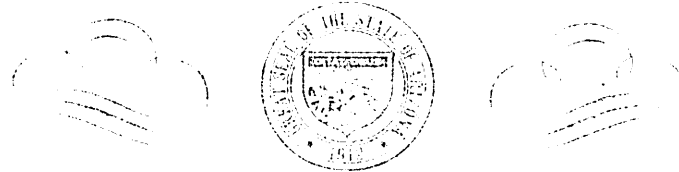


PROPERTY OF THE  
**ARIZONA DEPARTMENT OF HEALTH SERVICES**



**Devon Gables Rehabilitation Center, Llc, dba  
Devon Gables Rehabilitation Center  
6150 East Grant Road  
Tucson, AZ 85712**

**This facility is licensed to operate as a NURSING CARE INSTITUTION**

**Total Capacity: 312**

**From: August 1, 2017**

**To: July 31, 2018**

**Issued: June 20, 2017**

A handwritten signature in black ink, reading "Diane Eckles", written over a horizontal line.

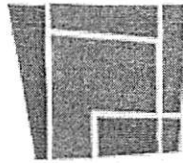
**Recommended By: Diane Eckles, Bureau Chief**

**License: NCI-2652**

A handwritten signature in black ink, reading "Colby Bower", written over a horizontal line.

**Issued By: Colby Bower, Assistant Director**

PURSUANT TO A.R.S. §41-1092.11 (A), UPON SUBMITTAL OF A TIMELY AND SUFFICIENT APPLICATION  
THIS LICENSE WILL REMAIN IN EFFECT UNTIL REISSUED OR REVOKED  
TO BE FRAMED AND DISPLAYED IN A CONSPICUOUS PLACE



ARIZONA DEPARTMENT  
OF HEALTH SERVICES

LICENSING

June 20, 2017

Heather Friebus, Administrator  
Devon Gables Rehabilitation Center  
6150 East Grant Road  
Tucson, AZ 85712

Dear Ms. Friebus:

Enclosed is Nursing Care Institution license number Nci-2652, which authorizes your facility to operate 312 beds. In accordance with A.R.S. § 36-407(C), this license is only valid for the location indicated on the license. Please note the expiration date on your license.

Please be advised that A.R.S. § 36-425(A) requires this license to be conspicuously posted in the reception area of your facility. In addition, A.R.S. § 36-422(D) requires the Department to be notified of a change of ownership at least thirty (30) days prior to the effective date.

The Department has also completed an administrative completeness review of the renewal application and documents you submitted and determined that the application and documents are administratively complete and in compliance with licensing requirements.

Should you have any questions or concerns, please contact the Bureau of Long Term Care at (602) 364-2690.

Sincerely,

A handwritten signature in cursive script that reads "Diane Eckles".

Diane Eckles  
Bureau Chief

DE/SGM

Enclosure

Douglas A. Ducey | Governor    Cara M. Christ MD, MS | Director

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150 North 18th Avenue, Suite 440, Phoenix, AZ 85007-3247    P | 602-364-2690    F | 602-324-0993

W | [azhealth.gov](http://azhealth.gov)

*Health and Wellness for all Arizonans*



# RENEWAL LICENSE APPLICATION FOR A HEALTH CARE INSTITUTION

ARIZONA DEPARTMENT OF HEALTH SERVICES

PUBLIC HEALTH LICENSING SERVICES – BUREAU OF LONG TERM CARE FACILITIES LICENSING

In accordance with A.R.S. §41-1030

B. An agency shall not base a licensing decision in whole or in part on a licensing requirement or condition that is not specifically authorized by statute, rule or state tribal gaming compact. A general grant of authority in statute does not constitute a basis for imposing a licensing requirement or condition unless a rule is made pursuant to that general grant of authority that specifically authorizes the requirement or condition.

D. This section may be enforced in a private civil action and relief may be awarded against the state. The court may award reasonable attorney fees, damages and all fees associated with the license application to a party that prevails in an action against the state for a violation of this section.

E. A state employee may not intentionally or knowingly violate this section. A violation of this section is cause for disciplinary action or dismissal pursuant to the Agency's adopted personnel policy.

