

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

James C. Wrenn, Jr. February 1, 2018 Page 2 of 2

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 at Aarth Caralina State at Aarth and Tuman Services 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 ind	icate Change A	pplication	n Attached:	Yes X No
Part A. F	acility Infor	mation		
Facility Name: Riverview				
Physical Address: 3407 Oaks Road	City: New Bo	ern .	State: NC	Zip: 28560-
Felephone Number: (252)633-1143	Fax Nun (252)633-			
If any of the above information is incorrect ple	ease call the Ad	ult Care L	icensure Sectio	n (919) 855-3765
Please provide your National Provider Identifier () For questions regarding NPI, contact 1-800-465-3203 (N)		NPI:	225216	5872
Correspondence Mailing Address: (where you was Division of Health Service Regulation): Make corr			ondence <u>includ</u>	ing the license from
Name: Rivarview			Title:	
Address: P.O Box 1189		Telephone Number: (282) 633 - 11 43		
City, State Zip Code: New Bern, NC 28563-				
Primary Email: riverviewassistedliving@gmail.com				
CERTIFIED ADMINISTRATOR:				
Name: Myra Shelly 10 Telephone Number: ()	X			
Telephone Number: () 252-633-1143	Fax: (252 -	633-0	422
Administrator Certificate No.	Expirat	ion Date:	633-0	2017
DHSR USE ONLY				

DHSR USE ONLY
License# HAL-025-031

FID# 920850

Region East
Compliance Check Completed (77 /2 /4/17

Entry by Reviewed by P7

Date: Date: 1/15/18

License Fee: \$1,812.50

FEE PAID

Date (0 , 10 , 17

Amounts 18 12.50

The 7155 Cash Other

License No: HAL-025-031 Facility ID: 920850

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	Dak Manor Inc		
Address: Po Bo	× 1189		
City: New Re		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: (Chec	ek one)		
Corporation (Inc	ndividual owner)	☐ Limited L	p (Unincorporated) iability Partnership (LLP)
☐ Proprietorship (i	ndividual owner)		iability Partnership (LLP)

- 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: (22) 633-1143	Fax Number: (20)633-0422
Address: 201 S. Mc Phen	on Clurch Rw	d, sk 226	
City: Fayetteville	State: NC	7im.	26303
Name		itle	
Name	Т	itle	
Name	Т	itle	

2018 License Renewal Application for Adult Care Homes: Riverview, Craven County

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:** □No If yes, please complete the following on the building/property owner. Company Name or Individual Name: Weler Oak Properties, LLC Name of Managing Member: Street/Box: 201 S. McPherson Church Telephone Number: 901 920-1180

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.

License No: HAL-025-031

Facility ID: 920850

License No: HAL-025-031 Facility ID: 920850

Part C Ownership Disclosure (REQUIRED)

OWNERS, PRINCIPLES, AFFILIATES, SHAREHOLDERS, MEMBERS

Complete the information below on <u>all</u> 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: Jony Big	ler	
Address: 2015. Mc	Pleason Church Red, Ste 226 State: NC Zip Code:	
city: Fayetters 1/2	State: NC Zip Code:	28303
hone #: (910) 920-1	180 Fax (90) 920 - 1545	
Email Address: etcere	inc & earthlink.net	
Percentage interest in this licens	sed Facility: 50 Title: Alice	
	Care/Adult Care Home in which you are the owner or affilia	ate:
Name: Edoth Bigt		
Address: 201 S. mc	Pherson Church Road, Ste 226	
City: Fayethertle	State: NC Zip Code:	28303
Phone #: (910) 920-11	130 Fax (910) 920 -1545	
Email Address: edith	ubigler @ yeho. com	
Percentage interest in this licens	sed Facility: 50 Title: 56 Care/Adult Care Home in which you are the owner or affilia	ate:
Percentage interest in this licens List the names of other Family (Care/Adult Care Home in which you are the owner or affilia	ate:
Percentage interest in this licens List the names of other Family (Name: Address:	Care/Adult Care Home in which you are the owner or affilia	
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Percentage interest in this licens List the names of other Family (Name: Address: City: Phone #: () Email Address: Percentage interest in this licens	Care/Adult Care Home in which you are the owner or affilia State: Zip Code: Fax () sed Facility: Title:	
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Percentage interest in this licens List the names of other Family of the Name: Address: City: Phone #: () Email Address: Percentage interest in this licens List the names of other Family of the Name: Name: Address:	State: Zip Code: Fax () sed Facility: Title: Care/Adult Care Home in which you are the owner or affiliation.	
Percentage interest in this licens List the names of other Family (Name: Address: City: Phone #: () Email Address: Percentage interest in this licens List the names of other Family (Name: Address: City:	State: Zip Code: Fax (State: Title: Care/Adult Care Home in which you are the owner or affiliance of the company of the co	

License	No:	HAL-025-031
Wastlies.	III.	020050

Part D Census Data

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

	Attestation of Facility Cens	ous		
	his facility, please sign below. at this location	residents in the previous 12 months. If		
Signature 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
21 - 34	3	0	3
35 - 54		2	9
55 - 64	11.	6	17
65 - 74	7	3	10
75 - 84	3	6	9
85 or older		0	0
TOTAL	31	17	48

- 2. On July 31, 2017, number of residents receiving Medicaid reimbursed Consolidated Personal Care:
- 3. On July 31, 2017, number of residents on State/County Special Assistance (SA): 4Z
- 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*	Total must match total reported for July 31, 2017 census on page 11.
48	4	4	0	48	

License No: HAL-025-031

Facility ID: 920850

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

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

^{*}To calculate: Beginning Census + Admissions - Discharges - Deaths = Total

^{**}Total cannot be less than the minimum paid bed tdays 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.

