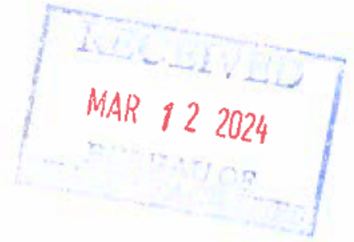
STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF LEGAL AND REGULATORY SERVICES
HEALTH FACILITIES ADMINISTRATION
129 Pleasant Street, Concord, NH 03301
TDD Access: Relay NH 1-800-735-2964
Agency Phone: 603-271-9039



APPLICATION FOR RESIDENTIAL, HEALTH CARE LICENSE OR SPECIAL HEALTH CARE SERVICES

EXISTING FACILITY LICENSE #: 02693
CURRENT FACILITY LICENSE EXPIRATION DATE, IF APPLICABLE: 03/31/2024

THIS APPLICATION SHALL BE FILLED OUT IN ACCORDANCE WITH RSA 151:4. A SEPARATE APPLICATION MUST BE SUBMITTED FOR EACH LICENSURE CATEGORY. **PLEASE BE SURE TO COMPLETE THE ENTIRE APPLICATION**. IF A SECTION DOES NOT APPLY TO YOUR FACILITY, MARK NOT APPLICABLE (N/A). FAILURE TO COMPLETE THE APPLICATION WILL RESULT IN A DELAY IN THE LICENSURE PROCESS. SEND THE ENTIRE COMPLETED FORM TO THE ADDRESS ABOVE. IF YOU NEED TO REVIEW YOUR LICENSING RULES, THEY CAN BE FOUND ONLINE AT: https://www.dhhs.nh.gov/administrative-rules-health-facilities

Check all applicable items:

- ☐ License renewal:
- ☒ *New owner:
- ☐ **Change in address:
- ☐ *New facility:
- ☐ **Change in # of beds:
- ☐ Other (please explain):
- ☐ ***Change in classification:

* Requires processing as a new application.
** Requires Local Approval Forms
***Requires both

LICENSEE (Legal Owner of Facility): Keene SNF OPCO LLC TELEPHONE #: (603) 357-3902

NAME OF FACILITY (DBA): Langdon Place of Keene TELEPHONE #: (603) 357-3902

FAX #: ( )

STREET ADDRESS: 136A Arch Street CITY: Keene STATE: NH ZIP: 03431

MAILING ADDRESS: 2420 Knapp Street CITY: Brooklyn STATE: NY ZIP: 11235

ADMINISTRATOR: Michael Johnson

MEDICAL DIRECTOR (IF APPLICABLE): Dr. Michael Kasschau

FACILITY E-MAIL ADDRESS (REQUIRED): sstevenson@righthealthr.com

IF APPLICABLE:
NUMBER OF BEDS: PRESENTLY LICENSED: 25 TOTAL # TO BE LICENSED: 25

NUMBER OF HCBC CFI OR STATE PLACED INDIVIDUALS IN HOME (Complete for He-P 804, He-P 805 and He-P 814): N/A

NUMBER OF ESRD STATIONS (Completed for He-P 811 licensees only): N/A

BRANCH OFFICE LOCATIONS (Complete if applies under He-P 809.07, 819.07, 822.07 & 823.07 only):
N/A

OWNERSHIP

a. Type of ownership: ☐ Association ☐ Partnership ☐ Corporation
[X] LLC ☐ Individual ☐ Other (explain

b. List name and address of each person having an ownership interest (directly or indirectly) of greater than 5% in the facility. **See attached.**

c. If the licensee is organized as an association or corporation, list the name of the association or corporation and the name, address, and title of each officer.

d. If the licensee is a partnership, list the name and address of each partner.

e. Is this a certified facility? **(Facilities with deem status under RSA 151)** [X] YES ☐ NO
Only applies to He-P 802, 803, 809, 811, 812, 815, & 823

If you are already a certified facility, is this an increase in services? If YES, please call 1-800-852-3345 ext. 9049

f. Are you planning on being a certified facility? If YES, please call 1-800-852-3345 ext. 9049

FEES:

Hospitals (General, CAH, Psychiatric, Rehabilitation) (802)	$25 per licensed bed
Free Standing Emergency Rooms (802)	$500
Nursing Homes (803)	$25 per licensed bed
Residential and Supported Residential Care Homes (804 & 805)	$15 per licensed bed (NO CHARGE FOR HCBC OR NH STATE PLACED RESIDENTS)
Non-Emergency Walk-In Care Centers (806)	$500
Residential Treatment and Rehabilitation Facilities (807)	$25 per licensed bed
Home Health Care Providers (809)	$250
Birthing Centers (810)	$150
End Stage Renal Disease Dialysis Centers (811)	$500
Ambulatory Surgical Centers (812)	$500
Intermediate Care Facilities for Individuals with Intellectual Disabilities(ICF/IID)(815)	$25 per licensed bed
Educational Health Centers (816)	$500
Adult Day Care Centers (818)	$200
Case Management Agencies (819)	$150
Home Care Service Provider Agencies (822)	Less than ten clients $25; Ten or more clients $250
Home Hospice Care Providers (823)	$250
Hospice Houses (824)	$25 per licensed bed
Substance Use Disorder Residential Treatment Facilities (826)	$25 per licensed bed
Freestanding Megavoltage Radiation Therapy Facility (827)	$500
Psychiatric Residential Treatment Programs (830)	$25 per licensed bed

A check or money order (payable to: TREASURER, **STATE OF NEW HAMPSHIRE)** must be attached to this application.

Applications submitted by those facilities exempt under RSA 151:4 I (a), (b) & (c) are not required to pay the license fee.

ADDITIONAL APPLICATION REQUIREMENTS: NOTE THAT NOT ALL APPLICATION REQUIREMENTS ARE LISTED HERE PLEASE REFER TO THE APPROPRIATE RULE TO DETERMINE OTHER ITEMS THAT NEED TO BE SUBMITTED.

