**Department of Health and Human Services**
**Division of Public Health**
**Licensure Unit**
**301 Centennial Mall So, P O Box 94986**
**Lincoln, NE 68509-4986**

4/6/16 dg

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH
CERTIFIES THAT

**Tabitha Nursing Center at Crete**
MEETS STATUTORY REQUIREMENTS AS
SNF/NF DUAL CERT

Services
PHYSICAL THERAPY
OCCUPATIONAL THERAPY
SPEECH THERAPY

Lic # NH0003

**EXPIRES**
03/31/2017

SEAL [redacted]
Courtney A. Phillips, MPA
Chief Executive Officer
Department of Health and Human Services

**Cut on heavy line and place on license.**

FACILITY NAME: Tabitha Nursing Center at Crete
ADDRESS: P O BOX 9, 1540 GROVE STREET, CRETE, NE 68333

This is to verify that your SNF/NF DUAL CERT is licensed through the date indicated on the above renewal card. Place the renewal card in the lower left hand corner of your original license.

Please notify this office at the address listed above of any change in name, address, or ownership.

3-10-15

DHHS NEBRASKA

**Expiration Date**
03/31/2016

# NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
## DIVISION OF PUBLIC HEALTH
## Licensure Unit

# Nursing Home Licensure Renewal Application

Make Payment to DHHS LU
Renewal Fees:
1 - 50 beds: $1550
51 - 100 beds: $1750
101 or more: $1950

Nursing Home Type: Please Check ☑ Skilled Nursing Facility ☐ Nursing Facility ☐ Intermediate Care Facility

## IDENTIFYING INFORMATION

1. NAME AND ADDRESS OF FACILITY:

Tabitha Nursing Center at Crete
P O BOX 9, 1540 GROVE STREET
CRETE, NE 68333

2. PREFERRED MAILING ADDRESS (IF DIFFERENT FROM FACILITY ADDRESS) FOR THE RECEIPT OF OFFICIAL NOTICES FROM THE DEPARTMENT:

c/o: TABITHA, INC.
ATTENTION: CFO
4720 RANDOLPH STREET
LINCOLN NE 68510

LICENSURE UNIT
MAR 29 2016
RECEIVED

LICENSE NO: NH0003
TELEPHONE NUMBER: (402) 826-6800
FAX NUMBER: (402) 826-6827
ADMINISTRATOR: SHERRI DUE
DIRECTOR OF NURSING: MICHELLE HUNTER, R.N.
E-Mail Address, If available: TNCCadministration@tabitha.org

3. FEDERAL EMPLOYER IDENTIFICATION NUMBER OF THE FACILITY: __

2016 APR 1 A 10:43
REGULATION & LICENSING

4. NUMBER OF BEDS TO BE RELICENSED: 44

5. ACCREDITATION/CERTIFICATION: ☐ JCAHO ☑ Medicare ☑ Medicaid ☐ Other _____
Are you requesting deemed status? ___yes ___ no

6. SPECIAL CARE AND TREATMENT SPECIFICALLY FOR THE FOLLOWING GROUPS:
If different from Current Services listed, please check changes.

☑ Physical Therapy ☐ Alzheimers/Special Care Unit ☑ Speech Therapy
☐ Pediatric ☐ Respiratory ☑ Occupational Therapy
☐ Behavioral Needs

**Current Services**
PHYSICAL THERAPY
OCCUPATIONAL THERAPY
SPEECH THERAPY

## OWNERSHIP INFORMATION

7. OWNERSHIP OF FACILITY: TABITHA INC.
(Legal Name of individual or business organization)

MAILING ADDRESS: 4720 RANDOLPH STREET
LINCOLN, NE 68510

8. BUSINESS ORGANIZATION: (Check one):
_____ Sole Proprietorship
_____ Partnership
_____ Limited Partnership
__✓__ Corporation
_____ Limited Liability Company
_____ Governmental ( _____ State, _____ District, _____ County, _____ City or Municipal)
_____ Other (Please Specify) _____

(check one)
☐ Profit ☑ Non Profit

### CERTIFICATION

I/we have read the Rules and Regulations issued by the Nebraska Department of Health and Human Services and will comply with them should a license be issued. I/we certify that to the best of my/our knowledge, all information and statements on the application are true and correct and I/we hereby apply for a renewal license.