F. This section does not abrogate the immunity provided by section 12-820.01 or 12-820.02.

## I. HEALTH CARE INSTITUTION INFORMATION

Name of Health Care Institution: <b>DEVON GABLES REHABILITATION CENTER</b>		License No. <b>NCI-2652</b>							
Mailing Address: <b>6150 EAST GRANT ROAD</b>									
City: <b>TUCSON</b>	State: <b>AZ</b>	Zip Code: <b>85712</b>							
Phone No. <b>(520) 296-6181</b>	Fax No. <b>(520) 298-0997</b>	E-mail: <b>hfriabus@devongables.com</b>							
Class: <b>Nursing Care Institution</b>									
What is the health care institution's scope of service: <b>Skilled Nursing, Sub-Acute, Alzheimer Secured, Behavioral Secured</b>									
Health care institution's days and hours of operation: <table style="width: 100%; border: none;"> <tr> <td style="text-align: center;">Sun 24/7</td> <td style="text-align: center;">Mon 24/7</td> <td style="text-align: center;">Tues 24/7</td> <td style="text-align: center;">Wed 24/7</td> <td style="text-align: center;">Thurs 24/7</td> <td style="text-align: center;">Fri 24/7</td> <td style="text-align: center;">Sat 24/7</td> </tr> </table>			Sun 24/7	Mon 24/7	Tues 24/7	Wed 24/7	Thurs 24/7	Fri 24/7	Sat 24/7
Sun 24/7	Mon 24/7	Tues 24/7	Wed 24/7	Thurs 24/7	Fri 24/7	Sat 24/7			
Is health care institution accredited? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
Name of accrediting organization (must be from a nationally recognized organization):									
Is health care institution requesting certification under Title XIX of the Social Security Act? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO									



**RENEWAL LICENSE APPLICATION FOR A HEALTH CARE INSTITUTION**  
ARIZONA DEPARTMENT OF HEALTH SERVICES  
PUBLIC HEALTH LICENSING SERVICES – BUREAU OF LONG TERM CARE FACILITIES LICENSING

**II. OWNER INFORMATION**

Owner's Name: DEVON GABLES REHABILITATION CENTER, LLC

Street Address: 2201 MAIN STREET

City: EVANSTON State: IL Zip Code: 60202

Phone No. (847) 905-4000 Fax No. (847) 905-4040

The owner is a (select one):

<input type="checkbox"/> Sole proprietorship	<input type="checkbox"/> Corporation	<input type="checkbox"/> Partnership
<input checked="" type="checkbox"/> Limited liability partnership	<input type="checkbox"/> Limited liability company	<input type="checkbox"/> Governmental agency

If the owner is a partnership or a limited liability partnership, the name of each partner;  
If the owner is a limited liability company, the name of the designated manager or, if no manager is designated, the names of any two members of the limited liability company;  
If the owner is a corporation, the name and title of each corporate officer; or  
If the owner is a governmental agency, the name and title of the individual in charge of the governmental agency or the name of an individual in charge of the health care institution designated in writing by the individual in charge of the governmental agency:

Name: William Rothner	Title: Manager
Name: Steve Miretzky	Title: Manager
Name:	Title: Manager

Has the owner or any person with 10% or more business interest in the health care institution had a license to operate a health care institution denied, revoked, or suspended since the previous license application was submitted?

YES  NO

If yes, indicate:  
The reason for denial, revocation, or suspension:

The date of the denial, revocation, or suspension:

The name and address of the licensing agency that denied, revoked, or suspended the license:





**RENEWAL LICENSE APPLICATION FOR A HEALTH CARE INSTITUTION**  
 ARIZONA DEPARTMENT OF HEALTH SERVICES  
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**V. CHIEF ADMINISTRATIVE OFFICER**

Name: Heather Friebus	Title: Administrator
Highest Educational Degree: Bachelor of Science Nutritional Sciences	
Work experience related to the health care institution class or subclass related to licensing requested: Devon Gables Rehabilitation Center Administrator 2012-Present, Devon Gables Health Care administrator 2007-2012, Devon Gables Health Care Center Assistant Administrator, RD, Dietary 1992-2012	

**VI. SIGNATURES**

1. If the applicant is an individual, the owner of the health care institution.	
2. If the applicant is a partnership or corporation, two of the partnership's or corporation's officers.	
3. If the applicant is a governmental agency, the head of the governmental agency.	
William Rothner _____ Signature	Manager _____ Title
Steve Miretzky _____ Signature	Manager _____ Title

**VII. ADDITIONAL DOCUMENTATION**

If the health care institution is located in a leased facility, submit a copy of the lease showing the rights and responsibilities of the parties and exclusive rights of possession of the leased facility. <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
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