DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH SERVICE REGULATION

ROY COOPER
GOVERNOR

MANDY COHEN, MD, MPH
SECRETARY

MARK PAYNE
DIRECTOR

February 1, 2018

James C. Wrenn, Jr.
Hopper, Hicks & Wrenn, PLLC
PO Box 247
Oxford, North Carolina 27565

Exempt from Review – Acquisition of Facility

Record #:	**2474**
Facility Name:	Riverview
Type of Facility:	Adult Care Home
FID #:	920850
Acquisition by:	S&S Senior Housing of New Bern, LLC
Business #:	2759
County:	Craven

Dear Mr. Wrenn:

The Healthcare Planning and Certificate of Need Section, Division of Health Service Regulation (Agency) determined that based on your letter of January 12, 2018 the above referenced proposal is exempt from certificate of need review in accordance with N.C. Gen. Stat. §131E-184(a)(8). Therefore, S&S Senior Housing of New Bern, LLC may proceed to acquire the above referenced 83-bed health service facility without first obtaining a certificate of need. However, you need to contact the Agency's Adult Care Licensure Section to obtain instructions for changing ownership of the existing facility. Note that pursuant to N.C. Gen. Stat. §131E-181(b): "*A recipient of a certificate of need, or any person who may subsequently acquire, in any manner whatsoever permitted by law, the service for which that certificate of need was issued, is required to materially comply with the representations made in its application for that certificate of need.*"

It should be noted that this Agency's position is based solely on the facts represented by you and that any change in facts as represented would require further consideration by this Agency and a separate determination. If you have any questions concerning this matter, please feel free to contact this office.

HEALTHCARE PLANNING AND CERTIFICATE OF NEED SECTION
WWW.NCDHHS.GOV
TELEPHONE 919-855-3873
LOCATION: EDGERTON BUILDING • 809 RUGGLES DRIVE • RALEIGH, NC 27603
MAILING ADDRESS: 2704 MAIL SERVICE CENTER •RALEIGH, NC 27699-2704
AN EQUAL OPPORTUNITY/ AFFIRMATIVE ACTION EMPLOYER

Sincerely,

Jane Rhoe-Jones
Project Analyst

Martha J. Frisone
Chief, Healthcare Planning and
Certificate of Need Section

cc: Adult Care Licensure Section, DHSR
Sharetta Blackwell, Program Assistant Healthcare Planning, DHSR

LAW OFFICES OF
HOPPER, HICKS & WRENN, PLLC
Telephone: (919) 693-8161
www.hopperhickswrenn.com

N. Kyle Hicks
James C. Wrenn, Jr.
Holly W. Batten
Gerald T. Koinis
C. Gill Frazier, II

Oxford Office:
PO Box 247
111 Gilliam Street
Oxford, NC 27565
Creedmoor Office:
PO Box 686
106 W. Church St., Ste. E
Creedmoor, NC 27522

January 12, 2018

Ms. Martha Frisone, Chief
Ms. Jane Rhoe-Jones, Project Analyst
Division of Health Service Regulation
Healthcare Planning and Certificate of Need Section
North Carolina Department of Health and Human Services
2704 Mail Service Center
Raleigh, NC 27699-2704

Via first class mail and e-mail transmission to martha.frisone@dhhs.nc.gov *and* Jane.Rhoe-Jones@dhhs.nc.gov

RE: Confirmation that acquisition of Riverview (Water Oak Manor, Inc.) located at 3407 Oaks Road, New Bern, NC 28560 (License Number: HAL-025-031) is not subject to Article 9, Chapter 131E of the North Carolina General Statutes

Dear Ms. Frisone and Ms. Rhoe-Jones:

I represent Southern Living for Seniors of New Bern NC, LLC ("Southern Living") and S&S Senior Housing of New Bern, LLC ("S&S") with respect to obtaining a license to operate that certain adult care home currently known as Water Oak Manor, Inc. ("WOMI") (License Number: HAL-025-031) (the "License") from the North Carolina Department of Health and Human Services, Division of Health Service Regulation, Adult Care Home Licensure Section and related issues. The Facility is situated on a parcel of land located at 3407 Oaks Road, New Bern, NC 28560 (the "Real Property"). The Real Property is currently owned by Pierce Properties #1, LLC ("Pierce").

S&S proposes to acquire possession and rights to the Real Property from Pierce pursuant to the terms of a Contract for Deed (the "Contract") between S&S, Southern Living, and Pierce. Under the terms of the Contract, title to the Real Property will remain with Pierce until full performance of the Contract by S&S at which time the Real Property will be conveyed to S&S.

Southern Living proposes to acquire the right to operate the Facility from Pierce. WOMI and Pierce have entered into a "Settlement and Transfer Agreement" pursuant to which WOMI has agreed to consent to a Change Licensure Application filed by Pierce or its designee. Pierce has agreed in the Contract for Deed to assign its rights to acquire the Facility operations from WOMI to Southern Living.

After the completion of the transactions described above, Southern Living will operate the Facility pursuant to a lease with S&S. After Southern Living receives its license to operate the Facility, the Facility will be known as Southern Living for Seniors of New Bern.

Pursuant to G.S. §131E-184(a)(8), I understand that this transaction is exempt from review and, as a result, we request that you confirm that understanding by providing us with a "no review" letter. I recognize that the proposed transaction is rather confusing, and I am happy to answer any questions you may have.

As always, thank you for your assistance.

Sincerely,

James C. Wrenn, Jr.

JCWjr/gtk

State of North Carolina

Department of Health and Human Services
Division of Health Service Regulation

Effective January 1, 2018, this license is issued to

Water Oak Manor Inc

to operate an Adult Care Home known as

Riverview

located at 3407 Oaks Road
New Bern, NC, Craven County.

This license is issued subject to the statutes of the State of North Carolina, is not transferable and shall expire
December 31, 2018.

License Number: HAL-025-031

Capacity: 83

Special Care Units: X *Yes* _ *No* *Type:* *Alzheimer's/Dementia* 20

Authorized by:

Secretary, N.C. Department of Health and Human Services

Director, Division of Health Service Regulation

North Carolina Department of Health and Human Services
Division of Health Service Regulation
Adult Care Licensure Section
801 Biggs Drive
2720 Mail Service Center
Raleigh, North Carolina 27699-2720

If you are submitting a change application please indicate **Change Application Attached:** ____ Yes X No

Part A. Facility Information

Facility Name: Riverview

Physical Address: 3407 Oaks Road	**City:** New Bern	**State:** NC	**Zip:** 28560-

Telephone Number: (252)633-1143	**Fax Number:** (252)633-0422

If any of the above information is incorrect please call the Adult Care Licensure Section (919) 855-3765

Please provide your National Provider Identifier (NPI) *For questions regarding NPI, contact 1-800-465-3203 (NPI Toll-Free)*	**NPI:** 1225216872

Correspondence Mailing Address: (where you want to receive ALL correspondence including the license from Division of Health Service Regulation): Make corrections as needed

Name: Riverview	**Title:**
Address: P.O Box 1189	**Telephone Number:** (252) 633-1143
City, State Zip Code: New Bern, NC 28563-	
Primary Email: riverviewassistedliving@gmail.com	

CERTIFIED ADMINISTRATOR:

Name: Myra Sinclair	
Telephone Number: ( ) 252-633-1143	**Fax:** ( ) 252-633-0422
Administrator Certificate No. A00000571	**Expiration Date:** 12/31/2017

DHSR USE ONLY
License# **HAL-025-031**
FID# **920850**
Region **East**
Compliance Check Completed by PT 12/4/17
Entry by ____ Reviewed by PT
Date: 1/4/18 Date: 1/5/18
License Fee: **$1,812.50**

SW

FEE PAID
Date 10 / 10 / 17
Amount $ 1812.50
Check 7155 Cash Other

Part B Operation Disclosure

LEGAL IDENTITY OF LICENSEE

Licensee Information

- The preprinted name is the data we currently hold for this licensed facility. Please fill in the full address and phone number(s) for licensee.
- The licensee is the name of the legal entity licensed to operate the business at that site as indicated in **Part A.**
- The licensee is responsible for compliance to State rules and laws governing adult care homes.
- The status of the legal entity will be verified with the NC Office of the Secretary of State.
- **A Change Application is required for ANY changes to the preprinted Licensee name.**

Licensee Name: Water Oak Manor Inc		
Address: Po Box 1189		
City: New Bern	**State:** NC	**Zip code:** 28563
Telephone Number: 252-633-1143	**Fax Number:** 252-633-0422	
The licensee is :	X For Profit	___ Not For Profit

The licensee is: (Check one)

☐ Proprietorship (individual owner)	☐ Partnership (Unincorporated)
☒ Corporation (Inc.)	☐ Limited Liability Partnership (LLP)
☐ Limited Liability Company (LLC)	☐ Government Unit

NC Secretary of State ID #: 580662 12/4/17 PA

☐ **Registered in Other State.** **(Attach a copy of the Certificate of Authority issued by NCSOS)**

COMPLETE THE FOLLOWING INFORMATION:

- If the licensee is **not for profit,** the name of each Officer, Director or Trustees.
- If the licensee is **a partnership or limited liability partnership (LLP),** the name of each partner.
- If the licensee is **a limited liability company (LLC),** the names of the managing members, attach a list of the names and address of the members of the limited liability company.
- If the licensee is **a corporation (Inc.),** the name and title of each corporate officer.
- If the licensee is **a governmental unit,** the name and title of the individual in charge of the governmental agency or the individual designated in writing by the individual in charge of the governmental agency.

Executive Officer, General Partner, Managing Member

Name: Tony Bigler	**Telephone Number:** (252) 633-1143	**Fax Number:** (252)633-0422
Address: 201 S. McPherson Church Rd, Ste 226		
City: Fayetteville	**State:** NC	**Zip:** 28303

Name	**Title**
Name	**Title**
Name	**Title**

Management Company:

Is the business operated under a management contract? ☐Yes ☒No **If yes, provide name and address of the management company.**		
Company Name:		
Owner of Management Company Entity:	**Telephone Number:** ( )	
Street/Box:		
City:	**State:**	**Zip:**

Building Owner:

Is the building where services are offered leased/ rented? ☒Yes ☐No **If yes, please complete the following on the building/property owner.**			
Company Name or Individual Name: Weber Oak Properties, LLC			
Name of Managing Member: Tony Bigler			
Street/Box: 201 S. McPherson Church Road, Ste 226			
City: Fayetteville	**State:** NC	**Zip:** 28303	
Telephone Number: (910) 920-1180	**Fax Number:** (910) 920-1545		

Part C Ownership Disclosure (REQUIRED)

For the purpose of this application the following definitions apply:
The following definitions shall apply throughout this application:

(1) "Person" means an individual; a trust or estate; a partnership; a corporation; or any grouping of individuals, each of whom owns five percent or more of a partnership or corporation, who collectively own a majority interest of either a partnership or a corporation.

(2) "Owner" means any person who has or had legal or equitable title to or a majority interest in an adult care home.

(3) "Affiliate" means any person that directly or indirectly controls or did control an adult care home or any person who is controlled by a person who controls or did control an adult care home. In addition, two or more adult care homes who are under common control are affiliates.

(4) "Principal" means any person who is or was the owner or operator of an adult care home, an executive officer of a corporation that does or did own or operate an adult care home, a general partner of a partnership that does or did own or operate an adult care home, or a sole proprietorship that does or did own or operate an adult care home.

