

Received 11/10/25

F-72
WTRO/FTSD/PR
APP# 22722



**NURSING HOME
APPLICATION FOR CHANGE OF OWNERSHIP**

All applicable laws, rules, policies, and guidelines affecting your practice are available for viewing at <https://www.tn.gov/hfc/division-of-licensure-and-regulation/hfc-licensure/licensure-applications.html>. Please check this website periodically for updates.

Name of the Facility/Agency Dickson Health and Rehab

Location of the Facility:

Street 901 N Charlotte St City Dickson

County Dickson State TN Zip 37055-1010

Phone Number (615) 446-5171 Fax Number (615) 446-7082

Twenty-four (24) Hour Emergency Phone Number (732) 619-3822

E-Mail Address Admin@dicksonhc.com

Total Bed Capacity 70

Does the facility have a Secure Unit? Yes ___ No X Number of Secured Beds N/A

Does the facility have an Alzheimer's Unit? Yes ___ No X Number of Alzheimer Beds N/A

Does this facility have a Ventilator Unit? Yes ___ No X Number of Ventilator Beds N/A

Does this facility offer dialysis services? Yes ___ No X

If yes, is it bedside dialysis? Yes ___ No X Number of Beds N/A

Administrator Information:

Administrator Jada McLeod Nursing Home Administrator License Number 4165

Have you (administrator) ever been convicted of a crime involving injury or harm to person(s), financial or business management (e.g., assault, battery, robbery, embezzlement, or fraud)? Yes ___ No X

If yes, what charge(s)? N/A

Location of Conviction N/A Date N/A
(City) (County) (State)

Mailing address if different from the Facility location address:

Name Same as facility

Street _____

City _____ State _____ Zip _____

Ownership of Building:

Name 901 N Charlotte LLC Phone (718) 338-2999

Street Address 2071 Flatbush Ave. Ste 22

City Brooklyn State NY Zip 11234

FEE SCHEDULE: (FEES ARE NON-REFUNDABLE)

<u>Bed Capacity</u>	<u>Fee</u>	<u>Bed Capacity</u>	<u>Fee</u>
Less than 25	\$1,040	100 thru 124	\$2,080
25 thru 49	\$1,300	125 thru 149	\$2,340
50 thru 74	\$1,560	150 thru 174	\$2,600
75 thru 99	\$1,820	175 thru 199	\$2,860

Facilities with 200 beds or more shall pay a flat rate of \$2,860 + \$200 for each additional 25 beds or fraction thereof (i.e., 200-224 pays \$3,060; 225-249 pays \$3,260).

OWNERSHIP OF BUSINESS:

1. a. Check the type of Legal Entity:

Individual Partnership Corporation Limited Liability Company
Church Related Government/County Other

b. Check One: For Profit Non-profit

c. Legal Entity Checked in 1.a:

Name Dickson Healthcare and Rehab LLC Phone Number (615) 446-5171

Street 901 N Charlotte St

City Dickson State TN Zip 37055

d. List name(s) and address(es) of individual owners, partners, directors of the corporation, or head of the governmental entity:

<u>Samuel Goldsmith</u>	<u>69 Piccadilly Dr</u>	<u>Jackson, NJ 08527</u>
Name	Street	City, State, Zip

Name	Street	City, State, Zip

Name	Street	City, State, Zip

(If additional space is needed, please use a separate sheet)

e. If a government/county owned facility, does the administrator have authority to act on behalf of the government/county as it relates to the operation of this facility? Yes No N/A

f. If no to e., who has said authority? N/A

2. a. In accordance with Rule 0720-18-.02, is this CHOW a lease of operation? Yes No

b. If yes, please provide the lessor's information below:

Name N/A Phone Number () N/A

Address N/A

3. a. Is your facility/organization accredited by a **federally approved** accrediting body including but not limited to JCAHO, CAREF, etc?
Provide proof of accreditation.
Yes _____ No X Expiration Date _____

4. Is this facility chain affiliated? Yes X No _____

5. If you have a parent company, please provide the following information:

Name TN Opco Holdings LLC Phone Number (845) 595-2444

Address 400 Rella Boulevard, Ste 200, Montebello, NY 10901

6. a. If a corporation, is there a holding company? Yes _____ No _____ N/A

b. If yes, list the name, address, and phone number of the holding company:

Name N/A Phone Number (_____) N/A

Street N/A

City N/A State N/A Zip N/A

7. a. Are any owners of the disclosing entity also owners of other health care facilities in Tennessee and/or other states?

