DEPARTMENT OF HEALTH AND HUMAN SERVICES — CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: EJE1XK

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: LTC0053

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) 035099

2. STATE VENDOR OR MEDICAID NO.
(L2) 835118

3. NAME AND ADDRESS OF FACILITY
(L3) **SAPPHIRE OF TUCSON NURSING AND REHAB, LLC**
(L4) **2900 EAST MILBER STREET**
(L5) **TUCSON, AZ** (L6) **85714**

4. TYPE OF ACTION: 4 (L8)

1. Initial
2. Recertification
3. Termination
4. CHOW
5. Validation
6. Complaint
7. On-Site Visit
9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) 08/17/2018

6. DATE OF SURVEY (L34)

8. ACCREDITATION STATUS: 3 (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

| | | | | |
|---|---|---|---|---|
| 01 Hospital | 05 HHA | 09 ESRD | 13 PTIP | 22 CLIA |
| 02 SNF/NF/Dual | 06 PRTF | 10 NF | 14 CORF | |
| 03 SNF/NF/Distinct | 07 X-Ray | 11 ICF/IID | 15 ASC | |
| 04 SNF | 08 OPT/SP | 12 RHC | 16 HOSPICE | |

FISCAL YEAR ENDING DATE: (L35)
12/31

11. LTC PERIOD OF CERTIFICATION
From (a):
To (b):

12. Total Facility Beds 240 (L18)

13. Total Certified Beds 240 (L17)

10. THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
___ 1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: A* (L12)

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | 240 | | | |
| (L37) | (L38) | (L39) | (L42) | (L43) |

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
ADHS has approved the facilities requested for the Change of Ownership, effective August 17, 2018

17. SURVEYOR SIGNATURE Date: (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Sharlyn Gilliland PPSII (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above:

22. ORIGINAL DATE OF PARTICIPATION (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY 00
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
01101 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

October 10, 2018

ATTN: ELISHA ATKIN
SAPPHIRE OF TUCSON NURSING AND REHAB LLC
9100 KARLOV AVE
SKOKIE IL 60076-1718

Reference # 1249346729

Dear Elisha,

Noridian has assessed your change of ownership application and has forwarded it to the State of Arizona. A copy has also been sent to the CMS San Francisco Regional Office of the Centers for Medicare & Medicaid Services (CMS). Once the CMS Regional Office completes its final review of your application, we will send you our decision.

| | |
|---|---|
| Date 855A Recommended for Approval | October 10, 2018 |
| NPI Number | 1912400755 |
| Provider Transaction Access Number (PTAN) | 03-5099 |
| Type of Enrollment Transaction | Buyer CHOW |
| CHOW effective date | August 17, 2018 |
| MAC Contractor/Intermediary Number | 3101 |
| Representative Direct Phone Number | (701) 715-9453 |
| MAC Contractor/Intermediary Phone Number | JF Office 1-877-908-8431 |
| Action Taken | Recommend Approval pending RO decision |
| Type of Facility | SNF |
| Practice Location: | 2900 E MILBERT ST<br>TUCSON AZ 85714-2097 |
| Buyer | SAPPHIRE OF TUCSON NURSING AND REHAB LLC |

| | |
|---|---|
| Seller | AVALON CARE CENTER-TUCSON, LLC dba AVALON SOUTHWEST HEALTH AND REHABILITATION |
| Requested Year End Cost Report Date | 12/31 |

If you have any questions concerning this letter, please contact the State of Arizona at 602-364-2690.

Sincerely,
Jenna H
Part A Provider Enrollment
Noridian Healthcare Solutions, LLC

cc: Copy of 855A and all documentation to State of Arizona.
Centers for Medicare and Medicaid Services: Copy of recommendation letter to Ariana Honeycutt.

August 20, 2018

**Receipt Of This Notice Is Presumed To Be 08/20/2018**
**Important Notice - Please Read Carefully**

Mr. William Amoureux, Administrator,
Sapphire Of Tucson Nursing And Rehab, Llc
2900 East Milber Street
Tucson, AZ 85714

Dear Mr. Amoureux:

Per your request, enclosed is an amended Nursing Care Institution license number Nci-2643 which reflects the recent name change of your facility from "Avalon Southwest Health and Rehabilitation" to "Sapphire of Tuscon Nursing and Rehab, LLC", effective August 17, 2018. This license limits the bed capacity of your facility to 240 and will expire July 31, 2019. In accordance with A.R.S. § 36-407(C), this license is only valid for the location indicated on the 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.