1. Renewal applications must be submitted at least 120 days prior to expiration of the current license. **(Yearly)**

2. Include qualifications, including a resume with education and experience, and copies of all applicable licenses and certifications, for the administrator and medical director **(if applicable)**. **(Initial Application Only, unless changing Administrator or Medical Director)**

3. Include information relative to whether the facility has been granted any waivers, exemptions, or variances to the rules by the Department of Health and Human Services and/or the State Fire Marshal. **(Yearly)**

4. Include a floor plan indicating the location of all rooms, # of beds in each bedroom, and fire exits. **(Initial Application Only – NOT FOR He-P 809, 819, 820 & 823)**

5. Include NH Secretary of State Authority to do business in the State of NH and/or tradename registration **(Initial Application Only)**

6. Include written local approvals from the health officer, the building official, the zoning officer, and the fire chief. For a building under construction, the written approvals required shall be submitted at the time of the application based on the local official's review of the building plans and again upon completion of the construction project. **(Initial Application Only for ALL categories)**

7 Include documentation that the water supply has been tested in accordance with RSA 485 and Env-Dw 702.02 and 704.02 (formerly Env-Ws 313.01 and 314.01). **(Initial Application Only – NOT FOR He-P 809. 819, 820 & 823)**

8. Include documentation that **every 3 years** the water supply has been tested for bacteria and nitrates and determined to be at acceptable levels, in accordance with Env-Dw 702.02 (formerly Env-Ws 313.01) for bacteria and Env-Dw 704.02 (formerly Env-Ws 314.01) for nitrates. **(NOT FOR He-P809. 819, 820 & 823)**

9. Include a list of all employees who have previously been granted waivers for criminal background check results from the Department of Health and Human Services. **(Yearly and on initial application if change of ownership or category)**

10. Include the results of a criminal records check to include results for the state of New Hampshire for the applicant(s), the licensee (owner even if entity) if different than the applicant, the administrator, medical director and, if applicable, each household member 17 years of age or older who resides at the facility. **(Initial Application Only)**

FACILITY SERVICE DESCRIPTION: Complete even on renewal

The following information will be used to determine which licensure category your facility will be placed in.

I. Provide a detailed description of the services and programs you wish to provide.

*II. Describe the facility's health care you wish to provide to residents.

*III. Identify who will provide the health care listed in II.

*To be completed if applying for beds

SIGNATURES: This application must be signed by:

1. The owner if a private facility;
2. Two officers if a corporation;
3. Two authorized individuals if an association or partnership; or
4. The head of the government agency if a government unit.

I affirm that I am familiar with the requirements of RSA 151 and the rules adopted thereunder and that the premises are in full compliance. I understand that providing false information shall be grounds for denial, suspension, or revocation of the license and the imposition of a fine.

DATE: 3/12/24 SIGNED: [signature] Ownership Representative
(NAME AND TITLE)

DATE: 3/12/24 SIGNED: [signature] Principal
(NAME AND TITLE)

For all facilities to be newly licensed as an ambulatory surgical center (He-P 812), hospital (He-P 802), birthing center (He-P 810), walk in care center (He-P 806), dialysis center (He-P 811), or special health care service (He-P 802 and He-P 827) located within a 15 mile radius of a hospital certified as a critical access hospital, pursuant to 42 C.F.R. section 485.610 (b) and (c):

I affirm that I have complied with 151:4-a and a determination is on file with the department that finds the proposed health care facility shall be allowed to apply for licensure.

DATE: ______________ SIGNED: ______________________________
(NAME AND TITLE)

DATE: ______________ SIGNED: ______________________________
(NAME AND TITLE)

HFA OFFICE USE ONLY

CHECK NUMBER: 12542 AMOUNT: 625.60

APPLICATION COMPLETE: ______ NOT COMPLETE: ______________ (Describe in comments)

NEW ☐ RENEWAL ☐ CHANGE ☐

QUALIFICATIONS OF ADMINISTRATOR	Required ☐	Not Required ☐	Received ☐
COPY OF ADMINISTRATOR LICENSE	Required ☐	Not Required ☐	Received ☐
LIST OF EMPLOYEES WITH WAIVERS	Required ☐	Not Required ☐	Received ☐
WATER TEST (INITIAL OR 3YR)	Required ☐	Not Required ☐	Received ☐
FLOOR PLAN*	Required ☐	Not Required ☐	Received ☐
SECRETARY OF STATE INFORMATION	Required ☐	Not Required ☐	Received ☐
LOCAL APPROVAL	Required ☐	Not Required ☐	Received ☐
LSC INSPECTION	Required ☐	Not Required ☐	Received ☐
LSC PLAN OF CORRECTION	Required ☐	Not Required ☐	Received ☐
LICENSURE INSPECTION	Required ☐	Not Required ☐	Received ☐
PLAN OF CORRECTION	Required ☐	Not Required ☐	Received ☐
COMPLIED WITH RSA 151:4-a	Required ☐	Not Required ☐	Received ☐

FEDERAL FACILITY (EXEMPT FROM INSPECTION) YES ☐ NO ☐

LICENSURE CATEGORY:

- ☐ 02 Hospitals (General, CAH, Psychiatric, Rehabilitation)
- ☐ 03 Nursing Homes
- ☐ 04 Residential Care Home Facility
- ☐ 05 Supported Residential Health Care Facility
- ☐ 06 Non-Emergency Walk-in Care
- ☐ 07 Residential Treatment & Rehabilitation Facility
- ☐ 09 Home Health Care Provider
- ☐ 10 Birthing Center
- ☐ 11 End Stage Renal Disease Dialysis
- ☐ 12 Ambulatory Surgical Center
- ☐ 14 Community Residence
- ☐ 15 ICF/IID
- ☐ 16 Educational Health Services
- ☐ 18 Adult Day Care
- ☐ 19 Case Management
- ☐ 22 Home Care Service Provider
- ☐ 23 Home Hospice Care Provider
- ☐ 24 Hospice House
- ☐ 26 Substance Use Disorder Res Treatment Facility
- ☐ 27 Freestanding Megavoltage Radiation Therapy
- ☐ 30 Psychiatric Residential Treatment

