NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane - Reno, NV 89509 - (775) 850-1440

APPLICATION FOR NEVADA PHARMACY LICENSE

\$500.00 Fee made payable to: Nevada State Board of Pharmacy

(non-refundable and not transferable money order or cashier's check only) Application must be printed legibly or typed

Any misrepresentation in the answer to any question on this application is grounds for refusal or denial of the application or subsequent revocation of the license issued and is a violation of the laws of the State of Nevada.

| Check box bel | □New Pharmacy or Ownership Change (Provide current license number if making changes: PH_C03284) Check box below for type of ownership and complete all required forms. **If LLC use Non Public | | | | | | |
|-----------------------------|---|--|------------|--|--|-------------------------|--|
| Corporation or Partnership. | | | | | | | |
| Publicly Tra | ded Corporation – Pages 1,2 y Traded Corporation – Page | ,3,10,11a&b | 1-06 | | tnership - Page | s 1,2,6,10,11a&b | |
| | IFORMATION to be comp | $\frac{S_{1,2,4,10,1}}{1000}$ | laon | | e Owner – Page | 5 1,2,0,10,11800 | |
| | | | | | <u>ersnip</u> | | |
| | me: United RX, LLC dba Aba | | nacy | | | | |
| Physical Add | Physical Address: | | | | | | |
| | enderson | | | | | | |
| Telephone: | 702- 475-4297 | _Fax: | 855-298 | 3-6584 | - - - - | | |
| Toll Free Nur | 702- 475-4297 nber: | E-m | nail: | kbcarlton | @abacusrxnv.com | 1 | |
| Website: | N/A | na na tana na katala da katala | | | | | |
| Managing Ph | armacist: Stephen Carl | ton | | Lice | nse Number: _ | 06471 🗸 | |
| | | | | | | | |
| | TYPE OF PHARMACY | AND | SEI | RVICES | PROVIDED | · | |
| | TYPE OF PHARMACY Yes/No | AND | SEI Yes | | PROVIDED | | |
| | | AND | Yes | /No | PROVIDED | vices | |
| | Yes/No □ Retail | | Yes | /No | te Cognitive Ser | vices | |
| | Yes/No | | Yes | /No ☑ Off-si □ Parer | te Cognitive Ser | | |
| | Yes/No Retail Hospital (# beds Internet | | Yes | /No ☑ Off-si ☑ Parer | te Cognitive Ser | | |
| | Yes/No Retail Hospital (# beds Internet Nuclear | _) | Yes | /No ☑ Off-si ☑ Parer | te Cognitive Ser hteral hteral (outpatient htient/Discharge | | |
| | Yes/No Retail Hospital (# beds) Internet Nuclear Ambulatory Surgery | _) | Yes | /No ☐ Off-si ☐ Parer ☑ Parer ☑ Outpa ☑ Mail S | te Cognitive Ser hteral hteral (outpatient htient/Discharge | | |
| | Yes/No Retail Hospital (# beds | _) Center | Yes | /No ☐ Off-si ☐ Parer ☐ Parer ☐ Outpa ☐ Mail S ☐ Long | te Cognitive Ser hteral hteral (outpatient htient/Discharge Service | | |
| | Yes/No Retail Hospital (# beds) Internet Nuclear Ambulatory Surgery Community | _) Center | Yes | No Off-si Parer V Parer Outpa Mail S Long Steril | te Cognitive Ser nteral nteral (outpatient atient/Discharge Service Term Care | :) | |
| | Yes/No Retail Hospital (# beds | _) Center | Yes | /No ☐ Off-si ☐ Parer ☑ Parer ☑ Outpa ☑ Mail S ☐ Long ☑ Sterill ☐ Non S | te Cognitive Ser nteral nteral (outpatient atient/Discharge Service Term Care e Compounding |) ding | |
| | Yes/No Retail Hospital (# beds Internet Nuclear Ambulatory Surgery Community Other: | _) Center | Yes | No ☐ Off-si ☐ Parer ☐ Parer ☐ Outpa ☐ Mail S ☐ Long ☐ Steril ☐ Non S ☐ Mail S | te Cognitive Ser nteral nteral (outpatient atient/Discharge Service Term Care e Compounding Sterile Compoun |) ding ompounding | |

This page must be submitted for all types of ownership.

Within the last five (5) years:

| misdemeanor (including by way of a guilty plea or no contest plea)? | | |
|--|--------|------|
| 2) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been denied a license, permit or certificate of registration? | es 🗆 I | No 🖌 |
| Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been the subject of an administrative action, board citation, site fine or proceeding relating to the pharmaceutical industry? | es 🗆 I | No 🖌 |
| 4) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been found guilty, pled guilty or entered a plea of nolo contendere to any offense federal or state, related to controlled substances? Ye | es 🗆 I | No 🗹 |
| 5) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever surrendered a license, permit or certificate of registration voluntarily or otherwise (other than upon voluntary close of a facility)? Ye | es 🗆 1 | No 🖌 |

If the answer to question 1 through 5 is "yes", a signed statement of explanation must be attached. Copies of any documents that identify the circumstance or contain an order, agreement, or other disposition may be required.

I hereby certify that the answers given in this application and attached documentation are true and correct. I understand that any infraction of the laws of the State of Nevada regulating the operation of an authorized pharmacy may be grounds for the revocation of this permit.

I have read all questions, answers and statements and know the contents thereof. I hereby certify, under penalty of perjury, that the information furnished on this application are true, accurate and correct. I hereby authorize the Nevada State Board of Pharmacy, its agents, servants and employees, to conduct any investigation(s) of the business, professional, social and moral background, gualification and reputation, as it may deem necessary, proper or desirable.