**PLEASE NOTE: Neb.Rev.Stat. Section 71-433 requires: Applications shall be signed by**
**(1) the owner, if the applicant is an individual or partnership,**
**(2) two of its members, if the applicant is a limited liability company,**
**(3) two of its officers, if the applicant is a corporation, or**
**(4) the head of the governmental unit having jurisdiction over the facility to be licensed, if the applicant is a governmental unit.**

Christie Hinrichs, President/CEO
AUTHORIZED REPRESENTATIVE - TYPE OR PRINT

[redacted]
SIGNATURE

DATE

Joyce Ebmeier, VP Strategic Planning
AUTHORIZED REPRESENTATIVE - TYPE OR PRINT

SIGNATURE

3-29-16
DATE

# NEBRASKA STATE FIRE MARSHAL

# OCCUPANCY PERMIT

**Certificate Number: 402983**

| | |
|---|---|
| Name of Facility: | **Tabitha Nursing Center at Crete** |
| Type of Facility: | **Nursing Home** |
| Location: | **1540 Grove St., Crete** |
| Maximum Occupancy: | **44 Beds** |
| Date Issued: | **3/10/2015** |

Approved By: [redacted]

Inspected By: **8748 Mark Manchester**
**Deputy State Fire Marshal**

**State Fire Marshal**

## POST IN PROMINENT PLACE

Change in occupancy classification or failure to meet State Fire Marshal codes shall invalidate this occupancy permit.

Department of Health & Human Services
DHHS
NEBRASKA

Nebraska Department of Health and Human Services

# NEBRASKA OWNERSHIP/CONTROLLING INTEREST AND CONVICTION DISCLOSURE

Completion of this form is required, as mandated by the Centers for Medicare and Medicaid Services, Department of Health and Human Services, and applicable regulations as found at 42 CFR 455.100 through 42. CFR 455.106. Disclosure must be made at the time of enrollment or contracting with the Department, at the time of survey, or within 35 days of a written request from the Department. It is the provider's responsibility to ensure all information is accurate, complete, and signed; and to report any changes as required by law by completing a new Ownership and Disclosure form.

## IDENTIFYING INFORMATION

| Name of Entity: (Legal name as it appears on tax identification form) | | | Provider Number (If currently enrolled in NE Medicaid): |
|---|---|---|---|
| Tabitha, Inc | | | [redacted] |
| Doing Business As: | | | NPI Number |
| Tabitha Nursing Center of Crete | | | 1679630792 |
| Street Address: | City: | State: | Zip Code: |
| 1540 Grove Avenue | Crete | Nebraska | 68333- 1749 |
| Telephone Number: | Fax Number: | E-mail Address: | |
| 402-486-8506 | 402-486-8578 | | |

**A.** Expanded Address Information: Corporate entities must provide, as applicable, primary business address, every business location, and P.O. Box address. *If more space is needed attach a separate list including the required information.*

| | |
|---|---|
| Primary Business Address | Address |
| P.O. Box Address | Address |
| Other Business Locations | Address |
| Other Business Locations | Address |

**B.** List the name, address, Federal Tax Identification Number (FTIN) (for corporations) or Social Security Number (SSN) and Date of Birth (DOB) (for persons) with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more. *If more space is needed attach a separate list including the required information.*

| Name | | Address | % Interest |
|---|---|---|---|
| SSN/FTIN | DOB | | |
| Name | | Address | % Interest |
| SSN/FTIN | DOB | | |
| Name | | Address | % Interest |
| SSN/FTIN | DOB | | |
| Name | | Address | % Interest |
| SSN/FTIN | DOB | | |