REVIEWED BY: ____

(NAME & TITLE) (DATE)

ISSUE ANNUAL LICENSE: YES ____ NO ____

LICENSE CERTIFICATE DATES: FROM ________ TO ________

NUMBER OF PATIENTS/STATIONS/BEDS: ______________________

NOTES:

COMMENTS ON CERTIFICATE:

● Fire Extinguishers
△ Pull Stations
▭ secure care doors
○ Exits for Evacuation

LANGDON PLACE OF KEENE

Command Center

Secondary Command Center (Backup)

2ND FLOOR

SOUTH WING
262, 261, 260, 259, 258, 257, 256, 255, 254, N, 253, 252, 251, E, KITCHEN, NCC DINING, MAINTENANCE

NURSING CARE
202, 201, 204, 203, 206, 205, 208, 207, 210, 209, 212, 211, 214, 213, B

OF, E, OF, OF, N, C, B, C, MED RM, U, U, OF, 216, 218, SUMMIT RM, K, 224, 226, REHAB DEPTARTMENT

ASSISTED LIVING
215, 217, 219, 221, 223, 225, OF, 222

ASSISTED LIVING
228, 227, 230, 229, 232, 231, 234, 233, 236, 235, 238, ACTIVITIES, 237, 239, U, E, B, N, S, L, DUBLIN ROOM, OF

ASSISTED LIVING
250, 249, 248, 247, 246, 245, 244, 243, 242, 241

1ST FLOOR

NCC DINING, 170, 171, 168, 169, 166, 167, 164, 165, 162, 163, 160, 161, 158, 159, 156, 157, 154, 155, 152, 153, 150, 151, 148, 149, K, S, S, S, S, N, L, U, U, B, OF, COURTYARD

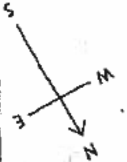
ALZHEIMERS CARE CENTER

ASSISTED LIVING
110, 108, 107, 106, 105, 104, 103, 102, 101

U, M, E, B, BUSINESS OFFICE, R, OF, EXEC. DIR., ADMISSIONS OFFICE, KITCHEN, MONADNOCK DINING ROOM, PIANO ROOM, FORMAL DINING ROOM, LIBRARY, PATIO, C, POOL, S, LOUNGE, B

ASSISTED LIVING
128, 127, 130, 129, 132, 131, 134, BEAUTY PARLOR, 133, 135, 137, E, U, U, B, MECH. ROOM, L, PATIO

ASSISTED LIVING
146, 147, 144, 145, 142, 143, 140, 141, 139



B - BATHROOM
C - CLOSET
E - ELEVATOR
K - KITCHEN
L - LAUNDRY
M - MAIL ROOM

Description of Services

The applicant intends to continue offering the same 24/7 healthcare and quality of life services. This includes:

- ShortStay care
- Memory Support
- Assisted / Senior Living
- Respite care
- Palliative care
- Rehabilitation therapy
- Physical therapy
- Occupational therapy
- Speech therapy
- Orthopedic Rehabilitation - including joint replacement, injuries and amputation
- On-site Medical Director
- Attending Physicians
- Registered Nurses
- IV Therapy
- Audiology care
- Colostomy care
- Dementia care
- Personal care
- Podiatry care
- Psychiatric services
- Vision care
- Wound care
- X-ray
- Hospice care
- Pain management
- Case management
- Dietary and nutrition needs management
- Discharge planning
- Individual treatment plans
- Medication management
- 24-hour emergency alert and response system
- Coordinated transportation
- Cultural, educational, religious and social activities
- Recreation activities

State of New Hampshire
Department of State

Accepted Date: **01/25/2024**

Business Name: **KEENE SNF OPCO LLC**

Principal Office Address: **2420 Knapp Street, Brooklyn, NY, 11235, USA**

RE: Acceptance of Business Formation

This letter is to confirm the acceptance of the following business formation:

Business ID: **952076**

Filing #: **6547017**

Expiration Date: **Perpetual**

Effective Date: **01/19/2024**

Payment Transaction #: **20249980842497001**

To maintain your business registration in good standing, you must maintain a Registered Agent at all times. You must also file an annual report no later than April 1st of each year. To file your annual report please go to https://quickstart.sos.nh.gov/online/Account.

It is incumbent upon you to keep this office informed of address or email changes to ensure that all communications from our office reaches you. There is no charge for address changes.

Please visit our website for helpful information regarding all your business needs. If you require assistance or should you have any questions, you may contact the Corporation Division using the information provided below.

Please reference your Business ID in your communication.

Thank you,

New Hampshire Department of State
Corporation Division

State of New Hampshire
Department of State

Filed
Date Filed : 01/19/2024 01:47:00 PM
Effective Date : 01/19/2024 01:47:00 PM
Filing # : 6547017 Pages : 2
Business ID : 952076
David M. Scanlan
Secretary of State
State of New Hampshire

Form LLC-1
RSA 304-C:31

CERTIFICATE OF FORMATION
NEW HAMPSHIRE LIMITED LIABILITY COMPANY

THE UNDERSIGNED, under the New Hampshire Limited Liability Company Laws submits the following certificate of formation:

FIRST: The name of the limited liability company is:

KEENE SNF OPCO LLC

Principal Business Information:

Principal Office Address:

2420 Knapp Street	**Brooklyn**	**NY**	**11235**
(no. & street)	(city/town)	(state)	(zip code)

Principal Mailing Address (if different):

2420 Knapp Street	**Brooklyn**	**NY**	**11235**
(no. & street)	(city/town)	(state)	(zip code)

Business Phone: **NONE**

Business Email: **agent@platinumfilings.com**

Notification Email: **agent@platinumfilings.com**

_____ Please check if you would prefer to receive the Annual Report Reminder Notice by email.

SECOND: Describe the nature of the primary business or purposes (and if known, list the NAICS Code and Sub Code):

62-Health Care and Social Assistance - 110-Nursing Care Facilities (Skilled Nursing Facilities)

THIRD: The name of the limited liability company's initial registered agent is:

PLATINUM REGISTERED AGENTS INC. (819912)

The complete address of its registered office (agent's business address) is:

10 Ferry Street, Suite 313	**Concord**	**NH**	**03301**
(no. & street)	(city/town)	(state)	(zip code)

FOURTH: The management of the limited liability company **is** vested in a manager or managers.