Original Signature of Person Authorized to Submit Application, no copies or stamps

Stephen W. Carlton

Print Name of Authorized Person

Date

Board Use Only Date Processed: Amount: _ 🖞 500,00

OWNERSHIP IS A NON PUBLICY TRADED CORPORATION

| State of Incorporation:Illinois |
|--|
| Parent Company if any:United Rx,LLC |
| Mailing Address: |
| City: Hillside State:L Zip:60162 |
| Telephone: |
| Contact Person: Chuck Benain,RPh |
| For any corporation non publicly traded, disclose the following: |
| |
| 1) List top 4 persons to whom the shares were issued by the corporation? |
| a) New York Boys Management, LLC 1230 Ridgedale Road, South Bend, IN 46614 |
| Name Business Address |
| b) Charles Benain 150 Fencil Lane, Hillside, IL 60162 |
| Name Business Address |
| c) A& F Realty 272 W. Tucker Drive. South Bend, IN 46624 |
| Name Business Address |
| d) |
| Name Business Address |
| 2) Provide the number of shares issued by the corporation10,000 |
| 3) What was the price paid per share? |
| |
| List any physician shareholders and percentage of ownership. |
| Name:%: |
| Name:%: |
| |
| Hours of Operation for the pharmacy: |
| Monday thru Friday 7 am 3 am pm Saturday 8 am 10 p |
| Sunday <u>8</u> am <u>10</u> pm 24 Hours |
| A Nevede business license is not required, however if the pharmacy has a Nevada business |

A Nevada business license is not required, however if the pharmacy has a Nevada business license please provide the number: <u>NV20141548460</u>

STATEMENT OF RESPONSIBILITY – Nevada Pharmacy FOR Corporations, Partnership or Sole Owners

| I, | STEPHEN W. | 1. CARLTON | |
|-------------------------|-------------------------|--|-----|
| Responsible Person of | ABACUS | 5 R PHARMACY | • |
| hereby acknowledge ar | nd understand that in | in addition to the corporation's, any owner(s), | |
| shareholder(s) or partn | er(s) responsibilities, | s, may be responsible for any violations of pharmacy I | law |
| that may occur in a pha | irmacy owned or ope | perated by said corporation. | |

I further acknowledge and understand that the corporation's, any owner(s), shareholder(s) or partner(s)may be named in any action taken by the Nevada State Board of Pharmacy against a pharmacy owned by or operated by said corporation.

I further acknowledge and understand that the corporation's, any owner(s), shareholder(s) or partner(s) cannot require or permit the pharmacist(s) in said pharmacy to violate any provision of any local, state or federal laws or regulations pertaining to the practice of pharmacy.

Original Signature of Person Authorized to Submit Application, no copies or stamps

STEPHEN W. CARLTON Print Name of Authorized Person

2/28/18

Date

Managing Pharmacist

| Pharmacist Name: | Stephen Carlton | License #: | 06471 | |
|------------------|-------------------|----------------|-------|--|
| Pharmacy Name: | AbacusRx Pharmacy | | | |

As a managing pharmacist of the above referenced pharmacy, I understand within 48 hours after I report for duty as the managing pharmacist, I shall cause an inventory of all controlled substances of the pharmacy according to the method prescribed by the provision of 21 CFR Part 1304; and cause a copy of the inventory to be on file at the pharmacy.

I understand that as the managing pharmacist I am responsible for compliance by the pharmacy and its personnel with all state and federal laws and regulations relating to the operation of the pharmacy and the practice of pharmacy. I understand my license can be revoked or that I can be the subject of disciplinary action if such laws or regulations are knowingly violated in the pharmacy in which I am managing pharmacist.

I understand that if I cease to be managing pharmacist of the above named pharmacy I will jointly, with the new managing pharmacist, take an inventory of all controlled substances.

| Y | 'es | No | | | |
|--|-----|----|--|--|--|
| Been diagnosed or treated for any mental illness, including alcohol or substance abuse, or physical condition that would impair your ability to perform the essential functions of your license? | | | | | |
| 1. been charged, arrested or convicted of a felony or misdemeanor in any state? | | | | | |
| been the subject of a board citation or an administrative action whether completed or pending in any state? | | | | | |
| 3. had your license subjected to any discipline for violation of pharmacy or drug laws in any state? | | | | | |
| If you marked YES to any of the numbered questions above, please include the following informati | on | | | | |
| Board Administrative Action: State: Date: Case #: | | - | | | |
| And/or Criminal Action: State: Date: Case #: County Court: | | - | | | |

Page 11a

NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane - Reno, NV 89509 - (775) 850-1440

APPLICATION FOR NEVADA PHARMACY LICENSE

\$500.00 Fee made payable to: Nevada State Board of Pharmacy

(non-refundable and not transferable money order or cashier's check only) Application must be printed legibly or typed

Any misrepresentation in the answer to any question on this application is grounds for refusal or denial of the application or subsequent revocation of the license issued and is a violation of the laws of the State of Nevada.

| □New Pharmacy or | | | | | | |
|--|---|--|--|--|--|--|
| | GENERAL INFORMATION to be completed by all types of ownership | | | | | |
| Pharmacy Name: CONCORDE TREATMENT CENTER | 2, LLC. d/b/a DESERT HOPE TREATMENT CENTER | | | | | |
| Physical Address: 2465 EAST TWAIN AVE | | | | | | |
| City: LAS VEGAS State: N | ✓ Zip Code: <u>89121</u> | | | | | |
| Telephone: (702) 848.6223 Fax: | | | | | | |
| Toll Free Number:E-ma | ail: nathen _ connolly@ yahoo.com | | | | | |
| Website: desert hope treatment. com | | | | | | |
| Managing Pharmacist: Nathen Connolly | License Number: 18540 V | | | | | |
| TYPE OF PHARMACY AND | SERVICES PROVIDED | | | | | |
| Yes/No | Yes/No | | | | | |
| C Retail | Off-site Cognitive Services | | | | | |
| ☑ □ Hospital (# beds <u>i4</u> \$_) | Parenteral | | | | | |
| 🗆 🗹 Internet | Parenteral (outpatient) | | | | | |
| 🗆 🗹 Nuclear | Outpatient/Discharge | | | | | |
| Ambulatory Surgery Center | Mail Service | | | | | |
| 🗆 🗹 Community | Long Term Care | | | | | |
| 🗆 🗹 Other: | Sterile Compounding | | | | | |
| | Mon Sterile Compounding | | | | | |
| All boxes must be checked | Mail Service Sterile Compounding | | | | | |
| | | | | | | |

This page must be submitted for all types of ownership.

