Avenue Eureka, CA 95501, one (1) immediate jeopardy was identified and violations written at harm level:

- **Level L – F323 – Free of Accidents Hazards / Supervision / Devices**
The facility failed to provide a safe environment by placing all 57 residents at risk when seven (7) portable space heaters were used in resident care areas accessible to both, ambulatory and wheelchair bound residents. This practice had the potential to cause harm by fire.

<u>Presidio Health Care Center</u>
On March 18, 2014, during a Federal Monitoring survey at the Presidio Health Care Center, located at 8625 Lamar Street, Spring Valley, CA 91977, one (1) immediate jeopardy was identified and violations written at harm level:

- **Level K – F329 – Drug Regimen Is Free From Unnecessary Drugs**
The facility failed to monitor for dangerous adverse effects of psychotropic medications for six (6) residents who were prescribed psychotropic medications. This failure placed these residents at risk of staff not recognizing serious, potentially life threatening adverse effects of psychotropic medication.

On most of the physician's orders, medication administration records (MAR), consents, and care plans for residents who had psychotropic medications prescribed listed the exact same side effects for staff to monitor which was, "Dry mouth, dizziness and drowsiness". However, the physician's orders did not include warnings of potentially dangerous, or life threatening side effects or the FDA issued boxed warnings for the use of Seroquel.

On June 26, 2014, during a compliant investigation survey at the Presidio Health Care Center, located at 8625 Lamar Street, Spring Valley, CA 91977, two (2) immediate jeopardies were identified and violations written at harm level:

- **Level L – F363 – Menus Meet Resident Needs / Prep in Advance / Followed**
The facility failed to maintain sufficient food supplies to ensure the planned menus would be followed as developed by the Registered Dietitian to meet the nutritional needs of 46 residents.

In addition, the facility failed to maintain the facility's planned par level of disaster food supplies to meet the nutritional needs of the residents and staff in the event of a disaster or emergency resulting in the loss of gas or electricity.

The lack of sufficient food supplies posed an immediate threat to the health and safety of the facility residents. There was no guarantee that the facility staff would have the means to meet the residents' nutritional needs in day–to-day meal planning. The lack of sufficient emergency food supplies could also result in not meeting the nutritional needs of the residents during a disaster. The facility failed to have a system in place to ensure adequate food supplies and to implement the facility's planned menus in order to meet the nutritional needs of the residents. The lack of guidance and monitoring of the facility staff to direct, prepare recipes and the quantities of food to serve to the residents impeded the staff's ability to ensure that the planned amount of calories, proteins, vitamins and minerals were provided to the residents on a daily basis for approximately 10 days. The lack of planning and food supplies had the potential to impact the nutritional status of the residents. In addition, there was inadequate guidance of dietary staff to ensure that therapeutic diets as ordered were provided in terms of modified textures. Dietary staff were not provided sufficient guidance and were not following recipes and planned menus.

- **Level L – F490 – Effective Administration / Resident Well-Being**

The facility failed to ensure that the administrator managed the facility in a manner that enhanced and supported the physical, mental and psychological well-being of the residents as evidenced by a failure to maintain sufficient food supplies at the facility to implement planned menus for daily operations, and failed to maintain sufficient disaster food supplies on hand. Thus, the facility was incapable of implementing the facility's disaster menu in the event of loss of gas or electricity. The facility further failed to ensure that there was a qualified full-time dietary services supervisor (DSS) or full-time Registered Dietician when a DSS was not employed full-time for the adequate oversight of the food-service operation. As a result, residents were placed at immediate risk for the potential of not having their nutritional needs met on a day to day basis or in the event of a disaster.

Point Loma Convalescent Hospital

On November 12, 2013, during a recertification survey at the Point Loma Convalescent Hospital, located at 3202 Duke Street, San Diego, CA 92110, one (1) immediate jeopardy was identified and violations written at harm level:

- **Level J – F323 – Free of Accidents Hazards / Supervision / Devices**

The facility failed to identify and manage potential smoking hazards for 4 residents. As a result:

1. Resident 61 was documented as a known smoker; however, was not assessed for safe smoking.
2. Resident 5 was identified as an unsafe smoker (requires supervision while smoking), per the Safe Smoking Assessment but was allowed to smoke

independently. As an unsafe smoker, Resident 5 kept personal smoking materials at the bedside, which included cigarettes and lighters.

3. Resident 23 was identified as an unsafe smoker, per the Safe Smoking Assessment but was allowed to smoke independently. Resident 23 was not identified on the facility's smoking list.
4. Resident 34 was initially identified as a safe smoker by the activity director. Upon re-assessment by a licensed nurse, Resident 34 was identified as an unsafe smoker who required supervision and a smoking apron. Resident 34 reported on several occasions that cigarettes and lighters were stolen off the bed.

The fire extinguisher was out of reach of the wheelchair bound residents. The facility did not provide a safe access to staff in case of an emergency situation while on the smoking patio. The facility process in place was to have the activity director, as a member of the interdisciplinary team, conduct the smoking assessment on all smokers. This assessment failed to take into consideration any resident's medical and medication history or health/or behavioral issues that would impact a resident's ability to smoke safely. The facility's systems failure presented a risk that residents who smoke could catch their clothes on fire when lighting cigarettes. Residents who smoke also could cause a fire inside the facility since they were allowed to keep their personal smoking materials in their rooms. These residents who smoke also could have been severely injured since there was no staff supervision and residents were allowed to smoke independently.

San Pablo Healthcare Center

On September 29, 2014, during a recertification survey at the San Pablo Healthcare Center, located at 13328 San Pablo Avenue, CA 94806, one (1) immediate jeopardy was identified and violations written at harm level:

- **Level L – F441 – Infection Control, Prevent Spread, Linens**

The facility failed to establish and maintain an Infection Control Program that helped to prevent the transmission of disease and infection when one (Resident 4) of 21 sampled residents had a transmittable disease and proper infection control practices were not followed throughout the facility.

On April 27, 2015, during a complaint investigation survey at the San Pablo Healthcare Center, located at 13328 San Pablo Avenue, San Pablo, CA 94806, one (1) immediate jeopardy was identified and violations written at harm level:

- **Level J – F365 – Food in Form to Meet Individual Needs**

The facility failed to ensure that food served to a resident was appropriate to meet his/her individual needs. Resident was served whole grapes for lunch when a mechanical soft diet was ordered. This deficient practice had the potential to result in choking and could lead to death.

This failure had the potential to cause all residents to be unnecessarily exposed to unsafe, unsanitary, harmful transmittable disease processes.

San Rafael Healthcare & Wellness Centre, LP
On November 3, 2015, during a recertification survey at the San Rafael Healthcare & Wellness Centre, LP, located at 1601 5th Avenue, San Rafael, CA 94901, one (1) immediate jeopardy (IJ) was identified and violations written at harm level:

- **Level K – F441 – Infection Control, Prevent Spread, Linens**

The facility failed to ensure infection control procedures were followed when:

1. Staff didn't clean glucometers between five residents. This resulted in the potential for transfer of blood borne organisms and infection between residents through cross contamination.
2. Housekeeping staff were not aware of the contact cleaning time for a disinfectant cleaner used to clean resident's room. This could result in the spread of infection to another resident.
3. Staff were not washing their hands after the removal of gloves which could lead to cross contamination and illness among facility residents.
4. Sterile urine culture cups were not stored out of the way of possible water droplet or spray contact.
5. Family member obtained water from a container on the medication cart after assisting a resident to eat and without washing their hands, which could lead to cross contamination of bacteria between residents.

South Pasadena Convalescent Hospital
On May 12, 2014, during a recertification survey at the South Pasadena Convalescent Hospital, located at 904 Mission Street, South Pasadena, CA 91030, two (2) immediate jeopardies were identified and violations written at harm level:

- **Level K – F323 – Free of Accidents Hazards / Supervision / Devices**

The facility failed to ensure the attending physician conducted an assessment for 7 residents with mental illness and "out on pass" medical orders as indicated in their policy and procedure prior to allowing a resident to leave out on pass unaccompanied by an adult.

This deficient practice consequently resulted in the actual harm and subsequent death of Resident 70, due to third degree burns and the potential for serious harm that is an immediate jeopardy to the health and safety of the remaining residents with mental illness diagnoses and "out on pass" medical orders.

Additionally, the facility failed to ensure Resident 57, who had a contracture to the left hand and used an electric flat iron was closely monitored to ensure safety. This deficient practice had the potential to result in possible injuries such as burns.

- **Level L – F309 – Provide Care / Services for Highest Well-Being**
The facility failed to ensure cardiopulmonary resuscitation (CPR) was performed correctly by a certified nursing assistant and licensed vocational nurse.

The nursing staff failed to use the proper technique for providing chest compressions to Resident 12 by not delivering chest compressions to the center of the resident's chest. This resulted in the resident not receiving an effective resuscitation effort. The LVN failed to provide the correct amount of chest compressions as indicated by the CPR Guidelines (American Heart Association) for Resident 12 during a Code Blue emergency response.

In addition, staff failed to respond correctly, when asked what to do if they were to find an unresponsive resident. The nursing staff responded with the incorrect information for both the ratio of Chest Compressions to Ventilation in two person adult CPR and the proper hand position for delivering CPR chest compressions.

These deficient practices resulted in the resident not receiving an effective resuscitation effort in violation of the resident's desire to be fully resuscitated, as indicated in the resident's wishes for life sustaining treatment of Full Code status. These deficient practices have the potential to result in physical injury to residents caused by improper and incorrect chest compressions for residents who have requested full Code status.

As a result of the findings of this survey, the Centers for Medicare and Medicaid Services (CMS), placed South Pasadena Convalescent Hospital on a termination track for the Medicare program, issued civil monetary penalties and denied payment for new admissions. The facility was terminated from the Medicare program on January 1, 2015. CMS also imposed a 2-year bar on re-enrollment in the Medicare and Medicaid Programs.

Verdugo Valley Skilled Nursing & Wellness Centre
On May 27, 2015, during a compliant investigation survey at the Verdugo Valley Skilled Nursing & Wellness Centre, located at 2635 Honolulu Avenue, Montrose, CA 91020, two (2) immediate jeopardies were identified and violations written at harm level:

- **Level K – F281 – Services Provided Meet Professional Needs**
The facility failure to provide skilled and timely emergency response to Resident 1, who was in need of immediate emergent care during a Code Blue (all-staff alert to gather in a life-saving effort) situation and Resident 1 died. The facility also failed to ensure that the nursing staff responding to such situations were properly trained in providing emergency care and services, according to professional standards to respond to life threatening medical emergency situations in a timely and effective manner.

In addition, the facility failed to ensure emergency equipment, which included walkie-talkies, was available for use, and failed to maintain updated staff records with updated information including current Basic Life Support [BLS - a level of medical care which is used for victims of life threatening medical situations until they can be given full medical care at a hospital] certification status for the staff.

- **Level K – F517 – Written Plans to Meet Emergencies / Disasters**

The facility failed to implement their written plans and procedures to meet all potential emergencies, including but not limited to ensuring:

1. Communication devices (walkie-talkie which is a two-way radio) were charged and available for use during an emergency;
2. Emergency equipment and supplies were available at the crash cart (a wheeled cart with drawers which carries medicine and equipment for the use in emergency resuscitations); and
3. Staff were current on CPR and emergency response procedures.

This deficient practice caused a delay in providing the appropriate level of response to Resident 1 during a medical emergency.

Vernon Healthcare Center

On September 8, 2014, during a compliant investigation survey at the Vernon Healthcare Center, located at 1037 W. Vernon Avenue, Los Angeles, CA 90037, five (5) immediate jeopardies were identified and violations written at harm level:

- **Level J – F333 – Resident Free of Significant Med Errors**

The facility failed to ensure that residents were free of any significant medication errors. Residents 4 and 76, did not have medications administered to them in accordance with the facility's pharmacy policy and procedure for medication administration guidelines. This failure had the potential to cause resident discomfort by not treating the infection timely and negatively affect the resident's health and safety.

- **Level K – F224 – Prohibit Mistreatment/Neglect/Misappropriation**

The facility failed to assure that each resident was free from mistreatment and neglect. The facility failed to ensure residents received the care they needed to avoid harm; failed to ensure residents were provided supervision when they left the facility and to ensure actions were taken to monitor their safety when their whereabouts were unknown for days; failed to ensure residents received essential medications including, but not limited to, insulin, anti-seizure medication and pain medication as ordered; failed to ensure physician orders were implemented; and failed to ensure staff did not falsify the administration of medication and monitoring related to clinical conditions.

The failure to provide the services each resident needed affected 49 residents and presented a risk of death or serious harm.

- **Level K – F309 – Provide Care / Services for Highest Well-Being**
The facility failed to provide the necessary care and services to ensure each resident attained their highest practicable well-being; failed to ensure residents received the care they needed to avoid harm; failed to ensure facility staff followed physician orders; failed to ensure residents received essential medications; failed to ensure staff did not falsify the administration of insulin and monitoring; failed to ensure pain management was provided when needed; failed to ensure residents were not subjected to pain and suffering and failed to ensure monitoring for clinical condition was completed.

The failure to provide the necessary care and services to meet each resident's individual needs affected 19 residents.

- **Level L – F225 – Investigate / Report Allegations / Individuals**
The facility failed to ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, were reported immediately to the administrator of the facility and to the State Survey Agency (SSA). Allegations of abuse and injuries of unknown origin were not immediately reported and investigated. The facility failed to complete thorough investigations. Results of all investigations were not reported to required officials, including the SSA, within five working days of the incident. The failure to thoroughly investigate and/or report allegations of abuse as required included 17 residents.

In addition, the facility failed to ensure it did not employ staff who had a finding of abuse or neglect entered against them into the State Nurse Aide registry prior to employment.

- **Level L – F226 – Develop / Implement Abuse / Neglect / Etc Policies**
The facility failed to develop and implement policies and procedures to protect residents from abuse and neglect. The facility failed to assure policies included specific information necessary to assure compliance with regulatory requirements in the areas of reporting and screening. In addition, the facility failed to implement abuse policies relevant to the seven required components (screening, training, prevention, identification, investigation, protection, and reporting).

On September 18, 2014, during a compliant investigation survey at the Vernon Healthcare Center, located at 1037 W. Vernon Avenue, Los Angeles, CA 90037, one (1) immediate jeopardies was identified and violations written at harm level:

- **Level K – F323 – Free of Accidents Hazards / Supervision / Devices**
The facility failed to implement the one-to-one supervision according to the plan of care that was developed to manage the wandering behavior for Resident 1.

Resident 1, who had dementia, was able to wander into the rooms of female residents, at various times between 4/25/14 and 9/20/14, and was able to enter the room of a male resident with dementia, Resident 3, and hit him on the left eye area of his face two weeks prior to 9/20/14 (exact date undetermined). The facility did not conduct a comprehensive assessment on Resident 1 to identify his wandering behavior since his admission to the facility.

The facility placed Resident 1 on 1:1 supervision on 9/12/14 to prevent him from hurting other residents and wandering into other residents' rooms. However, on 9/18/14, Resident 1 was able to enter the room of Resident 5 and 6 by himself. On 9/20/14, Resident 1 was able to enter inside the room of Resident 4 by himself. These female residents, Resident 4, 5, and 6, felt threatened that Resident 1 might hit them. Resident 4 was scared that Resident 1 might do something inappropriate to her.

This failure resulted in psychological harm to the female residents who felt threatened by Resident 1's behavior and had the potential to result in physical harm to Resident 1 himself and to other residents.

Windsor Chico Creek Care and Rehabilitation Center[1]

On March 24, 2015, during a complaint investigation survey at the Windsor Chico Creek Care and Rehabilitation Center, located at 587 Rio Lindo Avenue, Chico, CA 95926, two (2) immediate jeopardies were identified and violations written at harm level:

- **Level J - F223 – Abuse / Involuntary Seclusion**

The facility failed to protect four (4) Residents from abuse when Resident 2 made verbal insults towards Resident 1, punched Resident 1 in the face, and squeezed Resident 1's hand resulting in redness, bruising, and psychological trauma. The facility continued to allow Resident 2 to move through the hallway unsupervised, which resulted in another interaction where Resident 2 made verbal insults and threatened physical harm to Resident 1.

The facility then failed to ensure documentation of and follow-up treatment and services for the incident. Resident 2 made verbal insults and threats of physical harm to Resident 8. Resident 9 was fearful and did not feel safe due to Resident 2's violent talk. Resident 2 was verbally abusive to Resident 7 who was fearful and did not feel safe when around Resident 2.

- **Level J - F225 – Investigation / Report**

The facility failed to prevent, address, and report willful acts of verbal abuse by Resident 2 towards four residents and potentially any resident in close proximity of Resident 2.

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[1] Effective August 1, 2014, Anaheim Point Healthcare & Wellness Centre, LP entered into a Management and Operations Transfer Agreement with the current licensee, Windsor Anaheim Healthcare, LTD.

The facility was aware of Resident 2's verbally abusive behaviors towards other residents and allowed Resident 2 to move throughout the facility unsupervised, placing residents at risk for continued abuse and for the abuse to go unrecognized, unaddressed, and unreported.

Windsor Healthcare Center of Oakland[2]

On April 16, 2015, during a recertification survey at the Windsor Healthcare Center of Oakland, located at 2919 Fruitvale Avenue, Oakland, CA 94602, one (1) immediate jeopardy was identified and violations written at harm level:

- **Level J – F333 – Medications**

The facility failed to ensure residents were free of significant medication errors.

Resident 12 did not receive five doses of Triumeq necessary to slow down the replication of HIV which and can lead to Acquired Immune Deficiency Syndrome (AIDS) as ordered.

Resident 7 did not receive 4 doses of IV (intravenous) and 2 doses IM (intermuscular) Rocephin, once a day, prescribed for osteomyelitis, which could result in increasing the risk of further infection that is resistant to antibiotics. During an extended survey on 5/21/15, Resident 7's 9 am dose of IV Rocephin was administered at 11:23 a.m., more than two hours after it was due.

Resident 21 received two doses of Tylenol instead of aspirin which thins the blood and prevents clots which can lead to a stroke.

The IJ could not be lifted by the end of the standard survey, which was then extended due to substandard care. During the extended survey on 5/20/15 and 5/21/15, the IJ could not be lifted because of the continued significant medication errors. The IJ was abated on 6/08/15.

On May 4, 2015, during a complaint investigation survey, at the Windsor Healthcare Center of Oakland, located at 2919 Fruitvale Avenue, Oakland, CA 94602, two (2) immediate jeopardies were identified and violations written at harm level:

- **Level K – F224 – Prohibit Mistreatment / Neglect / Misappropriating**

The facility failed to provide services for untreated and unassessed skin ulcers, and untreated pain for six residents resulting in the neglect of residents' skin ulcers placing them at risk for infection and neglect of not receiving pain medications timely.

Resident 1 had physician's orders for daily treatment of an extensive diabetic ulcer

[2] Effective August 1, 2014, Brookdale Healthcare & Wellness Centre, LP entered into a Management and Operations Transfer Agreement with the current licensee, Windsor Oakridge Healthcare, L.P.

of the right heel and pressure ulcers on the buttocks and was not given the treatments as ordered for nine (9) days, resulting in Resident 1 being at risk for further damage to skin, bones, the possibility of losing one leg and at risk for infection due to the lack of nursing care as prescribed by the physician.

Resident 3 was placed on Hospice care and did not receive medications and pressure ulcer care as ordered. Resident 3 went without Morphine Sulfate for 19 hours when it was to be given every four hours, and the open pressure ulcers went untreated. The nurses did not follow doctor's orders for Hospice care resulting in Resident 3 suffering from pain and agitation due to not receiving Hospice medication, and not receiving pressure ulcer treatment.

Resident 13 was paralyzed and had extensive pressure ulcers to the buttocks and upper thighs. Resident 13 was exhibiting symptoms of illness and Resident 13's family insisted that Resident 13 be sent to the hospital. Resident 13 was sent to the ER where the doctor documented they found the resident covered in feces from the mid-back to the upper thighs, and was subsequently place in the intensive care unit for sepsis.

Resident 14 was admitted to the facility with orders for a medication to treat the pain which was not provided by the facility resulting in Resident 14 stating that Resident 14 felt like Resident 14 was going to die if Resident 14 did not get the medication. Resident 14 called 911 to take him/herself to the hospital in order to obtain the medication.

During the extended survey on 5/20/15 and 5/21/15, two additional residents were found to have ulcerated skin that was not assessed or treated.

