David G. Kostinas & Associates

Health Care Business-Brokering • Market Studies & Analysis • Regulatory Issues & Compliance

David G. Kostinas

August 6, 2012

Barbara Goldman, Director
Long Term Care Licensing
New Jersey State Department of Health & Senior Services
CN 367
Trenton, New Jersey 08625

Re: Sussex County Homestead
Facility License # 061905

Dear Ms. Goldman:

Pursuant to N.J.A.C. 8:33-6.1(a)8. I respectfully submit the required information to transfer the ownership of Sussex County Homestead from the County of Sussex to Homestead Rehabilitation & Health Care Center, LLC.

I have enclosed a Project Description, a Purchase Agreement, an Attestation, Track Record letter and a check in the amount of $ 4,030.00 made payable to *Treasurer, State of New Jersey* for the transfer of ownership processing fee and the first year licensing fee.

I will be available to assist you with any information necessary to meet all requirements of your office. Please call me with any questions at (609) 890-7286.

Sincerely,

David Kostinas

enclosure

Phone: (609) 890-7286 • E-Mail dkostinas@davidkostinas.com • Website www.davidkostinas.com

PROJECT DESCRIPTION

The County of Sussex presently owns and operates Sussex County Homestead in Sussex County. The facility is licensed to operate one hundred two long term care beds and is located at:

129 Morris Turnpike
Newton, New Jersey 07860

It is the intent of the County of Sussex to transfer the ownership of the rights to own and operate Sussex County Homestead to Homestead Rehabilitation & Health Care Center, LLC. Homestead Rehabilitation & Health Care Center, LLC is owned by:

Benjamin Landa	129 Morris Turnpike, Newton, New Jersey 07860	100%

All facilities owned, operated or managed by Mr. Landa are listed on the attachment . All facilities are in full compliance with State and Federal requirements. It is anticipated that the transfer will be completed immediately upon approval by the Department of Health & Senior Services. The transfer of ownership will not adversely affect the continuity of care to the patients at the facility. No patient will be displaced as a result of this transfer.

Homestead Rehabilitation & Health Care Center
129 Morris Turnpike
Newton, New Jersey 07860

August 6, 2012

Barbara Goldman, Assistant Director
CN & Healthcare Licensure Program
NJ Department of Health & Senior Services
P.O. Box 358
Trenton, New Jersey 08625

Re: Sussex County Homestead
Facility License # 061905

Dear Ms. Goldman:

This letter will serve as my attestation as the Administrator of Homestead Rehabilitation & Health Care Center, that I am familiar with the requirements of N.J.A.C. 8:39 and that I recognize and accept that the facilities will be operated in compliance with its' requirements.

If you require any additional information, please contact me.

Signed:

Jake Lighten

New Jersey Department of Health and Senior Services
Office of Certificate of Need and Healthcare Facility Licensure
PO Box 358
Trenton, NJ 08625-0358

APPLICATION FOR A LONG TERM CARE FACILITY LICENSE

Type of Application:	**Date of Application:**	**Date of Check/Money Order:**
☐ New – CN#: ☐ New – No CN Required, ID#: ☒ Transfer of Ownership #: **061905** ☐ Other:	**Check/Money Order No.:**	**Amount of Check/MO:** $

Field	Value	Field	Value
Official Name of Facility (Provider Name):	**Homestead Rehabilitation & Healthcare Center**	**EIN Number:**	
Site Address:	**129 Morris Turpike**		
City:	**Newton**	State:	**NJ**
Zip:	**07860**	County:	**Sussex**
Telephone Number:	**973-948-5400**	Fax Number:	**973-948-5810**
Email Address:			
Name of Administrator:	**Jake Lighten**	License Number (LNHA/CALA if applicable):	**24085**
Emergency Contact:	**Jake Lighten**		
Emergency Telephone:	**732-543-0502**	Emergency Fax Number:	973-948-5810
Emergency Email Address:	**lightja@yahoo.com**		
Mailing Address (if different from above):			
City:		State:	
Zip:		County:	
Owner/Corporate Name *(LICENSED OPERATOR)*:	**Homestead Rehabilitation & Health Care Center, LLC**	**EIN Number:**	
Doing Business As (if applicable):			
Address:	**129 Morris Turnpike**		
City:	**Newton**	State:	**NJ**
Zip:	**07860**	County:	**Sussex**
Telephone Number:	**973-948-5400**	Fax Number:	**973-948-5810**
Email Address:			
Management Company (if applicable):			
Address:			
City:		State:	
Zip:		County:	
Telephone Number:		Fax Number:	
Email Address:			
Contact:		Title:	