We have also updated our Medicare records to reflect this name change.

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

Sincerely,

Diane Eckles

Diane Eckles,
Bureau Chief

DE\bh

Enclosure
cc: State Borad of Nursing
AHCCCS

PROPERTY OF THE

# ARIZONA DEPARTMENT OF HEALTH SERVICES

Sapphire Of Tucson Nursing And Rehab, Llc, dba
Sapphire Of Tucson Nursing And Rehab, Llc
2900 East Milber Street
Tucson, AZ 85714

This facility is licensed to operate as a NURSING CARE INSTITUTION

Total Capacity: 240

From: August 17, 2018 To: July 31, 2019

Issued: August 20, 2018

Recommended By: Diane Eckles, Bureau Chief

License: NCI-2643

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

# INITIAL 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: Sapphire of Tucson Nursing & Rehab, LLC Tax ID No. 82-4641520

Street Address: 2900 E. Milber St.

City: Tucson State: AZ Zip Code: 85714

Mailing Address: 2900 E. Milber St.

City: Tucson State: AZ Zip Code: 85714

Phone No. 520-294-0005 Fax No. 520-294-0076 E-mail: ______

Class: Nursing Care Institution

If a facility that is not required to comply with A.A.C. R9-1-412, indicate licensed capacity: 240

Is the health care institution located within ¼ mile of agricultural land? ☐YES ☒NO
If yes, the name and address of each owner or lessee of agricultural land regulated under A.R.S. § 3-365.

Name of owner or lessee of agricultural land: ______
Street Address: ______
City: ______ State: ______ Zip Code: ______

Name of owner or lessee of agricultural land: ______
Street Address: ______
City: ______ State: ______ Zip Code: ______

SUBMIT, for each owner or lessee identified, a copy of the written agreement between the applicant and the owner or lessee of the agricultural land as prescribed in A.R.S. § 36-421(D).

RECEIVED
APR 09 2018
ADHS BUREAU OF MEDICAL FACILITIES LICENSING

Is the health care institution located in a leased facility? ☒ YES ☐ NO

If yes, provide a copy of the lease showing the rights and responsibilities of the parties and exclusive rights of possession of the leased facility.

Is the health care institution ready for a licensing inspection by the Department? ☒ YES ☐ NO

If no, indicate the date the health care institution will be ready for a licensing inspection: ____________________

Health care institution's days and hours of operation:
Sun 24 hrs Mon 24 hrs Tues 24 hrs Wed 24 hrs Thurs 24 hrs Fri 24 hrs Sat 24 hrs

Is health care institution accredited? ☐ YES ☒ 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? ☒ YES ☐ NO

II. OWNER INFORMATION

The owner is a (select one):

☐ Sole proprietorship ☐ Corporation ☐ Partnership

☐ Limited liability partnership ☒ Limited liability company ☐ Governmental agency

Owner's Name: Sapphire of Tucson Nursing and Rehab, L.L.C.

Street Address: 3901 Glenview Road

City: Glenview State: IL Zip Code: 60025-2467

Phone No. (847)812-3648 Fax #: ____________ Email: kishmere1@aol.com

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: Elisha Atkin Title: Member

Name: Yehoshua Seif Title: Member

Name: ______________________ Title: ______________________

SUBMIT, if applicable, a copy of the owner's articles of incorporation, partnership or joint venture documents, or limited liability documents.

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? ☐ 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 :

______________________________________________

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? ☐ 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:

______________________________

What is the health care institution's proposed scope of services?

skilled nursing services, including post-acute rehabilitation, wound care, clinical lab services, behavioral health, memory care, respiratory care, diagnostic imaging & radiology services, and 24-hour long-term skilled nursing

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

## III. SUPPLEMENTAL APPLICATION – NURSING CARE INSTITUTIONS

Does the nursing care institution have a secured area for a resident with Alzheimer's disease or other dementia?

☒ YES ☐ NO

Does the nursing care institution have an area for a resident on a ventilator?