The period of its duration is: **Perpetual**

Manager/Member Information:

Name	Title	Address
Zisha Margulies	Manager	2420 Knapp Street, Brooklyn, NY, 11235, USA

Raphael Treitel	Manager	2420 Knapp Street, Brooklyn, NY, 11235, USA
Nathan Treitel	Manager	2420 Knapp Street, Brooklyn, NY, 11235, USA

Title: **Authorized Signer**
Signature: **Zisha Margulies**
Name of Signer: **Zisha Margulies**
Date signed: **01/19/2024**
Effective Date: **01/19/2024 01:47:00 PM**

Note: The sale or offer for sale of membership interests of the limited liability company will comply with the requirements of the New Hampshire Uniform Securities Act (RSA 421-B). The membership interests of the limited liability company: 1) have been registered or when offered will be registered under RSA 421-B; 2) are exempted or when offered will be exempted under RSA 421-B; 3) are or will be offered in a transaction exempted from registration under RSA 421-B; 4) are not securities under RSA 421-B; OR 5) are federal covered securities under RSA 421-B. The statement above shall not by itself constitute a registration or a notice of exemption from registration of securities within the meaning of sections 448 and 461(i)(3) of the United States Internal Revenue Code and the regulation promulgated thereunder.

* Must be signed by a **manager**; if no manager, must be signed by a **member**.

DISCLAIMER: All documents filed with the Corporation Division become public records and will be available for public inspection in either tangible or electronic form.

State of New Hampshire
Department of State

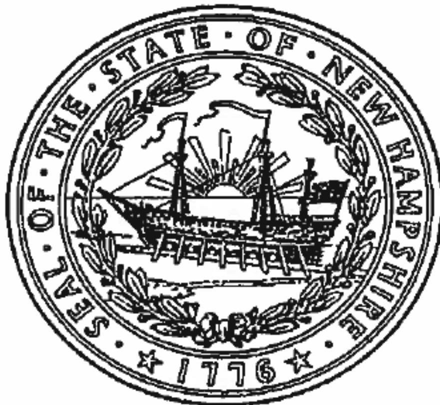
CERTIFICATE OF EXISTENCE

OF

KEENE SNF OPCO LLC

This is to certify that **KEENE SNF OPCO LLC** is registered in this office as a **New Hampshire Limited Liability Company** to transact business in New Hampshire on 1/19/2024 1:47:00 PM.

Business ID: **952076**



IN TESTIMONY WHEREOF,
I hereto set my hand and cause to be affixed
the Seal of the State of New Hampshire,
this 19th day of January A.D. 2024

David M. Scanlan
Secretary of State

State of New Hampshire

Department of State

Accepted Date: **03/05/2024**

Business Name: **KEENE SNF OPCO LLC**

Principal Office Address: **2420 Knapp Street, Brooklyn, NY, 11235, USA**

RE: Acceptance of Registered Agent Change

This letter is to confirm the acceptance of the following Registered Agent Change:

Business ID: **952076**

Filing #: **6596975**

Expiration Date: **Perpetual**

Effective Date: **03/01/2024**

Payment Transaction #: **20249980869355001**

To maintain your business registration in good standing, you must maintain a Registered Agent at all times. You must also file an annual report no later than April 1st of each year.

To file your annual report please go to https://quickstart.sos.nh.gov/online/Account.

It is incumbent upon you to keep this office informed of address or email changes to ensure that all communications from our office reaches you.

Please visit our website for helpful information regarding all your business needs. If you require assistance or should you have any questions, you may contact the Corporation Division using the information provided below.

Please reference your Business ID in your communication.

Thank you,

New Hampshire Department of State
Corporation Division

State of New Hampshire
Department of State

Filed
Date Filed : 03/01/2024 10:53:00 AM
Effective Date : 03/01/2024 10:53:40 AM
Filing # : 6596975 Pages : 1
Business ID : 952076
David M. Scanlan
Secretary of State
State of New Hampshire

Registered Agent Change

PURSUANT TO THE PROVISIONS of the New Hampshire Revised Statutes Annotated, the undersigned business, organized under the laws of New Hampshire submits the following statement for the purpose of changing the registered office or the registered agent, or both, in the state of New Hampshire. If submitted by the Registered Agent, the listed business has been notified in writing of the change in registered office.

BUSINESS NAME: **KEENE SNF OPCO LLC** BUSINESS ID: **952076**

BUSINESS TYPE: **Domestic Limited Liability Company** STATE OF FORMATION: **New Hampshire**

PREVIOUS REGISTERED AGENT:
PLATINUM REGISTERED AGENTS INC. (819912)

PREVIOUS REGISTERED AGENT OFFICE:
PRINCIPAL OFFICE ADDRESS: **10 Ferry Street, Suite 313, Concord, NH, 03301, USA**
MAILING ADDRESS: **10 Ferry Street, Suite 313, Concord, NH, 03301, USA**

NEW REGISTERED AGENT:
REGISTERED AGENTS INC (658418)

NEW REGISTERED AGENT OFFICE:
PRINCIPAL OFFICE ADDRESS: **84 W BROADWAY, STE 200, Derry, NH, 03038, USA**
MAILING ADDRESS: **84 W BROADWAY, STE 200, Derry, NH, 03038, USA**

☑ The street address, town/city of its registered office and the address of the business office of its registered agent, as changed, will be identical.