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:

License No: HAL-025-031 Facility ID: 920850

 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	٥	0
35 - 54	3		0
55 - 64	3	0	4
65 - 74	2	0	8
75 - 84	2		7/200
85 or older	0	0	Ó
TOTAL	10		19

_	Check here it this Adult Care Home serves <u>only</u> elderly persons. [G.S. 131D-21 (5)] Elderly Persons are defined as persons age 55 <u>OR</u> older or who have a primary diagnosis of Alzheimer's disea 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		

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

On July 31, 2017 number of occupied Special Care Unit beds 19

Signature: form 59 Date: 10/02/2017

Print Name 10ry Big for Phone Number: (9/0) 920-1180

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



nstructions ctions liste	istory Check. acility Name License # FID # County County Complete the second page worksheet using at the second page the one(s) that will attend page the one(s) the one of the one o	the sources described. Then for any findings of negative and for any findings of negative and for facility for the sources. Then make a
Reference G.S. 131D-2.4 (C) (2)	, and a second tree second tre	No Yes Appeal Date Monetary Imposition Date Penalty Due Date Confirmed Compliance Date
10A NCAC 13F .0203	Suspension of Admission (SOA) Deny until 6 months after SOA lifted	Penalty Paid Date 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 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 Administra	of the above, provider tracking database, a tive Officer / Program Development Coordi Date	dverse action or on secretary of state record, forward nator for approval.
comments:	pen at ties pd. 12/4/18	No Yes Initials of Reviewer: P7 8 OK to price is 1/15/18

RENEWAL LICENSURE
MPLIANCE HISTORY CHECK
Division of Health Service Regulation
alt 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

Ta	ners with 5% or more interest in	e business:
1	OAK Aldnow,	600
anno constituti de la c	ress	Zony
and the state of t	igher	EJHA
	25/20	Edith

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.

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

Out of State Facilities: Route to Administrative Officer Reviewed Date 12/4/17

Attached yes no

Reviewed Date 12/4/17

Initials 14

Attached yes no

*			Adverse Action	Effective Date	Meets Compliance
wner (s)	Facility	County	Auverse Action		
Attici (p)					
d					

-					
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				A CONTRACTOR OF THE PARTY OF TH	,



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.





Scan to verify online.

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.

Secretary of State

6 Jains & Marshall

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

State of Aurth 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:

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 Ap	plication A	ttached:	Yes	No
Part A. Facil					
Facility Name: Riverview					
Physical Address: 3407 Oaks Road Ci	ty: New Ber	n	State: NC	Zip: 2856	0-
Telephone Number:	Fax Numb (252)633-0				
(252)633-1143 *If any of the above information is incorrect please			ensure Section	n (919) 855-	3765
Please provide your National Provider Identifier (NPI))	NPI:			
For questions regarding NPI, contact 1-800-465-3203 (NPI To	oll-Free)	122	252168	72	
Correspondence Mailing Address: (where you want to Division of Health Service Regulation): *Make correct			dence <u>includi</u>	ng the licen	<u>se</u> from
Name: RIVERVIEW			Title:		
Address: P.O Box 1189			Telephone N (252) 63		
City, State Zip Code: New Bern, NC 28563-					
Primary Email: wateroakmanor@yahoo.com	ew exs.'s f	ed living	Øgneil.	con	
CERTIFIED ADMINISTRATOR:					
Name: Myra Sinchi- 929-14 Telephone Number: (252) 633-1143					
Telephone Number: (252) 633 - 1143	Fax: (25	2) 633	- 0422		
Administrator Certificate No.	Expiration	on Date:			
A00000571		12	2/31/20	17	
	Posts		FF PAI		
DYGD VGD OM V		foot.	La Carried	Book	a de la companya de l
DHSR USE ONLY License# HAL-025-031		ate \mathcal{A}	129	116	2
FID# 920850	LJ	A Company or a married to the	10170	D	-
Region Northeast	A	mount \$	1814.3	The first has been by been by the second of	- Party California
Compliance Check Completed () P7 10/7/16		Check	Cash	Othe	
Entry by Reviewed by S	15	The state of the s	and the second of the state of the second of	hapen stadened St. com i Aberia i i stephytesia genera pi unica gene	
Date: 10.76.2016 Date: 12-8-16 License Fee: \$1.812.50		10109	2.		

License No: HAL-025-031 Facility ID: 920850

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.
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- 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 Be	NEW DOWN				Zip code: 28563	
Telephone Number: 252 - 633 - 1143			Fax Number: 252-633-0422		-633-0422	
The licensee is: X For Profit				Not F	or Profit	
The licensee is: (Check one)	The licensee is: (Check one)					
 □ Proprietorship (individual owner) ☑ Corporation (Inc)* □ Limited Liability Company (LLC)* 			 □ Partnership (Unincorporated) □ Limited Liability Partnership (LLP)* □ Government Unit 			
Limited Liability Company (LLC)* *NC Secretary of State ID #:			10/6/16		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.

