

RECEIVED

FEB 25 2013

Application for License to Operate a Long-term Care Facility

For Office Use Only  
Received 2/25/13  
Amount 1800.00

I. OFFICE OF INSPECTOR GENERAL IDENTIFICATION

# 6770

Name LP Taylorsville, LLC d/b/a Signature HealthCARE of Spencer County  
Address 625 Taylorsville Road  
City/County/Zip Taylorsville, KY 40071-7798  
Telephone number 502-477-8838  
Administrator Tim Travis admin.valley@shccs.com  
Date facility operation began at current address  
Date facility began operation under current owner June 1, 2008

| II. TYPE BEDS     | No. beds licensed | No. beds requested |
|-------------------|-------------------|--------------------|
| Skilled           |                   |                    |
| Nursing Home      |                   |                    |
| Nursing Facility  | 120               | 120                |
| 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

Van

2/26

(OVER)

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

Name of corporation LP Taylorsville, 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**

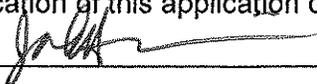
If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation. **None**

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><br><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

2-19-13  
Date

Return Application and fee to:

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

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(10/2002)