CHOW Application

Denied 07/08/16

Appeal Status - Pending

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	

License# 230000103 / App# 1390964

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: $ 35,256.00 — correct. CM.

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 #: [redacted]
   b. Fiscal Intermediary choice: Noridian Administrative Services, LLC

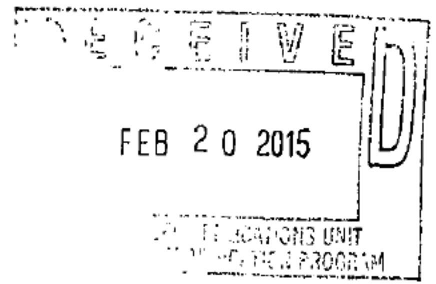
7. Do you wish to apply for the Medi-Cal (Medicaid) program? ● Yes ○ No

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



B. LICENSEE INFORMATION

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

2. Federal employer's tax ID number: [redacted]

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

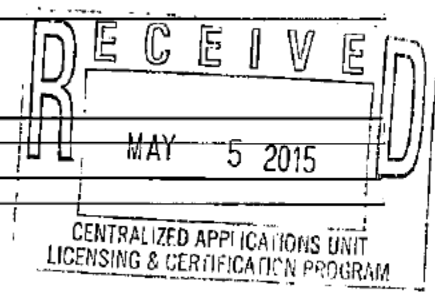
If "yes", complete the information below and ***submit*** an organizational chart:

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: 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	[redacted]	○ 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:

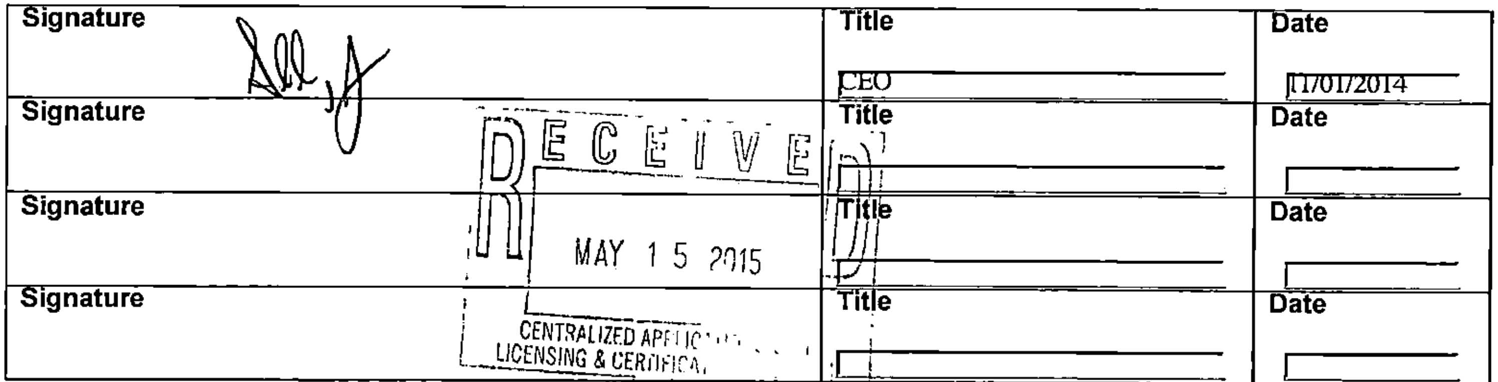
E. MANAGEMENT COMPANY

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

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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.

Organization Chart

River Valley Healthcare & Wellness Centre, LP

Shlomo Rechnitz	Member	96.9% Interest
Alain Kuppermann	Member	3% Interest
River Valley Wellness GP, LLC	Member	.1% Interest

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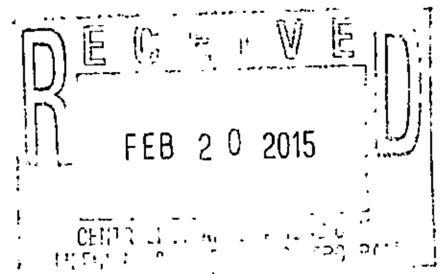


ADMINISTRATOR & DON Information

Name of Administrator (HS 200, Item C.6.a.): Donald Atterbury

☐	**215A Form** for Administrator
☐	**RESUME** -- file with the HS 215A form for the Administrator
☐	Copy of **professional "LICENSE"**, if applicable
☐	**Letter signed by Governing Body appointing the Administrator**
☐	**FINGERPRINT** clearance for Administrator, if applicable

Name of Administrator's DESIGNEE: ______

☐	**RESUME for Administrator's DESIGNEE – file with the HS 215A form for the Administrator**
☐	**Copy of professional "LICENSE"**, if applicable
☐	FYI – we do need **FINGERPRINT** Clearance for the Administrator's **DESIGNEE**

Name of Director of Patient Care Services (HHA) or DON (SNF):
(HS 200, Item C.6.b.) Sarah Doyle

☐	**RESUME** for Director of Patient Care Services or DON – file with the HS 215A form for the Administrator
☐	Copy of **professional LICENSE** – File with the HS 215A form for the Administrator

Name of Director of Patient Care Services Designee (Hospice)

______

☐	**RESUME** for Director of Patient Care Services or DON – file with the HS 215A form for the Administrator
☐	Copy of **professional LICENSE** – File with the HS 215A form for the Administrator

FOR DEPARTMENTAL USE ONLY	
District:	ELMS Facility Number: 230000080
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: Donald Atterberry

Date of Birth: [redacted]

Business address (number, street, apartment/suite number or letter if applicable): [redacted]

City, State, & Zip: [redacted]

Title in relation to this facility: Administrator

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

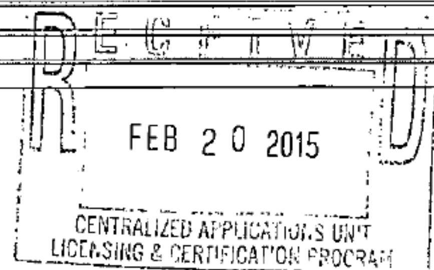
1. Have you ever been convicted of an offense that is still on your record, whether misdemeanor or felony? ● Yes ○ No

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): Back in the late 1980's and early 90's had some instances behind divorce situa
Hasn't been an issue for licensing or other they were misdemeanor charges.

C. Professional Licenses/Certificates – This requirement is mandatory for Primary Care Clinics and optional for Health facilities.