☐ YES ☒ NO

Services provided (select all those that apply):

■ Behavioral Health Services ■ Radiology Services and Diagnostic Imaging Services ■ Respiratory Care Services
■ Clinical Laboratory Services ■ Rehabilitation Services ☐ Dialysis Services

If applicable, name of the individual in charge of proposed nutrition and feeding assistant training program:

For each topic listed below, provide the information presented for each, the amount of time allotted to each, the skills an individual is expected to acquire for each, the testing method used to verify an individual has acquired the stated skills for each, and copies of the materials used during training in each:

a. Feeding techniques;
b. Assistance with feeding and hydration;
c. Communication and interpersonal skills;
d. Appropriate responses to resident behavior;
e. Safety and emergency procedures, including the Heimlich maneuver
f. Infection control;
g. Resident rights;
h. Recognizing a change in a resident that is inconsistent with the resident's normal behavior; or
i. Reporting a change in subsection (h) to a nurse at a nursing care institution.

## IV. FEES

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

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

Name: CT Corporation System Title: N/A

Street Address: 3800 North Central Ave., Suite 460

City: Phoenix State: AZ Zip Code: 85012

Phone No. (602)234-9600

## VI. GOVERNING AUTHORITY

Name: Elisha Atkin and Yehoshua Seif

Street Address: 3901 Glenview Road

City: Glenview State: IL Zip Code: 60025-2467

# INITIAL LICENSE APPLICATION FOR A HEALTH CARE INSTITUTION

ARIZONA DEPARTMENT OF HEALTH SERVICES

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

## VII. CHIEF ADMINISTRATIVE OFFICER

Name: William Amoureux    Title: Administrator

Highest Educational Degree: Master of Public Health, Univ. of Utah 1987

Work experience related to the health care institution class or subclass related to licensing requested:

Mr. Amoureux has served since Sept. 2000 as licensed Administrator for SNF's with bed counts ranging from 70 to 178 in AZ, NV, ID and NM. Resume attached.

## VIII. SIGNATURES

A.R.S. §36-422(B) states an initial licensing application filed shall contain the written or electronic signature of:

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.

| Signature | Title |
|---|---|
| [signature] | MEMBER |
| [signature] | Member |

## IX. ADDITIONAL DOCUMENTATION

Is the health care institution required to comply with physical plant codes and standards incorporated by reference in A.A.C. R9-1-412?

☐ YES ■ NO

If yes, provide documentation of the health care institution's architectural plans and specifications approval in R9-10-104. If no, provide one of the following:

- Documentation from the local jurisdiction of compliance with local building codes and zoning ordinances; or
- If documentation from the local jurisdiction is not available, documentation of the unavailability of the local jurisdiction compliance and documentation of a general contractor's inspection of the facility that states the facility is safe for occupancy as the applicable health care institution class or subclass;
- The licensed capacity requested by the applicant for the health care institution: 240
- If applicable, the licensed occupancy requested by applicant: 240
- A site plan showing each facility, the property lines of the health care institution, each street and walkway adjacent to the health care institution, parking for the health care institution, fencing and each gate on the health care institution premises, and if applicable, each swimming pool on the health care institution premises; and
- A floor plan showing, for each story of a facility, the room layout, room usage, each door and each window, plumbing fixtures, each exit, and the location of each fire protection device.

RECEIVED
MAR 15 2018
By

March 14, 2018

Shoalynn Gilliland-McCleery
Arizona Department of Health Services
Bureau of Long Term Care Licensing
150 North 18th Avenue
Phoenix, AZ 85007

Dear Shoalynn,

The purpose of this letter is to provide the Department of Health Services with notification that a Change of Ownership is being planned for Avalon Southwest Health & Rehabilitation, a skilled nursing facility located in Tucson.

The transfer of ownership is currently planned for an effective date of **May 1, 2018**, pending licensure and certification approval. Details of the Change of Ownership are as follows:

**Current Licensee**: Avalon Care Center-Tucson, LLC,
d/b/a Avalon Southwest Health & Rehabilitation
**New Licensee**: Sapphire of Tucson Nursing and Rehab, LLC
d/b/a Avalon Southwest Health & Rehabilitation
**Current Management Company**: Avalon Health Care Management of Arizona, LLC
**New Management Company**: N/A
**New Real Property Owner:** Sapphire of Tucson Properties, LLC
**Proposed Date of Transfer:** May 1, 2018

The key contact for the Change of Ownership licensing process will be Loreli Wright of Husch Blackwell, who serves as co-counsel to the buyer for regulatory requirements. Loreli can be reached directly at (303) 749-7293 or by email at Loreli.Wright@huschblackwell.com.

