

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

emailed validation letter

For Office Use Only Received <u>2/18/12</u> Amount <u>\$80.-</u>
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2/28/12
ch# 00109831

I. IDENTIFICATION

Name Monroe Health & Rehabilitation Center

Address 706 North Magnolia Street

City/County/Zip Tompkinsville, Monroe County, Kentucky 42167

Telephone number 270-487-6135

Administrator Mitzy Cook

Date facility operation began at current address 1970

Date facility began operation under current owner 7/1/2005

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	_____	_____
Nursing Home	_____	_____
Nursing Facility	_____	_____
Intermediate Care	_____	_____
ICF/MR	_____	_____
Personal Care	<u>4</u>	_____

III. CONTROL (check one in each column)

State _____	Profit <u>X</u>	Individual _____
County _____	Nonprofit _____	Partnership _____
City _____		Corporation _____
Private <u>X</u>		LLC <u>X</u>

IV. OWNERSHIP

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

New Monroe Health & Rehabilitation Center, LLC
9510 Ormsby Station Road, Suite 101
Louisville, KY 40223

RECEIVED
FEB 10 2012
OFFICE OF INSPECTOR GENERAL

(OVER)

2/28

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

Name of corporation United Rehab Realty Holding, LLC
Address of corporation 10350 Ormsby Park Place, #300, Louisville, KY 40223
President or Chairman _____
Ex. Vice President T. Richard Riney and Raymond Lewis
Secretary T. Richard Riney
Treasurer Brian K. Wood, 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
<u>Senior Care Operations Holdings, LLC</u>	_____
<u>9510 Ormsby Station Road #101</u>	_____
<u>Louisville, Kentucky 40223</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.

Robin Barber
Signature of authorized representative
Robin L. Barber

Vice President
Title

2/7/12
Date

Return Application and fee to:

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

OIG 5
(10/2002)