

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

For Office Use Only Received <u>2/22/12</u> Amount <u>900.00</u>
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007924

I. IDENTIFICATION

Name Ridgeway Nursing & Rehabilitation Facility
P. O. Box 560
 Address _____
 City/County/Zip Owingsville / Bath / 40360
606-674-6613
 Telephone number _____
 Administrator Heather O'Banion
 Date facility operation began at current address 1971
 Date facility began operation under current owner 2001

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	_____	_____
Nursing Home	_____	_____
Nursing Facility	<u>60</u>	<u>60</u>
Intermediate Care	_____	_____
ICF/MR	_____	_____
Personal Care	_____	_____

II. CONTROL (check one in each column)

State	Profit X	Individual
County	Nonprofit	Partnership
City		Corporation X
Private X		

II. OWNERSHIP

Name and address of individual owner, partners or corporation. If partnership, list partners.
Ridgeway Nursing & Rehabilitation, LLC
300 Provider Court, Suite 100
Richmond, KY 40475

(OVER)

<p>RECEIVED</p> <p>FEB 22 2012</p> <p>OFFICE OF INSPECTOR GENERAL</p>

56

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

Name of corporation Ridgeway Nursing & Rehabilitation, LLC
300 Provider Court, Suite 100, Richmond, KY 40475

Address of corporation _____

Member Delbert Ousley, Member

Member John D. Sword, Member

Secretary _____

Treasurer _____

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.

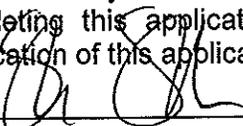
If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner.

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

Parent	Management Company
_____	PMD Corporation
_____	<u>300 Provider Court, Suite 100</u>
_____	<u>Richmond, KY 40475</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.

 _____	CFO	2/1/12
Signature of authorized representative	Title	Date

Return Application and fee to:

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

OIG 5
(10/2002)

Attachment

Schedule of Owners:

Ridgeway Nursing & Rehabilitation Facility

Delbert Ousley	Member	300 Provider Court, Suite 100 Richmond, KY 40475
John D. Sword	Member	300 Provider Court, Suite 100 Richmond, KY 40475
Sena Z. Sword	Member	300 Provider Court, Suite 100 Richmond, KY 40475