Marti Kullen, Director of Licensure & Certification, Avalon Health Care Group may be contacted for any questions re: the current licensee. Marti can be reached at (801) 325-0124 or by email at marti.kullen@avalonhealthcare.com.

Sincerely,

Charles R. Kirton

Chairman/CEO
Avalon Health Care, Inc.
on behalf of Avalon Care Center-Tucson, LLC

April 2, 2018

**VIA FAX**
602-792-0466

Medical Facilities Licensing
Arizona Department of Health Services
150 N. 18th Ave., Ste. 450
Phoenix AZ 85007

Re: Letter of Intent – Change of Ownership
License No: NCI-2643
Facility ID: LTC0053

Dear Sir or Madam,

This letter is for a request to issue a new state health care institution license to reflect a planned **change of ownership** of the facility listed below. Attached to this letter please find the following:

1. a completed AZDHS Initial License Application;
2. a completed "Health Care Institution Services Provided" form;
3. a copy of the current license of the facility's administrator;
4. a copy of the facility's Certificate of Occupancy from the City of Tucson;
5. a draft copy of the operator's lease agreement with Sapphire of Tucson Properties, L.L.C. (As soon as the real estate purchase closes, we will provide to you an executed, final copy.); and
6. a copy of the buyer's Articles of Organization.

It is requested that the following information be updated to reflect the change of ownership:

Seller Name: Avalon Care Center – Tucson, L.L.C.
Seller DBA: Avalon Southwest Health and Rehabilitation
Address of Facility: 2900 E. Milber St., Tucson, AZ 85714
Number of Beds: 240
Buyer Name: Sapphire of Tucson Nursing and Rehab, L.L.C.
Buyer DBA: n/a
Anticipated Date of Change of Ownership: May 1, 2018
Administrator Name: William Amoureux, License # 01635

This letter together with the enclosed license application and supporting documents is being submitted April 2, 2018 by fax with a hard copy to follow by mail.

RECEIVED
APR 09 2018
ADHS BUREAU OF MEDICAL FACILITIES LICENSING

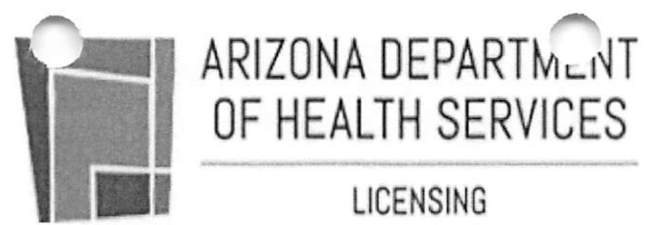
If there are any questions concerning this request, please contact Loreli Wright by email at Loreli.Wright@huschblackwell.com or by telephone 303.749.7293 or Bob Rabecs by email at Bob.Rabecs@huschblackwell.com or by telephone 480.824.7916.

Kindest regards,

Loreli Wright

Loreli D. Wright
Attorney for Applicant
Husch Blackwell LLP

Enclosures




April 4, 2018

Loreli D. Wright
Associate
1801 Wewatta St. Suite 1000
Denver, CO 80202

Dear Ms. Wright:

RE: C HOW application

The Arizona Department of Health Services (Department) has completed an administrative review of the Change of Ownership application (CHOW). The following information and/or documentation is required to complete the CHOW application.

______Current Fire Inspection

______Lease Agreement (if applicable)

______ Management Agreement (if applicable)

___X__ A copy of the IRS Department of The Treasury document to verify the owner's Tax Identification Number

_____ White out or correction tape is used on the initial application (The initial application is being returned. Please submit an initial application without any white out or correction tape.)

__X___ Bill of Sale or other documents verifying sale

___X__ Incorrect fee submitted/ fee not received (R9-10-122)

_____The Projects Construction /Modification has not been approved/release from Architectural review.

______ CMS 855A (if applicable) \

______ HH690 (if applicable) https://www.hhs.gov/civil-rights/for-providers/index.html

______ 1561 Health Insurance Benefit Agreement

If you have any questions about the change of ownership process, please contact the Bureau of Long Term Care at (602) 364-2690

Sincerely,

B Hernandez

Belinda Hernandez,
CSR4/Licensing Certification Specialist

/bh

August 3, 2018

**Receipt Of This Notice Is Presumed To Be 08/03/2018**
**Important Notice - Please Read Carefully**

Loreli D wright, Associate
1801 Wewatta Street Suite 1000
Denver, CO 80202

Dear Ms. Wright:

RE: CHOW application

The Arizona Department of Health Services (Department) has completed an administrative review of the Change of Ownership application (CHOW). The following information and/or documentation is required to complete the CHOW application.