Within the last five (5) years:

- Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been charged, or convicted of a felony or gross misdemeanor (including by way of a guilty plea or no contest plea)?
- 2) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been denied a license, permit or certificate of registration?
- 3) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been the subject of an administrative action, board citation, site fine or proceeding relating to the pharmaceutical industry?
- 4) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been found guilty, pled guilty or entered a plea of nolo contendere to any offense federal or state, related to controlled substances?
- 5) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever surrendered a license, permit or certificate of registration voluntarily or otherwise (other than upon voluntary close of a facility)?

If the answer to question 1 through 5 is "yes", a signed statement of explanation must be attached. Copies of any documents that identify the circumstance or contain an order, agreement, or other disposition may be required.

I hereby certify that the answers given in this application and attached documentation are true and correct. I understand that any infraction of the laws of the State of Nevada regulating the operation of an authorized pharmacy may be grounds for the revocation of this permit.

I have read all questions, answers and statements and know the contents thereof. I hereby certify, under penalty of perjury, that the information furnished on this application are true, accurate and correct. I hereby authorize the Nevada State Board of Pharmacy, its agents, servants and employees, to conduct any investigation(s) of the business, professional, social and moral background, qualification and reputation, as it may deem necessary, proper or desirable.

Original Signature of Person Authorized to Submit Application, no copies or stamps

anzalez

Print Name of Authorized Person

| | 4 | | 8 | - | à | 0 | l | 8 | |
|------|---|--|---|---|---|---|---|---|---|
| Date | | | | | | | | | - |

Yes 🗆 No 🕅

Yes 🗆 No 💢

Yes 🗆 No 💢

Yes 🗆 No 🕅

Yes 🗆 No 💢

Board Use Only

Date Processed:

Amount: \$500.00

Page 2

OWNERSHIP IS A NON PUBLICY TRADED CORPORATION

| State of Incorporation: <u>Nevada</u> | | and a second | | |
|--|-----------|--|--------------|--|
| Parent Company if any: <u>Advanced</u> | Pharma | centica) | Consultants, | inc |
| Mailing Address: 9999 NE 2nd A | ve ste 3 | 315 | | 999 (1911 - 1911 - 1917) - 1917 (1917 - 1917) - 1917 (1917 - 1917) - 1917 (1917 - 1917) - 1917 (1917 - 1917) - |
| City: miami shores | State: FL | Zip: | 33/38 | na ganadaga nga madalamini kana pang pang pang kana mada |
| Telephone: 305-751-7798 | Fax: | 305-75 | 51-7748 | enemente and a second second second second |
| Contact Person: Andrea Mason | n | | - | |

For any corporation non publicly traded, disclose the following:

1) List top 4 persons to whom the shares were issued by the corporation?

| | a) Raul | Gonzale | 2 910 | or NEZNO AU | e miami | shores, | FC 33 | 3/38 |
|--------|----------------|-------------------------|-----------------|--------------------------------|----------------|---------------|--|----------------|
| | | Name | | Business Address | | | | |
| | b) SUE | Fassler Name | 9101 | NE 2nd Ave Business Address | e miami | shores, | R 3 | 13/38 |
| | c) Bevi | <u>erly Sch</u> Name | ummel Spe | Business Address | NE 2ha | Aven | <u>uiamis</u> 331 | nores Pa 38 |
| | d) | | | | | | | |
| | u) | Name | | Business Address | | | an a | |
| 2) | Provide the | number of sh | ares issued by | the corporation. | NA | | | |
| 3) | What was t | he price paid | per share? | JA | | | | |
| List a | ny physician | shareholders | and percentage | e of ownership. | | | | |
| Name | NIA | | ······ | | % | | | |
| | | | | | | | | |
| Hour | s of Operati | on for the ph | armacy: | | | | | |
| Mond | lay thru Frida | ay <u>0:00</u> am | <u>2:30 pm</u> | Satu | urday <u>8</u> | <u>0</u> 6_am | 1:30 | om |
| | Sunday | am | pm | 24 H | Hours | | | |
| | undo huninou | na liconco is n | at required how | vover if the nharm | acy has a N | evada hus | iness | |

A Nevada business license is not required, however if the pharmacy has a Nevada business license please provide the number: $\underline{NV20101957}$

STATEMENT OF RESPONSIBILITY – Nevada Pharmacy FOR Corporations, Partnership or Sole Owners

1. Raul Gonzalez Responsible Person of Advanced Pharmaceutical Consultants, inc hereby acknowledge and understand that in addition to the corporation's, any owner(s), shareholder(s) or partner(s) responsibilities, may be responsible for any violations of pharmacy law that may occur in a pharmacy owned or operated by said corporation.

I further acknowledge and understand that the corporation's, any owner(s), shareholder(s) or partner(s)may be named in any action taken by the Nevada State Board of Pharmacy against a pharmacy owned by or operated by said corporation.