(5) "Indirect control" means any situation where one person is in a position to act through another person over whom the first person has control due to the legal or economic relationship between the two.

APPLICABLE RULES

§ 131D-34. Penalties; remedies (d1) The Department shall impose a civil penalty on any applicant for licensure who provides false information or omits information on the portion of the licensure application requesting information on owners, administrators, principals, or affiliates of the facility. The amount of the penalty shall be as is prescribed for a Type A1 Violation.

Part C Ownership Disclosure (REQUIRED)

OWNERS, PRINCIPLES, AFFILIATES, SHAREHOLDERS, MEMBERS

Complete the information below on **all** individuals who are owners, principles, affiliates, shareholders or members holding an interest of 5% or more of the licensee. Attach additional pages if necessary. **If you are the only owner, complete the information below, listing the percentage interest as 100%.**

Name: Tony Bigler
Address: 201 S. McPherson Church Road, ste 226
City: Fayetteville State: NC Zip Code: 28303
Phone #: (910) 920-1180 Fax (910) 920-1545
Email Address: etcareinc@earthlink.net
Percentage interest in this licensed Facility: 50 Title: officer
List the names of other Family Care/Adult Care Home in which you are the owner or affiliate:

Name: Edith Bigler
Address: 201 S. McPherson Church Road, ste 226
City: Fayetteville State: NC Zip Code: 28303
Phone #: (910) 920-1180 Fax (910) 920-1545
Email Address: edithwbigler@yahoo.com
Percentage interest in this licensed Facility: 50 Title: officer
List the names of other Family Care/Adult Care Home in which you are the owner or affiliate:

Name:
Address:
City: State: Zip Code:
Phone #: ( ) Fax ( )
Email Address:
Percentage interest in this licensed Facility: Title:
List the names of other Family Care/Adult Care Home in which you are the owner or affiliate:

Name:
Address:
City: State: Zip Code:
Phone #: ( ) Fax ( )
Email Address:
Percentage interest in this licensed Facility: Title:
List the names of other Family Care/Adult Care Home in which you are the owner or affiliate:

Part D Census Data

If facility DID NOT serve any residents in the last 12 months, please sign below.

Attestation of Facility Census

This facility operating as **Riverview** has **not** served one or more residents in the previous 12 months. If this is a true statement for this facility, please sign below.
Date of last resident served at this location _____.
Do you plan to serve residents in the next 12 months? _____

Signature _____ Title: _____ Date _____

Data requested for all questions in this section should be based on facility's July 31, 2017 Census

Complete this section if you have one or more residents.

1. Please give the **number** (1,2,3 etc.) of residents in facility as indicated on **July 31, 2017**:

Resident Age - years	Male	Female	Total
18 - 20	0	0	0
21 - 34	3	0	3
35 - 54	7	2	9
55 - 64	11	6	17
65 - 74	7	3	10
75 - 84	3	6	9
85 or older	0	0	0
TOTAL	31	17	48

2. On **July 31, 2017**, number of residents receiving Medicaid reimbursed Consolidated Personal Care: 39

3. On **July 31, 2017**, number of residents on State/County Special Assistance (SA): 42

4. On **July 31, 2017**, number of private pay residents: 6

RESIDENT UTILIZATION DATA

If you have questions about the items on this page, call Healthcare Planning at (919) 855-3865.

A. Beginning Census, Admissions, Discharges, and Deaths

Complete the chart below for the reporting period of August 1, 2016 through July 31, 2017.

Beginning Census (Aug. 1, 2016)	Admissions (Aug. 1, 2016 – July 31, 2017)	Discharges (excluding deaths) (Aug. 1, 2016 – July 31, 2017)	Deaths (Aug. 1, 2016 – July 31, 2017)	Total*
48	4	4	0	48

Total must match total reported for July 31, 2017 census on page 11.

*To calculate: ***Beginning Census + Admissions – Discharges – Deaths = Total***

Note: *Beginning Census* is the number of residents in your facility on Aug. 1, 2016.
Admissions is the number of residents admitted from Aug. 1, 2016 through July 31, 2017.
Discharges and *Deaths* are all discharges and deaths from Aug. 1, 2016 through July 31, 2017.

B. Paid Bed Days

Complete the chart below for the reporting period of August 1, 2016 through July 31, 2017.

(1) Paid Bed Days reimbursed by Private Pay (out-of-pocket)	2,475
(2) Paid Bed Days reimbursed by County Special Assistance (includes Medicaid)	13,776
(3) Paid Bed Days reimbursed by Other (insurance or other means of payment)	0
(4) Total** = { (1) + (2) + (3) }	16,251

Note: Report paid bed days as cumulative totals.
Example: total number of days of private pay for Resident #1+
total number of days of private pay for Resident #2+
total number of days of private pay for Resident #3+…
Continue for each resident in the facility and then repeat for each of the three categories

**Total cannot be less than the *minimum paid bed* †days or greater than *maximum paid bed*†† days.

†*minimum paid bed days* is equal to *Beginning Census* plus the *Admissions* (see Item A above).

††*maximum paid bed days* is equal to your licensed bed capacity multiplied the number of days in the year.
Example: 20 licensed beds x 365 days = 7,300 paid bed days.

The information on this page is collected pursuant to G.S. § 131E-177.

C. Census by Diagnosis and Age

Please give the number (1,2,3, etc.) of residents in facility (on **July 31, 2017**) with a physician's diagnosis of the following:

- **Mental Illness (MI)** which includes a psychiatric illness but does not include intellectual disability, developmental disability or Alzheimer's Disease/Related Dementia;

  **As defined under NC G.S. 122C-3 (21), Mental Illness means: when applied to an adult, (i) is an illness which lessens the capacity of the individual to use self-control, judgment and discretion in the conduct of his affairs and social relations so as it makes it necessary or advisable to be under treatment, care, supervision, guidance or control. Mental illnesses include but are not limited to major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder (OCD), panic disorder, post traumatic stress disorder (PTSD), and borderline personality disorder.*

- **Intellectual Disability/Developmental Disability** (ID/DD)

- **Alzheimer's Disease or Related Dementia**

If a resident is dually diagnosed, only count the resident once, based on the **primary** diagnosis.
Do not list names of residents.

Resident Age - years	MI* (See above definition for MI)	ID/DD	Alzheimer's Disease /Related Dementia
18 - 20	0	0	0
21 - 34	0	0	0
35 - 54	3	1	0
55 - 64	3	0	4
65 - 74	2	0	8
75 - 84	2	0	7
85 or older	0	0	0
TOTAL	10	1	19

☐ **Check here if this Adult Care Home serves only elderly persons. [G.S. 131D-21 (5)]**
Elderly Persons are defined as persons age 55 OR older or who have a primary diagnosis of Alzheimer's disease or other form of dementia that requires assistance with activities of daily living.

LICENSED CAPACITY: 83

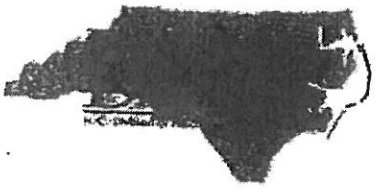
Licensed Special Care Unit, in accordance with 10A NCAC 13F .1300, Capacity: 20
On **July 31, 2017** number of occupied Special Care Unit beds 19

Authenticating Signature: The undersigned submits this application for licensure for the year 2018 in accordance with Article 1 Chapter 131 D-2 of the General Statutes of North Carolina and to the rules adopted there under by the North Carolina Medical Care Commission (10A NCAC 13F) and certifies the accuracy of this information.

Signature: Tony Sig D **Date:** 10/02/2017

Print Name Tony Bigler **Phone Number:** (910) 920-1180

RENEWAL LICENSURE
COMPLIANCE HISTORY CHECK
Division of Facility Services
Adult Care Licensure Section (ACLS)



Date of History Check 12/4/17
Facility Name Riverbrook
License # AAC-025-031
FID # 920850
County Craven

nstructions: ***Complete the second page worksheet using the sources described.*** Then for any findings of negative ictions listed below, record on this page the one(s) that will prevent issuing a renewal license. Then make a ecommendation regarding eligibility for renewal licensure of a facility for the licensee.

Reference		
G.S. 131D-2.4 (C) (2)	Type B or Type A Penalty Deny until 1 year after assessed OR.... until confirmed returned to substantial compliance which ever comes first	☐ No ☑ Yes ☐ Appeal Date Monetary Imposition Date several penalties SA 12/20/16 Penalty Due Date Confirmed Compliance Date 12/7/17 Penalty Paid Date 12/7/17
10A NCAC 13F .0203	Suspension of Admission (SOA) Deny until 6 months after SOA lifted	☐ No ☑ Yes ☐ Appeal Date Initiation Date 1/20/17 Lift Date
G.S. 131D-2.4 (C) (3) or (4)	Provisional Licensure Deny until 6 months from date license fully restored	☐ No ☐ Yes ☐ Appeal Date Restoration Date Termination Date
G.S. 131D-2.4 (C) (3) or (4)	Summarily Suspended Licensure Deny until 5 years from date suspension lifted or terminated.	☑ No ☐ Yes ☐ Appeal Date Restoration Date Termination Date
G.S. 131D-2.4 (C) (3) or (4)	Revocation Deny until 5 year after the date revocation became effective.	☑ No ☐ Yes ☐ Appeal Date Effective Date_____ Lift Date

If yes to any of the above, provider tracking database, adverse action or on secretary of state record, forward o Administrative Officer / Program Development Coordinator for approval.
pproved by _____ **Date** _____

Recommendation: The owners are eligible for licensure ☑ No ☐ Yes Initials of Reviewer: PT
Comments:
All penalties pd. 12/7/18 OK to process 1/15/18 PT

evised 09/29/2017

RENEWAL LICENSURE
MPLIANCE HISTORY CHECK
Division of Health Service Regulation
ılt Care Licensure Section (ACLS)
Worksheet

ck LTI for ACLS compliance.

Check each owner listed on application
Go To:
Reports
General Reports
Owners, Report Yes, SSN/Name
Check each facility listed on application
GoTo:
Facility by name or county,
Facility 1, R Action
Recommended Action 1

List all licensees/owners with 5% or more interest in the business:

Water Oak Alumni, Inc.
Tony Bigham
Edith Bigham

Cross check web for compliance in
Mental Health Licensure Section
Child Care Licensure Section
http://providertracking.dhhs.state.nc.us
* If any negative results print and attach.

Reviewed Date 12/4/17
Initials PT

Attached yes (no)

Cross check web for compliance in
NC Department Of The Secretary of State
http://www.secretary.state.nc.us/corporations/CSearch.aspx
* If any negative results print and attach

Reviewed Date 12/4/17
Initials PT

Attached (yes (no)

Out of State Facilities:
Route to Administrative Officer

Owner (s)	Facility	County	Adverse Action	Effective Date	Meets Compliance

evised 09/29/2017

NORTH CAROLINA
Department of the Secretary of State

CERTIFICATE OF EXISTENCE

I, Elaine F. Marshall, Secretary of State of the State of North Carolina, do hereby certify that

WATER OAK MANOR, INC.

is a corporation duly incorporated under the laws of the State of North Carolina, having been incorporated on the 1st day of January, 2007, with its period of duration being Perpetual.