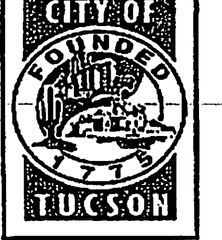
______ Fire Inspection
______ Lease Agreement (if applicable)
_____ Management Agreement (if applicable)
_____ IRS Employer Identification Letter (form SS-4)
__X__ Bill of Sale or other documents verifying sale
_____ Incorrect fee submitted (R9-10-122)
_____ The Projects Construction /Modification has not been approved/release from Architectural review.
_ _X__ CMS 855A Complete Medicare Enrollment Application
__X__ HH690 (if applicable) https://www.hhs.gov/civil-rights/for-providers/index.html
___X__ Fiscal Intermediary recommendation letter
___X___ CMS 1561 - Health Insurance Benefit Agreement
___X___ CMS 671

If you have any questions about the change of ownership process, please contact the Bureau of Long Term Care at (602) 364-2690

Sincerely,

B Hernandez

Belinda Hernandez,
CSR4/Licensing Certification Specialist




# Certificate of Occupancy

## City of Tucson
### Planning and Development Services

**Permit Activity Number: T17OT01223**

Structure Address: 2900 E MILBER ST TUC

Project Description: SKILLED NURSING FACILITY

Square Footage: 68806

Construction Type: VA

Fire Sprinkler System Provided: Y

Occupancy Group: I1,B2,A3

Fire Sprinkler System Required: Y

Applicable Building Code: 1991 UBC

Buiding Owner Information: LA COLINA INVESTORS LLC
ATTN: AVALON HEALTH CARE
255 E 400 S STE 200 SALT LAKE CITY UT 841112868

Design Occupant Load: 0

Zoning Classification: O-3

Land Use Group: Residetial

Building Official

10/29/1992
Issued Date

This certificate is issued pursuant to the requirements of the adopted Tucson Building Code certifying that at the time of issuance, the described project was inspected for compliance with the various ordinances regulating building construction and use.

# State of Arizona

## Board of Examiners of Nursing Care Institution Administrators and Assisted Living Facility Managers

*This is to certify*

# William P Amoureux

*Has been granted license number 01635 as a*

## Licensed Nursing Care Institution Administrator

*Having qualified under A.R.S. Title 36, Chapter 4, Article 6, for certification as a licensed nursing care institution administrator, and is entitled to practice nursing care institution administration in the State of Arizona as of September 11, 2009*

*This license expires on*

***June 30, 2010***

*President*

*Member*

THIS CERTIFIES THAT

**William P Amoureux**

IS THE HOLDER OF LICENSE NUMBER

**01635**

Expires June 30, 2018

Arizona Board of Examiners of
Nursing Care Institution Administrators and
Assisted Living Facility Managers

OMB Exempt

# LONG-TERM CARE FACILITY APPLICATION FOR MEDICARE AND MEDICAID

| Standard Survey: From: F1 *(mm/dd/yyyy)* | To: F2 *(mm/dd/yyyy)* | Extended Survey: From: F3 *(mm/dd/yyyy)* | To: F4 *(mm/dd/yyyy)* |
|---|---|---|---|
| | | | |

| Name of Facility | Provider Number | Fiscal Year Ending: F5 *(mm/dd/yyyy)* |
|---|---|---|
| Sapphire of Tucson Nursing and Rehab LLC | 03-5099 | 12/31/2018 |

Street Address
2900 E Milber St Tucson, AZ 85714

| City | County | State | Zip Code |
|---|---|---|---|
| Tucson | Pima | AZ | 85714 |

| Telephone Number: F6 | State/County Code: F7 | State/Region Code: F8 |
|---|---|---|
| (520) 294-0005 | | |

F9 [0 1]
01 Skilled Nursing Facility (SNF) - Medicare Participation
02 Nursing Facility (NF) - Medicaid Participation
03 SNF/NF - Medicare/Medicaid