Exec	utive Officer, General P	artner, Managing	Member	
Name: Tony Big	ler	Telephone Nu (252) 633	mber: -1143	Fax Number: (252) 633 -0422
Address: Z-01 5 M	1cpheson Chira	of Rosal,	Ste 2	226
City: Fayetten	State:	pe '	Zip:	283c3
Name		Title		
Name		Title		
Name		Title		

Management Company:						
Is the business operated under a management contr	ract? DYes 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/ red on the building/property owner.	es service (x/x). Cut invested content of the conte	Ü				
Company Name or Individual Name: Water (Oak Properties, LC					
Name of Managing Member:	Bigler					
On the building/property owner. Company Name or Individual Name: Water Osk Properties, LLC Name of Managing Member: Tony Bigler Street/Box: 201 Smyherron Church Rosel, Ste 226 City: Fayetkelle State: UC Zip: 28363						
City: Fayetkeille State:	VC Zip: 28363					
Telephone Number:	Fax Number:					
(910) 920-1180	(80) 920 -1540					

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.

Part C Ownership Disclosure (*REQUIRED)

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

Facility ID: 920850

License No: HAL-025-031

Part C Ownership Disclosure (*REQUIRED)

OWNERS, PRINCIPLES, AFFILIATES, SHAREHOLDERS, MEMBERS

Complete the information below on <u>all</u> 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%.

complete the information below,	nsting the percentage	nterest as 100 / 0.	
Name: lony Bigl	er_	/ - / ,	z.
Address: 201 5 mcP	Lessen Church	h Resul, Sk 221	
Name: Jony Bigil Address: 201 5 mcP. City: Fayetteville	State: <i>N</i> &	Zip Code:_	25303
Phone #: (910) 920 - 11	80 Fax (900	1 920-1545	
Email Address: et cire	nc @ earthlin	k. ret	
Percentage interest in this licensed	Facility: 50 T	itle: Office	
List the names of other Family Car	e/Adult Care Home in v	hich you are the owner or aff	iliate:
Name: Edith Bigle			
Address: Zol smith	was church	Rod, ete 226	
Address: 201 5 mcph. City: Tayetteville	State: NO	Zip Code:	28303
Phone #: (940) 920 - 111	36 Fax (51 €	1 920-1545	
Email Address: ed. Hw			
Percentage interest in this licensed	Facility: 50 T	itle: Office	
List the names of other Family Car			iliate:
List the names of other running car	chitain care frome in v	anon you are the owner or arr	mato.
Name:			
Address:			
City:	State:	Zip Code:_	
Phone #: ()			
Email Address:		7	
Percentage interest in this licensed	Facility: T	itle:	
List the names of other Family Car			
,			
Name:			
Address:			
City:	State:	Zip Code:	
Phone #: ()	Fax ()	
Email Address:			
Percentage interest in this licensed			
List the names of other Family Car			
		√	· · · · · · · · · · · · · · · · · · ·

License No: HAL-025-031 Facility ID: 920850

Part D Census Data

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

	Attestation of Facility Cen	sus
This facility operating as F	liverview has not served one or more	e residents in the previous 12 months. If
	his facility, please sign below.	•
Date of last resident served		·
Do you plan to serve reside	ents 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	O	0
21 - 34	3	0	3
35 - 54	7	2	9
55 - 64	11	6)7
65 - 74	7	3	10
75 - 84	3	6	9
85 or older	0	0	Ö
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 or	n State/County S	necial Assistance	(QA)	42
Э.	On July 31, 2010,	, number of residents of	i State/County S	pecial Assistance	(DA)	7 -

4.	On July	31, 2016,	number	of private	pay i	residents:	6	
т.	On July	31, 2010,	number	of private	pay	csidents.		

Riverview, Craven County

License No: HAL-025-031 Facility ID: 920850

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*	Total must match total reported for July 31, 2016 census on page 11.
46	14	12	0	48	

^{*}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) $\operatorname{Total}^{**} = \{ (1) + (2) + (3) \}$	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)

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

^{**}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).

License No: HAL-025-031 Facility ID: 920850

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	۵	0
21 - 34	2	0	0
35 - 54	3	2	0
55 - 64	3	೦	4
65 - 74	2	Q	8
75 - 84	2	0	7
85 or older	٥	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 //
On July 31, 2016 number of occupied Special Care Unit beds

Authenticating Signature: The undersigned submits this application for licensure for the year 2017 in accordance with						
Article 1 Chapter 131 D-2 of the Go	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 cer	rtifies the accuracy of this information.				
	B					
Signature: / OV		Date: 09/22/2018				
Print Name lony	SI GLER	Phone Number: (90) 920 - 1180				
**************************************	The same of the sa					

RENEWAL LICENSURE COMPLIANCE HISTORY CHECK

Division of Facility Services Adult Care Licensure Section (ACLS)



Fa	~ ~ ~ ~ ~ ~	he sources described. Then for any findings of negative
	tion regarding eligibility for renewal licensure	prevent issuing a renewal license. Then make a 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
Administr:	y of the above, provider tracking database, a ative Officer / Program Development Coord Date	dverse action or on secretary of state record, forward inator for approval.
Recommend Comments:	lation: The owners are eligible for licensure	No Yes Initials of performer: P7

RENEWAL LICENSURE COMPLIANCE HISTORY CHECK Division of Health Service Regulation

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 w.	III 3% of more mierest m
the business:	9
19	

Tony +	Gdith	Bio	Len
7		0.0	·

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.