TYPE	PERIOD HELD	ISSUING AGENCY
NHA	4 years	State of California



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:	8/2014	Windsor redding care/River Valley health	Administrator
To:	present	2490 Court St Redding CA 96001	
From:	4/2013	Vibra Hospital	
To:	7/2014	2801 Eureka Way, Redding, CA 96001	Administrator
From:	10/2012	Chehalem Health Center	Administrator
To:	4/2013	1900 Fulton Newberg OR 97132	
From:	9/2010	Laurel Hill Nursing and Rehab Center	Administrator
To:	10/2012	859 NE 6th St. Grants Pass, OR 97526	

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: 11/17/14

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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FACILITY INFORMATION SHEET

You are required to complete the following for **each** facility (including all facilities in all business entities) with which you have a current relationship or have had a past relationship (going back 3 years). **Refer to the INSTRUCTION SHEET.**

Facility name: Windsor Redding Care Center
Facility address (number, street, city): 2490 Court St. Redding
State: CA
Zip code: 96001

Type of Facility	"Type" of Business Entity	Individual's "Nature" of Involvement
○ Adult Day Health Care Center	For EACH business entity, identify the name & EIN of the entity:	● Administrator of Clinic, SNF or ICF
○ Clinic	○ Corporation:	○ Agent
○ COMMUNITY CARE FACILITY		○ Director
○ General Acute Care Hospital	○ Individual:	○ Licensee
○ Health Facility		○ Manager of "parent" organization
○ HHA	● LLC:	○ Managing employee of a HHA
○ Hospice	Windsor Redding Care Center, LLC -	○ Member
○ ICF	○ Management Company:	○ Officer of corporation
○ ICF/DD		○ Owner
○ ICF/DD-H	○ Partnership:	○ Partner
○ ICF/DD-N		○ Sole Proprietorship
○ ICF	○ OTHER Business Entity (explain):	○ Stockholder -- Ownership %:
○ Residential Care for the Elderly		○ Trustee
● SNF	Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain.	○ OTHER Nature of Involvement (explain):
○ OTHER FACILITY TYPE (explain):	○ Yes ● No	Dates of involvement: From: August 2014 To: Present

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Facility name: Vibra Hospital of Northern California
Facility address (number, street, city): 2801 Eureka Way, Redding
State: CA
Zip code: 96001

Type of Facility	"Type" of Business Entity	Individual's "Nature" of Involvement
○ Adult Day Health Care Center	For EACH business entity, identify the name & EIN of the entity:	● Administrator of Clinic, SNF or ICF
○ Clinic	● Corporation:	○ Agent
○ COMMUNITY CARE FACILITY	Vibra	○ Director
○ General Acute Care Hospital	○ Individual:	○ Licensee
○ Health Facility		○ Manager of "parent" organization
○ HHA	○ LLC:	○ Managing employee of a HHA
○ Hospice		○ Member
○ ICF	○ Management Company:	○ Officer of corporation
○ ICF/DD		○ Owner
○ ICF/DD-H	○ Partnership:	○ Partner
○ ICF/DD-N		○ Sole Proprietorship
○ ICF	○ OTHER Business Entity (explain):	○ Stockholder -- Ownership %:
○ Residential Care for the Elderly		○ Trustee
● SNF	Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain.	○ OTHER Nature of Involvement (explain):
○ OTHER FACILITY TYPE (explain):	○ Yes ● No	Dates of involvement: From: October 2012 To: May 2013

Facility name: Chehalem Health and Rehab
Facility address (number, street, city): 1900 Fulton St. Newberg
State: OR
Zip code: 97132

Type of Facility	"Type" of Business Entity	Individual's "Nature" of Involvement
○ Adult Day Health Care Center	For EACH business entity, identify the name & EIN of the entity:	● Administrator of Clinic, SNF or ICF
○ Clinic	● Corporation:	○ Agent
○ COMMUNITY CARE FACILITY	Chehalem	○ Director
○ General Acute Care Hospital	○ Individual:	○ Licensee
○ Health Facility		○ Manager of "parent" organization
○ HHA	○ LLC:	○ Managing employee of a HHA
○ Hospice		○ Member
○ ICF	○ Management Company:	○ Officer of corporation
○ ICF/DD		○ Owner
○ ICF/DD-H	○ Partnership:	○ Partner
○ ICF/DD-N		○ Sole Proprietorship
○ ICF	○ OTHER Business Entity (explain):	○ Stockholder -- Ownership %:
○ Residential Care for the Elderly		○ Trustee
● SNF	Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain.	○ OTHER Nature of Involvement (explain):
○ OTHER FACILITY TYPE (explain):	○ Yes ● No	Dates of involvement: From: Sept. 2010 To: Oct. 2012

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Facility name:	Facility address (number, street, city):	State:	Zip code:
Laurel Hill Nursing and Rehabilitation Center	859 NE 6th St. Grants Pass	OR	97526

Type of Facility	"Type" of Business Entity	Individual's "Nature" of Involvement
○ Adult Day Health Care Center	For EACH business entity, identify the name & EIN of the entity:	● Administrator of Clinic, SNF or ICF
○ Clinic	○ Corporation:	○ Agent
○ COMMUNITY CARE FACILITY		○ Director
○ General Acute Care Hospital	○ Individual:	○ Licensee
○ Health Facility		○ Manager of "parent" organization
○ HHA	○ LLC:	○ Managing employee of a HHA
○ Hospice		○ Member
○ ICF	○ Management Company:	○ Officer of corporation
○ ICF/DD		○ Owner
○ ICF/DD-H	○ Partnership:	○ Partner
○ ICF/DD-N		○ Sole Proprietorship
○ ICF	○ OTHER Business Entity (explain):	○ Stockholder – Ownership %:
○ Residential Care for the Elderly		○ Trustee
● SNF	Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain.	○ OTHER Nature of Involvement (explain):
○ OTHER FACILITY TYPE (explain):	○ Yes	Dates of involvement:
	● No	From: Sept. 2010
		To: Oct. 2012

Facility name:	Facility address (number, street, city):	State:	Zip code:

Type of Facility	"Type" of Business Entity	Individual's "Nature" of Involvement
○ Adult Day Health Care Center	For EACH business entity, identify the name & EIN of the entity:	○ Administrator of Clinic, SNF or ICF
○ Clinic	○ Corporation:	○ Agent
○ COMMUNITY CARE FACILITY		○ Director
○ General Acute Care Hospital	○ Individual:	○ Licensee
○ Health Facility		○ Manager of "parent" organization
○ HHA	○ LLC:	○ Managing employee of a HHA
○ Hospice		○ Member
○ ICF	○ Management Company:	○ Officer of corporation
○ ICF/DD		○ Owner
○ ICF/DD-H	○ Partnership:	○ Partner
○ ICF/DD-N		○ Sole Proprietorship
○ ICF	○ OTHER Business Entity (explain):	○ Stockholder -- Ownership %:
○ Residential Care for the Elderly		○ Trustee
○ SNF	Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain.	○ OTHER Nature of Involvement (explain):
○ OTHER FACILITY TYPE (explain):	○ Yes	Dates of involvement:
	○ No	From:
		To:

Facility name:	Facility address (number, street, city):	State:	Zip code:

Type of Facility	"Type" of Business Entity	Individual's "Nature" of Involvement
○ Adult Day Health Care Center	For EACH business entity, identify the name & EIN of the entity:	○ Administrator of Clinic, SNF or ICF
○ Clinic	○ Corporation:	○ Agent
○ COMMUNITY CARE FACILITY		○ Director
○ General Acute Care Hospital	○ Individual:	○ Licensee
○ Health Facility		○ Manager of "parent" organization
○ HHA	○ LLC:	○ Managing employee of a HHA
○ Hospice		○ Member
○ ICF	○ Management Company:	○ Officer of corporation
○ ICF/DD		○ Owner
○ ICF/DD-H	○ Partnership:	○ Partner
○ ICF/DD-N		○ Sole Proprietorship
○ ICF	○ OTHER Business Entity (explain):	○ Stockholder -- Ownership %:
○ Residential Care for the Elderly		○ Trustee
○ SNF	Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain.	○ OTHER Nature of Involvement (explain):
○ OTHER FACILITY TYPE (explain):	○ Yes	Dates of involvement:
	○ No	From:
		To:

State of California **Department of Public Health**

NURSING HOME ADMINISTRATOR PROGRAM

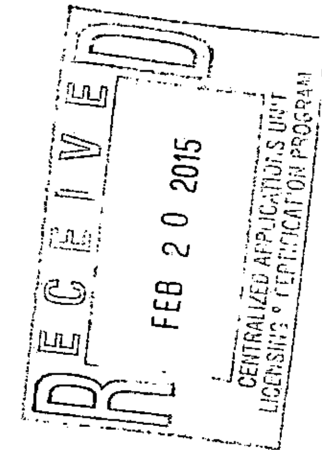
THIS IS TO CERTIFY THAT PURSUANT TO THE PROVISIONS OF
CHAPTER 2.35, ARTICLE 2 OF THE HEALTH AND SAFETY CODE

DONALD L ATTERBERRY

IS DULY LICENSED AS A
NURSING HOME ADMINISTRATOR
In the State of California and is entitled to all
the rights and privileges conferred in said code

License Number: NHA7425
Expiration Date: 09/30/2016

DEPARTMENT OF PUBLIC HEALTH
NURSING HOME ADMINISTRATOR PROGRAM
P.O. BOX 997416, MS 3302
SACRAMENTO, CA 95899-7416
(916) 552-8780



L & C Certification Verification Detail Page

Cert Details

Cert Holder: DONALD L ATTERBERRY
Cert Number: NHA 00007425
Cert Title: NURSING HOME ADMINISTRATOR
Expiration Date: 2016-09-30

End of Cert Details

Close Window

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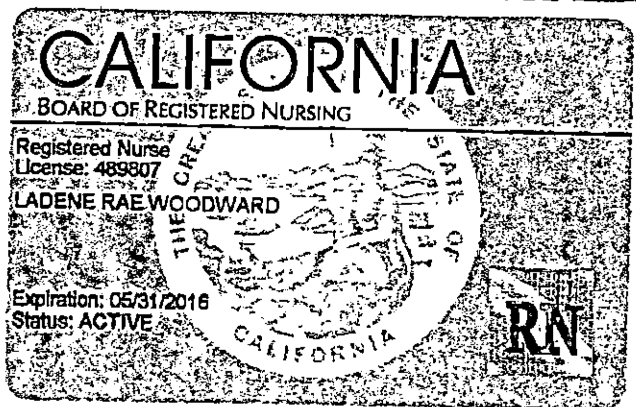

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CENTRALIZED APPLICATIONS UNIT
LICENSING & CERTIFICATION PROGRAM

LICENSEE

Filing of the HS 215A Forms for the LICENSEE

LICENSEE Name: ______________________________ (HS 200, Item B.1.)

List all persons (or attach a list of names) that submitted the **HS 215A Form** that are involved with the **LICENSEE** -- Owners, Officers, Board Members, Partners, LLC Members, etc. File all the HS 215A forms in alphabetical order.	
1	
2	
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9	
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11	
12	
13	
14	
15	

FOR DEPARTMENTAL USE ONLY	
District:	ELMS Facility Number:
Proposed name of facility/agency/clinic: 230020080	

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
Alain Kuppermann

Date of Birth

Business address (number, street, apartment/suite number or letter if applicable)

City, State, & Zip

Title in relation to this facility
Partner

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.
N/A

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

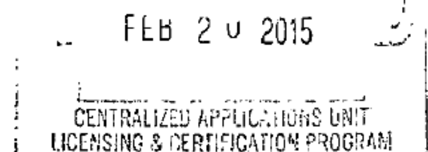
B. Criminal Record

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:	2008	Alain Kuppermann Esq. - 110 S. Fairfax Ave Suite 250	Attorney
To:	Present	Los Angeles, CA 90036	
From:	2008	Centinela Skilled Nursing & Wellness Centre East	AIT
To:	2008	1001 S. Osage Avenue Inglewood, CA 90301	
From:	2003	Student	Student
To:	2007		
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:* 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.

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CENTRALIZED APPLICATIONS UNIT
LICENSING & CERTIFICATION PROGRAM

FACILITY INFORMATION SHEET

You are required to complete the following for **each** facility (including all facilities in all business entities) with which you have a current relationship or have had a past relationship (going back 3 years). **Refer to the INSTRUCTION SHEET.**

Facility name: Alhambra Healthcare & Wellness Centre, LP
Facility address (number, street, city): 415 S. Garfield Ave. Alhambra
State: CA
Zip code: 91801

Type of Facility

- ( ) Adult Day Health Care Center
- ( ) Clinic
- ( ) COMMUNITY CARE FACILITY
- ( ) General Acute Care Hospital
- ( ) Health Facility
- ( ) HHA
- ( ) Hospice
- ( ) ICF
- ( ) ICF/DD
- ( ) ICF/DD-H
- ( ) ICF/DD-N
- ( ) ICF
- ( ) Residential Care for the Elderly
- (●) SNF
- ( ) OTHER FACILITY TYPE (explain):

"Type" of Business Entity

For EACH business entity, identify the name & EIN of the entity:

- ( ) Corporation:
- ( ) Individual:
- ( ) LLC:
- ( ) Management Company:
- (●) Partnership: 20-0853498 Alhambra Healthcare & Wellness Centre, LP
- ( ) OTHER Business Entity (explain):

Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain.