I FURTHER certify that, as of the date set forth hereunder, the said corporation's articles of incorporation are not suspended for failure to comply with the Revenue Act of the State of North Carolina; that the said corporation is not administratively dissolved for failure to comply with the provisions of the North Carolina Business Corporation Act; that its most recent annual report required by N.C.G.S. 55-16-22 has been delivered to the Secretary of State; and that the said corporation has not filed articles of dissolution as of the date of this certificate.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal at the City of Raleigh, this 24th day of August, 2012.

Elaine F. Marshall

Secretary of State

Scan to verify online.

tification# 93154428-1 Reference# 11160364- Page: 1 of 1
ify this certificate online at www.secretary.state.nc.us/verification

State of North Carolina

Department of Health and Human Services
Division of Health Service Regulation

Effective January 1, 2017, this license is issued to

Water Oak Manor Inc

to operate an Adult Care Home known as

Riverview

located at 3407 Oaks Road
New Bern, NC, Craven County.

This license is issued subject to the statutes of the State of North Carolina, is not transferable and shall expire
December 31, 2017.

License Number: HAL-025-031

Capacity: 83

Special Care Units: X *Yes* _ *No* *Type:* *Alzheimer's/Dementia* 20

Authorized by:

Richard O. Bay

Secretary, N.C. Department of Health and Human Services

Director, Division of Health Service Regulation

North Carolina Department of Health and Human Services
Division of Health Service Regulation
Adult Care Licensure Section
2720 Mail Service Center
Raleigh, North Carolina 27699-2720

If you are submitting a change application please indicate ***Change Application Attached:** _____ **Yes** _____ **No**

Part A. Facility Information

Facility Name: Riverview			
Physical Address: 3407 Oaks Road	**City:** New Bern	**State:** NC	**Zip:** 28560-
Telephone Number: (252)633-1143	**Fax Number:** (252)633-0422		
***If any of the above information is incorrect please call the Adult Care Licensure Section (919) 855-3765**			
Please provide your National Provider Identifier (NPI) *For questions regarding NPI, contact **1-800-465-3203 (NPI Toll-Free)***	**NPI:** 1225216872		

Correspondence Mailing Address: (where you want to receive ALL correspondence including the license from Division of Health Service Regulation): *Make corrections as needed

Name: Riverview	**Title:**
Address: P.O Box 1189	**Telephone Number:** (252) 633 - 1143
City, State Zip Code: New Bern, NC 28563-	
Primary Email: ~~wateroakmanor@yahoo.com~~ riverview assisted living @ gmail.com	

CERTIFIED ADMINISTRATOR:

Name: Myra Sinclair JS 9-29-16	
Telephone Number: (252) 633 - 1143	**Fax:** (252) 633 - 0422
Administrator Certificate No. A00000571	**Expiration Date:** 12/31/2017

DHSR USE ONLY
License# **HAL-025-031**
FID# **920850**
Region **Northeast**
Compliance Check Completed ✓ PT 10/7/16
Entry by LR Reviewed by JS
Date: 10-26-2016 Date: 12-8-16
License Fee: **$1,812.50**

FEE PAID
Date 9, 29, 16
Amount $ 1812.50
Check Cash Other
06092

Part B Operation Disclosure

LEGAL IDENTITY OF LICENSEE

Licensee Information

- The preprinted name is the data we currently hold for this licensed Facility. Please fill in the full address and phone number(s) for licensee.
- The Licensee is the name of the legal entity licensed to operate the business at that site as indicated in **Part A.**
- The Licensee is responsible for compliance to State rules and laws governing adult care homes.
- The status of the Legal entity will be verified with the NC Office of the Secretary of State.
- **A Change Application is required for ANY changes to the preprinted Licensee name.**

Licensee Name: Water Oak Manor Inc			
Address: PO Box 1189			
City: New Bern	**State:** NC	**Zip code:** 28563	
Telephone Number: 252-633-1143	**Fax Number:** 252-633-0422		
The licensee is :	X For Profit	___ Not For Profit	

The licensee is: (Check one)

☐ Proprietorship (individual owner)	☐ Partnership (Unincorporated)
☒ Corporation (Inc)*	☐ Limited Liability Partnership (LLP)*
☐ Limited Liability Company (LLC)*	☐ Government Unit

*NC Secretary of State ID #: 880662 10/6/16 DT

☐ **Registered in Other State.** **(Attach a copy of the Certificate of Authority issued by NCSOS)**

COMPLETE THE FOLLOWING INFORMATION:

- If the licensee is **not for profit,** the name of each Officer, Director or Trustees.
- If the licensee is **a partnership or limited liability partnership (LLP),** the name of each partner.
- If the licensee is **a limited liability company (LLC),** the names of the managing members, attach a list of the names and address of the members of the limited liability company.
- If the licensee is **a corporation (Inc),** the name and title of each corporate officer.
- If the licensee is **a governmental unit**, the name and title of the individual in charge of the governmental agency or the individual designated in writing by the individual in charge of the governmental agency.

Executive Officer, General Partner, Managing Member			
Name: Tony Bigler		**Telephone Number:** (252) 633-1143	**Fax Number:** (252) 633-0422
Address: 201 S McPherson Church Road, Ste 226			
City: Fayetteville	**State:** NC	**Zip:** 28303	

Name	**Title**
Name	**Title**
Name	**Title**

Management Company:

Is the business operated under a management contract? ☐Yes ☒No **If yes, provide name and address of the management company**		
Company Name:		
Owner of Management Company Entity:	**Telephone Number:** ( )	
Street/Box:		
City:	**State:**	**Zip:**

Building Owner

Is the building where services are offered leased/ rented? ☐Yes ☐No **If yes, please complete the following on the building/property owner.**		
Company Name or Individual Name: Water Oak Properties, LLC		
Name of Managing Member: Tony Bigler		
Street/Box: 201 S McPherson Church Road, Ste 226		
City: Fayetteville	**State:** NC	**Zip:** 28303
Telephone Number: (910) 920-1180	**Fax Number:** (910) 920-1545	

Part C Ownership Disclosure (*REQUIRED)

For the purpose of this application the following definitions apply:
The following definitions shall apply throughout this application:

(1) "Person" means an individual; a trust or estate; a partnership; a corporation; or any grouping of individuals, each of whom owns five percent or more of a partnership or corporation, who collectively own a majority interest of either a partnership or a corporation.

(2) "Owner" means any person who has or had legal or equitable title to or a majority interest in an adult care home.

(3) "Affiliate" means any person that directly or indirectly controls or did control an adult care home or any person who is controlled by a person who controls or did control an adult care home. In addition, two or more adult care homes who are under common control are affiliates.

(4) "Principal" means any person who is or was the owner or operator of an adult care home, an executive officer of a corporation that does or did own or operate an adult care home, a general partner of a partnership that does or did own or operate an adult care home, or a sole proprietorship that does or did own or operate an adult care home.

(5) "Indirect control" means any situation where one person is in a position to act through another person over whom the first person has control due to the legal or economic relationship between the two.

APPLICABLE RULES

"§ 131D-34. Penalties; remedies

(d1) The Department shall impose a civil penalty on any applicant for licensure who provides false information or omits information on the portion of the licensure application requesting information on owners, administrators, principals, or affiliates of the facility. The amount of the penalty shall be as is prescribed for a Type A1 Violation.

Part C Ownership Disclosure (*REQUIRED)

OWNERS, PRINCIPLES, AFFILIATES, SHAREHOLDERS, MEMBERS

Complete the information below on **all** individuals who are owners, principles, affiliates, shareholders or members holding an interest of 5% or more of the licensee. Attach additional pages if necessary. **If you are the only owner, complete the information below, listing the percentage interest as 100%.**

Name: Tony Bigler
Address: 201 S McPherson Church Road, Ste 226
City: Fayetteville State: NC Zip Code: 28303
Phone #: (910) 920-1180 Fax (910) 920-1545
Email Address: etcreinc@earthlink.net
Percentage interest in this licensed Facility: 50 Title: Officer
List the names of other Family Care/Adult Care Home in which you are the owner or affiliate:

Name: Edith Bigler
Address: 201 S McPherson Church Road, Ste 226
City: Fayetteville State: NC Zip Code: 28303
Phone #: (910) 920-1180 Fax (910) 920-1545
Email Address: edithwbigler@yahoo.com
Percentage interest in this licensed Facility: 50 Title: Officer
List the names of other Family Care/Adult Care Home in which you are the owner or affiliate:

Name:
Address:
City: State: Zip Code:
Phone #: ( ) Fax ( )
Email Address:
Percentage interest in this licensed Facility: Title:
List the names of other Family Care/Adult Care Home in which you are the owner or affiliate:

Name:
Address:
City: State: Zip Code:
Phone #: ( ) Fax ( )
Email Address:
Percentage interest in this licensed Facility: Title:
List the names of other Family Care/Adult Care Home in which you are the owner or affiliate:

Part D Census Data

If facility DID NOT serve any residents in the last 12 months, please sign below.

Attestation of Facility Census

This facility operating as **Riverview** has **not** served one or more residents in the previous 12 months. If this is a true statement for this facility, please sign below.
Date of last resident served at this location _____.
Do you plan to serve residents in the next 12 months? _____

Signature _____ Title: _____ Date _____

Data requested for all questions in this section should be based on facility's July 31, 2016 Census

Complete this section if you have one or more residents.

1. Please give the **number** (1,2,3 etc.) of residents in facility as indicated on **July 31, 2016**:

Resident Age - years	Male	Female	Total
18 - 20	0	0	0
21 - 34	3	0	3
35 - 54	7	2	9
55 - 64	11	6	17
65 - 74	7	3	10
75 - 84	3	6	9
85 or older	0	0	0
TOTAL	31	17	48

2. On **July 31, 2016**, number of residents receiving Medicaid reimbursed Consolidated Personal Care: 39
3. On **July 31, 2016**, number of residents on State/County Special Assistance (SA): 42
4. On **July 31, 2016**, number of private pay residents: 6

RESIDENT UTILIZATION DATA

If you have questions about the items on this page, call Healthcare Planning at (919) 855-3865.

A. Beginning Census, Admissions, Discharges, and Deaths

Complete the chart below for the reporting period of August 1, 2015 through July 31, 2016.

Beginning Census (Aug. 1, 2015)	**Admissions** (Aug. 1, 2015 – July 31, 2016)	**Discharges** (excluding deaths) (Aug. 1, 2015 – July 31, 2016)	**Deaths** (Aug. 1, 2015 – July 31, 2016)	**Total***
46	14	12	0	48

Total must match total reported for July 31, 2016 census on page 11.

To calculate:** ***Beginning Census + Admissions – Discharges – Deaths = Total

Note: *Beginning Census* is the number of residents in your facility on Aug. 1, 2015.
Admissions is the number of residents admitted from Aug. 1, 2015 through July 31, 2016.
Discharges and *Deaths* are all discharges and deaths from Aug. 1, 2015 through July 31, 2016.

B. Paid Bed Days

Complete the chart below for the reporting period of August 1, 2015 through July 31, 2016.

(1) Paid Bed Days reimbursed by Private Pay (out-of-pocket)	2,475
(2) Paid Bed Days reimbursed by County Special Assistance (includes Medicaid)	13,776
(3) Paid Bed Days reimbursed by Other (insurance or other means of payment)	0
(4) Total** = { (1) + (2) + (3) }	16,251

Note: Report paid bed days as cumulative totals.