Resident 29 had an open pressure ulcer on the right elbow which was identified by the Occupational Therapist (OT) and reported to the Director of Staff Development (DSD). The DSD did not notify the physician, obtain treatment orders or treat the resident's open area which put them at risk for further breakdown and/or infection.

Resident 30 had a pin (metal rod) in the left lower leg that had an open area around the pin site and was on antibiotic medication to treat a bone infection at the site. There was a doctor's order for pin care which was not clarified as to what pin care was needed. The wound around the pin had some depth, was crater shaped, was moist with yellow tissue, and loosely covered with a gauze wrap.

The IJ could not be lifted by the end of the standard survey, which was then extended due to substandard care. During the exit conference on 5/26/15, the IJ could not be lifted because of the continued neglect in not caring for Resident 29's newly acquired pressure ulcer and not following up on physician's orders for Resident 30 pin care resulting in a new open wound at the pin site. The IJ was abated on 6/8/15.

- **Level L – F441 – Infection Control, Prevent Spread, Linens**

The facility failed to establish and maintain an Infection Control Program to provide a safe and sanitary environment and to help prevent the development and transmission of disease and infection affecting Resident 9 who had an intestinal infection due to Clostridium difficile (C.Diff) with active diarrhea.

Resident 9 was identified during the survey as having an active C.Diff. infection beginning on 4/8/15. The facility did not have surveillance records for infections in March or May, 2015, and Resident 9 was the only identified infection in April 2015.

The facility also failed to prevent the spread of infection by not implementing their policies and procedures for handling the soiled linen, housekeeping and meal delivery for a Resident with active C.Diff.

The facility licensed nurses failed to follow policies and procedures for dressing changes when the DSD and LVN did not wear gloves while setting up the treatment supplies for two Residents.

The facility's staff lack of awareness of infected individuals, and lack of an infection control program with an appointed coordinator to monitor, control and prevent the spread of infection was a threat to the health of the individuals living and working in the facility.

The Director of Nursing nor any other nursing staff had any knowledge of the numbers of infected residents in the facility at the time of the survey. One resident was identified as having C.Diff. and had been moved to a single room from a three bed room two weeks ago. The facility records however, reflect the resident had C.Diff. since February 2015. The Certified Nursing Assistants, Laundry worker, Housekeeping, and Dietary departments were not notified and the contaminated linens were sent with the regular laundry, the meal trays sent to that resident was commingled with the other dirty trays after eating, and the housekeeper was not clear on the housekeeping procedures to prevent the spread of infection from the resident's room to the rest of the facility.

Wish-I-Ah Healthcare & Wellness Centre

On October 10, 2014, during a complaint investigation survey at the Wish-I-Ah Healthcare & Wellness Centre, located at 35680 Wish-I-Ah Road, Auberry, CA 93602, one (1) immediate jeopardy was identified and violations written at harm level:

- **Level L – F441 – Infection Control, Prevent Spread, Linens**

The facility failed to establish and maintain an effective Infection Control Program to prevent resident infection when the facility failed to identify a foodborne outbreak when 11 residents in the facility were identified with signs and symptoms of gastroenteritis. Resident 1's positive blood culture for Salmonella was confirmed prior to Resident 1's death. These failures were identified as follows:

1. Kitchen sanitation procedures were not maintained to minimize resident exposure to foodborne illness.
2. Facility staff returning to work after illness while still infectious.
3. Facility bathrooms were not maintained in a safe, functional, and sanitary manner.
4. Facility ice machine was not cleaned and sanitized according to manufacturer's recommendations.
5. Facility staff did not maintain contact isolation precautions when caring for a symptomatic resident.
6. Facility linen was not available for residents.
7. Resident contracted sepsis secondary to Salmonella infection. Resident was sent to the acute care hospital where she expired 7 days after admission.
8. Facility failed to maintain its sewage treatment system. Facility staff removed and disposed of raw sewage without appropriate personal protective equipment (PPE) and without a designated washing facility.

These failures exposed residents and staff to infectious disease which resulted in resident illness and harm to two known residents with laboratory confirmed Salmonella infection, and exposure of all residents and staff to gastrointestinal illness.

On October 14, 2014, during a complaint investigation survey at the Wish-I-Ah Healthcare & Wellness Centre, located at 35680 Wish-I-Ah Road, Auberry, CA 93602, one (1) immediate jeopardy was identified and violations written at harm level:

- **Level J – F309 – Provide Care / Services For Highest Well-Being**

The facility failed to provide the necessary care and services to attain the highest practicable physical well-being for Resident 1 when:

1. Wound vacuum dressing changes were not done in accordance with manufacturer's guidelines and physician orders. Resident 1 had a piece of foam attached to the skin where the wound vacuum dressing was placed and developed an infection.
2. No process in place to ensure the licensed nurses had been instructed and/or were competent to perform the wound vacuum dressing care.
3. No comprehensive assessment of the right chest wound done in order to monitor progress in healing of the wound for 25 days after Resident 1 returned to the facility with the wound vacuum.
4. No Nursing Care Plan was developed to guide interventions in wound care or Vacuum Assisted Closure (VAC) care.
5. Physician orders had not been followed when Resident 1's ordered lab tests had not been drawn which led to the cancellation of a physician appointment.

These failures led to pieces of the sponge used in the wound vacuum dressing change adhering to Resident 1's skin and had a high potential for Resident 1 to

develop an infection. These failures had a high potential for infections and medical complications.

On October 30, 2014, during a complaint investigation survey at the Wish-I-Ah Healthcare & Wellness Centre, located at 35680 Wish-I-Ah Road, Auberry, CA 93602, one (1) immediate jeopardy was identified and violations written at harm level:

- **Level K – F465 – Safe / Functional / Sanitary / Comfortable Environment**
  The facility failed to maintain a functional, safe, and sanitary environment for all residents, staff and visitors when:

  1. Kitchen sanitation procedures were not maintained to minimize resident exposure to foodborne illness.
  2. Facility staff returning to work after illness while still infectious.
  3. Facility bathrooms were not maintained in a safe, functional, and sanitary manner.
  4. Facility ice machine was not cleaned and sanitized according to manufacturer's recommendations.
  5. Facility staff did not maintain contact isolation precautions when caring for a symptomatic resident.
  6. Facility failed to maintain its sewage treatment system. Facility staff removed and disposed of raw sewage without appropriate personal protective equipment (PPE) and without a designated washing facility.
  7. Two of three Bathroom/Shower flooring had soft and spongy floor tiles near the shower and broken tiles and rotted subfloor beneath in the Bo-Hin-Tow building.
  8. Two resident bathrooms in the Administration building had soft squishy flooring around the toilet, and one room had water coming up around the toilet and onto the bathroom floor.
  9. There was no hot water in the Bo-Hin-Tow building and no water provided to residents for hand washing. Residents were given bed baths in tepid to cool water.

  These failures exposed residents and staff to infectious disease which resulted in resident illness and harm to two known residents with laboratory confirmed Salmonella infection, and exposure of all residents and staff to gastrointestinal illness.

As a result of the findings of this survey, on December 10, 2014, the Centers for Medicare and Medicaid Services (CMS) placed Wish-I-Ah Healthcare & Wellness Centre on a termination track for the Medicare program, issued civil monetary penalties, and denied payment for new admissions. Furthermore, CDPH issued a temporary suspension order on November 4, 2014, given the significant and on-going threats to the health and safety of the residents. The facility voluntarily closed on December 11, 2014.

In addition to the above federal regulatory violations, CDPH's review revealed the following citations for state licensing violations in facilities owned, managed, or operated, directly or indirectly, by the applicant for the past three years.

Three-Year State Licensing Citation History

Citation Level	Citation Level Description	Number of Citations
AA	A direct proximate cause of death of a patient of a long-term health care facility.	1
A	Imminent danger of death or serious harm to patients, or a substantial probability of death or serious physical harm to patients.	37
B	Has a direct or immediate relationship to patient health, safety, or security. Can include emotional and financial elements.	70

The enclosure displays the level AA and A state citations by facility.

Finally, CDPH's review revealed 13 administrative penalties for failure to comply with the legislatively mandated minimum staffing requirement of 3.2 Nursing Hours Per Patient Day (NHPPD) in facilities owned, managed, or operated, either directly or indirectly, by the applicant for the past three years.

The enclosure displays the NHPPD administrative penalties by facility.

CDPH has determined that you have not provided evidence satisfactory to be licensed as Chico Terrace Healthcare & Wellness Centre, LP located at 188 Cohasset Road, Chico, CA 95926, as a change of ownership (CHOW) from the current licensee Windsor Chico Care Center, LLC, to comply with statutes and regulations related to the operation of a skilled nursing facility (SNF). Therefore, based on the non-compliance with the requirements to complete the application for licensure, your application is denied.

Pursuant to Health and Safety Code section 1269, you have 20 days from the mailing of this notice to request a hearing regarding this denial action. If you desire to have a hearing to contest this action, you should address your written petition to the Department of Public Health at the following address:

California Department of Public Health
Licensing and Certification Program
Centralized Applications Unit
1615 Capitol Avenue
P.O. Box 997377, MS 3207
Sacramento, CA 95899-7377

Upon receipt of such petition, the matter will be set for hearing in accordance with Section 131071 of the Health and Safety Code.

If you have any questions regarding this letter, contact me at (916) 552-8756.

Thank You,

Teresa Gutierrez, Chief
Center for Health Care Quality
Licensing & Certification Program
Centralized Applications Unit

cc: Windsor Chico Care Center, LLC
9200 Sunset Blvd., Suite 725
West Hollywood, CA 90069

Joanne Gilchrist, Program Manager II
California Department of Public Health
Chico District Office
126 Mission Ranch Blvd.
Chico, CA 95926

Appendix D

Copies of 21 nursing home licensure application forms (HS 200 and HS 215A) submitted by Shlomo Rechnitz to the California Department of Public Health containing inaccurate information.

LICENSURE & CERTIFICATION APPLICATION

LA DO	FOR DEPARTMENTAL USE ONLY
District: East	ELMS Facility Number: 940000004
Proposed name of facility/agency/clinic:	
BAY VISTA Healthcare + Wellness Center, LP	

Lic #: 940000011 App ID#: 150090l

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: October 31, 2014

3. Amount of fee enclosed: $ ~~26,443.90~~ – correct amt. JH

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)

6. a. Do you wish to apply for the Medicare program? ● Yes ○ No Medicare Provider #: 056042
   b. Fiscal Intermediary choice: Noridian Healthcare Solutions

7. Do you wish to apply for the Medi-Cal (Medicaid) program? ● Yes ○ No

8. a. Current facility bed capacity: 70
   b. Proposed facility bed capacity: 70

9. Age range of clients: 21 and Up

10. Days and hours of operation: 24 hours per day 365 days per year

11. Is construction required? ○ Yes ● No
    If "yes", submit copy of "OSHPD" form (see instructions on page 6)
    If "yes", date construction to begin: N/A
    If "yes", date construction to be completed: N/A

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MAR 23 2016
Centralized Applications Unit
CDPH L&C Program

B. LICENSEE INFORMATION

1. Licensee name: Bay Vista Healthcare & Wellness Centre, LP

2. Federal employer's tax ID number: 47-1554753

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): 5900 Wilshire Blvd, Suite 1600
City, State, & Zip: Los Angeles, CA 90036
E-Mail: chow@rockporthc.com
Telephone number: (323) 330-6500
Fax number: (866) 603-3566

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: N/A
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:

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.

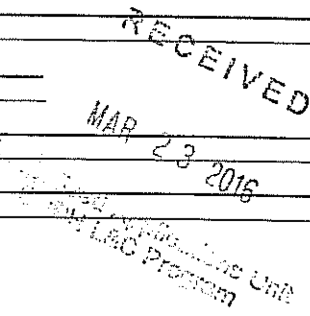
6. Is the licensee a **subsidiary** of another organization? ○ Yes ● No
If "yes", complete the information below and ***submit*** an organizational chart:

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: Bay Vista Healthcare & Wellness Centre, LP
   Current facility, agency, or clinic name (if change of ownership): Country Villa Bay Vista Healthcare Center
   Facility license number: 940000011

3. Address (number & street) of "proposed" facility, agency, or clinic: 5901 Downey Ave
   City, State, & Zip: Long Beach, CA 90805
   Telephone number: (562) 634-4693

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

5. **Name of person to be in charge of facility, agency, or clinic:** Garrett Martindale
   Title: Administrator
   Professional License number: 7926

6. **a.** Name of administrator: Garrett Martindale — Date of hire: 05/01/2015
   Professional License number: 7926 — Expiration date: 03/31/2017
   b. Name of director of nursing: Maria Antoniete Balla Bongo — Date of hire: 09/01/2015
   Professional License number: 514865 — Expiration date: 11/30/2016

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)	Shlomo Rechnitz	99.9	47-1554753	◯ Yes ● No	Self
(2)				◯ 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.

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D. PROPERTY INFORMATION

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

2. **Owner of Record** name in the real estate: 5901 Downey Avenue, LLC
Address (number & street): 12777 W. Jefferson Blvd Building D, Suite 3047
City, State, & Zip: Playa Vista, CA 90066

Lessee name: Bay Vista-Let, LLC
Address (number & street): 5900 Wilshire Blvd, Suite 1600
City, State, & Zip: Los Angeles, CA 90036

Sub-Lessee name: Bay Vista Healthcare & Wellness Centre, LP
Address (number & street): 5901 Downey Ave.
City, State, & Zip: Long Beach, CA 90805

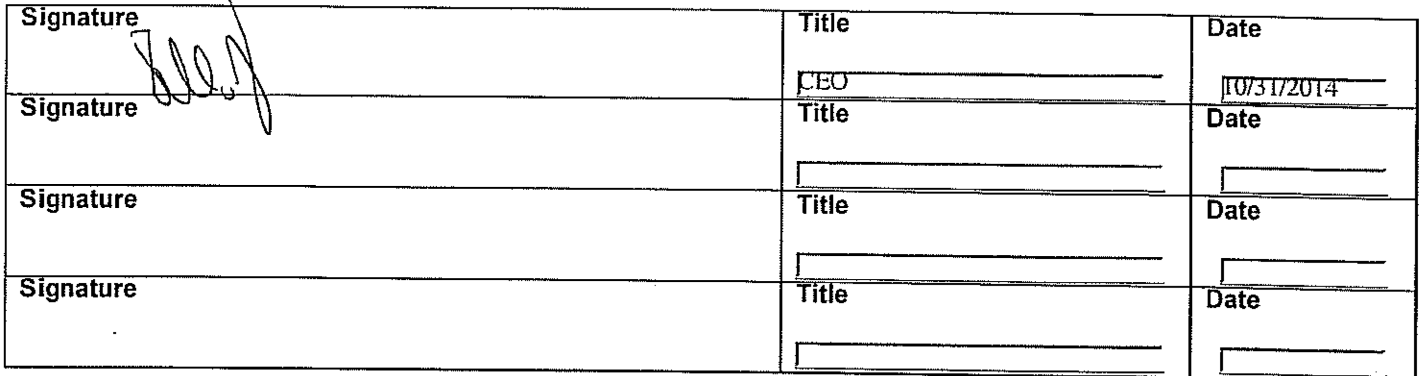
E. MANAGEMENT COMPANY

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
[signature]	CEO	10/31/2014

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.

MAR 23 2016

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.

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: Shlomo Rechnitz

Date of Birth: [redacted]

Business address (number, street, apartment/suite number or letter if applicable): 5901 Downey Ave

City, State, & Zip: Long Beach, CA 90805

Title in relation to this facility: CEO/Member of LP

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.

N/A

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
N/A		

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.

	Dates	Name and address of employer	Job title
From:	07/2005	Brius, LLC	CEO
To:	Present	5967 W. 3rd Street Suite 200 L.A., CA 90036	
From:	01/1995	Twin Med	CEO
To:	Present	11333 Greenstone Ave. Santa Fe Springs, CA	
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:* October 31, 2014

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.

LICENSURE & CERTIFICATION APPLICATION

LA DO – FOR DEPARTMENTAL USE ONLY	
District: West	ELMS Facility Number: 970000035
Proposed name of facility/agency/clinic:	
East Terrace Rehabilitation + Wellness Center	

LIC #: 970000018 APP ID#: 1501140

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: October 31, 2014

3. Amount of fee enclosed: $ 37,399.23 – correct amt. - JS

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)

6. a. Do you wish to apply for the Medicare program? ● Yes ○ No Medicare Provider #: 056114
   b. Fiscal Intermediary choice: Noridian Healthcare Solutions

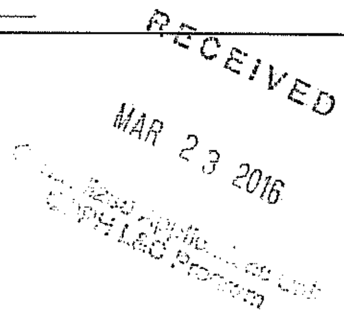
7. Do you wish to apply for the Medi-Cal (Medicaid) program? ● Yes ○ No

8. a. Current facility bed capacity: 99
   b. Proposed facility bed capacity: 99

9. Age range of clients: 21 and Up

10. Days and hours of operation: 24 hours per day 365 days per year

11. Is construction required? ○ Yes ● No
    If "yes", submit copy of "OSHPD" form (see instructions on page 6)
    If "yes", date construction to begin: N/A
    If "yes", date construction to be completed: N/A



B. LICENSEE INFORMATION

1. Licensee name: East Terrace Rehabilitation & Wellness Centre, LP

2. Federal employer's tax ID number: 47-1532176

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): 5900 Wilshire Blvd, Suite 1600
   City, State, & Zip: Los Angeles, CA 90036
   E-Mail: Ehow@rockporthc.com
   Telephone number: (323) 330-6500
   Fax number: (866) 603-3566

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: N/A
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:

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.

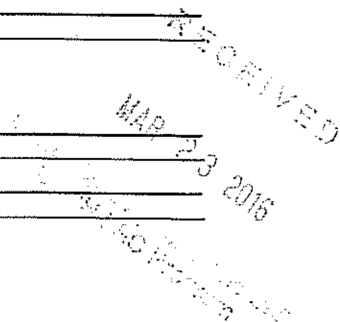
6. Is the licensee a **subsidiary** of another organization? ◯ Yes ◉ No
   If "yes", complete the information below and ***submit*** an organizational chart:

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: East Terrace Rehabilitation & Wellness Centre, LP
   Current facility, agency, or clinic name (if change of ownership): Country Villa East Nursing Center
   Facility license number: 970000018

3. Address (number & street) of "proposed" facility, agency, or clinic: 2415 S Western Ave
   Telephone number: (323) 734-1101
   City, State, & Zip: Los Angeles, CA 90018

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

5. **Name of person to be in charge of facility, agency, or clinic:** Louis Florin
   Title: Administrator
   Professional License number: NHA7818

6. **a.** Name of administrator: Louis Florin
   Date of hire: 10/31/2014
   Professional License number: NHA7818
   Expiration date: 01/31/2016
   b. Name of director of nursing: April Concepcion
   Date of hire: 10/31/2014
   Professional License number: NHA760512
   Expiration date: 05/31/2015

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)	Shlomo Rechnitz	99.9%	47-1532176	○ Yes ● No	Self
(2)				○ 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.

RECEIVED MAR 23 2016 Centralized Applications

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: 2415 S. Western Avenue, LLC
Address (number & street): 12777 W. Jefferson Blvd Building D, Suite 3047
City, State, & Zip: Playa Vista, CA 90066

Lessee name: East Terrace-Let, LLC
Address (number & street): 5900 Wilshire Blvd, Suite 1600
City, State, & Zip: Los Angeles, CA 90036

Sub-Lessee name: East Terrace Rehabilitation & Wellness Centre, LP
Address (number & street): 2415 S. Western Ave.
City, State, & Zip: Los Angeles, CA 90018

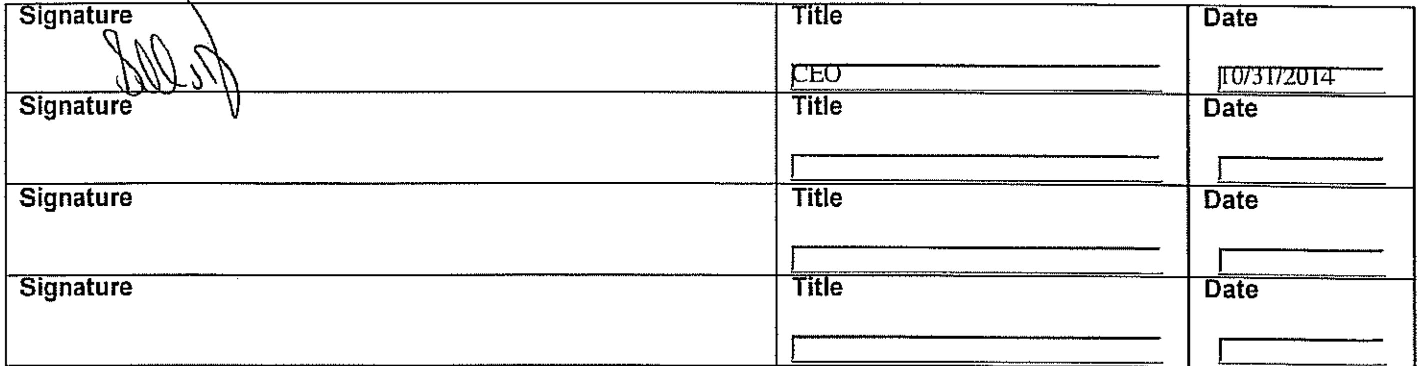
E. MANAGEMENT COMPANY

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
[signature]	CEO	10/31/2014

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.