- ( ) Yes
- (●) No

Individual's "Nature" of Involvement

- ( ) Administrator of Clinic, SNF or ICF
- ( ) Agent
- ( ) Director
- ( ) Licensee
- ( ) Manager of "parent" organization
- ( ) Managing employee of a HHA
- ( ) Member
- ( ) Officer of corporation
- ( ) Owner
- (●) Partner
- ( ) Sole Proprietorship
- ( ) Stockholder -- Ownership %: 3%
- ( ) Trustee
- ( ) OTHER Nature of Involvement (explain):

Dates of involvement:
From: 06-01-12
To: Current

Facility name: Pine Grove Healthcare & Wellness Centre, LP
Facility address (number, street, city): 126 N. San Gabriel Blvd. San Gabriel
State: CA
Zip code: 91775

Type of Facility

- ( ) Adult Day Health Care Center
- ( ) Clinic
- ( ) COMMUNITY CARE FACILITY
- ( ) General Acute Care Hospital
- ( ) Health Facility
- ( ) HHA
- ( ) Hospice
- ( ) ICF
- ( ) ICF/DD
- ( ) ICF/DD-H
- ( ) ICF/DD-N
- ( ) ICF
- ( ) Residential Care for the Elderly
- (●) SNF
- ( ) OTHER FACILITY TYPE (explain):

"Type" of Business Entity

For EACH business entity, identify the name & EIN of the entity:

- ( ) Corporation:
- ( ) Individual:
- ( ) LLC:
- ( ) Management Company:
- (●) Partnership: Pine Grove Healthcare & Wellness Centre, LP 20-0852683
- ( ) OTHER Business Entity (explain):

Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain.

- ( ) Yes
- (●) No

Individual's "Nature" of Involvement

- ( ) Administrator of Clinic, SNF or ICF
- ( ) Agent
- ( ) Director
- ( ) Licensee
- ( ) Manager of "parent" organization
- ( ) Managing employee of a HHA
- ( ) Member
- ( ) Officer of corporation
- ( ) Owner
- (●) Partner
- ( ) Sole Proprietorship
- ( ) Stockholder -- Ownership %: 3%
- ( ) Trustee
- ( ) OTHER Nature of Involvement (explain):

Dates of involvement:
From: 06-01-12
To: Current

Facility name: Ivy Creek Healthcare & Wellness Centre
Facility address (number, street, city): 115 Bridge Street San Gabriel
State: CA
Zip code: 91775

Type of Facility

- ( ) Adult Day Health Care Center
- ( ) Clinic
- ( ) COMMUNITY CARE FACILITY
- ( ) General Acute Care Hospital
- ( ) Health Facility
- ( ) HHA
- ( ) Hospice
- ( ) ICF
- ( ) ICF/DD
- ( ) ICF/DD-H
- ( ) ICF/DD-N
- ( ) ICF
- ( ) Residential Care for the Elderly
- (●) SNF
- ( ) OTHER FACILITY TYPE (explain):

"Type" of Business Entity

For EACH business entity, identify the name & EIN of the entity:

- ( ) Corporation:
- ( ) Individual:
- ( ) LLC:
- ( ) Management Company:
- (●) Partnership: San Gabriel Healthcare & Wellness Centre, LP 61-1684895
- ( ) OTHER Business Entity (explain):

Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain.

- ( ) Yes
- (●) No

Individual's "Nature" of Involvement

- ( ) Administrator of Clinic, SNF or ICF
- ( ) Agent
- ( ) Director
- ( ) Licensee
- ( ) Manager of "parent" organization
- ( ) Managing employee of a HHA
- ( ) Member
- ( ) Officer of corporation
- ( ) Owner
- (●) Partner
- ( ) Sole Proprietorship
- ( ) Stockholder -- Ownership %: 3%
- ( ) Trustee
- ( ) OTHER Nature of Involvement (explain):

Dates of involvement:
From: 06-01-12
To: Current

Facility name: York Healthcare & Wellness Centre, LP
Facility address (number, street, city): 5071 York Blvd Los Angeles
State: CA
Zip code: 90042

Type of Facility

- ○ Adult Day Health Care Center
- ○ Clinic
- ○ COMMUNITY CARE FACILITY
- ○ General Acute Care Hospital
- ○ Health Facility
- ○ HHA
- ○ Hospice
- ○ ICF
- ○ ICF/DD
- ○ ICF/DD-H
- ○ ICF/DD-N
- ○ ICF
- ○ Residential Care for the Elderly
- ● SNF
- ○ OTHER FACILITY TYPE (explain):

"Type" of Business Entity

For EACH business entity, identify the name & EIN of the entity:

- ○ Corporation:
- ○ Individual:
- ○ LLC:
- ○ Management Company:
- ● Partnership: York Healthcare & Wellness Centre, LP
  35-2446690
- ○ OTHER Business Entity (explain):

Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain.

- ○ Yes
- ● No

Individual's "Nature" of Involvement

- ○ Administrator of Clinic, SNF or ICF
- ○ Agent
- ○ Director
- ○ Licensee
- ○ Manager of "parent" organization
- ○ Managing employee of a HHA
- ○ Member
- ○ Officer of corporation
- ○ Owner
- ● Partner
- ○ Sole Proprietorship
- ○ Stockholder -- Ownership %: 3%
- ○ Trustee
- ○ OTHER Nature of Involvement (explain):

Dates of involvement:
From: 06-01-12
To: Current

Facility name: San Rafael Healthcare & Wellness Centre, LP
Facility address (number, street, city): 1601 5th Ave San Rafael
State: CA
Zip code: 94901

Type of Facility

- ○ Adult Day Health Care Center
- ○ Clinic
- ○ COMMUNITY CARE FACILITY
- ○ General Acute Care Hospital
- ○ Health Facility
- ○ HHA
- ○ Hospice
- ○ ICF
- ○ ICF/DD
- ○ ICF/DD-H
- ○ ICF/DD-N
- ○ ICF
- ○ Residential Care for the Elderly
- ● SNF
- ○ OTHER FACILITY TYPE (explain):

"Type" of Business Entity

For EACH business entity, identify the name & EIN of the entity:

- ○ Corporation:
- ○ Individual:
- ○ LLC:
- ○ Management Company:
- ● Partnership: San Rafael Healthcare & Wellness Centre, LP
  35-2452212
- ○ OTHER Business Entity (explain):

Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain.