Example: total number of days of private pay for Resident #1+
total number of days of private pay for Resident #2+
total number of days of private pay for Resident #3+...

(Continue for each resident in the facility and then repeat for each of the three categories)

**Total cannot be less than the *minimum paid bed* †days or greater than *maximum paid bed*†† days.

†*minimum paid bed days* is equal to *Beginning Census* plus the *Admissions* (see Item A above).
††*maximum paid bed days* is equal to your licensed bed capacity multiplied the number of days in the year. (Example: 20 licensed beds x 365 days = 7,300 paid bed days).

The information on this page is collected pursuant to G.S. § 131E-177.

C. Census by Diagnosis and Age

Please give the number (1,2,3, etc.) of residents in facility (on **July 31, 2016**) with a physician's diagnosis of the following:

- **Mental Illness (MI)** which includes a psychiatric illness but does not include intellectual disability, developmental disability or Alzheimer's Disease/Related Dementia;

  *****For the purpose of this application Mental Illness is an illness which lessens the capacity of the individual to use self-control, judgment and discretion in the conduct of his affairs and social relations so as it makes it necessary or advisable to be under treatment, care, supervision, guidance or control. Mental illnesses include major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder (OCD), panic disorder, post traumatic stress disorder (PTSD), and borderline personality disorder.*****

- **Intellectual Disability/Developmental Disability** (ID/DD) *This reflects change in wording from MR to ID*
- **Alzheimer's Disease or Related Dementia**

If a resident is dually diagnosed, only count the resident once, based on the **primary** diagnosis.
Do not list names of residents.

Resident Age - years	MI**** (See above definition for MI)	ID/DD	Alzheimer's Disease /Related Dementia
18 - 20	0	0	0
21 - 34	2	0	0
35 - 54	3	2	0
55 - 64	3	0	4
65 - 74	2	0	8
75 - 84	2	0	7
85 or older	0	0	0
TOTAL	12	2	19

☐ **Check here if this Adult Care Home serves Only elderly persons. [G.S. 131D-21 (5)]**
Elderly Persons are defined as persons age 55 OR older or who have a primary diagnosis of Alzheimer's disease or other form of dementia that requires assistance with activities of daily living.

***LICENSED CAPACITY:** 83

Licensed Special Care Unit, in accordance with 10A NCAC 13F .1300, Capacity: 20

On **July 31, 2016** number of occupied Special Care Unit beds 19

Authenticating Signature: The undersigned submits this application for licensure for the year 2017 in accordance with Article 1 Chapter 131 D-2 of the General Statutes of North Carolina and to the rules adopted there under by the North Carolina Medical Care Commission (10A NCAC 13F) and certifies the accuracy of this information.

Signature: Tony Bigler **Date:** 09/22/2016

Print Name Tony Bigler **Phone Number:** (910) 920-1180

RENEWAL LICENSURE
COMPLIANCE HISTORY CHECK
Division of Facility Services
Adult Care Licensure Section (ACLS)

Date of History Check 10/6/16
Facility Name Riverview
License # HAL-025-031
FID # 920850
County Craven

Instructions: *Complete the second page worksheet using the sources described.* Then for any findings of negative actions listed below, record on this page the one(s) that will prevent issuing a renewal license. Then make a recommendation regarding eligibility for renewal licensure of a facility for the licensee.

Reference G.S. 131D-2.4 (C) (2)	Type B or Type A Penalty Deny until 1 year after assessed OR.... until confirmed returned to substantial compliance which ever comes first	☐ No ☑ Yes ☑ Appeal Date 5/18/16 Monetary Assessment Date 4/22/16 Penalty Due Date 6/22/16 Confirmed Compliance Date ____ Penalty Paid Date
10A NCAC 13F .0203	Suspension of Admission (SOA) Deny until 6 months after SOA lifted	☑ No ☐ Yes ☐ Appeal Date ____ Initiation Date ____ Lift Date ____
G.S. 131D-2.4 (C) (3) or (4)	Provisional Licensure Deny until 6 months from date license fully restored	☑ No ☐ Yes ☐ Appeal Date ____ Restoration Date ____ Termination Date ____
G.S. 131D-2.4 (C) (3) or (4)	Summarily Suspended Licensure Deny until 6 months from date license fully restore	☑ No ☐ Yes ☐ Appeal Date ____ Restoration Date ____ Termination Date ____
G.S. 131D-2.4 (C) (3) or (4)	Revocation Deny until 1 year after revocation	☑ No ☐ Yes ☐ Appeal Date ____ Lift Date ____

If yes to any of the above, provider tracking database, adverse action or on secretary of state record, forward o Administrative Officer / Program Development Coordinator for approval.
Approved by _____ Date _____

Recommendation: The owners are eligible for licensure ☐ No ☑ Yes Initials of performer: PT

Comments:

RENEWAL LICENSURE
COMPLIANCE HISTORY CHECK
Division of Health Service Regulation
Adult Care Licensure Section (ACLS)
Worksheet

Check LTI for ACLS compliance.

Check each owner listed on application
Go To:
Reports
General Reports
Owners, Report Yes, SSN/Name
Check each facility listed on application
GoTo:
Facility by name or county,
Facility 1, R Action
Recommended Action 1

List all licensees/owners with 5% or more interest in the business:

Tony & Edith Bigelow

Cross check web for compliance in
Mental Health Licensure Section
Child Care Licensure Section
http://providertracking.dhhs.state.nc.us
* If any negative results print and attach.

Reviewed Date 10/6/16
Initials PT

Attached ☐ yes ☑ no

Cross check web for compliance in
NC Department Of The Secretary of State
http://www.secretary.state.nc.us/corporations/CSearch.aspx
* If any negative results print and attach

Reviewed Date 10/6/16
Initials PT

Attached ☐ yes ☑ no

Out of State Facilities:
Route to Administrative Officer

Owner (s)	Facility	County	Adverse Action	Effective Date	Meets Compliance
	Riverstone	Craven	3 penalties	12/29/15	Appeal 1/15/16
	Riverview	"	(5) penalties	4/22/16	appeal 5/18/16
	Pinewood Manor	Hertford	NONE		
	Wallace Garden	Duplin	"		
	Lake Pointe AL	Columbus	"		

State of North Carolina

Department of Health and Human Services
Division of Health Service Regulation

Effective January 1, 2016, this license is issued to

Water Oak Manor Inc

to operate an Adult Care Home known as

Riverview

located at 3407 Oaks Road
New Bern, NC, Craven County.

This license is issued subject to the statutes of the State of North Carolina, is not transferable and shall expire
December 31, 2016.

License Number: HAL-025-031

Capacity: 83

Special Care Units: X *Yes* _ *No* *Type:* *Alzheimer's/Dementia* 20

Authorized by:

Richard O. Bay

Secretary, N.C. Department of Health and Human Services

Director, Division of Health Service Regulation

North Carolina Department of Health and Human Services
Division of Health Service Regulation
Adult Care Licensure Section
2720 Mail Service Center
Raleigh, North Carolina 27699-2720

If you are submitting a change application please indicate ***Change Application Attached:** Yes X No

Part A. Facility Information

Facility Name: Riverview

Physical Address: 3407 Oaks Road	**City:** New Bern	**State:** NC	**Zip:** 28560-

Telephone Number: (252)633-1143	**Fax Number:** (252)633-0422

***If any of the above information is incorrect please call the Adult Care Licensure Section (919) 855-3765**

Please provide your National Provider Identifier (NPI) *For questions regarding NPI, contact 1-800-465-3203 (NPI Toll-Free)*	**NPI:**

Correspondence Mailing Address: (where you want to receive ALL correspondence including the license from Division of Health Service Regulation): *Make corrections as needed

Name: RIVERVIEW	**Title:**
Address: P.O Box 1189	**Telephone Number:** (252) 633-1143
City, State Zip Code: New Bern, NC 28563-	
Primary Email: wateroakmanor@yahoo.com	

CERTIFIED ADMINISTRATOR:

Name: Tony BIGLER JS 9/3/15	
Telephone Number: ( ) 910 520-1180	**Fax:** ( ) 910 520-1545
Administrator Certificate No. 60000076	**Expiration Date:** 12/31/2015

DHSR USE ONLY
License# **HAL-025-031**
FID# **920850**
Region **Northeast**
Compliance Check Completed 9/16/15 JS. 07 12/9/15 + 1/12/16
Entry by 07
Date: 1/12/16
Reviewed by AC
Date: 1/13/16
License Fee: **$1,812.50**

FEE PAID
Date 9 3 15
Amount 1812 50
Check 6166 Cash Other

Part B Operation Disclosure

LEGAL IDENTITY OF LICENSEE

Licensee Information

- The preprinted name is the data we currently hold for this licensed Facility. Please fill in the full address and phone number(s) for licensee.
- The Licensee is the name of the legal entity licensed to operate the business at that site as indicated in **Part A.**
- The Licensee is responsible for compliance to State rules and laws governing adult care homes.
- The status of the Legal entity will be verified with the NC Office of the Secretary of State.
- **A Change Application is required for ANY changes to the preprinted Licensee name.**

Licensee Name: Water Oak Manor Inc		
Address: Po Box 1189		
City: New Bern	**State:** NC	**Zip code:** 28563
Telephone Number: 252-633-1143	**Fax Number:** 252-633-0422	
The licensee is :	X For Profit	___ Not For Profit

The licensee is: (Check one)

☐ Proprietorship (individual owner)	☐ Partnership (Unincorporated)
☒ Corporation (Inc)*	☐ Limited Liability Partnership (LLP)*
☐ Limited Liability Company (LLC)*	☐ Government Unit

*NC Secretary of State ID #: 880662 1/12/16 PT

☐ **Registered in Other State.** **(Attach a copy of the Certificate of Authority issued by NCSOS)**

COMPLETE THE FOLLOWING INFORMATION:

- If the licensee is **not for profit,** the name of each Officer, Director or Trustees.
- If the licensee is **a partnership or limited liability partnership (LLP),** the name of each partner.
- If the licensee is **a limited liability company (LLC),** the names of the managing members, attach a list of the names and address of the members of the limited liability company.
- If the licensee is **a corporation (Inc),** the name and title of each corporate officer.
- If the licensee is **a governmental unit**, the name and title of the individual in charge of the governmental agency or the individual designated in writing by the individual in charge of the governmental agency.

Executive Officer, General Partner, Managing Member

Name: Tony Bigler	**Telephone Number:** (910) 920-1180	**Fax Number:** (910) 920-0545
Address: 201 S McPherson Church Rd, Ste 226		
City: Fayetteville	**State:** NC	**Zip:** 28303

Name	**Title**
Name	**Title**
Name	**Title**

Management Company:

Is the business operated under a management contract? ☐Yes ☒No **If yes, provide name and address of the management company**		
Company Name:		
Owner of Management Company Entity:	**Telephone Number:** ( )	
Street/Box:		
City:	**State:**	**Zip:**

Building Owner

Is the building where services are offered leased/ rented? ☐Yes ☒No **If yes, please complete the following on the building/property owner and provide a copy of the lease agreement.**		
Name: Water Oak Properties, LLC		
Street/Box: 201 S McPherson Church Rd, Ste 226		
City: Fayetteville	**State:** NC	**Zip:** 28303
Telephone Number: (910) 920-1150	**Fax Number:** (910) 920-1545	

Part C Ownership Disclosure (*REQUIRED)

For the purpose of this application the following definitions apply:
The following definitions shall apply throughout this application:

(1) "Person" means an individual; a trust or estate; a partnership; a corporation; or any grouping of individuals, each of whom owns five percent or more of a partnership or corporation, who collectively own a majority interest of either a partnership or a corporation.