APPLICATION FOR A LONG TERM CARE FACILITY LICENSE, Continued

Official Name of Facility (Provider Name): Homestead Rehabilitation & Healthcare Center	**EIN Number:**

Primary Type of Facility ***(check one)***

- ☐ Adult Day Health Services
- ☐ Alternate Family Care
- ☐ Assisted Living Program
- ☐ Assisted Living Residence
- ☐ Comprehensive Personal Care Home
- ☐ Hospital Based Subacute
- ☐ Pediatric Day Health Services
- ☐ Residential Health Care Facility
- ☐ Other: ______
- ☐ Long-Term Care T18 only
- ☐ Long-Term Care T19 only
- ☒ Long-Term Care T18/19
- ☒ Long-Term Care Private

Enter the Quantity of all Beds/Slots at this Location

Adult Day Health Service Slots		Long-Term Care Beds	102
Assisted Living Beds		Pediatric Day Health Slots	
Comprehensive Personal Care Beds		Residential Health Care Beds	
Hospital Based Subacute		Other/Type:	

Type of Ownership ***(check one)***

For-Profit: ☒ Yes ☐ No
Non-Profit: ☐ Yes ☒ No
Facility is Hospital Based: ☐ Yes ☒ No
Government Owned: ☐ Yes ☒ No

- ☐ *Corporation
- ☐ Partnership
- ☐ Other(specify): ______
- ☐ Proprietorship
- ☐ Limited Partnership
- ☒ Limited Liability Corp.
- ☐ Religious Affiliation
- ☐ Federal
- ☐ State
- ☐ County
- ☐ City
- ☐ City/County
- ☐ Hospital District

**If the corporate entity is a wholly-owned subsidiary, identify the parent corporation below:*

Name: ______

Address: ______

City, State, Zip Code: ______

Building Ownership ***(check one)***

- ☐ Wholly owned by licensed operator identified on page one
- ☐ Leased (Identify owner of physical assets and submit a copy of the signed lease)

______

Name and Title of Individual or Current Registered Agent Upon Whom Orders May Be Served ***(Must be NJ Resident)***

Name: **Benjamin Landa**

Address: **129 Morris Turpike**

City, State, Zip Code: **Newton, NJ 07860**

APPLICATION FOR A LONG TERM CARE FACILITY LICENSE, Continued

Official Name of Facility (Provider Name): Homestead Rehabilitation & Healthcare Center	**EIN Number:**

OWNER, OFFICERS, PARTNERS, STOCKHOLDERS, OR CORPORATE OFFICERS

- *IDENTIFY 100% OF THE OWNERSHIP BELOW.* (Attach additional sheets if necessary.)
- *For a publicly-held corporation, identify all stockholders with 10% or more of the outstanding stock.*
- ***If an owner, partner or shareholder is an entity, rather than an individual, provide the individual ownership of that entity as well.***
- *For Non-Profit entities, list Board Members.*

Name: Benajmin Landa
Title: Member
Address: 129 Morris Turpike
City: Newton
State: NJ Zip Code: 07860
SSN/Tax ID:
% Ownership: 100
☐ Proprietor ☐ Limited Partner ☐ Stockholder
☐ Partner ☐ General Partner ☐ Corporate Officer
☒ LLC-Member

Name:
Title:
Address:
City:
State: Zip Code:
SSN/Tax ID:
% Ownership:
☐ Proprietor ☐ Limited Partner ☐ Stockholder
☐ Partner ☐ General Partner ☐ Corporate Officer
☐ LLC-Member