I further acknowledge and understand that the corporation's, any owner(s), shareholder(s) or partner(s) cannot require or permit the pharmacist(s) in said pharmacy to violate any provision of any local, state or federal laws or regulations pertaining to the practice of pharmacy.

Original Signature of Person Authorized to Submit Application, no copies or stamps

Print Name of Authorized Person

4-18-2018 Date

Managing Pharmacist

| Pharmacist Name: | Nathen | Connolly | | License #: | 1954 () |
|-------------------|-------------|------------------|---------|------------------|--------------|
| Pharmacy Name: Co | WORDE TREAT | MENT CENTER, LLC | d/b/a i | DESERT HOPE TREA | TMENT CENTER |

As a managing pharmacist of the above referenced pharmacy, I understand within 48 hours after I report for duty as the managing pharmacist, I shall cause an inventory of all controlled substances of the pharmacy according to the method prescribed by the provision of 21 CFR Part 1304; and cause a copy of the inventory to be on file at the pharmacy.

I understand that as the managing pharmacist I am responsible for compliance by the pharmacy and its personnel with all state and federal laws and regulations relating to the operation of the pharmacy and the practice of pharmacy. I understand my license can be revoked or that I can be the subject of disciplinary action if such laws or regulations are knowingly violated in the pharmacy in which I am managing pharmacist.

I understand that if I cease to be managing pharmacist of the above named pharmacy I will jointly, with the new managing pharmacist, take an inventory of all controlled substances.

| Y | les | No | | | |
|--|-----|----|--|--|--|
| Been diagnosed or treated for any mental illness, including alcohol or substance abuse, or physical condition that would impair your ability to perform the essential functions of your license? | | Ł | | | |
| 1. been charged, arrested or convicted of a felony or misdemeanor in any state? | | Ŕ | | | |
| 2. been the subject of a board citation or an administrative action whether completed or pending in any state? | | 团 | | | |
| 3. had your license subjected to any discipline for violation of pharmacy or drug laws in any state? | | | | | |
| If you marked YES to any of the numbered questions above, please include the following informati | ion | | | | |
| Board Administrative Action: State: Date: | | _ | | | |
| And/or Criminal Action: State: Date: Case #: Case #: | | - | | | |

Page 11a

NEVADA STATE BOARD OF PHARMACY 431 W Plumb Lane – Reno, NV 89509 – (775) 850-1440

APPLICATION FOR NEVADA PHARMACY LICENSE

\$500.00 Fee made payable to: Nevada State Board of Pharmacy

(non-refundable and not transferable money order or cashier's check only)

Application must be printed legibly or typed

Any misrepresentation in the answer to any question on this application is grounds for refusal or denial of the application or subsequent revocation of the license issued and is a violation of the laws of the State of Nevada.

| ■New Pharmacy or □Ownership Change (Provide curre Check <u>box</u> below for type of ownership and complete all re Corporation or Partnership. | |
|---|--|
| Publicly Traded Corporation – Pages 1,2,3,10,11a&b Non Publicly Traded Corporation – Pages 1,2,4,10,11a | Partnership - Pages 1,2,6,10,11a&b &b □ Sole Owner – Pages 1,2,8,10,11a&b |
| GENERAL INFORMATION to be completed by all t | |
| Pharmacy Name: Las Vegas-AMG-Sp | ecialty Hospital, LLC |
| Physical Address: 4015 S. McLeod Dri | ve |
| City: Las Vegas State: N | 1V Zip Code: 89121-4305 |
| Telephone: 102-433-2200 Fax: 10 | 02-862-4435 |
| Toll Free Number:E-mai | l: jmcgee @ angihm.com |
| Website: <u>angregas</u> com | |
| | 1//12 |
| Managing Pharmacist: Lane M. Cheramie | License Number: (6015 |
| Managing Pharmacist: Lane Managing Pharmacist: TYPE OF PHARMACY AND | SERVICES PROVIDED |
| | |
| TYPE OF PHARMACY AND | SERVICES PROVIDED |
| TYPE OF PHARMACY AND Yes/No | SERVICES PROVIDED Yes/No |
| TYPE OF PHARMACY AND Yes/No | SERVICES PROVIDED Yes/No Image: Computive Services |
| TYPE OF PHARMACY AND Yes/No Image: Retail Image: Retail Image: Retail Image: Image: Retail Image: Retail Image: Image: Retail Image: Retail Image: Image: Image: Retail Image: Retail Image: | SERVICES PROVIDED Yes/No Off-site Cognitive Services Parenteral |
| TYPE OF PHARMACY AND Yes/No Image: Retail Image: Image: Pharmace internet Image: Pharmace internet Image: Pharmace internet Image: Pharmace internet | SERVICES PROVIDED Yes/No Image: Off-site Cognitive Services |
| TYPE OF PHARMACY AND Yes/No Image: Constraint of the state of the | SERVICES PROVIDED Yes/No Image: Construct of the services |
| TYPE OF PHARMACY AND Yes/No Image: Constraint of the state of the | SERVICES PROVIDED Yes/No Image: Off-site Cognitive Services Image: Image: Off-site Cognitive Service Image: Image: Off-site Cognitive Service |
| TYPE OF PHARMACY AND Yes/No Image: Retail Image: Retail Image: Retail Image: Retail <t< td=""><td>SERVICES PROVIDED Yes/No Image: Off-site Cognitive Services Image: Off-site Cognitive Service Imag</td></t<> | SERVICES PROVIDED Yes/No Image: Off-site Cognitive Services Image: Off-site Cognitive Service Imag |
| TYPE OF PHARMACY AND Yes/No Image: Retail Image: Retail Image: Retail Image: Retail <t< td=""><td>SERVICES PROVIDED Yes/No Image: Off-site Cognitive Services Image: Off-site Compounding</td></t<> | SERVICES PROVIDED Yes/No Image: Off-site Cognitive Services Image: Off-site Compounding |
| TYPE OF PHARMACY AND Yes/No Image: Constraint of the state of the | SERVICES PROVIDED Yes/No Image: Off-site Cognitive Services Image: Off-site Compounding Image: Off-site Compounding Image: Off-site Compounding |

100896

This page must be submitted for all types of ownership.

