

LTC 31

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, 2016

To: July 31, 2017

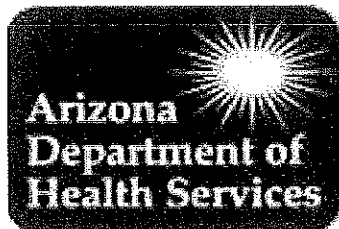
Issued: June 3, 2016

Joel Bunnis
Recommended By: Joel Bunnis, Bureau Chief

License: NCI-2652

Colby Bower
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



Public Health Licensing Services
Bureau of Long Term Care Licensing
150 North 18th Avenue, Suite 440
Phoenix, Arizona 85007-3242
(602) 364-2690 Office
(602) 324-0993 Fax

DOUGLAS A. DUCEY, GOVERNOR
CARA M. CHRIST, MD, DIRECTOR

June 3, 2016

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 "Joel Bunis".

Joel Bunis, MBA
Bureau Chief

JB:ib

Enclosure

LTC 31 Bed's APP 8-1-16
31Z 2027 7-31-17



**HEALTH CARE INSTITUTION
SERVICES PROVIDED**
ARIZONA DEPARTMENT OF HEALTH SERVICES
PUBLIC HEALTH LICENSING SERVICES - LONG TERM CARE FACILITIES

Name of Health Care Institution: Devon Gables Rehabilitation Center LLC License No. NCI-2652

Street Address: 6150 East Grant Road

City: Tucson State: Arizona Zip Code: 85712

Mailing Address: 6150 East Grant Road

City: Tucson State: Arizona Zip Code: 85712

Article 4

Currently Licensed as: Nursing Care Institution And Requesting Authorization to Provide:

- Behavioral health services
 1. Do you employ or contract your Behavioral Health Professionals? Yes - Employ Yes - Contract
 2. Do you employ Behavioral Health Technicians and/or Behavioral Health Para Professionals? Yes No
- Clinical laboratory services
- Dialysis services
- Radiology services and diagnostic imaging services

Authorized Manager or Administrator Signature

Manager
Title

Authorized Manager or Administrator Signature

Manager
Title



RENEWAL LICENSE APPLICATION FOR A HEALTH CARE INSTITUTION

ARIZONA DEPARTMENT OF HEALTH SERVICES

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

I. HEALTH CARE INSTITUTION INFORMATION

Name of Health Care Institution:	<u>Devon Gables Rehabilitation Center LLC</u>	License No.	<u>NCI-2652</u>		
Mailing Address:	<u>6150 East Grant Road</u>				
City:	<u>Tucson</u>	State:	<u>Arizona</u>	Zip Code:	<u>85712</u>
Phone No.	<u>520-296-6181</u>	Fax No.	<u>520-298-0997</u>	E-mail:	<u>hfriebus@devongables.com</u>

Class: <u>Nursing Care Institution</u>
What is the health care institution's scope of practice: <u>Skilled Nursing, Sub-Acute, Alzheimer Secured, Behavioral Secured</u>
Health care institution's days and hours of operation: Sun <u>24/7</u> Mon <u>24/7</u> Tues <u>24/7</u> Wed <u>24/7</u> Thurs <u>24/7</u> Fri <u>24/7</u> Sat <u>24/7</u>
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): _____
SUBMIT, if applicable, a copy of the full accreditation report and cover letter.
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: Illinois Zip Code: 60202

Phone No. 847-261-2400 Fax No. 847-261-2410

The owner is a (select one):

Sole proprietorship Corporation Partnership

Limited liability partnership Limited liability company 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: _____

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

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

Has the owner or any person with 10% or more business interest in the health care institution had a health care professional license or certificate 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 or certification:

Does the applicant agree to allow the Department to submit supplemental requests for information under A.A.C. R9-10-108(C)(2)? YES NO

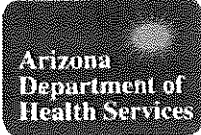
SUBMIT applicable fees required by R9-10-106. All fees are non-refundable except as provided in A.R.S. § 41-1077.

III. STATUTORY AGENT OR INDIVIDUAL WHO ACCEPTS SERVICE OF PROCESS AND SUBPOENAS

Name: <u>CSB Service Entity, LLC</u>	Title: <u>Statutory Agent</u>	
Street Address: <u>2800 N. Central Avenue Suite 1200</u>		
City: <u>Phoenix</u>	State: <u>Arizona</u>	Zip Code: <u>85004</u>
Phone No. <u>602-224-0999</u>		

IV. GOVERNING AUTHORITY

Name: <u>Devon Gables Rehabilitation Center LLC</u>		
Street Address: <u>2201 Main Street</u>		
City: <u>Evanston</u>	State: <u>Illinois</u>	Zip Code: <u>60202</u>



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V. CHIEF ADMINISTRATIVE OFFICER

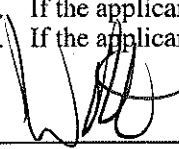
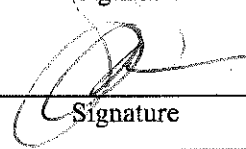
Name: Heather Friebus Title: Administrator

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 Health Care Center Administrator 2007-2012 Devon Gables Rehabilitation Center Administrator 2012-Present

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.

 <hr style="border: 0; border-top: 1px solid black;"/> Signature	<u>Manager</u> <hr style="border: 0; border-top: 1px solid black;"/> Title
 <hr style="border: 0; border-top: 1px solid black;"/> Signature	<u>Manager</u> <hr style="border: 0; border-top: 1px solid black;"/> 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.

Does the licensee have an accreditation report from a nationally recognized accrediting organization? YES NO

If yes, SUBMIT a copy of the health care institution's current accreditation report from a nationally recognized accrediting organization