Name:
Title:
Address:
City:
State: Zip Code:
SSN/Tax ID:
% Ownership:
☐ Proprietor ☐ Limited Partner ☐ Stockholder
☐ Partner ☐ General Partner ☐ Corporate Officer
☐ LLC-Member

Name:
Title:
Address:
City:
State: Zip Code:
SSN/Tax ID:
% Ownership:
☐ Proprietor ☐ Limited Partner ☐ Stockholder
☐ Partner ☐ General Partner ☐ Corporate Officer
☐ LLC-Member

Name:
Title:
Address:
City:
State: Zip Code:
SSN/Tax ID:
% Ownership:
☐ Proprietor ☐ Limited Partner ☐ Stockholder
☐ Partner ☐ General Partner ☐ Corporate Officer
☐ LLC-Member

Name:
Title:
Address:
City:
State: Zip Code:
SSN/Tax ID:
% Ownership:
☐ Proprietor ☐ Limited Partner ☐ Stockholder
☐ Partner ☐ General Partner ☐ Corporate Officer
☐ LLC-Member

APPLICATION FOR A LONG TERM CARE FACILITY LICENSE, Continued

Official Name of Facility (Provider Name):	**EIN Number:**
Homestead Rehabilitation & Healthcare Center	

Please indicate whether or not your facility offers the following:

	Yes	No	No. of Beds
Separate Units for Young Adults (Ages 21 through 64):	☐	☐	
Pediatrics:	☐	☐	
Ventilator:	☐	☐	
Behavioral Management:	☐	☐	
Private Long Term Care:	☐	☐	
Alzheimer's/Dementia:	☐	☐	
IV Therapy:	☐	☐	

Chronic Dialysis:	Yes	No
Performed by In-House Staff:		
-Peritoneal:	☐	☐
-Hemodialysis:	☐	☐
Performed by Outside Firm:		
-Peritoneal:	☐	☐
-Hemodialysis:	☐	☐

Assisted Living Programs and Alternate Family Care, list counties served from office site listed on page one:

Please answer the following questions. (Attach additional sheets if necessary.)

1. Have you or any person mentioned in this application ever had an interest, directly or indirectly, in any application for health care facility in New Jersey or any other state, which was denied or revoked?
   ☐ Yes ☒ No If Yes, indicate whom and give details (attach additional sheets if necessary):

2. Do any of the principals have ownership, management or operational interest in any other licensed health care facility in New Jersey, or any other state?
   ☒ Yes ☐ No If Yes, indicate whom and give details (attach additional sheets if necessary):
   See attachments

3. Are you related to any person who now operates or has ever operated a health care facility in New Jersey or elsewhere?
   ☒ Yes ☐ No If Yes, indicate whom and give details (attach additional sheets if necessary):
   See attachments

4. Have any principals, owners, operators or managers of the facility ever been found guilty of a criminal or administrative charge of resident/patient fraud, abuse and/or neglect? Have any of these ever been indicted for the same charge?
   ☐ Yes ☒ No If Yes, indicate whom and give details (attach additional sheets if necessary):

5. Have any principals, owners, operators or managers of the facility ever been indicted for or convicted of a felony crime?
   ☐ Yes ☒ No If Yes, indicate whom and give details (attach additional sheets if necessary):

CERTIFICATION

The applicant certifies:

1. that all information contained in this application and attachments is true and correct, to the best of his/her knowledge and belief, and that willful misrepresentation of these facts may make the applicant subject to civil penalties;
2. that the application been duly authorized by the governing body of the applicant; and
3) that the facility has been and will be operated in accordance with applicable licensing requirements.

