


**Department of Health and Human Services
Division of Public Health
Licensure Unit
301 Centennial Mall So, P O Box 94986
Lincoln, NE 68509-4986**

2/25/16 dj

DEPARTMENT OF HEALTH AND HUMAN SERVICES DIVISION OF PUBLIC HEALTH CERTIFIES THAT	
North Platte Care Center, LLC MEETS STATUTORY REQUIREMENTS AS SNF/NF DUAL CERT Lic # 514003	
Services PHYSICAL THERAPY OCCUPATIONAL THERAPY SPEECH THERAPY	
EXPIRES 03/31/2017	 COURTESY R. THOMPSON, CPA Chief Executive Officer Department of Health and Human Services

Cut on heavy line and place on license.

FACILITY NAME: North Platte Care Center, LLC

ADDRESS: 2900 WEST E STREET, NORTH PLATTE, NE 69101

This is to verify that your SNF/NF DUAL CERT is licensed through the date indicated on the above renewal card. Place the renewal card in the lower left hand corner of your original license.

Please notify this office at the address listed above of any change in name, address, or ownership.

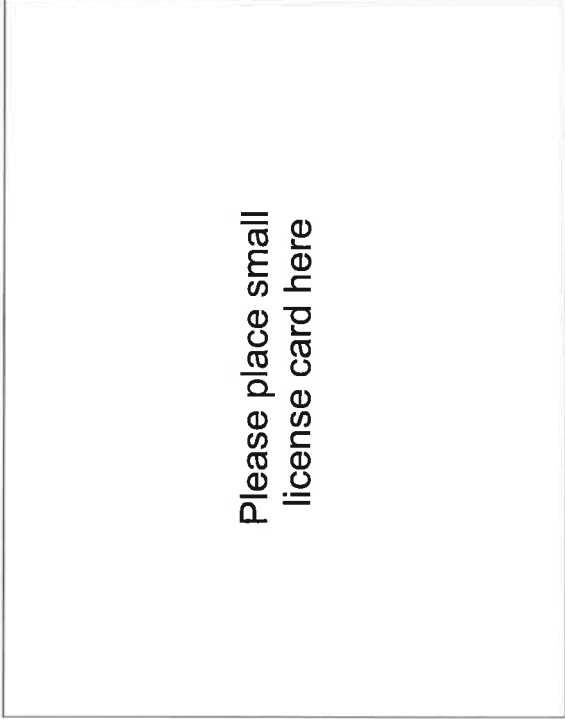
State of Nebraska

Department of Health and Human Services Division of Public Health

Lincoln, Nebraska

ISSUES LICENSE NO. 514003 to NORTH PLATTE CARE CENTER, LLC to operate a SNF/NF DUAL CERT located at 2900 WEST E STREET , NORTH PLATTE, NE. This facility is subject to rules and regulations lawfully promulgated by the State of Nebraska Department of Health and Human Services Division of Public Health.

Licensure Issuance Date: April 01, 2016



Please place small
license card here



Given under my hand and the seal of the State of Nebraska Department of Health and Human Services Division of Public Health at Lincoln, Nebraska, on February 25, 2016.



Courtney N. Phillips, MPA
Chief Executive Officer
Department of Health and Human Services

May be displayed on the licensed premises.

12-2-14

FEB 24 2016



NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH
Licensure Unit

Table with 2 columns: Fee Category, Amount. Includes Renewal Fees: 1-50 beds: \$1550, 51-100 beds: \$1750, 101 or more: \$1950.

Expiration Date
03/31/2016

Nursing Home Licensure Renewal Application

Nursing Home Type: Please Check
[X] Skilled Nursing Facility
[] Nursing Facility
[] Intermediate Care Facility

IDENTIFYING INFORMATION

1. NAME AND ADDRESS OF FACILITY:

North Platte Care Center, LLC
2900 WEST E STREET
NORTH PLATTE, NE 69101

2. PREFERRED MAILING ADDRESS (IF DIFFERENT FROM FACILITY ADDRESS) FOR THE RECEIPT OF OFFICIAL NOTICES FROM THE DEPARTMENT:

c/o: NORTH PLATTE CARE CENTER, LLC
TRILLIUM HEALTHCARE CONSULTING LLC
11523 PALM BRUSH TRAIL, SUITE 331
LAKEWOOD RANCH FL 34202

LICENSE NO: 514003
TELEPHONE NUMBER: (308) 534-2200
FAX NUMBER: (308) 534-9069
ADMINISTRATOR: MIKAYLA TANK
DIRECTOR OF NURSING: VERA HENDER Shawn Smith
E-Mail Address, if available: admin.npcc@trilliumhcg.com

5115 East State Rd 64
Bradenton, FL 34208

3. FEDERAL EMPLOYER IDENTIFICATION NUMBER OF THE FACILITY:

4. NUMBER OF BEDS TO BE RELICENSED: 71

5. ACCREDITATION/CERTIFICATION: [] JCAHO [X] Medicare [X] Medicaid [] Other
Are you requesting deemed status? ___yes ___no

6. SPECIAL CARE AND TREATMENT SPECIFICALLY FOR THE FOLLOWING GROUPS:
If different from Current Services listed, please check changes.