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

Out of State Facilities:

Route to Administrative Officer

Reviewed Date 10/6/16
Initials___PT

Attached | yes | 10

Reviewed Date 10/6/18
Initials DF

Attached | yes | no

Owner (s)	Facility	County	Adverse Action	Effective Date	Meets Compliance
-	Riverstone	Craven	Benatties	12/29/15	Appeal 1/15/16
	Diver Vive	41	(5) penalties	4/22/14	eppeal 5/18/16
	Pine wood Manor Wallace Gander Vale Pointe AL	thertford	NONE		
	Wallpre Conder	Duplin	1.1		
	Vale Pointe AL	Columbus	. 11		
		2)	\		
		6		<u> </u>	
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	~ .				

State of Auth Carolina Aenartment of Kealth and Kuman Services 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 Alzheimer's/Dementia 20 Type:

Authorized by:

Secretary, N.C. Department of Nealth 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 Ap	plication	Attached:	Yes X No
Part A. Facili	ty Inform	ation		
Facility Name: Riverview		1		
Physical Address: 3407 Oaks Road Cit	y: New Ber	n	State: NC	Zip: 28560-
Felephone Number: (252)633-1143	Fax Numb (252)633-0			
*If any of the above information is incorrect please of	call the Adu	t Care I	icensure Sectio	on (919) 855-3765
Please provide your National Provider Identifier (NPI) For questions regarding NPI, contact 1-800-465-3203 (NPI Tol	ll-Free)	NPI:		
Correspondence Mailing Address: (where you want to a Division of Health Service Regulation): *Make correction			ondence <u>includ</u>	ing the license from
Name: RIVERVIEW			Title:	
Address: P.O Box 1189			Telephone N	Number: 3 - 1143
City, State Zip Code: New Bern, NC 28563-		9 100 30-1100		
Primary Email: wateroakmanor@yahoo.com				
CERTIFIED ADMINISTRATOR:				0
Name: Tony BIGLER 59/3	115			
Name: Tony BIGLER 739131 Telephone Number: () 910 920—1160	Fax: () 10 5	20-1545	_
Administrator Certificate No.	Expiration	n Date:	2 /31 /201	
DHSR USE ONLY License# HAL-025-031 FID# 920850 Region Northeast Compliance Check Completed Entry by P7 Date: ///2/16 License Fee: \$1,812.50	Doi	į.	EE PAID 1 3	15 Omes

License No: HAL-025-031 Facility ID: 920850

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.

ak Manor Inc			
1189	ordine consider wells:		
3	State: NC	Zip co	ode: 28563
	Fax Numbe	r: 252-633	2540-
The licensee is: X For Profit		Not For Profit	
one)			
*	☐ Limited	l Liability Partner	
ID#: <u>88066</u> Z	1/12/16	(Attac	tered in Other State. h a copy of the Certificate hority issued by NCSOS)
	1189	State: Fax Numbe X For Profit dividual owner) Company (LLC)* State: Fax Numbe Fax Numbe Fax Numbe Govern	State: No Zip co Sign of State: No Zip co Sign of Si

- 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.

	General Partner, Managing Men	nber .
Name: Tony Bigler	Telephone Numbe	
Address: 201 5 mcPhean	hurch Rd 5-fe 22	6
City: Fayetheville		ip: 28393
Name	Title	
Name	Title	
Name	Title	Page 6

Part C Ownership Disclosure (*REQUIRED)

For the purpose of this application the following definitions apply:

The following definitions shall apply throughout this application:

mepheson church

State:

(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.

Fax Number:

(914) 920

Zip:

- (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

City:

Telephone Number:

(910) 920-1150

"§ 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.

License No: HAL-025-031 Facility ID: 920850

Part C Ownership Disclosure (*REQUIRED)

OWNERS, PRINCIPLES, AFFILIATES, SHAREHOLDERS, MEMBERS

Complete the information below on <u>all</u> 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%.