Name of Authorized Individual Completing Application (Print or Type)	Title
Jake Lighten	**Administrator**
Signature	Date

<u>Ownership Interest for Benjamin Landa</u>

Avalon Gardens Rehabilitation and Health Care Center
7 Route 25A
Smithtown, New York 11787
Manager/Member (31.50%)
5/12/2003 to Present
Licensing Agency: New York State Department of Health

Bay Park Center for Nursing and Rehab
801 Co-Op City Boulevard
Bronx, New York 10475
12/09/2009 to Present
Member (2.50%)
Licensing Agency: New York State Department of Health

Bayview Nursing and Rehabilitation Center
One Long Beach Road
Island Park, New York 11558
Manager/Member (23.50%)
4/6/2003 to Present
Licensing Agency: New York State Department of Health

Brookhaven Rehabilitation Healthcare Center
250 Beach 17th Street
Far Rockaway, New York 11691
Partner (32.00%)
4/26/2000 to Present
Licensing Agency: New York State Department of Health

Eastchester Rehabilitation and Health Care Center
2700 Eastchester Road
Bronx, New York 10469
Member (22.75%)
9/19/2002 to Present
Licensing Agency: New York State Department of Health

Forest Hills Care Center
71-44 Yellowstone Road
Bronx, N.Y. 11375
Member (25%)
7/1/1995 to Present
Licensing Agency: New York State Department of Health

Garden Care Center
135 Franklin Avenue
Franklin Square, N.Y. 11010
Member (34.50%)
9/12/1997 to Present
Licensing Agency: New York State Department of Health

Golden Gate Rehabilitation and Health Care Center
191 Bradley Avenue
Staten Island, New York 10314
Member (23.00%)
8/1/2001 to Present
Licensing Agency: New York State Department of Health

Grace Plaza Nursing and Rehabilitation Center
15 St. Paul's Place
Great Neck, NY 11021
Member (50.00%)
6/2/2003 to Present
Licensing Agency: New York State Department of Health

Meadow Park Rehabilitation and Health Care Center
7810 164th Street
Flushing, N.Y. 11366
Member (21%)
12/22/1999 to Present
Licensing Agency: New York State Department of Health

New Surfside Nursing Home
2241 New Haven Avenue
Far Rockaway, NY 11691
Member (50.00%)
5/1/1988 to Present
Licensing Agency: New York State Department of Health

Rockville Residence Manor
50 Maine Avenue
Rockville Centre, N.Y. 11570
Member (45%)
1/1/1999 to Present
Licensing Agency: New York State Department of Health

Split Rock Rehabilitation and Health Care Center
3525 Baychester Avenue
Bronx, N.Y. 10466
Member (20.75%)
9/19/2002 – 02/19/09

Tarrytown Hall Care Center
Wood Court
Tarrytown, N.Y. 10591
Member (18%)
7/23/1990 to 4/1/2008
Licensing Agency: New York State Department of Health

The Hamptons Center for Rehabilitation and Nursing
64 County Road 39
Southampton, N.Y. 11968
Member (15.75%)
11/16/2009 to Present
Licensing Agency: New York State Department of Health

Willoughby Rehabilitation and Health Care Center
945 Willoughby Avenue
Brooklyn, New York 11221
Member (46.25%)
4/6/2001 to Present
Licensing Agency: New York State Department of Health

Woodmere Rehabilitation and Health Care Center
121 Franklin Avenue
Woodmere, New York 11589
Member (35.050%)
9/1/1996 to Present
Licensing Agency: New York State Department of Health

Privilege Care Diagnostic and Treatment Center
40-18 76th Street
Elmhurst, New York 11373
Member (33%)
8/30/2005 to Present
Licensing Agency: New York State Department of Health

Oceanview Manor Home for Adults
3010 West 33rd Street
Brooklyn, New York 11224
Shareholder (50%)
8/28/2001 to Present
Licensing Agency: New York State Department of Health

Excellent Home Care
305 Berry Street
Brooklyn, New York 11211
Shareholder (50%)
11/2004 to Present
Licensing Agency: New York State Department of Health

FILED
JUL 26 2012
STATE TREASURER
0600389251

CERTIFICATE OF FORMATION

OF

HOMESTEAD REHABILITATION & HEALTH CARE CENTER, LLC

The undersigned, in order to form a limited liability company pursuant to the provisions of the New Jersey Limited Liability Company Act, does hereby certify:

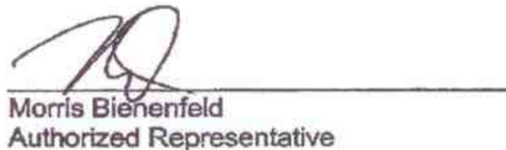
FIRST: The name of the limited liability company is HOMESTEAD REHABILITATION & HEALTH CARE CENTER, LLC.