(2) "Owner" means any person who has or had legal or equitable title to or a majority interest in an adult care home.

(3) "Affiliate" means any person that directly or indirectly controls or did control an adult care home or any person who is controlled by a person who controls or did control an adult care home. In addition, two or more adult care homes who are under common control are affiliates.

(4) "Principal" means any person who is or was the owner or operator of an adult care home, an executive officer of a corporation that does or did own or operate an adult care home, a general partner of a partnership that does or did own or operate an adult care home, or a sole proprietorship that does or did own or operate an adult care home.

(5) "Indirect control" means any situation where one person is in a position to act through another person over whom the first person has control due to the legal or economic relationship between the two.

APPLICABLE RULES

"§ 131D-34. Penalties; remedies

(d1) The Department shall impose a civil penalty on any applicant for licensure who provides false information or omits information on the portion of the licensure application requesting information on owners, administrators, principals, or affiliates of the facility. The amount of the penalty shall be as is prescribed for a Type A1 Violation.

Part C Ownership Disclosure (*REQUIRED)

OWNERS, PRINCIPLES, AFFILIATES, SHAREHOLDERS, MEMBERS

Complete the information below on **all** individuals who are owners, principles, affiliates, shareholders or members holding an interest of 5% or more of the licensee. Attach additional pages if necessary. **If you are the only owner, complete the information below, listing the percentage interest as 100%.**

Name: Tony Bigler
Address: 201 S McPherson Church Rd, ste 226
City: Fayetteville State: NC Zip Code: 28303
Phone #: (910) 920 - 1180 Fax (910) 920 - 1545
Email Address: etcareinc@earthlink.net
Percentage interest in this licensed Facility: 50 Title: officer
List the names of other Family Care/Adult Care Home in which you are the owner or affiliate:

Name: Edith Bigler
Address: 201 S McPherson Church Rd, ste 226
City: Fayetteville State: NC Zip Code: 28303
Phone #: (910) 920 - 1180 Fax (910) 920 - 1545
Email Address: edithwbigler@yahoo.com
Percentage interest in this licensed Facility: 50 Title: Officer
List the names of other Family Care/Adult Care Home in which you are the owner or affiliate:

Name:
Address:
City: State: Zip Code:
Phone #: ( ) Fax ( )
Email Address:
Percentage interest in this licensed Facility: Title:
List the names of other Family Care/Adult Care Home in which you are the owner or affiliate:

Name:
Address:
City: State: Zip Code:
Phone #: ( ) Fax ( )
Email Address:
Percentage interest in this licensed Facility: Title:
List the names of other Family Care/Adult Care Home in which you are the owner or affiliate:

Part D Census Data

If facility DID NOT serve any residents in the last 12 months, please sign below.

Attestation of Facility Census

This facility operating as **Riverview** has **not** served one or more residents in the previous 12 months. If this is a true statement for this facility, please sign below.
Date of Last resident served at this location _____.
Do you plan to serve residents in the next 12 months? _____

Signature _____ Title: _____ Date _____

Data requested for all questions in this section should be based on facility's July 31, 2015 Census

Complete this section if you have one or more residents.

1. Please give the **number** (1,2,3 etc.) of residents in facility as indicated on **July 31, 2015**:

Resident Age - years	Male	Female	Total
18 – 20	0	0	0
21 - 34	3	0	3
35- 54	7	2	9
55– 64	10	6	16
65 - 74	7	2	9
75 - 84	3	6	9
85 or older	0	0	0
TOTAL	30	16	46

2. On **July 31, 2015**, number of residents receiving Medicaid reimbursed Consolidated Personal Care: 37
3. On **July 31, 2015**, number of residents on State/County Special Assistance (SA): 41
4. On **July 31, 2015**, number of private pay residents: 5

RESIDENT UTILIZATION DATA

If you have questions about the items on this page, call Healthcare Planning at (919) 855-3865.

A. Beginning Census, Admissions, Discharges, and Deaths

Complete the chart below for the reporting period of August 1, 2014 through July 31, 2015.

Beginning Census (Aug. 1, 2014)	**Admissions** (Aug, 1, 2014 – July 31, 2015)	**Discharges** (excluding deaths) (Aug, 1, 2014 – July 31, 2015)	**Deaths** (Aug, 1, 2014 – July 31, 2015)	**Total***
50	4	8	0	46

Total must match total reported for July 31, 2015 census on page 11.

To calculate:** ***Beginning Census + Admissions – Discharges – Deaths = Total

Note: *Beginning Census* is the number of residents in your facility on Aug. 1, 2014.
Admissions is the number of residents admitted from Aug. 1, 2014 through July 31, 2015.
Discharges and *Deaths* are all discharges and deaths from Aug. 1, 2014 through July 31, 2015.

B. Paid Bed Days

Complete the chart below for the reporting period of August 1, 2014 through July 31, 2015.

(1) Paid Bed Days reimbursed by Private Pay (out-of-pocket)	2,475
(2) Paid Bed Days reimbursed by County Special Assistance (includes Medicaid)	13,460
(3) Paid Bed Days reimbursed by Other (insurance or other means of payment)	0
(4) Total** = { (1) + (2) + (3) }	15,935

Note: Report paid bed days as cumulative totals.

Example: total number of days of private pay for Resident #1+
total number of days of private pay for Resident #2+
total number of days of private pay for Resident #3+…

(Continue for each resident in the facility and then repeat for each of the three categories)

**Total cannot be less than the *minimum paid bed* †days or greater than *maximum paid bed*†† days.

†*minimum paid bed days* is equal to *Beginning Census* plus the *Admissions* (see Item A above).
††*maximum paid bed days* is equal to your licensed bed capacity multiplied the number of days in the year. (Example: 20 licensed beds x 365 days = 7,300 paid bed days).

The information on this page is collected pursuant to G.S. § 131E-177.

C. Census by Diagnosis and Age

Please give the number (1,2,3, etc.) of residents in facility (on **July 31, 2015**) with a physician's diagnosis of the following:

- **Mental Illness (MI)** which includes a psychiatric illness but does not include intellectual disability, developmental disability or Alzheimer's Disease/Related Dementia;

  *****For the purpose of this application Mental Illness is an illness which lessens the capacity of the individual to use self-control, judgment and discretion in the conduct of his affairs and social relations so as it makes it necessary or advisable to be under treatment, care, supervision, guidance or control. Mental illnesses include major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder (OCD), panic disorder, post traumatic stress disorder (PTSD), and borderline personality disorder.*****

- **Intellectual Disability/Developmental Disability** (ID/DD) *This reflects change in wording from MR to ID*
- **Alzheimer's Disease or Related Dementia**

If a resident is dually diagnosed, only count the resident once, based on the **primary** diagnosis.
Do not list names of residents.

Resident Age - years	MI**** (See above definition for MI)	ID/DD	Alzheimer's Disease /Related Dementia
18 - 20	0	0	0
21- 34	2	0	0
35 -54	3	2	0
55 -64	3	0	4
65 - 74	2	0	8
75 - 84	2	0	8
85 or older	0	0	0
TOTAL	12	2	20

☐ **Check here if this Adult Care Home is licensed for and serves Only elderly persons.**
Elderly Persons are defined as persons age 55 OR older or who have a primary diagnosis of Alzheimer's disease or other form of dementia that requires assistance with activities of daily living.

***LICENSED CAPACITY AND SPECIAL CARE UNIT**

Licensed Capacity **83**
Licensed Special Care Unit Capacity: **20**
On **July 31, 2015** number of occupied Special Care Unit beds 20

As defined in **10A NCAC 13F . 1302 SPECIAL CARE UNIT DISCLOSURE**

a. Only those facilities with units that meet the requirements of this Section may advertise, market or otherwise promote themselves as providing special care units for persons with Alzheimer's Disease or related disorders.
b. The facility shall disclose information about the special care unit according to G.S. 131D-8 and which address policies and procedures listed in Rule .1305 of this Section.

Authenticating Signature: The undersigned submits this application for licensure for the year 2016 in accordance with Article 1 Chapter 131 D-2 of the General Statutes of North Carolina and to the rules adopted there under by the North Carolina Medical Care Commission (10A NCAC 13F) and certifies the accuracy of this information.

Signature: Tony Sig ✓ **Date:** 08/28/2015

Print Name Tony BIGLER **Phone Number:** (910) 820-1180

Elaine F. Marshall
Secretary

North Carolina
DEPARTMENT OF THE SECRETARY OF STATE
PO Box 29622 Raleigh, NC 27626-0622 (919)807-2000

Account
Login
Register

Click Here To:

View Document Filings File an Annual Report Print a Pre-Populated Annual Report form
Amend a Previous Annual Report

Corporate Names

Prev Legal: Lake Waccamaw Senior Living, Inc.
Legal: Water Oak Manor, Inc.

Business Corporation Information

SosId:	0880662
Status:	Current-Active
Annual Report Status:	Current
Citizenship:	Domestic
Date Formed:	1/1/2007
Fiscal Month:	December
State of Incorporation:	NC
Registered Agent:	Bigler, Tony F.

Corporate Addresses

Reg Office:	201 S McPherson Church Road Suite 226 Suite 226 Fayetteville, NC 28303
Reg Mailing:	201 S McPherson Church Road Suite 226 Suite 226 Fayetteville, NC 28303
Mailing:	201 S McPherson Church Road Suite 226 Fayetteville, NC 28303
Principal Office:	201 S McPherson Church Road Suite 226 Fayetteville, NC 28303

Officers

Secretary: Edith W Bigler
178 Ellerslie Drive
Fayetteville NC 28303

President: Tony F. Bigler
178 Ellerslie Drive
Fayetteville NC 28303

Stock

Class:	Common
Shares:	100000
No Par Value:	Yes

RENEWAL LICENSURE
COMPLIANCE HISTORY CHECK
Division of Facility Services
Adult Care Licensure Section (ACLS)

Date of History Check 9-16-15 & 1/12/16 (PT)
Facility Name Riverview
License # Hal 025 031
FID # ~~Craven~~ 920850
County Craven

Instructions: ***Complete the second page worksheet using the sources described.*** Then for any findings of negative actions listed below, record on this page the one(s) that will prevent issuing a renewal license. Then make a recommendation regarding eligibility for renewal licensure of a facility for the licensee.