- ○ Yes
- ● No

Individual's "Nature" of Involvement

- ○ Administrator of Clinic, SNF or ICF
- ○ Agent
- ○ Director
- ○ Licensee
- ○ Manager of "parent" organization
- ○ Managing employee of a HHA
- ○ Member
- ○ Officer of corporation
- ○ Owner
- ● Partner
- ○ Sole Proprietorship
- ○ Stockholder -- Ownership %: 3%
- ○ Trustee
- ○ OTHER Nature of Involvement (explain):

Dates of involvement:
From: 11-1-12
To: Current

Facility name: Burlingame Long Term Care
Facility address (number, street, city): 1100 Trousdale Drive Burlingame
State: CA
Zip code: 94010

Type of Facility

- ○ Adult Day Health Care Center
- ○ Clinic
- ○ COMMUNITY CARE FACILITY
- ○ General Acute Care Hospital
- ○ Health Facility
- ○ HHA
- ○ Hospice
- ○ ICF
- ○ ICF/DD
- ○ ICF/DD-H
- ○ ICF/DD-N
- ○ ICF
- ○ Residential Care for the Elderly
- ● SNF
- ○ OTHER FACILITY TYPE (explain):

"Type" of Business Entity

For EACH business entity, identify the name & EIN of the entity:

- ○ Corporation:
- ○ Individual:
- ○ LLC:
- ○ Management Company:
- ● Partnership: City of San Mateo
  93-1686304
- ○ OTHER Business Entity (explain):

Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain.

- ○ Yes
- ● No

Individual's "Nature" of Involvement

- ○ Administrator of Clinic, SNF or ICF
- ○ Agent
- ○ Director
- ○ Licensee
- ○ Manager of "parent" organization
- ○ Managing employee of a HHA
- ○ Member
- ○ Officer of corporation
- ○ Owner
- ● Partner
- ○ Sole Proprietorship
- ○ Stockholder -- Ownership %: 3%
- ○ Trustee
- ○ OTHER Nature of Involvement (explain):

Dates of involvement:
From: 7-15-12
To: Current

Facility name: Fullerton Healthcare & Wellness Centre, LP
Facility address (number, street, city): 2222 N. Harbor Blvd
State: CA **Zip code:** 92835

Type of Facility	"Type" of Business Entity	Individual's "Nature" of Involvement
○ Adult Day Health Care Center	For EACH business entity, identify the name & EIN of the entity:	○ Administrator of Clinic, SNF or ICF
○ Clinic	○ Corporation:	○ Agent
○ COMMUNITY CARE FACILITY		○ Director
○ General Acute Care Hospital	○ Individual:	○ Licensee
○ Health Facility		○ Manager of "parent" organization
○ HHA	○ LLC:	○ Managing employee of a HHA
○ Hospice		○ Member
○ ICF	○ Management Company:	○ Officer of corporation
○ ICF/DD		○ Owner
○ ICF/DD-H	● Partnership: Fullerton Healthcare & Wellness Centre, LP	● Partner
○ ICF/DD-N	90-1032949	○ Sole Proprietorship
○ ICF	○ OTHER Business Entity (explain):	○ Stockholder -- Ownership %: 3%
○ Residential Care for the Elderly	Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain.	○ Trustee
● SNF	○ Yes	○ OTHER Nature of Involvement (explain):
○ OTHER FACILITY TYPE (explain):	● No	Dates of involvement: From: 12-20-13 To: Current

Facility name: Monterey Healthcare & Wellness Centre, LP
Facility address (number, street, city): 1267 San Gabriel Blvd
State: CA **Zip code:** 91770

Type of Facility	"Type" of Business Entity	Individual's "Nature" of Involvement
○ Adult Day Health Care Center	For EACH business entity, identify the name & EIN of the entity:	○ Administrator of Clinic, SNF or ICF
○ Clinic	○ Corporation:	○ Agent
○ COMMUNITY CARE FACILITY		○ Director
○ General Acute Care Hospital	○ Individual:	○ Licensee
○ Health Facility		○ Manager of "parent" organization
○ HHA	○ LLC:	○ Managing employee of a HHA
○ Hospice		○ Member
○ ICF	○ Management Company:	○ Officer of corporation
○ ICF/DD		○ Owner
○ ICF/DD-H	● Partnership: Monterey Healthcare & Wellness Centre, LP	● Partner
○ ICF/DD-N	86-4770161	○ Sole Proprietorship
○ ICF	○ OTHER Business Entity (explain):	○ Stockholder -- Ownership %: 3%
○ Residential Care for the Elderly	Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain.	○ Trustee
● SNF	○ Yes	○ OTHER Nature of Involvement (explain):
○ OTHER FACILITY TYPE (explain):	● No	Dates of involvement: From: 12-30-13 To: Current

Facility name: Montecito Heights Healthcare & Wellness Centre, LP
Facility address (number, street, city): 4585 N. Figueroa St. Los Angeles
State: CA **Zip code:** 90065

Type of Facility	"Type" of Business Entity	Individual's "Nature" of Involvement
○ Adult Day Health Care Center	For EACH business entity, identify the name & EIN of the entity:	○ Administrator of Clinic, SNF or ICF
○ Clinic	○ Corporation:	○ Agent
○ COMMUNITY CARE FACILITY		○ Director
○ General Acute Care Hospital	○ Individual:	○ Licensee
○ Health Facility		○ Manager of "parent" organization
○ HHA	○ LLC:	○ Managing employee of a HHA
○ Hospice		○ Member
○ ICF	○ Management Company:	○ Officer of corporation
○ ICF/DD		○ Owner
○ ICF/DD-H	● Partnership: Montecito Heights Healthcare & Wellness Centre, LP	● Partner
○ ICF/DD-N	80-0960276	○ Sole Proprietorship
○ ICF	○ OTHER Business Entity (explain):	○ Stockholder -- Ownership %: 3%
○ Residential Care for the Elderly	Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain.	○ Trustee
● SNF	○ Yes	○ OTHER Nature of Involvement (explain):
○ OTHER FACILITY TYPE (explain):	● No	Dates of involvement: From: 1-15-14 To: Current

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:

Business address (number, street, apartment/suite number or letter if applicable)

City, State, & Zip

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

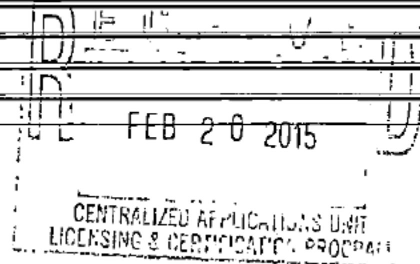
B. Criminal Record

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: [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.

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LICENSING & CERTIFICATION PROGRAM

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 96.9% of River Valley Healthcare & Wellness Centre, LP, Licensee

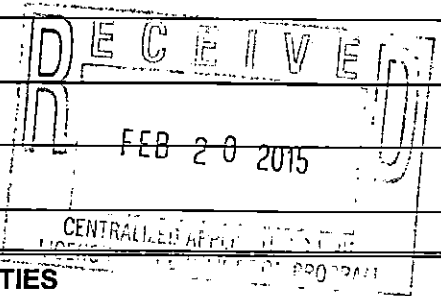
5900 Wilshire Blvd. Suite 1600

Los Angeles, CA 90036

PARTNERSHIPS

Attach a copy of partnership agreement.