- D			
() ()	igler	s comp g g	
	dephenson Church Re		
	e State: NC		3
Phone #: (9(0) 920	-1180 Fax (900) 93	20-1545	
	weine @ earthlink.		
	icensed Facility:Title:		
List the names of other Farr	nily Care/Adult Care Home in which yo	ou are the owner or affiliate:	
Name: Ed. 74	P.11.		
	Sigler Cophron Church Rel	10 226	
Address: 6 1	e State: PC	SHECKO 7 2 FZM	
			5
	1-1/80 Fax (910) 92		
	whigher @ yehoo. com		
D	censed Facility:	His ch	
		50000000	
Wex	nily Care/Adult Care Home in which yo	ou are the owner or affiliate:	
Wex	nily Care/Adult Care Home in which yo	ou are the owner or affiliate:	
List the names of other Fam		ou are the owner or affiliate:	
List the names of other Fam		ou are the owner or affiliate:	
List the names of other Fam Name: Address:			
List the names of other Fam Name: Address: City:	State:	Zip Code:	
List the names of other Fam Name: Address: City: Phone #: ()		Zip Code:	
Name:	State: Fax ()	Zip Code:	
Name: Address: City: Phone #: () Email Address: Percentage interest in this lie	State:	Zip Code:	
Name: Address: City: Phone #: () Email Address: Percentage interest in this lie	State: Fax ()	Zip Code:	
Name:	State:	Zip Code:	
Name: Address: City: Phone #: () Email Address: Percentage interest in this lie	State:	Zip Code:	
Name: Address: City: Phone #: () Email Address: Percentage interest in this lit. List the names of other Fam	State:	Zip Code:	
Name: Address: City: Phone #: () Email Address: Percentage interest in this li List the names of other Fam Name: Address:	State: Fax () censed Facility: Title: hily Care/Adult Care Home in which yo	Zip Code: Du are the owner or affiliate:	
Name: Address: City: Phone #: () Email Address: Percentage interest in this liculate the names of other Fame Name: Address: City: City: City: City: City:	State: Fax () censed Facility: Title: nily Care/Adult Care Home in which yo	Zip Code: ou are the owner or affiliate: Zip Code:	
Name: Address: City: Phone #: () Email Address: Percentage interest in this li List the names of other Fam Name: Address: City: Phone #: ()	State:	Zip Code: ou are the owner or affiliate: Zip Code:	
Name: Address: City: Phone #: () Email Address: Percentage interest in this li List the names of other Fam Name: Address: City: Phone #: () Email Address:	State:	Zip Code: Du are the owner or affiliate: Zip Code:	

License	No:	HAL-025-031
Facility	m.	020850

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 <u>Riverview</u> has <u>not</u> 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	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	D	O	0
21 - 34	3	0	3
35- 54	7	2	9
55-64	(8)	6	16
65 - 74	4	2	9
75 - 84	3	6	9
85 or older	0	O	0
TOTAL	3.0	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): 4/
- 4. On July 31, 2015, number of private pay residents: _______

License No: HAL-025-031 Facility ID: 920850

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*	Total must match total reported for July 31, 2015 census on page 11.
50	4	8	0	46	Excellent area along the control of

^{*}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)

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

^{**}Total cannot be <u>less</u> than the *minimum paid bed* †days or <u>greater</u> 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).

License No: HAL-025-031 Facility ID: 920850

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	Ø	٥	
35 -54	3	2.	0	
55 -64	3	0	4	
65 - 74	2	٥	8	
75 - 84	2	0	F	
85 or older	0	Ó	Ø	
TOTAL	12	2	20	

Elderly Persons are defined as persons age 55 <u>OR</u> 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				

.... !- linewood for and carries Only alderly nersons

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 Article 1 Chapter 131 D-2 of the General Statutes of North Carolina Medical Care Commission (10A NCAC 13F) and certification (10A NCAC 13F).	ina and to the rules adopted there under by the North
Signature: Signature:	Date: 08/28/2015
Print Name Towy BIGLER	Phone Number: (910) 980 -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

Lake Waccamaw Senior Living, Inc. Prev Legal:

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:

Registered Agent:

Bigler, Tony F.

Corporate Addresses

Reg Office:

201 S McPherson Church Road Suite 226 Suite 226

Favetteville, 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:

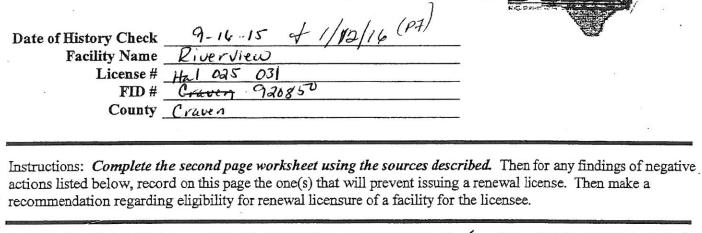
100000

No Par Value:

Yes

RENEWAL LICENSURE COMPLIANCE HISTORY CHECK

Division of Facility Services
Adult Care Licensure Section (ACLS)



Reference	Type B or Type A Penalty	No Yes Appeal Date 2-13-15
G.S.	Deny until 1 year after assessed OR	Monetary Assessment Date 1/5/15
131D-2.4	until confirmed returned to substantial	
	compliance which ever comes first	Penalty Due Date 3-15-15
(C) (2)	Compliance which ever comes hist	Confirmed Compliance Date ///23/15
	G : (11:::(00.1)	Penalty Paid Date 3-15-15 11/6
10A	Suspension of Admission (SOA)	No Yes Appeal Date 6-18-15
NCAC	Deny until 6 months after SOA lifted	Initiation Date
13F .0203	**	Lift Date 8-25-15
G.S.	Provisional Licensure	No Yes Appeal Date
131D-2.4	Deny until 6 months from date license fully	Restoration Date &-
(C) (3) or	restored	Termination Date
(4)		
G.S.	Summarily Suspended Licensure	No Yes Appeal Date
131D-2.4	Deny until 6 months from date license fully	Restoration Date
(C) (3) or	restore	Termination Date
(4)		
G.S.	Revocation	No Yes Appeal Date
131D-2.4	Deny until 1 year after revocation	Lift Date
(C) (3) or		
(4)		. *
to Administr	y of the above, provider tracking database, a ative Officer / Program Development Coord	inator for approval. Ok to process PI //12/16
		The first of the first
Recommend	dation: The owners are eligible for licensure	No Yes Initials of performer.
Comments:		
Penati	ties paid in full and	Total put \$10,000.00 11/23/15
Sellle	ment Agreenant, 9/3/15	Total put \$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	com	pliance.

