

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

For Office Use Only Received <u>3/21/12</u> Amount <u>2310.00</u>

#10971

I. IDENTIFICATION

Name Highlands Nursing & Rehabilitation Center
 Address 1705 Stevens Avenue
 City/County/Zip Louisville KY 40205
 Telephone number 502-451-7330
 Administrator KAROLE HAMILTON
 Date facility operation began at current address 3-2006
 Date facility began operation under current owner 3-1-2006

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	<u>154</u>	<u>154</u>
Nursing Home	_____	_____
Nursing Facility	_____	_____
Intermediate Care	_____	_____
ICF/MR	_____	_____
Personal Care	_____	_____

II. CONTROL (check one in each column)

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

II. OWNERSHIP

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

Debby FANNIN

MARCIA GONZALEZ
RECEIVED
 MAR 21 2012
 OFFICE OF INSPECTOR GENERAL

(OVER)

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

Name of corporation Highlands Nursing and Rehabilitation Center, LC
 Address of corporation 6075 Sunset Drive, Suite 201, South Miami, FL
33143
 President or Chairman _____
 Vice President _____
 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
_____	<u>Synergy Healthcare</u>
_____	<u>1835 Miami Gardens Dr. #167</u>
_____	<u>Nb. Miami Beach, FL 33179</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]

 Signature of authorized representative

Administrator 3-19-12

 Title Date

Return Application and fee to:

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