RECEIVED MAR 23 2015

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: Shlomo Rechnitz

Date of Birth: [redacted]

Business address (number, street, apartment/suite number or letter if applicable): 2415 S Western Ave

City, State, & Zip: Los Angeles, CA 90018

Title in relation to this facility: CEO/Member of LP

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.

N/A

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
N/A		

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.

	Dates	Name and address of employer	Job title
From:	07/2005	Brius, LLC	CEO
To:	Present	5967 W. 3rd Street Suite 200 L.A., CA 90036	
From:	01/1995	Twin Med	CEO
To:	Present	11333 Greenstone Ave. Santa Fe Springs, CA	
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:* October 31, 2014

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.

LICENSURE & CERTIFICATION APPLICATION

LA-DO- FOR DEPARTMENTAL USE ONLY	
District: San Gabriel	ELMS Facility Number: 950000042
Proposed name of facility/agency/clinic:	
Gardenview Healthcare & Wellness Center, LP	

Lic#: 950000053 App ID#: 150157

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: October 31, 2014

3. Amount of fee enclosed: $ 37,399.23 – Correct amt. JJ

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)

6. a. Do you wish to apply for the Medicare program? ● Yes ○ No Medicare Provider #: 055344
   b. Fiscal Intermediary choice: Noridian Healthcare Solutions

7. Do you wish to apply for the Medi-Cal (Medicaid) program? ● Yes ○ No

8. a. Current facility bed capacity: 99
   b. Proposed facility bed capacity: 99

9. Age range of clients: 21 and Up

10. Days and hours of operation: 24 hours per day 365 days per year

11. Is construction required? ○ Yes ● No
    If "yes", submit copy of "OSHPD" form (see instructions on page 6)
    If "yes", date construction to begin: N/A
    If "yes", date construction to be completed: N/A

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HS 200 (02/08)

B. LICENSEE INFORMATION

1. Licensee name: Gardenview Healthcare & Wellness Centre, LP

2. Federal employer's tax ID number: 47-1603445

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): 5900 Wilshire Blvd, Suite 1600
   City, State, & Zip: Los Angeles, CA 90036
   E-Mail: chow@rockporthc.com
   Telephone number: (323) 330-6500
   Fax number: (866) 603-3566

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: N/A
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:

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.

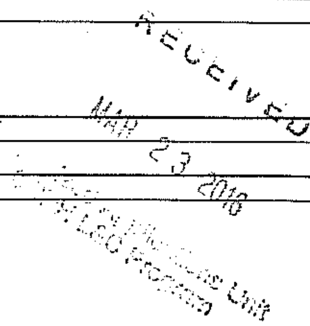
6. Is the licensee a **subsidiary** of another organization? ◯ Yes ● No
   If "yes", complete the information below and ***submit*** an organizational chart:

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: Gardenview Healthcare & Wellness Centre, LP
   Current facility, agency, or clinic name (if change of ownership): Country Villa Claremont Healthcare Center
   Facility license number: 950000053

3. Address (number & street) of "proposed" facility, agency, or clinic: 590 S Indian Hill Blvd
   Telephone number: (909) 624-4511
   City, State, & Zip: Claremont, CA 91711

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

5. **Name of person to be in charge of facility, agency, or clinic:** Sonia Cardenas
   Title: Administrator
   Professional License number: NHA7293

6. **a.** Name of administrator: Sonia Cardenas Date of hire: 10/31/2014
   Professional License number: NHA7293 Expiration date: 06/30/2015
   b. Name of director of nursing: Charles Cornelius Date of hire: 10/31/2014
   Professional License number: 475130 Expiration date: 03/31/2016

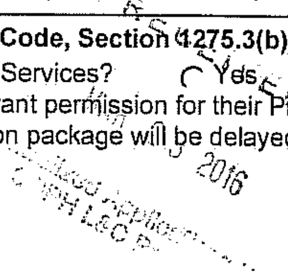
7. List persons having **5 percent** or more direct or indirect (42 CFR, Section 455.102) interest in the ownership of this facility if applying for skilled nursing or intermediate care licensure, and **10 percent** for all other facilities, agencies, or clinics. Provide federal employer's tax ID number. 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)	Shlomo Rechnitz	99.9%	47-1603445	○ Yes	● No	Self
(2)				○ 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: Health Care Property Investors, Inc.
   Address (number & street): 4675 MacArthur Court, 9th Floor
   City, State, & Zip: Newport Beach, CA 92660

   Lessee name: Gardenview-Let, LLC
   Address (number & street): 5900 Wilshire Blvd, Suite 1600
   City, State, & Zip: Los Angeles, CA 90036

   Sub-Lessee name: Gardenview Healthcare & Wellness Centre, LP
   Address (number & street): 590 S. Indian Blvd
   City, State, & Zip: Claremont, CA 91711

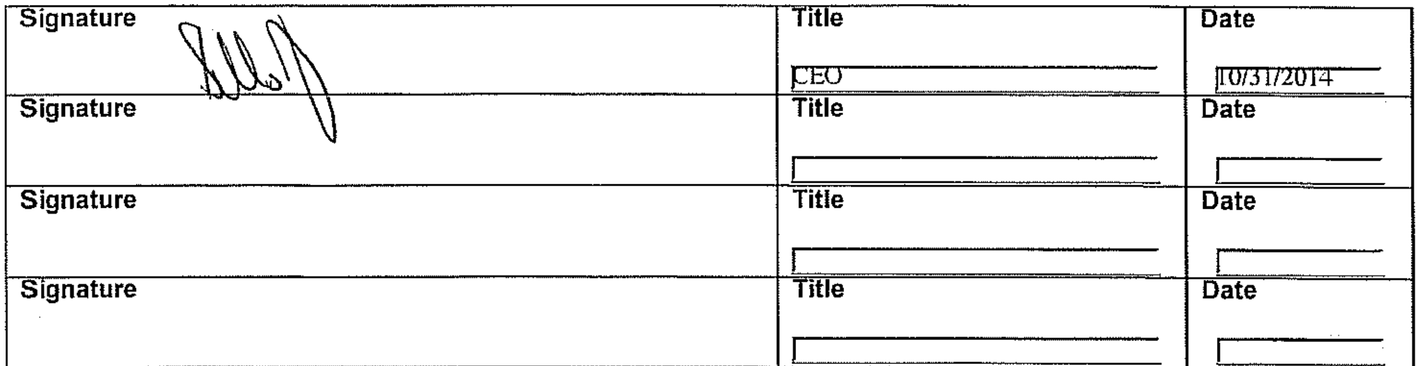
E. MANAGEMENT COMPANY

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
Signature	CEO	10/31/2014
Signature		
Signature		
Signature		

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.

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: Shlomo Rechnitz

Date of Birth: [redacted]

Business address (number, street, apartment/suite number or letter if applicable): 590 S Indian Hill Blvd

City, State, & Zip: Claremont, CA 91711

Title in relation to this facility: CEO/Member of LP

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.

N/A

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
N/A		

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:	07/2005	Brius, LLC	CEO
To:	Present	5967 W. 3rd Street Suite 200 L.A., CA 90036	
From:	01/1995	Twin Med	CEO
To:	Present	11333 Greenstone Ave. Santa Fe Springs, CA	
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 <u>5 percent</u> 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 **<u>If YES, check all applicable:</u>**

○ 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:* October 31, 2014

<u>RELEASE OF INFORMATION STATEMENT</u>

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.

LICENSURE & CERTIFICATION APPLICATION

LA DO FOR DEPARTMENTAL USE ONLY	
District: East	ELMS Facility Number: 940000053
Proposed name of facility/agency/clinic: Grand Avenue Healthcare + Wellness Centre, LP	

Lic #: 940000082 App ID#: 150091?

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: October 31, 2014

3. Amount of fee enclosed: $ ~~14,199.09~~ – consultant. JS

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)

6. a. Do you wish to apply for the Medicare program? (●) Yes ( ) No Medicare Provider #: 055077
   b. Fiscal Intermediary choice: Noridian Healthcare Solutions

7. Do you wish to apply for the Medi-Cal (Medicaid) program? (●) Yes ( ) No

8. a. Current facility bed capacity: 117
   b. Proposed facility bed capacity: 117

9. Age range of clients: 21 and Up

10. Days and hours of operation: 24 hours per day 365 days per year

11. Is construction required? ( ) Yes (●) No
    If "yes", submit copy of "OSHPD" form (see instructions on page 6)
    If "yes", date construction to begin: N/A
    If "yes", date construction to be completed: N/A

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B. LICENSEE INFORMATION

1. Licensee name: Grand Avenue Healthcare & Wellness Centre, LP

2. Federal employer's tax ID number: 35-2505308

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): 5900 Wilshire Blvd, Suite 1600
Telephone number: (323) 330-6500
City, State, & Zip: Los Angeles, CA 90036
E-Mail: ehow@rockporthc.com
Fax number: (866) 603-3566

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: N/A
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:

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:

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LAC Program

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: Grand Avenue Healthcare & Wellness Centre, LP
   Current facility, agency, or clinic name (if change of ownership): Country Villa Belmont Heights Healthcare Center
   Facility license number: 940000082

3. Address (number & street) of "proposed" facility, agency, or clinic: 1730 Grand Ave
   City, State, & Zip: Long Beach, CA 90804
   Telephone number: (562) 597-8817

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

5. **Name of person to be in charge of facility, agency, or clinic:** Batsheva Gradon
   Title: Administrator
   Professional License number: NHA7829

6. **a.** Name of administrator: Batsheva Gradon — Date of hire: 10/31/2014
   Professional License number: NHA7829 — Expiration date: 03/31/2016
   b. Name of director of nursing: Jose Henry Prieto Servidad — Date of hire: 10/31/2014
   Professional License number: 505060 — Expiration date: 06/30/20116

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)	Shlomo Rechnitz	99.9%	35-2505308	○ Yes	● No	Self
(2)				○ 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.

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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: Newman Family Trust Est. August 9, 1994 c/o Emanuel Newman
Address (number & street): 18261 Lake Encino Drive
City, State, & Zip: Encino, CA 91316

Lessee name: Grand Avenue-Let, LLC
Address (number & street): 5900 Wilshire Blvd, Suite 1600
City, State, & Zip: Los Angeles, CA 90036

Sub-Lessee name: Grand Avenue Healthcare & Wellness Centre, LP
Address (number & street): 1730 Grand Ave
City, State, & Zip: Long Beach, CA 90804

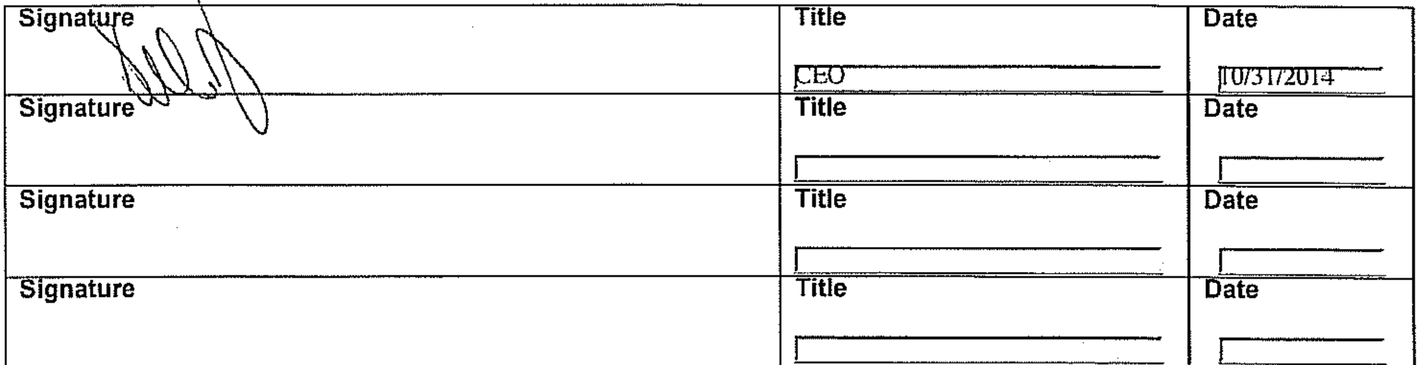
E. MANAGEMENT COMPANY

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
Signature	Title CEO	Date 10/31/2014
Signature	Title	Date
Signature	Title	Date
Signature	Title	Date

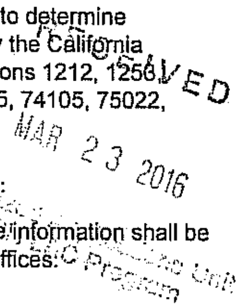
Release of Information Statement

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, 1256, 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.



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: Shlomo Rechnitz

Date of Birth: [redacted]

Business address (number, street, apartment/suite number or letter if applicable): 1730 Grand Ave

City, State, & Zip: Long Beach, CA 90804

Title in relation to this facility: CEO/Member of LP

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.

N/A

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
N/A		

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.

	Dates	Name and address of employer	Job title
From:	07/2005	Brius, LLC	CEO
To:	Present	5967 W. 3rd Street Suite 200 L.A., CA 90036	
From:	01/1995	Twin Med	CEO
To:	Present	11333 Greenstone Ave. Santa Fe Springs, CA	
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:* October 31, 2014

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.

State of California – Health and Human Services Agency

California Department of Public Health
Licensing and Certification

LICENSURE & CERTIFICATION APPLICATION

FOR DEPARTMENTAL USE ONLY	
District: San Bernadino	ELMS Facility Number: 240000058
Proposed name of facility/agency/clinic: Hacienda Heights Healthcare + Wellness Centre, LP	

License # 240000136

App id # 1501059

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: October 31, 2014

3. Amount of fee enclosed: $ 37,399.23

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) ______

6. a. Do you wish to apply for the Medicare program? (●) Yes ( ) No Medicare Provider #: 056053
   b. Fiscal Intermediary choice: Noridian Healthcare Solutions

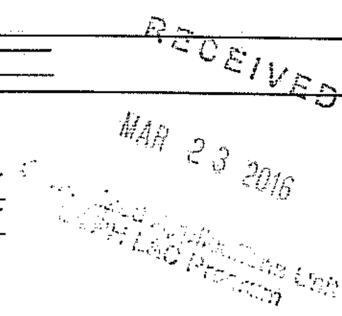
7. Do you wish to apply for the Medi-Cal (Medicaid) program? (●) Yes ( ) No

8. a. Current facility bed capacity: 99
   b. Proposed facility bed capacity: 99

9. Age range of clients: 21 and Up

10. Days and hours of operation: 24 hours per day 365 days per year

11. Is construction required? ( ) Yes (●) No
    If "yes", submit copy of "OSHPD" form (see instructions on page 6)
    If "yes", date construction to begin: N/A
    If "yes", date construction to be completed: N/A



B. LICENSEE INFORMATION

1. Licensee name: Hacienda Heights Healthcare & Wellness Centre, LP

2. Federal employer's tax ID number: 47-1603475

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): 5900 Wilshire Blvd, Suite 1600
   Telephone number: (323) 330-6500
   City, State, & Zip: Los Angeles, Ca 90036
   E-Mail: Ehow@rockporthc.com
   Fax number: (866) 603-3566

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: N/A
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:

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.

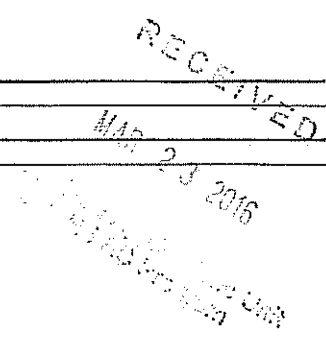
6. Is the licensee a **subsidiary** of another organization? ◯ Yes ● No
   If "yes", complete the information below and ***submit*** an organizational chart:

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: Hacienda Heights Healthcare & Wellness Centre, LP
   Current facility, agency, or clinic name (if change of ownership): Country Villa Healthcare
   Facility license number: 240000136

3. Address (number & street) of "proposed" facility, agency, or clinic: 1311 E Date St
   City, State, & Zip: San Bernardino, CA 92404
   Telephone number: (909) 882-3316

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

5. **Name of person to be in charge of facility, agency, or clinic:** Mitchell Reichman
   Title: Administrator
   Professional License number: NHA7531

6. **a.** Name of administrator: Mitchell Reichman — Date of hire: 10/31/2014
   Professional License number: NHA7531 — Expiration date: 07/31/2015
   b. Name of director of nursing: Shemika Mitchell — Date of hire: 10/31/2014
   Professional License number: 693931 — Expiration date: 09/30/2016

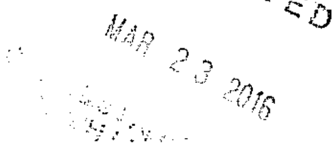
7. List persons having **5 percent** or more direct or indirect (42 CFR, Section 455.102) interest in the ownership of this facility if applying for skilled nursing or intermediate care licensure, and **10 percent** for all other facilities, agencies, or clinics. Provide federal employer's tax ID number. 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)	Shlomo Rechnitz	99.9	47-1603475	◯ Yes ● No	Self
(2)				◯ 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: 1311 East Date Street, LLC
Address (number & street): 21204 Rimpath Drive
City, State, & Zip: Covina, CA 91724

Lessee name: Hacienda Heights-Let, LLC
Address (number & street): 5900 Wilshire Blvd, Suite 1600
City, State, & Zip: Los Angeles, CA 90036

Sub-Lessee name: Hacienda Heights Healthcare & Wellness Centre, LP
Address (number & street): 1311 E. Date St.
City, State, & Zip: San Bernardino, CA 92404

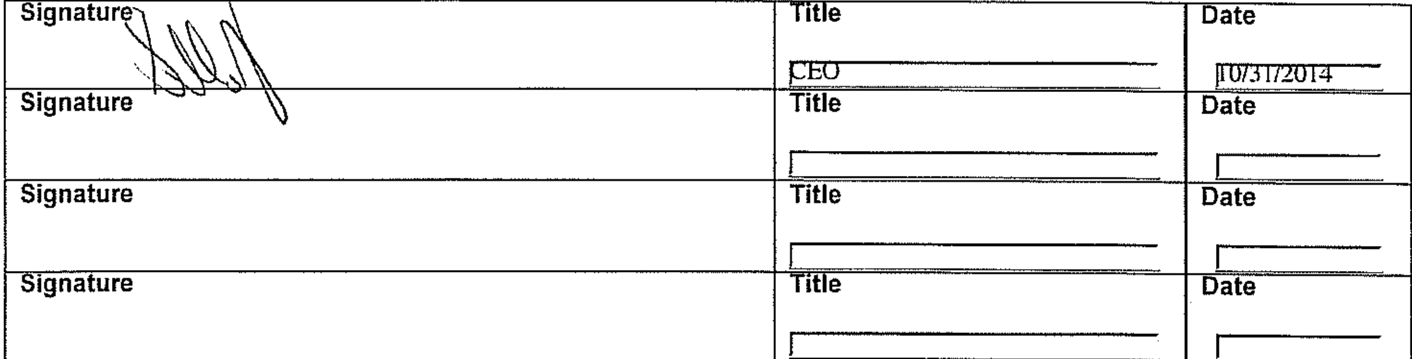
E. MANAGEMENT COMPANY

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
[signature]	CEO	10/31/2014
Signature	Title	Date
Signature	Title	Date
Signature	Title	Date

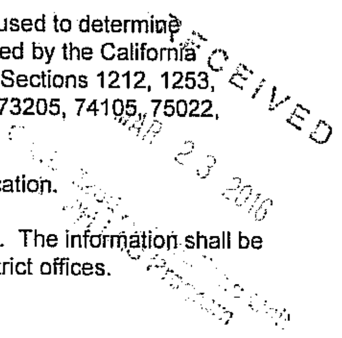
Release of Information Statement

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.