First partner	☑ Limited ☐ General	Name Shlomo Rechnitz Business address 2490 Court St. Redding, CA 96001-2540
Second partner	☑ Limited ☐ General	Name Alain Kuppermann Business address 2490 Court St. Redding, CA 96001-2540



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.

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 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, 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 files located in Licensing and Certification district offices.

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)

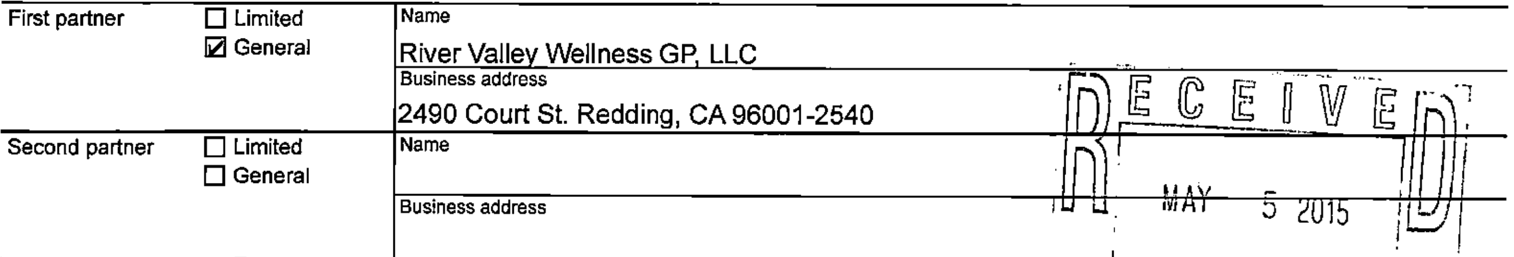
Specify geographic area

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 96.9% of River Valley Healthcare & Wellness Centre, LP, Licensee
5900 Wilshire Blvd. Suite 1600
Los Angeles, CA 90036

PARTNERSHIPS

Attach a copy of partnership agreement.



First partner	☐ Limited ☑ General	Name: River Valley Wellness GP, LLC Business address: 2490 Court St. Redding, CA 96001-2540
Second partner	☐ Limited ☐ General	Name: Business address:

RECEIVED MAY 5 2015 CENTRALIZED APPLICATIONS UNIT LICENSING & CERTIFICATION PROGRAM

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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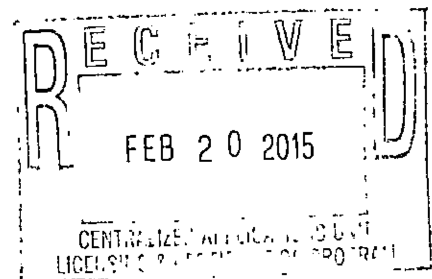
Organization Chart

River Valley Healthcare & Wellness Centre, LP

Shlomo Rechnitz	Member	96.9% Interest
Alain Kuppermann	Member	3% Interest
River Valley Wellness GP, LLC	Member	.1% Interest

****



Business Entity Detail

Data is updated to the California Business Search on Wednesday and Saturday mornings. Results reflect work processed through Friday, March 06, 2015. Please refer to **Processing Times** for the received dates of filings currently being processed. The data provided is not a complete or certified record of an entity.

Entity Name:	RIVER VALLEY HEALTHCARE & WELLNESS CENTRE, LP
Entity Number:	201334000014
Date Filed:	12/06/2013
Status:	ACTIVE
Jurisdiction:	CALIFORNIA
Entity Address:	5900 WILSHIRE BLVD STE 1600
Entity City, State, Zip:	LOS ANGELES CA 90036
Agent for Service of Process:	STEVEN STROLL
Agent Address:	4929 WILSHIRE BLVD STE 388
Agent City, State, Zip:	LOS ANGELES CA 90010

* Indicates the information is not contained in the California Secretary of State's database.

* **Note:** If the agent for service of process is a corporation, the address of the agent may be requested by ordering a status report.

- For information on checking or reserving a name, refer to **Name Availability**.
- For information on ordering certificates, copies of documents and/or status reports or to request a more extensive search, refer to **Information Requests**.
- For help with searching an entity name, refer to **Search Tips**.
- For descriptions of the various fields and status types, refer to **Field Descriptions and Status Definitions**.

Modify Search **New Search** **Printer Friendly** **Back to Search Results**

Privacy Statement | **Free Document Readers**

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CERTIFICATE OF RESOLUTION

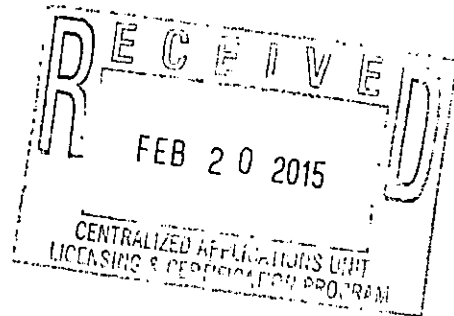
RESOLVED the River Valley Healthcare & Wellness Centre, LP hereby authorizes Shlomo Rechnitz to execute any and all documents required to obtain a license from the California Department of Public Health, Licensing and Certification Program, to operate that certain skilled nursing facility located at 2490 Court St. Redding, CA 96001 currently known as Windsor Redding Care Center a 113-bed skilled nursing facility.

RESOLVED FURTHER, that Shlomo Rechnitz is hereby authorized to execute any and all documents required to undertake the operations of said Facility as a skilled nursing facility, including but not limited to any and all documents required to participate in the Medicare and Medi-Cal programs and bill for those services provided to residents at the Facility.

Executed at Los Angeles, California, this 1st day of November 2014.

River Valley Healthcare & Wellness Centre, LP

By: ______________________
Shlomo Rechnitz, CEO



AFFIDAVIT REGARDING PATIENT MONEY

In accordance with California Health and Safety Code, Section 1318, this form is intended to ensure that all licensed health facilities comply with statutory bonding requirements if they handle patient money. This form is required on all new applications and whenever the Department deems it is necessary to reevaluate the bonding need of a health facility.

I (We) River Valley Healthcare & Wellness Centre, LP
Name(s) of Applicants (i.e., licensee)

As applicant(s) for River Valley Healthcare & Wellness Centre, LP
Name of Facility

Facility address 2490 Court St. (Street) Redding (City) CA (State) 96001 (ZIP Code) Shasta (County)

I (We) certify that I (check A or B below):

☐ A. Will handle less than $25 per patient and less than $500 for all patients in any one month.

☑ B. Will handle more than $25 per patient or more than $500 for all patients in any one month. (If B is checked, please indicate the maximum amount of money that will be handled.)
Amount of money to be handled. $74,500.00

Note: If "B" is checked, you will need to submit a Surety Bond Verification (form HS 402).