Within the last five (5) years:

| 1) | Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been charged, or convicted of a felony or gross misdemeanor (including by way of a guilty plea or no contest plea)? | Yes 🗆 No 📴 |
|----|--|------------|
| 2) | Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been denied a license, permit or certificate of registration? | Yes 🗆 No 🗗 |
| 3) | Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been the subject of an administrative action, board citation, site fine or proceeding relating to the pharmaceutical industry? | Yes 🗆 No 皆 |
| 4) | Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been found guilty, pled guilty or entered a plea of nolo contendere to any offense federal or state, related to controlled substances? | Yes 🗆 No 🖆 |
| 5) | Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever surrendered a license, permit or certificate of registration voluntarily or otherwise (other than upon voluntary close of a facility)? | Yes 🗆 No 🖻 |
| | | |

If the answer to question 1 through 5 is "yes", a signed statement of explanation must be attached. Copies of any documents that identify the circumstance or contain an order, agreement, or other disposition may be required.

I hereby certify that the answers given in this application and attached documentation are true and correct. I understand that any infraction of the laws of the State of Nevada regulating the operation of an authorized pharmacy may be grounds for the revocation of this permit.

I have read all questions, answers and statements and know the contents thereof. I hereby certify, under penalty of perjury, that the information furnished on this application are true, accurate and correct. I hereby authorize the Nevada State Board of Pharmacy, its agents, servants and employees, to conduct any investigation(s) of the business, professional, social and moral background, gualification and reputation, as it may deem necessary, proper or desirable.

Original Signature of Person Authorized to Submit Application, no copies or stamps

August J. Rantz IV Print Name of Authorized Person

05/02/2018

Board Use Only

Date Processed:

| Amount: | \$ 500.00 |
|-------------|--|
| . and a new | and the second |

Page 2

OWNERSHIP IS A PARTNERSHIP. All persons listed as a partner must accurately complete a personal history record form.

| Type of Partnership: | General | / (LLc) Limited | | | |
|-------------------------------------|----------------|--------------------|------------------------------|------|----------------|
| List names of 4 largest partners an | d percentage d | of ownership: | | | |
| Name: August J. Rantz | TV | | _%: | 50 | 21 CHARLES 200 |
| Name: Timothy Howard | L | | _%:_ | 50 | |
| Name: | | | | | |
| Name: | | | | | |
| Partnership Name: Las Vega | s-AMG-S | pecialty Hospital, | LLC | | <u></u> |
| Mailing Address: Loi La R | ue France | . Ste. 100 | Kont une sin germany in itse | | |
| City, State Zip Code: Lafaye | tte LA | 70508 | | | |
| Telephone Number: 337-269 | -9566 | Fax Number: 337- 3 | 269 - | 9823 | |
| Contact Person: Jessica N | NcGee CF | 0 | | | |
| List any physician shareholders an | d percentage o | of ownership. | | | |
| Name: NA | | | %: | , | |
| Name: | | | | | |
| Name: | | | | | |
| Hours of Operation for the pharr | macy: | | | | |
| Monday thru Fridayam | pm | Saturday | | _am | pm |
| Sundayam | pm | 24 Hours | V | | |
| | | | | | |

A Nevada business license is not required, however if the pharmacy has a Nevada business license please provide the number: NV20151121058

STATEMENT OF RESPONSIBILITY – Nevada Pharmacy FOR Corporations, Partnership or Sole Owners

I, _______August J. Rantz, TX Responsible Person of ______Las Vegas -AMG Specialty Hospital_LLC hereby acknowledge and understand that in addition to the corporation's, any owner(s), shareholder(s) or partner(s) responsibilities, may be responsible for any violations of pharmacy law that may occur in a pharmacy owned or operated by said corporation.

I further acknowledge and understand that the corporation's, any owner(s), shareholder(s) or partner(s)may be named in any action taken by the Nevada State Board of Pharmacy against a pharmacy owned by or operated by said corporation.

I further acknowledge and understand that the corporation's, any owner(s), shareholder(s) or partner(s) cannot require or permit the pharmacist(s) in said pharmacy to violate any provision of any local, state or federal laws or regulations pertaining to the practice of pharmacy.

Original Signature of Person Authorized to Submit Application, no copies or stamps

August J. Rantz, II

Print Name of Authorized Person

05/02/2018

Page 10

Managing Pharmacist

| Pharmacist Name: LANE CHERAMIE | | License #: 16613 |
|--------------------------------|----------------------------------|------------------|
| Pharmacy Name: | Las Vegas-AMG Specialty Hospital | , LLC |

As a managing pharmacist of the above referenced pharmacy, I understand within 48 hours after I report for duty as the managing pharmacist, I shall cause an inventory of all controlled substances of the pharmacy according to the method prescribed by the provision of 21 CFR Part 1304; and cause a copy of the inventory to be on file at the pharmacy.

I understand that as the managing pharmacist I am responsible for compliance by the pharmacy and its personnel with all state and federal laws and regulations relating to the operation of the pharmacy and the practice of pharmacy. I understand my license can be revoked or that I can be the subject of disciplinary action if such laws or regulations are knowingly violated in the pharmacy in which I am managing pharmacist.