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: Shlomo Rechnitz

Date of Birth: [redacted]

Business address (number, street, apartment/suite number or letter if applicable): 1311 E Date St

City, State, & Zip: San Bernardino, CA 92404

Title in relation to this facility: CEO/Member of LP

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.

N/A

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
N/A		

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.

	Dates	Name and address of employer	Job title
From:	07/2005	Brius, LLC	CEO
To:	Present	5967 W. 3rd Street Suite 200 L.A., CA 90036	
From:	01/1995	Twin Med	CEO
To:	Present	11333 Greenstone Ave. Santa Fe Springs, CA	
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:* October 31, 2014

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.

LICENSURE & CERTIFICATION APPLICATION

LA DO – FOR DEPARTMENTAL USE ONLY

District: NORTH	ELMS Facility Number: 970000083
Proposed name of facility/agency/clinic: Los Feliz Healthcare + Wellness Centre, LP	

Lic #: 970000041 App ID #: 150120

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: October 31, 2014

3. Amount of fee enclosed: $ ~~19,487.87~~ – correct amt. JS

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)

6. a. Do you wish to apply for the Medicare program? (●) Yes ( ) No Medicare Provider #: 056380
   b. Fiscal Intermediary choice: Noridian Healthcare Solutions

7. Do you wish to apply for the Medi-Cal (Medicaid) program? (●) Yes ( ) No

8. a. Current facility bed capacity: 131
   b. Proposed facility bed capacity: 131

9. Age range of clients: 21 and Up

10. Days and hours of operation: 24 hours per day 365 days per year

11. Is construction required? ( ) Yes (●) No
    If "yes", submit copy of "OSHPD" form (see instructions on page 6)
    If "yes", date construction to begin: N/A
    If "yes", date construction to be completed: N/A

RECEIVED
MAR 23 2016
Lead Applications Unit
CDPH L&C Program

B. LICENSEE INFORMATION

1. Licensee name: Los Feliz Healthcare & Wellness Centre, LP

2. Federal employer's tax ID number: 47-1567187

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): 5900 Wilshire Blvd, Suite 1600
Telephone number: (323) 330-6500
City, State, & Zip: Los Angeles, CA 90036
E-Mail: chow@rockporthc.com
Fax number: (866) 603-3566

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: N/A
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:

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.

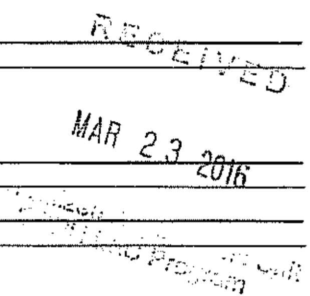
6. Is the licensee a **subsidiary** of another organization? ○ Yes ● No
If "yes", complete the information below and ***submit*** an organizational chart:

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: Los Feliz Healthcare & Wellness Centre, LP
   Current facility, agency, or clinic name (if change of ownership): Country Villa Los Feliz Nursing Center
   Facility license number: 970000041

3. Address (number & street) of "proposed" facility, agency, or clinic: 3002 Rowena Ave
   Telephone number: (323) 666-1544
   City, State, & Zip: Los Angeles, CA 90039

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

5. **Name of person to be in charge of facility, agency, or clinic:** Steeve Henry
   Title: Administrator
   Professional License number: NHA7347

6. **a.** Name of administrator: Steeve Henry — Date of hire: 12/01/2014
   Professional License number: NHA7347 — Expiration date: 12/31/2015
   b. Name of director of nursing: Carol Poblete — Date of hire: 10/31/2014
   Professional License number: 515073 — Expiration date: 01/31/2017

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)	Shlomo Rechnitz	99.9%	47-1567187	◯ Yes ◉ No	Self
(2)				◯ 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.

2016

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: Los Feliz-Lct, LLC
   Address (number & street): 5900 Wilshire Blvd, Suite 1600
   City, State, & Zip: Los Angeles, CA 90036

   Lessee name: Los Feliz Healthcare & Wellness Centre, LP
   Address (number & street): 3002 Rowena Ave
   City, State, & Zip: Los Angeles, CA 90039

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

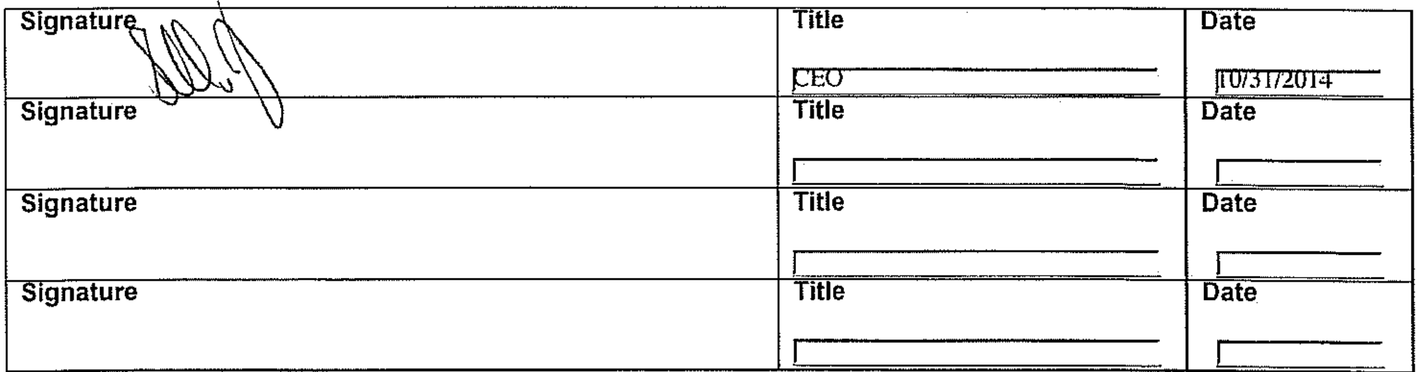
E. MANAGEMENT COMPANY

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
[signature]	CEO	10/31/2014

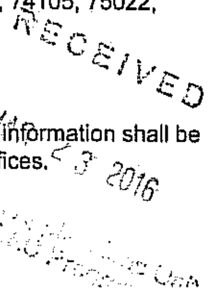
Release of Information Statement

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.



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: Shlomo Rechnitz

Date of Birth: [redacted]

Business address (number, street, apartment/suite number or letter if applicable): 3002 Rowena Ave

City, State, & Zip: Los Angeles, CA 90039

Title in relation to this facility: CEO/Member of LP

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.

N/A

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
N/A		

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:	07/2005	Brius, LLC	CEO
To:	Present	5967 W. 3rd Street Suite 200 L.A., CA 90036	
From:	01/1995	Twin Med	CEO
To:	Present	11333 Greenstone Ave. Santa Fe Springs, CA	
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).**

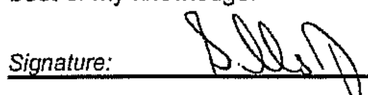
F. Adverse Actions

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:* October 31, 2014

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.

LICENSURE & CERTIFICATION APPLICATION

FOR DEPARTMENTAL USE ONLY	
District: LA-West	ELMS Facility Number: 910000058
Proposed name of facility/agency/clinic: Mar Vista Country Villa Healthcare & Wellness Centre, LP	

License #910000077
Appl id # 1501088

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: October 31, 2014

3. Amount of fee enclosed: $ 25,688.36 – correct amt. AF

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)

6. a. Do you wish to apply for the Medicare program? ● Yes ○ No Medicare Provider #: 555726
   b. Fiscal Intermediary choice: Noridian Healthcare Solutions

7. Do you wish to apply for the Medi-Cal (Medicaid) program? ● Yes ○ No

8. a. Current facility bed capacity: 68
   b. Proposed facility bed capacity: 68

9. Age range of clients: 21 and Up

10. Days and hours of operation: 24 hours per day 365 days per year

11. Is construction required? ○ Yes ● No
    If "yes", submit copy of "OSHPD" form (see instructions on page 6)
    If "yes", date construction to begin: N/A
    If "yes", date construction to be completed: N/A

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MAR 23 2016
Centralized Applications Unit
CDPH L&C Program

B. LICENSEE INFORMATION

1. Licensee name: Mar Vista Country Villa Healthcare & Wellness Centre, LP

2. Federal employer's tax ID number: 47-1661149

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): 5900 Wilshire Blvd, Suite 1600

Telephone number: (323) 330-6500

City, State, & Zip: Los Angeles, CA 90036

E-Mail: Chow@rockporthc.com

Fax number: (866) 603-3566

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: N/A

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:

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:

RECEIVED

MAR 23 2016

Centralized Applications Unit
CDPH L&C Program

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: Mar Vista Country Villa Healthcare & Wellness Centre, LP
   Current facility, agency, or clinic name (if change of ownership): Country Villa Mar Vista Nursing Center
   Facility license number: 910000077

3. Address (number & street) of "proposed" facility, agency, or clinic: 3966 Marcasel Ave
   Telephone number: (310) 397-2372
   City, State, & Zip: Los Angeles, CA 90066

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

5. **Name of person to be in charge of facility, agency, or clinic:** Sabina Clark
   Title: Administrator
   Professional License number: NHA7743

6. **a.** Name of administrator: Sabina Clark — Date of hire: 10/31/2014
   Professional License number: NHA7743 — Expiration date: 07/31/2015
   b. Name of director of nursing: Virginia Ypil — Date of hire: 10/31/1014
   Professional License number: 478124 — Expiration date: 08/31/2015

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)	Shlomo Rechnitz	99.9%	47-1661149	○ Yes ● No	Self
(2)				○ 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: 3966 Marcasel Avenue, LLC
   Address (number & street): 12777 W. Jefferson Blvd, Building D, Suite 3047
   City, State, & Zip: Playa Vista, CA 90066

   Lessee name: Mar Vista-Let, LLC
   Address (number & street): 5900 Wilshire Blvd, Suite 1600
   City, State, & Zip: Los Angeles, CA 90036

   Sub-Lessee name: Mar Vista Country Villa Healthcare & Wellness Centre, LP
   Address (number & street): 3966 Marcasel Ave.
   City, State, & Zip: Los Angeles, CA 90066

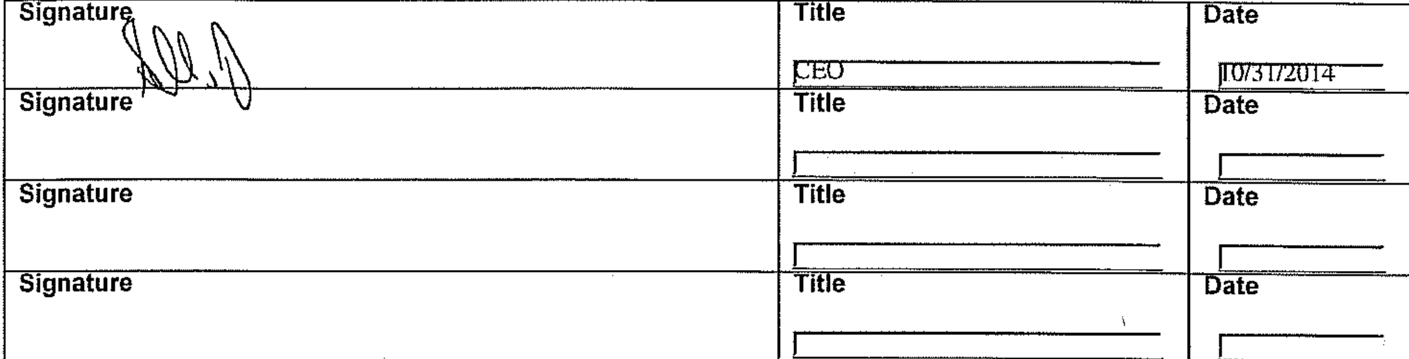
E. MANAGEMENT COMPANY

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
[signature]	CEO	10/31/2014

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.

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: Shlomo Rechnitz

Date of Birth: [redacted]

Business address (number, street, apartment/suite number or letter if applicable): 3966 Marcasel Ave

City, State, & Zip: Los Angeles, CA 90066

Title in relation to this facility: CEO/Member of LP

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.
N/A

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
N/A		

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:	07/2005	Brius, LLC	CEO
To:	Present	5967 W. 3rd Street Suite 200 L.A., CA 90036	
From:	01/1995	Twin Med	CEO
To:	Present	11333 Greenstone Ave. Santa Fe Springs, CA	
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: October 31, 2014

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.

State of California – Health and Human Services Agency

California Department of Public Health
Licensing and Certification

LICENSURE & CERTIFICATION APPLICATION

FOR DEPARTMENTAL USE ONLY	
District: Fresno	ELMS Facility Number: 040000059
Proposed name of facility/agency/clinic:	
North Point Healthcare + Wellness Center, LP	

License # 040000152 App id # 1501008

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: October 31, 2014

3. Amount of fee enclosed: $ 37,399.23

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)

6. a. Do you wish to apply for the Medicare program? (●) Yes ( ) No Medicare Provider #: 555179
   b. Fiscal Intermediary choice: Noridian Healthcare Solutions

7. Do you wish to apply for the Medi-Cal (Medicaid) program? (●) Yes ( ) No

8. a. Current facility bed capacity: 99
   b. Proposed facility bed capacity: 99

9. Age range of clients: 21 and Up

10. Days and hours of operation: 24 hours per day 365 days per year

11. Is construction required? ( ) Yes (●) No
    If "yes", submit copy of "OSHPD" form (see instructions on page 6)
    If "yes", date construction to begin: N/A
    If "yes", date construction to be completed: N/A

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HS 200 (02/08)

B. LICENSEE INFORMATION

1. Licensee name: North Point Healthcare & Wellness Centre, LP

2. Federal employer's tax ID number: 32-0448266

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): 5900 Wilshire Blvd, Suite 1600

Telephone number: (323) 330-6500

City, State, & Zip: Los Angeles, CA 90036

E-Mail: chow@rockporthc.com

Fax number: (866) 603-3566

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: N/A
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:

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:

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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: North Point Healthcare & Wellness Centre, LP
   Current facility, agency, or clinic name (if change of ownership): Northpointe Healthcare Centre
   Facility license number: 040000152

3. Address (number & street) of "proposed" facility, agency, or clinic: 568 E Bullard Ave
   City, State, & Zip: Fresno, CA 93710-5401
   Telephone number: (559) 320-2281

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

5. **Name of person to be in charge of facility, agency, or clinic:** Udayraj Desai
   Title: Administrator
   Professional License number: 7397

6. **a.** Name of administrator: Udayraj Desai — Date of hire: 10/31/2014
   Professional License number: 7397 — Expiration date: 06/30/2016
   b. Name of director of nursing: Nora Valdez Viloria — Date of hire: 10/31/2014
   Professional License number: 680529 — Expiration date: 06/30/2016

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)	Shlomo Rechnitz	99.9	32-0448266	○ Yes ● No	Self
(2)				○ 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.

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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: Bullard Fresno Investments, LLC
Address (number & street): 16145 High Valley, Place
City, State, & Zip: Encino, CA 91436

Lessee name: North Point-Let, LLC
Address (number & street): 5900 Wilshire Blvd, Suite 1600
City, State, & Zip: Los Angeles, CA 90036

Sub-Lessee name: North Point Healthcare & Wellness Centre, LP
Address (number & street): 568 E. Bullard Ave.
City, State, & Zip: Fresno, CA 93710

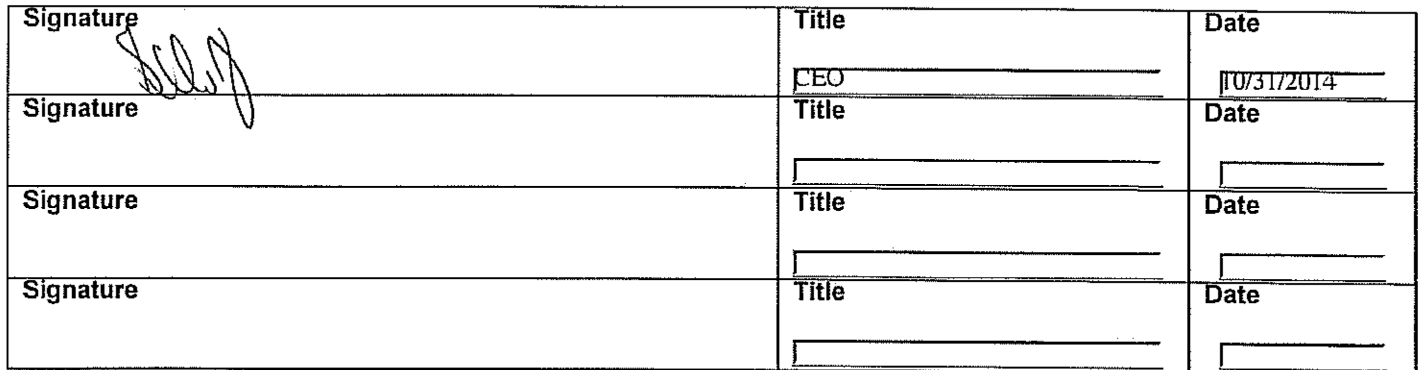
E. MANAGEMENT COMPANY

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
[signature]	CEO	10/31/2014

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, 75082, 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.

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CDPH L&C Program

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
Shlomo Rechnitz

Date of Birth
[redacted]

Business address (number, street, apartment/suite number or letter if applicable)
568 E Bullard Ave

City, State, & Zip
Fresno, CA 93710

Title in relation to this facility
CEO/Member of LP

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.
N/A

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
N/A		

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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:	07/2005	Brius, LLC	CEO
To:	Present	5967 W. 3rd Street Suite 200 L.A., CA 90036	
From:	01/1995	Twin Med	CEO
To:	Present	11333 Greenstone Ave. Santa Fe Springs, CA	
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: October 31, 2014

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.

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Centralized Applications Unit
CDPH L&C Program

State of California – Health and Human Services Agency

California Department of Public Health
Licensing and Certification

LICENSURE & CERTIFICATION APPLICATION

FOR DEPARTMENTAL USE ONLY	
District: San Bernardino	ELMS Facility Number: 240000018
Proposed name of facility/agency/clinic:	
Ontario Grove Healthcare + Wellness Centre, LL	

License #240000113 Appid# 1501027

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: October 31, 2014

3. Amount of fee enclosed: $ 22,288.43

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)

6. a. Do you wish to apply for the Medicare program? ● Yes ◯ No Medicare Provider #: 055693
   b. Fiscal Intermediary choice: Noridian Healthcare Solutions

7. Do you wish to apply for the Medi-Cal (Medicaid) program? ● Yes ◯ No

8. a. Current facility bed capacity: 59
   b. Proposed facility bed capacity: 59

9. Age range of clients: 21 and Up

10. Days and hours of operation: 24 hours per day 365 days per year

11. Is construction required? ◯ Yes ● No
    If "yes", submit copy of "OSHPD" form (see instructions on page 6)
    If "yes", date construction to begin: N/A
    If "yes", date construction to be completed: N/A

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B. LICENSEE INFORMATION

1. Licensee name: Ontario Grove Healthcare & Wellness Centre, LP

2. Federal employer's tax ID number: 47-1673649

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): 5900 Wilshire Blvd, Suite 1600

Telephone number: (323) 330-6500

City, State, & Zip: Los Angeles, CA 90036

E-Mail: chow@rockporthc.com

Fax number: (866) 603-3566

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: N/A

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:

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:

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Centralized Applications Unit

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: Ontario Grove Healthcare & Wellness Centre, LP
   Current facility, agency, or clinic name (if change of ownership): Healthcare Center of Bella Vista
   Facility license number: 240000113

3. Address (number & street) of "proposed" facility, agency, or clinic: 933 E Deodar St
   Telephone number: (909) 985-2731
   City, State, & Zip: Ontario, CA 91764-1309

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

5. **Name of person to be in charge of facility, agency, or clinic:** Michael Harrison
   Title: Administrator
   Professional License number: NHA7840

6. **a.** Name of administrator: Carla Arellano — Date of hire: 10/31/2014
   Professional License number: 7871 — Expiration date: 07/31/2016
   b. Name of director of nursing: Urmila Patel — Date of hire: 10/31/2014
   Professional License number: 438502 — Expiration date: 07/31/2016

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)	Shlomo Rechnitz	99.9%	47-1673649	○ Yes ● No	Self
(2)				○ 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).