Yes X No _____

b. If yes, list names and addresses of all such facilities. *(If additional space is needed, please use a separate sheet)*

See Attachment

8. a. Do you have a contract with a management firm to operate this facility? Yes _____ No X

If yes, specify dates: From _____ To _____

b. If yes, specify name of firm: N/A

Phone Number (_____) N/A

Address N/A

9. For any item in (9) a-h below, please identify, explain, and provide documentation of the item(s) noted if response is "Yes". Have either the licensed entity for any of the other health care facilities in Tennessee and/or other states on the list in question (7.b.) above, OR the management firm listed in question (8.) above; been subjected to any of the following within the last (5) years:

a. Licensure

i) denied a license? Yes _____ No X

ii) had a license suspended or revoked by any state licensure action? Yes _____ No X

iii) been subject to a final order or judgement in a state licensure action? Yes _____ No X

b. Convictions

i) convicted of a criminal offense related to that person's involvement in any program under any state or Federal health care program (including Medicare, Medicaid, and Tricare)? Yes _____ No X

c. Exclusion

i) excluded from participation in Federal health care programs (Medicare, Medicaid, CHIP, or Tricare) in the past? Yes _____ No X

(Note: "Excluded" is defined as a provider or entity has been told by the Department of Health and Human Services, Office Inspector General (HHS-OIG) that they may no longer be a provider for any federally funded healthcare program).

d. Termination/Suspension

i) suspended or terminated from participation in Medicare or Medicaid/TennCare programs? Yes ___ No X

(Note: This would include involuntary termination of a nursing facility or skilled nursing facility by the Centers for Medicare and Medicaid and Medicaid Services (CMS) or state Medicaid agency).

e. Fraud and Abuse

i) paid through settlement, or civil or criminal fines, any monies to the federal government or any state as a result of any administrative or judicial proceeding based on allegations of fraud or abuse involving claims related to the provision of health care items and services? Yes ___ No X

f. Corporate Integrity Agreement

i) Is presently an entity covered by and subject the terms of a corporate integrity agreement? Yes ___ No X

(Note: If yes, provide a copy of CIA)

g. Bankruptcy

i) filed bankruptcy under any provision of the United States Bankruptcy Code? Yes ___ No X

h. Civil Monetary Penalty(CMP)

i) paid to the Centers for Medicare and Medicaid Services or any state Medicaid agency a civil money penalty equal to or greater than \$250,000.00 as a result of an enforcement action during a survey? Yes ___ No X

Failure to provide true and correct copies of any documents related to the items list in 9(a-h) listed above may be grounds for referral of the application for special consideration, and/or may be grounds for disciplines.

If the applicant answered "Yes" to any of the questions (a)-(h) above, please provide copies of any documentation associated with the event and/or sanction. The documentation should provide the Health Facilities Commission with sufficient information regarding the nature of the event and/or sanction, the current status of the issue, as well as details regarding what corrective action have been implemented (as applicable).

VERIFICATION BY NOTARY PUBLIC:

Signee for application certifies that he or she is of responsible character and able to comply with the minimum standards and regulations established by Tennessee pertaining to the type of facility or agency for which application for licensure is made and with the rules promulgated under Tennessee Code Annotated (TCA) § 68-11-201.

Signee also certifies that a policy has been implemented to inform all employees of their obligation under TCA § 71-6-103 to report incidents of abuse or neglect.

Signee acknowledges that the State of Tennessee may share information regarding the activities and compliance of the licensee, if the submitted CHOW application is a lessor and/or lessee transaction as described in the above Ownership of Business section of this application.


