

emailed validation letter  
4/30/12

**Application for License to  
Operate a Long-term Care Facility**

For Office Use Only  
Received 4.23.12  
Amount \$1830.-

Ch #  
6047

**I. IDENTIFICATION**

Name LP Morgantown, LLC d/b/a Morgantown Care & Rehabilitation Center  
Address 201 South Warren Street  
City/County/Zip Morgantown, KY 42261-9418  
Telephone number 270-526-3368  
Administrator Tiffany R. Clark  
Date facility operation began at current address \_\_\_\_\_  
Date facility began operation under current owner November 1, 2007

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	_____	_____
Nursing Home	_____	_____
Nursing Facility	<b>122</b>	<b>122</b>
Intermediate Care	_____	_____
ICF/MR	_____	_____
Personal Care	_____	_____

**II. CONTROL** (check one in each column)

State	<input checked="" type="checkbox"/> Profit	Individual
County	<input type="checkbox"/> Nonprofit	Partnership
City		Corporation
<input checked="" type="checkbox"/> Private		<input checked="" type="checkbox"/> LLC

**II. OWNERSHIP**

Name and address of individual owner, partners or corporation. If partnership, list partners.

N/A

\_\_\_\_\_  
\_\_\_\_\_

**RECEIVED**  
APR 23 2012  
OFFICE OF INSPECTOR GENERAL

(OVER)

4/30  
RB

If facility owned or leased by a corporation, complete the following:

Name of corporation LP Morgantown, LLC  
Address of corporation 12201 Bluegrass Parkway, Louisville, KY 40299  
President or Chairman N/A  
Vice President N/A  
Secretary N/A  
Treasurer N/A

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility. **None**

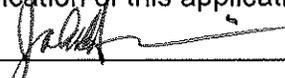
If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation. **None**

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner. **None**

Name and address of parent corporation and/or management company, if applicable.

Parent	Management Company
<u>Signature HealthCARE, LLC</u>	<u>Signature Consulting Service, LLC</u> <u>Signature Clinical Consulting Services, LLC</u>
<u>12201 Bluegrass Parkway</u>	<u>12201 Bluegrass Parkway</u>
<u>Louisville, KY 40299</u>	<u>Louisville, KY 40299</u>

I understand that any change in the application that affects my licensure status will be reported to the Office of Inspector General and a new application will be completed at that time. I agree that this facility and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.

  
Signature of authorized representative

CFO  
Title

4/18/12  
Date

Return Application and fee to:

Office of Inspector General  
275 East Main Street, 5E-A  
Frankfort, Kentucky 40621

OIG 5  
(10/2002)