☑ Pursuant to the provisions of RSA 293-A:5.02(a), RSA 293-A:15.08(a), RSA 304-C:36 II, RSA 304-C:177 V, RSA 304-A:49 II, RSA 564-F:5-501 or RSA 564-F:5-2107, this document must be executed by an officer or director, a manager or member, a partner or agent.

I, the undersigned, do hereby certify that the above information is true to the best of my knowledge and belief.

Title: **Manager**
Signature: **Robert Rausman**
Name of Signer: **Robert Rausman**
Date signed: **03/01/2024**

Philip Rausman

100%

PR NH Holdings LLC [DE]

47.5%

Robert Rausman

100%

RR NH Holdings LLC [DE]

47.5%

Sean Stevenson

5%

NORTHERN CARE NH HOLDINGS LLC (Master Sub Sub-Tenant) [NH]

603 Healthcare LLC (Management Agent) [NH]

BLACK MOUNTAIN PEAK HEALTHCARE LLC [NH]

100%

BEDFORD HILLS SNF OPCO LLC [NH]

WOLFEBORO SNF OPCO LLC [NH]

DOVER SNF OPCO LLC [NH]

EXETER SNF OPCO LLC [NH]

KEENE SNF OPCO LLC [NH]

NASHUA SNF OPCO LLC [NH]

NORTH CONWAY SNF OPCO LLC [NH]

Person Information

Name: MICHAEL JOHNSON

Address Information

State: NH

License Information

License No:	3736	**Profession:**	Nursing Home Administrators	**License Type:**	Nursing Home Administrator
License Status:	Active			**Expiration Date:**	12/31/2025

Remarks

No Related Documents

Disclaimer: The JCAHO and the NCQA consider on-line status information as fulfilling the primary source requirement for verification of licensure in compliance with their respective credentialing standards.

Michael Johnson

Administrator

Michael Johnson has worked for the Company for over 25 years including thirteen years at Langdon Place of Keene. Johnson began his career at Langdon Place of Keene in 1995 in the dietary department during his senior year at Keene High School. Johnson's skilled nursing and assisted living background includes working in the kitchen, admissions, and business office. During Johnson's thirteen years as a nursing home administrator, his centers have received several awards including multiple Eli Pick Facility Leadership Awards and the Bronze and Silver Quality awards through the American Healthcare Association. Johnson currently volunteers as an examiner for the American Healthcare Association's quality award program. Johnson lives in Keene and enjoys spending time with his two daughters Ava and Emma.

Person Information

Name: MICHAEL F KASSCHAU, MD

License Information

License No: 13287 **Profession:** Medicine **License Type:** Physician
License Status: Active **Issue Date:** 10/4/2006 **Expiration Date:** 6/30/2024

Additional Information

Specialty: Family Practice/Family Medicine

Board Certification Information

Board Certified	Certification	Expiration	ABMS Board Specialties
Yes	Family Medicine	Jan 1 2029 12:00AM	family medicine

Medical Education Information

Type	Facility Name	Country	Year
Medical School	UNIVERSITY OF TEXAS, DALLAS TX	US	1999
Internship	JOHN PETER SMITH HOSP, FORT WORTH TX		2000
Residency	JOHN PETER SMITH HOSP, FORT WORTH TX		2002

Remarks

No Related Documents

Disclaimer: The JCAHO and the NCQA consider on-line status information as fulfilling the primary source requirement for verification of licensure in compliance with their respective credentialing standards.

Michael Kasschau, MD

Medical Director Rehabilitation Unit

Practice: Keene Family Medicine Court Street Team B
Medical School: MD, University of Texas Southwestern Medical School, Dallas, TX, 1999
Residency: Family Practice, John Peter Smith Hospital, Fort Worth, TX, 2002
Board Certification: Family Medicine, 2002 Family Medicine, 2009
Languages: English and Spanish

City of Keene
PO Box 544
Keene, NH 03431

09994257716 12283 0296

Utility Bill
CUSTOMER COPY

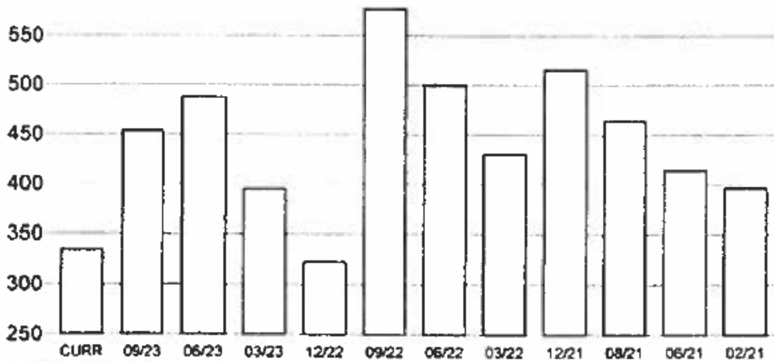
CUSTOMER NAME	CUSTOMER NO.	PARCEL ID	SERVICE LOCATION
LANGDON PLACE OF KEENE LTD PTNRSHP	[redacted]		136 ARCH ST

BILL NUMBER	BILL DATE	ACCOUNT #	ACCOUNT TYPE	DUE DATE
10455	11/30/2023	[redacted]	RESIDENTIAL	01/22/2024

DESCRIPTION	METER NUMBER	READ CODE	PREVIOUS READ DATE	CURRENT READ DATE	PREVIOUS READING	CURRENT READING	USAGE	RATE	CHARGE AMOUNT
WATER	70326845	A	09/06/2023	11/13/2023	7516	7850	334	3" WATER	[redacted]
FIRELINE			09/06/2023	11/13/2023					
SEWER			09/06/2023	11/13/2023					

Billing - 603-352-3239 Mon-Fri 8:00am-4:00pm Service- 603-352-6550 Mon-Fri 7:30am-3:00pm Off hours - Police Dept 603-357-9813

CONSUMPTION HISTORY



Previous Balance	[redacted]
Total Current Billing	[redacted]
Adjustments	[redacted]
Interest	[redacted]
Less Payments Received	[redacted]
Penalties	[redacted]
Total Amount Due	[redacted]

