

Participation in Medicare Part A Skilled Nursing Facility (SNF) Co-Insurance Application

1. Facility Information

Name of Facility Ignite Medical Resort Round Rock, LLC		DADS Issued Provider No.	County Williamson
Address (Street, City, State, ZIP) 16219 Ranch Road 620 N, Austin, TX, 78717			
Mailing Address (If Different)			
Business Address (Used for Warrants) 1550 N Northwest HWY STE 430, Park Ridge, IL, 60068			
Facility Telephone No. (512) 520 - 1834	Facility FAX Telephone No. (737) 202 - 4399	Facility Internet Address tjf@ignitemedicalresorts.com	No. of Certified SNF Beds 70

2. Type of Application

<input type="checkbox"/> New	_____ Effective Date	<input checked="" type="checkbox"/> Ownership Change	<u>04/01/2022</u> Effective Date	<input type="checkbox"/> Stock Transfer	_____ Effective Date
<input type="checkbox"/> Merger	_____ Effective Date	<input type="checkbox"/> Relocation	_____ Effective Date	<input type="checkbox"/> Update	_____ Effective Date

3. Business Owner-Applicant Entity Information

Name of Owner-Applicant (Legal Business Name, exactly as chartered or otherwise legally declared.) Ignite Medical Resort Round Rock, LLC		
Owner Mailing Address (Street, City, State, ZIP) 1550 N Northwest HWY STE 430, Park Ridge, IL, 60068		
Telephone No. (630) 327 - 2951	FAX Telephone No. () -	E-Mail Address tjf@ignitemedicalresorts.com
Type of Ownership Entity		
<input type="checkbox"/> Corporation	<input type="checkbox"/> Church	
<input type="checkbox"/> Federal, State, County or City	<input type="checkbox"/> General Partnership	
<input type="checkbox"/> Hospital District/Authority	<input checked="" type="checkbox"/> Limited Liability Corporation	
<input type="checkbox"/> Limited Liability Partnership	<input type="checkbox"/> Limited Partnership	
<input type="checkbox"/> Sole Proprietor	<input type="checkbox"/> Trust	
<input type="checkbox"/> Other (Specify): _____		
Owner Applicant Fiscal Year Ending 12/31/2022	<input type="checkbox"/> Non-Profit <input checked="" type="checkbox"/> For Profit	
Name of Contact Person of Applying Entity Timothy Fields	Title of Contact Person Manager	
Telephone No. of Contact Person (630) 327 - 2951	FAX Telephone No. () -	Internet Address tjf@ignitemedicalresorts.com

This application does not authorize participation and creates no obligation on the part of Texas Department of Aging and Disability Services (DADS). Only after the applicant business entity supplies a complete application to include Form 3601, Form 3603, Form 4108, required legal entity documents as outlined in application cover letter and attachments, will the facility and applicant receive confirmation of final enrollment. At that time, a Vendor Number and Payee Identification Number will be supplied, which enables reimbursement payment to the business/owner.

I understand that as a condition for continued participation, the information supplied in this application must be kept up-to-date and current.



Timothy Fields
Printed Name

5/5/22

Date

Manager

Title/Relationship of Signer