**C.** Are any of the above mentioned persons related to one another as a spouse, parent, child, or sibling? *If more space is needed attach a separate list including the required information.*

☐ Yes ☐ No If yes, please name and show relationship.

| Name | | Relationship |
|---|---|---|
| SSN | DOB | |
| Name | | Relationship |
| SSN | DOB | |
| Name | | Relationship |
| SSN | DOB | |

**D.** List any person who holds a position of managing employee within the disclosing entity.
*If more space is needed attach a separate sheet with the required information.*

| Name | Position Title |
|---|---|
| Christine Hinrichs | President/Chief Executive Officer |
| Darcie Brink | Chief Financial Officer |
| Joyce Ebmeier | Senior VP of Strategic Planning Communications |
| Sherri Due | Administrator |

**E.** Does any person, business, organization or corporations with an ownership or control interest (identified in A or B) have an ownership or controlling interest of 5% or more in any other Nebraska Medicaid Provider? *If more space is needed attach a separate sheet with the required information.*

☐ Yes ☒ No If yes, please name and show information.

| Name | SSN/FTIN | DOB | Other Provider Name | % Interest |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**F.** List any person (identified in A, B, or C) who has an ownership or control interest in the disclosing entity (provider), or is an agent or employee of the disclosing entity (provider) who has ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Waivers, CHIP or the Title XX services since the inception of these programs.
*If more space is needed attach a separate sheet with the required information.*

| Name | SSN | DOB | Conviction Details |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**PROVIDER STATEMENT**. I certify that information provided on this form is true, accurate and complete. I will notify Nebraska Department of Health and Human Services of any additions/changes to the information

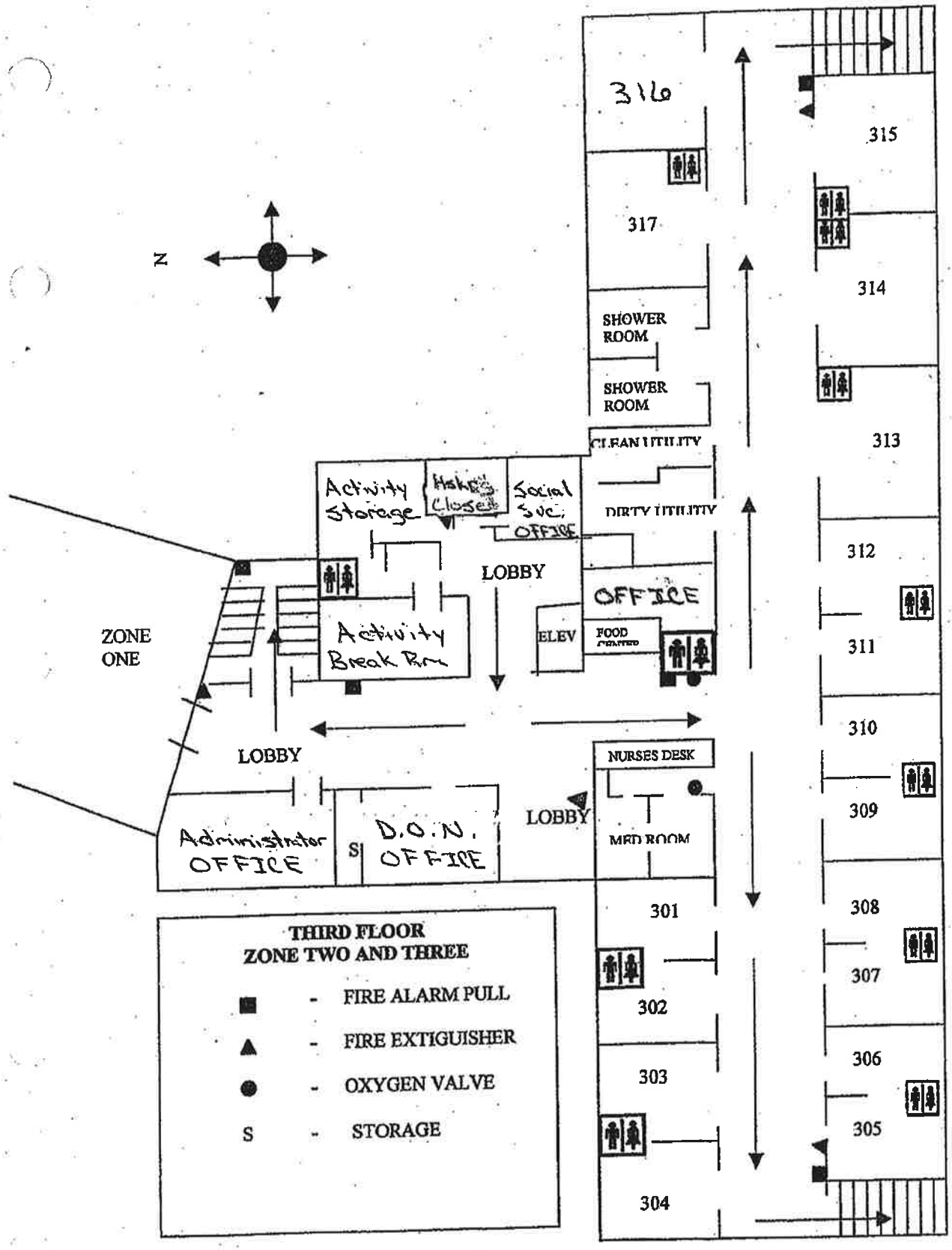
Sign Here [redacted], Director of Patient Financial Services