✂ DETACH AND RETURN THE PORTION BELOW WITH YOUR PAYMENT ✂

City of Keene
PO Box 544
Keene, NH 03431

Utility Bill
REMIT PORTION

SERVICE LOCATION	BILL NUMBER	CUSTOMER #	ACCOUNT #	DUE DATE	TOTAL DUE
136 ARCH ST	10455	[redacted]	[redacted]	01/22/2024	[redacted]

LANGDON PLACE OF KEENE LTD PTNRSHP
GENESIS MS #8/KEENE CTR 57036
PO BOX 182943
COLUMBUS, OH 43218-2943

600000604202480001045540000561728

REGULATORY COMPLIANCE INFORMATION

Black Mountain Peak Healthcare LLC is an LLC established as the owner of the operating companies that will operate the facilities. Although this is a new entity, the LLC is 95% owned by Philip and Robert Rausman, Principles and managers of Northern Group LLC and the remaining 5% of the entity is owned by Sean Stevenson. As detailed below, Sean Stevenson has a lengthy background managing long term care operations in New Hampshire, and the Rausmans have signficant experience managing healthcare facilities in New York.

Members:

Sean Stevenson is a 25+ year highly skilled and passionate operations executive that meets and exceeds business performance targets including consistent growth and improvement. Consistently recognized for superior performance, reliability, and work ethic resulting in promotions focused on business excellence improvement. An energetic leader and skilled communicator responsible for directing and assuring operations and specialty leadership teams run the healthcare centers to maximum efficiency and highest quality. Adept at instilling alignment between departments towards common goals to ensure financial and clinical outcome success of each center through margin optimization and census/revenue control, labor management, clinical and service quality, cash collection and compassionate customer experience.

Sean served Genesis Healthcare 10 years as Regional Vice President of Operations (4 years) and then promoted to Senior Vice President of Operations (6 years). The Senior VP role had responsibility for half of the whole Genesis portfolio, 9 states and 140+ centers. Sean also served Sunbridge Healthcare and Harborside Healthcare in Regional Vice President of Operations role for 10 years and was a Nursing Home Administrator for Integrated Health Services (IHS) for 5 years. Sean graduated from the University of New Hampshire with a degree in Health Management and Policy and also earned a master's degree in Business Education from Southern New Hampshire University.

Sean has a history of managing operations in New Hampshire and ensuring that his facilities comply with their regulatory obligations and any deficiencies are immediately addressed and corrected.

Philip Rausman, has played a pivotal role in the day-to-day operations of the family business running the facilities described below. As CEO, he is deeply involved in various aspects, including clinical reimbursement, staffing, and compliance. Philip's hands-on approach and leadership have been vital in fostering a cohesive team environment and maintaining the quality of care across the facilities.

Robert Rausman, the newest addition to the family business in 2020, has quickly made his mark as CFO strategizing and leading the growth initiative. With a focus on financial management and fiscal well-being, Robert oversees the financial aspects of the company, ensuring efficiency and sustainability. His strategic insights and dedication contribute significantly to the continued success and growth of the business.

Northern Group facilities:

1. Northern Manhattan Nursing and Rehabilitation center.
   - 320 bed Skilled Nursing facility in New York, NY, 10035
   - Facility was built and licensed by Phillip and Robert's father in 1996
   - 5 Star quality measures
2. Medford MultiCare Center for Living
   - 320 Bed skilled nursing facility at 3115 Horseblock Rd., Medford, NY, 11763
   - 40 Vent beds
   - Facility was licensed and built by Phillip and Robert's father in 2000
   - 5 Star quality measures
3. Manhattanville Health Care center
   - 200 Bed skilled nursing facility at 311 West 231st St., Bronx, NY.
   - 5-star Quality measures
   - Owned and operated since 2002
4. Waterview Nursing center for rehabilitation
   - 200 bed skilled nursing facility at 119-15 27th St., Flushing, NY.
   - 5-star facility
   - Leased to purchase back in 2023
5. Park Avenue Dialysis Center
   - 24 Station Dialysis center at 116 East 124th St., New York, NY 10035

The facilities referenced above have substantially complied with regulatory requirements in New York throughout the past five years and any complaints or notices of deficiency have been addressed.

KEENE SNF OPCO LLC APPLICATION

Keene SNF Opco LLC is not aware of any waivers that have been provided for the facility by the New Hampshire Department of Health & Human Services or the State Fire Marshal.

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH & HUMAN SERVICES
Bureau of Licensing and Certification
HEALTH FACILITIES ADMINISTRATION
129 Pleasant Street, Concord, New Hampshire 03301-3857
TDD Access: Relay NH 1-800-735-2964
Agency Phone Number: 603-271-9039

[X] Initial Licensing – This includes a change in ownership or address other than a 911 change
[ ] A change in current licensing category
[ ] New Construction and/or Renovation of Existing Building
[ ] An increase in occupancy (ie: Beds, ESRD Stations or Clients)

Please note: All applicants must have each final inspection signed by local officials, even if they do not see clients at their place of business. This is to confirm that the local authorities are aware that a business is operating at the identified location and that the business complies with all local ordinances pursuant to RSA 151:4,III(3).

Please note: Applicants that are planning new construction, modifying/renovating or requesting a bed increase that involves modifications to the building must have both the plan review sections as well as the final inspection sections of the form completed and signed by building and fire officials.

FACILITY NAME: Langdon Place of Keene
STREET ADDRESS: 136A Arch Street, Keene, NH 03431
OWNERS'S NAME: Keene SNF OPCO LLC
ADMINISTRATOR NAME: Michael Johnson
TELEPHONE NUMBER: 603-357-3902
PROPOSED TYPE OF FACILITY: Nursing Home and Assisted Living Facility

Local authorities please complete and sign each section:

HEALTH OFFICER

I HEREBY CERTIFY THAT THE ENTITY ______________________ COMPLIES WITH ALL APPLICABLE HEALTH, SEWAGE AND WATER REGULATIONS FOR THE CITY/TOWN OF__________.