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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: Krieger Family Trust
Address (number & street): 300 N. Swall Drive, #168
City, State, & Zip: Beverly Hills, CA 90211

Lessee name: Ontario Grove-Let, LLC
Address (number & street): 5900 Wilshire Blvd, Suite 1600
City, State, & Zip: Los Angeles, CA 90036

Sub-Lessee name: Ontario Grove Healthcare & Wellness Centre, LP
Address (number & street): 933 E. Deodar St.
City, State, & Zip: Ontario, CA 91764

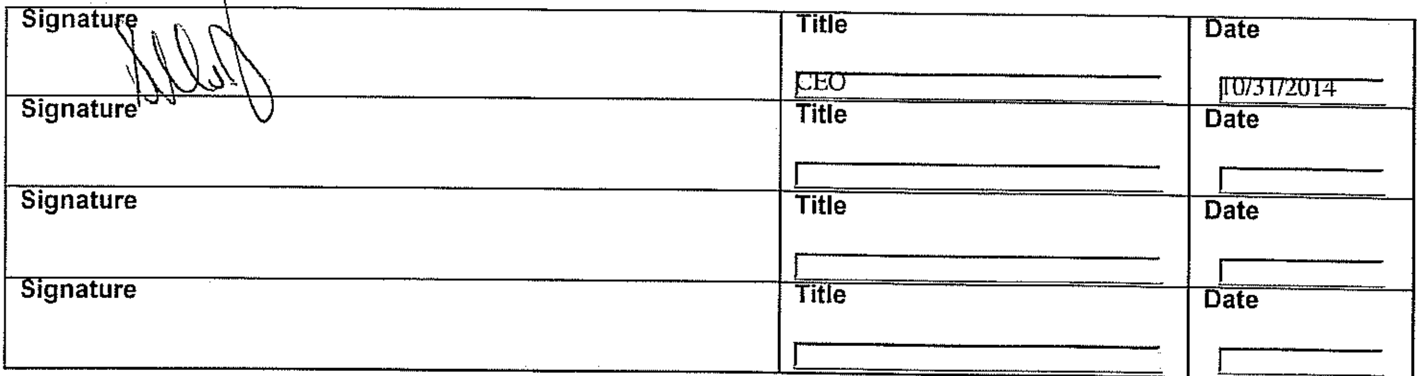
E. MANAGEMENT COMPANY

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
[signature]	CEO	10/31/2014
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.

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
Shlomo Rechnitz

Date of Birth
[redacted]

Business address (number, street, apartment/suite number or letter if applicable)
933 E Deodar St

City, State, & Zip
Ontario, CA 91764

Title in relation to this facility
CEO/Member of LP

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.
N/A

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
N/A		

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: 07/2005 To: Present	Brius, LLC 5967 W. 3rd Street Suite 200 L.A., CA 90036	CEO
From: 01/1995 To: Present	Twin Med 11333 Greenstone Ave. Santa Fe Springs, CA	CEO
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:* October 31, 2014

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.

LICENSURE & CERTIFICATION APPLICATION

LA DO FOR DEPARTMENTAL USE ONLY	
District: West	ELMS Facility Number: 910000027
Proposed name of facility/agency/clinic: OVERLAND TERRACE Healthcare + Wellness Center, LP	

Lic #: 910000122 App ID #: 1200807

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: October 31, 2014

3. Amount of fee enclosed: $ ~~32,865.99~~ – correct amt. JS

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)

6. a. Do you wish to apply for the Medicare program? ● Yes ○ No Medicare Provider #: 055504
   b. Fiscal Intermediary choice: Noridian Healthcare Solutions

7. Do you wish to apply for the Medi-Cal (Medicaid) program? ● Yes ○ No

8. a. Current facility bed capacity: 87
   b. Proposed facility bed capacity: 87

9. Age range of clients: 21 and Up

10. Days and hours of operation: 24 hours per day 365 days per year

11. Is construction required? ○ Yes ● No
    If "yes", submit copy of "OSHPD" form (see instructions on page 6)
    If "yes", date construction to begin: N/A
    If "yes", date construction to be completed: N/A

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B. LICENSEE INFORMATION

1. Licensee name: Overland Terrace Healthcare & Wellness Centre, LP

2. Federal employer's tax ID number: 47-1673730

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): 5900 Wilshire Blvd, Suite 1600
City, State, & Zip: Los Angeles, CA 90036
E-Mail: chow@rockporthc.com
Telephone number: (323) 330-6500
Fax number: (866) 603-3566

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: N/A
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:

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:

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L&C Program

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: Overland Terrace Healthcare & Wellness Centre, LP
   Current facility, agency, or clinic name (if change of ownership): Country Villa South Convalescent Center
   Facility license number: 910000122

3. Address (number & street) of "proposed" facility, agency, or clinic: 3515 Overland Ave
   Telephone number: (310) 839-5201
   City, State, & Zip: Los Angeles, CA 90034

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

5. **Name of person to be in charge of facility, agency, or clinic:** Sonia Joshi
   Title: Administrator
   Professional License number: NHA7839

6. **a.** Name of administrator: Sonia Joshi — Date of hire: 02/02/2015
   Professional License number: 7839 — Expiration date: 04/30/2016
   b. Name of director of nursing: Yalla Max — Date of hire: 06/04/2015
   Professional License number: 463807 — Expiration date: 01/31/2017

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)	Shlomo Rechnitz	99.9%	47-1673730	( ) Yes	(●) No	Self
(2)				( ) 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.

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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: Westover Properties
Address (number & street): 15760 Ventura Blvd, Suite 801
City, State, & Zip: Encino, CA 91436

Lessee name: Overland Terrace-Let, LLC
Address (number & street): 5900 Wilshire Blvd, Suite 1600
City, State, & Zip: Los Angeles, CA 90036

Sub-Lessee name: Overland Terrace Healthcare & Wellness Centre, LP
Address (number & street): 3515 Overland Ave
City, State, & Zip: Los Angeles, CA 90034

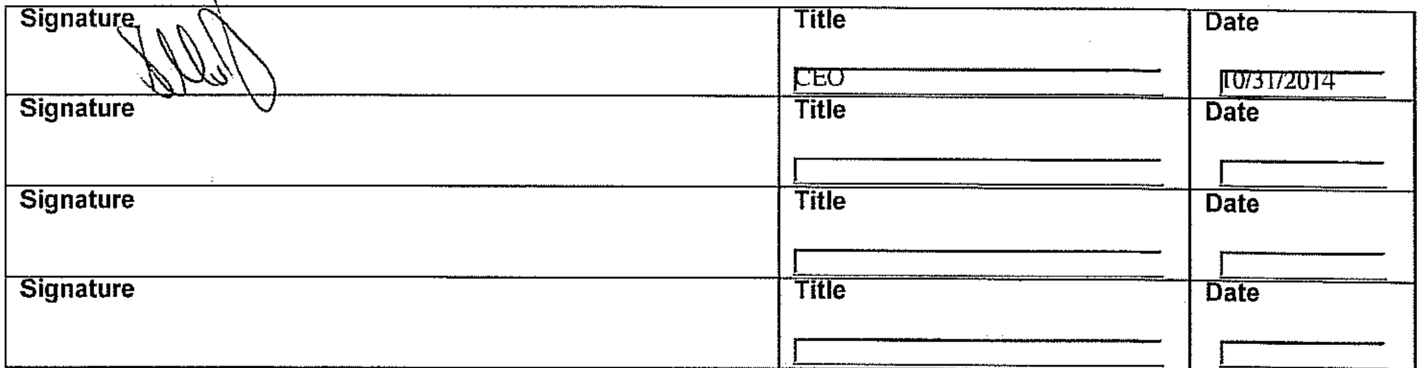
E. MANAGEMENT COMPANY

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
[signature]	CEO	10/31/2014
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.

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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: Shlomo Rechnitz

Date of Birth: [redacted]

Business address (number, street, apartment/suite number or letter if applicable): 3515 Overland Ave

City, State, & Zip: Los Angeles, CA 90034

Title in relation to this facility: CEO/Member of LP

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.

N/A

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
N/A		

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:	07/2005	Brius, LLC	CEO
To:	Present	5967 W. 3rd Street Suite 200 L.A., CA 90036	
From:	01/1995	Twin Med	CEO
To:	Present	11333 Greenstone Ave. Santa Fe Springs, CA	
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:* October 31, 2014

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.

State of California – Health and Human Services Agency

California Department of Public Health
Licensing and Certification

LICENSURE & CERTIFICATION APPLICATION

FOR DEPARTMENTAL USE ONLY	
District: LA-West	ELMS Facility Number: 910000318
Proposed name of facility/agency/clinic: Pavilion on Pico Healthcare + Wellness Centre, LP	

License # 910000145 Appl Id # 150104

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: October 31, 2014

3. Amount of fee enclosed: $ 22,288.43

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)

6. a. Do you wish to apply for the Medicare program? (●) Yes ( ) No Medicare Provider #: 055160
   b. Fiscal Intermediary choice: Noridian Healthcare Solutions

7. Do you wish to apply for the Medi-Cal (Medicaid) program? (●) Yes ( ) No

8. a. Current facility bed capacity: 59
   b. Proposed facility bed capacity: 59

9. Age range of clients: 21 and Up

10. Days and hours of operation: 24 hours per day 365 days per year

11. Is construction required? ( ) Yes (●) No
    If "yes", submit copy of "OSHPD" form (see instructions on page 6)
    If "yes", date construction to begin: N/A
    If "yes", date construction to be completed: N/A

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B. LICENSEE INFORMATION

1. Licensee name: Pavilion on Pico Healthcare & Wellness Centre, LP

2. Federal employer's tax ID number: 47-1668069

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): 5900 Wilshire Blvd, Suite 1600
Telephone number: (323) 330-6500
City, State, & Zip: Los Angeles, CA 90036
E-Mail: Ehow@rockporthc.com
Fax number: (866) 603-3566

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: N/A
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:

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:

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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: Pavilion on Pico Healthcare & Wellness Centre, LP
   Current facility, agency, or clinic name (if change of ownership): Country Villa Pavilion Nursing Center
   Facility license number: 910000145

3. Address (number & street) of "proposed" facility, agency, or clinic: 5916 W Pico Blvd
   Telephone number: (323) 939-3184
   City, State, & Zip: Los Angeles, CA 90035

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

5. **Name of person to be in charge of facility, agency, or clinic:** Mariette Salama
   Title: Administrator
   Professional License number: NHA6748

6. **a.** Name of administrator: Mariette Salama — Date of hire: 02/12/2015
   Professional License number: NHA6748 — Expiration date: 12/31/2015
   b. Name of director of nursing: Demetria R Penera — Date of hire: 10/31/2014
   Professional License number: 500115 — Expiration date: 12/31/2015

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)	Shlomo Rechnitz	99.9%	47-1668069	○ Yes ● No	Self
(2)				○ 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).

RECEIVED
MAR 2 3 2016
Applications Unit

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: Flora Rosman, Trustee of the Rosman Trust U/T/D February 19, 1980
Address (number & street): 716 N. Oakhurst Drive
City, State, & Zip: Beverly Hills, CA 90210

Lessee name: West Pico Terrace-Let, LLC
Address (number & street): 5900 Wilshire Blvd, Suite 1600
City, State, & Zip: Los Angeles, CA 90036

Sub-Lessee name: Pavilion on Pico Healthcare & Wellness Centre, LP
Address (number & street): 5916 W. Pico Blvd
City, State, & Zip: Los Angeles, CA 90035

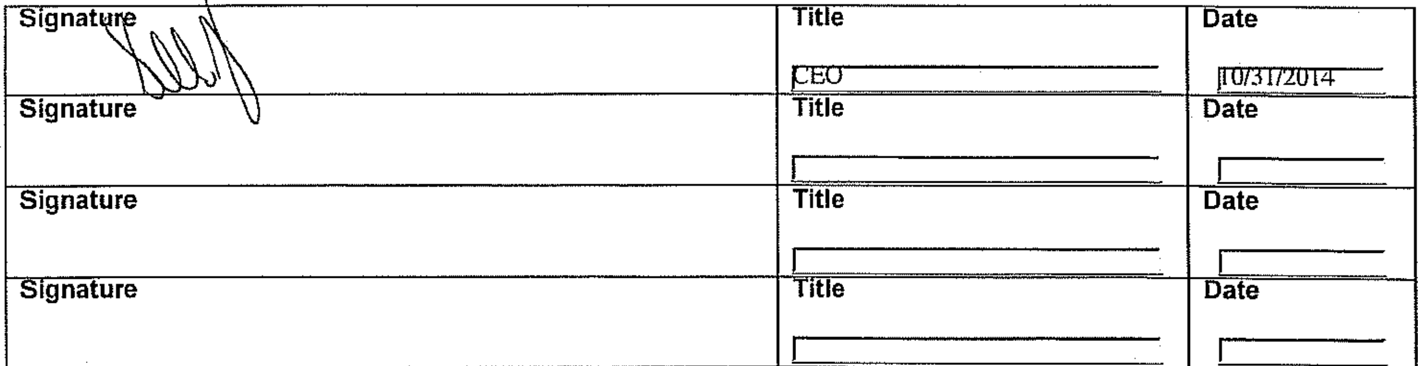
E. MANAGEMENT COMPANY

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 <u>SUBMIT</u> 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
[signature]	CEO	10/31/2014
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.

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: Shlomo Rechnitz

Date of Birth: [redacted]

Business address (number, street, apartment/suite number or letter if applicable): 5916 W Pico Blvd

City, State, & Zip: Los Angeles, CA 90035

Title in relation to this facility: CEO/Member of LP

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.

N/A

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
N/A		

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:	07/2005	Brius, LLC	CEO
To:	Present	5967 W. 3rd Street Suite 200 L.A., CA 90036	
From:	01/1995	Twin Med	CEO
To:	Present	11333 Greenstone Ave. Santa Fe Springs, CA	
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:* October 31, 2014

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.

LICENSURE & CERTIFICATION APPLICATION

FOR DEPARTMENTAL USE ONLY	
District: Orange	ELMS Facility Number: 060000020
Proposed name of facility/agency/clinic:	
Santa Ana Healthcare + Wellness Centre, LP	

License # 060000168

App Id # 15010779

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: October 31, 2014

3. Amount of fee enclosed: $ 54,776.65 –correct amt AF

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)

6. a. Do you wish to apply for the Medicare program? ● Yes ○ No Medicare Provider #: 055206
   b. Fiscal Intermediary choice: Noridian Healthcare Solutions

7. Do you wish to apply for the Medi-Cal (Medicaid) program? ● Yes ○ No

8. a. Current facility bed capacity: 145
   b. Proposed facility bed capacity: 145

9. Age range of clients: 21 and Up

10. Days and hours of operation: 24 hours per day 365 days per year

11. Is construction required? ○ Yes ● No
    If "yes", submit copy of "OSHPD" form (see instructions on page 6)
    If "yes", date construction to begin: N/A
    If "yes", date construction to be completed: N/A

B. LICENSEE INFORMATION

1. Licensee name: Santa Ana Healthcare & Wellness Centre, LP

2. Federal employer's tax ID number: 47-1673805

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): 5900 Wilshire Blvd, Suite 1600
   City, State, & Zip: Los Angeles, CA 90036
   E-Mail: Ehow@rockporthc.com
   Telephone number: (323) 330-6500
   Fax number: (866) 603-3566

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: N/A
   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:

   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: Santa Ana Healthcare & Wellness Centre, LP
   Current facility, agency, or clinic name (if change of ownership): County Villa Plaza Convalescent Center
   Facility license number: 060000168

3. Address (number & street) of "proposed" facility, agency, or clinic: 1209 Hemlock Way
   Telephone number: (714) 546-1966
   City, State, & Zip: Santa Ana, CA 92707

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

5. **Name of person to be in charge of facility, agency, or clinic:** Michael Harrison
   Title: Administrator
   Professional License number: NHA7840

6. **a.** Name of administrator: Michael Harrison — Date of hire: 10/31/2014
   Professional License number: NHA7840 — Expiration date: 04/30/2016
   b. Name of director of nursing: Leticia Edith Silva — Date of hire: 10/31/2014
   Professional License number: 553225 — Expiration date: 10/31/2016

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)	Shlomo Rechnitz	99.9%	47-1673805	○ Yes ● No	Self
(2)				○ 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: Phillip M. Eyring
Address (number & street): 1657 N. California Blvd, Suite 201
City, State, & Zip: Walnut Creek, CA 94596

Lessee name: Santa Ana-Let, LLC
Address (number & street): 5900 Wilshire Blvd, Suite 1600
City, State, & Zip: Los Angeles, CA 90036

Sub-Lessee name: Santa Ana Healthcare & Wellness Centre, LP
Address (number & street): 1209 Hemlock Way
City, State, & Zip: Santa Ana, CA 92707

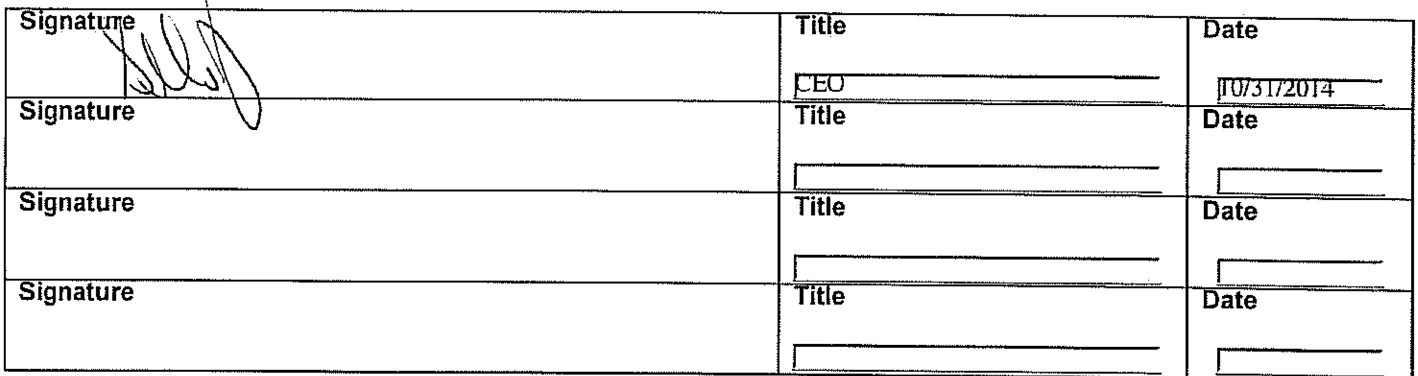
E. MANAGEMENT COMPANY

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 <u>SUBMIT</u> 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
[signature]	CEO	10/31/2014
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.

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: Shlomo Rechnitz

Date of Birth: [redacted]

Business address (number, street, apartment/suite number or letter if applicable): 1209 Hemlock Way

City, State, & Zip: Santa Ana, CA 92707

Title in relation to this facility: CEO/Member of LP

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.

N/A

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
N/A		

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.

	Dates	Name and address of employer	Job title
From:	07/2005	Brius, LLC	CEO
To:	Present	5967 W. 3rd Street Suite 200 L.A., CA 90036	
From:	01/1995	Twin Med	CEO
To:	Present	11333 Greenstone Ave. Santa Fe Springs, CA	
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).**

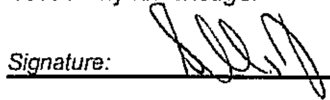
F. Adverse Actions

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:* October 31, 2014

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.