Reference G.S. 131D-2.4 (C) (2)	Type B or Type A Penalty Deny until 1 year after assessed OR.... until confirmed returned to substantial compliance which ever comes first	☐ No ☑ Yes ☐ Appeal Date 2-13-15 Monetary Assessment Date 1/5/15 Penalty Due Date 3-15-15 Confirmed Compliance Date 11/23/15 Penalty Paid Date ~~3-15-15~~ 11/23/15
10A NCAC 13F .0203	Suspension of Admission (SOA) Deny until 6 months after SOA lifted	☐ No ☑ Yes ☐ Appeal Date 6-18-15 Initiation Date Lift Date 8-25-15
G.S. 131D-2.4 (C) (3) or (4)	Provisional Licensure Deny until 6 months from date license fully restored	☑ No ☐ Yes ☐ Appeal Date Restoration Date Termination Date
G.S. 131D-2.4 (C) (3) or (4)	Summarily Suspended Licensure Deny until 6 months from date license fully restore	☑ No ☐ Yes ☐ Appeal Date Restoration Date Termination Date
G.S. 131D-2.4 (C) (3) or (4)	Revocation Deny until 1 year after revocation	☑ No ☐ Yes ☐ Appeal Date Lift Date

*** If yes to any of the above, provider tracking database, adverse action or on secretary of state record, forward to Administrative Officer / Program Development Coordinator for approval.**

Approved by _____ **Date** _____

OK to process PT 1/12/16

Recommendation: The owners are eligible for licensure ☐ No ☑ Yes Initials of performer: JS

Comments:

Penalties paid in full and on time according to Settlement Agreement 9/8/15 Total paid $10,000.00 11/23/15

RENEWAL LICENSURE
COMPLIANCE HISTORY CHECK
Division of Health Service Regulation
Adult Care Licensure Section (ACLS)
Worksheet

Check LTI for ACLS compliance.

Check each owner listed on application
Go To:
Reports
General Reports
Owners, Report Yes, SSN/Name

Check each facility listed on application
GoTo:
Facility by name or county,
Facility 1, R Action
Recommended Action 1

List all licensees/owners with 5% or more interest in the business:
Water Oak Manor
Tony Bigler
Edith Bigler

Cross check web for compliance in
Mental Health Licensure Section
Child Care Licensure Section
http://providertracking.dhhs.state.nc.us
* If any negative results print and attach.

Reviewed Date 11/12/16
Initials PT

Attached yes ~~no~~

Cross check web for compliance in
NC Department Of The Secretary of State
http://www.secretary.state.nc.us/corporations/CSearch.aspx
* If any negative results print and attach

Reviewed Date 9-16-15
Initials JJ

Attached (yes) no

Out of State Facilities:
Route to Administrative Officer

Owner (s)	Facility	County	Adverse Action	Effective Date	Meets Compliance
Tony +	Pine Wood Manor	Hertford			
Edith Biger	Lake Pointe AL	Columbus			
	Wallau Garden	Duplin			
	~~Lake Pointe AL~~				
	Riverstone	Craven			
	River View	Craven			

State of North Carolina

Department of Health and Human Services
Division of Health Service Regulation

Effective January 1, 2015, this license is issued to

Water Oak Manor Inc

to operate an Adult Care Home known as

Water Oak Manor

located at 3407 Oaks Road
New Bern, NC, Craven County.

This license is issued subject to the statutes of the State of North Carolina, is not transferable and shall expire
December 31, 2015.

License Number: HAL-025-031

Capacity: 83

Special Care Units: X *Yes* _ *No* *Type:* *Alzheimer's/Dementia* 20

Authorized by:

Secretary, N.C. Department of Health and Human Services

Director, Division of Health Service Regulation

North Carolina Department of Health and Human Services
Division of Health Service Regulation
Adult Care Licensure Section
2720 Mail Service Center
Raleigh, North Carolina 27699-2720

If you are submitting a change application please indicate ***Change Application Attached:** _____ Yes X No

Part A. Facility Information

Facility Name: Water Oak Manor			
Physical Address: 3407 Oaks Road	**City:** New Bern	**State:** NC	**Zip:** 28560-
Telephone Number: (252)633-1143	**Fax Number:** (252)633-0422		
***If any of the above information is incorrect please call the Adult Care Licensure Section (919) 855-3765**			
Please provide your National Provider Identifier (NPI) *For questions regarding NPI, contact 1-800-465-3203 (NPI Toll-Free)*	**NPI:** 1225216872		

Correspondence Mailing Address: (where you want to receive ALL correspondence including the license from Division of Health Service Regulation): *Make corrections as needed

Name: Water Oak Manor	**Title:**
Address: P.O Box 1189	**Telephone Number:** (252)633-1143
City, State Zip Code: New Bern, NC 28563-	
Primary Email: wateroakmanor@yahoo.com	

CERTIFIED ADMINISTRATOR:

Name: Tony BIGLER 8/25/14	
Telephone Number: (252 633-1143	**Fax: (** 252 633-0422
Administrator Certificate No. G000007716	**Expiration Date:** 12/31/2015

DHSR USE ONLY
License# **HAL-025-031**
FID# **920850**
Region **Clinton**
Compliance Check Completed VTP7 9/11/14
Entry by JJS Reviewed by AC
Date: 9-25-14 Date: 9/5/14
License Fee: **$1,812.50**

PAID
8 05 14
1812.50
5727

Part B Operation Disclosure

LEGAL IDENTITY OF LICENSEE

Licensee Information

- The preprinted name, address and phone number(s) is the data we currently hold for this licensed Facility.
- The Licensee is the name of the legal entity licensed to operate the business at that site as indicated in **Part A.**
- The Licensee is responsible for compliance to State rules and laws governing adult care homes.
- The status of the Legal entity will be verified with the NC Office of the Secretary of State.
- **A Change Application is required for ANY changes to the preprinted Licensee name.**

Licensee Name: Water Oak Manor Inc		
Address: P.O Box 1189		
City: New Bern	**State:** NC	**Zip code:** 28563-
Telephone Number: (252)633-1143	**Fax Number:** (252)633-0422	
The licensee is a: (check one)	☒ For Profit	☒ Not For Profit

The licensee is: (Check one)

☐ Proprietorship (individual owner)	☐ Partnership (Unincorporated)
☒ Corporation (Inc)*	☐ Limited Liability Partnership (LLP)*
☐ Limited Liability Company (LLC)*	☐ Government Unit

***NC Secretary of State ID #:** 880662 9/11/14 PZ ☐ **Registered in Other State. (Attach a copy of the Certificate of Authority issued by NCSOS)**

COMPLETE THE FOLLOWING INFORMATION:

- If the licensee is **not for profit,** the name of each Officer, Director or Trustees.
- If the licensee is **a partnership or limited liability partnership (LLP),** the name of each partner.
- If the licensee is **a limited liability company (LLC),** the names of the managing members, attach a list of the names and address of the members of the limited liability company.
- If the licensee is **a corporation (Inc),** the name and title of each corporate officer.
- If the licensee is **a governmental unit,** the name and title of the individual in charge of the governmental agency or the individual designated in writing by the individual in charge of the governmental agency.

Executive Officer, General Partner, Managing Member		
Name: Tony Bigler	**Telephone Number:** (910) 920-1180	**Fax Number:** (910) 920-1545
Address: 201 S McPherson Church Road Suite 226		
City: Fayetteville	**State:** NC	**Zip:** 28303

Name	**Title**
Name	**Title**
Name	**Title**

Management Company:

Is the business operated under a management contract? ☒No ☐Yes **If yes, provide name and address of the management company**		
Company Name:		
Owner of Management Company Entity:	**Telephone Number:** ( )	
Street/Box:		
City:	**State:**	**Zip:**

Building Owner

Is the building where services are offered leased/ rented? ____Yes __x__No. **If yes, please complete the following on the building/property owner and provide a copy of the lease agreement.**		
Name: Water Oak Properties, LLC		
Street/Box: 2015 McPherson Church Road, Suite 226		
City: Fayetteville	**State:** NC	**Zip:** 28303
Telephone Number: (910) 920-1150	**Fax Number:** (910) 920-1545	

Part C Ownership Disclosure (*REQUIRED)

For the purpose of this application the following definitions apply:
The following definitions shall apply throughout this application:

(1) "Person" means an individual; a trust or estate; a partnership; a corporation; or any grouping of individuals, each of whom owns five percent or more of a partnership or corporation, who collectively own a majority interest of either a partnership or a corporation.

(2) "Owner" means any person who has or had legal or equitable title to or a majority interest in an adult care home.

(3) "Affiliate" means any person that directly or indirectly controls or did control an adult care home or any person who is controlled by a person who controls or did control an adult care home. In addition, two or more adult care homes who are under common control are affiliates.

(4) "Principal" means any person who is or was the owner or operator of an adult care home, an executive officer of a corporation that does or did own or operate an adult care home, a general partner of a partnership that does or did own or operate an adult care home, or a sole proprietorship that does or did own or operate an adult care home.

(5) "Indirect control" means any situation where one person is in a position to act through another person over whom the first person has control due to the legal or economic relationship between the two.

APPLICABLE RULES

"§ 131D-34. Penalties; remedies

(d1) The Department shall impose a civil penalty on any applicant for licensure who provides false information or omits information on the portion of the licensure application requesting information on owners, administrators, principals, or affiliates of the facility. The amount of the penalty shall be as is prescribed for a Type A1 Violation.

Part C Ownership Disclosure (*REQUIRED)

OWNERS, PRINCIPLES, AFFILIATES, SHAREHOLDERS, MEMBERS

Complete the information below on **all** individuals who are owners, principles, affiliates, shareholders or members holding an interest of 5% or more of the licensee. Attach additional pages if necessary. **If you are the only owner, complete the information below, listing the percentage interest as 100%.**

Name: Tony Bigler
Address: 201 S McPherson Church Road Suite 226
City: Fayetteville State: NC Zip Code: 28303
Phone #: (910) 920-1150 Fax (910) 920-1545
Email Address: etcareinc @ earthlink.net
Percentage interest in this licensed Facility: 50 Title: officer
List the names of other Family Care/Adult Care Home in which you are the owner or affiliate:

Name: Edith Bigler
Address: 201 S McPherson Church Road, Suite 226
City: Fayetteville State: NC Zip Code: 28303
Phone #: (910) 920-1150 Fax (910) 920-1545
Email Address: edithwbigler @ yahoo.com
Percentage interest in this licensed Facility: 50 Title: officer
List the names of other Family Care/Adult Care Home in which you are the owner or affiliate:

Name:
Address:
City: State: Zip Code:
Phone #: ( ) Fax ( )
Email Address:
Percentage interest in this licensed Facility: Title:
List the names of other Family Care/Adult Care Home in which you are the owner or affiliate:

Name:
Address:
City: State: Zip Code:
Phone #: ( ) Fax ( )
Email Address:
Percentage interest in this licensed Facility: Title:
List the names of other Family Care/Adult Care Home in which you are the owner or affiliate:

Part D Census Data

If facility DID NOT serve any residents in the last 12 months, please sign below.

Attestation of Facility Census

This facility operating as **Water Oak Manor** has **not** served one or more residents in the previous 12 months. If this is a true statement for this facility, please sign below.
Date of Last resident served at this location _____.
Do you plan to serve residents in the next 12 months? _____

Signature _____ Title: _____ Date _____

Data requested for all questions in this section should be based on facility's July 31, 2014 Census

Complete this section if you have one or more residents.

1. Please give the **number** (1,2,3 etc.) of residents in facility as indicated on **July 31, 2014**:

Resident Age - years	Male	Female	Total
18 – 20	0	0	0
21 - 34	3	0	3
35- 54	7	2	9
55– 64	12	6	18
65 - 74	9	2	11
75 - 84	3	6	9
85 or older	0	0	0
TOTAL	34	16	50

2. On **July 31, 2014**, number of residents receiving Medicaid reimbursed Consolidated Personal Care: 37
3. On **July 31, 2014**, number of residents on State/County Special Assistance (SA): 41
4. On **July 31, 2014**, number of private pay residents: 9

RESIDENT UTILIZATION DATA **If you have questions about this item, call Medical Facilities Planning at (919) 855-3865.**

Answer these questions for the reporting period of August 1, 2013 through July 31, 2014.