Is this facility hospital based? F10 ........................ ○ Yes ◉ No
If yes, indicate Hospital Provider Number: F11 [ | | | | | ]

Ownership: F12 [0 3]

| For-Profit | Non-Profit | Government | |
|---|---|---|---|
| 01 Individual | 04 Church Related | 07 State | 10 City/County |
| 02 Partnership | 05 Nonprofit Corporation | 08 County | 11 Hospital District |
| 03 Corporation | 06 Other Nonprofit | 09 City | 12 Federal |

Owned or leased by Multi-Facility Organization: F13 ........................ ○ Yes ◉ No

Name of Multi-Facility Organization: F14

Dedicated Special Care Units: *(show number of beds for all that apply)*

| F15 AIDS | F16 Alzheimer's Disease | F17 Dialysis |
|---|---|---|
| 0 0 0 | 0 0 0 | 0 0 0 |
| **F18 Disabled Children/Young Adults** | **F19 Head Trauma** | **F20 Hospice** |
| 0 0 0 | 0 0 0 | 0 0 0 |
| **F21 Huntington's Disease** | **F22 Ventilator/Respiratory Care** | **F23 Other Specialized Rehabilitation** |
| 0 0 0 | 0 0 0 | 0 0 0 |

Does the facility currently have an organized residents' group? F24 ........................ ◉ Yes ○ No

Does the facility currently have an organized group of family members of residents? ........................ ◉ Yes ○ No

Does the facility conduct experimental research? F26 ........................ ○ Yes ◉ No

Is the facility part of a continuing care retirement community (CCRC)? F27 ........................ ○ Yes ◉ No

If the facility currently has a staffing waiver, indicate the type(s) of waiver(s) by writing in the date(s) of last approval. Indicate the number of hours waived for each type of waiver granted. If the facility does not have a waiver, write NA in the blanks.

| Waiver of seven day RN requirement: Date: F28 *(mm/dd/yyyy)* | Hours waived per week: F29 | Waiver of 24 hr licensed nursing requirement: Date: F30 *(mm/dd/yyyy)* | Hours waived per week: F31 |
|---|---|---|---|
| | | | |

Does the facility currently have an approved Nurse Aide Training and Competency Evaluation Program? F32 ........................ ○ Yes ◉ No

| Name of Person Completing Form | Time |
|---|---|
| Elisha Atkin | 9:44 AM |
| **Signature** | **Date** |
| [signature] | 08/17/2018 |

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Western Division of Survey and Certification
San Francisco Regional Office
90 7th Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

Refer to: WDSC-RA

**Official Approval Document - Please read carefully and retain for your records.**

November 14, 2018

CMS Certification Number (CCN): 035099

Elisha Atkin, Manager
Sapphire Of Tucson Nursing And Rehab, LLC
2900 East Milber Street
Tucson, AZ 85714

Dear Ms. Atkin:

Based on information forwarded by the Arizona Department of Health Services, the Centers for Medicare & Medicaid Services (CMS) has determined that the above-named Medicare provider has undergone a change of ownership as defined in 42 C.F.R. § 489.18. According to the information available to this office, the ownership changed from Avalon Care Center Tucson. LLC dba Avalon Southwest Health and Rehabilitation to **Sapphire Of Tucson Nursing And Rehab, LLC dba Sapphire Of Tucson Nursing And Rehab, LLC. This change of ownership is effective August 17, 2018**. Your Medicare cost-reporting year is 12/31.

Sapphire Of Tucson Nursing And Rehab, LLC dba Sapphire Of Tucson Nursing And Rehab, Llc entered into a provider agreement with the Secretary of Health and Human Services to participate in the Medicare Program as a Skilled Nursing Facility. Governing regulations specify that when a change of ownership occurs, the existing Medicare agreement is automatically assigned to the new owner. 42 C.F.R. § 489.18(c). The assigned agreement is subject to all applicable statutes and regulations, and is subject to the terms and conditions under which it was originally issued. This includes, but is not limited to, full compliance of the following: all applicable health and safety requirements (including life safety code provisions); full compliance with any existing plan of correction and/or credible allegation of correction/compliance; the ownership and financial interest disclosure requirements of 42 C.F.R. Subpart C; and civil rights requirements set forth in 45 C.F.R. Parts 80, 84, 90, and 42 C.F.R. § 489.18(d). Significantly, therefore, as the new owner you are fully liable for any penalties and sanctions incurred by the previous owner, as well as any Medicare overpayments, (even if such overpayments have yet to be determined). (See 42 U.S.C. § 1395g(a))

Enclosed is a Health Insurance Benefit Agreement Form CMS-1561 which CMS has countersigned.