State of California – Health and Human Services Agency

California Department of Public Health
Licensing and Certification

LICENSURE & CERTIFICATION APPLICATION

LA DO FOR DEPARTMENTAL USE ONLY	
District: West	ELMS Facility Number: 970000137
Proposed name of facility/agency/clinic: The Rehabilitation Center of Los Angeles	

Lic #: 970000068 App ID #: 1501027

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: October 31, 2014

3. Amount of fee enclosed: $ 67,998.60 – correct amt.

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)

6. a. Do you wish to apply for the Medicare program? ● Yes ○ No Medicare Provider #: 555397
   b. Fiscal Intermediary choice: Noridian Healthcare Solutions

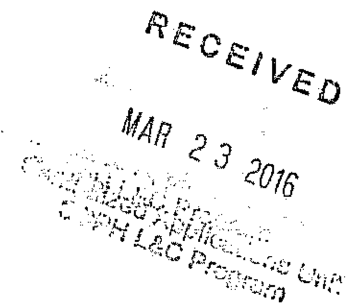
7. Do you wish to apply for the Medi-Cal (Medicaid) program? ● Yes ○ No

8. a. Current facility bed capacity: 180
   b. Proposed facility bed capacity: 180

9. Age range of clients: 21 and Up

10. Days and hours of operation: 24 hours per day 365 days per year

11. Is construction required? ○ Yes ● No
    If "yes", submit copy of "OSHPD" form (see instructions on page 6)
    If "yes", date construction to begin: N/A
    If "yes", date construction to be completed: N/A



B. LICENSEE INFORMATION

1. Licensee name: Los Angeles Rehabilitation & Wellness Centre, LP

2. Federal employer's tax ID number: 47-1615133

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): 5900 Wilshire Blvd. Suite 1600
Telephone number: (323) 330-6500
City, State, & Zip: Los Angeles, CA 90036
E-Mail: chow@pursuehealthllc.com
Fax number: (866) 603-3566

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: N/A
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:

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.

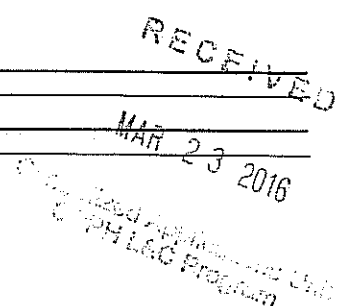
6. Is the licensee a **subsidiary** of another organization? ◯ Yes ● No
If "yes", complete the information below and ***submit*** an organizational chart:

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: The Rehabilitation Center of Los Angeles
   Current facility, agency, or clinic name (if change of ownership): Country Villa Rehabilitation Center
   Facility license number: 970000068

3. Address (number & street) of "proposed" facility, agency, or clinic: 340 S Alvarado St
   Telephone number: (213) 484-9730
   City, State, & Zip: Los Angeles, CA 90057

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

5. **Name of person to be in charge of facility, agency, or clinic:** Barry Gans
   Title: Administrator
   Professional License number: 7428

6. **a.** Name of administrator: Barry Gans
   Date of hire: 02/09/2015
   Professional License number: 7428
   Expiration date: 09/30/2016

   b. Name of director of nursing: Myra Francisco
   Date of hire: 02/09/2015
   Professional License number: 534949
   Expiration date: 07/31/2017

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)	Shlomo Rechnitz	93.9	47-1615133	◯ Yes ● No	Self
(2)	Jose Lynch	6%	47-1615133	◯ Yes ● No	Self
(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.

MAR 2 3 2016

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: 340 S. Alvarado, Inc.
   Address (number & street): 12777 W. Jefferson Blvd, Building D, Suite 3047
   City, State, & Zip: Playa Vista, CA 90066

   Lessee name: Los Angeles-Let, LLC
   Address (number & street): 5900 Wilshire Blvd, Suite 1600
   City, State, & Zip: Los Angeles, CA 90036

   Sub-Lessee name: Los Angeles Rehabilitation & Wellness Centre, LP
   Address (number & street): 340 S. Alvarado St.
   City, State, & Zip: Los Angeles, CA 90057

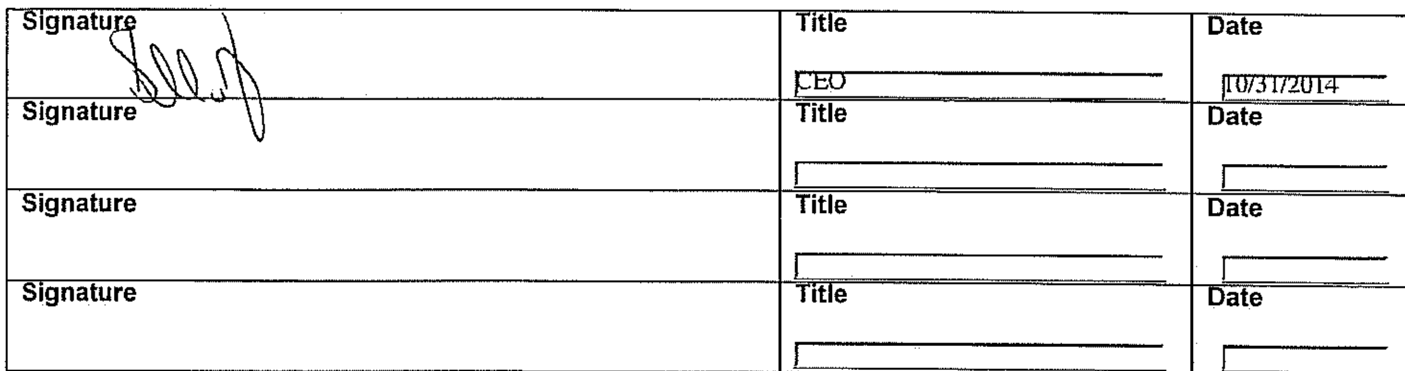
E. MANAGEMENT COMPANY

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
[signature]	CEO	10/31/2014

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.

RECEI...

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.

MAR 23 2015

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
Shlomo Rechnitz

Date of Birth
[redacted]

Business address (number, street, apartment/suite number or letter if applicable)
840 S Alvarado St

City, State, & Zip
Los Angeles, CA 90057

Title in relation to this facility
CEO/Member of LP

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.
N/A

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
N/A		

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.

	Dates	Name and address of employer	Job title
From:	07/2005	Brius, LLC	CEO
To:	Present	5967 W. 3rd Street Suite 200 L.A., CA 90036	
From:	01/1995	Twin Med	CEO
To:	Present	11333 Greenstone Ave. Santa Fe Springs, CA	
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).**

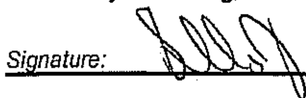
F. Adverse Actions

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: October 31, 2014

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.

LICENSURE & CERTIFICATION APPLICATION

LA D.O. – FOR DEPARTMENTAL USE ONLY	
District: North	ELMS Facility Number: 920000089
Proposed name of facility/agency/clinic: The Rehabilitation Center of North Hills	

Lic #: 920000065 App ID #: 1500860

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: October 31, 2014

3. Amount of fee enclosed: $ 52,132.26 – correct amt. JS

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)

6. a. Do you wish to apply for the Medicare program? (●) Yes ( ) No Medicare Provider #: 056367
   b. Fiscal Intermediary choice: Noridian Healthcare Solutions

7. Do you wish to apply for the Medi-Cal (Medicaid) program? (●) Yes ( ) No

8. a. Current facility bed capacity: 138
   b. Proposed facility bed capacity: 138

9. Age range of clients: 21 and Up

10. Days and hours of operation: 24 hours per day 365 days per year

11. Is construction required? ( ) Yes (●) No
    If "yes", submit copy of "OSHPD" form (see instructions on page 6)
    If "yes", date construction to begin: N/A
    If "yes", date construction to be completed: N/A

RECEIVED
MAR 23 2016
Centralized Applications Unit
CDPH L&C Program

B. LICENSEE INFORMATION

1. Licensee name: North Hills Healthcare & Wellness Centre, LP

2. Federal employer's tax ID number: 47-1581232

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): 5900 Wilshire Blvd., Suite 1600
Telephone number: (323) 330-6500
City, State, & Zip: Los Angeles, CA 90036
E-Mail: chow@pursuehealthllc.com
Fax number: (866) 603-3566

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: N/A
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:

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.

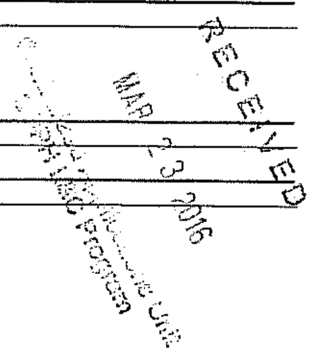
6. Is the licensee a **subsidiary** of another organization? ◯ Yes ● No
If "yes", complete the information below and ***submit*** an organizational chart:

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: The Rehabilitation Center of North Hills
   Current facility, agency, or clinic name (if change of ownership): Country Villa Sheraton Nursing & Rehab Center
   Facility license number: 920000065

3. Address (number & street) of "proposed" facility, agency, or clinic: 9655 Sepulveda Blvd
   Telephone number: (818) 892-8665
   City, State, & Zip: North Hills, CA 91343

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

5. **Name of person to be in charge of facility, agency, or clinic:** Julio Cruz
   Title: Administrator
   Professional License number: 7298

6. **a.** Name of administrator: Julio Cruz — Date of hire: 04/27/2015
   Professional License number: 7298 — Expiration date: 07/31/2017
   b. Name of director of nursing: Flor Pascual — Date of hire: 01/19/2015
   Professional License number: 667922 — Expiration date: 11/30/2015

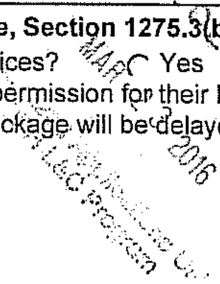
7. List persons having **5 percent** or more direct or indirect (42 CFR, Section 455.102) interest in the ownership of this facility if applying for skilled nursing or intermediate care licensure, and **10 percent** for all other facilities, agencies, or clinics. Provide federal employer's tax ID number. 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)	Shlomo Rechnitz	93.9%	47-1581232	○ Yes ● No	Self
(2)	Jose Lynch	6%	47-1581232	○ Yes ○ No	Self
(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: Sheraton Convalescent Home
   Address (number & street): 5150 Overland Avenue
   City, State, & Zip: Culver City, CA 90230

   Lessee name: North Hills-Let, LLC
   Address (number & street): 5900 Wilshire Blvd, Suite 1600
   City, State, & Zip: Los Angeles, CA 90036

   Sub-Lessee name: North Hills Healthcare & Wellness Centre, LP
   Address (number & street): 9655 Sepulveda Blvd.
   City, State, & Zip: Los Angeles, CA 91343

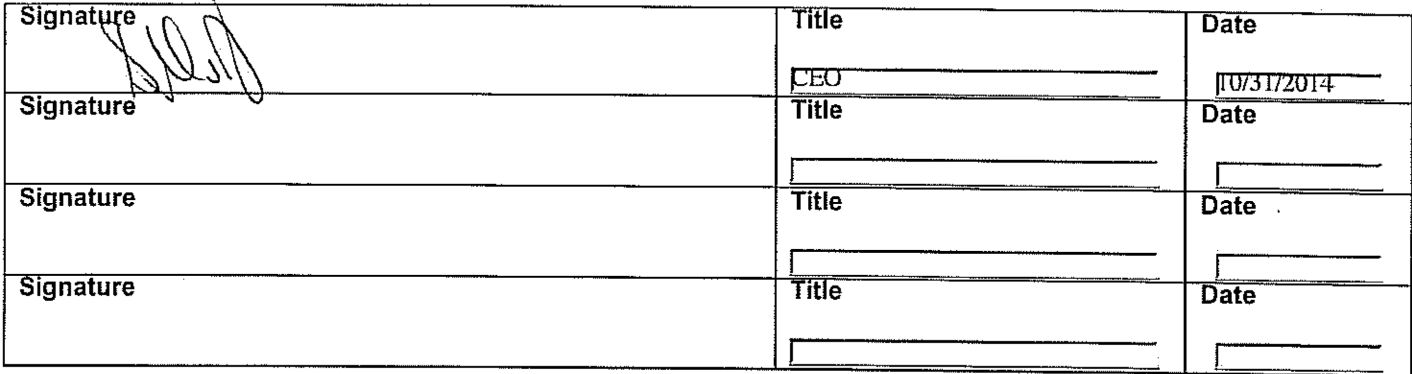
E. MANAGEMENT COMPANY

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 <u>SUBMIT</u> 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
[signature]	CEO	10/31/2014
Signature	Title	Date
Signature	Title	Date
Signature	Title	Date

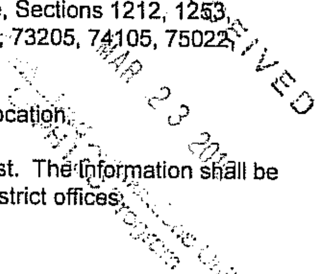
Release of Information Statement

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.



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: Shlomo Rechnitz

Date of Birth: [redacted]

Business address (number, street, apartment/suite number or letter if applicable): 9655 Sepulveda Blvd

City, State, & Zip: North Hills, CA 91343

Title in relation to this facility: CEO/Member of LP

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.
N/A

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
N/A		

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:	07/2005	Brius, LLC	CEO
To:	Present	5967 W. 3rd Street Suite 200 L.A., CA 90036	
From:	01/1995	Twin Med	CEO
To:	Present	11333 Greenstone Ave. Santa Fe Springs, CA	
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:* October 31, 2014

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.

State of California – Health and Human Services Agency

California Department of Public Health
Licensing and Certification

LICENSURE & CERTIFICATION APPLICATION

LA DO – FOR DEPARTMENTAL USE ONLY	
District: West	ELMS Facility Number: 910000332
Proposed name of facility/agency/clinic: The Rehabilitation Center of Pico	

Lic #: 910000152 App ID#: 1500892

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: October 31, 2014

3. Amount of fee enclosed: $ 37,399.23 – correct amt. 98

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)

6. a. Do you wish to apply for the Medicare program? ● Yes ○ No Medicare Provider #: 056377
   b. Fiscal Intermediary choice: Noridian Healthcare Solutions

7. Do you wish to apply for the Medi-Cal (Medicaid) program? ● Yes ○ No

8. a. Current facility bed capacity: 99
   b. Proposed facility bed capacity: 99

9. Age range of clients: 21 and Up

10. Days and hours of operation: 24 hours per day 365 days per year

11. Is construction required? ○ Yes ● No
    If "yes", submit copy of "OSHPD" form (see instructions on page 6)
    If "yes", date construction to begin: N/A
    If "yes", date construction to be completed: N/A

MAR 23 2016
CDPH L&C Program

B. LICENSEE INFORMATION

1. Licensee name: North Palms Rehabilitation & Wellness Centre, LP

2. Federal employer's tax ID number: 47-1634312

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): 5900 Wilshire Blvd., Suite 1600

Telephone number: (323) 330-6500

City, State, & Zip: Los Angeles, CA 90036

E-Mail: ehow@pursuehealthllc.com

Fax number: (866) 603-3566

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: N/A

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:

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:

RECEIVED

MAR 23 2016

Centralized Applications Unit
CDPH L&C Program

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: The Rehabilitation Center on Pico
   Current facility, agency, or clinic name (if change of ownership): Country Villa North Convalescent Center
   Facility license number: 910000152

3. Address (number & street) of "proposed" facility, agency, or clinic: 3233 W Pico Blvd
   Telephone number: (323) 734-9122
   City, State, & Zip: Los Angeles, CA 90019

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

5. **Name of person to be in charge of facility, agency, or clinic:** Eric McClellan
   Title: Administrator
   Professional License number: 7390

6. **a.** Name of administrator: Eric McClellan — Date of hire: 04/06/2015
   Professional License number: 7390 — Expiration date: 05/31/2016

   b. Name of director of nursing: Sharmaine Felina Zamora — Date of hire: 10/31/2014
   Professional License number: 735974 — Expiration date: 04/30/2016

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)	Shlomo Rechnitz	93.9%	47-1634312	◯ Yes ● No	Self
(2)	Jose Lynch	6%	47-1634312	◯ Yes ● No	Self
(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.

RECEIVED MAR 2016 Centralized Applications Unit CDPH L&C Program

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: 3233 West Pico Boulevard, LLC
   Address (number & street): 12777 W. Jefferson Blvd, Building D, Suite 3047
   City, State, & Zip: Playa Vista, CA 90066

   Lessee name: North Palms-Let, LLC
   Address (number & street): 5900 Wilshire Blvd, Suite 1600
   City, State, & Zip: Los Angeles, CA 90036

   Sub-Lessee name: North Palms Rehabilitation & Wellness Centre, LP
   Address (number & street): 3233 W. Pico Blvd
   City, State, & Zip: Los Angeles, CA 90019

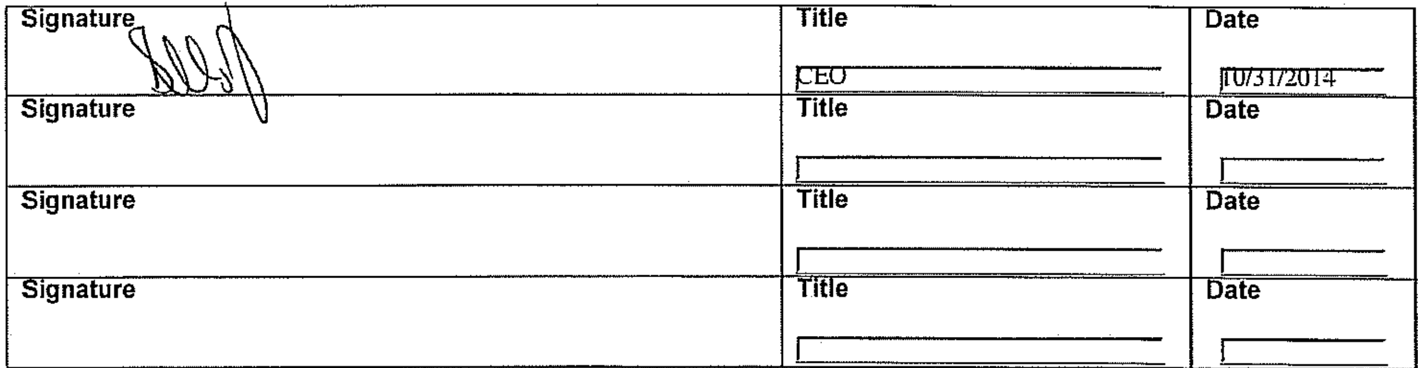
E. MANAGEMENT COMPANY

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
[signature]	CEO	10/31/2014

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.

MAR 23 2016

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.

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: Shlomo Rechnitz

Date of Birth: [redacted]

Business address (number, street, apartment/suite number or letter if applicable): 3233 W Pico Blvd

City, State, & Zip: Los Angeles, CA 90019

Title in relation to this facility: CEO/Member of LP

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.

N/A

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
N/A		

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.

	Dates	Name and address of employer	Job title
From:	07/2005	Brius, LLC	CEO
To:	Present	5967 W. 3rd Street Suite 200 L.A., CA 90036	
From:	01/1995	Twin Med	CEO
To:	Present	11333 Greenstone Ave. Santa Fe Springs, CA	
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).**

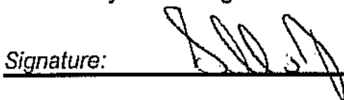
F. Adverse Actions

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: October 31, 2014

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.

LICENSURE & CERTIFICATION APPLICATION

LA DO- FOR DEPARTMENTAL USE ONLY	
District: West	ELMS Facility Number: 910000326
Proposed name of facility/agency/clinic: West Hollywood Healthcare + Wellness Centre, LP	

LIC #: 910000149 App ID#: 1501422

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: October 31, 2014

3. Amount of fee enclosed: $ 30,599.37 – correct amt. JS

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)

6. a. Do you wish to apply for the Medicare program? (●) Yes ( ) No Medicare Provider #: 055710
   b. Fiscal Intermediary choice: Noridian Healthcare Solutions

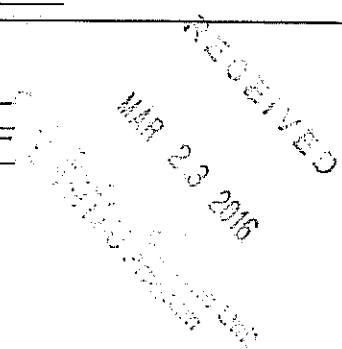
7. Do you wish to apply for the Medi-Cal (Medicaid) program? (●) Yes ( ) No

8. a. Current facility bed capacity: 81
   b. Proposed facility bed capacity: 81

9. Age range of clients: 21 and Up

10. Days and hours of operation: 24 hours per day 365 days per year

11. Is construction required? ( ) Yes (●) No
    If "yes", submit copy of "OSHPD" form (see instructions on page 6)
    If "yes", date construction to begin: N/A
    If "yes", date construction to be completed: N/A



B. LICENSEE INFORMATION

1. Licensee name: West Hollywood Healthcare & Wellness Centre, LP

2. Federal employer's tax ID number: 47-1707940

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): 5900 Wilshire Blvd, Suite 1600
Telephone number: (323) 330-6500
City, State, & Zip: Los Angeles, CA 90036
E-Mail: chow@rockporthc.com
Fax number: (866) 603-3566

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: N/A
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:

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.