SECOND: The address of the limited liability company's initial registered office is 129 Morris Turnpike, Newton, New Jersey 07860, and the name of the limited liability company's initial registered agent at such address is Benjamin Landa.

THIRD: The limited liability company shall have perpetual existence, unless sooner terminated in accordance with the operating agreement of the limited liability company.

FOURTH: The purposes of the limited liability company are to engage in all activities and enterprises for which limited liability companies may be formed under the New Jersey Limited Liability Company Act.

IN WITNESS WHEREOF, the undersigned has set his hand as of the 26th day of July, 2012.



Morris Bienenfeld
Authorized Representative

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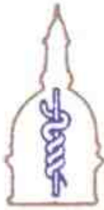

David G. Kostinas & Associates

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David G. Kostinas

August 6, 2012

Patricia M. Kennedy, Director
Bureau of Surveillance & Quality Assurance
State of New York Department of Health
161 Delaware Avenue
Delmar, New York 12054-1393

Re: Benjamin Landa

Dear Ms. Kennedy:

Benjamin Landa is in the process of acquiring a new long term care facility in the State of New Jersey. As part of the review process, we are required to provide certain specific information with respect to the prior operating experience ("track record") of the health care facilities identified on the attached pages in which Mr. Landa has an ownership, operational or management interest. All of the facilities owned by Mr. Landa are included on the attached pages.

In particular, we have been asked to indicate whether, within the 12 month period preceding the date of this letter, any of the identified facilities have been subject to any of the following:

i. An action by your state or a federal agency to ban, curtail or temporarily suspend admissions to that facility or to suspend or revoke its license;

ii. A decertification, termination or exclusion from Medicaid or Medicare participation, including denial of payment for new admissions as a result of noncompliance with Medicaid or Medicare conditions of participation.

iii A citation of any deficiency posing immediate jeopardy at a pattern or widespread scope level or any deficiency causing actual harm at a widespread scope level as described at 42 CFR 488;

iv. A determination by the Health Care Financing Administration that, as a result of deficiencies on successive surveys, the facility has been deemed a "poor performer;"

v. A citation of a deficiency based on a finding of substandard quality of care in two different areas on the same survey.

Phone: (609) 890-7286 • E-Mail dkostinas@davidkostinas.com • Website www.davidkostinas.com

Please indicate on the checklist below your response to these specific inquiries. In order to minimize paperwork, please include additional background materials only with respect to those facilities identified as having been subject to such findings within the past 12 months. In such cases, please provide copies of the survey results, plans of correction and any other records maintained by your agency to indicate the current status of the facility.

Thank you for your assistance in this matter. If you have any questions, please feel free to call me at 609-890-7286.

Sincerely,

David Kostinas

Please Return by E-mail to : dkostinas@davidkostinas.com

[ ] No such deficiencies have been noted at the listed facilities within the past 12 months

[ ] Yes, such deficiencies have been noted within the past 12 months (see attached)

Name:______________________________

Title:______________________________

Ownership Interest for Benjamin Landa

Avalon Gardens Rehabilitation and Health Care Center
7 Route 25A
Smithtown, New York 11787
Manager/Member (31.50%)
5/12/2003 to Present
Licensing Agency: New York State Department of Health

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7810 164th Street
Flushing, N.Y. 11366
Member (21%)
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Member (50.00%)
5/1/1988 to Present
Licensing Agency: New York State Department of Health

Rockville Residence Manor
50 Maine Avenue
Rockville Centre, N.Y. 11570
Member (45%)
1/1/1999 to Present
Licensing Agency: New York State Department of Health

Split Rock Rehabilitation and Health Care Center
3525 Baychester Avenue
Bronx, N.Y. 10466
Member (20.75%)
9/19/2002 – 02/19/09

Tarrytown Hall Care Center
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Excellent Home Care
305 Berry Street
Brooklyn, New York 11211
Shareholder (50%)
11/2004 to Present
Licensing Agency: New York State Department of Health

ATTACHMENT

PURCHASE AGREEMENT