The State survey agency and/or CMS may inspect your facility to determine your compliance with federal regulations. See 42 C.F.R. Part 488, Subpart A.

At this time you should submit your Medicare claims and all other routine communications concerning Medicare reimbursement matters to the Medicare Administrative Contractor (MAC), Noridian. If this was a change of ownership between related organizations (see 42 C.F.R. § 413.17) the provisions of 42 C.F.R. § 413.134 may preclude re-evaluation of your assets for purposes of Medicare reimbursement.

In accordance with regulations at 42 C.F.R. § 489.18(b), you must notify CMS if you are contemplating or negotiating a future change of ownership, as described at 42 C.F.R. § 489.18(a). All changes must be reported to the Arizona Department of Health Services.

If you have any questions regarding this letter, please call Rosanna Angeldones at 415-744-3735 or Rosanna.Angeldones@cms.hhs.gov.

Sincerely,

Paula Perse, Manager
Certification and Enforcement
Western Division of Survey and Certification

Enclosure: Health Insurance Benefit Agreement

cc: Arizona Department of Health Services
AHCCCS

FORM APPROVED
OMB No. 0938-0832

# HEALTH INSURANCE BENEFIT AGREEMENT

(Agreement with Provider Pursuant to Section 1866 of the Social Security Act, as Amended and Title 42 Code of Federal Regulations (CFR) Chapter IV, Part 489)

## AGREEMENT

between

THE SECRETARY OF HEALTH AND HUMAN SERVICES

and

Sapphire of Tucson Nursing and Rehab LLC

doing business as (D/B/A) Sapphire of Tucson Nursing and Rehab LLC

In order to receive payment under title XVIII of the Social Security Act, Sapphire of Tucson Nursing and Rehab LLC

D/B/A Sapphire of Tucson Nursing and Rehab LLC as the provider of services, agrees to conform to the provisions of section of 1866 of the Social Security Act and applicable provisions in 42 CFR.

This agreement, upon submission by the provider of services of acceptable assurance of compliance with title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 as amended, and upon acceptance by the Secretary of Health and Human Services, shall be binding on the provider of services and the Secretary.

In the event of a transfer of ownership, this agreement is automatically assigned to the new owner subject to the conditions specified in this agreement and 42 CFR 489, to include existing plans of correction and the duration of this agreement, if the agreement is time limited.

ATTENTION: Read the following provision of Federal law carefully before signing.

Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or make any false, fictitious or fraudulent statement or representation, or makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry, shall be fined not more than $10,000 or imprisoned not more than 5 years or both (18 U.S.C. section 1001).

Name Elisha Atkin    Title Manager

Date 8/17/2018

ACCEPTED FOR THE PROVIDER OF SERVICES BY:

NAME *(signature)*

TITLE Manager    DATE 08/17/18

ACCEPTED BY THE SECRETARY OF HEALTH AND HUMAN SERVICES BY:

NAME *(signature)*

TITLE    DATE

ACCEPTED FOR THE SUCCESSOR PROVIDER OF SERVICES BY:

NAME *(signature)*

TITLE    DATE

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0832. The time required to complete this information collection is estimated to average 5 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

# Assurance of Compliance

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. **Title VI of the Civil Rights Act of 1964** (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. **Section 504 of the Rehabilitation Act of 1973** (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of his or her disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. **Title IX of the Education Amendments of 1972** (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. **The Age Discrimination Act of 1975** (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. **Section 1557 of the Affordable Care Act** (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

You have successfully submitted the HHS-690 for your organization. You confirmation number is 15182598

The following information was provided:

| | |
|---|---|
| Date: | 08/20/2018 |
| Name and Title of Authorized Official: | Mr. Elisha Atkin |
| Name of Healthcare Facility Receiving / Requesting Funding: | Sapphire of Tucson Nursing and Rehab LLC |
| Address: | 2900 East Milber avenue<br>Tucson, AZ 85715<br>USA |