A. Beginning Census, Admissions, Discharges, and Deaths by Level of Care

- The "Beginning Census" refers to the number of patients/residents in your facility on Aug. 1, 2013.
- "Admissions" refers to the number of persons admitted from Aug. 1, 2013 through July 31, 2014.
- "Discharges" and "Deaths" refer to all discharges and deaths from Aug. 1, 2013 through July 31, 2014.

Beginning Census * (Aug. 1, 2013)	**Discharges** (excluding deaths) (Aug, 1, 2013 – July 31, 2014)	**Admissions** (Aug, 1, 2013 – July 31, 2014)	**Deaths** (Aug, 1, 2013 – July 31, 2014)	**Total****
49	3	4	0	50

NOTE: Total must match total reported for July 31, 2014 census on page 11.

** To calculate the Total, use this formula: Beginning Census + Admissions - Discharges – Deaths = Total

B. Paid Bed Days

Number of Paid Bed Days rendered during the reporting period. (8/1/2013-7/31/2014)
If you have questions about this item, call Medical Facilities Planning at (919) 855-3865.

(1) Paid Bed Days reimbursed by Private Pay (out-of-pocket)	2,675
(2) Paid Bed Days reimbursed by County Special Assistance (includes Medicaid)	14,600
(3) Paid Bed Days reimbursed by Other (insurance or other means of payment)	0
(4) Total { (1) + (2) + (3) }	17,275

Notes for Paid Bed Days:

1. Paid Bed Days means the number of days a bed is used or held for use by an individual resident.
2. **To calculate your Paid Bed Days for each category, follow this formula:**
   a. Paid Bed Days reimbursed by Private Pay= Days paid by private pay for Resident #1 + Days paid by private pay for Resident #2 + Days paid by private pay for Resident #3 + …. (continue for each resident in the facility)
   b. The *minimum paid bed days* your facility could provide in a year would be equal to Beginning Census + Admissions (see Item A above).
   c. The *maximum paid bed days* your facility could provide in a year would be your licensed bed capacity X the number of days in the year. (example: 20 licensed beds x 365 days of care = 7,300 paid bed days).
3. This information is collected for use in the State Medical Facilities Plan as part of the methodology for determining each county's bed utilization, which is used to project need for additional Adult Care Home beds in each county annually under the direction of the State Health Coordinating Council (pursuant to G.S. §131E-177).

C. Census by Diagnosis and Age

Please give the number (1,2,3, etc.) of residents in facility (on **July 31, 2014**) with a physician's diagnosis of the following:

- **Mental Illness (MI)** which includes a psychiatric illness but does not include intellectual disability, developmental disability or Alzheimer's Disease/Related Dementia;

  *****For the purpose of this application Mental Illness is an illness which lessens the capacity of the individual to use self-control, judgment and discretion in the conduct of his affairs and social relations so as it makes it necessary or advisable to be under treatment, care, supervision, guidance or control. Mental illnesses include major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder (OCD), panic disorder, post traumatic stress disorder (PTSD), and borderline personality disorder.*****

- **Intellectual Disability/Developmental Disability** (ID/DD) *This reflects change in wording from MR to ID*
- **Alzheimer's Disease or Related Dementia**

If a resident is dually diagnosed, only count the resident once, based on the **primary** diagnosis.
Do not list names of residents.

Resident Age - years	MI**** (See above definition for MI)	ID/DD	Alzheimer's Disease /Related Dementia
18 - 20	0	0	0
21- 34	2	0	0
35 -54	3	2	0
55 -64	3	0	4
65 - 74	2	0	8
75 - 84	2	0	8
85 or older	0	0	0
TOTAL	12	2	20

☐ **Check here if this Adult Care Home is licensed for and serves Only elderly persons.**
Elderly Persons are defined as persons age 55 OR older or who have a primary diagnosis of Alzheimer's disease or other form of dementia that requires assistance with activities of daily living.

***LICENSED CAPACITY AND SPECIAL CARE UNIT**

Licensed Capacity **83**
Licensed Special Care Unit Capacity: **20**
On **July 31, 2014** number of occupied Special Care Unit beds 20

As defined in **10A NCAC 13F . 1302 SPECIAL CARE UNIT DISCLOSURE**

a. Only those facilities with units that meet the requirements of this Section may advertise, market or otherwise promote themselves as providing special care units for persons with Alzheimer's Disease or related disorders.
b. The facility shall disclose information about the special care unit according to G.S. 131D-8 and which address policies and procedures listed in Rule .1305 of this Section.

Authenticating Signature: The undersigned submits this application for licensure for the year 2015 in accordance with Article 1 Chapter 131 D-2 of the General Statutes of North Carolina and to the rules adopted there under by the North Carolina Medical Care Commission (10A NCAC 13F) and certifies the accuracy of this information.

Signature: Tony Sig **Date:** 05/15/2014

Print Name TONY BIGLER **Phone Number:** (910) 920-1180

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RENEWAL LICENSURE
COMPLIANCE HISTORY CHECK
Division of Facility Services
Adult Care Licensure Section (ACLS)

Date of History Check 9-11-14
Facility Name Water Oak Manor
License # HAL-025-031
FID # 920850
County Craven

Instructions: ***Complete the second page worksheet using the sources described.*** Then for any findings of negative actions listed below, record on this page the one(s) that will prevent issuing a renewal license. Then make a recommendation regarding eligibility for renewal licensure of a facility for the licensee.

Reference		
G.S. 131D-2.4 (C) (2)	Type B or Type A Penalty Deny until 1 year after assessed OR.... until confirmed returned to substantial compliance which ever comes first	☒ No ☐ Yes ☐ Appeal Date _____ Monetary Assessment Date _____ Penalty Due Date _____ Confirmed Compliance Date _____ Penalty Paid Date
10A NCAC 13F .0203	Suspension of Admission (SOA) Deny until 6 months after SOA lifted	☒ No ☐ Yes ☐ Appeal Date _____ Initiation Date _____ Lift Date _____
G.S. 131D-2.4 (C) (3) or (4)	Provisional Licensure Deny until 6 months from date license fully restored	☒ No ☐ Yes ☐ Appeal Date _____ Restoration Date _____ Termination Date _____
G.S. 131D-2.4 (C) (3) or (4)	Summarily Suspended Licensure Deny until 6 months from date license fully restore	☒ No ☐ Yes ☐ Appeal Date _____ Restoration Date _____ Termination Date _____
G.S. 131D-2.4 (C) (3) or (4)	Revocation Deny until 1 year after revocation	☒ No ☐ Yes ☐ Appeal Date _____ Lift Date _____

*** If yes to any of the above, provider tracking database, adverse action or on secretary of state record, forward to Administrative Officer / Program Development Coordinator for approval.**
Approved by _____ **Date** _____

Recommendation: The owners are eligible for licensure ☐ No ☒ Yes Initials of performer: PT

Comments:

RENEWAL LICENSURE
COMPLIANCE HISTORY CHECK
Division of Health Service Regulation
Adult Care Licensure Section (ACLS)
Worksheet

Check LTI for ACLS compliance.

Check each owner listed on application
Go To:
Reports
General Reports
Owners, Report Yes, SSN/Name

Check each facility listed on application
GoTo:
Facility by name or county,
Facility 1, R Action
Recommended Action 1

List all licensees/owners with 5% or more interest in the business:

Edith Bigler
Tony Bigler

Cross check web for compliance in
Mental Health Licensure Section
Child Care Licensure Section
http://providertracking.dhhs.state.nc.us
* If any negative results print and attach.

Reviewed Date 9-11-14
Initials PT

Attached ☐ yes ☒ no

Cross check web for compliance in
NC Department Of The Secretary of State
http://www.secretary.state.nc.us/corporations/CSearch.aspx
* If any negative results print and attach

Reviewed Date 9-11-14
Initials PT

Attached ☐ yes ☒ no

Out of State Facilities:
Route to Administrative Officer

Owner (s)	Facility	County	Adverse Action	Effective Date	Meets Compliance
	Wallace Gardens	Duplin	NONE		
	Lake Pointe AL	Columbus	"		
	Waden Oak Manor	Craven	SOA	8/26/14	
	Pinewood Manor	Hertford	NONE		
	River Stone	Craven	"		

State of North Carolina

Department of Health and Human Services
Division of Health Service Regulation

Effective January 1, 2014, this license is issued to

Water Oak Manor Inc

to operate an Adult Care Home known as

Water Oak Manor

located at 3407 Oaks Road
New Bern, NC, Craven County.

This license is issued subject to the statutes of the State of North Carolina, is not transferable and shall expire
December 31, 2014.

License Number: HAL-025-031

Capacity: 83

Special Care Units: X *Yes* _ *No* *Type: Alzheimer's/Dementia* 20

Authorized by:

Secretary, N.C. Department of Health and Human Services

Director, Division of Health Service Regulation

North Carolina Department of Health and Human Services
Division of Health Service Regulation
Adult Care Licensure Section
2720 Mail Service Center
Raleigh, North Carolina 27699-2720

If you are submitting a change application please indicate ***Change Application Attached:** _____ Yes __X__ No

Part A. Facility Information

Facility Name: Water Oak Manor

Physical Address: 3407 Oaks Road	**City:** New Bern	**State:** NC	**Zip:** 28560-

Telephone Number: (252)633-1143	**Fax Number:** (252)633-0422

***If any of the above information is incorrect please call the Adult Care Licensure Section (919) 855-3765**

Please provide your National Provider Identifier (NPI) *For questions regarding NPI, contact 1-800-465-3203 (NPI Toll-Free)*	**NPI:** 1225216872

Correspondence Mailing Address: (where you want to receive ALL correspondence including the license from Division of Health Service Regulation): *Make corrections as needed

Name: Tony Bigler	**Title:** Administrator
Address: P.O Box 1189	**Telephone Number:** (252) 633-4681
City, State Zip Code: New Bern, NC 28563-	
Primary Email: Wateroakmanor@yahoo.com	

CERTIFIED ADMINISTRATOR:

Name: Tony Bigler 8/21/13 AB	
Telephone Number: (252) 633-[redacted]1143	**Fax:** (252) 633-0422
Administrator Certificate No. G00000716	**Expiration Date:** 12-31-2013

DHSR USE ONLY
License# **HAL-025-031**
FID# **920850**
Region **Clinton**
Compliance Check Completed [✓] AB 8/21/13
Entry by JT
Date: 10/14
Reviewed by MC
Date: 10/14/13
License Fee: **$1,812.50**

FEE PAID
Date 8 / 16 / 13
Amount $ 1812.50
Check ✓ Cash Other
Check # 5342

Part B Operation Disclosure

LEGAL IDENTITY OF LICENSEE

Licensee Information

- The preprinted name, address and phone number(s) is the data we currently hold for this licensed Facility.
- The Licensee is the name of the legal entity licensed to operate the business at that site as indicated in **Part A.**
- The Licensee is responsible for compliance to State rules and laws governing adult care homes.
- The status of the Legal entity will be verified with the NC Office of the Secretary of State.
- **A Change Application is required for ANY changes to the preprinted Licensee name.**

Licensee Name: Water Oak Manor Inc		
Address: P.O Box 1189		
City: New Bern	**State:** NC	**Zip code:** 28563-
Telephone Number: (252)633-1143	**Fax Number:** 252-633-6422	
The licensee is a: (check one)	X For Profit	___ Not For Profit

The licensee is: (Check one)

☐ Proprietorship (individual owner)	☐ Partnership (Unincorporated)
☒ Corporation (Inc)*	☐ Limited Liability Partnership (LLP)*
☐ Limited Liability Company (LLC)*	☐ Government Unit

***NC Secretary of State ID #:** 880662 PRB 8/21/13

☐ **Registered in Other State.** **(Attach a copy of the Certificate of Authority issued by NCSOS)**

COMPLETE THE FOLLOWING INFORMATION:

- If the licensee is **not for profit,** the name of each Officer, Director or Trustees.
- If the licensee is **a partnership or limited liability partnership (LLP),** the name of each partner.
- If the licensee is **a limited liability company (LLC),** the names of the managing members, attach a list of the names and address of the members of the limited liability company.
- If the licensee is **a corporation (Inc),** the name and title of each corporate officer.
- If the licensee is **a governmental unit,** the name and title of the individual in charge of the governmental agency or the individual designated in writing by the individual in charge of the governmental agency.