Applicant Signature

Authorized Signatory
Title or Position

11/06/2025
Date

STATE OF ~~TENNESSEE~~ ^{New Jersey}

County of Ocean

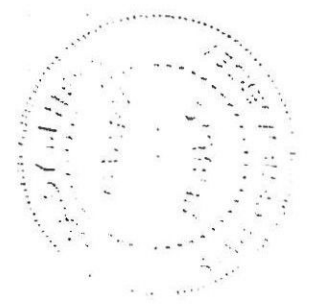
The above-named applicant (print name) Samuel B.J. Goldsmith, being by me duly sworn on his/her oath, deposes and says that he/she has read the forgoing application and knows the contents thereof: that the statements concerning the above-named facility or agency, therein contained, are correct and true to his/her own knowledge.

Subscribed to and sworn to me before this 6th day of November 2025
(Month) (Year)

Notary Public: Fraidy M. Hess

My commission expires: _____

FRAIDY M HESS
Notary Public, State of New Jersey
Comm. # 50204090
My Commission Expires 10/27/2027





State of Tennessee
Health Facilities Commission
Andrew Jackson State Building
502 Deaderick Street, 9th Floor, Nashville, TN 37243
www.tn.gov/hfc Phone: 615-741-7221

March 12, 2026

Sent Via Email

Brandie Lambert
New Legacy Professional Services
C/O Dickson Health and Rehab
915 Main Street, Suite C
Perry, Georgia 31069

Facility Type: Nursing Home
License Number: 72

Dear Brandie Lambert:

It is my pleasure to inform you that your application for change of ownership of Dickson Health and Rehab located at 901 North Charlotte Street, Dickson, Tennessee 37055 has been initially approved effective February 1, 2026 . The license number shall be 72. For this initial approval to become final and permanent, your application must be ratified by the Commission pursuant to T.C.A. §68-11-206. The Commission will consider your application at its next meeting, scheduled for April 22, 2026 . **You are hereby authorized to commence operation pending the final decision of the Commission.** No further action is necessary on your part at this time.

If the Commission **does** ratify the approval of your application, the license number listed above will become your permanent license number and a letter will be forwarded to you within three (3) business days; notifying you of the Commission's final decision.

If the Commission **does not** ratify the initial approval of your application, a letter will be forwarded to you providing an explanation and specific instructions as to any action(s) you may take to have the decision reviewed, at which time this authorization shall cease to be effective.

Please contact me if I can be of further assistance.

Sincerely,

Niraj Soni

Niraj Soni, ASA 3
Phone: (615) 741-7539
Fax: (615) 253-8798
Email: Niraj.Soni@tn.gov



State of Tennessee

Health Facilities Commission

665 Mainstream Drive, 2nd Floor, Nashville, TN 37243

www.tn.gov/hfc Phone: 615-741-7221

November 13, 2025

Sent Via Email

Brandie Lambert
C/O Dickson Health and Rehab
New Legacy Professional Service
915 Main Street, Suite C
Perry, Georgia 31069

Dear Brandie Lambert:

License number 72 has been initially approved due to the change of ownership for Dickson Health and Rehab pending completion and submission of the Bill of Sale; effective November 13, 2025. The previous owner of the facility was Dickson Operator, LLC **d/b/a** Dickson Health and Rehab . The owner of the facility is Dickson Healthcare and Rehab, LLC **d/b/a** Dickson Health and Rehab. The new owner of the facility is Dickson Healthcare and Rehab, LLC **d/b/a** Dickson Health and Rehab.

For certification purposes, please be advised that it is your responsibility to contact your Health Facilities Commission regional office to make changes to your Medicare/Medicaid participation including a name change of the facility. The West phone number is 731-984-9684.

Please contact me if I can be of further assistance.