I HEREBY CERTIFY THAT THE CITY/TOWN OF ______________________ DOES NOT REQUIRE HEALTH, SEWAGE AND WATER APPROVAL OF THIS FACILITY/ESTABLISHMENT.

NUMBER OF BEDS/CLIENTS: ________

FINAL INSPECTION: DATE: ________ SIGNATURE: ______________________
(NAME AND TITLE OF HEALTH OFFICIAL)

BUILDING REGULATIONS

I HEREBY CERTIFY THAT THE CITY/TOWN OF ______________________ BUILDING DEPARTMENT HAS REVIEWED THE PLANS FOR______________________ ON __________APPROVED___DENIED___

PLAN REVIEW: DATE: ________ SIGNATURE: ______________________
(NAME AND TITLE OF BUILDING OFFICIAL)

I HEREBY CERTIFY THAT THE CITY/TOWN OF ______________________ BUILDING DEPARTMENT HAS INSPECTED ____________ ON ________ AND OBSERVED THE FOLLOWING VIOLATIONS:

____

____

I HEREBY CERTIFY THAT THE CITY/TOWN OF ______________________ BUILDING DEPARTMENT HAS INSPECTED ____________ ON ________ AND ALL PREVIOUS VIOLATIONS HAVE BEEN CORRECTED.

ZONING REGULATIONS

I HEREBY CERTIFY THAT ______________________________
COMPLIES WITH ALL APPLICABLE ZONING REGULATIONS FOR THE CITY/TOWN OF
______________________________.

I HEREBY CERTIFY THAT ______________________________ DOES
NOT HAVE LOCAL ZONING REGULATIONS.

NUMBER OF BEDS/CLIENTS: ________ NUMBER OF ESRD* STATIONS: ________ N/A: ________

DATE: ________ SIGNATURE: ______________________________
(NAME AND TITLE OF ZONING OFFICIAL)

FIRE REGULATIONS

THIS CITY/TOWN USES THE FOLLOWING FIRE CODES: (EXAMPLE NFPA 101 (2003 EDITION) CHAPTER ____.)

NFPA 1 2018
NFPA 101 2018
____

☐ I HEREBY CERTIFY THAT ______________________ FD HAS INSPECTED ______________________
ON ______________________ AND OBSERVED THE FOLLOWING VIOLATIONS:

____
____
____

☒ I HEREBY CERTIFY THAT Lt McGahan Manke FD HAS INSPECTED 136 Arch St
ON 1/18/2024 AND FIND THAT ON THE DATE OF INSPECTION NO VIOLATIONS OF THE FIRE CODE ADOPTED BY THE STATE FIRE MARSHAL AND/OR LOCAL MUNICIPAL CODES WERE OBSERVED.

☐ I HEREBY CERTIFY THAT ______________________ FD HAS INSPECTED ______________________
ON ______________________ AND ALL PREVIOUSLY VIOLATIONS NOTED HAVE BEEN CORRECTED.

NUMBER OF BEDS/CLIENTS: ________ NUMBER OF ESRD* STATIONS: ________ N/A: ________

DATE: 3/4/2024 SIGNATURE: [signature]
(FIRE CHIEF OR DESIGNEE)

* ESRD = End Stage Renal Dialysis

COMMENTS:

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF LEGAL AND REGULATORY SERVICES
HEALTH FACILITIES ADMINISTRATION
129 Pleasant Street, Concord, New Hampshire 03301-3857
TDD Access: Relay NH 1-800-735-2964
Agency Phone Number: 800-852-3345, Extension 9039 or 603-271-9039

The facility listed below is requesting through the Department of Health and Human Services the following action:

- [x] Initial Licensing
- [ ] A change in current licensing category
- [ ] Renovation of Existing Building
- [ ] New Construction and/or Addition to Existing Building
- [ ] An increase in current licensed beds / ESRD stations/ or Adult Day Clients

Please note: All applicants must have this form filled out by the local officials, even if they do not see clients at their place of business. This is to confirm that the local authorities are aware that a business is operating at the identified location and that the business complies with all local ordinances.

Local authorities please complete and sign each section.

FACILITY/ESTABLISHMENT NAME: Langdon Place of Keene
STREET ADDRESS: 136A Arch Street Keene, NH 03431
OWNER'S NAME: Keene SNF Opco LLC
ADMINISTRATORS NAME: Michael Johnson
TELEPHONE NUMBER: 603-357-3902
PROPOSED TYPE OF FACILITY: Nursing Home and Assisted Living Facility

HEALTH OFFICER

I HEREBY ~~CERTIFY~~ Confirm THAT Langdon Place of Keene
COMPLIES WITH ALL APPLICABLE HEALTH, SEWAGE AND WATER REGULATIONS FOR THE CITY/TOWN OF Keene.

I HEREBY ~~CERTIFY~~ Confirm THAT ______ DOES NOT REQUIRE HEALTH, SEWAGE AND WATER APPROVAL OF THIS FACILITY/ESTABLISHMENT.

NUMBER OF BEDS/CLIENTS: ______ NUMBER OF ESRD* STATIONS: ______ N/A: ______

DATE: 3/5/24 SIGNATURE: [signature]
(NAME AND TITLE OF HEALTH OFFICIAL)

BUILDING REGULATIONS

I HEREBY ~~CERTIFY~~ CONFIRM THAT LANGDON PLACE OF KEENE
COMPLIES WITH ALL APPLICABLE BUILDING REGULATIONS FOR THE CITY/TOWN OF KEENE.

I HEREBY ~~CERTIFY~~ Confirm THAT ______ DOES NOT HAVE LOCAL BUILDING CODES OR REGULATIONS.