I understand that if I cease to be managing pharmacist of the above named pharmacy I will jointly, with the new managing pharmacist, take an inventory of all controlled substances.

| Υ | ′es | No |
|--|-----|-----------|
| Been diagnosed or treated for any mental illness, including alcohol or substance abuse, or physical condition that would impair your ability to perform the essential functions of your license? | | |
| 1. been charged, arrested or convicted of a felony or misdemeanor in any state? | | \square |
| 2. been the subject of a board citation or an administrative action whether completed or pending in any state? | | Ŕ |
| 3. had your license subjected to any discipline for violation of pharmacy or drug laws in any state? | | Ŕ |
| If you marked YES to any of the numbered questions above, please include the following information | on | |
| Board Administrative Action: State: Date: | | - |
| And/or Criminal Action: State: Date: Case #: County Court: Court: | | _ |

Page 11a

NEVADA STATE BOARD OF PHARMACY 431 W Plumb Lane – Reno, NV 89509 – (775) 850-1440 APPLICATION FOR NEVADA PHARMACY LICENSE

\$500.00 Fee made payable to: Nevada State Board of Pharmacy

(non-refundable and not transferable money order or cashier's check only) Application must be printed legibly or typed

Any misrepresentation in the answer to any question on this application is grounds for refusal or denial of the application or subsequent revocation of the license issued and is a violation of the laws of the State of Nevada.

| New Pharmacy or Ownership Char Check box below for type of ownership a Corporation or Partnership. Publicly Traded Corporation – Pages Non Publicly Traded Corporation – Pages | nd complete 1,2,3,10,11a ages 1,2,4,1 | e all require a&b 0,11a&b | ed for | ms. **If LLC use Non Public] Partnership - Pages 1,2,6,10,11a&b] Sole Owner – Pages 1,2,8,10,11a&b |
|--|---|---------------------------------|-------------|--|
| GENERAL INFORMATION to be con | mpleted by | y all types | ofo | ownership |
| Pharmacy Name: Nimble Pharmacy | | | | |
| Physical Address: | | | | |
| City: Las Vegas | State: | Nevada | | Zip Code: |
| Telephone: (866) 966-4625 | Fax: _ | 650.889.41 | 99 | |
| Toll Free Number: | | E-mail: ^{lice} | ensing | g@nimblerx.com |
| Website:www.nimblerx.com | | | | |
| Managing Pharmacist: Ralph Fiandra | | | | License Number: <u>8487</u> |
| TYPE OF PHARMACY | AND | SEF | RVIC | ES PROVIDED |
| Yes/No | | Yes | /No | |
| 🛛 🗆 Retail | | | | Off-site Cognitive Services |
| □ ☑ Hospital (# beds _ |) | | ₽F | Parenteral |
| Internet | | | ☑ F | Parenteral (outpatient) |
| 🗆 🗹 Nuclear | | | \square (| Dutpatient/Discharge |
| 🔲 🗹 Ambulatory Surge | ery Center | D | | Mail Service |
| 🗆 🗹 Community | | Ľ | ☑L | ₋ong Term Care |
| □ ☑ Other: | | | \square | Sterile Compounding |
| | | | ØN | Non Sterile Compounding |
| All boxes must be checke | ed | | Ø N | Vail Service Sterile Compounding |
| For the application to be o | complete | | | Other Services: |

100566

This page must be submitted for all types of ownership.

Within the last five (5) years:

| 1) | Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been charged, or convicted of a felony or gross misdemeanor (including by way of a guilty plea or no contest plea)? | Yes 🗆 No 🗹 |
|----|--|------------|
| 2) | Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been denied a license, permit or certificate of registration? | Yes 🗆 No 🗹 |
| 3) | Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been the subject of an administrative action, board citation, site fine or proceeding relating to the pharmaceutical industry? | Yes 🗆 No 🗹 |
| 4) | Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been found guilty, pled guilty or entered a plea of nolo contendere to any offense federal or state, related to controlled substances? | Yes 🗆 No ☑ |
| 5) | Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever surrendered a license, permit or certificate of registration voluntarily or otherwise (other than upon voluntary close of a facility)? | Yes 🗆 No 🗹 |
| | | |

If the answer to question 1 through 5 is "yes", a signed statement of explanation must be attached. Copies of any documents that identify the circumstance or contain an order, agreement, or other disposition may be required.

I hereby certify that the answers given in this application and attached documentation are true and correct. I understand that any infraction of the laws of the State of Nevada regulating the operation of an authorized pharmacy may be grounds for the revocation of this permit.

I have read all questions, answers and statements and know the contents thereof. I hereby certify, under penalty of perjury, that the information furnished on this application are true, accurate and correct. I hereby authorize the Nevada State Board of Pharmacy, its agents, servants and employees, to conduct any investigation(s) of the business, professional, social and moral background, qualification and reputation, as it may deem necessary, proper or desirable.

Taek-

| Original Signature of Person Authorized to Submit Application, no copies or stamps | | | | |
|--|-----------------|--|-------------------------|--|
| Talha Waqar Print Name of Authorized Person | | | 03/27/18 | |
| | | 88.448.644.6 86.686.696.696.696.696.696.699 | Date | |
| Board Use Only | Date Processed: | | Amount: <u>\$500.00</u> | |
| | | Page 2 | | |

OWNERSHIP IS A NON PUBLICY TRADED CORPORATION

| OWNERSHIP IS A NON PUBLICT TR | ADED CONFORTION |
|---|--|
| State of Incorporation: | |
| Parent Company if any: | |
| Mailing Address:1134 Crane St. Ste. 10 | 0 |
| City:Menlo Park | State:CA Zip:94025 |
| Telephone: (866) 966-4625 | Fax:650.889.4199 |
| Contact Person:Eva Ong | |
| For any corporation non publicly traded | d, disclose the following: |
| 1) List top 4 persons to whom the | shares were issued by the corporation? |
| a) Talha Waqar | 1134 Crane St. Ste 100, Menlo Park, CA 94025 |
| Name | Business Address |
| b) Name | Business Address |
| c) Name | Business Address |
| d) | |
| Name | Business Address |
| 2) Provide the number of shares is | ssued by the corporation |
| 3) What was the price paid per sha | are? |
| List any physician shareholders and po | ercentage of ownership. |
| | %: |
| | %: |
| Hours of Operation for the pharmac | |
| Monday thru Fridayam5 | pm Saturday ampm |
| Sundayam | pm 24 Hours |