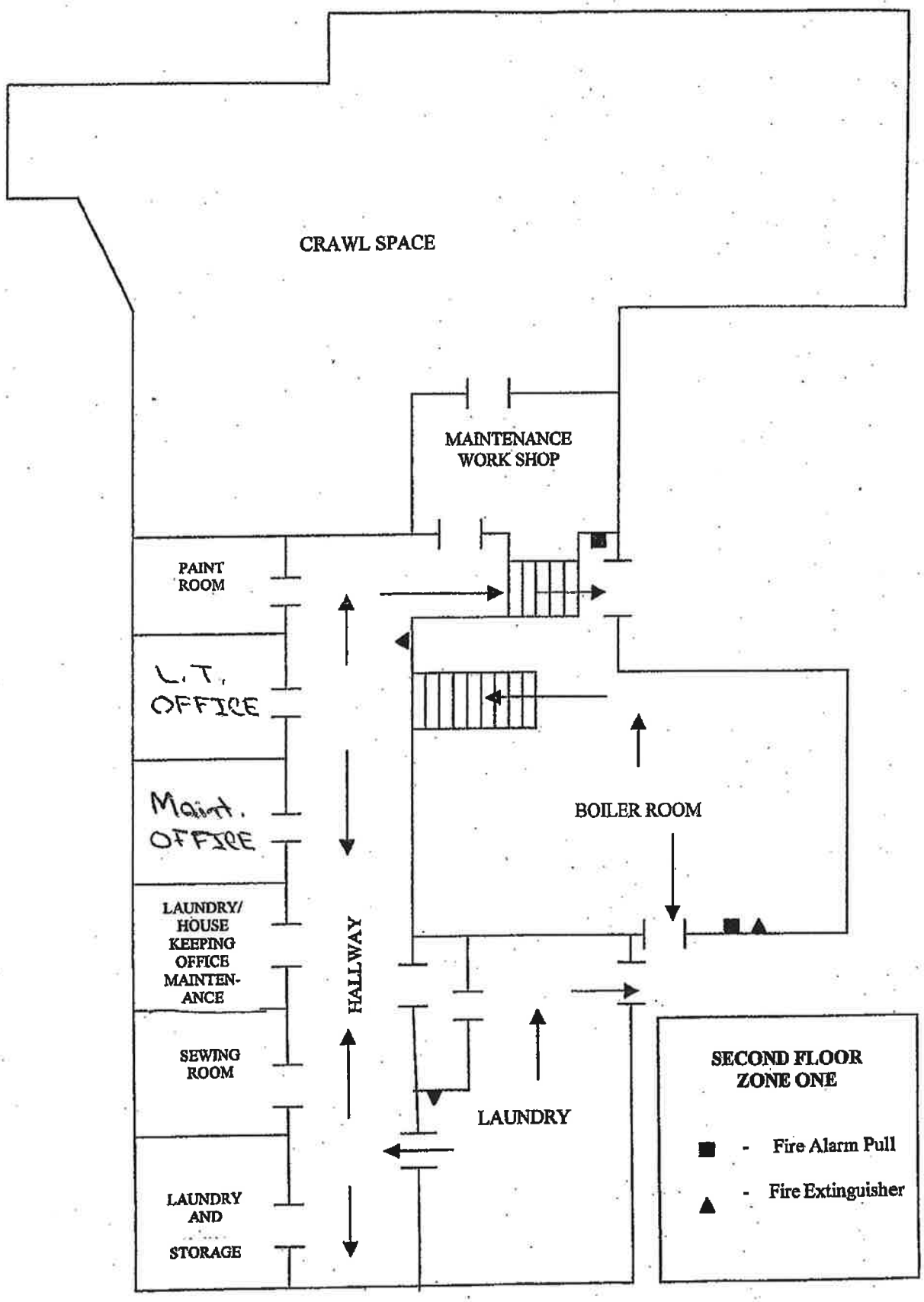
Signature of Provider/Authorized Representative/Agent and Title (Stamped Signature NOT Accepted)