Check each owner listed on application

Go To: Reports

General Reports

Owners, Report Yes, SSN/Name

Route to Administrative Officer

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	1
the business: Water Oak Manur		
Tony Bigler		
Tony Bigler Edith Biller		
2		

Cross check web for compliance in Mental Health Licensure Section Child Care Licensure Section	Reviewed Date // 12/16 Initials
http://providertracking.dhhs.state.nc.us	
* If any negative results print and attach.	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 9-14-15 Initials 10 Attached (ves) no
Out of State Facilities:	

Owner (s)	Facility	County	Adverse Action	Effective Date	Meets Compliance
Tony +	Pine wood Manor	Hertford			
Edith Biger	Lake Pointe AL	Columbia			
	Wallau Garden	Duplin			
	Late Pointe AL				
	Reversone	Craven			
		Craven			
	,				•

State of Aurth 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
	ty Information		
Tait A. Taem	ty information		
Facility Name: Water Oak Manor	<u> </u>		
Physical Address: 3407 Oaks Road Cit	ty: 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	1 ' ' '	icensure Section	n (919) 855-3765
Please provide your National Provider Identifier (NPI) For questions regarding NPI, contact 1-800-465-3203 (NPI To	NPI:	122521	
Correspondence Mailing Address: (where you want to Division of Health Service Regulation): *Make correcti		ondence <u>includi</u>	ng the license from
Name: Water Oak Manor		Title:	
Address: P.O Box 1189	and the second s	Telephone N (252)633-114	
City, State Zip Code: New Bern, NC 28563-			
Primary Email: Wateroakminer 6	ythoo.com		7 -
CERTIFIED ADMINISTRATOR:			<u> </u>
Name: Tony BIGLERAN			
Name: Tony BIGLERA WE' Telephone Number: () 252 633 - 1143	Fax: () 252 6	33-0422	۷.
Administrator Certificate No.	Expiration Date:	33-0422	5
		, ,	
DHSR USE ONLY License# HAL-025-031 FID# 920850 Region Clinton Compliance Check Completed P7 9/11/14 Entry by JJS Reviewed by Stephen Date: 4-25-14 Date: 2(5/14) License Fee: \$1.812.50	And the same of th	7812.	14
	5717	_	

Part B Operation Disclosure

License No: HAL-025-031

Facility ID: 920850

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.

A Change Application is required			inted Estees	The state of the s
Licensee Name: Water Oak Manor Inc		· · · · · · · · · · · · · · · · · · ·		
Address: P.O Box 1189				
City: New Bern	Sta	te: NC		Zip code: 28563-
Telephone Number: (252)633-1143		Fax Number:	(252)633	-0422
The licensee is a: (check one) For Prof	fit	ð	Not F	or Profit
The licensee is: (Check one)				
 □ Proprietorship (individual owner) ☒ Corporation (Inc)* □ Limited Liability Company (LLC)* 		☐ Limited		orporated) Partnership (LLP)*
*NC Secretary of State ID #:	662	9/11/19	/	Registered in Other State. (Attach a copy of the Certificate of Authority issued by NCSOS)
COMPLETE THE FOLLOWING INFO		r D:		
 If the licensee is not for profit, the na 	ame of each Off	ncer, Director of	r i rustees.	

- 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, Ge	neral Partn	er, Managing Memb	er
Name: TONY BIGLER		Telephone Number: (910) 920-1186	Fax Number: (9/0) 920-1545
Address: 201 S McPhesson Church	Rosal S.	uje 226	
City: Fayetteville	State:	Zip:	28303
Name		Title	
Name		Title	
Name		Title	

Management Company: Is the business operated under a management contract? ☐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** × No. Is the building where services are offered leased/rented? Yes If yes, please complete the following on the building/property owner and provide a copy of the lease agreement. Name: Street/Box: 2015 MiPharson Church State: City: Telephoné Number: Fax Number:

License No: HAL-025-031

Facility ID: 920850

Part C Ownership Disclosure (*REQUIRED)

(9(0)

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

(910) 920 -1180

"§ 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 <u>all</u> 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%.

complete the information below, listing the percentage interest as 100%.	
Name: Tony Bigla-	
Address: 201'S MEPherson Church Rosel Suite 22h	
City: Fyetteville State: NC Zip Code: 28303	
Phone #: (910) 920-160 Fax (910) 920-1545	
Email Address: etaraine @ earthlink.net	
Percentage interest in this licensed Facility: 50 Title: 4	
List the names of other Family Care/Adult Care Home in which you are the owner or affiliate:	
Name: Edith Bigler	
Address: 201 5 Mephron Church Rosal Suite 225	
City: Fayetteville State: NC Zip Code: 28303	
Phone #: (910) 920 - 1180 Fax (910) 920 - 1545	
Email Address: edithwbigher @ yelos. com	
Percentage interest in this licensed Facility: 50 Title: 0	_
List the names of other Family Care/Adult Care Home in which you are the owner or affiliate:	
i i i	
Name:	
Name:Address:	
Name:	
Name: Address: City: State: Fax (Email Address: Percentage interest in this licensed Facility: List the names of other Family Care/Adult Care Home in which you are the owner or affiliate: Name: Address: Address:	
Name: Address: City: State: Fax (Fax (
Name:	
Name: Address: City: State: Zip Code: Phone #: () 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 #: () Email Address:	
Name:	