A Nevada business license is not required, however if the pharmacy has a Nevada business license please provide the number:

STATEMENT OF RESPONSIBILITY – Nevada Pharmacy FOR Corporations, Partnership or Sole Owners

I, Talha Waqar

Responsible Person of Nimble Pharmacy

hereby acknowledge and understand that in addition to the corporation's, any owner(s), shareholder(s) or partner(s) responsibilities, may be responsible for any violations of pharmacy law that may occur in a pharmacy owned or operated by said corporation.

I further acknowledge and understand that the corporation's, any owner(s), shareholder(s) or partner(s)may be named in any action taken by the Nevada State Board of Pharmacy against a pharmacy owned by or operated by said corporation.

I further acknowledge and understand that the corporation's, any owner(s), shareholder(s) or partner(s) cannot require or permit the pharmacist(s) in said pharmacy to violate any provision of any local, state or federal laws or regulations pertaining to the practice of pharmacy.

lag

Original Signature of Person Authorized to Submit Application, no copies or stamps

Talha Waqar

Print Name of Authorized Person

03/27/18

Date

Managing Pharmacist

Pharmacist Name:

| lican | "H FIANDRA |
|-------|------------|
| | |

License #: 08487

Pharmacy Name: _

As a managing pharmacist of the above referenced pharmacy, I understand within 48 hours after I report for duty as the managing pharmacist, I shall cause an inventory of all controlled substances of the pharmacy according to the method prescribed by the provision of 21 CFR Part 1304; and cause a copy of the inventory to be on file at the pharmacy.

I understand that as the managing pharmacist I am responsible for compliance by the pharmacy and its personnel with all state and federal laws and regulations relating to the operation of the pharmacy and the practice of pharmacy. I understand my license can be revoked or that I can be the subject of disciplinary action if such laws or regulations are knowingly violated in the pharmacy in which I am managing pharmacist.

I understand that if I cease to be managing pharmacist of the above named pharmacy I will jointly, with the new managing pharmacist, take an inventory of all controlled substances.

| | Yes | No | | |
|--|-----|----|--|--|
| Been diagnosed or treated for any mental illness, including alcohol or substance abuse, or physical condition that would impair your ability to perform the essential functions of your license? | | X | | |
| 1. been charged, arrested or convicted of a felony or misdemeanor in any state? | | ĠV | | |
| 2. been the subject of a board citation or an administrative action whether completed or pending in any state? | | 这 | | |
| 3. had your license subjected to any discipline for violation of pharmacy or drug laws in any state? | | R | | |
| If you marked YES to any of the numbered questions above, please include the following information | | | | |
| Board Administrative Action: State: Date: | | _ | | |
| And/or Criminal Action: State: Date: Case #: Case #: | | | | |

Page 11a

NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane - Reno, NV 89509 - (775) 850-1440

APPLICATION FOR NEVADA PHARMACY LICENSE

\$500.00 Fee made payable to: Nevada State Board of Pharmacy

(non-refundable and not transferable money order or cashier's check only)

Application must be printed legibly or typed

Any misrepresentation in the answer to any question on this application is grounds for refusal or denial of the application or subsequent revocation of the license issued and is a violation of the laws of the State of Nevada.

| More than the second s | ent license number if making changes: PH equired forms. **If LLC use Non Public |
|---|---|
| □ Publicly Traded Corporation – Pages 1,2,3,10,11a&b | □ Partnership - Pages 1,2,6,10,11a&b |
| Von Publicly Traded Corporation - Pages 1,2,4,10,11a | |
| GENERAL INFORMATION to be completed by all t | types of ownership |
| Pharmacy Name: Silvee State Pilde | esay UC |
| Physical Address: 1074 Dove Cengle | |
| City: <u>AS VEGAS</u> State: | |
| Telephone: (703) 335 1990 Fax: | · · · · · · · · · · · · · · · · · · · |
| Toll Free Number:E-ma | il: Silver STATEPHARMACLE g.S.L.). col |
| Website: | |
| Managing Pharmacist: KJE009 KADG | License Number: _/CCS/ |
| TYPE OF PHARMACY AND | SERVICES PROVIDED |
| Yes/No | Yes/No |
| 🔀 🗆 Retail | □ 🗹 Off-site Cognitive Services |
| □ 🗗 Hospital (# beds) | Image: Second |
| □ 12 Internet | □ |
| □ 12 Nuclear | □ ☑ Outpatient/Discharge |
| Ø Ambulatory Surgery Center | Mail Service |
| □ ⊠ Community | □ 🕅 Long Term Care |
| □ S Other: | Kerile Compounding |
| | □ ☑ Non Sterile Compounding |
| All boxes must be checked | Kail Service Sterile Compounding |
| For the application to be complete | We Other Services: |
| | |



May/04/2018

Hello Miss Candy

My name is Lizet Torres Leon, I'm applying for a new Pharmacy (Silver State Pharmacy LLC) this is my business location

1591 N. Buffalo Dr #140, Las Vegas, NV, 89128

Thank You very much

Lizet Torres Leon

This page must be submitted for all types of ownership.