- [] Physical Therapy [] Alzheimers/Special Care Unit [] Speech Therapy
[] Pediatric [] Respiratory [] Occupational Therapy
[] Behavioral Needs

Current Services

PHYSICAL THERAPY
OCCUPATIONAL THERAPY
SPEECH THERAPY

OWNERSHIP INFORMATION

7. OWNERSHIP OF FACILITY: IANE PROPERTIES I, LLC North Platte Care Center, LLC
(Legal Name of individual or business organization)

MAILING ADDRESS: 11523 PALM BRUSH TRAIL, SUITE 331 2900 West E Street
LAKEWOOD RANCH, FL 34202 North Platte, NE 69101

8. BUSINESS ORGANIZATION: (Check one):

- [] Sole Proprietorship
[] Partnership
[] Limited Partnership
[] Corporation
[X] Limited Liability Company
[] Governmental (___ State, ___ District, ___ County, ___ City or Municipal)
[] Other (Please Specify)

(check one)
[X] Profit [] Non Profit

CERTIFICATION

I/we have read the Rules and Regulations issued by the Nebraska Department of Health and Human Services and will comply with them should a license be issued. I/we certify that to the best of my/our knowledge, all information and statements on the application are true and correct and I/we hereby apply for a renewal license.

PLEASE NOTE: Neb.Rev.Stat. Section 71-433 requires: Applications shall be signed by

- (1) the owner, if the applicant is an individual or partnership,
(2) two of its members, if the applicant is a limited liability company,
(3) two of its officers, if the applicant is a corporation, or
(4) the head of the governmental unit having jurisdiction over the facility to be licensed, if the applicant is a governmental unit.

Richard T. Mason
AUTHORIZED REPRESENTATIVE - TYPE OR PRINT

Gregory S. Bench
AUTHORIZED REPRESENTATIVE - TYPE OR PRINT

[Redacted Signature]

SIGNATURE

2/23/16
DATE

2/23/16
DATE



5115 E. State Road 64, Bradenton, 34208-5509
Office: 941-758-4745 Fax: 941-751-2135

LICENSURE UNIT

FEB 24 2016

RECEIVED

February 23, 2016

Please note correction for Item 7. When the application was originally submitted, we put the incorrect information in this field. The correct information should be the same as item 1.

This is NOT a Change of Ownership. However just correcting an error in the document.

[Redacted signature area]

Rich Mason
Authorized Representative



NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH
Licensure Unit

Make Payment to DHHS LU

Renewal Fees:
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51 - 100 beds: \$1750
101 or more: \$1950

Expiration Date

03/31/2016

Nursing Home Licensure Renewal Application

Nursing Home Type: Please Check

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5115 East State Road 64
Bradenton, FL 34208

LICENSE NO: 514003

TELEPHONE NUMBER: (308) 534-2200

FAX NUMBER: (308) 534-9069

ADMINISTRATOR: MIKAYLA TANK

DIRECTOR OF NURSING: VERA HENDER Shawn Smith

E-Mail Address, if available: admin.npcc@trilliumhca.com

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- Physical Therapy, Pediatric, Behavioral Needs, Alzheimers/Special Care Unit, Respiratory, Speech Therapy, Occupational Therapy

Current Services: PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH THERAPY

OWNERSHIP INFORMATION

7. OWNERSHIP OF FACILITY: IANE PROPERTIES I, LLC
5115 East State Road 64
Bradenton, FL 34208

MAILING ADDRESS: Bradenton, FL 34208

* Please update records *
* see new app

8. BUSINESS ORGANIZATION:

- Sole Proprietorship, Partnership, Limited Partnership, Corporation, [X] Limited Liability Company, Governmental, Other

(check one) [X] Profit [] Non Profit

CERTIFICATION

I/we have read the Rules and Regulations issued by the Nebraska Department of Health and Human Services and will comply with them should a license be issued. I/we certify that to the best of my/our knowledge, all information and statements on the application are true and correct and I/we hereby apply for a renewal license.

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(2) two of its members, if the applicant is a limited liability company,
(3) two of its officers, if the applicant is a corporation, or
(4) the head of the governmental unit having jurisdiction over the facility to be licensed, if the applicant is a governmental unit.