Part D Census Data

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

	Attestation of Facility Cen	
This facility operating as W	ater Oak Manor has not served on	e or more residents in the previous 12
months. If this is a true stat	ement for this facility, please sign be	elow.
Date of Last resident served	l at this location	•
Do you plan to serve reside	nts in the next 12 months?	e or more residents in the previous 12 elow
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	Ó
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):	3.	. (On July 31, 2014	, number of resider	nts on State/County	y Special A	ssistance (SA):	41	
---	----	-----	------------------	---------------------	---------------------	-------------	-----------------	----	--

4.	On July 31, 2014	, number of private	pay residents:	9
	and the second s			

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	Discharges (excluding	Admissions	Deaths	Total**	
Census * (Aug. 1, 2013)	deaths) (Aug, 1, 2013 – July 31, 2014)	(Aug, 1, 2013 – July 31, 2014)	(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.

License No: HAL-025-031

Facility ID: 920850

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).

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

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:

License No: HAL-025-031

Facility ID: 920850

 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	D	0
35 -54	3	2	0
55 -64	3	0	4
65 - 74	2	0	8
75 - 84	2	0	8
85 or older	٥	0	0
TOTAL	12	2	20

Elderly Persons are defined as persons age 55 <u>OR</u> older of or other form of dementia that requires assistance with a	or who have a primary diagnosis of Alzheimer's disease
*LICENSED CAPACITY AND SPECIAL CARE UNIT	
Licensed Capacity 83	
Licensed Special Care Unit Capacity: 20	4

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

On July 31, 2014 number of occupied Special Care Unit beds

- 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 Article 1 Chapter 131 D-2 of the General Statutes of North Car	
Carolina Medical Care Commission (10A NGAC 13F) and cer	tifies the accuracy of this information.
Signature:	Date: 08/18/2014
Print Name Tony BIGLER	Phone Number: (9/0) 920 -1180
	Page 13

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RENEWAL LICENSURE COMPLIANCE HISTORY CHECK

Division of Facility Services Adult Care Licensure Section (ACLS)



Date of His Fa	tory Check cility Name Water Oak Ma License # HAL-025-03 FID # 92-0850 County Craver	
actions listed		the sources described. Then for any findings of negative prevent issuing a renewal license. Then make a 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	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	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	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
o Administr	y of the above, provider tracking database, a ative Officer / Program Development Coord Date	dverse action or on secretary of state record, forward inator for approval.
Recommends:	lation: The owners are eligible for licensure	No Yes Initials of performer: P7

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

		1.0	
Edith B	Tolow.		(10)
	18:1		

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

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.

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

Initials P7

Attached □ yes □ 100

Initials 7

Reviewed Date 9-11-14

Reviewed Date 9-11-14

Attached | yes Ino

Out of State Facilities:

Route to Administrative Officer

			8 - 4-		
Owner (s)	Facility	County	Adverse Action	Effective Date	Meets Compliance
	WALLACE GARdens	Duplin	abno		
	ROVE Pointe A1	Columbus	11		
	Wasen DAK MANOR Pine wood MANOR River Stone	Evaven Heitfad Craven	50A	8/26/14	
	Pine wood Mange	Heitland	None		
	River Stone	Craven	11	A	
77 Million (1969) 25 - 25 Million (1969)					
	`				
					A CONTROL OF THE CONT

State of Aorth Carolina Brunetunal of Worlth and Human Services 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

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

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	on Attached:YesNo
Part A. Facilit	ty Information	
Facility Name: Water Oak Manor		
Physical Address: 3407 Oaks Road City	y: 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 c	all 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 Tole	NPI:	1225216872
Correspondence Mailing Address: (where you want to r Division of Health Service Regulation): *Make correction	eceive ALL corre	
		Title: Administrator
Name: Tony BIGLER Address: P.O Box 11'89		Title: Administrator Telephone Number: (252) 633-468/
City, State Zip Code: New Bern, NC 28563-		
Primary Email: Wateroakmanor @ yahoo.	com	
CERTIFIED ADMINISTRATOR:		
Name: Tony BIGLER 8/21/1	ANS	
Name: Tony BIGLER 8/21/1 Telephone Number: (252) 633 - 4143	Fax: (252) 6.	33-6422
Administrator Certificate No.	Expiration Date	e:
600000716		12-31-2013
		CONTRACTOR OF THE STATE OF THE
DHSR USE ONLY	A Company of the Comp	
License# HAL-025-031		8 / 16 / 13
FID# 920850	5	
Region Clinton Compliance Check Completed (2) AB 8/21/13	terreress.	\$ 1812.50
Entry by T Reviewed by MC Date: 1014 Date: 1014 13	Chack 4	- Frank 5
License Fee: \$1,812.50	An annual contraction of the con	herk # 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.