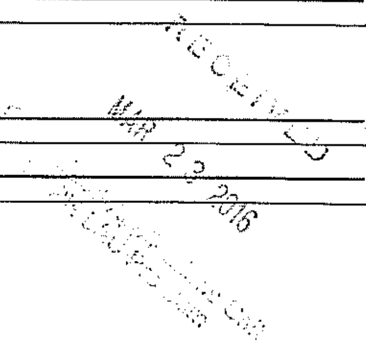
6. Is the licensee a **subsidiary** of another organization? ◯ Yes ◉ No
If "yes", complete the information below and ***submit*** an organizational chart:

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: West Hollywood Healthcare & Wellness Centre, LP
   Current facility, agency, or clinic name (if change of ownership): Country Villa Wilshire Convalescent Center
   Facility license number: 910000149

3. Address (number & street) of "proposed" facility, agency, or clinic: 855 N Fairfax Ave
   City, State, & Zip: Los Angeles, CA 90046
   Telephone number: (323) 653-1521

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

5. **Name of person to be in charge of facility, agency, or clinic:** Avraham Saada
   Title: Administrator
   Professional License number: 7819

6. **a.** Name of administrator: Avraham Saada — Date of hire: 02/26/2015
   Professional License number: 7819 — Expiration date: 02/29/2016
   b. Name of director of nursing: David Angoma — Date of hire: 02/26/2015
   Professional License number: 756267 — Expiration date: 10/31/2016

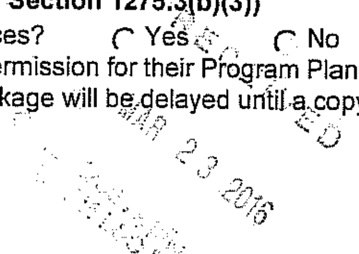
7. List persons having **5 percent** or more direct or indirect (42 CFR, Section 455.102) interest in the ownership of this facility if applying for skilled nursing or intermediate care licensure, and **10 percent** for all other facilities, agencies, or clinics. Provide federal employer's tax ID number. 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)	Shlomo Rechnitz	99.9%	47-1707940	○ Yes ● No	Self
(2)				○ 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: 855 North Fairfax Avenue, LLC
Address (number & street): 12777 W. Jefferson Blvd, Building D, Suite 3047
City, State, & Zip: Playa Vista, CA 90066

Lessee name: West Hollywood-Lct, LLC
Address (number & street): 5900 Wilshire Blvd, Suite 1600
City, State, & Zip: Los Angeles, CA 90036

Sub-Lessee name: West Hollywood Healthcare & Wellness Centre, LP
Address (number & street): 855 N . Fairfax Ave.
City, State, & Zip: Los Angeles, CA 90046

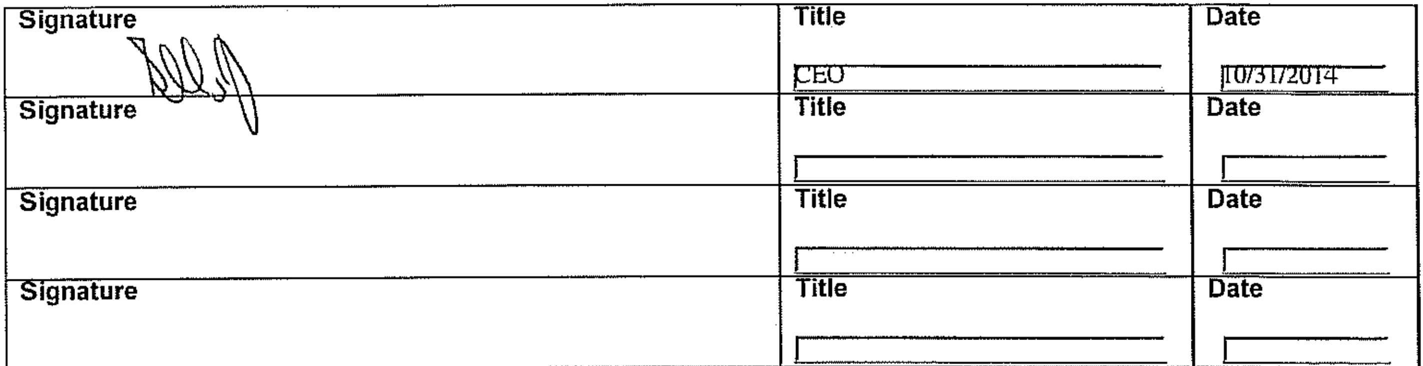
E. MANAGEMENT COMPANY

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
Signature	**Title** CEO	**Date** 10/31/2014
Signature	**Title**	**Date**
Signature	**Title**	**Date**
Signature	**Title**	**Date**

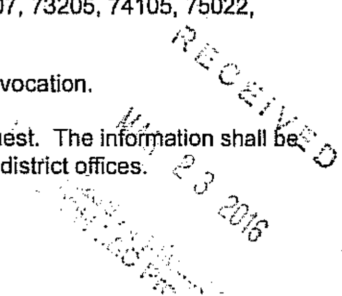
Release of Information Statement

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.



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
Shlomo Rechnitz

Date of Birth
[redacted]

Business address (number, street, apartment/suite number or letter if applicable)
855 N Farifax Ave

City, State, & Zip
Los Angeles, CA 90046

Title in relation to this facility
CEO/Member of LP

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.
N/A

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
N/A		

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:	07/2005	Brius, LLC	CEO
To:	Present	5967 W. 3rd Street Suite 200 L.A., CA 90036	
From:	01/1995	Twin Med	CEO
To:	Present	11333 Greenstone Ave. Santa Fe Springs, CA	
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).**

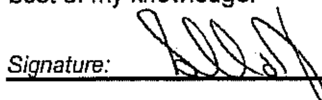
F. Adverse Actions

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: October 31, 2014

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.

LICENSURE & CERTIFICATION APPLICATION

LA DO- FOR DEPARTMENTAL USE ONLY	
District: West	ELMS Facility Number: 910000316
Proposed name of facility/agency/clinic: West Pico Terrace Healthcare + Wellness Centre, LP	

Lic#: 910000144 App ID#: 1501183

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: October 31, 2014

3. Amount of fee enclosed: $ 18,510.73 – correct amt. JS

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)

6. a. Do you wish to apply for the Medicare program? (●) Yes ( ) No Medicare Provider #: 055119
   b. Fiscal Intermediary choice: Noridian Healthcare Solutions

7. Do you wish to apply for the Medi-Cal (Medicaid) program? (●) Yes ( ) No

8. a. Current facility bed capacity: 49
   b. Proposed facility bed capacity: 49

9. Age range of clients: 21 and Up

10. Days and hours of operation: 24 hours per day 365 days per year

11. Is construction required? ( ) Yes (●) No
    If "yes", submit copy of "OSHPD" form (see instructions on page 6)
    If "yes", date construction to begin: N/A
    If "yes", date construction to be completed: N/A

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MAR 23 2016

B. LICENSEE INFORMATION

1. Licensee name: West Pico Terrace Healthcare & Wellness Centre, LP

2. Federal employer's tax ID number: 47-1705912

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): 5900 Wilshire Blvd, Suite 1600
Telephone number: (323) 330-6500
City, State, & Zip: Los Angeles, CA 90036
E-Mail: chow@rockporthc.com
Fax number: (866) 603-3566

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: N/A
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:

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:

RECEIVED
MAR 23 2016
LAG Program

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: West Pico Terrace Healthcare & Wellness Centre, LP
   Current facility, agency, or clinic name (if change of ownership): Country Villa Terrace Nursing Center
   Facility license number: 910000144

3. Address (number & street) of "proposed" facility, agency, or clinic: 6070 W Pico Blvd
   Telephone number: (323) 653-3980
   City, State, & Zip: Los Angeles, CA 90035

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

5. **Name of person to be in charge of facility, agency, or clinic:** Mariette Salama
   Title: Administrator
   Professional License number: NHA6748

6. **a.** Name of administrator: Mariette Salama — Date of hire: 02/12/2015
   Professional License number: NHA6748 — Expiration date: 12/31/2015
   b. Name of director of nursing: Dina Alpuerto — Date of hire: 10/31/2014
   Professional License number: 500763 — Expiration date: 01/31/2016

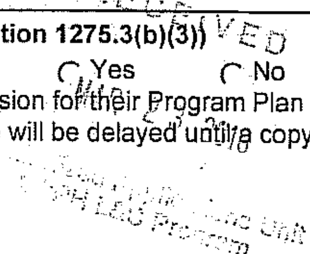
7. List persons having **5 percent** or more direct or indirect (42 CFR, Section 455.102) interest in the ownership of this facility if applying for skilled nursing or intermediate care licensure, and **10 percent** for all other facilities, agencies, or clinics. Provide federal employer's tax ID number. 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)	Shlomo Rechnitz	99.9%	47-1705912	○ Yes	● No	Self
(2)				○ 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: Flora Rosman, Trustee of the Rosman Trust U/T/D February 19, 1980
Address (number & street): 716 N. Oakhurst Drive
City, State, & Zip: Beverly Hills, CA 90210

Lessee name: West Pico Terrace-Let, LLC
Address (number & street): 5900 Wilshire Blvd, Suite 1600
City, State, & Zip: Los Angeles, CA 90036

Sub-Lessee name: West Pico Terrace Healthcare & Wellness Centre, LP
Address (number & street): 6070 West Pico Blvd
City, State, & Zip: Los Angeles, CA 90035

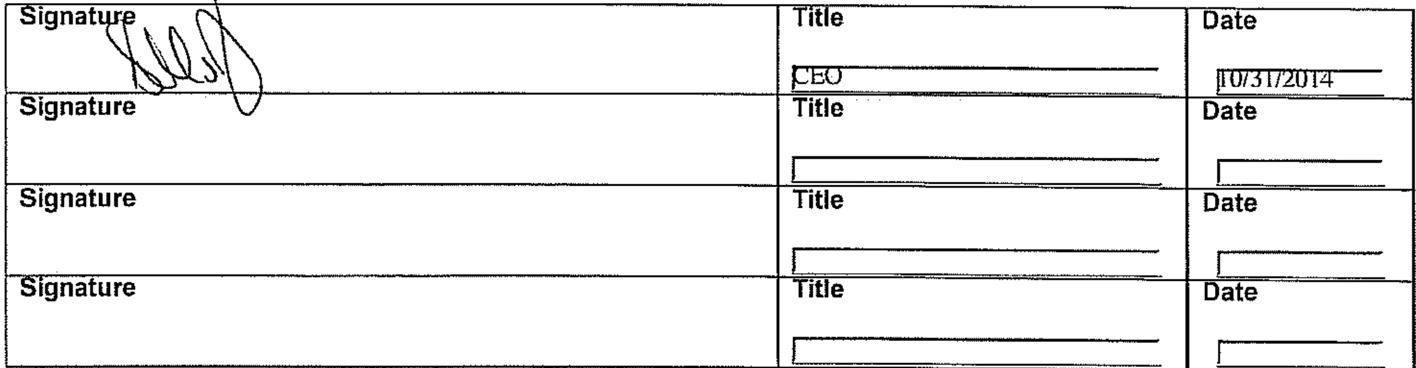
E. MANAGEMENT COMPANY

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 <u>SUBMIT</u> 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
Signature [signed]	Title: CEO	Date: 10/31/2014
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.

RECEIVED MAR 23

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: Shlomo Rechnitz

Date of Birth: [redacted]

Business address (number, street, apartment/suite number or letter if applicable): 6070 W Pico Blvd

City, State, & Zip: Los Angeles, CA 90035

Title in relation to this facility: CEO/Member of LP

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.

N/A

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
N/A		

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.

	Dates	Name and address of employer	Job title
From:	07/2005	Brius, LLC	CEO
To:	Present	5967 W. 3rd Street Suite 200 L.A., CA 90036	
From:	01/1995	Twin Med	CEO
To:	Present	11333 Greenstone Ave. Santa Fe Springs, CA	
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).**

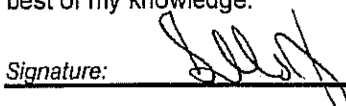
F. Adverse Actions

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:* October 31, 2014

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.

LICENSURE & CERTIFICATION APPLICATION

LA DO – FOR DEPARTMENTAL USE ONLY	
District: West	ELMS Facility Number: 910000028
Proposed name of facility/agency/clinic: Westwood Post Acute Care	

Lic #: 910000123 App ID #: 1501040

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: October 31, 2014

3. Amount of fee enclosed: $ 35,132.61 – correct amt. JJ

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)

6. a. Do you wish to apply for the Medicare program? ● Yes ○ No Medicare Provider #: 055060
   b. Fiscal Intermediary choice: Noridian Healthcare Solutions

7. Do you wish to apply for the Medi-Cal (Medicaid) program? ● Yes ○ No

8. a. Current facility bed capacity: 93
   b. Proposed facility bed capacity: 93

9. Age range of clients: 21 and Up

10. Days and hours of operation: 24 hours per day 365 days per year

11. Is construction required? ○ Yes ● No
    If "yes", submit copy of "OSHPD" form (see instructions on page 6)
    If "yes", date construction to begin: N/A
    If "yes", date construction to be completed: N/A

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MAR 23 2016
Centralized Applications Unit
CDPH L&C Program

B. LICENSEE INFORMATION

1. Licensee name: Westwood Healthcare & Wellness Centre, LP

2. Federal employer's tax ID number: 47-1671687

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): 5900 Wilshire Bvd., Suite 1600
Telephone number: (323) 330-6500
City, State, & Zip: Los Angeles, CA 90036
E-Mail: ehow@pursuehealthllc.com
Fax number: (866) 603-3566

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: N/A
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:

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.

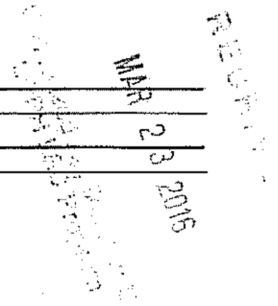
6. Is the licensee a **subsidiary** of another organization? ( ) Yes (●) No
If "yes", complete the information below and ***submit*** an organizational chart:

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: Westwood Post Acute Care
   Current facility, agency, or clinic name (if change of ownership): Country Villa Westwood Convalescent Center
   Facility license number: 910000123

3. Address (number & street) of "proposed" facility, agency, or clinic: 12121 Santa Monica Blvd
   Telephone number: (310) 826-0821
   City, State, & Zip: Los Angeles, CA 90025

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

5. **Name of person to be in charge of facility, agency, or clinic:** Fernando C. Camacho II
   Title: Administrator
   Professional License number: 7440

6. **a.** Name of administrator: Louis Florin — Date of hire: 01/04/2016
   Professional License number: 7818 — Expiration date: 01/31/2018
   b. Name of director of nursing: Diane Cabaler — Date of hire: 12/27/2014
   Professional License number: 742728 — Expiration date: 12/31/2016

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)	Shlomo Rechnitz	93.9%	47-1671687	○ Yes ● No	Self
(2)	Jose Lynch	6%	47-1671687	○ Yes ● No	Self
(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.

RECEIVED MAR 23 2016

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: 12121 Santa Monica Blvd, LLC
Address (number & street): 12777 W. Jefferson Blvd, Building D, Suite 3047
City, State, & Zip: Playa Vista, CA 90066

Lessee name: Westwood-Let, LLC
Address (number & street): 5900 Wilshire Blvd, Suite 1600
City, State, & Zip: Los Angeles, CA 90036

Sub-Lessee name: Westwood Healthcare & Wellness Centre, LP
Address (number & street): 12121 Santa Monica Blvd
City, State, & Zip: Los Angeles, CA 90025

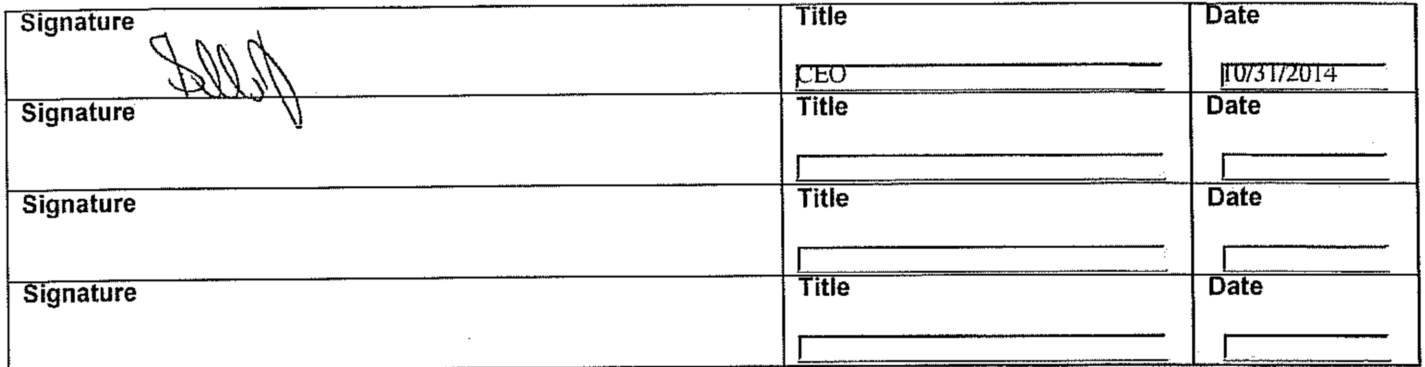
E. MANAGEMENT COMPANY

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.



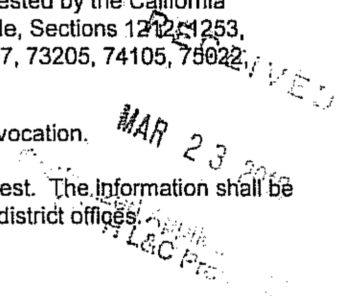
Signature	Title	Date
[signature]	CEO	10/31/2014

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.

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: Shlomo Rechnitz

Date of Birth: [redacted]

Business address (number, street, apartment/suite number or letter if applicable): 12121 Santa Monica Blvd

City, State, & Zip: Los Angeles, CA 90025

Title in relation to this facility: CEO/Member of LP

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.

N/A

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
N/A		

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: 07/2005 To: Present	Brius, LLC 5967 W. 3rd Street Suite 200 L.A., CA 90036	CEO
From: 01/1995 To: Present	Twin Med 11333 Greenstone Ave. Santa Fe Springs, CA	CEO
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).**

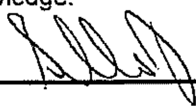
F. Adverse Actions

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:* October 31, 2014

RELEASE OF INFORMATION STATEMENT

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State of California – Health and Human Services Agency

California Department of Public Health
Licensing and Certification

LICENSURE & CERTIFICATION APPLICATION

FOR DEPARTMENTAL USE ONLY	
District: Chico	ELMS Facility Number: 230000029
Proposed name of facility/agency/clinic: Chico Heights Rehabilitation + Wellness Centre, LP	

LIC #: 230000046

App ID #: 1390707

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: December 1, 2014

3. Amount of fee enclosed: $ 57,408.00 – Correct amt. JS

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)

6. a. Do you wish to apply for the Medicare program? (●) Yes ( ) No Medicare Provider #: 056074
   b. Fiscal Intermediary choice: Noridian Healthcare Solutions

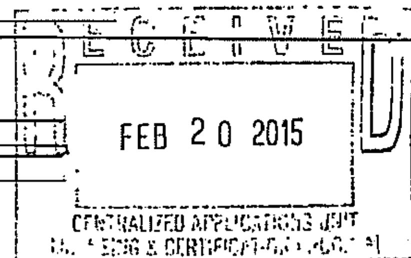
7. Do you wish to apply for the Medi-Cal (Medicaid) program? (●) Yes ( ) No

8. a. Current facility bed capacity: 184
   b. Proposed facility bed capacity: 184

9. Age range of clients: 21 and Up

10. Days and hours of operation: 24 hours per day 365 days per year

11. Is construction required? ( ) Yes (●) No
    If "yes", submit copy of "OSHPD" form (see instructions on page 6)
    If "yes", date construction to begin: N/A
    If "yes", date construction to be completed: N/A



HS 200 (02/08)

B. LICENSEE INFORMATION

1. Licensee name: Chico Heights Rehabilitation & Wellness Centre, LP

2. Federal employer's tax ID number: 47-1446528

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): 5900 Wilshire Blvd, Suite 1600

Telephone number: (323) 330-6500

City, State, & Zip: Los Angeles, CA 90036

E-Mail: chow@rockporthc.com

Fax number: (866) 603-3566

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: N/A
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:

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.

