

RECEIVED

APR 11 2013

Application for License to Operate a Long-term Care Facility

For Office Use Only
Received 4/11/13
Amount 1,830.00

OFFICE OF INSPECTOR GENERAL

0000007001

I. IDENTIFICATION

Name LP Morgantown, LLC d/b/a Morgantown Care & Rehabilitation Center
Address 201 South Warren Street
City/County/Zip Morgantown, KY 42261
Telephone number 270-526-3368 (admin.morgantown@shccs.com)
Administrator Logan Midkiff
Date facility operation began at current address
Date facility began operation under current owner 11-1-07

Table with 3 columns: TYPE BEDS, No. beds licensed, No. beds requested. Rows include Skilled, Nursing Home, Nursing Facility (122), Intermediate Care, ICF/MR, and Personal Care.

II. CONTROL (check one in each column)

State, County, City, Private (checked), Profit (checked), Nonprofit, Individual, Partnership, Corporation, LLC (checked)

II. OWNERSHIP

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

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

Name of corporation LP Morgantown, 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

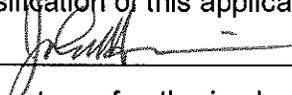
If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation. None

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>LP CR Holdings, LLC</u>	<u>Signature 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

4-5-13

Date

Return Application and fee to:

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

OIG 5
(10/2002)