A Change Application is required for ANY	manges to the preprint	ted Licensee name.
Licensee Name: Water Oak Manor Inc		
Address: P.O Box 1189		4,740,800,000
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)	4	
□ Proprietorship (individual owner)☒ Corporation (Inc)*□ Limited Liability Company (LLC)*		p (Unincorporated) ability Partnership (LLP)* nt Unit
*NC Secretary of State ID #: 880662	pab slaild	Registered in Other State. (Attach a copy of the Certificate of Authority issued by NCSOS)
COMPLETE THE FOLLOWING INFORMATIO	N:	
 If the licensee is not for profit, the name of each 	ch Officer, Director or T	rustees.
 If the licensee is a partnership or limited liabi 	lity partnership (LLP)), the name of each partner.
 If the licensee is a limited liability company (I 	LLC), the names of the	managing members, attach a list of the
names and address of the members of the limite	d 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.

Executiv	ve Officer, General	Partner, Managi	ng Member	
Name: Tony BIGL	EE	Telephone	Number: 20/180	Fax Number: (910) 920 1545
Address: 2015 MCPh.	erson Church	Road /=	Suite 22	26
City: Fayetteville	Stat	e: NC	Zip:	78303
Name		Title		2
Name		Title		
Name		Title		

Part C Ownership Disclosure (*REQUIRED)

OWNERS, PRINCIPLES, AFFILIATES, SHAREHOLDERS, MEMBERS

Complete the information below on <u>all</u> 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 5 Methor	Church Rosal, Suite 226
City: Fayetheu'lle St	ate:Zip Code:Zip Code:
Phone #: (910) 920 (180 Fa	1x (910) 920 NY5
Email Address: etcreine @ ed	with link, net
Percentage interest in this licensed Facility:,	50 Title: Officer
List the names of other Family Care/Adult Care	c Home in which you are the owner or affiliate:
15-11/ 8:1-	"
Name: Edith Bigler	1 () 221
Address: 201 5 McPherson Ch	Turch Road, Superior
City: <u>fayetterile</u> St	tate: NC Zip Code: 28323
Phone #: (9(0) 920 150 Fa	ax (9(0) 920 1545
Email Address: 2dith w by level	SO Title: Officer
List the names of other Family Care/Adult Car	e Home in which you are the owner or affiliate:
Name:	
Address:	
	tate:Zip Code:
Phone #: () F:	
Email Address:	an ()
	Title:
Percentage interest in this necessor admiry	
I ist the names of other Family Care/Adult Car	o Home in which you are the owner or attiliate.
List the names of other Family Care/Adult Car	e Home in which you are the owner or attiliate:
List the names of other Family Care/Adult Car	e Home in which you are the owner or affiliate:
List the names of other Family Care/Adult Car Name:	The Home in which you are the owner or attitude:
Name:Address:	
Name:	tate:Zip Code:
Name:	tate:Zip Code:
Name:	tate:Zip Code:
Name:	tate:Zip Code:ax ()

Management Company:				
Is the business operated under a ma	nagement contract?	⊠No □Ye	s If yes, pro	vide name and address of
the management company				
Company Name:				
Owner of Management Company En	ntity:	Telephone Nur	nber:	
9-0 1000)**	()		
Street/Box:				
City:		State:	9	Zip:
Building Owner	u 1850			
Is the building where services are of	fered leased/ rented?	Yes X	No. If yes	s, please complete the
following on the building/property o	wner and provide a	copy of the lease	agreement.	
Name: WATER OAK	PROPERTIE	es, LLC		
Street/Box: 201 5 MCPh City: Fayeffeville	esson Church	Rosel, Su	uk 226	, a
City: Fayeffeville	State: NC	7;	Zip: 28	303
Telephone Number:	F F F 500 S	Fax Number:		
(913) 920 (180		(9(0) 920	1545	4

License No: HAL-025-031

Facility ID: 920850

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.

Part C Ownership Disclosure (*REQUIRED)

- (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 Cens	sus
		e or more residents in the previous 12
Date of Last resident served	ement for this facility, please sign be at this location	
Do you plan to serve residen		
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 <u>July 31, 2013</u>:

Resident Age - years	Male	Female	Total
18 – 20	0	0	0
21 - 34	.3	Ø	3
35- 54	7	2	9
55-64	12	6	18
65 - 74	9	2	10
75 - 84	3	6	9
85 or older	O	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 *	Discharges (excluding	Admissions	Deaths	Total**
(Aug. 1, 2012)	deaths) (Aug, 1, 2012 – July 31, 2013)	(Aug, 1, 2012 – July 31, 2013)	(Aug, 1, 2012 – July 31, 2013)	I Otal
42	4	11	0	49

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

License No: HAL-025-031

Facility ID: 920850

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).

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

License No: HAL-025-031 Facility ID: 920850 Water Oak Manor, Craven County

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	O	0
35 -54	3	1	0
55 -64	3	0	4
65 - 74	2	0	8
75 - 84	7_	0	8
85 or older	0	0	٥
TOTAL	1 1	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 <u>OR</u> older or who have a primary diagnosis of Alzheimer' or other form of dementia that requires assistance with activities of daily living.				
*LICENSED CAPACITY AND SPECIAL CARE UNIT				
Licensed Capacity <u>83</u> Licensed Special Care Unit Capacity: <u>20</u>				

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

On July 31, 2013 number of occupied Special Care Unit beds

- 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: lang 54	Date: 8/13/13	
Print Name / Towy BIG	WR Phone Number: (910) 920 180	