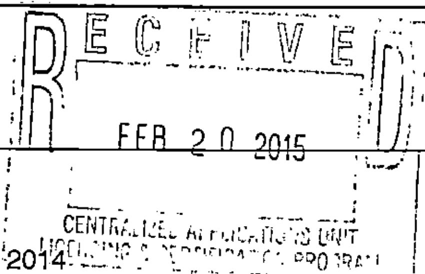
Money Handled	Bond Required	Money Handled	Bond Required
$ 500.00 to 750.00	$ 1,000.00	$10,501.00 to 11,500.00	$12,000.00
751.00 to 1,500.00	2,000.00	11,501.00 to 12,500.00	13,000.00
1,501.00 to 2,500.00	3,000.00	12,501.00 to 13,500.00	14,000.00
2,501.00 to 3,500.00	4,000.00	13,501.00 to 14,500.00	15,000.00
3,501.00 to 4,500.00	5,000.00	14,501.00 to 15,500.00	16,000.00
4,501.00 to 5,500.00	6,000.00	15,501.00 to 16,500.00	17,000.00
5,501.00 to 6,500.00	7,000.00	16,501.00 to 17,500.00	18,000.00
6,501.00 to 7,500.00	8,000.00	17,501.00 to 18,500.00	19,000.00
7,501.00 to 8,500.00	9,000.00	18,501.00 to 19,500.00	20,000.00
8,501.00 to 9,500.00	10,000.00	19,501.00 to 20,500.00	21,000.00
9,501.00 to 10,500.00	11,000.00	20,501.00 to 21,500.00	22,000.00

Every additional increment of $1,000.00 or fraction thereof shall require an additional $1,000.00 on the bond.

Licensees are required to:

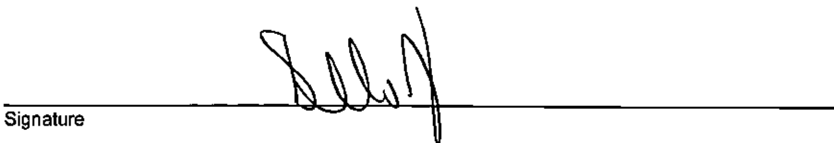
- Immediately notify the licensing agency in writing when the stated amount is exceeded.
- Maintain adequate safeguards and accurate records of monies and valuables entrusted to the facility, in accordance with regulations of the State Department of Public Health.

I (We) certify that the foregoing statements are true to the best of my (our) knowledge.



Shlomo Rechnitz
Print name

CEO
Title


Signature

November 1, 2014
Date

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 Health and Safety Code, Sections 1253, 1265, and 1267.5, and California Code of Regulations (CCR), Title 22, Sections 70107, 70137, 71107, 71135, 73205, 73241, 76205, and 76241.

Failure to provide the information as requested or submission of willful false statements 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.

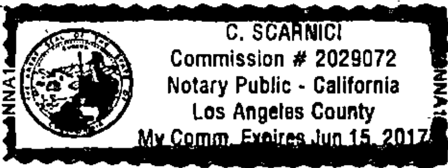
CALIFORNIA ALL-PURPOSE ACKNOWLEDGMENT

State of California

County of Los Angeles

On 12/20/13 before me, C. Scarnici-Notary Public,
Date — Here Insert Name and Title of the Officer

personally appeared Jennifer Wayne
Name(s) of Signer(s)



Place Notary Seal Above

who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature ______
Signature of Notary Public

OPTIONAL

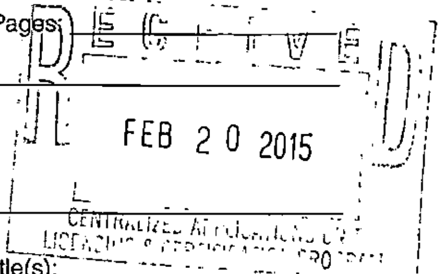
Though the information below is not required by law, it may prove valuable to persons relying on the document and could prevent fraudulent removal and reattachment of this form to another document.

Description of Attached Document

Title or Type of Document: ______

Document Date: ______ Number of Pages: ______

Signer(s) Other Than Named Above: ______

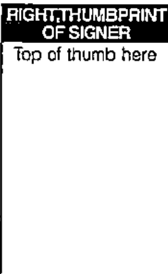


Capacity(ies) Claimed by Signer(s)

Signer's Name: ______
- ☐ Individual
- ☐ Corporate Officer — Title(s): ______
- ☐ Partner — ☐ Limited ☐ General
- ☐ Attorney in Fact
- ☐ Trustee
- ☐ Guardian or Conservator
- ☐ Other: ______

Signer Is Representing: ______

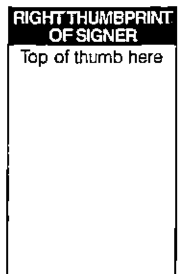
RIGHT THUMBPRINT OF SIGNER
Top of thumb here



Signer's Name: ______
- ☐ Individual
- ☐ Corporate Officer — Title(s): ______
- ☐ Partner — ☐ Limited ☐ General
- ☐ Attorney in Fact
- ☐ Trustee
- ☐ Guardian or Conservator
- ☐ Other: ______

Signer Is Representing: ______

RIGHT THUMBPRINT OF SIGNER
Top of thumb here



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BED OR SERVICE REQUEST

Date: 11-01-2014

This form is intended to identify the types of beds or services requested for health facilities. For new facilities, complete the column marked "Requested Beds." For existing facilities, complete both columns. The form is to accompany the application form (HS 200) for any new facility, change in capacity, service, facility type, or bed classification.

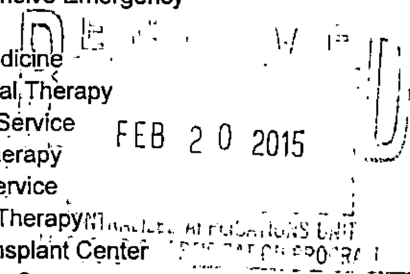
Name of facility	Type		
River Valley Healthcare & Wellness Centre, LP	Skilled Nursing Facility		
Address (number, street)	**City**	**State**	**ZIP code**
2490 Court St.	Redding	CA	96001

Please insert number:

EXISTING BEDS		REQUESTED BEDS	
____	Acute Respiratory	____	Acute Respiratory
____	*Burn	____	*Burn
____	Coronary Care	____	Coronary Care
113	General Nursing (Long-term)	113	General Nursing (Long-term)
____	Intensive Care	____	Intensive Care
____	*Intensive Care (Newborn)	____	*Intensive Care (Newborn)
____	Intermediate Care	____	Intermediate Care
____	Medical—Surgical	____	Medical—Surgical
____	Mental (Long-term)	____	Mental (Long-term)
____	Pediatrics	____	Pediatrics
____	Perinatal	____	Perinatal
____	*Psychiatric	____	*Psychiatric
____	Rehabilitation	____	Rehabilitation
____	Other (specify): ____	____	Other (specify): ____
113	APPROVED CAPACITY	____	APPROVED CAPACITY