Sincerely,

Niraj Soni

Niraj Soni, ASA 3
Phone: (615) 741-7539
Fax: (615) 253-8798
Email: Niraj.Soni@tn.gov

cc: West Tennessee Regional Office



**CHANGE OF OWNERSHIP (CHOW) APPROVAL/DENIAL FORM
(For Health Facilities Commission USE ONLY)**

Instructions: This form is to be completed upon receipt of a CHOW application for all facility types. The effective date of a change of ownership will be the date the closing documents are signed & dated by seller/buyer or lessee; or the date recommended by the Regional Office if occurring after the date of the signed closing documents.

Facility Type: LTC County: Dickson

Facility Name (Current D/B/A): Dickson Health and Rehab

Facility Name (New D/B/A if applicable): Dickson Health and Rehab

Street Address: 901 N Charlotte

City/State/Zip Code: Dickson, TN 37055

Health Licensure Last Survey Date: 4/29/25 (Annual or Complaint (circle one) Survey
**Review of three (3) year survey history including both annual and/or complaint surveys

Outstanding Complaint(s): Y or N (circle one; if yes, proceed to next question)

Number of Outstanding Complaint(s): 49

Date(s) of Outstanding Complaint(s): 3/6/25 - 10/23/25

Life Safety Licensure Last Survey Date: 4/29/25 (Annual or Complaint (circle one) Survey
**Review of three (3) year survey history including both annual and/or complaint surveys

Outstanding Complaint(s): Y or N (circle one; if yes, proceed to next question)

Number of Outstanding Complaint(s): 0

Date(s) of Outstanding Complaint(s): _____

Approved: Denied: _____

Reason for denial: _____

Recommended CHOW Approval Date: February 1, 2026

Kathy Zeigler
Regional Administrator Signature

11.12.25
Date



State of Tennessee
Health Facilities Commission

665 Mainstream Drive, 2nd Floor, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-7221

TennCare Change of Ownership (CHOW) Nursing Facility Assessment

DATE: November 10, 2025

TO: Samantha Rummage, Fiscal Chief of Staff; Phillip Lester; Cindy Rittenberry; Michelle Williams

FROM: Niraj Soni

SUBJECT: Change of Ownership (CHOW)

A change of ownership is to occur on January 1, 2026 for Dickson Health and Rehab located at 901 N Charlotte Street, Dickson, Tennessee 37055. This facility is currently owned by Dickson Operator, LLC dba Dickson Health and Rehab. The change of ownership applicant is Dickson Healthcare and Rehab, LLC dba Dickson Health and Rehab.

Please review your files to determine if there are any delinquent/outstanding nursing facility assessments and/or corresponding penalties & interest for the current licensed facility/owner.

If a nursing facility assessment is outstanding, please indicate the amount/ quarters in which payment is outstanding and has not been made.

If a facility is currently on a payment plan, please indicate whether the facility has maintained compliance with their payment plan and the current status.

To complete the recommendation for change of ownership, please indicate below approval or denial and provide additional detail, as indicated above, along with rationale for any denial.

Approval: X

Denial: _____

TennCare Representative Signature: *Michelle Williams*

Date: 11.12.2025

If you have any questions, please call the Division of Licensure and Regulation, Health Facilities Commission at (615)741-7539 or via email Niraj.soni@tn.gov .



State of Tennessee
Health Facilities Commission
Andrew Jackson State Building
502 Deaderick Street, 9th Floor, Nashville, TN 37243
www.tn.gov/hfc Phone: 615-741-7221

DIVISION OF LICENSURE AND REGULATION MEMORANDUM

DATE: April 22, 2026

TO: HEALTH FACILITIES COMMISSION

SUBJECT: CHOW OUT OF STATE VERIFICATION SUMMARY

To streamline the Change of Ownership Package(s) for Dickson Health and Rehab for the Commission's ratification, the following out of state verifications summary of results are listed below:

Pennsylvania-In Compliance
District of Columbia-In Compliance
Delaware- In Compliance
Florida-In Compliance
Georgia-In Compliance
Nebraska-In Compliance
New Jersey- In Compliance
North Carolina- In Compliance
Pennsylvania-In Compliance
Virginia- In Compliance

8/21/2024

BILL OF SALE

[To Operator]