Executive Officer, General Partner, Managing Member

Name: Tony Bigler	**Telephone Number:** (910) 920-1180	**Fax Number:** (910) 920-1545
Address: 201 S McPherson Church Road, Suite 226		
City: Fayetteville	**State:** NC	**Zip:** 28303

Name	**Title**
Name	**Title**
Name	**Title**

Part C Ownership Disclosure (*REQUIRED)

OWNERS, PRINCIPLES, AFFILIATES, SHAREHOLDERS, MEMBERS

Complete the information below on **all** individuals who are owners, principles, affiliates, shareholders or members holding an interest of 5% or more of the licensee. Attach additional pages if necessary. **If you are the only owner, complete the information below, listing the percentage interest as 100%.**

Name: Tony Bigler
Address: 201 S McPherson Church Road, Suite 226
City: Fayetteville State: NC Zip Code: 28303
Phone #: (910) 920 1180 Fax (910) 920 1545
Email Address: efcare inc @ earthlink.net
Percentage interest in this licensed Facility: 50 Title: officer
List the names of other Family Care/Adult Care Home in which you are the owner or affiliate:

Name: Edith Bigler
Address: 201 S McPherson Church Road, Suite 226
City: Fayetteville State: NC Zip Code: 28303
Phone #: (910) 920 1180 Fax (910) 920 1545
Email Address: edithwbigler@yahoo.com
Percentage interest in this licensed Facility: 50 Title: officer
List the names of other Family Care/Adult Care Home in which you are the owner or affiliate:

Name:
Address:
City: State: Zip Code:
Phone #: ( ) Fax ( )
Email Address:
Percentage interest in this licensed Facility: Title:
List the names of other Family Care/Adult Care Home in which you are the owner or affiliate:

Name:
Address:
City: State: Zip Code:
Phone #: ( ) Fax ( )
Email Address:
Percentage interest in this licensed Facility: Title:
List the names of other Family Care/Adult Care Home in which you are the owner or affiliate:

Management Company:

Is the business operated under a management contract? ☒No ☐Yes **If yes, provide name and address of the management company**		
Company Name:		
Owner of Management Company Entity:	**Telephone Number:** ( )	
Street/Box:		
City:	**State:**	**Zip:**

Building Owner

Is the building where services are offered leased/ rented? ____Yes __X__No. **If yes, please complete the following on the building/property owner and provide a copy of the lease agreement.**		
Name: WATER OAK PROPERTIES, LLC		
Street/Box: 201 S McPherson Church Road, Suite 226		
City: Fayetteville	**State:** NC	**Zip:** 28303
Telephone Number: (910) 920 1180	**Fax Number:** (910) 920 1545	

Part C Ownership Disclosure (*REQUIRED)

For the purpose of this application the following definitions apply:
The following definitions shall apply throughout this application:

(1) "Person" means an individual; a trust or estate; a partnership; a corporation; or any grouping of individuals, each of whom owns five percent or more of a partnership or corporation, who collectively own a majority interest of either a partnership or a corporation.

(2) "Owner" means any person who has or had legal or equitable title to or a majority interest in an adult care home.

(3) "Affiliate" means any person that directly or indirectly controls or did control an adult care home or any person who is controlled by a person who controls or did control an adult care home. In addition, two or more adult care homes who are under common control are affiliates.

(4) "Principal" means any person who is or was the owner or operator of an adult care home, an executive officer of a corporation that does or did own or operate an adult care home, a general partner of a partnership that does or did own or operate an adult care home, or a sole proprietorship that does or did own or operate an adult care home.

(5) "Indirect control" means any situation where one person is in a position to act through another person over whom the first person has control due to the legal or economic relationship between the two.

APPLICABLE RULES

"§ 131D-34. Penalties; remedies

(d1) The Department shall impose a civil penalty on any applicant for licensure who provides false information or omits information on the portion of the licensure application requesting information on owners, administrators, principals, or affiliates of the facility. The amount of the penalty shall be as is prescribed for a Type A1 Violation.

Part D Census Data

If facility DID NOT serve any residents in the last 12 months, please sign below.

Attestation of Facility Census

This facility operating as **Water Oak Manor** has **not** served one or more residents in the previous 12 months. If this is a true statement for this facility, please sign below.
Date of Last resident served at this location _____.
Do you plan to serve residents in the next 12 months? _____

Signature _____ Title: _____ Date _____

Data requested for all questions in this section should be based on facility's July 31, 2013 Census

Complete this section if you have one or more residents.

1. Please give the **number** (1,2,3 etc.) of residents in facility as indicated on **July 31, 2013**:

Resident Age - years	Male	Female	Total
18 – 20	0	0	0
21 - 34	3	0	3
35- 54	7	2	9
55– 64	12	6	18
65 - 74	8	2	10
75 - 84	3	6	9
85 or older	0	0	0
TOTAL	33	16	49

2. On **July 31, 2013**, number of residents receiving Medicaid reimbursed Consolidated Personal Care: 36
3. On **July 31, 2013**, number of residents on State/County Special Assistance (SA): 40
4. On **July 31, 2013**, number of private pay residents: 9

RESIDENT UTILIZATION DATA **If you have questions about this item, call Medical Facilities Planning at (919) 855-3865.**

Answer these questions for the reporting period of August 1, 2012 through July 31, 2013.

A. Beginning Census, Admissions, Discharges, and Deaths by Level of Care

- The "Beginning Census" refers to the number of patients/residents in your facility on Aug. 1, 2012.
- "Admissions" refers to the number of persons admitted from Aug. 1, 2012 through July 31, 2013.
- "Discharges" and "Deaths" refer to all discharges and deaths from Aug. 1, 2012 through July 31, 2013.

Beginning Census * (Aug. 1, 2012)	**Discharges** (excluding deaths) (Aug, 1, 2012 – July 31, 2013)	**Admissions** (Aug, 1, 2012 – July 31, 2013)	**Deaths** (Aug, 1, 2012 – July 31, 2013)	**Total****
42	4	11	0	49

NOTE: Total must match total reported for July 31, 2013 census on page 11.

** To calculate the Total, use this formula: Beginning Census + Admissions - Discharges – Deaths = Total

B. Paid Bed Days

Number of Paid Bed Days rendered during the reporting period. (8/1/2012-7/31/2013)
If you have questions about this item, call Medical Facilities Planning at (919) 855-3865.

(1) Paid Bed Days reimbursed by Private Pay (out-of-pocket)	2,675
(2) Paid Bed Days reimbursed by County Special Assistance (includes Medicaid)	14,600
(3) Paid Bed Days reimbursed by Other (insurance or other means of payment)	0
(4) Total { (1) + (2) + (3) }	17,275

Notes for Paid Bed Days:

82. Paid Bed Days means the number of days a bed is used or held for use by an individual resident.
83. **To calculate your Paid Bed Days for each category, follow this formula:**
    a. Paid Bed Days reimbursed by Private Pay= Days paid by private pay for Resident #1 + Days paid by private pay for Resident #2 + Days paid by private pay for Resident #3 + …. (continue for each resident in the facility)
    b. The *minimum paid bed days* your facility could provide in a year would be equal to Beginning Census + Admissions (see Item A above).
    c. The *maximum paid bed days* your facility could provide in a year would be your licensed bed capacity X the number of days in the year. (example: 20 licensed beds x 365 days of care = 7,300 paid bed days).
84. This information is collected for use in the State Medical Facilities Plan as part of the methodology for determining each county's bed utilization, which is used to project need for additional Adult Care Home beds in each county annually under the direction of the State Health Coordinating Council (pursuant to G.S. §131E-177).

C. Census by Diagnosis and Age

Please give the number (1,2,3, etc.) of residents in facility (on **July 31, 2013**) with a physician's diagnosis of the following:

- **Mental Illness (MI)** which includes a psychiatric illness but does not include intellectual disability, developmental disability or Alzheimer's Disease/Related Dementia;

  *****For the purpose of this application Mental Illness is an illness which lessens the capacity of the individual to use self-control, judgment and discretion in the conduct of his affairs and social relations so as it makes it necessary or advisable to be under treatment, care, supervision, guidance or control. Mental illnesses include major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder (OCD), panic disorder, post traumatic stress disorder (PTSD), and borderline personality disorder.*****

- **Intellectual Disability/Developmental Disability** (ID/DD) *This reflects change in wording from MR to ID*
- **Alzheimer's Disease or Related Dementia**

If a resident is dually diagnosed, only count the resident once, based on the **primary** diagnosis.
Do not list names of residents.

Resident Age - years	MI**** (See above definition for MI)	ID/DD	Alzheimer's Disease /Related Dementia
18 - 20	0	0	0
21- 34	1	0	0
35 -54	3	2	0
55 -64	3	0	4
65 - 74	2	0	8
75 - 84	2	0	8
85 or older	0	0	0
TOTAL	11	2	20

☐ **Check here if this Adult Care Home is licensed for and serves Only elderly persons.**
Elderly Persons are defined as persons age 55 OR older or who have a primary diagnosis of Alzheimer's disease or other form of dementia that requires assistance with activities of daily living.

***LICENSED CAPACITY AND SPECIAL CARE UNIT**

Licensed Capacity **83**
Licensed Special Care Unit Capacity: **20**
On **July 31, 2013** number of occupied Special Care Unit beds 20

As defined in **10A NCAC 13F . 1302 SPECIAL CARE UNIT DISCLOSURE**

a. Only those facilities with units that meet the requirements of this Section may advertise, market or otherwise promote themselves as providing special care units for persons with Alzheimer's Disease or related disorders.
b. The facility shall disclose information about the special care unit according to G.S. 131D-8 and which address policies and procedures listed in Rule .1305 of this Section.

Authenticating Signature: The undersigned submits this application for licensure for the year 2014 in accordance with Article 1 Chapter 131 D-2 of the General Statutes of North Carolina and to the rules adopted there under by the North Carolina Medical Care Commission (10A NCAC 13F) and certifies the accuracy of this information.

Signature: Tony Sig **Date:** 8/13/13

Print Name TONY BIGLER **Phone Number:** (910) 920 1180

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