Within the last five (5) years:

| 1) | Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been charged, or convicted of a felony or gross misdemeanor (including by way of a guilty plea or no contest plea)? | Yes | No | à |
|----|--|-----|----|--------|
| 2) | Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been denied a license, permit or certificate of registration? | Yes | No | M |
| 3) | Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been the subject of an administrative action, board citation, site fine or proceeding relating to the pharmaceutical industry? | Yes | No | Ø |
| 4) | Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been found guilty, pled guilty or entered a plea of nolo contendere to any offense federal or state, related to controlled substances? | Yes | No | A |
| 5) | Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever surrendered a license, permit or certificate of registration voluntarily or otherwise (other than upon voluntary close of a facility)? | Yes | No | N N |

If the answer to question 1 through 5 is "yes", a signed statement of explanation must be attached. Copies of any documents that identify the circumstance or contain an order, agreement, or other disposition may be required.

I hereby certify that the answers given in this application and attached documentation are true and correct. I understand that any infraction of the laws of the State of Nevada regulating the operation of an authorized pharmacy may be grounds for the revocation of this permit.

I have read all questions, answers and statements and know the contents thereof. I hereby certify, under penalty of perjury, that the information furnished on this application are true, accurate and correct. I hereby authorize the Nevada State Board of Pharmacy, its agents, servants and employees, to conduct any investigation(s) of the business, professional, social and moral background, qualification and reputation, as it may deem necessary, proper or desirable.

T

Original Signature of Person Authorized to Submit Application, no copies or stamps

Lizer TOPPES LEOD Print Name of Authorized Person

03/19/2018 Date

| Board | llse | Only |
|-------|------|------|
| Doala | 030 | Unit |

Date Processed: _____

OWNERSHIP IS A NON PUBLICY TRADED CORPORATION

| State of Incorporation: | Derasa | |
|-----------------------------|---------------------------------------|---|
| Parent Company if any: | | |
| Mailing Address:う | L'Dove Engle CT | |
| City: LAS VEGAS | State: <u>State</u> Zip: <u>P5183</u> | |
| Telephone: (<u>)00) 33</u> | 5/980 Fax: | · |
| Contact Person: | ET TORRES LEOD | |

For any corporation non publicly traded, disclose the following:

1) List top 4 persons to whom the shares were issued by the corporation?

| | a) \sim/\checkmark | |
|--------|---|---|
| | Name | Business Address |
| | b)\ | |
| | Name | Business Address |
| | c)\ | |
| | Nante | Business Address |
| | d)(b | |
| | Name | Business Address |
| 2) | Provide the number of shares issued | by the corporation. |
| 3) | What was the price paid per share? _ | ø – – – – – – – – – – – – – – – – – – – |
| | | / |
| List a | ny physician shareholders and percenta | age of ownership. |
| Name | | %: |
| Name | : <u> </u> | %:% |
| Hours | s of Operation for the pharmacy: | |
| Mond | ay thru Friday <u>9.00</u> am <u>600</u> pm | Saturday closes am closes pm |
| | Sunday <u>closes</u> am <u>closes</u> om | 24 Hours 🖂 🗹 |
| | rada business license is not required b | , , , , , , , , , , , , , , , , , , , |

A Nevada business license is not required, however if the pharmacy has a Nevada business license please provide the number: <u>ヘン みり りり うり うし</u>

STATEMENT OF RESPONSIBILITY – Nevada Pharmacy FOR Corporations, Partnership or Sole Owners

1, L'ZET TORRES LEOD Responsible Person of Silver STATE PLARACY LC hereby acknowledge and understand that in addition to the corporation's, any owner(s), shareholder(s) or partner(s) responsibilities, may be responsible for any violations of pharmacy law that may occur in a pharmacy owned or operated by said corporation.

I further acknowledge and understand that the corporation's, any owner(s), shareholder(s) or partner(s)may be named in any action taken by the Nevada State Board of Pharmacy against a pharmacy owned by or operated by said corporation.

I further acknowledge and understand that the corporation's, any owner(s), shareholder(s) or partner(s) cannot require or permit the pharmacist(s) in said pharmacy to violate any provision of any local, state or federal laws or regulations pertaining to the practice of pharmacy.

Original Signature of Person Authorized to Submit Application, no copies or stamps

Print Name of Authorized Person

03/19/2018

Managing Pharmacist

| Pharmacist Name: | Kyeong Kang | License #: /668/ |
|------------------|--------------|------------------|
| Pharmacy Name: _ | Silver State | Prisalsay UC |

As a managing pharmacist of the above referenced pharmacy, I understand within 48 hours after I report for duty as the managing pharmacist, I shall cause an inventory of all controlled substances of the pharmacy according to the method prescribed by the provision of 21 CFR Part 1304; and cause a copy of the inventory to be on file at the pharmacy.

I understand that as the managing pharmacist I am responsible for compliance by the pharmacy and its personnel with all state and federal laws and regulations relating to the operation of the pharmacy and the practice of pharmacy. I understand my license can be revoked or that I can be the subject of disciplinary action if such laws or regulations are knowingly violated in the pharmacy in which I am managing pharmacist.

I understand that if I cease to be managing pharmacist of the above named pharmacy I will jointly, with the new managing pharmacist, take an inventory of all controlled substances.

| Been diagnosed or treated for any mental illness, including alcohol or substance abuse, or | Yes | No | |
|---|-----|----------|--|
| physical condition that would impair your ability to perform the essential functions of your license? | | tt / | |
| 1. been charged, arrested or convicted of a felony or misdemeanor in any state? | | P | |
| been the subject of a board citation or an administrative action whether completed or pending in any state? | | M | |
| 3. had your license subjected to any discipline for violation of pharmacy or drug laws in any state? | | M | |
| If you marked YES to any of the numbered questions above, please include the following information | | | |
| Board Administrative Action: State: Date: Case #: | | | |
| And/or Criminal Action: State: Date: Case #: County Court: | | | |

Page 11a