KNOW ALL MEN BY THESE PRESENTS THAT, **DICKSON OPERATOR, LLC**, a Florida limited liability company (the “**Current Operator**”), for the sum of \$10.00 and other good and valuable consideration to it in hand paid, does by these presents, sell, assign, transfer and convey unto **DICKSON HEALTHCARE AND REHAB LLC**, a Nevada limited liability company (the “**New Operator**”), the “**Transferred Assets**” located at that certain skilled nursing facility located in the State of Tennessee, as more particularly described on Exhibit A attached hereto and made a part hereof (the “**Facility**”), as defined in that certain Operations Transfer Agreement dated as of October 1, 2025, as assigned, between Current Operator and New Operator.

Current Operator hereby covenants that it will, at any time and from time to time upon written request therefor, execute and deliver to New Operator, its nominees, successors and/or assigns, any new or confirmatory instruments which New Operator, its nominees, successors and/or assigns, may reasonably request in order to assign and transfer to New Operator its rights, title and interest in, the Transferred Asset.

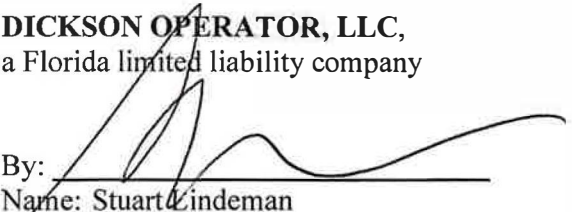
Current Operator makes no warranties of any kind or nature whatsoever, express or implied, of suitability, merchantability or fitness for a particular purpose, any and all such warranties being hereby expressly disclaimed and on as “AS-IS” “WHERE-IS” basis, with all faults, as of the Effective Time; provided, however that Current Operator does warrant as to its ownership of the Transferred Assets free and clear of all liens.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

SIGNATURE PAGE FOLLOWS

IN WITNESS WHEREOF, the undersigned, being duly authorized, has executed and delivered this instrument effective as of February 1, 2026.

DICKSON OPERATOR, LLC,
a Florida limited liability company

By: 
Name: Stuart Lindeman
Title: President and Chief Executive Officer



January 20, 2025

Tennessee Health Facilities Commission
Attn: Niraj Soni
665 Mainstream Drive
Second Floor
Nashville, TN 37243

**Re: Nursing Home Change of Ownership Notification
Dickson Health and Rehab – License # 72
Change of Ownership Effective date UPDATE: February 1, 2026**

Dear Mr. Soni:

We are notifying the Tennessee Health Facilities Commission that the facility currently known as Dickson Health and Rehab located at 901 N Charlotte St, Dickson, TN 37055 is expected to change ownership effective on **February 1, 2026**. Previously, the anticipated change of ownership effective date was January 1, 2026. Enclosed are the change of ownership acknowledgement letters received to date from the Commission for your reference.

If you have any questions or concerns, please contact me at (478) 396-4777 or blamberth@newlegacypro.com.

Sincerely,

A handwritten signature in black ink that reads 'Brandie P. Lamberth'. The signature is written in a cursive, flowing style.

Brandie P. Lamberth, CPA
President, New Legacy Professional Services

Enclosures



November 7, 2025

Tennessee Health Facilities Commission
Attn: Niraj Soni
665 Mainstream Drive
Second Floor
Nashville, TN 37243

**Re: Dickson Healthcare and Rehab LLC d/b/a Dickson Health and Rehab
901 N Charlotte St, Dickson, TN 37055-1010
EIN: 39-4921464
Facility License #: 00000072
Nursing Home Application for Change of Ownership
Change of Ownership Effective Date: January 1, 2026**

Dear Mr. Soni:

We have enclosed the Nursing Home Application for Change of Ownership along with the required license fee for the above-referenced facility.

If you have any questions or need any additional information, please contact me at (478) 396-4777 or blamberth@newlegacypro.com.

Sincerely,

Brandie P. Lamberth, CPA
President, New Legacy Professional Services

Enclosures