Please check (✓) services:

EXISTING SERVICES		REQUESTED SERVICES	
____	*Basic Emergency	____	*Basic Emergency
____	*Cardiovascular Surgery	____	*Cardiovascular Surgery
____	*Chronic Dialysis Unit	____	*Chronic Dialysis Unit
____	*Comprehensive Emergency	____	*Comprehensive Emergency
____	Dental	____	Dental
____	Nuclear Medicine	____	Nuclear Medicine
____	Occupational Therapy	____	Occupational Therapy
____	Outpatient Service	____	Outpatient Service
____	Physical Therapy	____	Physical Therapy
____	Podiatric Service	____	Podiatric Service
____	*Radiation Therapy	____	*Radiation Therapy
____	*Renal Transplant Center	____	*Renal Transplant Center
____	*Respiratory Care	____	*Respiratory Care
____	Social Service	____	Social Service
____	Speech Pathology/Audio	____	Speech Pathology/Audio
____	Standby Emergency	____	Standby Emergency
____	Clinic Only:	____	Clinic Only:
____	Abortion Service	____	Abortion Service
____	Birthing Service	____	Birthing Service
		____	Optometric
____	Psychology	____	Psychology
____	Other (specify): ____	____	Other (specify): ____



*Special Permit Services

RIVER VALLEY HEALTHCARE & WELLNESS CENTRE, LP

2409 Court St. | Redding, CA 96001-2540
(530) 246-0600 | (530) 246-0558

November 1, 2014

California Department of Public Health
Licensing and Certification Program
Centralized Applications Unit
1615 Capitol Avenue, MS 3402
Sacramento, CA 95814

Re: Change of Ownership of Windsor Redding Care Center Storage of Medical Records

TO WHOM IT MAY CONCERN:

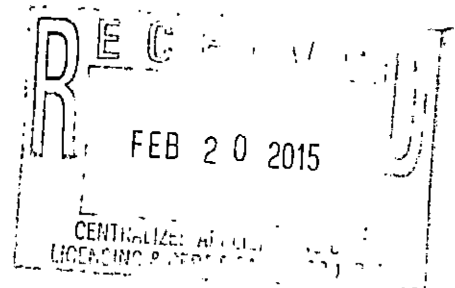
This correspondence shall serve as notice to the Department of Public Health regarding the storage of and access to, the residents' records after the change of ownership of the above referenced skilled nursing facility to River Valley Healthcare & Wellness Centre, LP (the "New Licensee").

The New Licensee will store the current residents' records at the facility at 2490 Court St. Redding, CA 96001. The current records will be made available to the prior licensee, where applicable, and to other authorized persons, as needed.

Discharge resident health records will be stored at the facility at American Records Management 5242 Westside Road #1 Redding, CA 96001. The discharge resident health records will be accessible 7 days a week, 24 hours a day, and will be made available to the prior licensee, and to other authorized persons, as needed.

Sincerely,

Shlomo Rechnitz
CEO



The parties agree that this agre[illegible]nt is a legal and binding document a[illegible]s fully enforceable in a court of competent jurisdiction. The pro[illegible] signing this agreement warrants that [illegible]he has read this agreement and understands it.

I declare under penalty of perjury under the laws of the State of California that the foregoing information is true, accurate, and complete to the best of my knowledge and belief.

I declare I am the provider or I have the authority to legally bind the provider, which is an entity and not an individual person.

1. Printed legal name of provider

River Valley Healthcare & Wellness Centre, LP

2. Printed name of person signing this declaration on behalf of provider (if an entity or business name is listed in Item 1 above)

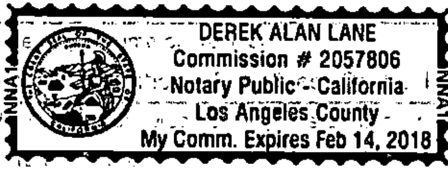
Shlomo Rechnitz

3. Original signature of provider or representative if this provider is an entity other than an individual person as sole proprietor

4. Title of person signing this declaration

CEO

5. Notary Public (Affix notary seal or stamp in the space below)



State of California, County of Los Angeles
On 11/1/2014 before me, Derek Alan Lane, Notary Public,
Personally appeared Shlomo Rechnitz,
who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument. I certify under **PENALTY OF PURJURY under the laws of the State of California** that the foregoing paragraph is true and correct.
WITNESS my hand and official seal.

Derek Alan Lane

Executed at: Los Angeles (City), California (State) on 11/1/2014 (Date)

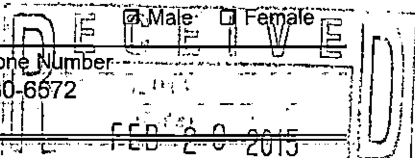
Applicants and providers licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act ARE NOT REQUIRED to have this form notarized. If notarization is required, the Certificate of Acknowledgement signed by the Notary Public must be in the form specified in Section 1189 of the Civil Code.

6. **Contact Person's Information**

☐ Check here if you are the same person identified in item 2. If you checked the box, provide only the email address and phone number below.

Contact Person's Name (last)	(first)	(middle)	(gender)
Brooks	Sharrod		☒ Male ☐ Female

Title/Position	Email address	Telephone Number
Preparer	sbrooks@rockporthc.com	323 330-6572



Privacy Statement

(Civil Code Section 1798 et seq.)

All information requested on the application, the disclosure statement, and the provider agreement is mandatory with the exception of the social security number for any person other than the person or entity for whom an IRS Form 1099 must be provided by the Department pursuant to 26 USC 6041. This information is required by the Department of Health Care Services, Provider Enrollment Division, by the authority of Welfare and Institutions Code Section 14043.2(a). The consequences of not supplying the mandatory information requested are denial of enrollment as a Medi-Cal provider or denial of continued enrollment as a provider and deactivation of all provider numbers used by the provider to obtain reimbursement from the Medi-Cal program. The consequence of not supplying the voluntary social security number information requested is delay in the application process while other documentation is used to verify the information supplied. Any information provided will be used to verify eligibility to participate as a provider in the Medi-Cal program. Any information may also be provided to the State Controller's Office, the California Department of Justice, the Department of Consumer Affairs, the Department of Corporations, or other state or local agencies as appropriate, fiscal intermediaries, managed care plans, the Federal Bureau of Investigation, the Internal Revenue Service, Medicare Fiscal Intermediaries, Centers for Medicare and Medicaid Services, Office of the Inspector General, Medicaid, and licensing programs in other states.