

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

For Office Use Only Received <u>10/20/11</u> Amount <u>1860.00</u>
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LP Lexington Pimlico, LLC #4991

I. IDENTIFICATION

Name LP Lexington Pimlico, LLC d/b/a Bluegrass care & Rehabilitation Center
3576 Pimlico Parkway

Address _____

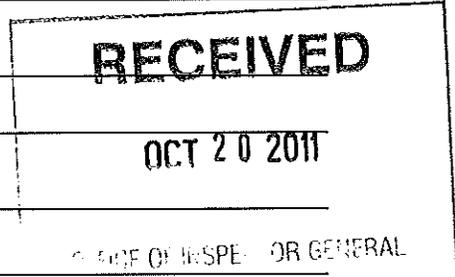
City/County/Zip Lexington/ Fayette/40517
859-272-0608

Telephone number _____

Administrator Jeff Stidham

Date facility operation began at current address _____

Date facility began operation under current owner 09/01/08



II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	_____	_____
Nursing Home	_____	_____
Nursing Facility	<u>124</u>	<u>124</u>
Intermediate Care	_____	_____
ICF/MR	_____	_____
Personal Care	_____	_____

II. CONTROL (check one in each column)

State _____
County _____
City _____

Private

Profit
Nonprofit

Individual
Partnership
Corporation
LLC

II. OWNERSHIP

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

N/A

10/31

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

Name of corporation LP Lexington Pimlico, 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**

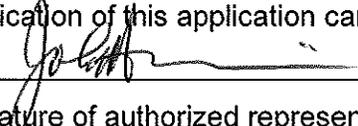
If owned by a partnership, attach a separate sheet listing the names and addresses of each partner. **None**

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

Parent
Signature Healthcare, LLC
12201 Bluegrass Pky
Louisville, KY 40299

Management Company
Signature Consulting Services, LLC
Signature Clinical Consulting Services, LLC
12201 Bluegrass Parkway
Louisville, KY 40299

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

10/10/11

Date

Return Application and fee to:

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

OIG 5
(10/2002)