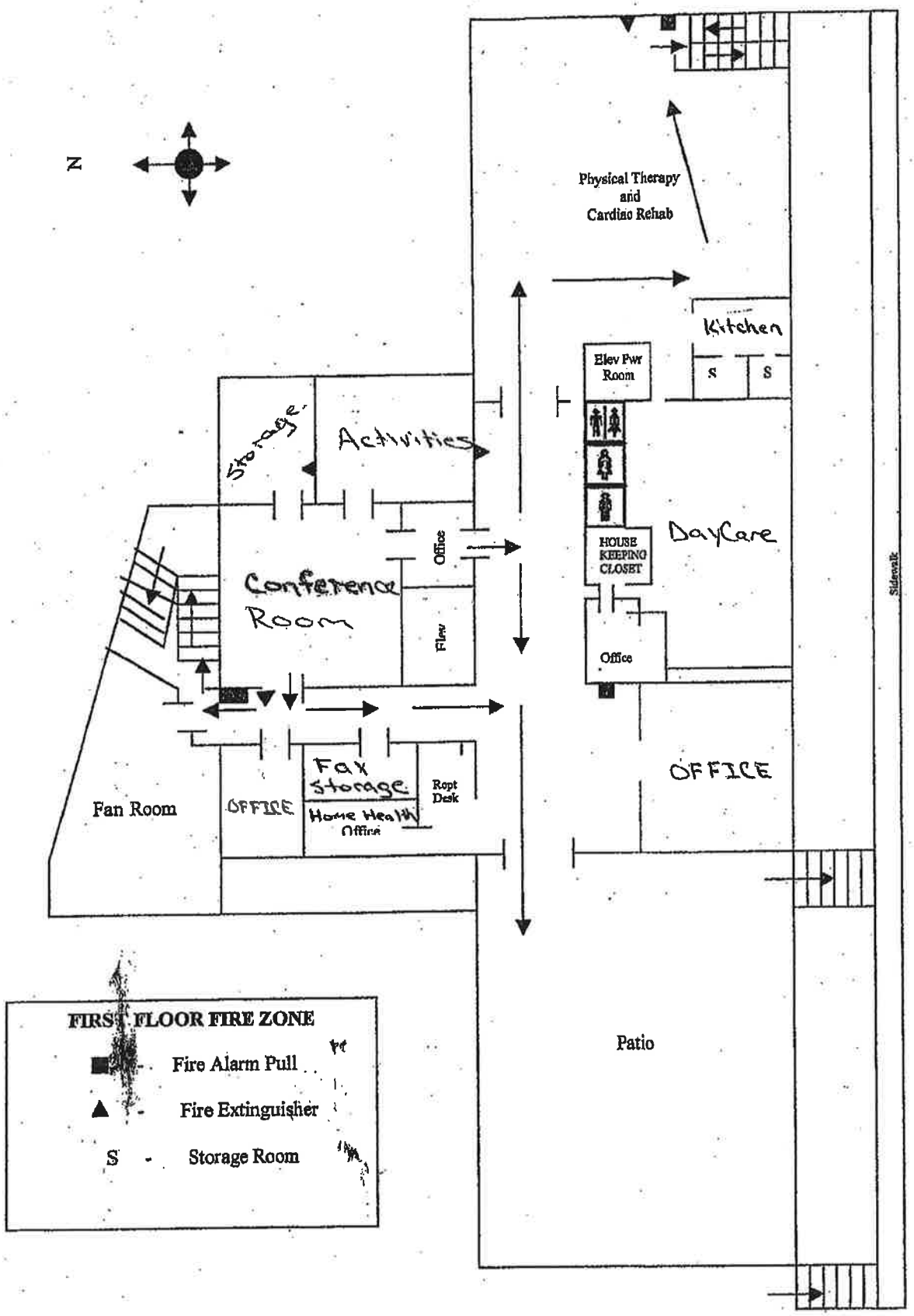
Sarah Friedman — Print Name

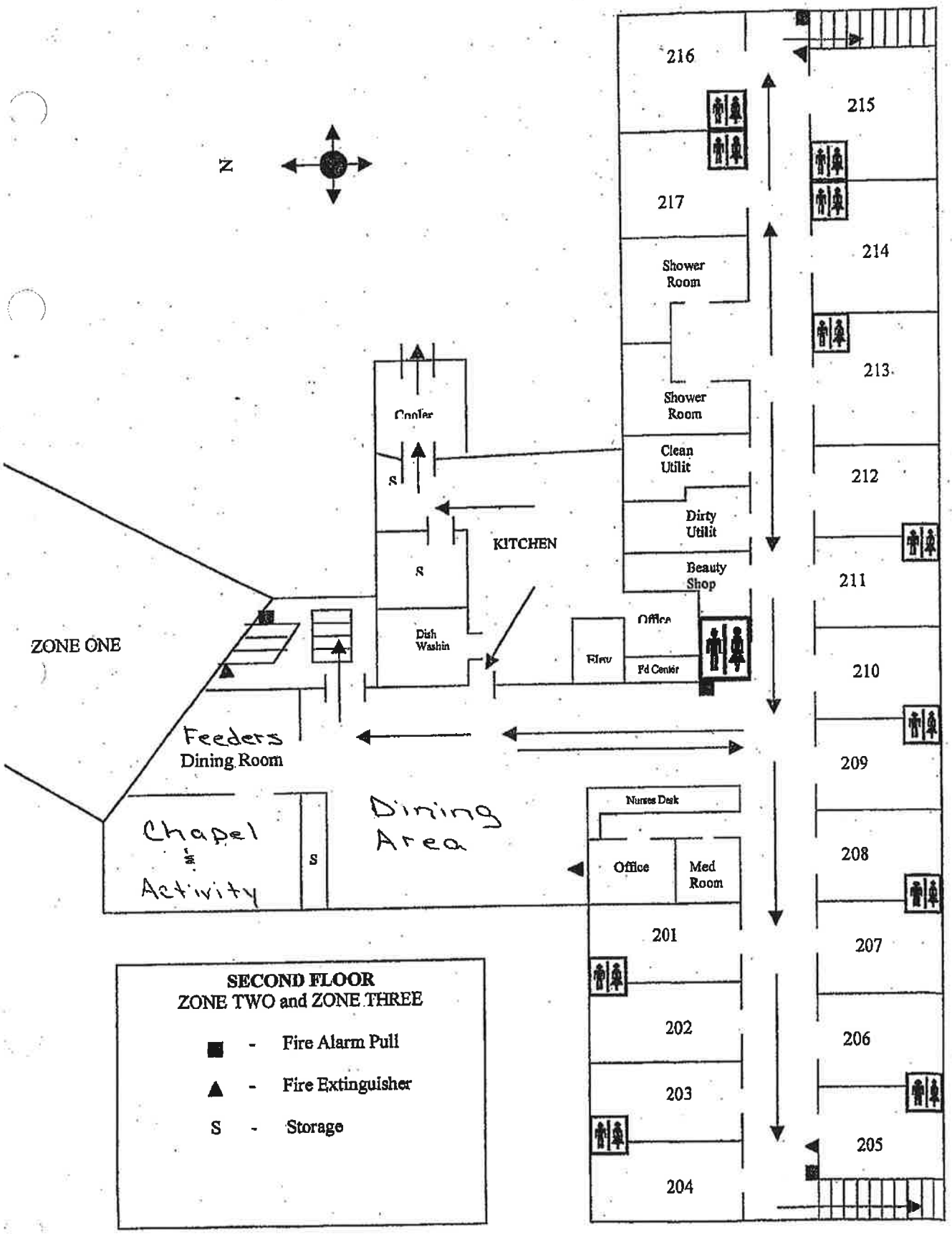
03/29/2016 — Date

(402) 484-9651 — Phone Number


N
316
315
317
314
SHOWER ROOM
SHOWER ROOM
CLEANUTILITY
313
Activity Storage
Social Svc. OFFICE
DIRTY UTILITY
312
LOBBY
OFFICE
ZONE ONE
Activity Break Rm
ELEV
311
310
LOBBY
NURSES DESK
LOBBY
Administrator OFFICE
S
D.O.N. OFFICE
MED ROOM
309
301
308
307
302
306
303
305
304
THIRD FLOOR
ZONE TWO AND THREE