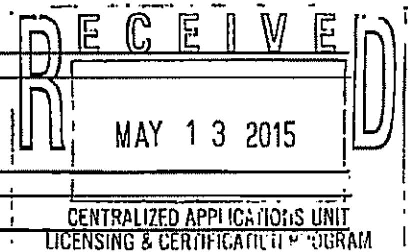
6. Is the licensee a **subsidiary** of another organization? ○ Yes ● No
If "yes", complete the information below and ***submit*** an organizational chart:

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: Chico Heights Rehabilitation & Wellness Centre, LP
   Current facility, agency, or clinic name (if change of ownership): Windsor Chico Creek Care and Rehabilitation Center
   Facility license number: 230000046

3. Address (number & street) of "proposed" facility, agency, or clinic: 587 Rio Lindo Ave
   Telephone number: (530) 345-1306
   City, State, & Zip: Chico, CA 95926

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

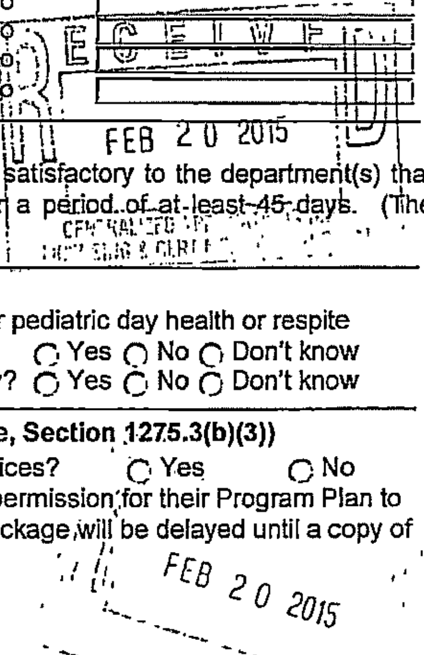
5. **Name of person to be in charge of facility, agency, or clinic:** Diana Haines
   Title: Administrator
   Professional License number: NHA6801

6. **a.** Name of administrator: Diana Haines — Date of hire: 12/01/2014
   Professional License number: NHA6801 — Expiration date: 07/31/2016
   b. Name of director of nursing: Patricia Wythe — Date of hire: 12/01/2014
   Professional License number: 717497 — Expiration date: 09/30/2015

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)	Shlomo Rechnitz	99.9%	47-1446528	○ Yes ● No	Self
(2)				○ 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: Crestwood of California
   Address (number & street): 520 Capitol Mall #800
   City, State, & Zip: Sacramento, CA 95814

   Lessee name: Chico Heights-LBI, LLC
   Address (number & street): 5900 Wilshire Blvd, Suite 1600
   City, State, & Zip: Los Angeles, CA 90036

   Sub-Lessee name: Chico Heights Rehabilitation & Wellness Centre, LP
   Address (number & street): 5900 Wilshire Blvd, Suite 1600
   City, State, & Zip: Los Angeles, CA 90036

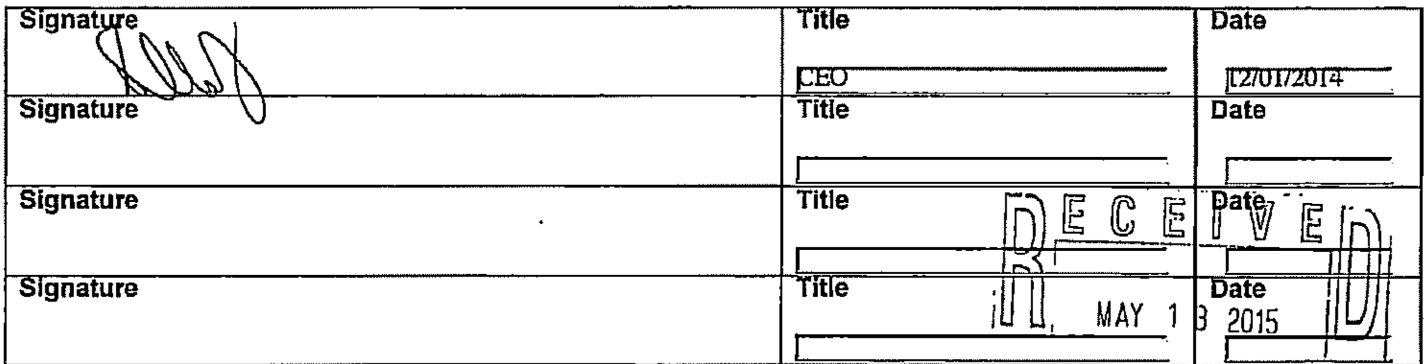
E. MANAGEMENT COMPANY

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.

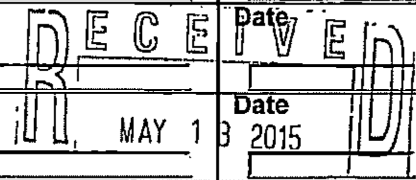
F. I (we) Accept responsibility to:

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
[signature]	CEO	12/01/2014
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.

State of California – Health and Human Services Agency

California Department of Public Health
Licensing and Certification

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: Shlomo Rechnitz
Date of Birth: July 29, 1971

Business address (number, street, apartment/suite number or letter if applicable): 587 Rio Lindo Ave
City, State, & Zip: Chico, CA 95926-2211

Title in relation to this facility: CEO/Member of LP

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.
N/A

B. Criminal Record

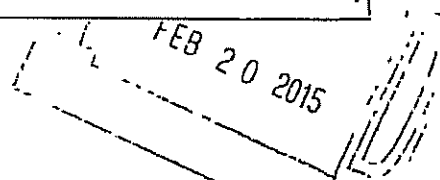
1. Have you ever been convicted of an offense that is still on your record, whether misdemeanor or felony? ○ Yes ● No

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
N/A		



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.

	Dates	Name and address of employer	Job title
From:	07/2005	Brius, LLC	CEO
To:	Present	5967 W. 3rd Street Suite 200 L.A., CA 90036	
From:	01/1995	Twin Med	CEO
To:	Present	11333 Greenstone Ave. Santa Fe Springs, CA	
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 <u>5 percent</u> 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).**

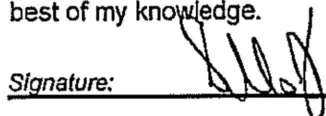
F. Adverse Actions

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: December 1, 2014

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.

State of California – Health and Human Services Agency

California Department of Public Health
Licensing and Certification

LICENSURE & CERTIFICATION APPLICATION

FOR DEPARTMENTAL USE ONLY	
District: CHICO	ELMS Facility Number: 230000025
Proposed name of facility/agency/clinic: CHICO TERRACE HEALTHCARE + WELLNESS Centre, LP	

LIC#: 230000006
APP ID #: 1390677

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: November 1, 2014

3. Amount of fee enclosed: $ 23,712.00 - Correct amt. JT

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)

6. a. Do you wish to apply for the Medicare program? ● Yes ○ No Medicare Provider #: 055516
   b. Fiscal Intermediary choice: Noridian Healthcare Solutions

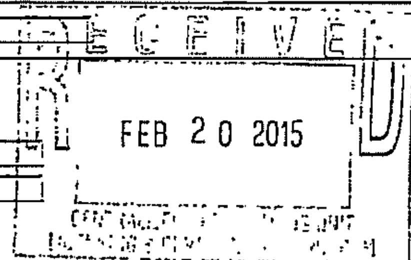
7. Do you wish to apply for the Medi-Cal (Medicaid) program? ● Yes ○ No

8. a. Current facility bed capacity: 76
   b. Proposed facility bed capacity: 76

9. Age range of clients: 21 and Up

10. Days and hours of operation: 24 hours per day 365 days per year

11. Is construction required? ○ Yes ● No
    If "yes", submit copy of "OSHPD" form (see instructions on page 6)
    If "yes", date construction to begin: N/A
    If "yes", date construction to be completed: N/A



HS 200 (02/08)

B. LICENSEE INFORMATION

1. Licensee name: Chico Terrace Healthcare & Wellness Centre, LP

2. Federal employer's tax ID number: 37-1765514

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): 5900 Wilshire Blvd, Suite 1600
Telephone number: (323) 330-6500
City, State, & Zip: Los Angeles, CA 90036
E-Mail: thow@rockporthc.com
Fax number: (866) 603-3566

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: N/A
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:

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.

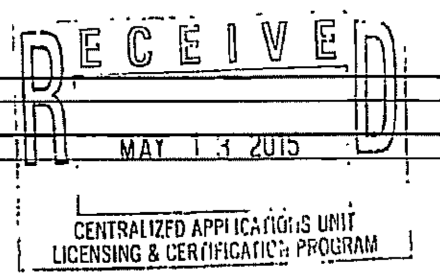
6. Is the licensee a **subsidiary** of another organization? ○ Yes ● No
If "yes", complete the information below and ***submit*** an organizational chart:

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: Chico Terrace Healthcare & Wellness Centre, LP
   Current facility, agency, or clinic name (if change of ownership): Windsor Chico Care Center
   Facility license number: 230000006

3. Address (number & street) of "proposed" facility, agency, or clinic: 188 Cohasset Rd.
   Telephone number: (530) 343-6084
   City, State, & Zip: Chico, CA 95926

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

5. **Name of person to be in charge of facility, agency, or clinic:** John Crowley
   Title: Administrator
   Professional License number: NHA4464

6. **a.** Name of administrator: John Crowley — Date of hire: 11/01/2014
   Professional License number: NHA4464 — Expiration date: 02/29/2016
   b. Name of director of nursing: Dianna Alesci — Date of hire: 11/01/2014
   Professional License number: 566223 — Expiration date: 04/30/2016

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)	Shlomo Rechnitz	99.9	35-1765514	○ Yes ● No	Self
(2)				○ Yes ○ No	
(3)				○ Yes ○ No	
(4)				○ Yes ○ No	
(5)				○ Yes ○ No	

FEB 20 2015

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.

FEB 20 2015

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: Anderson-Dobbins Chico Hospital
Address (number & street): 555 W. Benjamin Holt #424
City, State, & Zip: Stockton, CA 95207

Lessee name: Chico Terrace-LBT, LLC
Address (number & street): 5900 Wilshire Blvd, Suite 1600
City, State, & Zip: Los Angeles, CA 90036

Sub-Lessee name: Chico Terrace Healthcare & Wellness Centre, LP
Address (number & street): 5900 Wilshire Blvd, Suite 1600
City, State, & Zip: Los Angeles, CA 90036

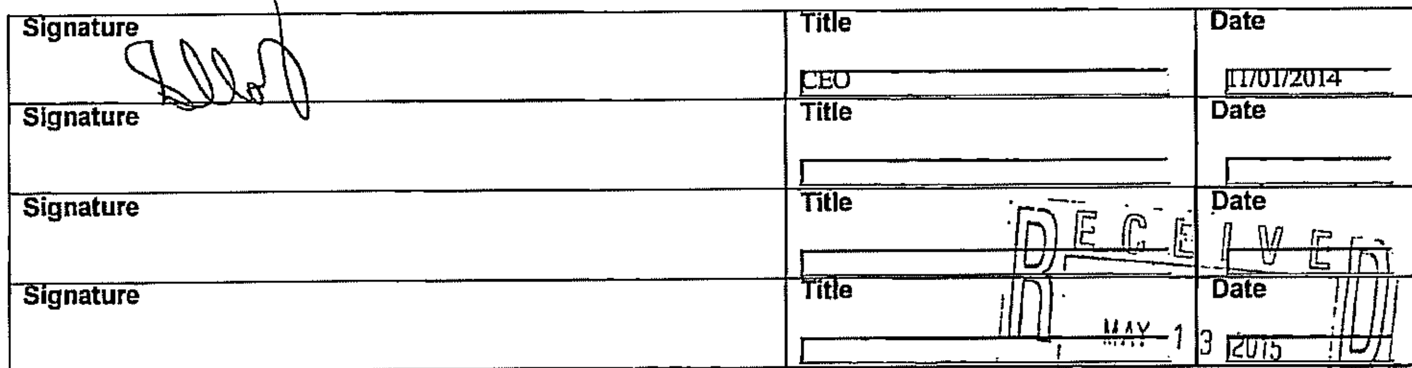
E. MANAGEMENT COMPANY

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 <u>SUBMIT</u> 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
[signature]	CEO	11/01/2014
Signature	Title	Date
Signature	Title	Date
Signature	Title	Date

RECEIVED MAY 13 2015

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.

FOR DEPARTMENTAL USE ONLY	
District:	ELMS Facility Number:
Proposed name of facility/agency/clinic: 230000025	

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: Shlomo Rechnitz

Date of Birth: July 29, 1971

Business address (number, street, apartment/suite number or letter if applicable): 188 Cohasset Rd.

City, State, & Zip: Chico, CA 95926-2206

Title in relation to this facility: CEO/Member of LP

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.

N/A

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
N/A		

FEB 20 2015

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.

	Dates	Name and address of employer	Job title
From:	07/2005	Brius, LLC	CEO
To:	Present	5967 W. 3rd Street Suite 200 L.A., CA 90036	
From:	01/1995	Twin Med	CEO
To:	Present	11333 Greenstone Ave. Santa Fe Springs, CA	
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 <u>5 percent</u> 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 **<u>If YES, check all applicable:</u>**

○ 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:* November 1, 2014

<u>RELEASE OF INFORMATION STATEMENT</u>

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.

State of California – Health and Human Services Agency

California Department of Public Health
Licensing and Certification

LICENSURE & CERTIFICATION APPLICATION

FOR DEPARTMENTAL USE ONLY	
District: CHICO	ELMS Facility Number: 230000030
Proposed name of facility/agency/clinic: River Valley Healthcare & Wellness Centre, LP	

A. APPLICATION INFORMATION

License# 230000103 / App# 1390964

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: November 1, 2014

3. Amount of fee enclosed: $ 35,256.00 – correct. [initials]

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)

6. a. Do you wish to apply for the Medicare program? ● Yes ○ No Medicare Provider #: 056258
   b. Fiscal Intermediary choice: Noridian Administrative Services, LLC

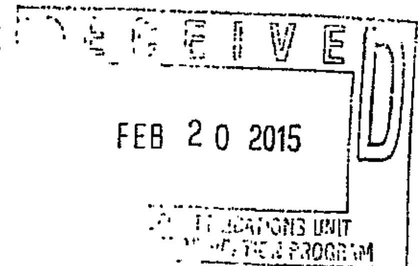
7. Do you wish to apply for the Medi-Cal (Medicaid) program? ● Yes ○ No

8. a. Current facility bed capacity: 113
   b. Proposed facility bed capacity: 113

9. Age range of clients: 21 and Up

10. Days and hours of operation: 24 hours per day 365 days per year

11. Is construction required? ○ Yes ● No
    If "yes", submit copy of "OSHPD" form (see instructions on page 6)
    If "yes", date construction to begin: N/A
    If "yes", date construction to be completed: N/A



HS 200 (02/08)

B. LICENSEE INFORMATION

1. Licensee name: River Valley Healthcare & Wellness Centre, LP

2. Federal employer's tax ID number: 90-1032628

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): 6900 Wilshire Blvd, Suite 1600

Telephone number: (323) 330-6500

City, State, & Zip: Los Angeles, CA 90036

E-Mail: chow@rockporthc.com

Fax number: (866) 603-3566

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: N/A

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:

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

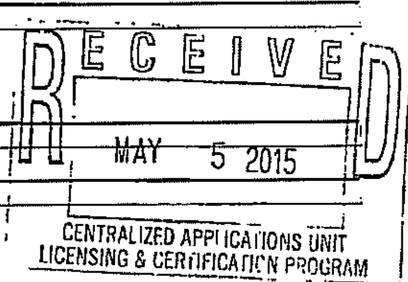
If "yes", complete the information below and ***submit*** an organizational chart:

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: River Valley Healthcare & Wellness Centre, LP
   Current facility, agency, or clinic name (if change of ownership): Windsor Redding Care Center
   Facility license number: 230000103

3. Address (number & street) of "proposed" facility, agency, or clinic: 2490 Court St.
   Telephone number: (530) 246-0600
   City, State, & Zip: Redding, CA 96001

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

5. **Name of person to be in charge of facility, agency, or clinic:** Donald Atterberry
   Title: Administrator
   Professional License number: NHA7425

6. a. Name of administrator: Donald Atterberry — Date of hire: 11/01/2014
   Professional License number: NHA7425 — Expiration date: 09/30/2016
   b. Name of director of nursing: Ladene Woodward — Date of hire: 01/20/2015
   Professional License number: 489807 — Expiration date: 05/31/2016

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)	Shlomo Rechnitz	96.9	90-1032628	○ Yes ● No	Self
(2)				○ 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: Monaco Properties
Address (number & street): 228 Ninth Street
City, State, & Zip: San Francisco, CA 94103

Lessee name: River Valley Healthcare & Wellness Centre, LP
Address (number & street): 5900 Wilshire Blvd Suite 1600
City, State, & Zip: Los Angeles, CA 90036

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

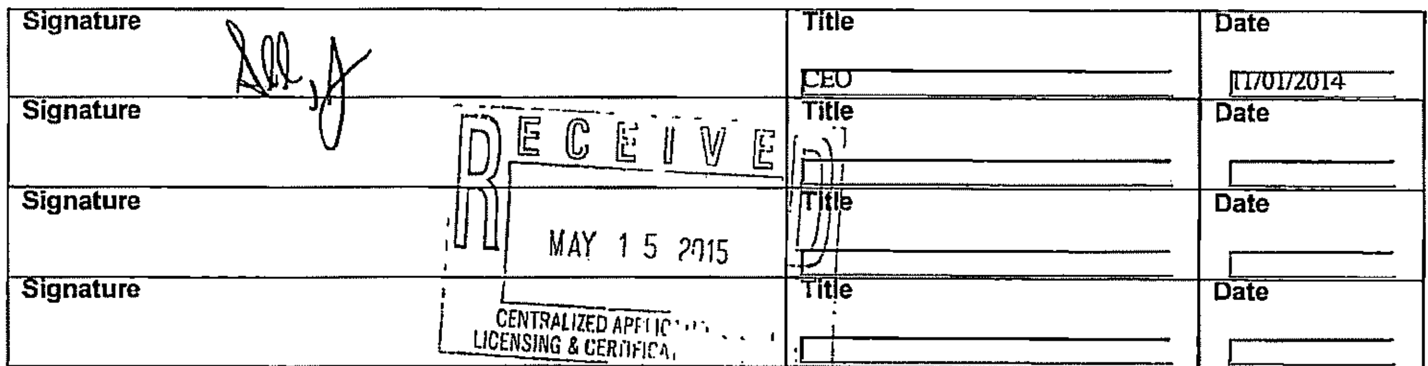
E. MANAGEMENT COMPANY

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.

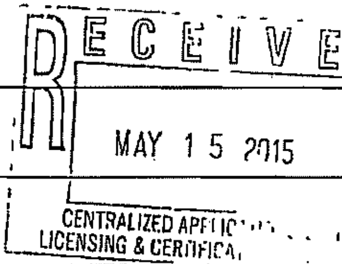
F. I (we) Accept responsibility to:

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
[signature]	CEO	11/01/2014
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.

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.

	Dates	Name and address of employer	Job title
From:	07/2005	Brius, LLC	CEO
To:	Present	5967 W. 3rd Street Suite 200 L.A., CA 90036	
From:	01/1995	Twin Med	CEO
To:	Present	11333 Greenstone Ave. Santa Fe Springs, CA	
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 <u>5 percent</u> 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).**

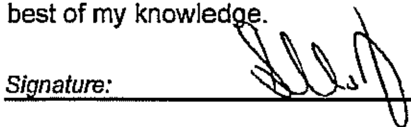
F. Adverse Actions

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: November 1, 2014

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.

FEB 2 0 2015
CENTRALIZED APPLICATIONS UNIT
LICENSING & CERTIFICATION PROGRAM

FOR DEPARTMENTAL USE ONLY	
District:	ELMS Facility Number:
Proposed name of facility/agency/clinic: 230000810	

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: Shlomo Rechnitz

Date of Birth: July 29, 1971

Business address (number, street, apartment/suite number or letter if applicable): 2490 Court St.

City, State, & Zip: Redding, CA 96001-2540

Title in relation to this facility: CEO/Member of LP

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.

N/A

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
N/A		

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CENTRALIZED APPLICATIONS UNIT
LICENSING & CERTIFICATION PROGRAM