AUTHORIZED REPRESENTATIVE - TYPE OR PRINT

[Redacted Signature]

AUTHORIZED REPRESENTATIVE - TYPE OR PRINT

G. Shayne Bend

SIGNATURE

[Redacted Signature]

2/10/2016
DATE

2/10/2016
DATE

LICENSURE UNIT
FEB 12 2016
RECEIVED

REC'D HHS ACCOUNTING
2016 FEB 17 4:11:16



NEBRASKA OWNERSHIP/CONTROLLING INTEREST AND CONVICTION DISCLOSURE

Completion of this form is required, as mandated by the Centers for Medicare and Medicaid Services, Department of Health and Human Services, and applicable regulations as found at 42 CFR 455.100 through 42. CFR 455.106. Disclosure must be made at the time of enrollment or contracting with the Department, at the time of survey, or within 35 days of a written request from the Department. It is the provider's responsibility to ensure all information is accurate, complete, and signed; and to report any changes as required by law by completing a new Ownership and Disclosure form.

IDENTIFYING INFORMATION

Name of Entity: (Legal name as it appears on tax identification form) North Platte Care Center		Provider Number (If currently enrolled in NE Medicaid): [REDACTED]	
Doing Business As:		NPI Number 1174586705	
Street Address: 2900 West East Street	City: North Platte	State: NE	Zip Code: 69101
Telephone Number: 308-534-2200	Fax Number: 308-534-9069	E-mail Address: ShariBench@Trilliumhcg.com	

A. Expanded Address Information: Corporate entities must provide, as applicable, primary business address, every business location, and P.O. Box address. *If more space is needed attach a separate list including the required information.*

Primary Business Address	Address
P.O. Box Address	Address
Other Business Locations	Address
Other Business Locations	Address

B. List the name, address, Federal Tax Identification Number (FTIN) (for corporations) or Social Security Number (SSN) and Date of Birth (DOB) (for persons) with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more. *If more space is needed attach a separate list including the required information.*

Name	Address	% Interest
Richard T. Mason (Indirect) SSN/FTIN _____ DOB _____	5115 East State Road 64 Bradenton, FL 34208	50%
Shayne Bench (Indirect) SSN/FTIN _____ DOB _____	5115 East State Road 64 Bradenton, FL 34208	25%
Shari Bench (Indirect) SSN/FTIN _____ DOB _____	5115 East State Road 64 Bradenton, FL 34208	25%
IANE PROPERTIES 1, LLC (Direct) SSN/FTIN _____ DOB _____	5115 East State Road 64 Bradenton, FL 34208	100%

C. Are any of the above mentioned persons related to one another as a spouse, parent, child, or sibling? *If more space is needed attach a separate list including the required information.*

Yes No If yes, please name and show relationship.

Name	Relationship
Shayne Bench SSN _____ DOB _____	Spouse
Shari Bench SSN _____ DOB _____	Spouse
Name _____ SSN _____ DOB _____	Relationship

D. List any person who holds a position of managing employee within the disclosing entity. If more space is needed attach a separate sheet with the required information.

Name MiKayla Tank	Position Title Administrator
SSN	DOB
Name	Position Title
SSN	DOB
Name	Position Title
SSN	DOB
Name	Position Title
SSN	DOB

E. Does any person, business, organization or corporations with an ownership or control interest (identified in A or B) have an ownership or controlling interest of 5% or more in any other Nebraska Medicaid Provider? If more space is needed attach a separate sheet with the required information.


Yes No If yes, please name and show information.

Name	Other Provider Name	% Interest
SSN/FTIN	DOB	
Name	Other Provider Name	% Interest
SSN/FTIN	DOB	
Name	Other Provider Name	% Interest
SSN/FTIN	DOB	
Name	Other Provider Name	% Interest
SSN/FTIN	DOB	

F. List any person (identified in A, B, or C) who has an ownership or control interest in the disclosing entity (provider), or is an agent or employee of the disclosing entity (provider) who has ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Waivers, CHIP or the Title XX services since the inception of these programs. If more space is needed attach a separate sheet with the required information.

Name	Conviction Details
SSN	DOB
Name	Conviction Details
SSN	DOB
Name	Conviction Details
SSN	DOB

PROVIDER STATEMENT. I certify that information provided on this form is true, accurate and complete. I will notify Nebraska Department of Health and Human Services of any additions/changes to the information

Sign Here  _____
 Signature of Provider/Authorized Representative/Agent and Title (Stamped Signature NOT Accepted)

Richard T. Mason 2/23/16 941-758-4745
 Print Name Date Phone Number

NEBRASKA STATE FIRE MARSHAL OCCUPANCY PERMIT

Certificate Number: 402779

Name of Facility: **North Platte Care Center**
Type of Facility: **Nursing Home**
Location: **2900 West E St., North Platte**
Maximum Occupancy: **71 Beds**
Date Issued: **12/2/2014**

Approved By:

Inspected By: **8733 Mike Hoefft**
Deputy State Fire Marshal



State Fire Marshal



POST IN PROMINENT PLACE

Change in occupancy classification or failure to meet State Fire Marshal codes shall invalidate this occupancy permit.