- FIRE ALARM PULL
- FIRE EXTIGUISHER
- OXYGEN VALVE
S - STORAGE


CRAWL SPACE
MAINTENANCE WORK SHOP
PAINT ROOM
L.T. OFFICE
Maint. OFFICE
LAUNDRY/ HOUSE KEEPING OFFICE MAINTEN-ANCE
SEWING ROOM
LAUNDRY AND STORAGE
HALLWAY
BOILER ROOM
LAUNDRY
SECOND FLOOR ZONE ONE
- Fire Alarm Pull
- Fire Extinguisher


N
Physical Therapy
and
Cardiac Rehab
Kitchen
Elev Pwr
Room
S
S
Storage
Activities
DayCare
HOUSE
KEEPING
CLOSET
Office
Conference
Room
Filer
Office
Fax
Storage
Rcpt
Desk
Fan Room
OFFICE
Home Health
Office
OFFICE
Patio
Sidewalk
FIRST FLOOR FIRE ZONE
Fire Alarm Pull
Fire Extinguisher
S - Storage Room


N
216
215
217
214
Shower Room
213
Shower Room
Cooler
Clean Utilit
212
KITCHEN
Dirty Utilit
Beauty Shop
211
Office
Elev
Fd Center
ZONE ONE
Dish Washin
210
Feeders Dining Room
209
Nurses Desk
Dining Area
Chapel & Activity
Office
Med Room
208
201
207
202
206
203
205
204
SECOND FLOOR
ZONE TWO and ZONE THREE
- Fire Alarm Pull
- Fire Extinguisher
S - Storage