NUMBER OF BEDS/CLIENTS: ______ NUMBER OF ESRD* STATIONS: ______ N/A: ______

DATE: 3/6/24 SIGNATURE: [signature]
(NAME AND TITLE OF BUILDING OFFICIAL)

ZONING REGULATIONS

I HEREBY ~~CERTIFY~~ Confirm THAT Langdon Place of Keene.
COMPLIES WITH ALL APPLICABLE ZONING REGULATIONS FOR THE (CITY)/TOWN OF
Keene.

I HEREBY CERTIFY THAT ______________________________ DOES
NOT HAVE LOCAL ZONING REGULATIONS.

NUMBER OF BEDS/CLIENTS: ________ NUMBER OF ESRD* STATIONS: ________ N/A: ________

DATE: 3-6-2024 SIGNATURE: [signature]
(NAME AND TITLE OF ZONING OFFICIAL)

FIRE REGULATIONS

THIS CITY/TOWN USES THE FOLLOWING FIRE CODES: (EXAMPLE NFPA 101 (2003 EDITION) CHAPTER _____.)

____
____
____

☐ I HEREBY CERTIFY THAT ______________________ FD HAS INSPECTED ______________
ON ______________ AND OBSERVED THE FOLLOWING VIOLATIONS:

____
____
____

☐ I HEREBY CERTIFY THAT ______________________ FD HAS INSPECTED ______________
ON ______________ AND FIND THAT ON THE DATE OF INSPECTION NO VIOLATIONS OF THE FIRE CODE ADOPTED BY THE STATE FIRE MARSHAL AND/OR LOCAL MUNICIPAL CODES WERE OBSERVED.

☐ I HEREBY CERTIFY THAT ______________________ FD HAS INSPECTED ______________
ON ______________ AND ALL PREVIOUSLY VIOLATIONS NOTED HAVE BEEN CORRECTED.

NUMBER OF BEDS/CLIENTS: ________ NUMBER OF ESRD* STATIONS: ________ N/A: ________

DATE: ________ SIGNATURE: ______________________________
(FIRE CHIEF OR DESIGNEE)

* ESRD = End Stage Renal Dialysis

COMMENTS:

LANGDON PLACE OF KEENE

STATE OF NEW HAMPSHIRE ASSISTED LIVING FACILITIES

He-P 805.18(w)

All personnel shall sign a statement at the time of the initial offer of employment is made, and then annually thereafter stating that they:

1. Do not have a felony conviction in this or any other State.
2. Have not been convicted of a sexual assault, or other violent crime, assault, fraud, abuse, neglect, or exploitation or post a threat to the health, safety, or well-being of a resident.
3. Have not had a finding by the Department or any administrative agency in this or any other State for assault, fraud, abuse, neglect or exploitation of any person.

I have read the above statement and my signature below is agreement that the above statement is correct to the best of my knowledge.

Michael Kasschau 4/15/24

Printed name Signature Date

He-p 805.10 Applicants or licensees waivers shall submit a written request for waiver to the commissioner that includes:

(a)1. The specific reference to the rule for which a waiver is being sought;

2. A full explanation of why a waiver is necessary;

3. A full explanation of alternatives proposed by the applicant or license holder, which shall be equally as protective of public health and residents as the rule from which the waiver is sought; and

4. The period of time for which a waiver is sought.

(b) A waiver shall not exceed 12 months or the current license expiration date.

(f). When a licensee wishes to renew the waiver beyond the approved period of time, the licensee shall apply for a new waiver by submitting the information required above at least 15 days prior to the expiration of the waiver or the licensing certificate.

LANGDON PLACE OF KEENE

STATE OF NEW HAMPSHIRE ASSISTED LIVING FACILITIES

He-P 805.18(w)

All personnel shall sign a statement at the time of the initial offer of employment is made, and then annually thereafter stating that they:

1. Do not have a felony conviction in this or any other State.
2. Have not been convicted of a sexual assault, or other violent crime, assault, fraud, abuse, neglect, or exploitation or post a threat to the health, safety, or well-being of a resident.
3. Have not had a finding by the Department or any administrative agency in this or any other State for assault, fraud, abuse, neglect or exploitation of any person.

I have read the above statement and my signature below is agreement that the above statement is correct to the best of my knowledge.

Ho-p 805.10 Applicants or licensees waivers shall submit a written request for waiver to the commissioner that includes:

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3. A full explanation of alternatives proposed by the applicant or license holder, which shall be equally as protective of public health and residents as the rule from which the waiver is sought; and

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(f) When a licensee wishes to renew the waiver beyond the approved period of time, the licensee shall apply for a new waiver by submitting the information required above at least 15 days peior to the expiration of the waiver or the licensing certificate.

STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

LEGAL AND REGULATORY SERVICES

HEALTH FACILITIES LICENSING AND CERTIFICATION

Lori A. Weaver
Commissioner

Melissa A. St. Cyr, Esq.
Chief Legal Officer

129 PLEASANT STREET, CONCORD, NH 03301-3857
603-271-9499 1-800-852-3345 Ext. 9499
Fax: 603-271-4968 TDD Access: 1-800-735-2964
www.dhhs.nh.gov

April 16, 2024

Nathan Fennessy
PretiFlaherty
57 North Main St
Concord NH 03301

Re: Langdon Place of Keene 803

Dear Attorney Fennessy:

In accordance with RSA 151-A:14, the Office of Legal and Regulatory Services hereby acknowledges receipt of the application and fees in the amount of $3625.00 for a Nursing Home. This application has been submitted in anticipation of a future purchase.

Review of your application indicates that it has been completed in accordance with RSA 151:4, and He-P 803, the rules of the Office of Legal and Regulatory Services for a Nursing Home.

Once the sale has been concluded you must submit the appropriate documentation. At that time the Office of Legal and Regulatory Services will issue a new license.

If you have any questions regarding your application the application process or the provisions of RSA 151 and the rules of the Office of Legal and Regulatory Services which apply to your licensure request, Please do not hesitate to contact this bureau at (603) 271-9041.

Sincerely,

Marilee D. Curran, MS
Licensing Database Administrator
Health Facilities Administration